UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

APR 18 2013

The Honorable Harold Rogers
Chairman
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

In 2011, the Departments of Defense (DoD) and Veterans Affairs completed implementation of the Integrated Disability Evaluation System (DES), a joint process whereby DoD determines fitness for duty and both Departments determine eligibility for disability compensation and benefits for wounded, ill, or injured Service members. Although encouraged by initial feedback on Integrated DES performance, the House Committee on Armed Services, in House Report 112-78, to accompany H.R. 1540, the National Defense Authorization Act of Fiscal Year 2012, expressed concern about inconsistent ratings and asked the Secretary of Defense to report on the feasibility, propriety, and cost of implementing a consolidated DoD DES to achieve more consistent disability outcomes. I apologize for the delay in providing this information.

The enclosed report outlines DoD's review of options for a Consolidated DES. DoD determined two options are feasible and maintain the propriety of the Integrated DES sought by Congress. Even though both options identify strategic reform opportunities, there were limitations identified during this study that time did not permit us to address. Given the importance of the DES program to our Service members and their families, DoD concluded further research is needed to determine if consolidation would resolve perceived or real problems with disparate ratings. The Department intends to launch a broad, comprehensive study on how to best implement appropriate reforms. Due to the complex nature of this issue, the study will take 15 months (estimated) to complete. I will provide an interim report by December 2013, and a final report by August 2014.

The Department welcomes the interest of Congress in the management of DES and the improvement of care and treatment of our wounded, ill, and injured Service members. A similar letter is being sent to the Chairmen of the other congressional defense committees.

Sincerely,

Jessica L. Wright
Acting

Enclosure:
As stated

cc:
The Honorable Nita M. Lowey
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

APR 18 2013

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

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Jessica L. Wright
Acting

Enclosure:
As stated

cc:
The Honorable James M. Inhofe
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

APR 18 2013

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

Dear Mr. Chairman:

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Sincerely,

Jessica L. Wright
Acting

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

APR 18 2013

The Honorable Barbara A. Milkulski
Chairwoman
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Madam Chairwoman:

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Sincerely,

Jessica L. Wright
Acting

Enclosure:
As stated

cc:
The Honorable Richard C. Shelby
Vice Chairman

Report to the Congressional Committees

Consolidation of the Disability Evaluation System

In response to: House Committee Report 112-78, to accompany H.R. 1540, the National Defense Authorization Act for FY 2012

Preparation of this report/study cost the Department of Defense a total of approximately $460,000 in Fiscal Years 2012 - 2013.Generated on 2012Sep21 1618 RefID: 9-18A82CD

Executive Summary

In 2011, the Departments of Defense (DoD) and Veterans Affairs (VA) completed implementation of the Integrated Disability Evaluation System (DES). Although encouraged by initial feedback on Integrated DES performance, the House Armed Services Committee, in its report to accompany H.R. 1540, the National Defense Authorization Act for Fiscal Year (FY) 2012 (Appendix 1: House Report 112-78), expressed concern about inconsistent ratings and asked the Secretary of Defense to report on the feasibility, propriety, and cost of implementing a consolidated DoD DES to achieve more consistent disability outcomes. This report provides results of a study addressing the Committee's concerns.

The committee report, which assumed that consistent results are easier to achieve in centralized organizations, focused primarily on achieving consistent disability outcomes. DoD identified multiple decision points in the Integrated DES that could potentially lead to inconsistent outcomes and discharge disabled Service members without due disability consideration or full compensation. During the Service controlled treatment/pre-screening process, these include the potential for overlapping symptomatology that can lead to diagnostic differences during treatment, mis-categorization of a Service member's medical condition as existing prior to military service, and failure to accurately consider all conditions that cause or contribute to unfitness. In addition, differences in Military Department implementation of DoD policy addressing appeal and review options in the disability system can create the perception that soldiers, sailors, marines, or airmen do not have the same opportunities to assure they receive a fair outcome.

While acknowledging that decisions during treatment or transition can affect disability evaluation outcomes, DoD focused the study on the Integrated DES process. DoD developed five alternative organizational structures that centralize the medical and physical evaluation and appeal portions of disability evaluation and disability determination. DoD categorized these consolidation options according to their degree of geographic centralization (decentralized, regional, or centralized) and centralization of organizational decision-making (Military Service or DoD agency). In all cases, DoD assumed DoD and VA disability evaluation processes would remain closely integrated as they are in the Integrated DES (for example, VA takes disability claims from Service members and provides disability examinations and ratings to DoD).

A subject matter expert cadre compared the feasibility, propriety, and cost of the five alternative structures to the Integrated DES, focusing on the Medical Evaluation Board and Physical Evaluation Board phases. The Medical Evaluation Board process begins after the point of a Service member's referral into the Integrated DES process and includes gathering all pertinent medical records, conducting a VA compensation and pension examination, and determination by a board of DoD physicians whether the Service member meets or does not meet retention standards. The Military Departments employ Physical Evaluation Board liaison officer case managers and lawyers to counsel Service members on expectations during this process. Once the Service member has been determined to not meet retention standards, a Physical Evaluation Board consisting of one or two line officers and a medical officer determine if the Service member does or does not meet fitness standards as required by law for their office, grade, rank, or rating.

Of the five alternative structures, DoD determined that two options were considered feasible for a Consolidated DES: 1) a DoD regional medical evaluation board with a centralized physical evaluation board, and 2) a DoD disability evaluation adjudication agency. Results of the analyses determined that both options allow efficient transfer of the Medical Evaluation Board and Physical Evaluation Board Service-specific functions to a regional or centralized organization while maintaining the propriety of the Integrated DES sought by Congress. This is especially important because Military Departments remain actively engaged with the Service member at the installation level in either option.

Under Option 1, a DoD regional medical evaluation board and centralized physical evaluation board consolidates Medical Evaluation Board responsibilities currently located at 139 Service-level Military Treatment Facilities into an east and west coast DoD regional organization. This approach eliminates Service differences in the Medical Evaluation Board that include dissimilar board composition, format, and training standards. Similarly, the DoD Centralized Physical Evaluation Board consolidates five Military Department Physical Evaluation Boards into one DoD agency that standardizes the Physical Evaluation Board format, composition, and training standards. DoD and VA disability evaluation processes remain integrated with the VA Disability Rating Activity Site rendering a disability rating for all claimed and referred conditions using the VA Schedule for Rating Disabilities. A DoD disability board of review offers an additional opportunity to standardize outcomes by allowing the Service member to request a review of their DoD physical evaluation board fitness determination.

Because the Military Departments maintain responsibility for initial referral of Service members into the Integrated DES process, there remains some opportunity for disparate outcomes during the treatment/pre-screen process. A DoD regional medical evaluation board and centralized physical evaluation board option also contains a risk in that, even though improved, the geographic detachment of the regional medical evaluation boards could still have a negative effect on consistency. The risk is somewhat minimized with the DoD Centralized Physical Evaluation Board maintaining oversight for both regional medical evaluation boards. A centralized DoD physical evaluation board provides Service members with their disability determination and utilizes a quality assurance office that coordinates with the DoD regional Medical Evaluation Board to fill the void that currently exists in the Integrated DES. The quality assurance program is considered a key component in providing Service members more consistent disability outcomes for the medical and physical evaluation boards by standardizing processes and identifying training deficiencies.

For Option 2**,** the Disability Evaluation Adjudication Agency (DEAA) restructures the Integrated DES by placing specially trained Federal employees, medical experts, and line officers under the oversight of a central DoD agency. This agency replaces the authority of a Military Department medical evaluation board and physical evaluation board in determining whether the Service member is physically fit for military service. Disparities in the composition and format of Service-level boards would no longer be an issue and the disability determination would be accomplished with little risk of impropriety as it would be conducted through a single agency using applicable DoD and Military Department standards. Replacing the non-standardized appeal options that currently exist between the Services allows the Service member to request the DoD agency reconsider their disability case by utilizing a different adjudicator.

Similarly, under Option 2 DoD and VA disability evaluation processes remain integrated with the VA Disability Rating Activity Site rendering a disability rating for all claimed and referred conditions using the VA Schedule for Rating Disabilities. As in Option 1, Service members who have received their DoD Adjudication decision can request a DoD Disability Board of Review evaluate their case to correct any inaccuracies based on the record of evidence. Because the Military Departments maintain responsibility for initial referral of Service members into the Integrated DES process, there remains some opportunity for disparate outcomes based on actions taken at 139 military treatment facilities during the treatment/pre-screen process.

Even though both options provide opportunities for further consideration of a Consolidated DES, there were limitations identified during this study that time did not permit us to address. Lacking a thorough Integrated DES manpower study, DoD was not able to determine from available information if current staffing levels and other critical resources are sufficient to meet Integrated DES goals. Given this key factor and the importance of the DES program to our Service members and their families, DoD concluded further research is needed prior to initiating such a major revision of the current system that: determines if consolidation would resolve any perceived or real problems with disparate ratings; ensures any undesirable impacts to the Service member and stakeholders are fully considered; identifies the role of the Service Secretaries in making the final determination of a Service member's fitness; and conducts a more complete cost analysis to determine resource impacts on the Military Departments.

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1. Overview

DoD and VA piloted the Integrated DES in 2007 within the limits of current law as a joint process whereby DoD determines fitness for duty and both Departments determine eligibility for disability compensation and benefits for wounded, ill, or injured Service members. The Integrated DES design addressed Congressional commission and task force recommendations to improve timeliness and consistency of disability benefit decisions. DoD surveys show Service members prefer the Integrated DES program over the "Legacy" DES and it has proven to be faster and more equitable and transparent. An added feature of the Integrated DES is that the unfit Service member receives DoD and VA disability benefits shortly after separation from service. Previously, the independent legacy DoD and VA processes resulted in an approximate 8-month gap between separation from service and receipt of VA compensation and benefits.

Although encouraged by initial Integrated DES feedback, the Committee on Armed Services of the House of Representatives expressed concern in its report accompanying H.R. 1540, the National Defense Authorization Act of FY12 "…that service members with similar disabilities are receiving disparate disability ratings because of different standards, policies, and procedures used by the Physical Evaluation Boards…" The House report further stated "that one method for ensuring such consistent outcomes is to operate a consolidated disability evaluation system within the Department of Defense" and requested the Secretary of Defense submit a report "on the feasibility, propriety, cost, and recommended legislation to implement such a consolidated disability evaluation system."

This report presents results from a study of options to consolidate the DoD DES. The study analyzed the processes used to determine a Service member's ability to continue in military service and disability level. The transition processes to veteran status after a final disability decision were considered but not analyzed. The study describes the manpower requirements and costs necessary to implement the best alternatives to a consolidated DES organizational structure. DoD found that while it is feasible to consolidate geographic organization and decision making, additional research is needed to determine if such a recommendation is advisable.

2. Methodology

This study examined congressional desire to determine the feasibility (capable of being done or dealt with successfully), propriety (suitable and appropriate for Service members and stakeholders), and cost (start-up and sustainment) of a consolidated DoD DES. The study evaluated each of these elements across four dimensions of organizational change that would be required to implement a consolidated DoD DES: people, processes, technology, and infrastructure. The study combined quantitative and qualitative analysis of DoD and Military Service policy, and Military Service organizational, manpower, and funding documents.

To inform understanding of current Integrated DES operations across each Service, the study collected and analyzed relevant process documents, including forms, policy memorandums, and DoD directives, and conducted interviews with Integrated DES process owners. DoD's review initially focused on identifying the points in the Integrated DES process where different Service standards, policies, and procedures could potentially result in inconsistent disability outcomes. Although Congress' language focused only on physical evaluation boards, DoD examined a broader span of activities from treatment/pre-screen to the physical evaluation board decision.

Through this approach, DoD identified several activities in the treatment/pre-screening, medical evaluation board or physical evaluation board phases of the disability process that can lead to inconsistent disability outcomes. From this examination of the Integrated DES process, DoD developed and evaluated several consolidation options. Figure 1 below illustrates DoD's research process; and, the following sections detail each step of the evaluation.

Figure 1: Approach to Reach Initial CDES Trends and Findings

2.1 Evaluation of Disability Evaluation System. After mapping each Service's Integrated DES processes and comparing them to DoD policy guidance, DoD identified the points in the Integrated DES process where decision errors or different standards, policies, and procedures could result in inconsistent disability outcomes. DoD also noted those areas where the Services maintain similar processes which might increase the feasibility of consolidation. Through this approach, DoD identified activities in the treatment/pre-screening, medical evaluation board and physical evaluation board phases of the disability process where errors or different standards, policies, and procedures may lead to inconsistent disability outcomes.

2.1.1 Treatment/Pre-screening Process. The treatment/pre-screening process occurs prior to referral into the Integrated DES. This process begins during medical treatment of the Service member at a Military Treatment Facility, a VA health care facility, or a civilian health care facility. All Services allow their physicians to place Service members in a limited duty status during this time to ensure they are not required to perform duties that would impede their recovery or allow them to be reassigned, transferred, or deployed during treatment and healing. Under DoD policy, a competent medical authority determines the Service member has one or more condition(s) which is suspected of not meeting medical retention standards. Once determination is made the physician will refer the Service member into the DES at the point of hospitalization or treatment when a member's progress appears to have medically stabilized (and the course of further recovery is relatively predictable) and when it can be reasonably determined that the member is most likely not capable of performing the duties of his office, grade, rank, or rating. The pre-screening process is complete upon successful recovery and return to duty or referral of a Service member into the Integrated DES. While each performs a similar function, the Military Departments utilize differing screening processes.

The Department of the Air Force implemented the most extensive pre-screen process, creating a full adjudicatory board, the Deployment Availability Working Group, at each of its Military Treatment Facilities. The Air Force Deployment Availability Working Groups determine the eligibility of all physician-referred cases prior to approving them for referral into the Integrated DES. Air Force Physical Evaluation Board Liaison Officers create case files on these Service members, and physicians complete a preliminary narrative summary to help inform the working group's decision. These Air Force working groups evaluate all Service members placed in a limited duty status. By comparison, the Army and Navy leave pre-screening responsibilities to their individual physicians. The Army requires that a physician, specialized in medical

evaluation board procedures, provide a second review of all potential Integrated DES cases prior to referral while the Navy allows all physicians to use their discretion in the screening and referral of Integrated DES cases. The training for physicians who make these decisions differs across the Military Departments. The Army requires physicians to undergo an extensive training program, whereas the Air Force and Navy conduct much of their training on-the-job.

In addition to procedural differences, DoD identified two key decisions during treatment and screening that can lead to inconsistent disability outcomes across the Military Departments. The first is the diagnostic process during treatment. A second decision that is critical to disability evaluation outcomes is whether a medical condition existed prior to military service. Pre-existing conditions are often excluded from disability evaluation or eligibility for compensation, unless they are aggravated by military service. Both of these differences suggest the need to examine whether changes in treatment and screening actions would increase the consistency of outcomes for disabled Service members.

2.1.2 Medical Evaluation Board Process. DoD identified activities in the medical evaluation board process that can lead to inconsistent outcomes for Service members undergoing disability evaluation. The medical evaluation board process begins after the point of a Service member's referral into the Integrated DES process and includes gathering all pertinent medical records, conducting a VA compensation and pension examination, and determination by a board of DoD physicians whether the Service member meets or does not meet retention standards. The Military Departments employ physical evaluation board liaison officer case managers and lawyers to counsel Service members on expectations during this process. Regardless of the initiating Military Treatment Facility into the Integrated DES, the Military Departments ensure all Service members receive a briefing on the Integrated DES process, their rights and expectations for outcomes.

At the beginning of the medical evaluation board process, the Military Department physician identifies the medical condition(s) leading to referral into the disability process. Although medical and physical evaluation board dispositions are is limited by the referring physician's decisions, the misidentification of potentially unfitting conditions, unintentional or otherwise, creates the possibility for medical and physical evaluation boards to exclude disabling conditions from consideration. This may occur when the referring physician must adjudicate cases of Service members with multiple, complex, inter-related conditions, some of which may not be compensable (for example, post-traumatic stress disorder superimposed on personality disorder). Another possibility is when the physician must categorize conditions that are not unfitting individually but may be unfitting in combination or in combined effect. While the medical and physical evaluation boards may reevaluate and correct a referring physician's decision, the distinctions made early in the medical evaluation process likely influence decisions rendered during each subsequent process. Decentralized decision making by referring physicians at the 139 military treatment facilities utilizing the Integrated DES creates a challenge to standardizing the identification of referred conditions in the medical evaluation board process.

Different standards across the Military Departments extend to the preparation for and execution of the medical evaluation board. Prior to this board, military physicians summarize medical evidence related to potentially unfitting conditions in a narrative summary, which informs the decisions of board members. Standards for the creation of this narrative summary vary across the Services, with differences including the author, details included, and length. The Navy and

Air Force use a narrative summary for referred conditions only, while the Army completes a narrative summary for all conditions. Medical evaluation board composition also varies across the Services. The Navy requires three board members, while the Army and Air Force require only two except for those cases involving a behavioral health diagnosis. For cases involving behavioral health issues, the Army and Air Force require three board members.

2.1.3 Physical Evaluation Board Process. Military Departments face similar challenges when striving for consistency of outcomes among separate physical evaluation boards. These boards determine the Service member's fitness to continue their military career. Each Military Service authors its own procedural guidance and standards for this fitness decision process that includes offering different appeal and review options.

As with the medical evaluation board, each Service has different requirements for the composition of their informal and formal physical evaluation boards. A current DoD exception to policy allows the Military Departments to utilize two-member boards to ease staffing constraints. While the Army and Air Force requires two board members, one line officer, and one physician, the Navy requires two line officers and one physician on their boards. Although Military Department physical evaluation boards are based on the same legislation and DoD policy, the existence of five Physical Evaluation Boards across the three Military Departments (three Army, one Navy, one Air Force) presents inherent challenges to maintaining consistency. Subject matter experts from the Department of the Navy indicated that inconsistent decision-making served as a primary driver behind the Navy's consolidation to a single physical evaluation board in 2004. Unlike VA, which employs a Systematic Technical Accuracy Review (STAR) quality control process to increase accuracy and uniformity among disability rating activities[1], DoD does not currently review completed case files to ensure consistency across the Military Departments.

2.1.4 Secretarial Review/Appeal Process. Once the physical evaluation board is complete, the criteria for a review by the Service Secretary and which cases are eligible for appeal differ across the Services, which may add to the perception that a soldier, sailor, marine, and airman do not have the same opportunities to assure they receive a fair outcome.

2.1.5 Transition Process. Once a Service member accepts the unfit disability evaluation finding, he or she must complete out-processing and separation or retirement obligations to transition from military service to the civilian community.

2.2 Options for Consolidation. Given that decentralized military treatment facilities provide treatment of similar quality and offer the advantage of collocating Service members with their families and treating physicians, DoD did not consider the treatment/pre-screen or referral process for geographic consolidation. Overlapping symptomatology and diagnostic differences during treatment can create inconsistent disability outcomes. However, DoD eliminated the issue of diagnostic differences during treatment from this study for two reasons. First, treatment is outside the scope of the Integrated DES; and, second, after initial diagnosis by a treating physician and upon referral to the Integrated DES, the Integrated DES includes a disability

[1] GAO, *VA Has Improved Its Programs for Measuring Accuracy and Consistency, but challenges Remain*, GAO-10-530T (Washington, D.C.: March 24, 2010).

examination and diagnosis by VA medical professionals, and provides for the opportunity to correct any diagnostic differences as necessary. DoD notes this decision created a limitation in the current study.

The study focused on opportunities to increase consistency in disability outcomes by analyzing the medical and physical evaluation board processes of the Integrated DES. The study categorized consolidation options according to their degree of geographic centralization (decentralized, regional, or centralized) and centralization of organizational decision-making (Military Service or DoD agency). DoD made the following distinctions: the organizational structure with the most geographic decentralization is one where military treatment facilities serve the Integrated DES; a regional structure is one in which east and west coast organizations make determinations on Service members; and a centralized geographic structure is one in which disability determinations occur at a single geographic location.

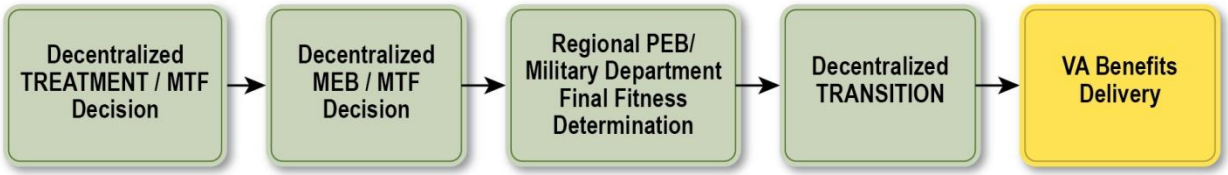
DoD defined three levels of centralization for decision-making. The most decentralized form of organizational decision-making is one in which the Military Secretary concerned (for example, the Secretary who leads the Military Service of the disabled member) or their designated representative holds authority to make all final disability determinations, such as disability rating level and fitness for military service. DoD defined a DoD organization as the mid-range degree of centralization for decision-making authority. In a DoD organization, adjudicators from each of the Military Departments would jointly make disability decisions about members of all Services. In this option, decision-making authority rests with the joint DoD board rather than the Military Secretary concerned. In the highest form of centralized decision-making, a DoD agency staffed with a mix of military and civil servant adjudicators, rather than just Military Service representatives, have the authority to make final disability determinations. This form of centralized decision-making is similar to the approach used by other Federal and State disability agencies wherein a single adjudicator makes the disability determination. Implementation of either the DoD organization or the DoD agency requires legislative change.

The last element for consolidation options DoD considered supports standardization of the disability evaluation appeal process. Congress directed, in National Defense Authorization Act for FY 2008, the creation of the DoD Physical Disability Board of Review (PDBR). Congress intended the physical disability board of review provide Service members, who had been separated by their Military Department with a 20 percent or less disability rating, an opportunity to request review of their physical evaluation board results. Using a similar approach, each Consolidated DES option, described below, creates a DoD disability board of review that offers the Service member an opportunity to request an appeal of their DoD fitness decision. The DoD disability board of review is a separate agency that, similar to the current DoD Physical Disability Board of Review, can correct inaccuracies in the outcome of a particular case based on the record of evidence.

Even limiting the consolidation options to only the medical and physical evaluation processes of the disability process resulted in numerous options to analyze. Therefore, based on an assumption that standardization is easier to achieve in centralized organizations, DoD developed five alternative organizational structures to compare with the current Integrated DES that lean toward greater centralization for the disability determination. In all cases, DoD assumed the DoD and VA disability evaluation processes would remain integrated as closely as in the

Integrated DES (for example, VA provides disability examinations and ratings). A description of the degree of geographical and organizational decision-making for the Integrated DES and for each of the alternatives follows.

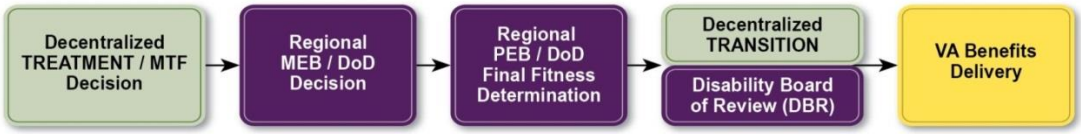
Option 1- Integrated DES (Military Department): Decentralized Medical Evaluation Board and Regional Physical Evaluation Boards with Military Secretary Final Fitness Determination.



The current Integrated DES employs 139 medical evaluation boards located at military treatment facilities. The Military Department Secretary concerned authorizes these boards to examine and determine whether a Service member meets the medical retention standards for that Military Service. A centralized authority for each Military Service creates the standards, which include requirements that apply to all job specialties (for example, all Marines must be able to carry a rifle) as well as requirements that are specific to selected job specialties (for example, Air Force Ground Controllers may not have a history of myocardial infarction). The Military Departments delegate medical evaluation decisions, including resolution of appeals of those decisions, to the leadership of the military treatment facility. If the medical evaluation board determines the Service member does not meet retention standards, they forward the case to the physical evaluation board to determine fitness for continued military service.

The Departments of the Navy (Navy and Marine Corps) and the Air Force each use a single geographically centralized physical evaluation board. The Army uses three regional physical evaluation boards. In all cases, the decision authority for physical evaluation board disability outcomes, including the outcomes decided by informal and formal boards and appeal decisions, rests with the Military Department Secretary or his or her delegated approval authority. However, unlike medical retention standards, which are established by the Military Secretary concerned based on DoD policy, U.S.C. and federal regulations define the parameters for making a fitness determination (for example, ability to perform the duties of the office, grade, rank, or rating), disability level (title 10, U.S.C., chapter 61, Separation or Retirement; title 10 U.S.C., chapter 55, section 1071) and compensability decisions (title 10, U.S.C., chapter 61 and part 4 of title 38 Code of Federal Regulations).

Option 2 – Regional Medical Evaluation Board and Regional Physical Evaluation Board with DoD Determinations and DoD Disability Board of Review.



This option retains decentralized treatment and medical examination at the 139 military treatment facilities in the Integrated DES. It consolidates authority for adjudicating medical retention standards to two regional, DoD medical evaluation boards on the east and west coasts. Service members would be assigned to a regional board based on the geographic location of their

military treatment facility. Upon completion of the treatment/screening process, the Service member would enter the disability evaluation process at their local military treatment facility, receiving examinations for disabling conditions at the nearest VA or contract medical facility. The military treatment facility would forward the Service member's records to the regional medical evaluation board for review by a cross-Service DoD team of physicians dedicated to medical board processing. The regional, DoD organization, rather than the Service's military treatment facility, would have the authority to determine whether the Service member meets medical retention standards.

This option also consolidates the geographic structure of physical evaluation board activities from the five current Service physical evaluation boards to two DoD organizations on the east and west coasts. If the regional, DoD medical evaluation organization finds the Service member does not meet retention standards, the organization would forward the case to the regional physical evaluation board where the initial fitness determination for continued military service would be completed by the DoD Informal Physical Evaluation Board. If a Service member does not agree with their initial fitness determination, they can request reconsideration by the Formal Physical Evaluation Board. If approved, the Service member may travel to the regional physical evaluation board for a formal hearing. This option differs from the Integrated DES because the authority for determining fitness and disability level no longer resides with the Military Secretary concerned. Service members in receipt of their DoD physical evaluation board decision may request that a DoD disability board of review evaluate their case.

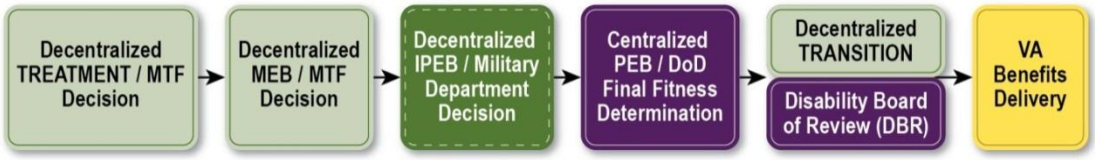
Option 3 – Regional Medical Evaluation Board and Centralized Physical Evaluation Board with DoD Determinations and DoD Disability Board of Review.

Option 3 is similar to option 2 except that a centralized, rather than regional, DoD physical evaluation board replaces the five military department regional boards under the current Integrated DES. Upon referral into the disability evaluation process, the Service member receives examinations for disabling conditions at or near their local military treatment facility. A joint service team of physicians dedicated to medical boards would adjudicate the case at a DoD, east or west coast facility with the authority to determine whether the Service member meets the medical retention standards of the Military Service concerned. The DoD organization would forward the cases of Service members who do not meet retention standards to the centralized, DoD physical evaluation board. As in option 2, the DoD centralized vice regional physical evaluation board makes the fitness and disability determinations. If a Service member does not agree with their initial fitness determination, they can request reconsideration by the Formal Physical Evaluation Board. If approved, the Service member may travel to the centralized physical evaluation board for a formal hearing. Service members in receipt of their DoD physical evaluation board decision may request that a DoD disability board of review evaluate their case.

Option 4 – Decentralized Medical Evaluation Board and Centralized Physical Evaluation Board with DoD Determinations and DoD Disability Board of Review.

This option maintains decentralized disability determinations and medical retention decisions made by 139 military treatment facilities as in the Integrated DES, but consolidates the five current Service physical evaluation boards to one centralized, DoD organization. Upon referral into the disability evaluation process, the Service member receives examinations for disabling conditions in or near their local military treatment facility. Physicians from the military treatment facility would adjudicate the case to determine whether the Service member meets the medical retention standards of the Military Service concerned. The local medical evaluation board would forward the cases of Service members who do not meet retention standards to the centralized, DoD physical evaluation board. As in option 2, the DoD centralized physical evaluation board makes the fitness and disability determinations. If a Service member does not agree with their initial fitness determination, they can request reconsideration by the Formal Physical Evaluation Board. If approved, the Service member may travel to the centralized physical evaluation board for a formal hearing. Service members in receipt of their DoD physical evaluation board decision may request that a DoD disability board of review evaluate their case.

Option 5 – Decentralized Medical Evaluation Board, Decentralized Informal Physical Evaluation Board, Centralized Formal Physical Evaluation Board with DoD Final Fitness Determination and DoD Disability Board of Review.



This option maintains decentralized medical examinations and medical retention decisions made by 139 military treatment facilities as in the Integrated DES, but separates physical evaluation board operations into two steps. The Military Department Secretaries would continue to operate the current five physical evaluation boards to determine initial fitness and disability level. If a Service member does not agree with their initial fitness determination, they can request reconsideration by a centralized Formal Physical Evaluation Board. If granted, the Service member may travel to the centralized formal board to appear in person at a formal hearing. The centralized DoD board would adjudicate requests (currently approximately five percent of Integrated DES cases) and make a determination at the formal hearing. Service members may appeal the results of the Formal Physical Evaluation Board to a DoD disability board of review.

Option 6 - Centralized DoD Disability Evaluation Agency with DoD Final Determination and Disability Board of Review.

In this option, a centralized DoD agency, rather than the Military Secretary concerned, adjudicates a Service member's disability case similar to the process used by other Federal and State disability agencies. Upon referral into the disability process by the servicing Military Treatment Facility, the Service member would receive examinations for disabling conditions locally at their military treatment facility, local VA, or contract medical facility. The case manager would forward the Service member's records to the Disability Evaluation Agency where a single adjudicator would evaluate the case using established DoD and Military Department standards. The Service member may request that the DoD agency reconsider their disability case by utilizing a different adjudicator within the DoD agency who is independent of the normal adjudication process. Service members may then appeal their case to an independent DoD disability board of review.

2.2.1 Option Analysis. DoD evaluated the degree to which each consolidation option meets the dimension of organizational change combinations and measures of effectiveness, then determined the ratings to assign to each option (Appendix 2: Option Decision Rubric). The ratings assigned to each option were based on an analysis of the relevant law, DoD and Military Service policy, and subject matter expertise to determine feasibility, propriety, and purported cost.

- Infrastructure: the general and medical physical space requirements (for example, buildings, offices, cubicles, meeting space, storage space, et cetera).
- Technology: requirements to automate the creation, accumulation, analysis, and transfer of information.
- People: organizational structure and human capital management requirements (for example, workforce planning, leadership development, recruiting, performance management, and training and development).
- Process: the activities, activity sequences, and business rules.

DoD analyzed each dimension against the three measures of effectiveness outlined in the Congressional language to assess their potential success in meeting their intent of determining:

- Feasibility of assembling the right infrastructure, technology, people, and processes required to create the disability organization for each option.
- Propriety of whether each option meets the needs of Service members and stakeholders, as well as the degree to which consistency improves.
- Cost of initial and sustainment costs of people, process, technology, and infrastructure for each option.

Finally, DoD developed the following, subjective rating scale to measure the degree to which an option meets each measure of effectiveness and dimension of organizational change combination:

+2 = Option substantially meets the measure of effectiveness compared to the Integrated DES
+1 = Option partially meets the measure of effectiveness compared to the Integrated DES
0 = Option is neither better nor worse on the measure of effectiveness compared to the Integrated DES
-1 = Option somewhat fails to meet the measure of effectiveness compared to the Integrated DES

-2 = Option substantially fails to meet the measure of effectiveness compared to the Integrated DES

***2.2.2 Option Determination*.** Appendix 3: Aggregated Decision Table Ratings Sorted by Preferred Option lists the consolidation options sorted first by highest for feasibility. Our initial findings indicate that all options received a positive aggregate feasibility score, demonstrating they are all at least as feasible to implement as the Integrated DES.

After determining all the options were feasible, DoD ranked each option by the aggregate propriety score which is most closely related to the objective of ensuring consistent disability outcomes. Option 6, Centralized DoD Disability Evaluation Agency with a Disability Board of Review, scored the highest for propriety while option 5, Centralized Formal Physical Evaluation Board with a DoD Disability Board of Review, scored the lowest.

The final measure of effectiveness concerns the anticipated short- and long-term costs of each option. All of the options scored poorly—by varying degrees—in regards to start-up costs; with option 2 scoring least favorably. This can be explained in part because each option requires varying portions of the existing Integrated DES to remain at each of the 139 current locations with standup of a new regional or centralized organization. When coupled with process changes and added resource requirements, start-up costs will increase. Option 6, Centralized DoD Disability Evaluation Agency with a Disability Board of Review, scored the most favorably for long-term costs. With use of single adjudicators vice multi-person boards reduces the resource footprint and reduces costs. Option 5 was projected to have the highest long-term cost because it maintains the existing Integrated DES infrastructure and adds a centralized Formal Physical Evaluation Board.

Again, as illustrated in Appendix 3, option 3 and option 6 ranked the highest across the majority of measures of effectiveness. These preliminary findings support a full consolidation of the Integrated DES from the point of the Medical Evaluation Board through the point of final appeal of a Service member's fitness determination. Implementation of either option 3 or 6 would give Service members the opportunity to be evaluated by a DoD body during each of the major decision points within the Integrated DES. This type of consolidation should provide the greatest standardization of Service member outcomes, as reflected in the favorable propriety scores for these options. Consolidating just the Physical Evaluation Board or Formal Physical Evaluation Board as in options 4 and 5 would not allow for the same level of benefit.

2.3 Analysis of Option 3 and Option 6. At the interim project review, the DoD directed further analysis of option 3 and option 6 to determine the process changes, manpower requirements, costs, and risks necessary for these two options. DoD continued working with DoD agencies, Military Departments, and other subject matter experts to gather the information necessary to conduct the analysis. What follows is a detailed description for each of the analyses conducted as part of this review.

2.3.1 Process Analysis. The first layer of option analysis focused on the specific process changes required for each option and how those changes might affect the Service member and Military Departments. Specifically, DoD sought to understand how each option might address the perceived inconsistencies among the Military Department processes identified in section 2.1

of this report. DoD compared the processes in each step of the Integrated DES to determine how they would vary in options 3 and 6.

2.3.2 Manpower Analysis. DoD acknowledges that the Department has not conducted a manpower study for the Integrated DES. Without a baseline study or the opportunity to conduct one within the time allotted for this report, DoD was not able to determine if the Integrated DES is currently adequately staffed. However, DoD's inability to meet Integrated DES performance goals is an indication that FY11 staff levels may be inadequate.

Given this limitation, DoD looked to alternative methods for determining the current manpower composition of the Integrated DES (baseline) and associated costs with any consolidated options. The five phased approach (Figure 2), looked to establish the best method to determine options given the time period for this study. DoD first considered the Handbook for Performance Based Financing for the Measurement of Mission Essential Non-Benefit Activities (MENBA) developed by the Office of the Assistant Secretary of Defense for Health Affairs (ASD(HA), Health Budgets and Financial Policy Office in October 2011. DoD's MENBA study focuses on determining performance-based financing targets by identifying outputs and associated activities for clinical aspects of the medical evaluation board, and administrative activities for the physical evaluation board to determine their resource-based relative value.

Figure 2: Consolidated DES Manpower Study Phases

Lacking a similar physical evaluation board study, DoD conducted a Physical Evaluation Board Operational Audit with Departments of the Army, Navy, and Air Force subject matter experts to measure the time required to complete individual Integrated DES tasks and the frequency at which the task should be performed. The combination of per accomplishment time and frequency yielded a total time requirement for each task for the Physical Evaluation Board Process. DoD initiated a manpower review to assess the current Integrated DES enterprise workload, the anticipated workload for each option, and the expected increase in workloads for surges in Integrated DES case flow due to the re-deployment of Service members.

As a cross check to the MENBA and Physical Evaluation Board Operational Audit DoD also surveyed the Military Departments to determine their current manpower requirements for the Integrated DES. This generated actual Service staff levels as well as information on the grade levels and percentage of workload (for example, physicians, Physical Evaluation Board Liaison Officers, et cetera) necessary to accomplish the tasks for the Integrated DES.

DoD identified a wide disparity between the MENBA and the Military Department current manpower performing the Integrated DES process. Without the ability to determine which approach accurately reflects the manpower requirement, DoD identified cost estimates by using MENBA for the low-end cost and Military Department provided staff requirements for the high-end cost estimate for each option considered.

2.3.3 Cost Analysis. DoD used parametric cost estimating relationships, analogous system comparisons, engineering build-up, and actual cost data estimating methodologies to develop the cost estimates for this study. DoD estimated each cost element (Appendix 5: Cost Element Structure) using one, two, three, or all of the methodologies and rationales. Suitability is normally determined by the degree of definition and availability of data sources (Appendix 6: Cost Data Sources). During the estimating process, DoD concentrated data collection efforts on gathering available data within the Warrior Care Policy Office, Office of the Under Secretary of Defense (Comptroller), Office of Cost Assessment and Program Evaluation (CAPE), Military Departments, the ASD(HA), and onsite visits to Washington, DC, medical and physical evaluation board offices. DoD used actual cost data for task activities when available along with a bottom-up estimation approach for cost elements where sufficient detailed requirements were available. DoD used cost factors to estimate cost elements where actual costs did not exist or data was not available for engineering build-up estimation.

All costs depicted in this analysis, and used to determine the alternative cost comparisons, are expressed in Then-Year Dollars. The use of then-year dollars is a function of the proper inflation index applied against the individual cost elements. DoD Cost Methodology follows a six-phased approach as shown in Figure 3. All costs have been calculated at an 80th percentile confidence level to be in line with DoD cost estimating standards in providing a budget quality estimate.

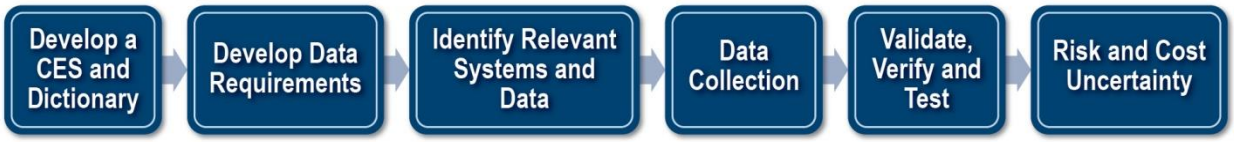


Figure 3: Cost Methodology

Table 1 below is an estimate of the FY11 Integrated DES operational costs. Unlike option 3 and option 6 costs in sections 3.1.3 and 3.2.3, FY11 costs are not inflated nor do they include start-up or IT broadband costs. Personnel costs are based on Full Time Equivalents (FTE) and pay grades submitted by the Military Departments. These costs are based on DoD Composite rates for active duty Service members and Office of Personnel Management rates for civilian employees. Per OMB A-76, civilian rates include a fringe benefit factor of 36.45 percent. And, include training costs of $3,500 per FTE as well and travel costs of approximately $1,600 per trip for Service member appeal of their informal physical evaluation boards.

Information Technology (IT) costs are comprised of hardware, software, IT specific training, and LAN connectivity. IT unit costs were provided by ASD(HA)/TRICARE Management Activity and applied against service manpower inputs. Process costs are those costs associated with the copying, shipping, and storage of medical records and are extrapolated from Military Department costs applied against the DES average annual case load (Table 2, page 19). Finally, with Integrated DES operations located at military installations, Military Departments did not report any infrastructure costs.

FY11 Integrated Disability Evaluation System Costs	
Program	**Costs**
Personnel	**$149.5**
IT	**$2.3**
Process	**$0.8**
Infrastructure	**$0.0**
Total	**$152.6**

Table 1: FY11 Integrated DES Costs

2.3.4 Risk Selection Process. An integral part of change management, risk control serves as an essential component in feasibility reviews to determine uncertainties with any organizational change. Risk management is the systematic approach to setting the best course of action to mitigate the risks identified through the process of risk assessment, response, and evaluation. DoD quantified risk (Appendix 7: Risk Descriptions) by the probability of occurrence (of the event) and impact against measures of effectiveness (feasibility, propriety, and cost). After measuring risk by probability and impact, DoD validated these findings through subject matter expert interviews and extensive policy review for each measure of effectiveness.

Using these criteria, study team members evaluated the likelihood that each risk might occur for both options and the consequences associated with each risk. Considering data collection and analysis efforts from subject matter experts, DoD and Military Department policy, legislation, organizational structure, and funding documents, the team assigned probabilities and consequences for each option. Directly affecting the proposed options, consolidation risks cover a range of topics, including the necessary space to relocate to regional or centralized offices, the transition from current to new system requirements, and the impact of utilizing DoD processes verses Service-centric. As the separate Service-level disability evaluation systems potentially merge into a standard process, the assessment also captures the associated risks with changes in legislation and policy and the cost of hiring and training personnel. Final risk exposure scores were determined using the Risk Exposure Table (Appendix 8: Risk Analysis Tables).

3. Option 3 and Option 6 Results

Results of the analyses described in Section 2.3 determined that options 3 and 6 appear to be the most efficient and effective transfer of the medical evaluation board and physical evaluation board Service specific functions to a regional or centralized organization while maintaining the propriety of the Integrated DES sought by Congress. This is especially important because Military Departments remain actively engaged with the Service member at the installation level in either option. Analysis of both options took into account the manpower necessary to meet Service member and stakeholder needs, associated costs of relocating facilities, required process changes, and necessary information technology. Finally, DoD considered the risk involved with these reorganizations and any possible negative impacts on the stakeholders and Service members. Outlined below are the results of the option 3 and option 6 analyses.

3.1.1 Option 3 Process. Option 3 consolidates medical evaluation board responsibilities located at 139 Service-level Military Treatment Facilities into an east and west coast DoD regional organization. This approach eliminates Service differences in the medical evaluation board highlighted earlier in this report that include dissimilar board composition, format, and training standards. Similarly, the DoD Centralized Physical Evaluation Board consolidates five Military Department Physical Evaluation Boards into one DoD agency that standardizes the Physical

Evaluation Board format, composition, and training standards. DoD and VA disability evaluation processes remain integrated (for example, VA provides disability examinations and ratings) as closely as they are in the Integrated DES by allowing the VA Disability Rating Activity Site to maintain responsibility for rendering a disability rating for all claimed and referred conditions using the VA Schedule for Rating Disabilities. A DoD disability board of review offers an additional opportunity to standardize outcomes by allowing the Service member to request a review of their DoD physical evaluation board fitness determination.

Because the Military Departments maintain responsibility for initial referral of Service members into the DES process, there remains some opportunity for disparate outcomes during the treatment/pre-screen process. Option 3 contains a risk in that, even though improved, the geographic detachment of the regional medical evaluation boards could still have a negative effect on propriety. The risk is somewhat minimized with the DoD Centralized Physical Evaluation Board maintaining oversight for both regional medical evaluation boards.

A centralized DoD physical evaluation board provides Service members with their disability determination and utilizes a quality assurance office that coordinates with the DoD regional Medical Evaluation Board to fill the void that currently exists in the Integrated DES. The quality assurance program is considered a key component in providing Service members more consistent disability outcomes for the medical and physical evaluation boards by standardizing processes, and identifying training deficiencies.

***3.1.2 Option 3 Manpower*.** With the medical evaluation board regionalized, some DES functions remain at the Service-level military treatment facility to include: support for the Service member's referral into the DES, development of the case file, administrative support to the Service member for the Compensation & Pension (C&P) examination and their impartial medical review. For the centralized physical evaluation board, military treatment facility personnel (e.g., Physical Evaluation Board Liaison Officer, Judge Advocate General) provide the Service member assistance with understanding their Informal Physical Evaluation Board Findings, applying for an Informal Physical Evaluation Board Reconsideration, or requesting a Formal Physical Evaluation Board. For this review, DoD categorized these Service-level functions as clinicians, administration, and indirect support.

While a Service member support team remains in place at the military treatment facility, each Military Department will be responsible to support staffing at the Regional Medical Evaluation Board. The regional medical evaluation board develops the narrative summary for all referred medical conditions, narrative summary addendums to add other medical evidence to the case file, medical evaluation board results, and support to the Service member for a medical evaluation board rebuttal. The regional medical evaluation board organizational structure utilizes standard requirements for command and control, along with necessary administrative support. The regional board requires a Director and Deputy Director to provide oversight and leadership, as well as multi-service military and civilian physicians, physical evaluation board liaison officers, legal advisors, and support personnel. A quality assurance function is added to help with consistency in Service member outcomes.

To determine manpower requirements or FTE, the caseload factor uses DoD data from FY 2004-2011. The caseload data analysis includes both "Legacy" and Integrated DES information. FY04 was chosen because it provides one full year of data after beginning Operation Iraqi Freedom

(March 2003). Analyzing "Legacy" and Integrated DES data through FY11 identified a DES average annual caseload of 21,495 (Table 2).

Average DES Annual Referral Caseload			
Army	Navy	Air Force	DoD Total
12,176	5,059	4,260	21,495

Table 2: DES Annual Referral Caseload

Early in this study the Military Departments informed DoD they were adding approximately 900 additional manpower authorizations in FY12 and FY13 to support an anticipated average DES annual caseload increase of 8,000 cases associated with the drawdown of Operation Enduring Freedom. Even though an exact number of cases cannot be determined, DoD considered manpower requirements and costs by applying the baseline average of 21,495, then extrapolating that same information for an DES average annual caseload of 25,000 or 30,000.

Option 3 and Option 6 - Military Treatment Facility (MTF) Manpower Requirements									
Annual Caseload		21,495							
Personnel Category		Clinician		Administration		Indirect Labor		Total	
FTE Methodology		MENBA	MilDep	MENBA	MilDep	MENBA	MilDep	MENBA	MilDep
MTF	Army	18	46	106	268	11	29	135	343
	Navy	8	12	44	71	5	8	57	91
	Air Force	6	18	36	103	4	11	46	132
Total MTF Manpower Requirements		32	76	186	442	20	48	238	566
Annual Caseload		25,000							
Personnel Category		Clinician		Administration		Indirect Labor		Total	
FTE Methodology		MENBA	MilDep	MENBA	MilDep	MENBA	MilDep	MENBA	MilDep
MTF	Army	22	54	124	311	13	34	159	399
	Navy	9	14	52	83	6	9	67	106
	Air Force	7	21	42	120	5	13	54	154
Total MTF Manpower Requirements		38	89	218	514	24	56	280	659
Annual Caseload		30,000							
Personnel Category		Clinician		Administration		Indirect Labor		Total	
FTE Methodology		MENBA	MilDep	MENBA	MilDep	MENBA	MilDep	MENBA	MilDep
MTF	Army	26	65	149	374	16	40	191	479
	Navy	11	17	62	100	7	11	80	128
	Air Force	9	25	51	144	5	16	65	185
Total MTF Manpower Requirements		46	107	262	618	28	67	336	792

Table 3: Option 3 and Option 6 - Military Treatment Facility (MTF) Manpower Requirements

As of September 30, 2011, the Military Departments have 1,008 FTEs at 139 military treatment facilities. Using the DES annual referral caseload of 21,495, MENBA requires 238 FTEs remain at the medical treatment facilities. Using Military Department manpower requirements, 566 FTEs are necessary to meet base level needs. A DES annual caseload of 25,000 requires 280 (MENBA) compared to 659 (Military Department). With a 30,000 DES caseload, the requirement increases to 336 and 792 respectively for MENBA and the Military Department.

Option 3 – DoD Regional Medical Evaluation Board (MEB) Manpower Requirements						
Average Annual Caseload	21,495		25,000		30,000	
FTE Methodology	MENBA	MilDep	MENBA	MilDep	MENBA	MilDep
Director	1	1	1	1	1	1
Deputy Director	1	1	1	1	1	1
Executive Administrator (Plus Executive staff)	3	3	3	3	3	3
Medical Division Chief (Plus Executive Assistants)	3	3	3	3	3	3
Medical Staff	40	85	47	99	56	119
MEB Administration Division Chief (Plus Executive Assistants)	2	2	2	2	2	2
Records Management Branch Chief	1	1	1	1	1	1
Records Management Branch Staff	3	3	3	4	4	5
Data Analysis/Quality Assurance, Branch Chief	1	1	1	1	1	1
Data Analysis/Quality Assurance Staff	6	6	6	7	7	9
PEBLO Coordination Division Chief (Plus Executive Assistants)	3	3	3	3	3	3

PEBLO Coordination Staff	49	111	59	129	71	155
Legal Division Chief (Plus Executive Assistant)	2	2	2	2	2	2
Attorneys	3	3	3	3	4	4
Paralegals	3	3	3	3	4	4
Total Regional MEB	121	228	138	262	163	313
Total Regional (East / West Coast) MEB Manpower Requirements	242	456	276	524	326	626

Table 4: Option 3 – DoD Regional Medical Evaluation Board Manpower Requirements

Table 4: Option 3 – DoD Regional Medical Evaluation Board Requirements identifies the military treatment facility staffing requirements transferring to the DoD Regional Medical Evaluation Board. The Regional Medical Evaluation Board is structured with a Director and Deputy Director to provide leadership and coordination with the DoD Centralized Physical Evaluation Board. The Medical Division conducts the medical evaluation boards with support from the Medical Evaluation Board Administration Division and Physical Evaluation Board Liaison Officer Coordination Division Chief. A data analysis and quality assurance branch provides status on the Regional Medical Evaluation Board's ability to meet mission requirements and maintain program compliance and effectiveness.

Using a DES annual caseload of 21,495, MENBA requires 242 FTEs compared to the Military Department requirements which indicate 456 FTEs are necessary to meet regional requirements. A 25,000 average annual DES caseload requires 276 FTEs for MENBA compared to 524 (Military Department); 30,000 cases require 326 and 626 FTEs respectively for MENBA and Military Department.

Option 3 – DoD Centralized Physical Evaluation Board (PEB) Manpower Requirements						
Average Annual Caseload	21,495		25,000		30,000	
FTE Methodology	MENBA	MilDep	MENBA	MilDep	MENBA	MilDep
Director	1	1	1	1	1	1
Deputy Director	1	1	1	1	1	1
Executive Administrator (Plus Executive staff)	3	3	3	3	3	3
Physical Evaluation Board Division Chief (Plus Executive Assistant)	2	2	2	2	2	2
Line Officers	25	27	30	31	35	38
Physicians	16	16	19	20	22	23
Physical Evaluation Board Administration Division Chief (Plus Executive Assistants)	3	3	3	3	4	4
Physical Evaluation Board Liaison Officer Coordination Branch Chief	1	1	1	1	1	1
Physical Evaluation Board Liaison Officer Coordination staff	2	2	2	2	2	2
Records Management Branch Chief	1	1	1	1	1	1
Records Management Branch	5	5	5	6	6	7
Data Analysis/Quality Assurance Branch Chief	1	1	1	1	1	1
Data Analysis/Quality Assurance Staff	4	4	4	4	4	4
Board Support Branch Chief	2	2	2	2	2	2
Board Support Staff	71	103	85	120	103	144
Legal Division Chief (Plus Executive Assistants)	2	2	2	2	2	2
Attorneys	10	10	12	12	14	14
Paralegals	6	6	7	7	8	8
Total Centralized PEB Manpower Requirements	156	190	181	219	212	258

Table 5: Option 3 – DoD Centralized Physical Evaluation Board Manpower Requirements

Table 5: Option 3 – DoD Centralized Physical Evaluation Board Manpower Requirement identifies staffing needs for the DoD Centralized Physical Evaluation Board. As lead agency for DoD, the centralized physical evaluation board maintains oversight for both DoD Regional Medical Evaluation Boards. Therefore, a similar organizational structure has been applied. The Centralized Physical Evaluation Board is structured with a Director and Deputy Director to provide leadership and coordinate with the DoD Regional Medical Evaluation Boards. The Physical Evaluation Board Division conducts the informal / formal boards and coordinates all actions through the Physical Evaluation Board Administration Division. A data analysis and quality assurance branch provides status on the Centralized Physical Evaluation Board and

Regional Medical Evaluation Boards ability to meet mission requirements, maintain program compliance as well as effectiveness.

The five Military Department Physical Evaluation Boards have a total of 175 manpower requirements. Using the Military Departments current manpower standard of 175 as the baseline and a DES annual caseload of 21,495, MENBA require 156 FTEs compared to 190 using the Military Department standard. A caseload of 25,000, requires 181 FTEs using MENBA versus 219 for the Military Department requirement. A 30,000 caseload creates a range of 212 compared to 258 FTEs using the MENBA and Military Department numbers.

3.1.3 Option 3 Costs. The primary driver between the low-end and high-end range of costs for option 3 is the number of manpower requirements. Table 6: Option 3 – DoD Regionalized Medical Evaluation Board and DoD Centralized Physical Evaluation Board Costs provides a breakout for start-up costs and what is required over the Five Year Defense Plan (FYDP) (2015-2019). Start-up costs are defined as those costs necessary to stand-up a new organization and include transition costs of personnel, IT investments, infrastructure modifications, and office equipment. All costs are calculated using Then-Year Dollars to account for inflation.

Option 3 - Regionalized MEB & Centralized PEB Costs				
Average Annual Case Load	**21,495**			
Cost Parameter	**Start-up Costs**		**5 Year Costs**	
CDES Option	**MENBA**	**MilDep**	**MENBA**	**MilDep**
Personnel	**$0.5**	**$0.8**	**$515.6**	**$921.2**
IT	**$11.9**	**$16.8**	**$29.2**	**$40.3**
Infrastructure	**$6.4**	**$8.2**	**$6.4**	**$8.2**
Total	**$18.8**	**$25.8**	**$551.2**	**$969.7**
Average Annual Case Load				**25,000**
Cost Parameter		**Start-up Costs**		**5 Year Costs**
CDES Option	**MENBA**	**MilDep**	**MENBA**	**MilDep**
Personnel	**$0.6**	**$1.0**	**$595.4**	**$1,055.5**
IT	**$13.1**	**$18.7**	**$32.4**	**$44.2**
Infrastructure	**$6.9**	**$9.0**	**$6.9**	**$9.0**
Total	**$20.6**	**$28.7**	**$634.7**	**$1,108.7**
Average Annual Case Load				**30,000**
Cost Parameter		**Start-up Costs**		**5 Year Costs**
CDES Option	**MENBA**	**MilDep**	**MENBA**	**MilDep**
Personnel	**$0.7**	**$1.2**	**$697.2**	**$1,270.4**
IT	**$14.7**	**$21.5**	**$32.7**	**$49.9**
Infrastructure	**$7.6**	**$10.2**	**$7.6**	**$10.2**
Total	**$23.0**	**$32.9**	**$737.5**	**$1,330.5**

Table 6: Option 3 – DoD Regionalized Medical Evaluation Board and DoD Centralized Physical Evaluation Board Costs

Assuming an average case load of 21,495, start -up costs under MENBA are $18.8 million compared to $25.8 million for the Military Department requirements. Over the FYDP costs are $551.2 million for MENBA compared to $969.7 million for the Military Department. Using the same cost range, start -up costs for 25,000 cases is $20.6 million to $28.7 million. Over the FYDP, those costs are $634.7 million to $1,108.7 million. The start-up costs for 30,000 cases are $23.0 million to $32.9 million for the MENBA and Military Department respectively. Finally, costs over the FYDP are $737.5 million to $1,330.5 million.

Costs assume that option 3 will utilize existing DoD facilities. If existing space is not available, building a new facility increases start-up costs between $8.4million (MENBA) to $11.8 million (Military Department). For an annual lease option, start-up costs increase by $0.3 million under both methodologies.

3.1.4 Option 3 Risks. Looking at option 3 and the four risks (Appendix 7: Risk Descriptions) associated with the dimensions of change a summary risk score is calculated by taking the average of the consequence scores for each dimension and multiplying it by the probability; or, likelihood that the risk will occur. The resulting value is the risk score. Table 7: Option 3 – DoD Regional Medical Evaluation Board and DoD Centralized Physical Evaluation Board Risk Exposure Results summarizes those risks.

Option 3 Risk Exposure Results						
4-D of Change	Risks	Probability Score	Consequence Scores			Risk Score
			Feasibility	Propriety	Cost	
Infrastructure	Consolidation of MEB and PEB services at locations negatively impacts span of control and delivery of services	0.3	2	3	3	0.9
Technology	Capability for sufficient case management and/or case file transfer is not available at the time of CDES implementation	0.5	3	3	3	1.5
People	Staffing the consolidated DES with necessary human capital present start-up and organizational challenges	0.5	3	4	2	1.5
Process	Substantial changes to existing policy and processes may necessitate a comprehensive change communications effort in order to build consensus and effect successful implementation	0.5	3	3	3	1.5

Table 7: Option 3 – DoD Regional Medical Evaluation Board and DoD Centralized Physical Evaluation Board Risk Exposure Results

There are clearly other risks to consider, however, they are determined to be either outside the scope of this review or they are assessed as being equal regardless of the alternative and thus not deterministic for option 3. Those included reflect the most impactful risks to the options and their cumulative effect; represented by the risk exposure score. According to Table 7, the probability that risks will occur for option 3 are all deemed as 'possible' or 'unlikely'. This is most likely due to the fact that option 3 does not represent a radical change in process. The consequences associated with the risks are all generally moderate with the exception of the 'Propriety' consequence score for 'People' where there appears to be a moderate negative impact to suitability and appropriateness. This impact is explained by the need to hire and train staff across the regional medical evaluation board and centralized physical evaluation board. The risk is seen as temporary for initial standup of option 3.

3.2.1 Option 6 Process. Option 6, the DEAA, restructures the Integrated DES by placing specially trained Federal employees, medical experts, and line officers under the oversight of a central DoD agency. This agency replaces the authority of a Military Department medical evaluation board and physical evaluation board in determining whether the Service member is physically fit for military service. Disparities in the composition and format of the Service boards would no longer be an issue and the disability determination would be accomplished with little risk of impropriety as it would be conducted through a single agency using applicable DoD and Military Department standards. Replacing the non-standardized appeal options that

currently exist between the Services allows the Service member to request the DoD agency reconsider their disability case by utilizing a different adjudicator.

For option 6, the DoD and VA disability evaluation processes remain integrated as closely as in the Integrated DES (for example, VA provides disability examinations and ratings). Therefore, the VA Disability Rating Activity Site (D-RAS) maintains responsibility for rendering a disability rating for all claimed and referred conditions using the VA Schedule for Rating Disabilities. As in option 3, Service members who have received their DoD Adjudication decision can request a DoD Disability Board of Review evaluate their case to correct any inaccuracies based on the record of evidence. Because the Military Departments maintain responsibility for initial referral of Service members into the DES process, there remains some opportunity for disparate outcomes based on actions taken at 139 military treatment facilities during the treatment/pre-screen process.

3.2.2 Option 6 Manpower. Similar to option 3, option 6 requires some DES functions remain at the military treatment facility to provide support to the Service member. These include: the Service member's referral into the Integrated DES, case file development, and administrative support for the C&P examination and the impartial medical review. The military treatment facility provides the Service member assistance with understanding the Adjudication Agency's findings, and applying for an appellate review. The Adjudication Agency requires a Director and Deputy Director to provide oversight and leadership. A quality assurance function is added to help with consistency in Service member outcomes.

Option 6 – DoD Disability Evaluation Adjudication Agency Manpower Requirements						
Average Annual Caseload	21,495		25,000		30,000	
Data Source	MENBA	MilDep	MENBA	MilDep	MENBA	MilDep
Director	1	1	1	1	1	1
Deputy Director	1	1	1	1	1	1
Executive Administrator (Plus Executive staff)	3	3	3	3	3	3
Adjudication, Division Chief	3	4	3	4	3	4
Adjudication Staff	57	87	66	101	80	121
Physicians	13	20	15	23	17	28
Psychologist/Psychiatrist	7	11	8	13	9	15
Line Officers	8	12	9	14	11	17
DEAA Administration Division Chief	2	3	2	3	2	3
Admin Support	4	4	5	5	6	6
Technicians	12	17	13	20	15	24
Data Analysis/Quality Assurance Division Chief	1	1	1	1	1	1
Data Analysis/Quality Assurance Staff	8	8	9	9	10	12
Legal, Division Chief	2	2	2	2	2	2
Attorneys	3	3	3	3	4	4
Paralegals	3	3	3	3	4	4
Total	128	179	144	206	169	246

Table 8: Option 6 – DoD Disability Evaluation Adjudication Agency Manpower Requirements

As the single DoD agency for all disability determinations, Table 8 identifies necessary staffing levels. Use of a single adjudicator instead of a multi-member medical and physical evaluation board significantly reduces the staff required to provide a disability determination. The caseload requirements for a single adjudicator are similar to those of other Federal and State agencies. A DES annual caseload of 21,495 requires 128 (MENBA) FTEs compared to 179 for the Military Departments. A caseload of 25,000 requires 144 FTEs (MENBA) versus 206 (Military Departments). A 30,000 caseload creates a range of 169 compared to 246 FTEs.

3.2.3 Option 6 Cost. Similar to option 3, the primary driver between the low-end and high-end range of costs for option 6 is the number of manpower requirements. Table 9: Option 6 – DoD Disability Evaluation Adjudication Agency Costs provides a breakout for start-up costs and the funding level required over the FYDP (2015-2019). Start-up costs are defined as those costs necessary to stand-up a new organization and include transition costs of personnel, IT investments for new facilities and new hires, new infrastructure modifications, and office equipment. FYDP costs include all start-up and recurring costs for Personnel, IT, and Infrastructure. All costs are calculated using Then-Year Dollars to account for inflation.

Option 6 - DoD Disability Evaluation Adjudication Agency				
Average Annual Case Load	**21,495**			
Cost Parameter	**Start-up Costs**		**5 Year Costs**	
CDES Option	**MENBA**	**MilDep**	**MENBA**	**MilDep**
Personnel	**$0.1**	**$0.2**	**$275.6**	**$511.8**
IT	**$3.9**	**$4.9**	**$11.6**	**$16.8**
Infrastructure	**$2.0**	**$2.3**	**$2.0**	**$2.3**
Total	**$6.0**	**$7.4**	**$289.2**	**$530.9**
Average Annual Case Load				**25,000**
Cost Parameter		**Start-up Costs**		**5 Year Costs**
CDES Option	**MENBA**	**MilDep**	**MENBA**	**MilDep**
Personnel	**$0.1**	**$0.2**	**$313.7**	**$595.2**
IT	**$4.2**	**$5.4**	**$12.5**	**$18.7**
Infrastructure	**$2.1**	**$2.5**	**$2.1**	**$2.5**
Total	**$6.4**	**$8.1**	**$328.3**	**$616.4**
Average Annual Case Load	**30,000**			
Cost Parameter	**Start-up Costs**		**5 Year Costs**	
CDES Option	**MENBA**	**MilDep**	**MENBA**	**MilDep**
Personnel	**$0.2**	**$0.2**	**$366.3**	**$705.9**
IT	**$4.7**	**$6.2**	**$13.9**	**$21.4**
Infrastructure	**$2.2**	**$2.8**	**$2.2**	**$2.8**
Total	**$7.1**	**$9.2**	**$382.4**	**$730.1**

Table 9: Option 6 - DoD Disability Evaluation Adjudication Agency Costs

Assuming an average annual case load of 21,495, start-up costs under MENBA are $6.0 million compared to $7.4 million using Military Department requirements. Compared to option 3, start-up costs are $12.8 million lower for MENBA and $18.4 million lower under the Military Department requirements. Costs over the FYDP are $289.2 million for MENBA compared to $530.9 million under the Military Department which is lower by $262.0 million (MENBA) and $438.7 million (Military Department) than those for option 3.

An average case load of 25,000, results in start -up costs of $6.4 million (MENBA) compared to $8.1 million for the Military Department and FYDP costs of $328.3 million to $616.4 million. Compared to option 3, start-up costs are $14.2 million lower for MENBA and $20.6 million lower using the Military Department. Option 6 FYDP costs are lower by $306.4 million (MENBA) and $492.3 million (Military Department) than those for option 3.

Using an average case load of 30,000, it is estimated that start-up costs range between $7.1 million to $9.2 million for MENBA compared to the Military Department. Costs over the FYDP are expected to be $382.4 million to $730.1 million. Compared to option 3, start-up costs are $15.9 million lower for MENBA and $23.7 million lower under the Military Department. Option 6 FYDP costs are lower by $355.1 million compared to $600.4 million for option 3.

Costs assume the DoD DEAA will utilize existing DoD facilities. If existing space is not available, building a new facility increases start-up costs between $2.5 million (MENBA) to $3.2 million (Military Department). For an annual lease option, start-up costs increase by $0.1 million under both MENBA and Military Department.

3.2.4 Option 6 Risks. For option 6 and the four risks (Appendix 7: Risk Descriptions) associated with the dimensions of change (Table 10) identified below, a summary risk score for each dimension is calculated by taking the average of the consequence scores for each dimension and multiplying it by the probability—or likelihood that the risk will occur—the resulting value is the risk score. Table 10: Option 6 – DoD Disability Evaluation Adjudication Agency Risk Exposure Results summarizes those risks for option 6.

Option 6 Risk Exposure Results						
4-D of Change	Risks	Probability Score	Consequence Scores			Risk Score
			Feasibility	Propriety	Cost	
Infrastructure	Consolidation of MEB and PEB services at locations negatively impacts span of control and delivery of services (Infrastructure).	0.3	2	2	2	0.6
Technology	Capability for sufficient case management and/or case file transfer is not available at the time of CDES implementation (Technology).	0.3	2	2	4	0.9
People	Staffing the consolidated DES with necessary human capital present start-up and organizational challenges (People).	0.7	2	3	3	2.1
Process	Substantial changes to existing policy and processes may necessitate a comprehensive change communications effort in order to build consensus and effect successful implementation (Process).	0.7	3	3	3	2.1

Table 10: Option 6 – DoD Disability Evaluation Adjudication Agency Risk Exposure Results

The four risks identified are the most applicable in determining the risk environment that option 6 might face during implementation. There are clearly other risks to consider, however, they were determined to be outside the scope of this study or assessed as being equal regardless of the alternative and thus not deterministic for this study. According to Table 10, the probability that the risks will occur for option 6 are 'unlikely' to 'likely'. The risks determined to be 'likely' occur in the areas of 'People' and 'Process.' This is most likely due to the fact that option 6 will require a greater overhaul of current Integrated DES policy and removes Service-level autonomy in administering their portion of the DES. The consequences, however, are no more severe than option 3—all are generally moderate in impact.

4. Conclusion

Congressional language requesting this study assumed DoD's current disability evaluation structure produces inconsistent results and that centralizing DES activities would increase consistency of disability evaluation outcomes. DoD did not test those assumptions in the current study but believes that such testing is critical before pursuing implementation of any of these potential constructs. Presented within this report are five alternative organizational structures that lean toward greater centralization to the IDES. In all cases, DoD assumed DoD and VA disability evaluation processes would remain integrated as closely as in the current DES (for example, VA provides disability examinations and ratings).

DoD determined multiple decision points in the treatment and disability evaluation continuum could potentially lead to inconsistent outcomes and potentially expose disabled Service members to discharge without disability consideration or full compensation. These decision points include

the potential for overlapping symptomatology that can lead to diagnostic differences during treatment, mis-categorization of a Service member's medical condition as existing prior to military service, and failure to accurately consider all conditions that cause or contribute to unfitness. In addition, differences in Military Department implementation of DoD policy addressing appeal and review options in the disability system can create the perception that soldiers, sailors, marines, or airmen do not have the same opportunities to assure they receive a fair outcome.

Lacking a thorough Integrated DES manpower study, DoD was not able to determine from available information if current staffing levels are sufficient to meet Integrated DES goals. However, DoD identified a wide disparity between the level of Military Department manpower currently supporting the Integrated DES process and the staffing levels suggested in the recent ASD(HA) MENBA Study and Service Subject Matter Expert Operational Audit. Therefore, DoD used both approaches to estimate a range of manpower and costs of the consolidation alternatives studied.

DoD compared five alternative structures to the Integrated DES. From this review, DoD identified two options for further study: 1) a DoD regional medical evaluation board and centralized physical evaluation board, and 2) a DoD disability evaluation adjudication agency. Both consolidation approaches included an independent disability board for appellate reviews. DoD determined that consolidation of the DES is feasible (capable of being done or dealt with successfully), would maintain propriety (suitable and appropriate for Service members and stakeholders), and would result in a short-term cost increase with a long-term cost savings.

Even though both options provide opportunities for further consideration of a Consolidated DES, there were limitations identified during this study that time did not permit us to address. Lacking a thorough Integrated DES manpower study, DoD was not able to determine from available information if current staffing levels and other critical resources are sufficient to meet Integrated DES goals. Given this key factor and, the importance of the DES program to our Service members and their families, DoD concluded further research is needed prior to initiating such a major revision of the current system that: determines if consolidation would resolve any perceived or real problems with disparate ratings; ensures any undesirable impacts to the Service member and stakeholders are fully considered; identifies the role of the Service Secretaries in making the final determination of a Service member's fitness; and conducts a more complete cost analysis to determine resource impacts on the Military Departments.

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[House Report 112-78]
[From the U.S. Government Printing Office]

112th Congress 1st Session HOUSE OF REPRESENTATIVES Report 112-78

NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2012

R E P O R T

OF THE

COMMITTEE ON ARMED SERVICES
HOUSE OF REPRESENTATIVES

ON

H.R. 1540

together with

ADDITIONAL VIEWS

[Including cost estimate of the Congressional Budget Office]

May 17, 2011.--Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2012

112th Congress 1st Session HOUSE OF REPRESENTATIVES Report 112-78

C O N T E N T S

TITLE VI--COMPENSATION AND OTHER PERSONNEL BENEFITS

OVERVIEW

The committee continues to believe. . .

ITEMS OF SPECIAL INTEREST

Consolidation of Disability Evaluation System

The committee is encouraged by the initial feedback that the Department of Defense Integrated Disability Evaluation System has reduced the time required to deliver benefits from the Department of Veterans Affairs to wounded warriors. However, the committee remains concerned that service members with similar disabilities are receiving disparate disability ratings because of different standards, policies, and procedures used by the Physical Evaluation Boards operated by the military departments. The committee believes that achieving consistent disability ratings regardless of service is an important objective that will ensure service members are treated equitably. The committee believes that one method for ensuring such consistent outcomes is to operate a consolidated disability evaluation system within the Department of Defense. Accordingly, the committee directs the Secretary of Defense to submit a report to the congressional defense committees by August 1, 2012, (Note: Based on December 31, 2011, enactment of FY12 NDAA, DoD has notified Congress of our intent to provide the final report by November 30, 2012) on the feasibility, propriety, cost, and recommended legislation to implement such a consolidated disability evaluation system, if the Secretary determines that recommended legislation is appropriate and necessary.

Appendix 2: Option Decision Rubric

The Consolidated Disability Evaluation System review used the Option Decision Rubric as a reference tool to assign a rating scale to measure the degree to which a proposed option meets the objective between each measure of effectiveness and dimension of organizational change combination.

Four Dimensions of Change	**Measures of Effectiveness**			
	a. Feasibility: *capable of being done or dealt with successfully*	**b. Propriety:** *suitable and appropriate for Service members and stakeholders*	***c.*** **Cost:** *satisfies budgetary constraints*	
			c.1 Start-up	**c.2 Long-term**
1. Infrastructure: *optimizes general and medical physical space requirements (e.g. buildings, offices, cubicles, meeting space, storage space, etc.)*	**1a.** Utilizes/consolidates current facilities or enables building/leasing new facilities to avoid redundancies in resources.	**1b.** Facilitates improved interactions (physical/virtual) between **Service members** and stakeholders.	**1c.1** Minimizes ***start-up*** building/leasing facilities cost.	**1c.2** Minimizes ***long-term*** sustainment/replacement of facilities costs.
2. Technology: *increases automated creation, accumulation, analysis and transfer of information*	**2a.** Develops/integrates the current systems to improve the capability, in terms of hardware, personnel and expertise, to provide case management, case tracking, and electronic file transfer capability through the IDES process.	**2b.** Provides a user-friendly interface that enhances stakeholder service delivery to **Service members**.	**2c.1** Minimizes ***start-up*** data, applications, and technical infrastructure costs.	**2c.2** Minimizes ***long-term*** sustainment/replacement of data, applications, and technical infrastructure costs.
3. People: *improves organizational structure and human capital management (e.g., workforce planning, leadership development, recruiting, performance management, and training and development)*	**3a.** Leverages strengths of existing expertise across Military Departments to ensure proper staffing and organizational structure to minimize redundancies.	**3b.** Enables stakeholders to appropriately administer the IDES while fully supporting and minimizing negative impacts (e.g. off-site physicals, board travel) to **Service members** through the process.	**3c.1** Minimizes ***start-up*** manpower and travel/transfer costs.	**3c.2** Minimizes ***long-term*** manpower/training and travel costs.
4. **Process:** *standardizes activities, activity sequences, and business rules*	**4a.** Can be implemented by Service and can lead to amenable legislative changes that ensure equitable outcomes.	**4b.** Creates processes that are understandable and fair to address stakeholder needs to ensure equitable outcomes for **Service members**.	**4c.1** Minimizes ***start-up*** operational costs (printing, mailing, records management, etc.).	**4c.2** Minimizes ***long-term*** operating costs (printing, mailing, records management).

Appendix 3: Aggregated Decision Table Ratings Sorted by Preferred Option

Subject matter experts rated the feasibility, propriety, and projected cost of the five organizational consolidation options compared to the Integrated DES. The results in the following table show the subject matter experts' aggregated scores relative to the Integrated DES with positive scores indicating more desirable results (for example, positive cost scores below indicate anticipated reduced costs compared to Integrated DES). In the following table, scores are sorted by feasibility, propriety, and then cost. This assessment indicated options 3 and 6 scored most favorably compared to the Integrated DES and warranted further study.

Aggregated Decision Table Rating Sorted by Preferred Alternative to the Integrated DES					
Options	**Measure of Effectiveness**				**Preliminary Conclusions**
	Feasibility	**Propriety**	**Start-up cost**	**Long-term cost**	
1. Integrated Disability Evaluation System (Baseline)	0	0	0	0	The current IDES was used as a baseline for comparison.
6. Centralized DoD Disability Evaluation Agency with a Disability Board of Review	3.50	4.50	-3.50	2.50	Provides a DoD Agency, single source adjudication that streamlines all processes; minimizes start-up/long-term cost; allows maximum opportunity for disability outcome congruency
3. Regional MEB and Centralized PEB with a DoD Disability Board of Review	3.00	4.33	-3.67	1.33	Provides a DoD regional MEB to standardize identification of Service members retention determination and centralized PEB to determine a Service members Fitness/Unfitness finding; moderate long-term MEB/PEB cost; good opportunity for outcome congruency
2. Regional Medical Evaluation Board (MEB) and Regional Physical Evaluation Board (PEB) with a DoD Disability Board of Review	2.67	4.00	-4.33	1.67	Provides dual DoD regional MEB/PEB's to standardize identification of Service members retention determination and Fitness/Unfitness finding; long-term MEB/ PEB savings; allows opportunity for outcome congruency
4. Centralized PEB with a DoD Disability Board of Review	2.50	4.00	-2.50	1.50	Provides a DoD centralized PEB to standardize identification of Service members Fitness/Unfitness finding; streamlines long-term PEB cost; allows opportunity for Fitness/Unfitness determination congruency
5. Centralized Formal PEB (FPEB) with a DoD Disability Board of Review	2.50	3.50	3.50	1.00	Provides a DoD centralized FPEB to determine a Service members appeal of the IPEB Fitness/Unfitness determination; may increase the number of FPEBs; drives up cost given Military Departments need to conduct MEB and Informal PEB

Appendix 4: Cost Factor Assumptions

Outlined below are detailed explanations for the cost factor assumptions that were used to determine cost for the Consolidated Disability Evaluation System.

People

- ***FTE*** –Based on the range between the Consolidated DES Manpower Analysis and information submitted by the Military Departments, option 6 and option 3 FTE's utilize the Consolidated DES developed numbers
- ***Pay grades*** – Based on current manpower standards and Military Department submissions
- ***Composite Pay scales*** – Based on 2012 DoD Pay Table for Military Personnel; 2012 General Schedule (GS) Pay Table for Federal Employees and OMB A-76 Fringe Benefit Factor; and, current Contractor Rates submitted by Military Departments
- ***Training Expense*** – Utilizes Army Annual Training and Certification rate of $3,500 per FTE
- ***Travel*** – Account for 4.8 percent of Service members, average stay of 5 nights at $120 per night, and daily per diem of $100. Round trip airfare of $500
- ***Annual Turnover*** – 9.3 percent based on Federal Government Turnover from the US Bureau of Labor Statistics. Ratio used as majority of workforce is civilian
- ***Transition*** – based on a rate of 20.00 percent of FTE's of GS-11 or above plus all military Cost factor of $15,000 per move. Rate and cost factor based on Booz Allen Subject Matter Expert

Information Technology

- ***Training*** – Determined by the number of FTE's. Cost of $21,825 per class of 20 participants
- ***Hardware*** – Number of workstations, print servers, etc., as determined by number of sites. Cost of $2,404 per FTE assuming a lifecycle of 5 years. Print Servers cost of $1,148,590 per location with a 5 year life cycle
- ***Software*** – Cost of $426 per FTE assuming a lifecycle of 5 years
- ***LAN connection*** – one-time cost of $13,713 per new FTE
- ***Broadband*** – Based on OSD (HA)/TMA estimate of OC-3 recurring and non-recurring connection costs for East Coast, West Coast and Midwest facilities. Annual Cost of $392,170 was used for East Coast Connectivity and $366,104 for West Coast Connectivity per location

Process

- ***Records Management –*** Cost of duplicating and mailing records. Assumed $0.0 cost as a result of current records and reporting automation efforts

Infrastructure

- ***Square Feet*** – Based on DoD Instruction Number 5305.5 - Space Management Procedures, National Capital Region and number of FTE's
- ***Build Cost per Square Feet*** – Based on FY11 DoD Facilities Pricing Guide cost of $261.98 per square foot
- ***Lease Cost per Square Feet*** – Based on lease cost averages using 4 locations across the southern tier of the United States for a cost of $24.32 per square foot

- ***Renovation Cost per Square Feet*** – cost factor of $90.95 per square foot based on Booz Allen subject matter expert input
- ***Programmatic Impact Study*** – $100,000 per site was provided by CAPE
- ***Utilities and Maintenance*** – $0.0 as costs are assumed to be covered by base
- ***Office Equipment*** – $5,000 per FTE (Military Departments)

Financial

- ***Inflation rates*** - Based on Medical Inflation Rates published by Office of Management and Budget's FY2012 Mid-Session Review Economic Assumptions for DoD
- ***Term*** – project is estimated to begin in 2015, assuming a 20 year life
- ***Cost uncertainty*** – Monte Carlo simulation was used assuming 15 percent standard deviation for Pay, 25 percent for IT, and 25 percent for Infrastructure. All costs are calculated at 80th percentile to meet DoD Government Budget Quality Estimate standards

Appendix 5: Cost Element Structure

For the Consolidated Disability Evaluation System, a cost element structure was developed for both options across the four dimensions of change (people, process, infrastructure, and technology).

1.0	MEB
1.1	Personnel
1.1.1	Total Compensation
1.1.2	Training Expense
1.1.3	Travel
1.1.4	Transition Costs
1.2	IT Investment
1.2.1	Hardware
1.2.2	Software
1.2.3	Network Mgmt
1.2.5	Training Expense
1.2.5	Broadband Costs
1.2.6	Implementation Costs
1.3	Process*
1.3.1	Records Processing - Paper/Manual
1.3.2	Records Storage - Paper/Manual
1.4	Infrastructure
1.4.1	Cost to Renovate(R) / Build(B) / Lease(L)
1.4.2	Maintenance
1.4.3	Utilities
1.4.4	Office Equipment
2.0	PEB
2.1	Personnel
2.1.1	Total Compensation
2.1.2	Training Expense
2.1.3	Travel
2.1.4	Transition Costs
2.2	IT Investment
2.2.1	Hardware
2.2.2	Software
2.2.3	Network Mgmt
2.2.4	Training Expense
2.2.5	Broadband Costs
2.2.6	Implementation Costs
2.3	Process*
2.3.1	Records Processing - Paper/Manual
2.3.2	Records Storage - Paper/Manual
2.4	Infrastructure
2.4.1	Cost to Renovate(R) / Build(B) / Lease(L)
2.4.2	Maintenance
2.4.3	Utilities
2.4.4	Office Equipment

3.0	DBR
3.1	Personnel
3.1.1	Total Compensation
3.1.2	Training Expense
3.1.3	Travel
3.1.4	Transition Costs
3.2	IT Investment
3.2.1	Hardware
3.2.2	Software
3.2.3	Network Mgmt
3.2.4	Training Expense
3.2.5	Broadband Costs
3.2.6	Implementation Costs
3.3	Process*
3.3.1	Records Processing - Paper/Manual
3.3.2	Records Storage - Paper/Manual
3.4	Infrastructure
3.4.1	Cost to Renovate(R) / Build(B) / Lease(L)
3.4.2	Maintenance
3.4.3	Utilities
3.4.4	Office Equipment
4.0	DEAA
4.1	Personnel
4.1.1	Total Compensation
4.1.2	Training Expense
4.1.3	Travel
4.1.4	Transition Costs
4.2	IT Investment
4.2.1	Hardware
4.2.2	Software
4.2.3	Network Mgmt
4.2.4	Training Expense
4.2.5	Broadband Costs
4.2.6	Implementation Costs
4.3	Process*
4.3.1	Records Processing - Paper/Manual
4.3.2	Records Storage - Paper/Manual
4.4	Infrastructure
4.4.1	Cost to Renovate(R) / Build(B) / Lease(L)
4.4.2	Maintenance
4.4.3	Utilities
4.4.4	Office Equipment

Appendix 6: Cost Data Sources

Below are data sources used to determine the overall cost for the Consolidated Disability Evaluation System.

Cost Data Source Table	
Data	**Source**
People	
Personnel Costs	
DoD Composite Rates	DoD Comptroller
Federal Employee Salaries	Office of Personnel Management (OPM)
Federal Benefits Factor	OPM A-76
Current MEB FTE's by Role/Type (AD, GS, K)	Military Departments
Current MEB AD Grade	Military Departments
Current MEB GS Grade	Military Departments
Current MEB Contractor Rate	Military Departments
Current PEB FTE's by Role/Type (AD, GS, K)	Military Departments
Current PEB AD Grade	Military Departments
Current PEB GS Grade	Military Departments
Current PEB Contractor Rate	Military Departments
Proposed MEB FTE's by Role/Type (AD, GS, K)	WCP Manpower Study
Proposed MEB Grades/Rates by Role/Type	WCP Manpower Study and Military Departments
Proposed PEB FTE's by Role/Type (AD, GS, K)	WCP Manpower Study
Proposed PEB Grades/Rates by Role/Type	WCP Manpower Study and Military Departments
Training/Recertifications	
Cost per personnel - Initial Training	Military Departments
Cost per personnel - Recertifications	Military Departments
Travel	
Number of Annual Cases	WCP Manpower Study
% of Service Members Traveling	WCP Manpower Study
Cost of Lodging per diem	Military Departments
Cost of Meals per diem	Military Departments
Cost of Airfare	Military Departments
Other Factors	
Annual Employee Turnover	US Bureau of Labor Statistics
IT	
Hardware	
Components by Role	ASD(HA)/TMA
Cost by per component	ASD(HA)/TMA
Initial Hardware Costs	ASD(HA)/TMA
Recurring Hardware Costs	ASD(HA)/TMA
Software	
Components by Role	ASD(HA)/TMA
Cost by per component	ASD(HA)/TMA
Initial Hardware Costs	ASD(HA)/TMA
Recurring Hardware Costs	ASD(HA)/TMA
Network LAN Connections	
Cost per seat	ASD(HA)/TMA
Training	
Cost for Initial training	ASD(HA)/TMA
Cost for Recurring training	ASD(HA)/TMA

Cost Data Source Table (Cont'd)	
Process	
Medical Records Management	
Cost per Case	Military Departments
Copying & Printing	Military Departments
Records Shipping & Handling	Military Departments
Records Storage	Military Departments
Other Admin Costs	Military Departments
Infrastructure	
Total Sqft Requirements	DoD Instruction Number 5305.5 - Space Management Procedures, NCR
Cost to Build/Maintain	DoD Infrastructure Pricing Guide FY11
Cost to Lease	CoStar Group Leasing website
Office Furniture	Military Departments

Appendix 7: Risk Descriptions

Risk identification depends on three basic components: root cause, probability, and consequence. These three components characterize a risk by causation from existing events, probability of occurrence, and resulting impact.

- A ***root cause*** (existing event), which, if eliminated or corrected, would prevent a potential consequence from occurring
- A ***probability*** (or chance) assessed at the present time of that root cause occurring
- The ***consequence*** (or impact) of that future occurrence.

Likelihood (probability) can be defined as the chance that the risk will occur. Risk likelihood (qualitative) and probability (quantitative) span a range of five levels. Consequence (impact) relates to the Measures of Effectiveness:

- ***Feasibility*** correlates to the risk associated with the ease and success of implementation.
- ***Propriety*** depends on the risk of suitability for Service members and stakeholders.
- ***Cost*** accounts for the impact on operational costs.

The risks identified result from the options presented against the INTEGRATED DES baseline. Risks were identified based on the nuances of both options and organized by the Four Dimensions of Change. The scoring of each risk for the options employs a two-pronged quantitative and qualitative approach with respect to the likelihood and the consequences. A risk exposure score is calculated based on the combination of the probability (or chance) that the risk will occur and the aggregated (a rounded average of Feasibility, Propriety, and Cost levels) consequence (or impact) of the risk. Below is a list of descriptions for each risk assessed for the Consolidated Disability Evaluation System Congressional Review.

Descriptions

Risk #1: Consolidation of Medical Evaluation Board and Physical Evaluation Board services at locations negatively impacts span of control and delivery of services (Infrastructure).

Risk #1 Root Cause. The root cause of this is the potential for the inability of current facilities to meet the needs and standards of space required for the proposed options.

Risk #1 Description. If an option requires physical relocation of the current Medical Evaluation Board and/or the Physical Evaluation Board to consolidated locations or a single location, then the DoD and the VA must assume the responsibility for ensuring that these newly established locations are equipped with the space necessary to support the service delivery process. This requires that the DoD and VA possess the required level of operational knowledge so that the geographic location of facilities are properly distributed which will help improve the flow and delivery of service important to the DES. This risk is primarily associated with a transition from a decentralized Medical Evaluation Board/Physical Evaluation Board facility framework to a regional or centralized model.

Risk #2: Capability for sufficient case management and/or case file transfer is not available at the time of Consolidated DES implementation (Technology).

Risk #2 Root Cause. There is a negative impact to the consolidation efforts if there are delays and/or disruptions in the electronic case file and management tool implementation schedule.

Risk #2 Description. If transition to and implementation of an electronic case file management system is delayed or disrupted, then there will be service disruption and/or service delivery performance problems. Subsequently, any efforts to increase automated creation, accumulation, analysis, and transfer of information could be hindered. Given the fact that electronic case file capabilities have not yet been implemented across the enterprise, there is high impact to the existing DES which can also impact any future consolidation efforts. This impact can be mitigated if an enterprise wide tool is in place at the time of Consolidated DES implementation.

Risk #3: Staffing the consolidated DES with necessary human capital present start-up and organizational challenges (People).

Risk #3 Root Cause. The root cause for this risk is the potential lack of the required staff that are trained and qualified to adequately integrate the consolidated processes.

Risk #3 Description. If properly trained staff is not available then the subsequent learning curve for new staff within the new agency/organization may be more severe than anticipated. This and any possible loss of institutional knowledge during the consolidation of resources will have a negative effect on the ability of the new organization to operate, leading to possible decreases in processing time resulting in a decline in quality and customer satisfaction. The level of impact of this risk will vary based on the degree of consolidation. From an organizational stand point any major consolidation of an organization will also likely lead to an increase in middle management requirements which may lead to additional bureaucracy. Additionally, integration challenges between Services have a negative effect on the ability of the new organization to operate.

Risk #4: Substantial changes to existing policy and processes may necessitate a comprehensive change communications effort in order to build consensus and effect successful implementation (Process).

Risk #4 Root Cause. The root cause for this risk is the potential need for significant structural and cultural changes that need to be socialized in order to generate support.

Risk #4 Description. Consolidating the DES may require significant structural and cultural change to effect required changes to the current processes. To alleviate this risk, action must be taken to develop a comprehensive communications plan that can garner appeal and lead to amenable change. The individual risk assessment results for options 3 and 6 can be found in sections 3.1.4 and 3.2.4, respectively.

Appendix 8: Risk Analysis Tables

Analysis for the Consolidated Disability Evaluation System used the tables below to determine risk exposure scores for each option. The scoring process involved the assignment of a probability level to each risk, then a consequence level for each measure of effectiveness (consequence). Finally, the probability level and the average of the consequence levels were applied to the risk exposure scale reference table to determine a final risk exposure score.

Probability Scale

Probability Levels		
Level	**Likelihood**	**Probability**
5	Almost Certain	~90 percent
4	Likely	~70 percent
3	Possible	~50 percent
2	Unlikely	~30 percent
1	Rare	~25 percent

Consequence Scale

Measure of Effectiveness	**Consequence Levels**				
	1	**2**	**3**	**4**	**5**
Feasibility	**Negligible** consequence to success of option being done or dealt with successfully	**Minor** consequence to success of option being done or dealt with successfully	**Moderate** consequence to success of option being done or dealt with successfully	**Major** degradation to success of option being done or dealt with successfully	**Severe** degradation to success of option being done or dealt with successfully
Propriety	**Negligible** impact to suitability and appropriateness for Service members and stakeholders	**Minor** negative impact to suitability and appropriateness for Service members and stakeholders	**Moderate** negative impact to suitability and appropriateness for Service members and stakeholders	**Major** negative impact to suitability and appropriateness for Service members and stakeholders	**Severe** negative impact to suitability and appropriateness for Service members and stakeholders
Cost	**Negligible** increase to budgetary constraints	**Minor** increase to budgetary constraints	**Moderate** increase to budgetary constraints	**Major** increase to budgetary constraints	**Exceeds** budgetary constraints

Risk Exposure Scale

Risk Exposure					
Probability	**Consequence Levels**				
	1	**2**	**3**	**4**	**5**
Almost Certain (5)	0.9	1.8	2.7	3.6	4.5
Likely (4)	0.7	1.4	2.1	2.8	3.5
Possible (3)	0.5	1.0	1.5	2.0	2.5
Unlikely (2)	0.3	0.6	0.9	1.2	1.5
Rare (1)	0.25	0.5	0.75	1.0	1.25