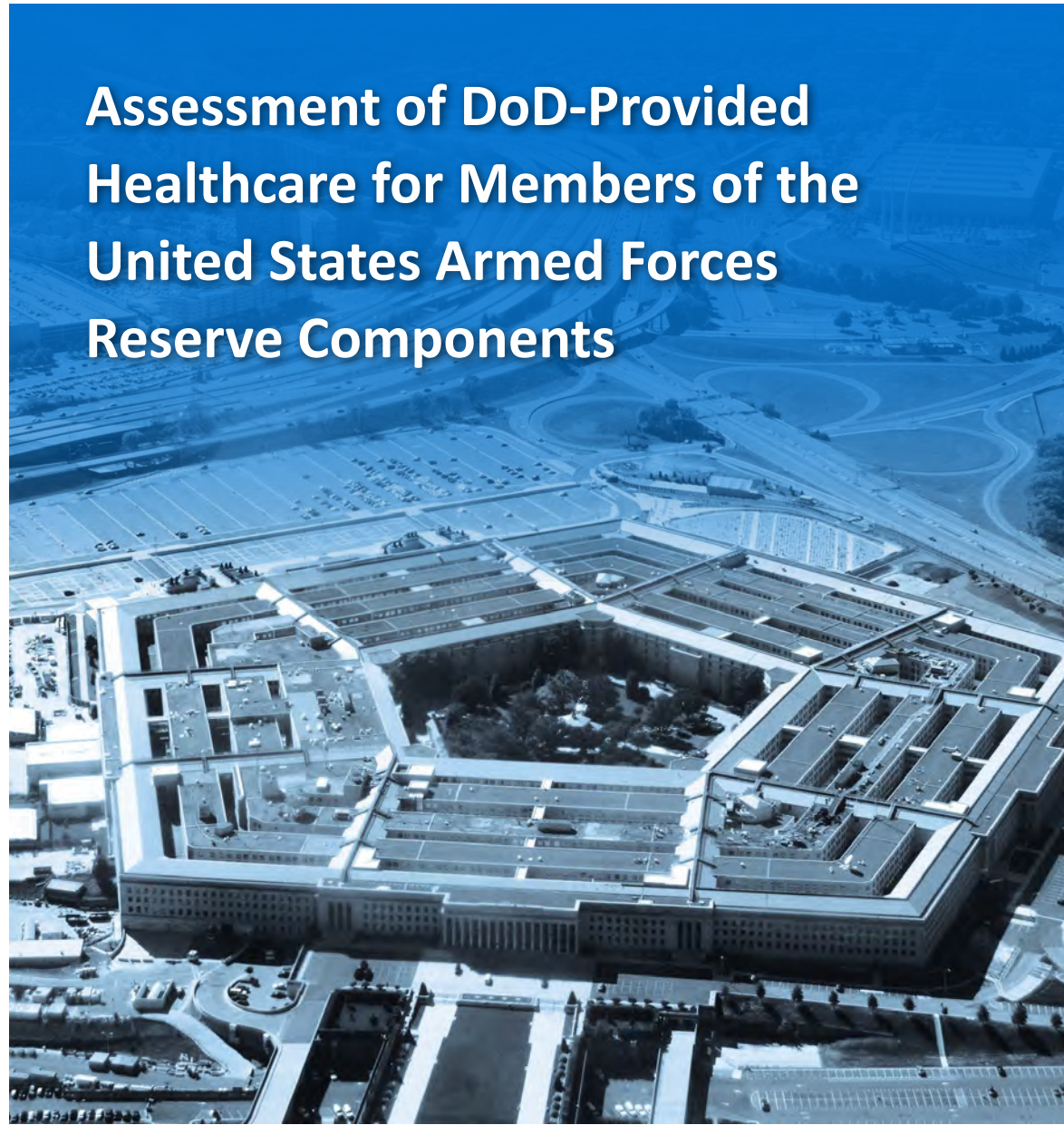




INSPECTOR GENERAL

U.S. Department of Defense

OCTOBER 8, 2014



Assessment of DoD-Provided Healthcare for Members of the United States Armed Forces Reserve Components

INTEGRITY ★ EFFICIENCY ★ ACCOUNTABILITY ★ EXCELLENCE

Report Documentation Page			Form Approved OMB No. 0704-0188		
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1. REPORT DATE 08 OCT 2014		2. REPORT TYPE		3. DATES COVERED 00-00-2014 to 00-00-2014	
4. TITLE AND SUBTITLE Assessment of DoD-Provided Healthcare for Members of the United States Armed Forces Reserve Components			5a. CONTRACT NUMBER		
			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) Department of Defense Inspector General, 4800 Mark Center Drive, Alexandria, VA, 22350-1500			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 Same as Report (SAR)	18. NUMBER OF PAGES 98	19a. NAME OF RESPONSIBLE PERSON
a. REPORT unclassified	b. ABSTRACT unclassified	c. THIS PAGE unclassified			

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Results in Brief

Assessment of DoD-Provided Healthcare for Members of the United States Armed Forces Reserve Components

October 8, 2014

Objective

The objectives of this assessment were to determine whether DoD-provided healthcare programs support pre-deployment medical readiness rates and the efficient and effective post-deployment care of Reserve Component (RC) service members. We examined DoD-provided healthcare programs used to maintain or improve required medical readiness rates and also examined DoD-provided healthcare programs for wounded, ill, and injured members of the RC.

This is a follow-on assessment to six previous Wounded Warrior assessment reports where we noted systemic issues with DoD-provided healthcare programs used by RC service members.

What We Found

We determined that RC service members, when eligible, had access to DoD-provided care to enable units to meet DoD-required individual medical readiness rates. We also determined that line of duty medical care was available to treat wounded, ill, and injured RC service members. However, we determined that delayed or denied access to line of duty care presented a risk, as outlined in this report.

Observations

This assessment identified several issues which, if addressed by DoD and the Military Services, will enhance the overall effectiveness of DoD-provided healthcare programs, help improve the RC's medical readiness rates, and improve care and transition services for wounded, ill, and injured RC members not receiving care at military treatment facilities.

The observations included in this report:

- Active Component (AC) service members transferred to the Reserve Component with medical conditions which limited their deployability or for which they were subsequently found to be non-deployable.
- RC service members who filled deployable billets could not be officially separated (for medical reasons) from the RC when they were found fit-for-duty by a medical board, even though they had medically-related limiting conditions that made them not deployable or only deployable with certain waivers.
- Army RC soldiers (not on active duty), who were issued temporary medical profiles, had limited access to DoD-provided healthcare to be medically evaluated in accordance with Army Regulation 40-501.
- RC service members returned from deployments or temporary duty with missing or incomplete medical histories and line of duty documentation. As a result, deactivated RC service members had to reconstruct medical histories and line of duty documentation in order to receive DoD-provided medical care for wounds, illnesses, and injuries incurred or aggravated while deployed or assigned temporary duty.
- Wounded, ill, and injured RC service members had difficulty accessing authorized medical services at military treatment facilities because different forms were used by each Service to prove line of duty medical entitlements.



Results in Brief

Assessment of DoD-Provided Healthcare for Members of the United States Armed Forces Reserve Components

Recommendations

We recommend the Under Secretary of Defense for Personnel and Readiness:

- Establish guidance that requires all Active Component service members who transfer into the Selected Reserve meet Individual Medical Readiness requirements.
- Develop and implement a plan that ensures Reserve Components' service personnel authorizations allow units to retain service members in accordance with 10 U.S.C. §1214a while meeting unit deployment requirements.
- Develop and implement a plan so that Army Reserve Component service members receive DoD-provided medical evaluations of temporary medical profiles in accordance with AR 40-501.
- Establish policy that assigns responsibilities to Commanders and medical authorities to manage medical histories and line of duty documentation for deployed or temporary duty RC service members in a standardized manner across all Services, so that both are complete and available to their units in a timely manner.
- Establish standardized DoD form(s) and procedures that provide access for all RC service members to line of duty care at all military treatment facilities.

Management Comments and Our Response

The Under Secretary of Defense for Personnel and Readiness provided all comments to this report. Management concurred with all recommendations.

Based on management comments, we redirected Recommendations 1, 3, 4, and 5 to the office of Undersecretary of Defense for Personnel and Readiness.

The DoD IG requests that the Under Secretary of Defense for Personnel and Readiness provide additional information to Recommendations 1, 2, and 3 of this report by more concisely describing the actions and projected timelines planned to accomplish the intent of the Recommendations.

Please provide comments to this final report by November 10, 2014. Management comments to the draft report are included, beginning at page 81 of this report.

Recommendations Table*

Management	Recommendations Requiring Comment	No Additional Comments Required
Under Secretary of Defense for Personnel and Readiness	1, 2, 3	4, 5

*Total recommendations in this report: 5

Please provide comments by November 10, 2014.





**INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
4800 MARK CENTER DRIVE
ALEXANDRIA, VIRGINIA 22350-1500**

October 8, 2014

MEMORANDUM FOR: UNDERSECRETARY OF DEFENSE FOR PERSONNEL AND READINESS
ASSISTANT SECRETARY OF DEFENSE FOR RESERVE AFFAIRS
ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

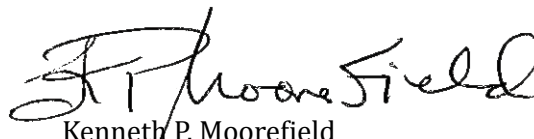
SUBJECT: Assessment of DoD-Provided Healthcare for Members of the United States
Armed Forces Reserve Component (Report No. DoDIG-2015-002)

We are providing this report for information and appropriate action. This report assesses how DoD-provided healthcare programs enable the Guard and Reserve to meet required DoD readiness rates. It also provides an assessment of how DoD-provided healthcare programs support wounded, ill, and injured Guard and Reserve members who are not receiving medical care at active duty military treatment facilities.

We considered management comments to a draft of this report when preparing the final report. Comments from the Under Secretary of Defense for Personnel and Readiness (USD(P&R)), to include comments on behalf of both the Assistant Secretary of Defense for Reserve Affairs and the Assistant Secretary of Defense for Health Affairs, were responsive and concurred with all recommendations. However, we request that USD (P&R) provide additional information regarding actions, planned or undertaken, with projected timelines to meet the intent of Recommendations 1, 2, and 3 of this report.

Please provide comments that conform to the requirements of DoD Directive 7650.3. If possible, send your comments in electronic format (Adobe Acrobat file only) to SPO@dodig.mil. Copies of your comments must have the actual signature of the authorizing official for your organization. We are unable to accept the /Signed/ symbol in place of the actual signature. If you arrange to send classified comments electronically, you must send them over the SECRET Internet Protocol Router Network (SIPRNET). We should receive your comments by November 10, 2014.

We appreciate the courtesies extended to our staff. Please direct questions to [REDACTED] or [REDACTED]. We will provide a formal briefing on the results if management requests.


Kenneth P. Moorefield
Deputy Inspector General
Special Plans and Operations



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Introduction

Objectives

The objective of this assessment was to determine the adequacy of policies and regulations governing the provision of healthcare to members of the Reserve Components.¹

Specifically, the assessment was conducted to determine whether:

- DoD-provided healthcare supports Guard and Reserve pre-deployment medical readiness rates so that the Guard and Reserve maintain required operational capabilities and provide strategic depth to U.S. forces to meet the U.S. defense requirements.
- DoD-provided healthcare supports efficient and effective, post-deployment care for Guard and Reserve who become wounded, ill, and injured.

Background

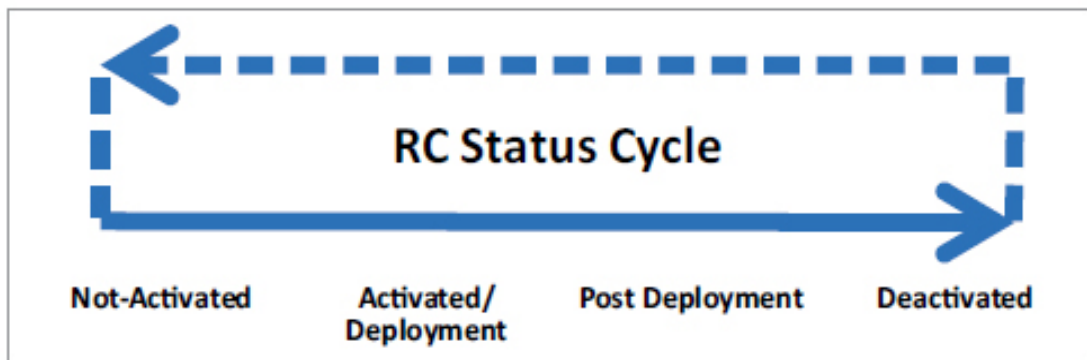
Federal law and DoD policies establish that programs will be in place to support the medical and dental readiness of Reserve Component (RC) service members so they comply with Individual Medical Readiness (IMR) requirements.

Federal law and DoD policies also establish that programs will be in place to provide medical and dental care to RC service members for all wounds, illnesses, and injuries incurred or aggravated in the line of duty until they have recovered.

Reserve Component Service Status

The status of RC service members' service status is cyclical in nature and can generally be broken down into four phases. Figure 1 (page 1) displays the RC status cycle and its four phases. Also, the accompanying Table 1 (page 2) explains the Reserve Component Member Status Cycle.

Figure 1. RC Status Cycle



Source: DoD IG-SPO.

¹ See Appendix D for a detailed description of the Reserve Components.

Table 1. Reserve Component Member Status Cycle Explanation

RC Status	Description
Not-Activated	RC service members' primary responsibilities are training and preparing for mobilization. The RC service member is typically in drilling status, but has not been activated for a period of more than 30 days. Most RC members perform 38 days of military duty per year (monthly 2-day drills + 14-days active duty training).
Activated/Deployment	RC service members are considered to be on active duty. The RC service member is on active duty orders for a minimum of 30 days which includes deployments.
Post Deployment	The RC service member has returned from active duty tour and is going through the de-activation process. RC service members are still considered to be on active duty, however their primary mission is complete, and the member is generally on reconstitution time and accrued leave.
Deactivated	The RC service member has been released from active duty (REFRAD). RC service members are no longer considered to be on active duty.

RC service members receive different DoD-provided healthcare entitlements in each different RC status. Table 2 (page 2-3) outlines the entitlements for each status.

Table 2. RC Status and DoD-Provided Healthcare Entitlements (Refer to Appendix E)

RC Status	DoD-Provided Healthcare	Entitlement
Not-Activated	Civilian Care (Not DoD-Provided)	The RC service member may have private or public healthcare insurance available or be uninsured. Qualified members may also receive care through the Veterans Administration.
	TRICARE Reserve Select	A premium-based healthcare insurance plan available to qualified selected Reserve members of the ready Reserve. (Refer to Appendix D)
	TRICARE Dental	Worldwide dental care plan offered to eligible beneficiaries by the Department of Defense through the TRICARE Management Activity.
	Reserve Health Readiness Program	A Department of Defense, Health Affairs program designed to supplement the RC by providing Periodic Health Assessment (PHA), Post-Deployment Health Reassessment (PDHRA), and other IMR services that satisfy key deployment requirements.
	TRICARE 180-Day Early Benefit	RC service members in receipt of valid mobilization orders are eligible for military health benefits under the TRICARE Early Eligibility Program – for up to 180 days prior to mobilization.
	Line of Duty Care	RC service members may be covered by Line of Duty care for a wound, illness, or injury determined to be incurred or aggravated while in a qualifying duty status or while traveling to or from the place of duty. Qualifying status may include inactive duty (drill) funeral honors duty, or active duty.

RC Status	DoD-Provided Healthcare	Entitlement
Activated/ Deployment	Mobilization Processing Sites	The Army, Navy, and Marine Corps mobilize and demobilize through specific locations that provide additional medical care to facilitate the mobilization and demobilization process.
	TRICARE Prime	TRICARE Prime and TRICARE Prime Remote provide comprehensive health coverage, including enhanced preventive care and vision benefits, without the cost of a premium.
	TRICARE through end of Active Duty Status	While activated for a period of more than 30 consecutive days, RC service members are covered as active duty service members. Upon reaching their final (mobilization/deployment) station for activation or deployment, they can enroll in TRICARE Prime, TRICARE Prime Remote.
	In-theater Support	While in-theater the RC service member receives the same medical and dental support as their active component counterparts.
Post Deployment	TRICARE Prime	The RC member is covered by TRICARE Prime or TRICARE Prime Remote until all accrued leave and compensatory time expires and the RC member officially comes off orders.
	Extension of Active Duty	RC service members can be recalled to active duty or have their current orders extended to receive authorized medical care and treatment.
Deactivated	Transitional Assistance Management Program	TAMP provides 180 days of transitional healthcare benefits after RC service members come off eligible mobilization or deployment orders.
	Line of Duty Care	RC service members receive medical treatment for wounds, illnesses, or injuries incurred or aggravated in the line of duty.

Source: Defense Health Agency

Individual Medical Readiness Rates

DoDI 6025.19, “Individual Medical Readiness (IMR),” June 9, 2014, established IMR requirements for units and individuals of the Active and Selected Reserve Components. IMR rates provide operational commanders and service leaders with a summary of the medical status of the force. IMR rates are assessed against six elements (listed below) of health and fitness used to determine the deployment availability of units and individuals. The IMR elements are:

- Periodic Health Assessments (PHA),
- deployment-limiting medical and dental conditions,
- dental assessment,

- immunization status,
- medical readiness and laboratory studies, and
- Individual medical equipment.

Each Military Department assesses and develops procedures to report the overall IMR status of each service member according to the following categories:

- Fully Medically Ready – service members who are current in PHA (completed), dental readiness classification² (DRC) 1 or 2, immunization status, medical readiness and laboratory studies, individual medical equipment; and without any deployment limiting medical conditions.
- Partially Medically Ready – service members who are lacking one or more immunizations, medical readiness laboratory studies, and/or individual medical equipment.
- Not Medically Ready – service members with a chronic or prolonged deployment-limiting medical or mental health condition. These conditions may also include hospitalization, recovery or rehabilitation time from a serious illness or injury, and/or individuals in DRC 3.
- Medical Readiness Indeterminate - Inability to determine a service members' current health status because of missing health information such as a lost medical record, an overdue PHA and/or being in DRC 4.

According to information provided by the Defense Health Agency (DHA), using the aforementioned six elements cited in DoDI 6025.19, the combined Reserve Component IMR rate remained below the targeted goal of 75 percent from CY 2009 through CY 2013.³ Refer to Figure 2 (page 5).

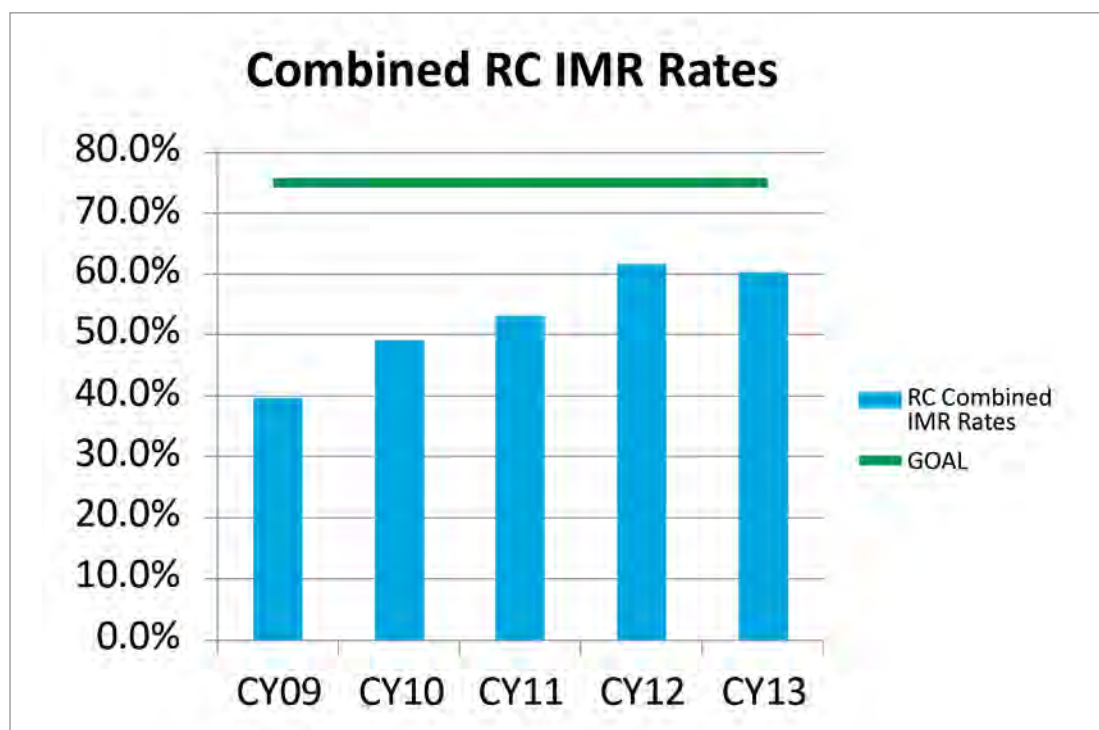
² DRC 1- service members with a current dental examination who do not require dental treatment or reevaluation and are world-wide deployable in regards to dental health. DRC 2 – service members with a current dental examination who require non-urgent dental treatment or reevaluation for oral conditions that are unlikely to result in dental emergencies within 12 months and are world-wide deployable in regards to dental health. DRC 3- service members who require urgent or emergent dental treatment and are normally not considered world-wide deployable. DRC 4- service members' dental readiness classification is undetermined by virtue of being overdue for their annual dental examination.

³

COMPO/YEAR	2009	2010	2011	2012	2013
ARNG	28%	38%	42%	54%	52%
USAR	22%	38%	43%	52%	46%
USNR	79%	80%	84%	84%	85%
ANG	78%	79%	80%	81%	82%
AFRC	70%	82%	84%	83%	86%
MARFORRES	53%	57%	63%	68%	70%

Source: Defense Health Agency.

Figure 2. Combined Reserve Component Individual Medical Readiness Rates



Source: Defense Health Agency

Not maintaining the targeted IMR rates put RC service members at risk of being not fully medically ready. Also, low IMR rates risked either delays in required deployments or the inability to deploy required units.

Scope

Given the scope of this project, we determined that we would assess first the Guard and Reserve units and members located in the continental United States (CONUS). We intended to assess units and RC service members outside CONUS if the report process indicated a unique requirement to do so, which it did not.

Methodology

First, our data collection process involved obtaining each RC IMR rate from DHA.

We then reviewed documents such as Federal laws and regulations, the National Defense Authorization Act, Chairman of the Joint Chiefs of Staff instructions, DoD directives and instructions, and relevant service directives, instructions, and orders.

We also reviewed previous reports from the Government Accountability Office (GAO), DoD IG, RAND, and the DoD Recovering Warrior Task Force. This review included six recent DoD IG assessments of Wounded Warrior matters with respect to RC service members who were assigned or attached to Wounded Warrior organizations.

Finally, we conducted site visits and interviews throughout the CONUS as shown in Figure 3 below. Appendix A provides the list of organizations we contacted through site visits, teleconferences, and requests for information.

Figure 3. Sites Visited or Contacted (Refer to Appendix A, Scope and Methodology)



Source: DoD IG SPO.

What We Found

Support of Individual Medical Readiness Rates

According to the Defense Health Agency (DHA), the combined RC IMR rate for calendar years 2009 through 2013 remained below the established DoD goals.

During our assessment we determined that RC service members, when eligible, had access to DoD-provided care to enable RC units to meet IMR requirements. TRICARE (Defense Health Agency) offered the majority of these programs. We also observed breaks in RC Service members' eligibility for TRICARE coverage, depending on their service status. Breaks in eligibility resulted in RC service members losing access to DoD-provided healthcare.

However, the TRICARE Reserve Select healthcare insurance plan could be used by RC service members to continue healthcare coverage during breaks in eligibility. While TRICARE Reserve Select was available, it was voluntary and required the payment of premiums by the RC service members. We did not assess the effect of non DoD-provided healthcare on RC service members' medical readiness.

We noted that current Service policies and procedures authorized AC service members who were not medically deployable to transfer into RC units. Furthermore, federal law prohibits the involuntary separation of RC service members found fit-for-duty but not deployable. These circumstances could potentially contribute to the lowering of IMR rates for RC units.

Support of Wounded, Ill, and Injured

We also found that DoD-provided line of duty medical care⁴ to restore wounded, ill, and injured RC service members to a medical status that satisfied IMR requirements. However, their access to line of duty medical care entitlements was at risk of either being delayed or denied because of administrative requirements such as incomplete medical histories or line of duty documentation. Consequently, some RC service members received delayed healthcare or were denied access to DoD-provided healthcare.

⁴ Line of duty medical care are DoD-provided entitlements available to RC service members who incurred or aggravated wounds, illnesses, and injuries in the line of duty, while on active duty, or due to other qualifying service status.



Noteworthy Practices

During this assessment we observed five noteworthy practices. Each of these five practices positively affected DoD's ability to support RC medical readiness rates so that the Guard and Reserve maintained operational capabilities and provided depth to meet U.S. defense requirements. Notable practices observed included:

- RCs' consistent provision of qualified service members available for active duty,
- TRICARE's coverage of RC service members throughout the entire RC Status Cycle,
- Services' medical care provided at mobilization and demobilization processing sites,
- Services' management of the Individual Ready Reserve, and
- DoD's authorization for non-DoD medical provider approval on Medical Forms DD 2807-1 and DD 2813.

Reserve Components' Consistent Provision of Qualified Service Members Available for Active Duty

This noteworthy practice addresses RCs' consistent provision of qualified personnel available for active duty mission requirements.

In accordance with section 10102, title 10, United States Code (10 U.S.C. § 10102 [2011]), the RCs consistently provided units and qualified personnel available for active duty. RC units reported minimal deployment limitations due to medical issues, despite having IMR rates lower than DoD required. The units replaced non-deployable service personnel with deployable service personnel from within their units or from other units.

TRICARE Coverage throughout the Entire Reserve Component Status Cycle

TRICARE healthcare entitlements were available to RC service members throughout the entire RC Status Cycle. (Refer to Table 2 on page 2-3 for a listing of each TRICARE entitlement available in each service status). Appendix F provides further information about TRICARE.

At a minimum, RC service members were eligible for TRICARE medical and dental care 180 days prior to activation, during activation, and 180 days after deactivation. TRICARE also provided line of duty medical care entitlements to RC Service members who became wounded, ill, and injured while on active duty or other qualifying status.

The TRICARE Reserve Select healthcare insurance plan provided continued healthcare coverage to RC service members during breaks in eligibility. TRICARE Reserve Select is available to all members of the Selected Reserve who are not on active duty, not covered by the Transitional Assistance Management Program, and not eligible for, or enrolled in the Federal Health Benefits program.

Different component Reserve Surgeons reported that, in their opinion, TRICARE Reserve Select was a viable medical insurance option compared to non-DoD procured insurance.

DHA reported a steady overall increase in TRICARE Reserve Select enrollment numbers. The TRICARE Reserve Select total enrollment rose from approximately ten thousand to over one hundred thousand between October 2007 and January 2014. This enrollment included Selected Reserve service members and their family members. Also, according to DHA, TRICARE Reserve Select provides the minimum essential coverage required under the Affordable Care Act. Appendix F provides an explanation of TRICARE Reserve Select.

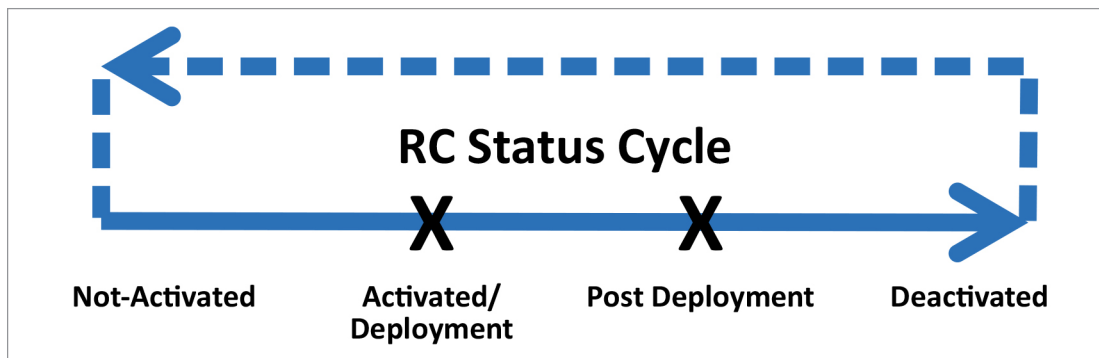
However, TRICARE Reserve Select healthcare insurance is:

- voluntary,
- requires payment of insurance premiums, and
- only available to qualified Selected Reserve members and their families.

Services' Medical Care Provided at Mobilization and Demobilization Sites

This noteworthy practice addresses services' medical care provided to RC service members at mobilization and demobilization sites. These medical services are vital to the RC service members while in the Activated/Deployment and Post-Deployment phases of the RC Status Cycle as shown in Figure 4 (page 11). Appendix G explains medical services available for mobilization/demobilization deployment/redeployment.

Figure 4. RC Status Cycle



Source: DoD IG-SPO.

U.S. Army, Navy, and Marine Corps mobilization site medical services positively affected the services' ability to achieve required medical readiness rates for operational deployment requirements. These medical services also ensured post-deployment/demobilization care for wounded, ill, and injured RC service members.

U.S. Army Soldier Readiness Processing Centers

The Army's Soldier Readiness Processing (SRP) Centers ensured RC soldiers met specific medical and dental requirements prior to activation or deployment. The centers also provided treatment and follow-up care for redeploying or deactivating wounded, ill, and injured RC soldiers. The SRP Centers also processed active duty soldiers and deploying civilian contractors.

The SRP Centers either remedied soldiers' deployment limiting conditions or had the conditions waived if possible. This was usually done within 25 days of soldiers' arrival to the SRP centers. RC soldiers were released from active duty (REFRAD),⁵ and subsequently not deployed, whenever the SRP Centers could not remedy the deployment limiting conditions or have them waived.

SRP Centers assessed re-deploying units approximately 120 days prior to the unit's re-deploying date to determine the requirements to support the returning unit.⁶ The SRP Center conducted post-deployment health assessments and supplied returning RC soldiers with individualized treatment plans for wounds, injuries, and illnesses suffered during their deployment. This included making the determination of whether the RC soldier should be transferred to a Warrior Transition Unit,⁷ finalizing any line of duty documentation, and ensuring RC soldiers had access to medical treatment upon being deactivated.

⁵ Release from Active Duty (REFRAD), Activated RC service members who are found ineligible to remain on active duty.

⁶ In some instances, RC Service members are returned from deployment early to allow adequate time to remedy required medical conditions while the RC member is still on active duty orders.

⁷ The mission of a Warrior Transition Unit is to successfully transition soldiers and their families back to the Army or to civilian life, through a comprehensive program of medical care, rehabilitation, professional development, and achievement of personal goals.



Figure 5. Airmen Complete Re-Deployment Medical Requirements, Grissom ARB, Indiana
Source: Grissom Air Reserve Base Public Affairs

Notably, in some instances, certain RC service members were actually returned early from their deployment to the SRP Center to allow adequate time to remedy medical conditions while the member was still on active duty orders.

U.S. Navy and Marine Corps Mobilization and Demobilization Processing Sites

The Navy and Marine Corps mobilization processing sites also ensured RC service members met specific medical requirements during activation or prior to deployment. The sites also provided treatment and follow-up care for wounded, ill, and injured RC service members during deactivation or redeployment. Prior to activation or deployment, the mobilization processing sites attempted to remedy RC service members' deployment limiting conditions. In the event a remedy was unavailable, the mobilization processing site either attempted to secure a waiver for the non-deployable condition or released the member from active duty and the deployment.

Both the Navy and Marine Corps processing sites could generally prepare all RC service members to deploy and the sites' medical disqualification rates were usually less than 2 percent.

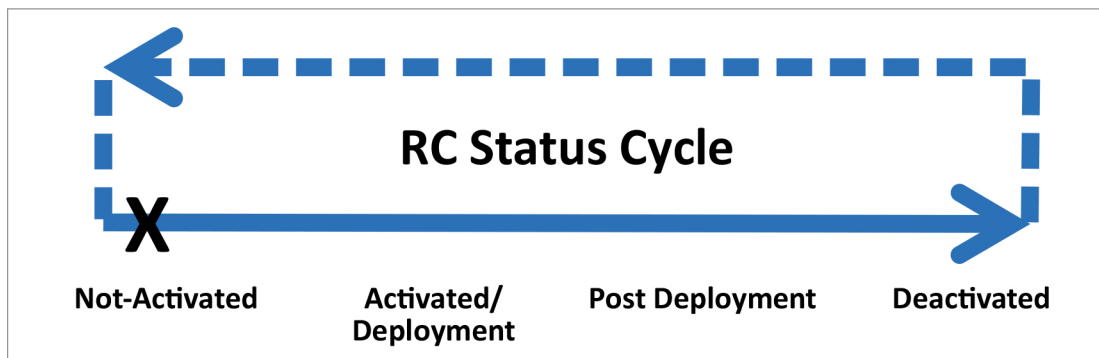
Upon returning from deployment, the mobilization processing sites conducted RC service members' post deployment health assessments. The mobilization processing sites used the assessments to determine whether returning RC service members should be retained on active duty orders to receive necessary medical treatment for wounds, illnesses, and injuries incurred or aggravated while in the line of duty. The sites also aided the RC service member in obtaining documentation required for line of duty determinations.

Overall, processing centers ensured that RC service members met specific medical and dental requirements upon activation and prior to deployment, if any. They also provided treatment and follow-up care during re-deployment for wounded, ill, and injured RC service members.

Services' Management of the Individual Ready Reserve

This noteworthy practice addresses the Services' medical management of the Individual Ready Reserve (IRR). This medical management is vital to the IRR while in the Not-Activated status in the RC Status Cycle shown in Figure 6 below. Appendix D provides an explanation of the IRR.

Figure 6. RC Status Cycle



Source: DoD IG-SPO.

The Army and Marine Corps medical management of their IRR personnel positively affected the IRR's ability to manage its medical readiness in order to meet required operational deployment capabilities.

The Army used a selective approach to monitor the medical readiness of their IRR. The Army reported that one-third of their estimated 91,000 to 92,000 IRR members muster⁸ yearly. During these musters, IRR members completed their Periodic Health Assessments (PHA) and annual dental examinations through the Army Reserve PHA program and Army Selected Reserve Dental Readiness System.

⁸ A muster is an assembling of troops in order to conduct a specific task.

These services were primarily contracted through the Reserve Health Readiness Program (RHRP). Appendix H provides an explanation of PHAs and Appendix I provides an explanation of the RHRP.

Likewise, the Marine Corps Individual Reserve Support Activity (MCIRSA)⁹ managed an estimated 68,000 IRR Marines. MCIRSA focused on members who were in the IRR from 6 months after their active duty contract expired to 2 years after joining the IRR. MCIRSA ensured this group of IRRs had their DD Form 2807, “Report of Medical History” completed every 2 years and that all post-deployment health reassessments were completed. MCIRSA assisted these IRR members in obtaining any required line of duty determination documentation. MCIRSA also provided IRR Marines access to DoD medical providers during musters.

MCIRSA primarily managed this group of IRRs with the use of musters. Musters were typically conducted at Marine training centers and involved approximately 100 to 150 IRR Marines. Larger musters were typically conducted at hotels or Veterans Affairs (VA) venues and involved approximately 800 to 1,000 IRR Marines. MCIRSA generally conducted 10 to 12 large musters per year with the support of \$2 million provided by the Headquarters Marine Corps, Program and Resources office.

MCIRSA used specific criteria to select IRR Marines for muster. Muster criteria included home of record, time served in the IRR, and combat veteran status. MCIRSA also selected the Marines who needed medical examinations or documentation updated.

Overall, selective mustering of the IRR was an effective approach to monitor the medical readiness of the IRR.

DoD’s Authorization for Non-DoD Medical Provider Approval on Medical Forms DD 2807-1 and DD 2813

During our assessment, we noted RC service members who did not reside geographically close to their units or to military treatment facilities. These members had limited access to DoD medical providers for timely approval of medical forms required to verify medical status. Allowing non-DoD (private or Veterans Administration) medical providers to approve the DD 2813 “Active Duty, Reserve, Guard, Civilian Forces Dental Examination” and DD 2807-1 “Report of Medical History” was a noteworthy practice that had a positive impact on units’ ability to keep RC service members’ medical status current.

⁹ MCIRSA was generally able to provide one DoD medical provider per muster. This medical provider generally accomplished 30 to 40 complete physical screenings per muster.

DD 2813 is used to record the assessment of a RC service member's dental health. The form also records determination of fitness for prolonged military duty without access to dental care. DD 2807-1 records the medical history of a RC service member and is used to determine whether RC service members incurred any medical events causing them to be non-deployable or not fit for duty. Authorizing non-DoD medical providers to sign both of these forms greatly alleviated RC service members' challenge of keeping their medical status current.



Observation 1

Active Duty to Selected Reserve Transfer

Active Component (AC) service members transferred into the Selected Reserve¹⁰ with medical conditions which limited their deployability or for which they were subsequently found non-deployable.

This occurred because established medical entrance criteria used by the Services did not prevent the transferring of medically-limited or non-deployable AC service members to the Selected Reserve.

As a result, medically limited or non-deployable AC service members transferred to the Selected Reserve, which decreased Individual Medical Readiness (IMR) rates.

¹⁰ The Selected Reserve includes those units and individuals within the Ready Reserve designated as so essential to initial wartime missions, that they have priority over all other Reserves.

Applicable Criteria

DoDI 6025.19, "Individual Medical Readiness (IMR)," June 9, 2014 requires quarterly reports summarizing the IMR status of all Service members, officer and enlisted, of the Active Component and Selected Reserve. It also states that the presence of a potentially deployment limiting medical condition renders a service member not medically ready (non-deployable).

DoDI 6130.03, "Medical Standards for Appointment, Enlistment, or Induction in the Military Services," April 28, 2010, explains that it is DoD policy to "ensure that individuals under consideration for appointment, enlistment, or induction into military services are medically adaptable to the military environment without the necessity of geographic area limitations."

DoDI 6490.07, "Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees," February 5, 2010, directs Secretaries of the Military Departments to ensure that DoD personnel who occupy deployable positions maintain a high state of pre-deployment health and medical readiness.

Each Service has established medical criteria for service members currently in the AC to transfer into the RC.

- Army: Army Regulation 601-280, "Army Retention Program," 2006, with rapid action revision in 2011, paragraph 7-4, states that soldiers fully eligible to re-enlist in the Regular Army based on their last physical examinations are qualified to join the RC without regard to the date of

their last physical examination.¹¹ However, as of May 27, 2014, a request to change this regulation was under review by Headquarters, Department of the Army G-1, to ensure soldiers' PHAs are up to date and soldiers meet re-enlistment requirements in order to transfer from the AC to the RC.

- Navy: COMNAVCRUITCOMINST 1131.2E, "Navy Recruiting Manual - Officer," 2011, and COMNAVCRUITCOMINST 1130.8J "Navy Recruiting Manual - Enlisted," 2011 designate active duty Navy service members who separated less than 6 months who meet the following criteria are able to transfer to the RC with no further medical review required:
 - The member is physically qualified for separation from the AC.
 - The member is not changing designators (job specialty).
 - The member has no factors that would limit world-wide assignment of deployability.
 - The member does not have a VA disability compensation pending.
- Marine Corps: NAVMED P-117 Article 15-22, "Manual of the Medical Department," May 10, 2014 states that all applicants to the Marine Corps Selected Reserve who have transferred from the AC within the previous 6 months of separation must:
 - Provide a copy of their DD Form 2807-1¹² completed prior to separation from the RC as well as an updated DD Form 2807-1, (both DD Forms 2807-1 must be reviewed by an appropriate medical examiner),
 - receive a physical examination and appropriate laboratory tests, and
 - complete a retention package if any new or previously existing medical condition has arisen or significantly changed since separation from AC.
- Air Force: Air Force Instruction 48-123, "Medical Examinations and Standards," November 5, 2013, Chapter 7, 7.5.2.2. explains that AC members transferring to the Air Reserve Component require a mandatory medical examination. The AF 422¹³ is used to document transferring members' retention qualifications. Also, AC members with current periodic health assessments will complete a DD 2697¹⁴ within 180 days of transfer.

¹¹ AR 601-280, paragraph 7-4 states that soldiers fully eligible to reenlist in the Regular Army based on their last physical examination are qualified to join the RC without regard to the date of the last physical examination. Soldiers who have a permanent profile resulting in a disqualification for duty in their primary military occupational specialty (MOS) must have the results of an MOS medical retention board authorizing retention in the Active Army.

¹² DD Form 2807-1 is a Report of Medical History.

¹³ AF 422 is a Physical Profile Serial Report.

¹⁴ DD 2697 is used to provide a comprehensive medical assessment for AC and RC members separating or retiring from AD.

Discussion

Despite established AC-to-RC transfer criteria, medically-limited or non-deployable AC service members have been allowed to transfer into Selected Reserve units. While transferring, these AC members may not be in violation with DoDI 6130.03 and DoDI 6490.07; however, this is at variance with IMR rate goals.

DoDI 6025.19 states that the presence of a potentially deployment limiting medical condition renders a service member not medically ready (non-deployable). IMR rate goals are established against the overall medical readiness (deployability) of the Selected Reserve. Therefore, Selected Reserve service members who are not medically ready (non-deployable), lower the IMR rates.

DoDI 6130.03 directs that individuals under consideration for appointment, enlistment, or induction into Military Services are medically adaptable to the military environment without the necessity of geographical area limitations. DoDI 6490.07 directs that the Military Departments ensure that DoD personnel who occupy deployable positions maintain a high state of pre-deployment health and medical readiness.

Several RC unit commanders noted that the transfer of AC service members with deployment limiting conditions into Selected Reserve units degraded their unit IMR rates. According to established IMR requirements, any service member with a deployment limiting condition cannot be rated fully-medically-ready.

RC medical leaders and staff members interviewed expressed concern about AC service members with deployment limiting conditions being transferred to the RC. During our assessment, one Reserve Component Surgeon explained that the medical criteria for transferring AC service members to the RC were not as stringent as the criteria required for personnel entering military service for the first time. He also explained that AC service members who transferred into RC units with medical conditions degraded RC units' readiness rates.

Another Reserve Component Surgeon expressed essentially the same concern - that many AC service members joined the RC with medical conditions limiting their deployability. A headquarters medical staff at an RC base also stated that a number of AC service members who were not medically deployable had been allowed to transfer into RC units.¹⁵

¹⁵ This headquarters-level medical staff was responsible for managing all medical activities for all RC members assigned to the base visited during this assessment.

Another Reserve Component Surgeon's staff recommended that the medical condition of AC personnel requesting transfer to the RC should be better monitored. They pointed out that the occurrence of transitioned AC-to-RC service members initiating line of duty (LOD)¹⁶ medical care arrangements at their very first RC drill activities was not uncommon.

When these types of AC to RC personnel actions occur, in accordance with DoDI 6025.19, service members with a deployment limiting condition will be assessed as not-medically-ready. As a result, the assignment of these service members rated as not-medically-ready lowers the RC unit's individual medical readiness rates.

Conclusion

Each Service had established medical criteria for service members currently serving in the AC to transfer into the RC. However, it was evident that, even with established criteria, AC service members with deployment limiting conditions were not restricted from transferring into the RC. Consequently, transferring AC service members who were rated as not-medically-ready put their RC units at risk of not meeting DoD-required IMR rates.

Recommendations, Management Comments, and Our Response

Redirected Recommendation

Recommendation 1 was originally directed to the Assistant Secretary of Defense for Reserve Affairs ((ASD(RA))) for response. The Under Secretary of Defense for Personnel and Readiness ((USD(P&R))) responded on behalf of ASD(RA) and requested we redirect the recommendation to their office, which we have done.

Recommendation 1

We recommend that the Under Secretary of Defense for Personnel and Readiness establish guidance that requires all Active Component service members who transfer into the Selected Reserve meet Individual Medical Readiness requirements.

¹⁶ Line of duty medical care is authorized for wounds, illnesses, and injuries incurred or aggravated while on active duty or in a qualified status.

Under Secretary of Defense for Personnel and Readiness

USD(P&R) concurred with comment to Recommendation 1. USD(P&R), responding for ASD(RA) stated that each Service implemented AC to RC transfer policies based on DoDI 6130.03.

USD(P&R) also stated that DoDI 1200.15, "Assignment to and Transfer Between Reserve Categories, Discharge from Reserve Status, Transfer to the Retired Reserve, and Notification of Eligibility for Retired Pay," 13 March, 2014, clarified the requirements for Service members to be physically fit before being able to transfer or access into the Selected Reserve.

Our Response

Comments from USD(P&R) were partially responsive. While concurring with the recommendation, the response did not address some of the actions required in the recommendation.

DoD IG acknowledges that each Service has established AC to RC transfer policy based on DoDI 6130.03. However, despite established AC-to-RC transfer criteria, we found that medically-limited or non-deployable AC service members transferred into the Selected Reserve.

USD(P&R) also stated that the policy noted in DoDI 1200.15 clarified the requirements for Service members to be physically fit before being able to transfer or assess into the Selected Reserve. DoDI 1200.15, Enclosure 3, states that Ready Reserve¹⁷ membership may be obtained by transfer as required on release from active duty under section 651 and 10145 of title 10, United States Code (10 U.S.C. §§ 651 & 10145 [2012]).

Section 651 of 10 U.S.C., "Members: required service" does not specifically address or clarify the need for service members to be physically fit before being able to transfer or access into the Selected Reserves. Likewise, section 10145 of 10 U.S.C., "Ready Reserve: placement in" does not specifically address or clarify the need for service members to be physically fit before being able to transfer or assess into the Selected Reserves.

In response to the final report, we request that USD(P&R) describe its plan to establish guidance that directs the Services to establish criteria and procedures that will ensure AC service members who transfer into the Selected Reserve meet IMR requirements.

¹⁷ The Ready Reserve is the primary manpower pool of the reserve components. The Ready Reserve consists of three reserve component subcategories: Selected Reserves, Individual Ready Reserves, and Inactive National Guard. Refer to Appendix D.



Observation 2

Fit-for-Duty versus Deployability

Reserve Component service members – who filled deployable billets – could not be involuntarily separated when they were found fit-for-duty by a medical board, even though they had medical conditions which limited their deployability.

This occurred because section 1214a, title 10, United States Code (10 U.S.C. § 1214a [2012]) prohibits the separation of a service member who has been determined fit-for-duty but unsuitable for deployment. Also, DoDI 1332.38, “Physical Disability Evaluation,” 2013, prescribes that deployment limiting conditions will not be the sole basis for fit-for-duty determination.

As a result, unit IMR rates and operational deployment capabilities were degraded by retaining RC service members who were found fit-for-duty but not deployable or only deployable with certain medical waivers.

Applicable Criteria

Section 1214a, title 10, United States Code prohibits the involuntary separation or denial of reenlistment of service members who have been determined by a Physical Evaluation Board (PEB) to be fit-for-duty, but were also determined to be unsuitable for deployment or worldwide assignment.

DoDI 1332.38 designates that the “inability to perform duties in every geographic location, and under every conceivable circumstance, will not be the sole basis for a finding of unfitness.”

DoDI 6025.19 established IMR requirements for units and individuals of the Active and Reserve Components.

DoDI 6490.07 directs that Service Secretaries shall ensure that DoD personnel, who occupy deployable positions, maintain a high state of pre-deployment health and medical readiness.

Discussion

Several RC unit commanders we interviewed reported that the PEB¹⁸ fitness evaluations had found service members fit-for-duty while they had medically-related deployment limiting conditions. According to DoDI 1332.38,

¹⁸ AR 40-501 explains that soldiers who receive medical or surgical care, or are recovering from wounds, illnesses, and injuries, are managed with temporary medical profiles.

a service member may be fit-for-duty, but deployment limited. DoDI 1332.38 states that “when a service member’s office, grade, rank, or rating requires deployability, and the member’s medical condition prevents positioning the member outside the CONUS, the member’s inability to perform their duties in every geographical location will not be the sole basis for a finding of unfit-for-duty.”

Once a PEB finds a service member with a medical condition to be fit-for-duty, that member’s involuntary separation from the Service cannot be based on the same medical condition for which the service member was evaluated by the PEB. As such, service members with medical conditions were allowed to remain in the Service. Service members with medical conditions could not be counted as fully-medically-ready for deployment according to DoDI 6025.19. Therefore, service members with deployment limiting medical conditions risked lowering their units’ IMR rates to levels below DoD requirements.

RC unit commanders expressed concerns that the requirement to keep members in the Service with deployment limiting conditions, even though they may have been found fit for duty, lowered their units’ IMR rates. RC service members with deployment limiting conditions continued to impact their units’ IMR rates until they either became medically deployable or departed the unit.

The retention of fit-for-duty RC service members with deployment limiting conditions limited the implementation of DoDI 6490.07. DoDI 6490.07 directs Military Departments to ensure that DoD personnel who occupy deployable positions maintain a high state of pre-deployment health and medical readiness.

During our assessment, different commanders and their staffs recommended how they would resolve the inconsistency between DoD requirements to retain service members in RCs with deployment limiting conditions, and maintaining required RC rates of medical readiness. One common recommendation suggested creating a number of additional non-deployable billet positions to which service members with deployment limiting conditions could be assigned. Another common recommendation suggested re-designating a number of existing billet positions as non-deployable to which service members with deployment limiting conditions could be assigned. Appendix J provides further information about fit-for-duty and deployment limiting conditions.

Conclusion

Retention of RC service members with medically-related deployment limiting conditions risked lowering RC's IMR rates. However, both Federal law and DoD instructions established requirements to retain fit-for-duty RC service members even though the members had medically-related, deployment limiting conditions. Meeting these statutory and DoDI requirements made it challenging for RC units to maintain required IMR rates.

Recommendations, Management Comments, and Our Response

Recommendation 2

We recommend that the Under Secretary of Defense for Personnel and Readiness develop and implement a plan that ensures Reserve Components' service personnel authorizations to retain service members in accordance with 10 U.S.C. § 1214a while meeting unit deployment requirements.

Under Secretary of Defense for Personnel and Readiness

The Under Secretary of Defense for Personnel and Readiness ((USD(P&R))) concurred without comment to Recommendation 2.

Our Response

Comments from USD(P&R) were partially responsive. While concurring with the recommendation, the response did not describe or address the actions planned to implement the recommendation. In response to the final report, therefore, we request that USD(P&R) describe the actions planned and an expected timeline to meet the intent of this recommendation.



Observation 3

Follow-up and Evaluation of Army Temporary Medical Profiles

Army Reserve Component soldiers (not on active duty), who had received temporary medical profiles, had limited or no access to DoD-provided healthcare to be medically evaluated in accordance with Army Regulation (AR) 40-501, "Medical Services, Standards of Medical Fitness," 2007 with rapid action revision 2011.¹⁹

This occurred because the issuance of a temporary medical profile, by itself, did not entitle RC soldiers to be medically evaluated in accordance with AR 40-501.

As a result, these RC soldiers were at risk of not having their temporary medical profiles managed in accordance with AR 40-501.

¹⁹ Refer to Appendix F for an explanation of the RSMO.

Applicable Criteria

Section 1074, Title 10, United States Code (10 U.S.C. § 1074 [2011]), does not authorize DoD-provided medical or dental care to members of the RC who are not on active duty.

However, AR 40-501 establishes follow-up requirements for temporary medical profiles issued to soldiers. The regulation requires that, RC soldiers (not on active duty), who are issued temporary medical profiles, will be medically evaluated at least every 3 months.

AR 40-501 designates that the following organizations may issue temporary medical profiles for RC soldiers:

- Army Regional Support Command Surgeons,
- Army Reserve Command Surgeon,
- Army Human Resource Command Surgeon or designees
- Army Division Staff Surgeons,
- AC Medical Treatment Facility Profiling Officers,²⁰

²⁰ Refer to Appendix I for further information about the Reserve Health Readiness Program which is an Army RC contracted profiling agency.

- Army Reserve and Army National Guard Contracted Agency Profiling Officers,
- Army Reserve Operational and Functional Command Surgeons and Division Surgeons (that function as Command Surgeons),
- National Guard Bureau Chief Surgeon,
- Army National Guard Division Surgeons, and
- State National Guard Providers (Army National Guard).

Discussion

AR 40-501 requires that all soldiers who receive medical or surgical care, regardless of service status, are to be managed with temporary medical profiles. Temporary medical profiles are given to soldiers who have a temporary medical condition in which correction or treatment of the condition is medically advisable, and for which the correction will most likely result in better health. Temporary medical profiles are normally issued for medical conditions that can be corrected within a year.

AR 40-501 also requires that all soldiers who received temporary medical profiles, regardless of service status, must be medically evaluated at least once every three months until the requirement for the temporary medical profile expires.

The Defense Health Agency (DHA) indicated that the issuance of a temporary medical profile, by itself, did not entitle RC soldiers to DoD-provided healthcare.²¹ Consequently, these RC soldiers (not on active duty) who had been issued temporary medical profiles were at risk of not having DoD-provided healthcare available in order to receive required follow-up in accordance with AR 40-501.

Conclusion

AR 40-501 requires all Army RC members issued temporary medical profiles to be medically evaluated at least once every three months until the requirement for the profile is no longer required. However, DHA indicated that the issuance of a temporary medical profile, by itself, did not entitle RC members to healthcare at DoD expense. Therefore, controlled access to DoD-provided healthcare and subsequent medical evaluations placed some RC soldiers at risk of not having their temporary medical profiles managed in accordance with AR 40-501.

²¹ Refer to Appendix E for a listing of RC members' DoD-provided healthcare entitlements.

Recommendations, Management Comments, and Our Response

Redirected Recommendation

Recommendation 3 was originally intended for the Assistant Secretary of Defense for Health Affairs ((ASD(HA)) for response. The Under Secretary of Defense for Personnel and Readiness ((USD(P&R)) responded on behalf of ASD(HA); therefore, DoD IG redirected the recommendation to USD(P&R).

Recommendation 3

We recommend that the Under Secretary of Defense for Personnel and Readiness implement a plan so that Army Reserve Component service members receive DoD-provided medical evaluations of temporary medical profiles in accordance with Army Regulation 40-501.

Under Secretary of Defense for Personnel and Readiness Comments

USD(P&R), responding for ASD(HA), concurred with comment to Recommendation 3.

USD(P&R) commented that a medical evaluation is not the same as medical treatment and stated that the eligibility criteria for medical treatment at DoD expense are specifically established by Congress in law. They further stated that Conclusion 3 suggested an entitlement to medical treatment at DoD expense when a condition was not incurred in the line of duty and the RC soldier was not entitled to medical care by law.

USD(P&R), for ASD(HA), suggested that the conclusion to Observation 3 in the draft report be revised to:

“Defense Health Agency (DHA) indicated that the issuance of a temporary medical profile, by itself, did not entitle RC members to healthcare at DoD expense. AR 40-501 requires all Army RC members issued temporary medical profiles to be medically evaluated at least once every three months until the requirement for the profile was no longer required (paragraph 7-4, page 74). It continues that Army RC members are responsible for providing the unit commander all medical documentation, including civilian health records that document a change which may impact their readiness status (paragraph 9-3, page 104). With the proper information, the Army Profiling Officer can proceed to complete the required medical evaluation, even if the treatment was rendered by a civilian provider at RC member expense.”

Our Response

Comments from USD(P&R), responding on behalf of ASD(HA), were partially responsive. While concurring with the recommendation, the management comments did not address the actions required to meet the intent stated in the recommendation.

DoD IG agrees with USD(P&R)'s comment that medical evaluations are not the same as medical treatment. Recommendation 3 is recommending USD(P&R) develop and implement a plan that ensures RC soldiers, who are issued a DoD temporary medical profile, receive medical evaluations of those temporary medical profiles in accordance with Army Regulation 40-501. Recommendation 3 does not recommend expanding eligibility criteria for medical treatment to remedy conditions causing issuances of DoD temporary medical profiles.

We did revise the conclusion paragraph of Observation 3 based on USD(P&R)'s management comments.

In response to the final report, we request that USD(P&R), in coordination with ASD(HA), describe the actions planned to meet the intent of this recommendation.

Observation 4

Medical History and Line of Duty Administrative Requirements

RC service members returned from deployments or temporary duty with missing or incomplete medical histories and LOD documentation.

This occurred because responsible Commanders and medical authorities did not consistently manage the medical histories and LOD documentation for deployed or temporary duty RC service members.

As a result, deactivated RC service members had to reconstruct incomplete or missing medical histories and line of duty documentation in order to receive DoD-provided medical care for wounds, illnesses, and injuries incurred or aggravated while deployed or assigned temporary duty.

Applicable Criteria

DoDD 1241.01, "Reserve Component Medical Care and Incapacitation Pay for Line of Duty Conditions," 2007, defines LOD as a finding after all available information has been reviewed that determines an injury, illness, or disease was incurred or aggravated as a result of military duty not due to gross negligence or misconduct of the member.

DoDI 1241.2, "Reserve Component Incapacitation System Management," 2001, prohibits the delay of medical treatment for LOD wounds, illnesses, and injuries due to administrative requirements. It also directs that Service Secretaries establish procedures to ensure that medical treatment for wounds, illnesses, and injuries incurred or aggravated in the line of duty will not be delayed because of administrative requirements.

The Defense Health Agency issued a guide titled *Reserve and Service Member Support Office (RSMSO)²² Process Guide*, 2013, that states that all RC service members' requests for medical care include a Service approved LOD determination.

Discussion

It is DoD policy to provide medical treatment to RC service members for an injury, illness, or injury incurred or aggravated in the line of duty. Once demobilized, RC service members who had become wounded, ill, or injured while on active duty

²² Refer to Appendix F for an explanation of the RSMSO.

required an LOD determination from their Service branch. LOD documentation was used to establish, manage, and authorize healthcare for eligible RC service members and necessary for RC members to receive treatment for any medical concerns incurred or aggravated in the line of duty. Refer to Appendix F for further information about line of duty care.

RC Surgeons, Headquarters-level medical staff members, and multiple RC units all reported occurrences of RC service members suffering wounds, illnesses, and injuries on active duty that were not documented or incorrectly documented. They further explained that these RC service members were required to reconstruct their own medical histories to prove their medical conditions were incurred or aggravated in the line of duty. This was a complex and time-consuming task. As a result, the administrative requirements to reconstruct medical histories and LOD paperwork put wounded, ill, and injured RC service members at risk of delayed or denied authorization for LOD medical treatment. Refer to Appendix E for further information about RC access to DoD-provided healthcare.

The Army's Human Resources Command staff members we contacted stated that a significant problem with RC service members' LODs was that requisite medical documentation did not always follow the member from his or her area-of-operation or deployment location. Conversely, the staff reported that there were generally no problems with access to LOD medical treatment when the proper documentation was available.

The staff at a Marine Corps Reserve Support Unit (RSU) estimated that 50 percent of re-deploying RC Marines returned without proper medical or LOD documentation.

DoD has an electronic and IT-based medical records data base (called In-Theater AHLTA) which records both AC and RC deployed service members' medical histories. However, RC units reported challenges retrieving RC service members' medical histories when their members returned to their unit.

The lack of overarching DoD guidance specifically assigning responsibilities to administratively manage deployed RC service members' medical history and LOD paperwork contributed to incomplete or missing documentation.

Since RC service members were at risk of becoming wounded, ill, and injured world-wide, RC service members, who lacked medical and LOD documentation were subject to not receiving timely or any DoD-provided medical care.

Conclusion

LOD medical treatment was vital to wounded, ill, and injured RC service members. However, without a LOD medical determination, wounded, ill, or injured RC service members' access to DoD-provided healthcare was limited, despite the fact that the wounds, illnesses, and injuries were incurred or aggravated while in the line of duty.

Frequently, RC service members returned from deployment with missing or incomplete medical histories and LOD documentation. The difficult administrative requirements to reconstruct medical histories or LOD paperwork put wounded, ill, and injured RC service members at risk of delayed or denied authorization for LOD medical treatment.

Recommendations, Management Comments, and Our Response

Redirected Recommendation

Recommendation 4 was originally intended for the Assistant Secretary of Defense for Health Affairs ((ASD(HA))) for response. The Under Secretary of Defense for Personnel and Readiness ((USD(P&R))) requested that we redirect the recommendation to their office, which we have done.

Recommendation 4

We recommend that the Under Secretary of Defense for Personnel and Readiness establish policy that assigns responsibilities to Commanders and medical authorities to manage medical histories and line of duty documentation for deployed or temporary duty RC service members in a standardized manner across all Services, so that both are complete and available to their units in a timely manner.

Under Secretary of Defense for Personnel and Readiness

USD(P&R) concurred with comment to Recommendation 4, stating that ASD(HA) will work with the Assistant Secretary for Reserve Affairs to update DoD policies cited in DoDD 1241.01 and DoDI 1241.2. USD(P&R) also commented that ASD(HA) is the policy proponent and oversight authority for the medical records and is responsible for establishing policy and procedure for managing the medical records and history of service members; and that the Director, Defense Health Agency (DHA) would establish proper management controls to assure Defense Health Program Appropriation (DHPA) funds are properly used for Line of Duty entitlements under law.

Our Response

Comments from USD(P&R) were responsive. We will follow up in six months on the status of updates to DoDD 1241.01 and DoDI 1241.2. At that time we will also seek updated information on what management controls the Director, DHA has established to assure DHPA funds are properly used for Line of Duty entitlements under law.

Observation 5

Proof of Line of Duty Entitlement Documents for Military Treatment Facility Care

Wounded, ill, and injured Reserve Component service members had difficulty accessing authorized medical services at Military Treatment Facilities (MTF) because different forms were used by each military Service to prove line of duty (LOD) medical care entitlements.

This was caused by the lack of standardized DoD forms for use by RC service members to establish proof of eligibility for LOD medical care at MTFs.

As a result of the differing LOD documentation requirements among the Services, RC service members risked being delayed or denied LOD authorized medical treatment at MTFs.

Applicable Criteria

The Services used differing forms for proof of LOD medical care entitlements.

- Army: According to the Reserve Affairs Office of the Army's Surgeon General, the Army did not have a single overarching regulation regarding LOD medical entitlement requirements. Instead, the requirements were derived from a number of individual sources. The Army requires a DA 2173, Statement of Medical Examination and Duty Status. Additional Army requirements include a DD 261, Report of Investigation Line of Duty and Misconduct Status and/or an appropriate approval memo.
- Navy: SECNAVINST 1770.3D, "Management and Disposition of Incapacitation and Incapacitation Benefits for Members of Navy and Marine Corps Reserve Components," March 17, 2006, designates that Navy personnel require a LOD approval letter from Navy Personnel Command (PERS-95).
- Marine Corps: Marine Corps Orders (MCO) 1770.2B, "Administration Regarding Injuries of Reserve Marines Performing Active Duty and Inactive Duty," April 2, 2014, and MCO 1001R.1K, "Marine Corps Reserve Administrative Management Manual," 2009, instruct that LOD requests will be submitted, updated, and tracked on-line through the automated Marine Corps Medical Entitlements Data System (MCMEDS).

- Air Force Instruction 36-2910, “Line of Duty,” 2002 incorporating change through 2010, Chapter 3, directs that members use an AF 348 Line of Duty Determination. Additional requirements may also include a DD 261.
- DoDI 1241.2 establishes that RC service members who incur a wound, illness, or injury in the line of duty will be provided with medical treatment. It also establishes that administrative requirements will not delay access to this medical treatment.

Discussion

It is DoD policy to provide medical treatment to RC service members for wounds, illnesses, and injuries incurred or aggravated in the line of duty. Once demobilized, RC service members who had become wounded, ill, or injured while on active duty required an LOD determination from their Service branch. LOD documentation was used to establish, manage, and authorize healthcare for eligible RC service members and was important in order to receive treatment for any medical issues incurred or aggravated in the line of duty. LOD entitlements also ensure RC service members do not incur out-of-pocket medical expenses for wounds, illnesses, and injuries incurred in the line of duty. Refer to Appendix F for further information about line of duty care.

Generally, RC service members received medical treatment at the nearest available MTF, regardless of their Service branch or the Service branch of the MTF. RC service members who sought LOD medical treatment at MTFs not affiliated with their own Service branch risked the MTF staff not fully understanding and accepting each Service’s different forms used as proof for LOD medical treatment.

Medical staff members we interviewed expressed concern about RC service members’ difficulty receiving authorized LOD medical treatment at MTFs. These medical staff members reported that although RC service members had the required forms issued in accordance with their own Service requirements, members still experienced administrative difficulty receiving medical treatment because each Service had different requirements to prove entitlement for LOD medical treatment. The use of different forms for proof of LOD entitlements by the Services resulted in varying requirements with ensuing administrative difficulties and delays in authorized medical treatment.

Conclusion

It is DoD policy to provide medical treatment to RC service members for wounds, illnesses, and injuries incurred or aggravated in the line of duty. RC service members, who became wounded, ill, and injured while on active duty, required service specific LOD documentation to receive treatment for any medical concerns incurred or aggravated in the line of duty.

Wounded, ill, and injured RC service members experienced difficulty receiving treatment at MTFs. The difficulty stemmed from differing administrative requirements for proof of LOD entitlements used by each Service. The differing administrative requirements (to prove LOD entitlements) put wounded, ill, and injured RC service members at risk of delayed or denied authorization for LOD medical treatment at MTFs, which is not in compliance with DoD Policy.

Recommendations, Management Comments, and Our Response

Redirected Recommendation

Recommendation 5 was originally intended for the Assistant Secretary of Defense for Health Affairs (ASD(HA)) for response. The Under Secretary of Defense for Personnel and Readiness (USD(P&R)) requested that we redirect the recommendation to their office, which we have done.

Recommendation 5

We recommend that the Under Secretary of Defense for Personnel and Readiness establish standardized DoD form(s) and procedures that provide access for all Reserve Component service members to line of duty care at all military treatment facilities.

Under Secretary of Defense for Personnel and Readiness

USD(P&R) concurred with comment to Recommendation 5, stating that Assistant Secretary for Reserve Affairs will establish a DD Form for entitlement to LOD healthcare in the reissuance of DoDD 1241.01. USD(P&R) also stated that there is an existing information requirement, Report Control DD-RA(AR)2421, to establish the requirement for the Defense Enrollment Entitlement Reporting System (DEERS)²³ to record entitlements to LOD healthcare.

Our Response

Comments from USD(P&R) were responsive. We will follow up in six months on the status of the reissuance of DoDD 1241.01. At that time we will also request status on progress in recording LOD healthcare entitlements into DEERS, as suggested by management.

²³ The Defense Enrollment Entitlement Reporting System, also referred to as DEERS, is the Department of Defense's medical entitlement repository.



Appendix A

Scope and Methodology

The DoD IG conducted this assessment from September 2013 to August 2014 in accordance with the Council of Inspectors General on Integrity and Efficiency, “Quality Standards for Inspections and Evaluations,” January 2012. We planned and performed the assessment to obtain sufficient and appropriate evidence that provided a reasonable basis for all observations and conclusions, based on the assessment objectives.

The overarching objective of the “Assessment of DoD Wounded Warrior Matters” (Project No. D2010-D00SPO-0209.000) was to assess DoD programs for the care, management, and transition of recovering service members wounded during deployment in Operation Iraqi Freedom or Operation Enduring Freedom. This follow-on assessment specifically addresses the theme of the DoD-provided health and medical care benefits and entitlements available to Reserve Component members who become injured in the line of duty. This assessment also includes the DoD-provided health and medical care benefits and entitlements available to RC members to maintain required medical readiness rates.

This assessment based the overall scope and methodology on the RC Status Cycle. Status of the RC service member is cyclical in nature and can generally be broken down into four phases.

- Not-Activated: RC service members’ primary responsibilities are training and preparing for activation.
- Activated/Deployment: RC service members are considered to be on active duty.
- Post-Deployment: RC service members are still considered to be on active duty, however their primary mission is complete and the member is generally on reconstitution time and accrued leave.
- Deactivated: RC service members are no longer considered to be on active duty.

The DoD IG stated in its April 16, 2010, project announcement memorandum that additional assessments on Wounded Warrior matters may be conducted as pertinent issues are identified. Once the subject of wounded, ill, and injured RC service members receiving care alternatively from the Army and Marine Corps Wounded Warrior programs was identified, we determined that further description of the methodology outside of what was documented in the original Wounded Warrior project design plan was required.

The objectives of this follow-on assessment were to specifically determine whether:

- DoD-provided healthcare supports Guard and Reserve pre-deployment medical readiness rates so that the Guard and Reserve maintain operational capabilities and provide strategic depth to U.S. forces to meet the U.S. defense requirements; and
- DoD-provided healthcare supports efficient and effective, post-deployment care for Guard and Reserve who become wounded, ill and injured.

We reviewed documents such as Federal laws and regulations, the National Defense Authorization Act, Chairman of the Joint Chiefs of Staff Instructions, DoD directives and instructions, relevant Service directives, instructions, and orders, and previous reports from GAO, DoD IG, and others.

We also contacted organizations through site visits, teleconferences, and requests for information in order to ensure that we had the most up-to-date information available. We contacted or visited the following organizations:

- Office of Secretary of Defense for Reserve Affairs
- Deputy Assistant of Defense for Force Health Protection and Readiness
- Office of Strategy Management, Defense Health Agency
- Reserve Members Support, Defense Health Agency
- DoD IMR Working Group, Defense Health Agency
- RHRP Metrics, Defense Health Agency
- TRICARE, Defense Health Agency
- TRICARE Regional Office – North
- TRICARE Regional Office – South
- TRICARE Regional Office – West
- Reserve and Service Member Support Office
- Joint Guard Surgeon's Office
- National Guard Surgeon's Office
- Army Reserve Surgeon's Office
- Navy Reserve Surgeon's Office
- Marine Reserve Surgeon's Office
- Air Force Reserve Surgeon's Office
- Air Guard Surgeon's Office
- Oregon National Guard & State Surgeon's Office
- Assistant Secretary of the Army, Manpower & Reserve Affairs, Pentagon

- Headquarters Department of the Army, Deputy Chief of Staff G-1
- Department of Army Military Operations – Operations Directorate Mobilization
- U.S. Army Forces Command
- U.S. Army Medical Command
- U.S. Army Dental Command
- Warrior Transition Command
- Community Based Warrior Transition Unit – Concord, Massachusetts
- Community Based Warrior Transition Unit – Sacramento, California
- Community Based Warrior Transition Unit – Salt Lake City, Utah
- Community Based Warrior Transition Unit – Orlando, Florida
- U.S. Army Installation Management Command
- U.S. Army Human Resources Command
- Army Reserve Affairs
- Reserve Component Soldier Medical Support Center
- Army Reserve Medical Management Center
- Army Reserve Recovery Care Coordinator
- Soldier Readiness Processing Center – Joint Base McGuire Dix, New Jersey
- Soldier Readiness Processing Center – Fort Hood, Texas
- Soldier Readiness Processing Center – Camp Shelby, Mississippi
- Soldier Readiness Processing Center – Fort Bliss, Texas
- 13th Battalion Army Reserve Careers Division, Phoenix, Arizona
- 189th General Support Aviation Battalion, Fort Harrison, Montana
- 191st Combat Sustainment Support Battalion, Salt Lake City, Utah
- 387th Military Police Battalion, Phoenix, Arizona
- 392nd Medical Logistics Company, Wichita, Kansas
- 399th Combat Support Hospital, Fort Devens, Massachusetts
- 469 Ambulance Company, Wichita, Kansas
- 652nd Regional Support Group – Helena, Montana
- 804th Medical Brigade – Fort Devens, Massachusetts
- Navy Operational Support Center – North Island, California
- Navy Operational Support Center – East, Norfolk, Virginia
- Navy Region Southwest Reserve Component Medical Hold – North Island, California

- Navy Region Mid-Atlantic Reserve Component Medical Hold-East – Norfolk, Virginia
- Navy Mobilization Processing Site – San Diego, California
- Navy Mobilization Processing Site – Camp Lejeune, North Carolina
- Navy Mobilization Processing Site – Norfolk, Virginia
- Marine Forces Reserve
- Marine Corps Individual Reserve Support Activity
- Wounded Warrior Regiment
- Reserve Medical Entitlements Division – Wounded Warrior Regiment
- Recovery Care Coordinators – Wounded Warrior Regiment
- Marine Reserve Support Unit West – Camp Pendleton, California
- Deployment Processing Command/Reserve Support Unit East, Camp Lejeune, North Carolina
- 1st Marine Expeditionary Force, Camp Pendleton, California
- 2nd Civil Affairs Group, United States Marine Corps Training Center, Joint Base Anacostia-Bolling, Washington, D.C.
- 4th Medical Battalion, Miramar, California
- Marine Aircraft Group 49 – Det C, New Orleans, Louisiana
- HQ USAF A1SZ, Warrior Survivor and Care Policy, Randolph Air Force Base, Texas
- HQ AFPC-DPFW, Randolph Air Force Base, Texas
- Air Force Reserve Command, Robins AFB, Georgia
- National Guard Bureau A3XW, Joint-Base Andrews, Maryland
- Warrior and Survivor Care, Randolph Air Force Base, Texas
- Air National Guard Combat Readiness Training Center, Alpena, Michigan
- 113th Air Support Operations Squadron, Terre Haute, Indiana
- 125th Fighter Wing, Jacksonville, Florida
- 127th Medical Group, Selfridge, Michigan
- 174th Attack Wing, Syracuse, New York
- 181st Intelligence Wing, Terre Haute, Indiana
- 185th Air Refueling Wing, Sioux City, Iowa
- 349 Air Mobility Wing, Travis Air Force Base, California
- 434 Air Refueling Wing, Grissom Air Reserve Base, Indiana
- 927th Air Refueling Wing, MacDill Air Force Base, Florida

The assessment of DoD-provided healthcare for members of the reserve components chronology was:

- | | |
|---------------------------------|--|
| • October through December 2013 | Research |
| • January through March 2014 | Fieldwork |
| • April through July 2014 | Analysis and report writing |
| • August 2014 | Draft assessment report issued |
| • 18 September, 2014 | Management comments received and evaluated |
| • 8 October, 2014 | Report Published |

Use of Computer-Processed Data

We did not use self-generated computer-processed data to perform this assessment. However, our assessment team relied on reports generated by the following:

- Defense Health Agency, Combined IRC IMR Rates (Figure 2, page 5)
- Defense Health Agency, TRICARE Historical Reserve Select Enrollment Rates
- Office of the Assistance Secretary of Defense, Reserve Affairs, Composition of the Reserve Component (Figure 7, page 48)

We did not test the validity or verify the results of any computer processed data used by these organizations. We determined that the reliability of the data would not materially affect our ability to conduct the assessment, formulate our findings, or make our recommendations.

Appendix B

Summary of Prior Coverage

Several reports were issued during the past 5 years about DoD and Department of Veterans Affairs healthcare services and management, disability programs, and benefits. We found that GAO, DoD IG, and the RAND Corporation have issued at least 17 reports specific to DoD-provided healthcare to members of the Reserve Components.

- Unrestricted GAO reports can be accessed over the Internet at <http://www.gao.gov>.
- Unrestricted DOD IG reports can be accessed at <http://www.dodig.mil/PUBS/index.html>.
- DoD Recovering Warrior Task Force reports can be assessed at <http://dtf.defense.gov/rwtf/>.

Government Accountability Office

GAO-13-364, “Defense Healthcare: TRICARE Multiyear Surveys Indicate Problems with Access to Care for Non-enrolled Beneficiaries,” April 2013

GAO-13-5, “Recovering Servicemembers and Veterans: Sustained Leadership Attention and Systematic Oversight Needed to Resolve Persistent Problems Affecting Care and Benefits,” November 2012

GAO-12-911, “Defense Health Care: Additional Analysis of Costs and Benefits of Potential Governance Structure is Needed,” September 2012

GAO-12-992, “VA and DoD Healthcare: Department-Level Actions Needed to Assess Collaboration Performance, Address Barriers, and Identify Opportunities,” September 2012

GAO-11-551, “Defense Health Care: DoD Lacks Assurance that Selected Reserve Members Are Informed About TRICARE Reserve Select,” June 2011

GAO-11-500, “Defense Health Care: Access to Civilian Providers under TRICARE Standard and Extra,” June 2011

GAO-10-402, “Defense Health Care: 2008 Access to Care Surveys Indicate Some Problems, but Beneficiary Satisfaction is Similar to Other Health Plans,” March 2010

Department of Defense Office of Inspector General

DODIG-2014-040, "Assessment of DoD Wounded Warrior Matters – Managing Risks of Multiple Medications," February 21, 2014

DODIG-2013-113, "Assessment of DoD Wounded Warrior Matters – Fort Riley," August 6, 2013

DODIG-2013-087, "Assessment of DoD Wounded Warrior Matters – Joint Base Lewis-McChord," May 31, 2013

DODIG-2012-120, "Assessment of DoD Wounded Warrior Matters – Wounded Warrior Battalion – West Headquarters and Southern California Units," August 22, 2012

DODIG-2012-067, "Assessment of DoD Wounded Warrior Matters – Camp Lejeune," March 30, 2012

SPO-2011-010, "Assessment of DOD Wounded Warrior Matters – Fort Drum," September 30, 2011

SPO-2011-004, "Assessment of DOD Wounded Warrior Matters – Fort Sam Houston," March 17, 2011

Other

Department of Defense Recovering Warrior Task Force, "2012-2103 Annual Report," September 3, 2013

RAND Research Brief RB-9670-OSD, "Improving Medical and Dental Readiness in the Reserve Components," 2012

RAND, "Medical Readiness of the Reserve Component," 2012

Appendix C

Legislative History and Related Activity

Office of the Under Secretary of Defense Personnel Readiness Report to Congress on Fit, But Unsuitable Administrative Separations. Refer to Appendix J for further information about Fit-for-Duty and Deployment Limiting Conditions.

Appendix D

Reserve Components

The National Guard and Reserves of the United States Armed Forces, collectively referred to as the RC, are military organizations whose members generally perform a minimum of 38 days of military duty per year and who augment the active duty (or full-time) military specific to the Services' regulations and instructions.²⁴

10 U.S.C. § 10102, (2011), states the purpose of each RC is to:

- “provide trained units and qualified persons available for active duty in the armed forces in time of war or national emergency and at such other times as the national security may require,” and
- “fill the needs of the armed forces whenever more units and persons are needed than are in the active duty components.”

The seven RCs of the U.S. military are:

- Army Reserve (USAR),
- Navy Reserve (USNR),
- Marine Corps Reserve (MARFORRES),
- Air Force Reserve Command (AFR),
- Coast Guard Reserve,²⁵
- Army National Guard of the United States (ARNG), and
- Air National Guard of the United States (ANG).²⁶

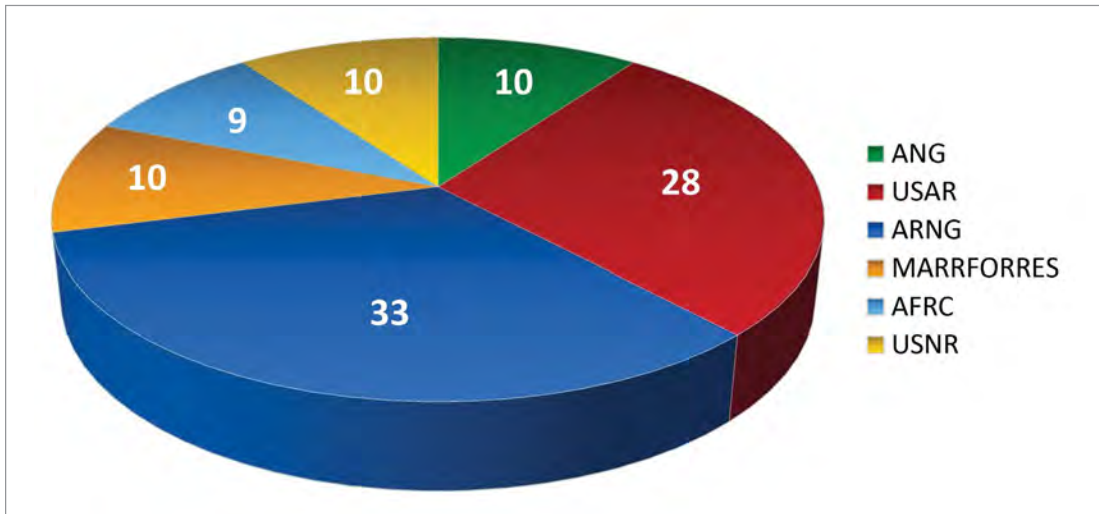
²⁴ The National Guard is a joint DoD activity composed of reserve components of the United States Army and the United States Air Force: the Army National Guard of the United States and the Air National Guard of the United States respectively.

²⁵ For purposes of this report, the Coast Guard Reserve is not included.

²⁶ The ARNG and ANG are the National Guard of the United States.

Figure 7 below represents the composition of the RC:

Figure 7. Composition of the Ready Reserve by Component (As of April, 2014)



Source: Office of the Assistance Secretary of Defense, Reserve Affairs

The United States Army Reserve

The USAR is the reserve component of the U.S. Army. The Army Reserve includes all Reserves of the Army who are not members of the Army National Guard of the United States.

The United States Navy Reserves

The USNR is the reserve component of the Navy. It is organized, administered, trained, and supplied under the direction of the Chief of Naval Operations.

The Marine Corps Reserve

The MARFORRES is the reserve component of the Marine Corps. It is organized, administered, trained, and supplied under the direction of the Commandant of the Marine Corps.

The United States Air Force Reserve

The AFR is the reserve component of the U.S. Air Force which is designed to provide a reserve force for active duty.

The Army National Guard of the United States

The ARNG consist of units stationed in each U.S. state, the District of Columbia, and territories. It is the reserve component of the Army and consists of federally recognized units and organizations of the Army National Guard and members of the Army National Guard who are also Reserves of the Army.

Air National Guard of the United States

The ANG is the Air Force component of each U.S. state, the District of Columbia, Puerto Rico, and territories. The ANG consists of federally recognized units and organizations of the ANG and members of the ANG who are also Reserves of the Air Force.

Categories of Reservists

The Ready Reserve

The Ready Reserve is the primary manpower pool of the reserve components. The Ready Reserve consists of three reserve component subcategories: Selected Reserves, Individual Ready Reserves, and Inactive National Guard.

The Selected Reserve

The Selected Reserve includes those units and individuals within the Ready Reserve designated as so essential to initial wartime missions, that they have priority over all other Reserves.

The Individual Ready Reserve

The IRR are tasked with providing a manpower pool composed principally of individuals having had training and having previously served in an Active Component or in the Selected Reserve.

Inactive National Guard

The Inactive National Guard (ING) are National Guard personnel in an inactive status attached to a specific National Guard unit, who are required to muster once a year with their assigned unit but do not participate in training activities.

The Standby Reserve

The Standby Reserve consists of personnel who have been designated key civilian employees, or who have a temporary hardship or disability. They are not required to perform training.

The Retired Reserve

The Retired Reserve consists of all reserve officers and enlisted personnel who receive retired pay on the basis of Active Duty and/or Reserve Service and reserve officers and enlisted personnel who are otherwise eligible for retired pay but have not reached age 60.

Federal Call-Up Authority

Reservists

Section 12301(a), title 10, United States Code (10 U.S.C. § 12301(a) [2013]) provides that, in time of war or national emergency declared by the Congress, the entire membership of all reserve components or any lesser number can be called to active duty for the duration of the war or national emergency plus 6 months.

Section 12301(b), title 10, United States Code (10 U.S.C. § 12301(b) [2013]) provides that at any time a Service secretary can order any reservist to active duty for up to 15 days each year.

Ready Reserves

Section 12302, title 10, United States Code (10 U.S.C. § 12301 [2013]) provides that, in time of national emergency declared by the President, up to one million members of the Ready Reserve can be called to active duty for not more than 24 consecutive months.

Selected Reserves

Section 12304, title 10, United States Code (10 U.S.C. § 12304 [2012]) provides that, when the President determines that it is necessary to augment the active forces for any operational mission, up to 200,000 members of the Selected Reserve can be called to active duty for not more than 365 days.

Appendix E

Reserve Component Access to Care

Not-Activated

Not-DoD-Provided Healthcare

The RC service member may have private or public healthcare insurance available or be uninsured. Qualified members may also be eligible for care through Veterans Administration.

TRICARE Reserve Select

TRICARE Reserve Select is a premium-based healthcare insurance plan available to qualified Selected Reserve members of the Ready Reserve and their beneficiaries. Refer to Appendix F for further information about TRICARE.

TRICARE DENTAL Program

The TRICARE Dental Program is a premium-based dental care plan offered to eligible service members by DoD through TRICARE (Defense Health Agency). Refer to Appendix F for further information about TRICARE.

Reserve Healthcare Readiness Program

The RHRP is a DoD, Health Affairs program designed to supplement the RC by providing PHA, Post-Deployment Health Reassessment (PDHRA), and other IMR services that satisfy key deployment requirements. RHRP provides medical and dental services to all RCs. Refer to Appendix I for further information about the RHRP.

TRICARE 180-Day Early Benefit

RC service members in receipt of valid activation orders are eligible for military health benefits under the TRICARE Early Eligibility Program. TRICARE Early Eligibility applies to RC service members up to 180 days prior to activation. Refer to Appendix F for further information about TRICARE.

Line of Duty Care

RC service members are covered for wounds, illnesses, and injuries incurred or aggravated in the line of duty. Refer to Appendix F for further information about TRICARE.

Activation/Deployment

Mobilization Processing Site

The Army, Navy, and Marine Corps mobilize and demobilize through specific locations that provide additional medical care to facilitate the mobilization and demobilization process. Refer to Appendix G for further information about mobilization/demobilization and deployment and redeployment medical services.

TRICARE Prime & TRICARE Prime Remote

TRICARE Prime and TRICARE Prime Remote provide comprehensive health coverage, including enhanced preventive care and vision benefits, without the cost of a premium. Refer to Appendix F for further information about TRICARE.

TRICARE Through the End of Active Duty Status

While activated for a period of more than 30 consecutive days, RC service members are covered as active duty service members. Upon reaching their final duty station they can enroll in TRICARE Prime, TRICARE Prime Remote, TRICARE Prime Overseas, or TRICARE Prime Overseas Remote. Refer to Appendix F for further information about TRICARE.

DoD/In-theater Support

While in-theater the RC service member receives the same support as their Active Component counterparts.

Post Deployment

TRICARE Prime & TRICARE Prime Remote

The RC service member is covered by TRICARE Prime or TRICARE Prime Remote until all accrued leave and compensatory time expires and the RC service member officially comes off orders. Refer to Appendix F for further information about TRICARE.

Extension of Active Duty & Recall to Active Duty

RC service members can be recalled to active duty or have their current orders extended to receive authorized medical care and treatment. Refer to Appendix K for further information about extended active duty orders.

Deactivated***Transitional Assistance Management Program***

Transitional Assistance Management Program (TAMP) provides 180 days of premium-free transitional health care benefits after RC service members come off eligible orders. Refer to Appendix F for further information about TRICARE.

Line of Duty Care

RC service members are covered for wounds, illnesses, and injuries incurred or aggravated in the line of duty. Refer to Appendix F for further information about TRICARE.

Appendix F

TRICARE

TRICARE Reserve Select

TRICARE Reserve Select is a worldwide premium-based health insurance plan that provides comprehensive health coverage. It covers most inpatient and outpatient care that is medically necessary and considered proven. It is available to members of the Selected Reserve of the Ready Reserve (and their beneficiaries) who meet the following conditions:

- Service members not on active duty orders,
- service members not covered under the Transitional Assistance Management Program, and
- service members not eligible for or enrolled in the Federal Employees Health Benefits (FEHB) program or currently covered under FEHB.

TRICARE Dental Program

The TRICARE Dental Program is a worldwide premium-based dental care plan offered to eligible service members by DoD through TRICARE. It is available to service members who meet the following conditions:

- Service members not on active duty orders for more than 30 consecutive days, and
- service members not covered under the TAMP.

The TRICARE Dental Program covers the following services:

- exams, cleanings, fluorides, sealants, and x-rays,
- fillings, including white fillings on back teeth,
- root canals,
- gum surgery,
- oral surgery and tooth extractions,
- crowns and dentures,
- orthodontics and braces,
- scaling and root planning (deep cleaning) for diabetics, and
- additional cleanings for pregnant women.

TRICARE Early Eligibility

TRICARE Early Eligibility applies to RC service members and eligible dependents up to 180 days prior to activation. To qualify for the TRICARE Early Eligibility benefit, the RC service member must be in receipt of valid activation orders. The TRICARE Early Eligibility benefit provides the RC service member with the same medical and dental benefits as members of the Active Component.

TRICARE Prime

TRICARE Prime is available to RC service members, who are called or ordered to active duty for more than 30 consecutive days or within 180 days of activation based on early activation orders.

Active Duty

TRICARE Prime provides comprehensive health coverage including enhanced preventive care and vision benefits. Service members have an assigned primary care manager (PCM) who provides most of the care through the Military or network provider and refers service members to specialists for care PCMs cannot provide. Service members and beneficiaries eligible for TRICARE Prime generally pay no out-of-pocket expenses for medical treatment.

TRICARE Prime Remote

TRICARE Prime Remote offers the same benefits as TRICARE Prime to eligible RC service members (and their beneficiaries), who generally live and work greater than 50 miles from a military hospital or clinic. The difference is that the PCM is a civilian provider in the TRICARE network.

Transitional Assistance Management Program

The TAMP provides 180 days of premium-free transition healthcare benefits after active duty TRICARE benefits end. To qualify for TAMP, the RC service member must have served on active duty for a period of more than thirty consecutive days in support of a contingency operation. The member is not eligible for TAMP while on terminal leave and eligibility must be documented and maintained in the DEERS. During the TAMP benefit period, members are eligible to use TRICARE Prime, TRICARE Standard and Extra, U.S. Family Health Plan, TRICARE Prime Overseas, or TRICARE Standard Overseas.

Line of Duty Care

RC service members may be covered by LOD care for wounds, illnesses, and injuries determined to be incurred or aggravated while in a qualifying duty status or while traveling to or from the place of duty. Qualifying status may include inactive duty (drill), funeral honors duty, or active duty.

RC service members' components issue LOD determinations that specifically identify the qualifying medical or dental condition to be treated by or covered at the expense of DoD. Since treatment and coverage are limited to the particular LOD condition only, LOD determinations are not recorded in the DEERS.

If RC service members reside in the general area of an MTF (as indicated by the member's residential ZIP code in DEERS) that MTF will manage the LOD care. Generally, this includes RC service members who reside within the catchment area of an MTF. The member needs to make sure that his or her Service-issued LOD determination is on file at the MTF

If the member does not reside on an MTF area, Reserve and Service Member Support Office (RSMSO) will authorize care through the member's unit medical representative.

RC service members may be eligible to receive reimbursement for medications in connection with their LOD determinations through the RSMSO.

Once the RC issues a LOD determination, it is the RC service member's responsibility to ensure the written LOD determination is submitted either to a MTF or RSMSO.

Line of Duty Dental Care

RCs use LOD determinations for RC service members who incur or aggravate a dental injury, illness, or disease while on active duty and are not otherwise eligible of care under the Active Duty Dental Program. A dental LOD determination is not a resource for funding dental care for pre-existing conditions or routine care – for example, untreated cavities, wisdom tooth extraction, and cleanings.

Reserve and Service Member Support Office

The RSMSO (formerly known as Military Medical Support Office (MMSO)) is responsible for the authorization of civilian medical care for RC service members who incur or aggravate a wound, illness, or injury in the line of duty and do not reside in the general area of a MTF. In order for the RSMSO to authorize care, the member's unit medical representative must submit the RSMSO Medical Eligibility Verification Worksheet and a copy of orders or drill attendance sheet to the RSMSO. After the required medical eligibility documents have been submitted to the RSMSO for the initial episode of care, units can request a pre-authorization for follow up medical care through the RSMSO, Line of Duty section. This request must include a Service-approved LOD.

Appendix G

Mobilization/Demobilization and Deployment/ Redeployment Medical Services

Soldier Readiness Processing

The basic concept of the United States Army SRP is a program to verify individual soldiers' readiness both pre- and post-deployment. The SRP includes individual soldiers' administration, evaluations, interviews, and medical examinations.

Medical personnel conduct evaluations and examinations to qualify soldiers physical profiles and rate the soldiers on a scale of "1" through "4" for each of physical stamina, upper body, lower body, hearing, eyes, and psychiatric. A physical profile of "1" indicates the highest level of fitness. A physical profile of "2" indicates some medical condition or physical defect that could require activity limitations. A profile of "3" indicates a medical condition or defect that may require significant limitations. A profile of "4" indicates the individual has one or more conditions or defects of such severity that performance of military duty must be drastically limited, and usually is disqualifying. Soldiers also give blood samples to ensure proper blood type is recorded in their records and to have a current HIV test. They also are screened for psychiatric issues, receive a dental exam, receive all required immunizations, and other tests as needed. Additionally, female soldiers will get a pregnancy test.

Upon completion of the evaluations and exams, a healthcare provider, who reviews the soldier's conditions, makes a recommendation to the commander that the soldier is either medically deployable or non-deployable. However, command makes the final decision to deploy a soldier with certain medical conditions.

Navy Mobilization and Processing Site/Operational Support Center

All mobilized Navy RC service members will be medically screened at the Navy Mobilization and Processing Site (NMPS) for a "fit for duty" determination. Personnel failing initial NMPS medical screening will be referred to the Senior Medical Officer (SMO).

The primary mission of NMPS Medical Department is to:

- mobilize and demobilize Navy RC service members,
- support medical & dental processing, and
- verify sailors' original medical/dental records.

The average processing time for mobilizations can average up to 14 days. For demobilization, the processing time varies with medical requirements, personal needs, and the number of personnel processing.

Mobilization/Medical In-Processing

The NMPS will ensure all RC service members are “fully medically ready.” This status includes current physical and dental exams (dental class “1” or “2”), immunizations updated and current, and lab tests updated and current. Also, the NMPS ensures RC service members complete appropriate health assessments and receive appropriate health promotion/preventive counseling.

Demobilization/Medical Out-Processing

All demobilized/post-deployment screenings that were not completed in theater must be completed at the NMPS; including required lab work. Also, medical screening consistent with all DoD guidance will be conducted to determine if there are any medical issues that require follow-up. Issues identified in the demobilization/post-deployment screening must be resolved prior to release from the NMPS. Records of any medical care received in theater should be included in the member’s medical and dental records.

RC service members failing medical out-processing will be retained on active duty until their physical condition is fully evaluated and resolved. Likewise, a separation physical will be performed at the NMPS when needed. RC service members determined “unfit” to demobilize will be retained on active duty to receive follow-on medical and/or dental care and treatment necessary to restore their health.

Unless otherwise directed, RC service members who have completed a dental class 2 examination within 180 days of their demobilization date do not require another dental examination.

Service-Connected Illnesses or Injuries

RC service members who incur or aggravate a Service connected wounds, illnesses, and injuries while activated for more than 29 days are eligible for continued medical care.

Activated RC service members injured while on active duty orders of more than 29 days may, with the RC service member's consent, be continued on active duty until the RC service member is determined "fit for duty" or until the resulting incapacitation cannot be materially improved by further hospitalization or treatment and the case has been processed and finalized through a Medical Evaluation Board (MEB) and/or a PEB.

RC service members electing not to remain on active duty for treatment, regardless of medical needs, shall have their medical conditions fully documented in their medical record prior to release from active duty. This includes signing a release attesting to the decision despite the identified medical conditions. Additionally, each RC service member will be thoroughly briefed on a personal Medical Continuity of Care Plan for coverage after release from active duty.

Appendix H

Health Care Assessments

Periodic Health Assessment

The PHA is a screening tool used by the RCs to evaluate the IMR of their Service members. It can be conducted alone or can be combined with other IMR needs—for example, dental exam, and immunizations. The PHA is completed annually and consists of the following:

- an overall assessment of current health and IMR deficiencies,
- identification of potential risk factors that could lead to decreased health,
- identification and recommendation of a plan to minimize potential health risks,
- recommendations for treatment of current health problems, and
- an update of the service members' medical readiness through completion of service and an update of medical records.

Pre-Deployment Health Assessment

All DoD personnel deploying outside the continental United States (OCONUS) for 30 days or more, to a location with non-fixed U.S. MTFs must complete a Pre-Deployment Health Assessment (PDHA)²⁷ using the form DD 2795. The DD 2795 must be completed electronically or in web-enabled format following Service-specific directives and using one of the Service specific data systems.²⁸ The data will be sent electronically through the Service-specific data system to the Armed Forces Health Surveillance Center. In order for the PDHA to be completed, the DD 2795 must be reviewed and discussed in a face-to-face interview with a credentialed healthcare provider. The DD 2795 must be completed or confirmed as current within 120 days of the expected date of deployment.

²⁷ For OCONUS deployments less than 30 days, OCONUS deployments to areas with fixed U.S. MTFs, and CONUS deployments, it is the operational commander's decision on whether a PDHA is required prior to deployment.

²⁸ Service specific data systems include service-specific data systems such as Army Medical Protection System (MEDPROS), Air Force Preventive Health Assessment and Individual Medical Readiness (PIMR) or Air Force Complete Immunization Tracking System (AFCITA), and Navy Electronic Deployment Health Assessment (EDHA).

Post Deployment Health Re-Assessment

The PDHRA is a comprehensive health screening that is used to identify physical and behavioral health concerns associated with deployment and facilitate access to care. All service members who deployed OCONUS for a period of more than 30 days to a location with a non-fixed MTF must complete the PDHRA within 90 to 180 days after re-deployment/demobilization. A timely completion of the PDHRA is vital to identifying deployment-related health issues before they develop into serious issues.

The screening is comprised of these components:

- post-deployment resilience training,
- DD 2900, and
- a confidential, one-on-one discussion with a health care provider.

Appendix I

Reserve Health Readiness Program

The RHRP is a Department of Defense (Defense Health Agency) program executed by its current contractor, Logistics Health Incorporated (LHI). The program is designed to supplement the RCs readiness mission by providing PHA, PDHA, PDHRA, and other IMR services that satisfy key deployment requirements.

The RHRP provides medical and dental services to all RCs. RHRP services are provided on a group or individual basis. A group event generally occurs during drill weekend and LHI brings the providers, equipment, supplies, and support staff to the RCs location. Services offered on an individual basis take place in the office of an LHI network provider. Refer to Table 3 (page 64) for a listing of services RHRP provides to each RC component.

Table 3: RHRP Services Provided to RC Components (as of April 1, 2014)

RHRP Service	USAR	ARNG	MARFORRES	USNR	AFRC	ANG
Dental Exam	✓	✓	✓	✓	✓	✓
Panoramic X-Ray	✓	✓	✓	✓	✓	✓
Dental Treatment	✓	✓				
PHA	✓	✓	✓	✓	Pending	✓
Audiogram	✓	✓	✓	✓	✓	✓
Vision Screening	✓	✓	✓	✓		✓
Prescription Eyewear	✓	✓	✓	✓		
CVSP Lab	✓	✓	✓	✓		
HIV Testing	✓	✓				✓
PDHRA	✓	✓	✓	✓	✓	✓
Stand Alone MHA			✓	✓	✓	✓
Immunizations	✓	✓	✓	✓	✓	✓
PPD/TB Screening	✓	✓	✓	✓	✓	✓
Pregnancy Test Lab Work	✓	✓				

Source: Defense Health Agency

Abbreviations

PHA	Periodic Health Assessment
CVSP	Cardiovascular Screening Program
HIV	Human Immunodeficiency Virus
PDHRA	Post-Deployment Health Reassessment
MHA	Mental Health Assessment
PPD/TB	Purified Protein Derivative/Tuberculosis (Tuberculosis Skin Test)

Appendix J

Fit-for-Duty and Deployment Limiting Conditions

Fit-for-Duty

In accordance with DoDI 1332.38, “Physical Disability Evaluation,” November 14, 1996, E3.P3.2, “General Criteria for Making Unfitness Determinations,” a service member shall be considered unfit when evidence establishes that the member, due to physical disability, is unable to reasonably perform duties of his or her office, grade, rank, or rating (hereafter called duties) to include duties during a remaining period of Reserve obligation.

- E3.P3.2.2: In making a determination of a member’s ability to so perform his/her duties, the following criteria may be included in the assessment.
- E3.P3.2.2.1: The medical condition represents a decided medical risk to the health of the member or the welfare of other members were the member to continue on active duty or in an Active Reserve status.
- E3.P3.2.2.2: The medical condition imposes unreasonable requirements on the military to maintain or protect the member.
- E3.P3.2.2.3: The service member’s established duties during any remaining periods of reserve obligation.

Duty Limiting Conditions

In accordance with DoDI 6490.07, “Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees,” February 5, 2010, Enclosure 3, “Medical Conditions Usually Precluding Contingency Deployment,” a list of all possible diagnoses and their severity that may cause an individual to be potentially non-deployable, pending further evaluation would be too extensive. Medical evaluators must consider climate, altitude, rations, housing, duty assignment, and medical services available in theater when deciding whether an individual with a specific medical condition is deployable. In general, individuals with the following conditions, based upon a medical assessment, shall not deploy unless a waiver is granted:

- conditions affecting force health protection,
- unresolved health conditions requiring care or affecting performance,
- conditions that could cause sudden incapacitation,
- pulmonary disorders,
- sensory disorders,

- cardiac and vascular disorders, and
- mental health disorders
- Duty Limiting Conditions.

Report To Congress

House Report 111-491, page 285, to accompany the H.R. 5136, the Ike Skelton National Defense Authorization Act for 2011, request the Secretary of Defense examine the use of, and justification for, the “Fit, But Unsuitable” administrative separation process within the Military Departments and report findings and recommendations to the House and Senate Armed services Committees by May 1, 2011. The following letters and report from the Undersecretary of Defense on pages 67-75 responded to that request.

**Office of the Under Secretary of Defense, Personnel
and Readiness Report to Congress: Fit But Unsuitable,
Administrative Separations**



PERSONNEL AND
READINESS

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

APR 25 2011

The Honorable Carl Levin
Chairman, Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

House Report 111-491, page 285, to accompany H.R. 5136, the Ike Skelton National Defense Authorization Act for Fiscal Year 2011, requested that the Secretary of Defense examine the use of, and justification for, the "Fit, But Unsuitable" administrative separation process within the Military Departments and report findings and recommendations to the House and Senate Armed Services Committees by May 1, 2011. This letter responds to that request.

The Military Departments were asked to report the number of administrative separations for the past 3 fiscal years that were based on a determination the member was unsuitable for deployment or worldwide assignment, after the member was deemed fit for duty by a Physical Evaluation Board for the same condition, and their justification for these separations. Enclosed is the Military Departments' response to those requests.

When compared to the more than 170,000 discharges that normally occur each year, the Military Departments' use of "Fit, But Unsuitable" administrative separations has been limited. The Department of the Air Force and Department of the Army reported they have had no "Fit, But Unsuitable" administrative separations during the last 3 fiscal years. The Department of the Navy reported a total of 173 "Fit, But Unsuitable" administrative separations during the last 3 fiscal years. Following enactment of section 534 of Public Law 111-383, the Department of the Navy has ceased using "Fit, But Unsuitable" administrative separations. In addition, Change 2, to Department of Defense Instruction 1332.14, *Enlisted Administrative Separations*, will incorporate provisions of title 10, United States Code, section 1214a, as added by section 534 of the Ike Skelton National Defense Authorization Act for Fiscal Year 2011 (Public Law 111-383).

The Department appreciates your interest in this matter and looks forward to working with Congress to ensure continued support of our military members.

Sincerely,

Clifford L. Stanley

Enclosure:
As stated

cc:
The Honorable John McCain
Ranking Member

Office of the Under Secretary of Defense, Personnel and Readiness Report to Congress: Fit But Unsuitable, Administrative Separations (cont'd)



PERSONNEL AND
READINESS

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

APR 25 2011

The Honorable Howard P. "Buck" McKeon
Chairman, Committee on Armed Services
U. S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

House Report 111-491, page 285, to accompany H.R. 5136, the Ike Skelton National Defense Authorization Act for Fiscal Year 2011, requested that the Secretary of Defense examine the use of, and justification for, the "Fit, But Unsuitable" administrative separation process within the Military Departments and report findings and recommendations to the House and Senate Armed Services Committees by May 1, 2011. This letter responds to that request.

The Military Departments were asked to report the number of administrative separations for the past 3 fiscal years that were based on a determination the member was unsuitable for deployment or worldwide assignment, after the member was deemed fit for duty by a Physical Evaluation Board for the same condition, and their justification for these separations. Enclosed is the Military Departments' response to those requests.

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The Department appreciates your interest in this matter and looks forward to working with Congress to ensure continued support of our military members.

Sincerely,

Clifford L. Stanley

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

***Office of the Under Secretary of Defense, Personnel
and Readiness Report to Congress: Fit But Unsuitable,
Administrative Separations (cont'd)***



REPORT TO CONGRESS
ON
FIT, BUT UNSUITABLE, ADMINISTRATIVE SEPARATIONS

April 2011

Prepared By:
Office of the Under Secretary of Defense
Personnel and Readiness

Preparation of this study/report cost the Department of Defense a total
of approximately \$14,941 in Fiscal Years 2010-2011.

Generated on 2011Apr05 1451 RefID: 3-3D7CCB7

Office of the Under Secretary of Defense, Personnel and Readiness Report to Congress: Fit But Unsuitable, Administrative Separations (cont'd)



PERSONNEL AND
READINESS

UNDER SECRETARY OF DEFENSE

4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

FEB 28 2011

MEMORANDUM FOR SECRETARIES OF THE MILITARY DEPARTMENTS

SUBJECT: Request for Military Department Inputs for Report to Congress – Fit, But Unsuitable Administrative Separations

- References:
- (a) House Report 111-491, page 285
 - (b) Section 534 of Public Law 111-383, "National Defense Authorization Act for Fiscal Year 2011," January 5, 2011
 - (c) DoD Instruction 1332.14, "Enlisted Administrative Separations," August 28, 2008

The House Committee on Armed Services, in House Report 111-491, page 285 (reference (a)), requested that the Secretary of Defense examine the use of and justification for the "Fit, But Unsuitable" separation process within the military departments and report findings and recommendations to the House and Senate Armed Services Committees by May 1, 2011.

Congress is clearly concerned with the Department's use of "Fit, But Unsuitable" administrative separations. Section 534 of Public Law 111-383 (Reference (b)), amends section 1214a of title 10, United States Code, placing new restrictions on the administrative separation of a member of the Armed Forces. These new restrictions will be incorporated into DoD Instruction 1332.14 (Reference (c)).

By March 24, 2011, please have your staff provide for each of the last 3 fiscal years, the number of administrative separations based on a determination the member was unsuitable for deployment or worldwide assignment after the member was deemed fit for duty by a Physical Evaluation Board for the same condition. If your Department used this basis for administrative separations, I will also need strong justification for your Department's use of such separations. My point of contact is [REDACTED], at [REDACTED] or [REDACTED].

A handwritten signature in black ink, appearing to read "Clifford L. Stanley".

Clifford L. Stanley

**Office of the Under Secretary of Defense, Personnel
and Readiness Report to Congress: Fit But Unsuitable,
Administrative Separations (cont'd)**



DEPARTMENT OF THE AIR FORCE
WASHINGTON, DC

MAR 30 2011

OFFICE OF THE ASSISTANT SECRETARY

MEMORANDUM FOR THE PRINCIPAL DEPUTY UNDER SECRETARY OF DEFENSE
(PERSONNEL AND READINESS)

FROM: Assistant Secretary of the Air Force (Manpower and Reserve Affairs)

SUBJECT: Air Force Inputs for Report to Congress – Fit, But Unsuitable Administrative
Separations

Reference your 28 Feb 11 memorandum, Request for Military Department Inputs for
Report to Congress – Fit, But Unsuitable Administrative Separation.

The Air Force reports zero findings to the tasking outlined in paragraph three of your
memorandum. The Air Force did not administratively separate any Airman in the last three
fiscal years who was found unsuitable for deployment or worldwide assignment after being
deemed fit for duty by a Physical Evaluation Board for the same condition.

My point of contact for this action is [REDACTED], ([REDACTED]) or via
email at [REDACTED].


DANIEL B. GINSBERG
Assistant Secretary
(Manpower and Reserve Affairs)

Attachment:
USD (P&R) Memo dated 28 Feb 11

Office of the Under Secretary of Defense, Personnel and Readiness Report to Congress: Fit But Unsuitable, Administrative Separations (cont'd)



REPLY TO
ATTENTION OF

DEPARTMENT OF THE ARMY
OFFICE OF THE ASSISTANT SECRETARY OF THE ARMY
MANPOWER AND RESERVE AFFAIRS
111 ARMY PENTAGON
WASHINGTON DC 20310-0111

SAMR-MP

25 APR 2011

MEMORANDUM FOR Under Secretary of Defense (Personnel and Readiness)

SUBJECT: Request for Military Department Inputs for Report to Congress – Fit, But Unsuitable Administrative Separations

1. Reference memorandum, Under Secretary of Defense (Personnel and Readiness), February 28, 2011, subject: Request for Military Department Inputs for Report to Congress – Fit, But Unsuitable Administrative Separations.
2. None of the three components of the Army have separated any Soldiers in the past 3 years after the member was deemed fit for Duty by a Physical Evaluation Board (PEB) for the same reason for which the PEB considered them.
3. The Active component of the Army had a total of 2,185 Soldiers found fit by a PEB. Of those, 70 were administratively separated from the Army in FY's 2008, 2009 and 2010 for the following reasons: Drug and Alcohol rehabilitation failure (1 in 2009, 1 in 2010), to attend civilian school (1 in 2008, 1 in 2009), dropped from the rolls (1 in 2008), dependency/hardship (1 in 2008, 1 in 2009, 1 in 2010), homosexual conduct (1 in 2008), in lieu of court-martial (2 in 2009, 2 in 2010), misconduct (1 in 2008, 4 in 2009, 10 in 2010), parenthood (3 in 2008, 5 in 2009 and 9 in 2010), pregnancy (1 in 2008, 1 in 2010), early separation (3 in 2010), surviving family member (1 in 2010), physical/mental condition different than what PEB considered (2 in 2008, 4 in 2009 and 5 in 2010), personality disorder (1 in 2008), unsatisfactory performance (3 in 2010), weight control (2 in 2009 and 2 in 2010).
4. The Army National Guard had a total of 431 Soldiers found fit by a PEB. Of those, 23 were administratively separated in FY's 2008, 2009 and 2010 for the following reasons: Voluntary retirement (3 in 2008, 5 in 2009 and 10 in 2010), voluntary resignation of commission (1), found unfit by State MOS/ medical retention board (MMRB) (2 in 2008, 3 in 2009).
5. The Army Reserve had a total of 496 Soldiers found fit by a PEB. Of those, none have been separated.

***Office of the Under Secretary of Defense, Personnel
and Readiness Report to Congress: Fit But Unsuitable,
Administrative Separations (cont'd)***

SAMR-MP

SUBJECT: Request for Military Department Inputs for Report to Congress – Fit, But
Unsuitable Administrative Separations

6. The point of contact for this action is [REDACTED], [REDACTED] or
[REDACTED]


SAMUEL B. RETHERFORD
Deputy Assistant Secretary of the Army
(Military Personnel) 1 Apr 2011

Office of the Under Secretary of Defense, Personnel and Readiness Report to Congress: Fit But Unsuitable, Administrative Separations (cont'd)



DEPARTMENT OF THE NAVY
OFFICE OF THE SECRETARY
1000 NAVY PENTAGON
WASHINGTON, D.C. 20350-1000

MAR 29 2011

MEMORANDUM FOR UNDER SECRETARY OF DEFENSE (PERSONNEL AND READINESS)

SUBJECT: Department of the Navy Review of Fit, But Unsuitable Administrative Separations

Navy and Marine Corps have reviewed subject separations in accordance with your memo of 28 February 2011. Navy involuntarily separated 43 Sailors in Fiscal Year (FY) 08, 45 Sailors in FY09 and 51 Sailors in FY10 who were found fit by the Physical Evaluation Board (PEB) but were later determined to be assignment-limited during operational screening. Marine Corps involuntarily separated 12 Marines in FY08, 12 Marines in FY09 and 10 Marines in FY10 who were found fit by the PEB but were later determined to be assignment limited during operational screening.

The Department of the Navy (DON) PEB considers assignability, among many other factors, when making a fitness determination in an “ability-based” system. The PEB cannot determine assignability to every location worldwide or in every operational environment.

Sailors and Marines who return to duty after being deemed “fit” by the PEB are required to undergo assignability screening in accordance with the Bureau of Medicine Instruction (BUMEDINST) 1300.2A. The intent of this screening is to identify Service members who may have a disease or condition that may be beyond the treatment capability of an operational unit or remote location. Service members who are deemed “fit”, but who are assignment-limited are referred to the Service distribution branches for assignment.

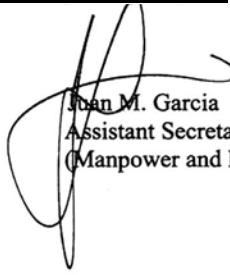
Generally speaking, the DON allows retention until the End of Active-duty Obligation of Service (EAOS) contract date of those found fit by the PEB, but who may have a condition that prohibits their operational assignment. This decision is made on a case-by-case basis, balancing the needs of the Service with the desires and capabilities of the individual member. The Navy and Marine Corps, as expeditionary forces, have significant deployment requirements to small units or remote locations, complicating medical support available to personnel. In certain instances, retaining these members on active duty compromises the ability of the Navy to meet shipboard or overseas manning needs, as these members count against end strength limitations despite their inability to fill any available operational billet. The issue is exacerbated in military operational specialties/ratings with high operational demand but low density (inventory) of

***Office of the Under Secretary of Defense, Personnel
and Readiness Report to Congress: Fit But Unsuitable,
Administrative Separations (cont'd)***

SUBJECT: Department of the Navy Review of Fit, but Unsuitable Administrative Separations

personnel, particularly while the DON undergoes efforts to reduce and shape its forces to meet operational needs.

In accordance with Section 534 of Public Law 111-383, the National Defense Authorization Act for FY 2011, DON has ceased the practice of involuntary administrative separation for those found fit by the PEB but unsuitable by the Service personnel commands. My point of contact is [REDACTED] who can be reached at [REDACTED] or electronically at [REDACTED].



Juan M. Garcia
Assistant Secretary of the Navy
(Manpower and Reserve Affairs)

Appendix K

Extension of Active Duty Orders

Active Duty Medical Extension

The Active Duty Medical Extension (ADME) program is an Army program designed to voluntarily place RC soldiers on temporary active duty in order to evaluate or treat their Service connected medical conditions or injuries so that they may be returned to back to duty as soon as possible. In order to be eligible for ADME orders, a soldier must have incurred or aggravated a Service-connected wound, injury, or illness while in an inactive-duty-for-training or non-mobilization active duty status. The medical condition must also prevent the soldier from performing his or her Military Occupation Specialty (MOS) or Area of Concentration (AOC) within the confines of a Profile (DA 3349) issued by a military medical authority.

Medical Retention Processing

The Medical Retention Processing (MRP) program is an Army program designed to compassionately evaluate and treat the RC Warrior in Transition with an in the line of duty incurred wound, illness, or injury, or an aggravated pre-existing medical condition which prevent them from performing the duties required by their MOS and or position. The program applies to outpatient and in-patient Warriors in Transition—for example, RC Warriors currently on active duty mobilized under 10 U.S.C. § 12301 (2013) partial mobilization orders for operations in support of the Global War on Terror. A soldier is eligible for MRP when he or she is not expected to return to duty within 60 days from time of injury or if the soldier could return to duty within 60 days, but will have fewer than 120 days left on his or her current mobilization orders.

Medical Retention Processing 2

The Medical Retention Processing 2 (MRP2) program is an Army program designed to voluntarily place RC Soldiers on temporary active duty for medical evaluation or medical treatment. MRP2 orders apply to RC soldiers with unresolved mobilization connected medical conditions that either were not identified or did not reach optimal medical benefit prior to their release from active duty (REFRAD). The medical condition must have occurred while mobilized under section 12301 (d), title 10, United States Code (10 USC § 12301 (d) [2013]) and 10 USC § 12302 (2013) partial mobilization orders for operations in support of Overseas Contingency Operation.

Reserve Component Managed Care – Mobilization

Army National Guard soldiers who incurred a line of duty Service-connected wound illness or injury while mobilized in support of a contingency operation and who were released from active duty, may voluntarily return to title 10 Active Duty for care utilizing Reserve Component Managed Care-Mobilization (RCMC-M) orders for medical treatment or evaluation. Only Soldiers with low risk, low acuity conditions requiring medical care for 179 days or less are eligible for managed care under this policy. RCMC-M active duty orders can be published at any time during the treatment period, based on the severity of the injury or illness diagnosed. The soldier's duty location will be the nearest State Armory or United States Army Reserve unit when the soldier is not attending appointments, and will not exceed 50-mile radius from the soldier's home of record. While participating in the RCMC-M program, the soldier will not be permitted to perform title 32 duties or mission, civilian employment, civilian education, or civilian training classes during normal duty hours.

Reserve Component Managed Care – Training

Army National Guard soldiers who incurred a LOD, Service-connected wound, illness, or injury while participating in training, and who were released from training, may voluntarily return to active duty in order to use Reserve Component Managed Care-Training (RCMC-T) orders for medical treatment or evaluation. Only soldiers with low risk, low acuity conditions requiring medical care for 179 days or less are eligible for managed care under this policy.

RCMC-T active duty orders can be published at any time during the treatment period, based on the severity of the injury or illness diagnosed. The soldier's duty location will be the nearest State Armory or United States Army Reserve unit when the soldier is not attending appointments, and will not exceed a 50-mile radius from the soldier's home of record. While participating in the RCMC-T program, the soldier will not be permitted to perform title 32 duties or mission, civilian employment, civilian education, or civilian training classes during normal duty hours.

Medical Continuation Orders

Medical Continuation Orders (MEDCON) orders extend entitlements to Airmen who are unable to perform military duties due to wounds, illnesses, or injuries incurred or aggravated while on orders or in inactive duty training status (IDT). MEDCON eligibility requires a line of duty determination and a finding by a credentialed military health care provider that the Airman is unable to perform military duties. The provider must determine the Airman has an unresolved condition that requires treatment and renders the Airman unable to meet mobility or retention standards. Airmen who meet eligibility criteria for MEDCON orders must volunteer for retention or recall to duty. While on MEDCON orders, the Airman is primarily responsible for medically improving in order to return to full duty or to process through the integrated disability evaluation system (IDES).

Medical Hold

The Navy and Marine Corps Medical Hold (MEDHOLD) programs are personnel programs developed to allow RC service members serving on active duty for more than 30 consecutive days to remain on active duty for medical care and treatment. MEDHOLD is intended as a short-term medical treatment program, with the ultimate goal of returning the service member to a fit for duty status, or to have them process through the Disability Evaluation System (DES). The benefit Issuing Authorities of the Navy and Marine Corps MEDHOLD programs are responsible for establishing administrative procedures for determining placement of members in a MEDHOLD status, issuing of LOD determination documentation as appropriate, and central tracking and monitoring of members on MEDHOLD and on an LOD.

The benefits issuing authority for Navy MEDHOLD is the Reserve Component Command. The benefits issuing authority for the Marine Corps MEDHOLD is the Wounded Warrior Regiment – Reserve Medical Entitlements Division and Medical Review Team. Both Navy and Marine Corps MEDHOLD members require a detailed care plan, placement in a Limited Duty (LIMDU) status, and processed through the Medical Evaluation Board and/or (Integrated) Disability Evaluation System as appropriate.

Appendix L

Recommendations for Future Assessments

Interconnectivity of Medical Systems

Throughout this assessment, it was reported that the medical information systems required to properly manage RC service members medical and dental care did not always have the ability to share information. This has the potential to degrade the medical readiness of the RCs. Recommend an assessment dedicated specifically to the effectiveness of the interconnectivity of all medical systems required to properly manage the medical and dental status of RC service members.

Self-Reporting Health Assessments

Throughout this assessment, concerns were expressed about the portion of self-reporting medical status during health assessments. The first concern was that RC service members may not actually know they have medical conditions to report. The second concern was that RC service members may be reluctant to disclose known medical conditions because of concern of possibly being denied mobilization/deployment, re-enlistment, or retainability. This has the potential to degrade the medical readiness of the RCs or risk deploying medically non-deployable persons. Recommend an assessment of how RC service members' self-reporting on health assessments evaluates the RCs' actual Individual Medical Readiness. Likewise, include how self-reporting on periodic and pre-deployment health assessments ensures that the complete medical status of RC service members is established prior to mobilization/deployment. Furthermore, assess how self-reporting on post-deployment health assessments correctly identifies RC service members Service-related wounds, illnesses and injuries incurred or aggravated in the line of duty.



Management Comments

Under Secretary of Defense Response



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

██████████
Director, Medical Division, Inspector General, Special Plans and Operations
Department of Defense
4800 Mark Center Drive, Suite II K25
Alexandria, VA 22350-1500

Dear ██████████

I am responding to your request for comments to recommendations 1, 2, 3, 4, and 5 of the Department of Defense Inspector General's (DoDIG) "Draft Assessment of DoD-Provided Healthcare for Members of the United States Armed Forces Reserve Components" (RC; p. iii, Project No. D2013-DOOSPO-0212.000).

Recommendation #1: Assistant Secretary of Defense for Reserve Affairs establish guidance that requires all Active Component service members who transfer into the Selected Reserve meet individual Medical Readiness Requirements.

Comment: Concur with comment. Request to change follow-up to Office of the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) as the point of contact (POC).

Justification: This issue crosses multiple ASDs within USD(P&R). USD(P&R) will assign appropriate responsibilities for required changes.

Health Affairs (HA) is the proponent for policies and procedures for both DoD Instructions 6025.19, "[Individual Medical Readiness \(IMR\)](#)," and 6130.03, "[Medical Standards for Appointment, Enlistment, or Induction in the Military Services](#)." Any guidance for medical standards requirement upon affiliation into the Selected Reserve should be incorporated into these issuances. The concerns identified by the Reserve Components (RC) regarding the transfer/accesion from Active Component (AC) to RC are covered in policies residing in both Reserve Affairs (RA) and HA. The Services have implemented policies based on DODI 6130.03, however further policy noted in DODI 1200.15, "[Assignment to and Transfer Between Reserve Categories, Discharge from Reserve Status, Transfer to the Retired Reserve, and Notification of Eligibility for Retired Pay](#)," will clarify the need for Service members to be physically fit before being able to transfer/assess into the Selected Reserve.

Under Secretary of Defense Response (cont'd)

Recommendation #2: Under Secretary of Defense for Personnel and Readiness develop and implement a plan that ensures Reserve Components' service personnel authorizations allow units to retain service members in accordance with 10 U.S.C. §1214a while meeting unit deployment requirements.

Comment: Concur.

Recommendation 3: Assistant Secretary of Defense for Health Affairs ensure that Army Reserve Component service members receive DoD-provided medical evaluations of temporary medical profiles in accordance with AR 40-501" (p. 29).

Comment: Concur with comment. A medical evaluation is not the same as medical treatment. The eligibility criteria for medical treatment at DoD expense are specifically established by Congress in law. As stated, the conclusion (p. 29) suggests an entitlement to medical treatment at DoD expense when a condition was not incurred in the line of duty and a Reserve Component (RC) member is not entitled to it by law. AR 40-501 further specifies, "It is the responsibility of RC Soldiers to maintain their medical and dental fitness ... [and they] are responsible for providing the unit commander all medical documentation, including civilian health records ... documenting a change which may impact their readiness status" (paragraph 9-3, page 104). With the proper information, the Army Profiling Officer can proceed to complete the required medical evaluation, even if the treatment was rendered by a civilian provider at RC member expense. I suggest that the conclusion immediately preceding recommendation 3 be revised as follows:

"Conclusion – Defense Health Agency (DHA) indicated that the issuance of a temporary medical profile, by itself, did not entitle RC members to healthcare at DoD expense. AR 40-501 requires all Army RC members issued temporary medical profiles to be medically evaluated at least once every three months until the requirement for the profile was no longer required (paragraph 7-4, page 74). It continues that Army RC members are responsible for providing the unit commander all medical documentation, including civilian health records that document a change which may impact their readiness status (paragraph 9-3, page 104). With the proper information, the Army Profiling Officer can proceed to complete the required medical evaluation, even if the treatment was rendered by a civilian provider at RC member expense."

"Recommendation 4 – Assistant Secretary of Defense for Health Affairs establish policy that assigns responsibilities to Commanders and medical authorities to manage medical histories and line of duty documentation for deployed or temporary duty RC service members in a standardized manner across all Services, so that both are complete and available to their units in a timely manner" (p. 33).

Comment: Concur with comment. Request to change follow-up to USD(P&R) as POC.

Under Secretary of Defense Response (cont'd)

Justification: This issue crosses multiple ASDs within USD(P&R). USD(P&R) will assign appropriate responsibilities for required policy changes.

HA will work with RA to update DoD policies cited in the DoDIG Assessment (DoD Directive 1241.01 and DoD Issuance 1241.2). HA is the policy proponent and oversight authority for the medical records and has responsibility to establish policies and procedures for managing the medical records and history of Service members. Director, Defense Health Agency (DHA), will establish proper management controls required to assure Defense Health Program Appropriation funds are properly used for Line of Duty (LOD) entitlements under law.

“Recommendation 5 – Assistant Secretary of Defense for Health Affairs establish standardized DoD form(s) and procedures that provide access for all Reserve Component service members to line of duty care at all Military Treatment Facilities” (p. 37).


Comment: Concur with comment. Request to change follow-up to USD(P&R) as the POC.

Justification: This issue crosses multiple ASDs within USD(P&R). USD(P&R) will assign appropriate responsibilities for required changes.

RA is establishing a DD Form for entitlement to line of duty health care in the reissuance of DoD Directive 1241.01. There is already an established information requirement, Report Control Symbol DD-RA(AR)2421, for establishing an entitlement condition for line of duty health care in the Reserve Components Common Personnel Data System. This information will be used to establish a requirement in to the Defense Enrollment Entitlement Reporting System, the Department's medical entitlement repository, to record an entitlement to line of duty health care conditions. As needed, HA will task the Director, DHA, to establish any additional standardized DoD form(s) and the procedures to make it usable for purchased care as well.

P&R appreciates the opportunity to comment on the draft assessment. The point of contact in this matter is [REDACTED] [REDACTED] may be reached at [REDACTED] or [REDACTED]

Sincerely,


Virginia S. Penrod
Chief of Staff

cc:
HA
RA



Acronyms and Abbreviations

AD	Active Duty
ADME	Active Duty Medical Extension
AFR	Air Force Reserve
AGR	Active Guard Reserve
ANG	Air National Guard
ARNG	Army National Guard
CONUS	Continental United States
CVSP	Cardiovascular Screening Program
DEERS	Defense Enrollment Eligibility Reporting System
DES/IDES	Disability Evaluation System/Integrated Disability Evaluation System
IMA	Individual Mobilization Augmentee
IMR	Individual Medical Readiness
ING	Inactive National Guard
IRR	Individual Ready Reserve
LIMDU	Limited Duty
LOD	Line of Duty
MARFORRES	Marine Forces Reserve
MCIRSA	Marine Core Individual Reserve Support Active
MEB	Medical Evaluation Board
MEDCON	Medical Continuation (orders)
MEDHOLD	Medical Hold (Navy and Marine Corps)
MHA	Mental Health Assessment
MMSO	Military Medical Support Office
MRP	Medical Retention Processing
MRP 2	Medical Retention Processing 2
MTF	Military Treatment Facility
NMPS	Navy Mobilization and Processing Site
NOSC	Navy Operational Support Center
OCONUS	Outside the Continental United States
P&R	Program and Resources
PDHA	Pre (or Post) Deployment Health Assessment
PDHRA	Post Deployment Health Reassessment
PEB	Physical Evaluation Board
PHA	Periodic Health Assessment
PPD/TB	Purified Protein Derivative / Tuberculosis
RSMSO	Reserve and Service Member Support Office

Acronyms and Abbreviations (cont'd)

RC	Reserve Component
RCMC-M	Reserve Component Managed Care-Mobilization
RCMC-T	Reserve Component Managed Care-Training
REFRAD	Release From Active Duty
RHRP	Reserve Health Readiness Program
SRP	Soldier Readiness Processing
TAMP	Transitional Assistance Management Program
TPU	Troop Program Unit
USAR	United States Army Reserve
USNR	United States Navy Reserve
USAFR	United States Air Force Reserve

Whistleblower Protection

U.S. DEPARTMENT OF DEFENSE

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