



PERSONNEL AND
READINESS

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

AUG 24 2023

The Honorable Jon Tester
Chairman
Subcommittee on Defense
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The Department's response to the Explanatory Statement accompanying H.R. 133, the Consolidated Appropriations Act, 2021 (Public Law 116-120), "Facilities Sustainment, Restoration and Modernization," is enclosed. The Explanatory Statement requests the establishment of a comprehensive plan to address the unfunded requirements of the defense medical facilities sustainment, restoration, and modernization, informed by the recommendations detailed in the Department of Defense Inspector General (DoD IG) 2020 audit report.

Many of the DoD IG recommendations have been addressed by Defense Health Agency policies, guidance, and standard operating procedures, while the remaining recommendations are being addressed through internal management and policy processes. The comprehensive plan addresses and defines the current backlog, and sets funding thresholds for military medical treatment facilities (MTFs). The current work process of scrutinizing and prioritizing MTF requirements within designated boards is based on a hierarchical analysis that ranks and scores each requirement. The plan covers strategic funding options and offers three scenarios: preserving current funding and the consequent impact it has on the backlog; exercising a buy down plan to eliminate the backlog; and maintaining the current level of backlog, including the funding required to sustain it at a steady state.

Thank you for your continued strong support for our Service members and civilian workforce. I am sending similar letters to the other congressional defense committees.

Sincerely,

A large black rectangular redaction box covering the signature area.

Gilbert R. Cisneros, Jr.

Enclosure:
As stated

cc:
The Honorable Susan Collins
Ranking Member



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

PERSONNEL AND
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AUG 24 2023

The Honorable Jack Reed
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

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As stated

cc:
The Honorable Roger F. Wicker
Ranking Member



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

PERSONNEL AND
READINESS

AUG 24 2023

The Honorable Mike D. Rogers
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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Gilbert R. Cisneros, Jr.

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member



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

PERSONNEL AND
READINESS

AUG 24 2023

The Honorable Ken Calvert
Chairman
Subcommittee on Defense
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The Department's response to the Explanatory Statement accompanying H.R. 133, the Consolidated Appropriations Act, 2021 (Public Law 116-120), "Facilities Sustainment, Restoration and Modernization," is enclosed. The Explanatory Statement requests the establishment of a comprehensive plan to address the unfunded requirements of the defense medical facilities sustainment, restoration, and modernization, informed by the recommendations detailed in the Department of Defense Inspector General (DoD IG) 2020 audit report.

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Gilbert R. Cisneros, Jr.

Enclosure:
As stated

cc:
The Honorable Betty McCollum
Ranking Member

Report to the Congressional Defense Committees



Comprehensive Plan to Address the Unfunded Requirements and Recommendations Detailed in the DODIG-2020-103 Audit Report

August 2023

The estimated cost of this report or study for the Department of Defense is approximately \$10,000 for the 2021 Fiscal Year. This includes \$8,300 in expenses and \$2,000 in DoD labor.

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Executive Summary

Background

The Department of Defense Office of Inspector General (DoD OIG) conducted an audit of the Department of Defense's (DoD), "Sustainment, Restoration, and Modernization of Military Medical Treatment Facilities" (DODIG-2020-103) in July 2020. The report highlighted a backlog of \$552 million in defense medical facilities sustainment, restoration, and modernization (FSRM) at six visited sites as of September 17, 2019. The Subcommittee on Defense (SAC-D), Committee on Appropriations of the Senate, stated they were concerned with the findings of the audit report. SAC-D further noted that due to the audit report, the Office of the Secretary of Defense committed to providing \$107.2 million of available Fiscal Year (FY) 2019 Operations and Maintenance (O&M) carryover funding to reduce medical FSRM unfunded requirements. However, given the large remaining FSRM shortfall, SAC-D directed the Director, Defense Health Agency (DHA) to develop a comprehensive plan to address the unfunded requirements and a plan to address recommendations detailed in the DODIG-2020-103 audit report.

DoD OIG Audit Report Data

Use of Defense Medical Logistics Standard Support-Facilities Management (DMLSS-FM) vs BUILDER for Deferred Maintenance and Restoration (DM&R) Data

The DoD OIG Audit Report used data from the DMLSS-FM system to quantify DHA DM&R. DHA, however, uses the BUILDER module of the Sustainment Management System as the database of record for DM&R data. These two complimentary systems are used for different purposes; they have some functional overlap, but the data is not interchangeable. One of BUILDER's specialized functionalities is to model DM&R requirements. BUILDER is set to become the DoD standard for quantifying DM&R. In contrast, DMLSS-FM was designed as a work order management system to document known facilities deficiencies (or requirements) and to organize those requirements for resolution. DMLSS-FM is not as accurate as BUILDER for obtaining DM&R data, and it requires specific filtering be applied to develop a good DM&R estimate. See "Use of DMLSS-FM to Obtain DM&R Requirement Data" and "Use of BUILDER to Obtain DM&R Requirement Data" sections of this report for further details on the functionality and use of both systems.

Use of DMLSS-FM to Obtain DM&R Requirement Data

DHA was unable to replicate the DoD OIG DM&R data from September 2019. Since that time, many requirements have been closed or added, bundled with other requirements, or included in larger renovation projects. As an alternative, in February 2021, DHA calculated the DM&R for the six sites to compare to the DoD OIG reported backlog, with the expectation that the change in DM&R over the past 18 months would be relatively small. Instead, the DHA DMLSS-FM calculated DM&R, as of February 2021, was over 50 percent lower than the DoD OIG reported DM&R. DHA calculated the current backlog in DMLSS-FM at \$245 million compared to the DoD OIG calculated backlog of \$552 million. DM&R costs obtained from DMLSS-FM can be inaccurately high if DMLSS-FM data filters are not applied. Without proper filtering, the

backlog number may count requirement costs multiple times due to the system's bundling of work in requirement packages. In addition, the dataset may include current year sustainment (recurring maintenance), already funded requirements, requirements with a need date in current or future years, and discretionary requirements with no impact on the operational ability of a facility to meet its mission.

DMLSS-FM is a work order management system used to document known deficiencies (or requirements) and to organize those requirements for execution and resolution. The identification and submission of future requirements varies widely between individual sites in DMLSS-FM. Therefore, use of DMLSS-FM to identify DM&R is not a documentable and repeatable process that can be universally applied across the enterprise.

Use of BUILDER to Obtain DM&R Requirement Data

BUILDER has been designated as the DHA system of record to identify and project DM&R backlog. BUILDER provides a more accurate depiction of a facility's current condition based upon predicted deterioration of its components over time, coupled with field verification, to provide DHA with a documentable and repeatable process to identify and project DM&R. Using current year BUILDER data, which is more accurate than DMLSS-FM, the DM&R backlog at the six sites is \$169 million versus the DHA derived DMLSS-FM DM&R backlog of \$245 million or the DoD OIG reported DMLSS-FM DM&R backlog of \$552 million.

Use of DMLSS-FM vs BUILDER for Entire DHA Inventory DM&R Data

The DoD OIG Audit Report reported \$14.9 billion "in unfunded requirements that were reported as of September 2019, for the more than 576 hospitals and clinics and 87 dental facilities worldwide."¹ DHA was unable to replicate this data from the DMLSS-FM system. As of February 2021, DHA can show the DMLSS-FM produced total DM&R backlog, with the applicable filter queries applied, was \$3.464 billion for the entire DHA inventory. Comparatively, BUILDER (the DHA DM&R system of record) shows a DM&R backlog of \$3.312 billion as reported to the auditors for the second quarter of FY 2021.

Comprehensive Plan to Reduce DM&R Backlog

The DoD OIG Audit Report was undertaken during the early stages of DHA's legally required transition of military medical treatment facilities (MTFs) from the Military Departments to DHA. The report did not reflect efforts underway to improve and standardize facilities life cycle management for gained DHA MTFs that were previously managed differently by each Military Department. Since then, DHA has made great strides toward improving FM operations and standardization to include developing detailed procedures and guidance, establishing uniform training (including proper use of both DMLSS-FM and BUILDER for their respective purposes),

¹ DODIG-2020-103, page ii.

providing one-stop FM support through Sustainment, Restoration & Modernization Portfolio Managers (SRM-PMs), and providing comprehensive technical guidance through subject matter experts (SMEs), as needed.

In addition, to ensure optimal use of Sustainment, Restoration, & Modernization (SRM) funding, DHA has created comprehensive processes and tools to validate, prioritize, and program facilities requirements.

Because the Military Departments' Service Medical Activities categorized requirements differently, DHA revamped the DMLSS-FM requirements codes and provided uniform rules for defining and categorizing requirements. Requirements Hazard Severity, Criticality, and Priority choices are now based on the probability of the occurrence. DHA also standardized rules for the information that must be submitted to justify a requirement to ensure fully informed decision making.

To improve and standardize the requirements prioritization process, DHA developed an objective data-driven tool, the analytic hierarchy process (AHP), as a first step in ranking requirements. DHA also created two requirements review boards, the Facilities Sustainment Board (FSB) for requirements between \$10,000 and \$250,000 and the Work Induction Board (WIB) for requirements greater than \$250,000. These boards further review requirements after the initial AHP ranking and develop finalized rank-ordering for use in creating the Three-Year Enterprise Project List (EPL), which is a funding execution plan by FY. Local DHA MTFs have been given the authority to approve requirements costing less than \$10,000 and procedures have been established to expedite urgent and compelling requirements.

The EPL, together with condition assessment information and life cycle cost forecasts (i.e., BUILDER), will be used to maintain a DM&R list. All projects that are on the DM&R list for more than 2 years will be reviewed for continuance on the EPL or cancellation.

Constraints Affecting DM&R Backlog Reduction

The current BUILDER derived DM&R amount for the DHA inventory is \$3.312 billion and this number is projected to grow at present funding levels to \$6.226 billion by FY 2027 based on funding scenarios within BUILDER utilizing FY 2021 values with inflation applied. To maintain the current DM&R level at \$3.312 billion and avoid any further growth, DHA funding scenarios indicate an average need of \$775 million per year in additional restoration funding to flatline backlog growth. To make significant progress in reducing the DM&R backlog to zero by FY 2027 and completely fund current year work items, DHA requires an increase in Restoration funding based on BUILDER scenario models of \$1,211 million per year through 2027. DHA would need to ensure there is adequate contract capacity available through DoD Design & Construction Agents to execute the associated increased volume of work should additional funding be provided.

Bottom Line on DM&R Backlog Reduction

DHA requires an adequate and reliable FSRM funding stream to execute valid requirements in a timely manner to avoid increasing the DM&R backlog. However, DHA must balance funding

needs for many competing priorities: therefore, the entire DHA budget needs to be adjusted and stabilized, post legally required transition, across all programs. Based on current funding levels, DHA will not be able to buy down the DM&R backlog, and the backlog will continue to grow. DHA stands ready to work with DoD to resolve this important issue.

DoD OIG Audit Report Data

The DoD OIG report stated that, as of September 17, 2019, data was queried for 60 MTFs, on six sites, producing 760 unfunded requirements with a value of approximately \$552 million². It is unclear exactly which 60 MTFs were included in the aggregated data as there are currently 84 MTFs associated with those six sites. The audit report listed 24 MTFs physically visited on the six sites (see Appendix for the specific list)³.

The report also stated the Military Departments' FM personnel reported unfunded repair requirements of \$14.8 billion in DMLSS-FM, for the more than 576 hospitals and clinics and 88 dental facilities worldwide⁴. However, DHA was unable to duplicate the dollar amounts cited in the DoD OIG report.

DHA's Process to Validate the Audit Report's Backlog Costs for the Six Sites

The Audit report stated the DoD OIG did not validate the data they received (as of September 2019)⁵ from the DMLSS-FM computerized maintenance management system. DHA attempted to validate the DoD OIG data by running similar reports based on current data, because it is not possible to run a retrospective, point in time data report in DMLSS-FM. Because it has been 18 months since the DoD OIG backlog data was produced, DHA's expectation was that the current DM&R backlog data would vary from the DoD OIG September 2019 data, but by a relatively small percentage. Expected reasons for a small variance between the current DM&R backlog and the DoD OIG reported DM&R backlog include:

- Duplicate requirements have been deleted;
- Invalid requirements have been canceled; and
- New Requirements have been added.

However, the DHA DM&R current backlog numbers varied much more than expected; the current total is more than 50 percent lower than the DoD OIG audit report numbers, as depicted in Table 1. DHA's DMLSS-FM calculated value was \$245 million for current DM&R backlog for the six sites as compared to the \$552 million cited in the DoD OIG report.

² DODIG-2020-103 report, page 19.

³ DODIG-2020-103 report, page 17.

⁴ DODIG-2020-103 report, page 19.

⁵ DODIG-2020-103 report, page 23.

Installation	DHA (Feb 2021)					
Fort Campbell	30	\$85,932,955	224	15	\$229,944,000	160
Fort Riley	10	\$10,050,115	62	10	\$15,954,000	62
Naval Air Station Pensacola	8	\$19,111,021	48	6	\$10,212,000	27
Marine Corps Base Camp Pendleton	20	\$35,351,395	244	18	\$43,651,000	296
Eglin Air Force Base	12	\$29,517,175	19	7	\$83,337,000	93
Nellis Air Force Base	4	\$65,535,024	66	4	\$168,700,000	122

Table 1 – Comparison of DMLSS-FM DM&R backlog: DHA February 2021 vs DoD OIG September 2019 Queries

Note: The DoD OIG numbers includes both individual requirements and bundled requirement packages reported in DMLSS-FM for SRM.

**This number includes all the MTFs (84 total) DHA identified as assigned to the six installations.*

***This number only includes the 60 MTFs on the six installations the DoD OIG included in their aggregated data.*

Because the variance between current DM&R backlog and the DoD OIG reported backlog in DMLSS-FM is so large, DHA suspects necessary filters in the original data query were not applied.

The DoD OIG used data from the DMLSS-FM system for 60 MTFs across six installations. However, DMLSS-FM requirements are not an accurate representation of the current DHA DM&R backlog. Many of the DMLSS-FM requirements may include new military construction (MILCON) items and/or completed items that were not yet or properly closed. DMLSS-FM is a work order management system that documents known deficiencies (or requirements) and organizes those requirements for their execution and resolution. As a work order management system, the identification and submission of future requirements could vary widely between individual sites. This is not a documentable and repeatable process that can be universally applied across the enterprise. Instead, BUILDER is the DHA system of record to identify and project DM&R backlog. BUILDER indicates facility component degradation over time and provides DHA with a documentable and repeatable process to identify and project DM&R.

DMLSS-FM and BUILDER are complementary systems but are not interchangeable, and the data from the two systems can only be combined and aggregated with a thorough reconciliation of DMLSS-FM requirements to the BUILDER Annual Work Plan Items.

DMLSS-FM can yield inaccurate results when appropriate queries using necessary filters are not applied. For this reason, there are many possible reasons for the significantly higher backlog costs in the audit report. These may include:

- Duplication of requirements – Many individual requirements listed in DMLSS-FM may also be included in bundled larger requirements, such as modernization projects that also address infrastructure issues.
- Incorrect categorization of requirements – Historically, the three Military Departments have categorized their requirements differently, resulting in inconsistencies. Some requirements may be listed as critical, serious, or imminent, but, upon review, the requirement may really be a lower priority/criticality. An example would be a life safety code violation requirement listed as critical, but because the condition is grandfathered in the code, is not a mandatory requirement.
- Sustainment requirements versus Restoration & Modernization – Sustainment requirements should not be included as backlog requirements. Sustainment is recurring maintenance plus end-of-life cycle replacement only. It does not include backlog items. If an equipment item reaches the end of its life cycle, and it is not replaced that year, it becomes a restoration since the definition of restoration includes replacement work due to excessive age.
- DMLSS-FM also includes many kinds of deferred maintenance requirements other than pure infrastructure repairs. Valid modernization projects are considered unfunded backlog; however, this type of requirement doesn't necessarily mean there is a failed or failing infrastructure condition and, therefore, should not be considered DM&R backlog.
- In DMLSS-FM, when several individual requirements are linked to a bundled requirement package, both the individual "Cost" of the requirement and the total bundled cost of all requirements, or the "Work Amount," are listed for each requirement. Because this larger "Work Amount" value is assigned to each requirement, if this "Work Amount" is included in the query, it results in a much higher dollar total as indicated in Table 2, where the correct total cost of individual requirements is \$3.45 million but summing the "Work Amount" yields an inaccurate total of \$24.15 million.

FACILITY								
MEDICAL WAREHOUSE	324	298580	EXPAND AND REPAIR BUILDING 324	RP1900009	RQ1600065	18GORD003	\$150,000	\$3,450,000
MEDICAL WAREHOUSE	324	298580	EXPAND AND REPAIR BUILDING 324	RP1900009	RQ1900008	18GORD003	\$2,000,000	\$3,450,000
MEDICAL WAREHOUSE	324	298580	EXPAND AND REPAIR BUILDING 324	RP1900009	RQ1900038	18GORD003	\$200,000	\$3,450,000
MEDICAL WAREHOUSE	324	298580	EXPAND AND REPAIR BUILDING 324	RP1900009	RQ1900037	18GORD003	\$200,000	\$3,450,000
MEDICAL WAREHOUSE	324	298580	EXPAND AND REPAIR BUILDING 324	RP1900009	RQ1900036	18GORD003	\$300,000	\$3,450,000
MEDICAL WAREHOUSE	324	298580	EXPAND AND REPAIR BUILDING 324	RP1900009	RQ1900035	18GORD003	\$300,000	\$3,450,000
MEDICAL WAREHOUSE	324	298580	EXPAND AND REPAIR BUILDING 324	RP1900009	RQ1900029	18GORD003	\$300,000	\$3,450,000

Table 2 – Individual Requirement “Cost” versus the Bundled Requirement Package “Work Amount”

DMLSS-FM DM&R Backlog Data as of February 2021

To demonstrate the impact to DMLSS-FM data when queries with filtering are applied, the following section depicts the step-by-step process to pull, interpret, and analyze requirements (RQMTs) data using the appropriate filters.

Filtering

Table 3 is a summary of each site identified in the audit with a cost sum and requirement count as of February 2021. This table provides an aggregate overview of the requirements for each site

without the query filters applied. It indicates the DM&R backlog for the 84 MTFs DHA identified at the six sites listed in the audit is \$874,951,612 as of February 2021.

Installation		
Fort Campbell	\$314,440,930	365
Fort Riley	\$32,614,365	153
Naval Air Station Pensacola	\$25,430,640	86
Marine Corps Base Camp Pendleton	\$166,895,595	551
Eglin Air Force Base	\$118,761,026	199
Nellis Air Force Base	\$216,809,056	183

Table 3 – February 2021 DM&R Requirements for Six DoD OIG Sites – No Filtering

The resultant Feb 2021 \$875 million backlog cost provides an inaccurate result. To obtain an accurate representation of unfunded DMLSS-FM requirements, three filters must be applied to the data to address how DHA manages requirements within the DMLSS-FM system.

Filter 1 – RQMT Status

The RQMT status indicates the current status of the RQMT (i.e., whether the RQMT has been assigned to a project, closed, assigned to a package, assigned to a work request, or is open). The only two statuses that are included when determining DM&R backlog, are “OPEN” and “Assigned to Package.” A status of “OPEN” indicates the RQMT has not been funded, nor has it been assigned to a package. A status of “Assigned to Package” indicates the RQMT has been bundled into a package with other RQMTs for scoring and prioritization against other packages based on DHA’s defined process. If a requirement has a status of “Assigned to Work Request” or “Assigned to Project” this means that the RQMT has already been funded and does not count towards DM&R backlog.

Table 4 is an installation summary with the first filter applied to include only RQMTs with a RQMT Status of “OPEN” and “Assigned to Package.” This first filter has reduced the original, unfiltered Table 3 requirement count by 79 and reduced the cost by \$86 million.

Installation		
Fort Campbell	243,914,755	334
Fort Riley	\$32,414,365	152
Naval Air Station Pensacola	\$25,430,640	76
Marine Corps Base Camp Pendleton	\$164,986,095	533
Eglin Air Force Base	\$109,620,025	195
Nellis Air Force Base	\$212,274,555	168

Table 4 – February 2021 DM&R Requirements for Six DoD OIG Sites – Filter 1 – RQMT Status Applied

Filter 2 – Work FY

Work FY is a data field FMs use to indicate the year they believe the work to repair or replace an item needs to occur. If the FY is equal to the current FY, then the work needs to be completed. If the FY is prior to the current FY, then the work is considered DM&R backlog and should be prioritized as unfunded. If the FY is later than the current FY, then the RQMT should not be considered as an unfunded RQMT because the work is currently not required but will be required in the out years. For this example, only the prior and current FYs should be used to identify unfunded RQMTs.

Table 5 is an installation summary with filters 1 and 2 applied. Only RQMTs with a RQMT Status of “OPEN” and “Assigned to Package,” as well as those with current FYs and all previous FYs are included. Total RQMT count has dropped from the original, unfiltered 1,537 to 1,006 and total cost has dropped from \$874 million to \$601 million.

Installation		
Fort Campbell	\$188,848,305	272
Fort Riley	\$31,444,815	144
Naval Air Station Pensacola	\$21,861,427	64
Marine Corps Base Camp Pendleton	\$68,169,706	286
Eglin Air Force Base	\$79,756,625	79
Nellis Air Force Base	\$211,029,569	161

Table 5 – February 2021 DM&R Requirements for Six DoD OIG Sites – Filters 1 & 2 Applied

Filter 3 – Facility Condition Index (FCI) Calculation

The “FCI Calc” field determines whether the RQMT has an impact on the facility’s overall condition index and its operational ability to meet its mission. An FCI Calc of “Y” meets these conditions. An FCI Calc of “N” does not meet these conditions and should not be considered DM&R backlog. Many RQMTs with a FCI Calc of “N”, especially large items with high costs, are placeholders for MILCON projects and major modernization efforts.

Table 6 is an Installation summary that has all three filters applied, to include only RQMTs with a RQMT Status of “OPEN” and “Assigned to Package” and RQMTS with the current FY and all previous FYs and with an FCI Calc of “Y”.

Installation		
Fort Campbell	\$85,932,955	224
Fort Riley	\$10,050,115	62
Naval Air Station Pensacola	\$19,111,021	48
Marine Corps Base Camp Pendleton	\$35,351,395	244
Eglin Air Force Base	\$29,517,176	19
Nellis Air Force Base	\$65,535,025	66

Table 6 – February 2021 DM&R Requirements for Six DoD OIG Sites – Filters 1, 2, & 3 Applied

Applying all three filters results in the most accurate calculation of the DMLSS-FM DM&R backlog, which is \$245 million for the six sites identified in the audit compared to the \$552 million reported in the audit. However, DMLSS-FM is not DHA's system of record to identify and project DM&R backlog. BUILDER is used for that purpose. The following section shows the BUILDER DM&R calculation for the same sites.

BUILDER DM&R Backlog Data as of February 2021

BUILDER cannot re-create historical data. Therefore, DHA cannot calculate the September 2019 DM&R using BUILDER data. DHA can, however, calculate present year DM&R as a comparison to the DoD OIG September 2019 DMLSS-FM DM&R calculation.

BUILDER Process

BUILDER provides a fairly accurate depiction of a facility's current condition based on predicted deterioration of its components over time, coupled with periodic field verification. BUILDER data is purely condition-based. BUILDER uses RSMeans to provide an accurate cost for each requirement. BUILDER projects an item's life cycle based on a Weibull distribution curve⁶ to predict when the item will require repairs or replacement. This provides DHA with a reliable method to project future facility needs and to avoid reaching failure conditions. The BUILDER methodology reduces user error and/or influence over a funding requirement and provides a truer condition-based assessment of a facility.

BUILDER's Annual Work Plan

The BUILDER Annual Work Plan provides a 7 year look at DHA's facilities portfolio requirements. To calculate the number and cost of unfunded requirements, the current FY's work requirements are extracted.

DM&R Backlog Based on BUILDER

The BUILDER backlog consists of items on the Annual Work Plan in the current FY, filtered with a Status of "Valid – Awaiting Funds," "Valid – Deferred," and "Valid – No Action." Table 7 reflects these filters and indicates the current DM&R backlog is **\$169,571,201**. This total cost is more accurate than the DMLSS-FM DM&R backlog and is \$75 million lower.

⁶ Weibull distribution models are used to describe various types of observed failures of components and phenomena. They are widely used in reliability and survival analysis.

Installation		
Fort Campbell	\$29,760,668	653
Fort Riley	\$13,572,632	158
Naval Air Station Pensacola	\$19,084,700	452
Marine Corps Base Camp Pendleton	\$22,371,700	405
Eglin Air Force Base	\$36,158,150	470
Nellis Air Force Base	\$48,623,350	252

Table 7 – Current BUILDER DM&R Backlog

DMLSS-FM and BUILDER Derived DM&R for Entire DHA Inventory

The DoD OIG 2020 audit report stated DHA had: "...\$14.8 billion in unfunded requirements that were reported as of September 2019, for the more than 576 hospitals and clinics and 87 dental facilities worldwide..."⁷. Because it is not possible to run a retrospective, point in time, data report in DMLSS-FM, DHA was unable to recreate the \$14.8 billion total DM&R backlog identified in the audit report. DHA can show that the current DMLSS-FM produced DM&R backlog as of February 2021, with the appropriate filters applied, is \$3.464 billion for the entire DHA Inventory. Additionally, the more accurate BUILDER DM&R backlog as of February 2021 is \$3.312 billion, as reported to the auditors, for the second quarter of FY 2021.

Comprehensive Plan to Address the DM&R Backlog

To reduce the DM&R Backlog, and prevent it from recurring, DHA has identified the following priorities:

- Develop comprehensive, standardized facilities management guidance, procedures, and training.
- Ensure valid requirements are submitted in DMLSS-FM by the MTFs, to include all required documentation, to facilitate DHA Headquarters review and prioritization.
- Standardize the requirements prioritization process using an AHP to minimize subjectivity as much as possible.
- Establish an EPL of valid prioritized projects for use in developing a funded project execution program.
- Coordinate with Construction Agents to ensure there is enough capacity on contracts to execute funded projects in a timely manner.

⁷ DODIG-2020-103 report, page 19.

DHA is well on its way at addressing and achieving many of these priorities as described below.

Facilities Management Support & Training

Background

The National Defense Authorization Act for FY 2017 called for transitioning the administration and management of military hospitals and clinics of the Army, Navy, and Air Force to one system managed by DHA. As part of this consolidation, DHA is expected to standardize processes and improve efficiency. Prior to the transition, the Army, Navy, Air Force, and DHA delivered health services independently with varying degrees of integration.

As of October 1, 2018, DHA inherited many MTFs from the Services that were plagued with inconsistencies in the way the Services conducted their SRM programs, to include the way data in DMLSS-FM was collected, analyzed, and used.

New Policies and Procedures

DHA quickly recognized changes needed to be made to the facilities SRM programs. DHA has been working with SME representatives from within DHA, the three Military Departments, and industry to develop and implement new policies and procedures that incorporate best practices. To date, DHA has developed (or is in the process of developing) 68 new policy and procedural documents. Of this total, 39 documents are already available for DHA and DHA components to begin to use and follow. The rest of the policy and procedural documents are underway in various stages of development.

MTF Assistance and Support

To establish organizational controls and better manage SRM program initiatives, DHA implemented six areas of responsibility (AORs) worldwide for managing workload, workflow, and MTF assistance. Four AORs were established within the continental United States and two AORs were established outside the continental United States in Europe and the Indo-Pacific. DHA designated an SRM-PM and supporting staff for each AOR to provide support and guidance to MTF FMs. The SRM-PMs will assist FMs in shifting from their legacy business practices to the new, standardized DHA processes.

An SRM-PM Standard Operating Procedure (SOP) has been developed describing the roles and responsibilities of the SRM-PMs. This SOP provides the FMs with clear information on how the SRM-PMs can support them.

Formal Guidance and Training for BUILDER and DMLSS-FM

DHA continues to develop and implement formal guidance for managing and updating the BUILDER program. DHA issued Interim Procedures Memorandum 19-005, “BUILDER™ SMS,” establishing DHA’s procedures for managing data in BUILDER, and DHA developed a comprehensive BUILDER Technical Guide. The Interim Procedures Memorandum was

superseded by a formal DHA Procedural Instruction (DHA-PI) 4270.01, “Sustainment Management System (SMS) BUILDER Site Support for Real Property Assets.” DHA actively reconciles BUILDER data with the local MTF staff at the site level at least annually, and in some cases monthly, due to the high volume of work items. Data reconciliation will become more streamlined with coming software improvements for both BUILDER & DMLSS-FM.

Since 2014, DHA has provided an online comprehensive 40-hour BUILDER course in alignment with BUILDER program recommendations, and since 2018, DHA has also provided a BUILDER executive introductory 4-hour online course. Users are allowed to enroll in the course that best fits their expected use of the BUILDER system.

Military Department DMLSS-FM training programs have been in place since 1997 and are routinely conducted to address current system capabilities. To facilitate the MTF transition to DHA, online DHA DMLSS-FM training will be provided covering standardized administration and use of DMLSS-FM across the facilities portfolio. In addition, a mandatory 40-hour classroom DMLSS-FM training program for DMLSS-FM Sustainment Specialist clerks will be implemented after MTF transition. Finally, online programs are being developed to address specialized training. Because DMLSS-FM is transitioning to the new LogiCole cloud-based platform, DHA is preparing LogiCole training for the entire facilities enterprise community.

Both DMLSS-FM and BUILDER training are being incorporated into DHA’s training management system to ensure all facilities personnel have the skills required to be effective in their positions.

Ensuring Requirements are Properly Prioritized and Approved

Previously, the Military Departments had different processes to score, prioritize, and approve SRM requirements. To standardize the SRM requirements prioritization and approval process, DHA developed DHA-PI 4100.01, “Sustainment, Restoration, and Modernization (SRM) Enterprise Project List (EPL),” and an internal SOP describing procedures for the newly created WIB and FSB. The type of requirement, funding threshold, and other conditions determine if the SRM requirement goes through the WIB or FSB process or is exempt from either.

Requirements Exempt from the FSB and WIB Process

Not all requirements go to the FSB or WIB. Each FM is granted limited authority to approve use of available local funds of up to \$10,000 per service order on the project contract line-item number with the contracting agent. In-house sites also use similar contracts for support to ensure minimal impact to the workforce.

One of the inconsistencies in the way the Military Departments managed sustainment work was the differences in the FM’s local authority thresholds, as shown in the Table 8.

Military			
Army	Less than \$25,000	\$25,000 through \$300,000	Greater than \$300,000
Navy	Less than \$200,000	\$200,000 through \$500,000	Greater than \$500,000
Air Force	Less than \$2,500	Not Applicable	Greater than \$2,500

Table 8 – Military Department and DHA Funds Authority Thresholds

To standardize the local authority thresholds, DHA set the FM approval limit at \$10,000. This is a typical funding authority level which can be adjusted upward or downward at the discretion of DHA Headquarters. This means the FMs do not need to submit requirements less than \$10,000 to DHA for approval, as long as the requirement does not increase square footage or capacity. However, all expenditures still need to be entered into DMLSS-FM. In cases where the FM does not have sufficient local funds available, they will need to submit the requirement to DHA.

Because the DHA FMs have the authority to approve expenditures under \$10,000, they have the responsibility to spend the funds properly and may be subject to audits and/or reviews at any time.

In addition to expenditures under \$10,000, “Emergency” and “Urgent” requirements can be approved for execution outside of the normal FSB or the WIB processes. Section 18.104 of the Federal Acquisition Regulation states, “Agencies may limit the number of sources and full and open competition need not be provided for contracting actions involving urgent requirements.”

Because not all Urgent requirements are equal, DHA has subdivided the term into two priorities “Emergency” and “Urgent” for the contractual terms in O&M contracts and for use with in-house O&M maintenance staff. Creating two priorities provides greater clarity on the different response times required based on the following definitions:

Emergency: Any work required to correct a condition which poses an immediate danger and is likely to cause major injury or death of patients, staff, or visitors, or any work that involves the failure or reduced operability of facility, infrastructure, or equipment that is detrimental to the mission and causes a major or complete reduction in operational effectiveness. All Emergency work must be completed without a break in the work until the Emergency condition is corrected.

Urgent: Any work required to correct a condition which is likely to cause minor injury or discomfort to patients, staff, or visitors, or, any work that involves the failure or reduced operability of infrastructure, or equipment that is detrimental to the mission and causes a minor or partial reduction in operational effectiveness (to include if a redundant system/component, per original design, is reduced to a single system/component). The work shall be expedited until the Urgent repairs are completed.

The third work request priority used is “Routine,” which is work that does not meet the definitions of either “Emergency” or “Urgent” and, therefore, does not require special handling. All routine requirements are submitted through the FSB or the WIB.

FSB and WIB Requirement Development and Submission Process

For requirements that are required to be submitted to DHA, the AHP was developed to rank order the \$10,000-\$250,000 FSB requirements and the > \$250,000 WIB requirements. Both processes use the new DMLSS-FM requirements categories (as described in the “Requirements Module Decision Tree”) to standardize across all DHA MTFs. DHA-PI 4100.01 provides the overarching guidance for this new process. DHA also has a detailed SOP that describes the Emergency, Urgent, and Routine processes to include the FSB, and WIB.

DHA is responsible for ensuring limited SRM funds are disbursed to cover the most critical infrastructure needs across the entire Military Health System. To accomplish this, DHA has developed a comprehensive requirements prioritization process for all DHA facility real property asset projects above \$10,000. All requirements above \$10,000 must go through a thorough submission process before they can be submitted to the FSB or the WIB.

1. DMLSS-FM Requirements Module Decision Tree

The FMs have been directed to load all requirements correctly and completely into DMLSS-FM, per the newly established “Requirements Module Decision Tree.” After a review of the Military Departments’ different uses of DMLSS-FM requirement codes in late FY 2019, DHA worked with them to create a new standard set of requirement codes (the new codes and descriptions are shown in the AHP section of this plan in Table 10 and are further defined in Tables 12-17). The new standardized requirement codes provide a more uniform approach to correctly defining the requirement. The decision tree also includes definitions of each code and the associated “Hazard Severity,” “Criticality,” and “Priority” choices for each based on the probability of the occurrence. The decision tree also lists what must be included in the justification for each requirement.

Many requirements can logically be bundled into a requirement package (RP). An RP should be thought of as if an actual project contract were being developed. DHA looks at the building holistically and matches building trades, where applicable, when determining which requirements should be bundled together into an RP.

Once the requirements are loaded into DMLSS-FM as RPs, the SRM-PMs validate all RPs that will be considered in the next FSB or WIB for funding. As the SRM-PM validates the RPs, they use the AOR collaborative team for assistance and input to ensure that every RP is complete prior to sending to the boards.

2. AOR Collaborative Team Review

The AOR collaborative team members, listed in Table 9, participate in reviewing each RP and provide input as needed. This step is much like a “triage” where the SRM-PM engages with the

team members to examine RPs, leveraging their expertise as SMEs within their AORs and discipline. The collaborative team assists in evaluating the RPs and ensuring they are valid and complete prior to submission to the board. Team members also help minimize incorrect categorization or “gaming of the system” to move requirements higher on the list. They also help to identify potential bundling of requirements into more comprehensive RPs and to identify critical projects that, in the past, may not have been approved or ranked high enough due to weak descriptions and/or justifications. Collaborative team members are drawn from the DHA Facilities Enterprise Division (DHA-FE) and include representatives from the Facilities Operations Branch (FOB) and Capital Strategy Management Branch (CSM), among others.

Organization	
DHA-FE	AOR SRM-PM (Chair)
DHA-FE	FOB Project Management Representative
DHA-FE	CSM Market Lead (for the Market the RP’s activity resides in)
DHA-FE	FOB Engineering & Design (E&D) Representative (from each discipline as required)
DHA-FE	Real Property Management (RPM) Representative

Table 9 – AOR Collaborative Team Members

The results of the team’s review are provided to the SRM-PMs. Requirements needing further information/revision to complete analysis will be returned to the FM for revision. RPs will remain in a holding pattern until an appropriate analysis can be completed, and they are ready to move forward. The collaborative team will recommend whether the reviewed RP should go to the FSB or to the WIB.

3. The AHP

The AHP is a mathematical data-driven tool developed to aid decision making in complex environments where multiple factors must be considered. The AHP method looks at the problem in three parts. The first part is identifying relevant decision objectives and defining objective criteria; the second part is evaluating pair-wise comparisons to determine weights. The third part is applying the algorithm to data to create the prioritized 1-N list.

The DHA SRM AHP is designed to intake RPs across multiple work FYs and work types and then categorize RPs by cost and work type; assign RPs to FSB, WIB, Development, Other, and to Sustainment (S) or Restoration (R) or Modernization (M) or MILCON fund types; and provide a common score across work type and year for prioritization.

Both the FSB and the WIB, for SRM funded projects, will use the AHP to prioritize RPs. The objective criteria for the model are defined in Table 10 and further defined in Tables 12-17.

AHP Criteria	
Requirement Code (see Table 11)	The primary driver of the requirement as specified in the DMLSS-FM RP.
Normalized BCI (see Table 12)	Building Condition Index (BCI) of the facility as captured in BUILDER, normalized against facilities of similar use and age.
Requirement Criticality (see Tables 13, 14, & 15)	The criticality of the requirement determined by the probability of the occurrence of a mishap or facility failure and the severity of the deficiency. Source: DMLSS-FM RP.
Asset Category (see Table 16)	Category of the asset defined by Facility Asset Code as Direct Patient Care, Support, or other.
Clinical Production (see Table 17)	Clinical production defined by average encounters compared to the overall average of like-sized facilities.
Asset Category (see Table 16)	Category of the asset defined by Facility Asset Code as Direct Patient Care, Support, or other.
Clinical Production (see Table 17)	Clinical production defined by average encounters compared to the overall average of like-sized facilities.

Table 10 – AHP Decision Model Objective Criteria

The objective criteria and their weights will be determined through a pair-wise comparison that was used to develop the AHP. Representatives listed in Table 11 (or their designee) will review the “Objective Criteria” on an annual basis to ensure it best supports SRM project prioritization needs. Once revisions to the Objective Criteria are approved by all Representatives, DHA will advise DHA facilities of the changes.

Organization	
DHA-FE FOB	FOB Chief or Deputy (Chair)
DHA-FE RPM	RPM Section Chief
DHA-FE CSM	CSM Chief or Deputy
DHA-FE DCA	Design, Construction & Activation (DCA) Chief or Deputy
DHA-FE FMB	Financial Management Branch Chief or Deputy
DHA-FE SAB	Staff & Administration Branch (SAB) Chief or Deputy

Table 11 – DHA AHP Objective Criteria Review Representatives

The objective criteria will be scored as follows:

Requirement		
Life Safety	Impact to NFPA 101 Life Safety related to construction, protection, and occupancy features. Requires an approved Life Safety Assessment that outlines noncompliant life safety provisions or fire protection features with approved actions to alleviate/mitigate the non-compliant issues, approved equivalencies, and required Interim Life Safety Measures in accordance with Unified Facilities Criteria, UFC 4-510-01.	5
Code Compliance	Identifies a facility, system, or component deficiency that is not fully in compliance with an issued law, regulation, or code. Include applicable law, regulation or code and specific paragraph number in justification.	4
Integrity (Patient Areas)*	Repair or replacement of an asset due to it not meeting original operational parameters, approaching or exceeded its design life expectancy, or improved energy/performance efficiency.	3
Integrity (Non-Patient Areas)**	Repair or replacement of an asset due to it not meeting original operational parameters, approaching or exceeded its design life expectancy, or improved energy/performance efficiency	2
Mission Change	A change to an asset (facility, system, equipment) due to a change in how it is used based on a new mission, occupancy, or a change in the business process.	5***

Table 12 – Requirement Code

* Within a Category (CAT) I Facility: In-Patient/Out-Patient Labs, Operating Rooms, Intensive Care Unit, Radiology, Pharmacy.

** CAT II or III bldgs. Non-patient areas in CAT I bldgs.

*** Mission Change requirements are prioritized against each other and do not run against Integrity, Code Compliance, or Life Safety therefore the score of a “5” does not represent the importance of the requirement. The package score will be based on the remaining four criteria (Normalized BCI, Criticality, Asset Category and Clinical Production).

Note: Mission Change and Integrity includes disposal requirements (Demolition or Transfer of an asset to include all associated requirements with the process, such as: decontamination, decommissioning, etc.).

Under	The asset BCI is under the average BCI of similar assets constructed within 5 years of each other. The asset condition is worse than average.	3
Over	The asset BCI is over the average BCI of similar assets constructed within 5 years of each other. The asset condition is better than average.	1
Null	Asset has no BCI. Asset is not in BUILDER or has no Real Property Unique Identification match to a DMLSS-FM RP.	1

Table 13 – Normalized BCI

Criticality		
MC-Imminent	Mission change is likely to occur within 6 months.	5
MC-Serious	Mission change is likely to occur within 6 months to 1 year.	4
MC-Moderate	Mission change is likely to occur within 1-2 years.	3
MC-Minor	Mission change is likely to occur within 2-5 years.	2
MC-Negligible	Mission change is likely to occur within 5 or more years.	1

Table 14 – Requirement Criticality (Mission Change)

Criticality		
Imminent	Likely to occur immediately and/or may cause death and/or major property damage.	5
Serious	Moderate property damage probably will occur in time and/or may cause severe injury and/or property damage.	4
Moderate	Failure is likely to occur within the year.	3
Minor	Failure is likely to occur within 1-5 years.	2
Negligible	Property damage unlikely to occur, will not cause injury, illness, or property damage and/or is an improvement initiative.	1

Table 15 – Requirement Criticality (Life Safety and Code Compliance)

Facility Categories		
(CAT I) Direct Patient Care	Asset directly associated with mission; direct patient care, research, education.	5
(CAT II) Support	Asset directly support mission; utilities.	3
(CAT III) Other	All other assets.	1

Table 16 – Facility Categories (CAT)

Over	Average encounters are over those of similar assets.	2
Under	Average encounters are under those of similar assets.	1
Null	No data.	1

Table 17 – Clinical Production

For each RP, the scores are scaled by turning the scores into proportions, then multiplying by the weights, and finally adding together for an AHP Score. The RPs will then be ranked 1 to “N”.

The AHP outcome is a one page summary containing the RP’s required data, recommendations and the AHP ranking results. The RP “One Pager” is then submitted to the FOB FSB or Pre-WIB.

4. Pre-WIB

The DHA-FE FOB conducts a Pre-WIB board consisting of the representatives (or their designees) listed in Table 18. The board will act as a “gateway” to the WIB by reviewing and validating the ranking of each of the RPs submitted to ensure they are truly ready for final board review.

Organization	
DHA-FE FOB	FOB Chief or Deputy (Chair)
DHA-FE FOB	E&D Section Chief
DHA-FE FOB	Project Management Section Chief
DHA-FE FOB	O&M Section Chief
DHA-FE FOB	SRM-PM Section Chief
DHA-FE RPM	RPM Section Chief/Rep
DHA-FE CSM	CSM Branch Chief/Rep

Table 18 – Pre-WIB Board Representatives

The board reviews each RP to determine which ones are complete and ready to present to the WIB or which ones need to be returned for further work (missing, inconsistent, or weak data, or requires additional documentation to show consistency with the enterprise’s most current business plan).

Each SRM-PM (and DHA facility and/or Market representatives, as needed) will brief the board (in person or via teleconferencing) advocating their projects. The board will review for concurrence with the SRM-PM (and if applicable, concurrence from the AOR collaborative team) on recommendations for whether the RP should go to the WIB. If the board concurs, the board submits their recommended list of RPs to the WIB, as appropriate.

5. WIB

The WIB is the DHA forum that provides oversight and decision making at the enterprise level to ensure a consistent approach to facility life cycle management, optimal expenditure of Defense Health Program (DHP) SRM funds, and achievement of strategic priorities across the DHA facilities portfolio. The WIB consists of DHA senior leadership representatives (or their designees) listed in Table 19.

Most of the heavy lift of validating, ranking, and other decisions such as proper work classification, appropriate funding source, clinical impact, what contract method should be used to execute, and which project management team to assign the RP to for support have been accomplished in the lower boards review process. The main function of the WIB is to review their recommendations and vote on approval.

Once the AHP racked RP list is voted on for approval the approved list becomes the established prioritized list of WIB projects (which, when combined with the prioritized list of FSB projects, forms the EPL).

Organization	
DHA-FE FOB	FOB Chief or Deputy (Chair)
DHA-FE RPM	Real Property Management (RPM) Section Chief
DHA-FE CSM	CSM Chief or Deputy
DHA-FE DCA	Design Construction Activation Chief or Deputy
DHA-FE FMB	Financial Management Branch Chief or Deputy
DHA-FE SAB	SAB Chief or Deputy
DHA-FE	Chief, Facilities Enterprise (tie breaker)

Table 19 – DHA WIB Representatives

6. FSB

The FSB is a review board that focuses on RPs that are purely infrastructure in nature. The board is held on a quarterly basis and consists of the senior FOB and RPM section representatives (or their designees) listed in Table 20. The FSB is the FOB level forum that provides oversight and decision making to ensure that limited SRM funds are disbursed responsibly to cover the most critical infrastructure needs across the entire DHA.

Organization	
DHA-FE FOB	FOB Chief or Deputy (Chair)
DHA-FE FOB	E&D Section Chief
DHA-FE FOB	Project Management Section Chief
DHA-FE FOB	O&M Section Chief
DHA-FE RPM	RPM Section Chief
DHA-FE FOB	SRM-PM Section Chief

Table 20 – Defense Health Agency FSB Representatives

Like the WIB, most of the heavy lift of validating, ranking and other decisions such as proper work classification, appropriate funding source, clinical impact, what contract method should be used to execute, and which project management team to assign the RP to for support have been accomplished in earlier review processes. The main function of the FSB is to review their recommendations and vote on approval.

The outcome of the FSB is the FSB's 1-N prioritized list of approved projects. This list will be combined with the WIB's 1-N list to create the EPL.

7. EPL

The DHA EPL is the prioritized listing of real property project requirements that combines the DHA's prioritized project lists from the FSB (projects valued from \$10,000 to \$250,000) and the WIB (projects valued over \$250,000). The EPL is used to establish, at a minimum, a 3-year execution plan based on projected funding levels.

The EPL is reviewed for proper funding types (S, R, or M) according to the work classification rules. If the Sustainment RPs amount to more than the available funds, those RPs below the cutline will be moved to the following year for execution. Subsequent WIBs and FSBs will review any RP below the cutline of available sustainment funds for possible execution in program out years.

The restoration (R) portion of the Restoration & Modernization (RM) budget will be applied to the restoration identified RPs on the EPL. Due to the existing DHP facilities backlog, a major portion of R funds will be applied to buy down the backlog. There is no set percentage for R; amount is balanced between R RPs and Modernization (M) RPs.

Likewise, the M portion of the RM budget will be applied based on available RM funds in any given year. The DHA RM model provides for 0.05 percent of the overall Plant Replacement Value (PRV) as a starting funding point based on a fully funded program. When RM is underfunded, the overall percentage of reduction is applied to M funds.

Based on the available funding, the DHA will build out the 3-year program. When additional funding becomes available and is applied, below the cutline RPs can be considered for possible funding. Should SRM funds be reduced, a new cutline will be established. These changes will be communicated with DHA leadership and DoD contracting agents to help inform the overall O&M program and constraints.

All RPs included in the EPL will be communicated with the local MTFs, the Market, and DHA leadership through the governance structure.

The EPL routed through DHA governance will be a locked list once the DHA leadership has approved. Should a new RP requirement be added to the approved list, the RP will be coordinated with the WIB and will receive WIB voting before being added to any given year's program list. DHA leadership may direct that an RP be moved up or down in the 3-year program, but it must be endorsed by DHA leadership at a Flag Rank (O-8) or Senior Executive Service Tier 2 and be presented to the Director, DHA/Deputy Director, DHA for acknowledgement. This is not a common occurrence.

The EPL, together with condition assessment information and life cycle cost forecasts (i.e., BUILDER), will be used to maintain a listing of DM&R that meets the reporting requirements cited in the DoD 7000.14-R, Volume 4, Chapter 24. The DHA-FE FMB will

coordinate with DHA Deputy Assistant Director Financial Operations on the preparation of required supplementary information submittals for DM&R that meet the requirements of the DoD 7000.14-R, Volume 6B, Chapter 12.

In accordance with the DoD 7000.14-R, Volume 4, Chapter 24, all projects that are on the DM&R listing for more than 2 years shall be reviewed for continuance or cancellation on the EPL. All cancelled projects shall be returned to the initiating DHA activity for either review and resubmittal or cancellation from their respective DMLSS-FM requirements list.

Constraints

Funding Constraints

The DM&R backlog is not calculated as a simple percentage of the PRV. Instead, BUILDER uses several factors to calculate the current DM&R backlog of requirements. It evaluates items on the current FY's Annual Work Plan with a work item status of "Valid – Deferred," "Valid – On Hold," and "Valid – Awaiting Funds". These statuses make up the unfunded backlog requirements and are factored into the FCI calculation. The FCI is a quality rating expressed as a comparison between the cost of repairing a facility to like-new condition, versus the cost of fully replacing that facility. The standard is to maintain facilities to at least a minimum FCI based on their category code as follows:

- CAT I – Direct Patient Care Facilities – FCI of >90
- CAT II – Support Facilities – FCI of >80
- CAT III – All Others – FCI of >60

BUILDER only considers requirements that have a direct impact on the facility's overall condition and its operational ability to meet its identified mission. The BUILDER FCI calculation is $\{1 - (\text{current FY unfunded DM\&R/PRV})\} * 100$. The current year's DM&R, based on the statuses above, becomes the backlog of unfunded requirements.

FY Backlog Rollover

At the beginning of each FY a new Annual Work Plan is run by BUILDER. This process rolls the previous year's work items into the new current FY. The items from the previous FY, that remain unfunded, roll into the current FY, and become the new FY's backlog because BUILDER has determined the work is necessary. However, the work cannot be funded or completed in the current FY. Therefore, the work becomes DM&R, or backlog. As new items age into the BUILDER Annual Work Plan each new FY, the amount of backlog continues to grow.

Funding Needed for DHA to Maintain DM&R Backlog Status-Quo

As our facilities, systems, and equipment continue to age the need for major repairs will increase. Applying life cycle scenario projections based on inflating the FY 2021 funding value indicates DHA will require an average annual funding of \$775,708,155 for the restoration portion of RM funding (with an adjustment for inflation through FY 2027) to prevent the DM&R backlog from

growing any further over the next 7 years. The result of this BUILDER scenario model provided the end of year (EOY) DM&R. This number was then subtracted from the previous year’s EOY DM&R to identify the level of estimated funding necessary to maintain the current backlog levels. Those numbers are represented in Table 21. Table 21 notes FY 2021 enacted funding value (\$390 million) and the model generates the values based on previous work items not addressed and current work items not funded with sustainment; these numbers, totaling \$5,429,957,086 are then divided by seven to arrive at the \$775,708,155 average.

FY	R-Line AMT Required to	
2021	\$390,981,000	\$3,666,345,414
2022	\$667,126,627	\$3,666,345,414
2023	\$587,656,339	\$3,666,345,414
2024	\$1,057,746,289	\$3,666,345,414
2025	\$1,072,715,041	\$3,666,345,414
2026	\$1,048,669,289	\$3,666,345,414
2027	\$605,062,501	\$3,666,345,414
Total	\$5,429,957,086	
7 Year Average	\$775,708,155	

Table 21 – RM Funding Needed to Maintain Backlog Status Quo

What DHA Needs to Reduce the DM&R Backlog:

Table 22 shows the DHA’s RM modeled funding required to reduce the DM&R backlog over the FY 2021-2027 Future Years Defense Program (FYDP) based on BUILDER scenario model. Column (1) represents the Restoration portion of the RM funding estimate required to buy-down the backlog by 2027. Column (2) represents the Modernization portion of the RM formula and is a fixed amount based on PRV. Column (1) + Column (2) is the full RM funding model required to buy down backlog and continue Modernization activities. Column (3) contains FY 2021 and FY 2022 published RM controls while FY 2023 through FY 2027 are inflated off the FY 2022 values to model in BUILDER. Column (4) is Columns (1) (Restoration Only) plus Column (2) (Modernization Only) minus Column (3) (FY 2021/FY 2022 Enacted and inflated FY 2023-2027 RM estimates) to buy-down backlog by 2027. This number shows the required funding model increase to begin buying down the backlog of unfunded requirements.

Fiscal Year	(1) R-Line			
2021	\$738,386,023	\$237,798,789	\$390,981,000	\$585,203,812
2022	\$794,232,347	\$237,798,789	\$375,428,000	\$656,603,136
2023	\$829,443,380	\$237,798,789	\$382,936,560	\$684,305,609
2024	\$952,705,036	\$237,798,789	\$390,595,291	\$799,908,534
2025	\$1,076,566,905	\$237,798,789	\$398,407,197	\$915,958,497
2026	\$1,194,173,972	\$237,798,789	\$406,375,341	\$1,025,597,420
2027	\$1,225,912,803	\$237,798,789	\$414,502,848	\$1,049,208,744
Total	\$6,811,420,467	\$1,664,591,523	\$2,759,226,237	\$5,716,785,752
7 Year Avg.	\$973,060,067	\$237,798,789	\$412,119,571	\$798,739,284

Table 22 – DHA Funding Needed to Buy Down DM&R vs RM Funding in PB, FY 2021-2027

* (3) RM Funding in President’s Budget (PB) - projections for FY 2023 – FY 2027 are based on 2 percent inflation growth

Diverting funds from Modernization is one option to buy down backlog even further. However, this is an unacceptable option as it negatively impacts clinical modalities and the ability to meet new changes in healthcare delivery.

The chart in Figure 1 graphically illustrates changes to the backlog based on changes to the modeled RM funding and inflated future year funding based on FY 2021 controls. The orange line in the graph in Figure 1 represents how the backlog can be reduced when the DHA modeled Restoration funding is increased consistent with the amounts shown in column (1) of Table 23. The blue line represents how the backlog will increase based on the current FY 2021 and FY 2022 controls and inflated FY 2023-2027 fund estimates in column (3) of Table 23. If R-Line is funded at the levels identified in column (1) of Table 23 (averaging \$1,210.9 million per year), the requirements backlog would be bought down at an average rate of \$421.7 million per year for the next 6 years (FY 2022-2027). Conversely, at the current FY 2021 enacted and inflated out years for modeling purposes, the RM estimated funding amount (averaging \$412.1 million per year), the backlog will grow \$426.7 million per year for the next 6 years (or \$2.56 billion).

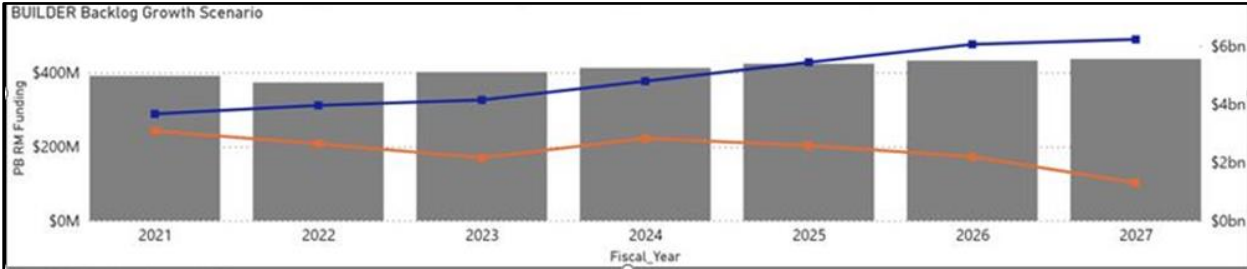


Figure 1 – DM&R Backlog Changes: Increased funding to reduce backlog (orange line) vs PB funding (blue line)

The DHA RM funding needed to reduce the backlog over 6 years was based on the following calculation (see Table 23 for further details, including DM&R backlog calculation):

- Step 1: Recommend 15 percent required RM activities rate* not attributed to FCI improvement and 0.5 percent for modernization requirements.
- Step 2: Recommend to buy down the DM&R backlog requirements over a 6-year period, utilizing the FYDP+1 as the strategic approach to planning, programming, and budgeting for R requirements.

$$\text{RM Funding} = (1+.15)\{(\text{DM\&R}\$/6 \text{ Years}) + (.005*\text{PRV})\}$$

*15 percent based on DHA FY 2012-2016 review of ongoing projects including contracting agents, planning & design, emergencies, master planning, personnel, and special studies.

*0.5 percent based on the total PRV (1.3 percent for Private Sector Capital Investment (Replacement & Modernization))

	3,967,053,875	3,666,345,414	3,957,717,541	4,161,395,278	4,828,141,567	5,501,511,407	6,044,369,499
		579,466,338	503,045,700	976,811,500	994,868,302	973,968,050	532,375,950
	3,967,053,875	4,245,811,752	4,460,763,241	5,138,206,778	5,823,009,869	6,475,479,457	6,576,745,449
	147,526,250	150,465,000	153,575,750	156,864,000	160,297,250	163,508,750	165,143,838
	3,819,527,625	4,095,346,752	4,307,187,491	4,981,342,778	5,662,712,619	6,311,970,707	6,411,601,611
	390,981,000	375,428,000	382,936,560	390,595,291	398,407,197	406,375,341	414,502,847
	237,798,789	237,798,789	237,798,789	237,798,789	237,798,789	237,798,789	237,798,789
	153,182,211	137,629,211	165,760,211	176,843,211	188,335,211	196,857,211	201,638,211
	3,666,345,414	3,957,717,541	4,161,395,278	4,828,141,567	5,501,511,407	6,142,769,496	6,332,800,397
	92.4	91.9	91.6	90.4	88.9	87.7	86.9
	976,184,812	1,032,031,136	1,067,242,169	1,190,503,825	1,314,365,694	1,431,972,761	1,463,711,592

Table 23 – DHA DM&R Backlog Calculation & Backlog Reduction Funding Needed, FY 2021-2027

* F. R&M Budget control - projections for FY 2023 – FY 2027 are based on 2% inflation growth

Table 23 Explanation:

- A. Carryover RQMT:** Carryover requirement consists of the prior year's DM&R backlog carrying over into the new current FY.
- B. BUILDER New RQMT:** The BUILDER New RQMT consists of the new BUILDER Requirements aging into the Annual Work Plan for a given year.
- C. BUILDER Total RQMT:** BUILDER Total RQMT consists of Row A Carryover RQMT added to Row B BUILDER New RQMT.
- D. Estimate 25 Percent Sustainment Reduction:** This number is an assumption value for modeling purposes. Actual value will vary year to year. It consists of FY 2022 published values and inflated 2 percent per year. Each years modeled Sustainment value is multiplied by .25 providing a 25 percent of model funds for use on life cycle replacement projects. It is assumed that 25 percent of sustainment activities may remediate some Restoration requirements.
- E. Total Requirement:** The Total Requirement consists of Row C BUILDER Total Requirement less Row D 25 percent Sustainment Reduction. This number represents a truer picture of the total RM activities required for the FY.
- F. RM Budget Estimate:** This number is the FY 2022 enacted budget and inflated 2 percent over the FYDP. It consists of each FYs Estimated Requirement for RM Funds.
- G. Modernization:** This number is $\frac{1}{2}$ a percent of PRV or $(\text{Total PRV}) * (.005)$ that is assumed to be applied towards modernization activities.
- H. Restoration Budget:** This number consists of Row F less Row G.
- I. EOY DM&R (D-G):** The EOY DM&R consists of Row E – Row H. This is an accurate representation of the current DM&R Backlog of unfunded requirements.
- J. Portfolio FCI:** Portfolio FCI with current programmed funding from PB.
- K. FYDP Request:** This consists of the already described RM Funding formula to buy down the DM&R backlog over a 6-year period. The formula is $= (1+.15) \{(\text{DM\&R}\$/6 \text{ Years}) + (.005*\text{PRV})\}$ with DM&R\$ coming from column I.

Historical RM Budget Execution

Table 24 shows historical SRM and total FSRM per year from FY 2002 through FY 2022. FSRM funding is irregular, and the DM&R backlog continues to grow significantly.

FY			
FY 2002	\$ 258,227	\$ 444,074	
FY 2003	\$ 140,926	\$ 295,582	
FY 2004	\$ 100,545	\$ 319,774	
FY 2005	\$ 318,279	\$ 461,373	
FY 2006	\$ 419,697	\$ 512,078	
FY 2007	\$ 499,100	\$ 641,527	
FY 2008	\$ 596,753	\$ 529,933	
FY 2009	\$ 487,008	\$ 498,916	
FY 2010	\$ 472,914	\$ 528,848	
FY 2011	\$ 565,387	\$ 568,867	
FY 2012	\$ 698,598	\$ 544,328	
FY 2013	\$ 631,868	\$ 504,019	
FY 2014	\$ 964,956	\$ 629,968	
FY 2015	\$ 481,277	\$ 533,767	
FY 2016	\$ 389,367	\$ 531,243	
FY 2017	\$ 551,471	\$ 601,683	
FY 2018	\$ 594,423	\$ 694,149	
FY 2019	\$ 259,857	\$ 636,737	
FY 2020	\$ 352,517	\$ 644,853	
FY 2021	\$ 390,981	\$ 619,128	
FY 2022	\$ 375,428	\$ 601,654	

Table 24 – FSRM by FY

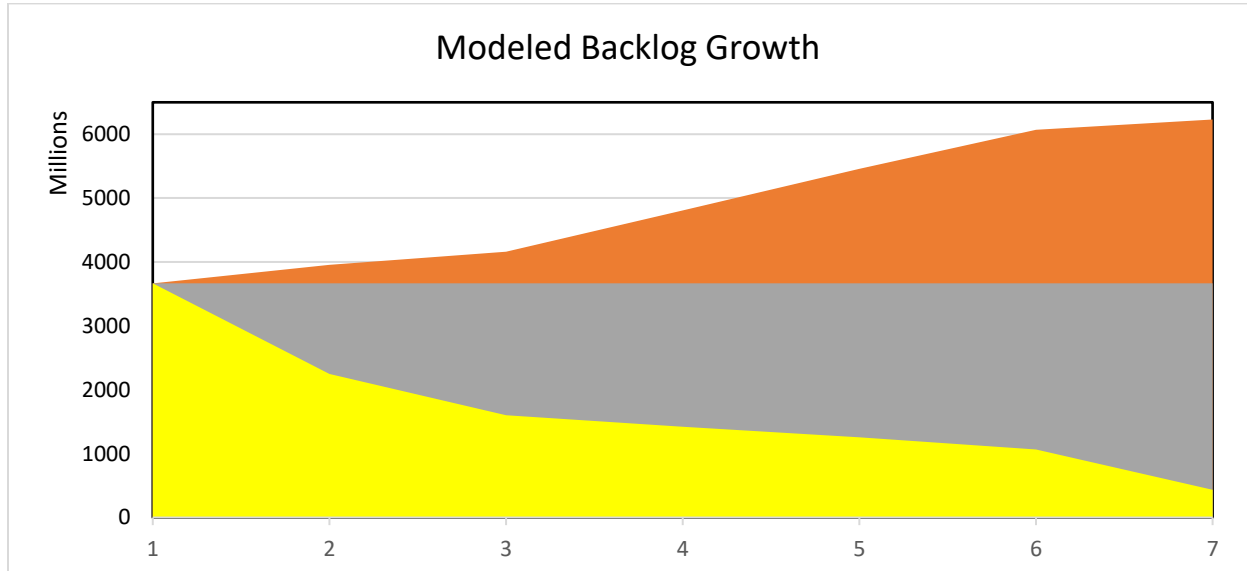
DHA Decrements to the RM Program

DHA recognizes that the growing DM&R backlog is unacceptable. DM&R is growing due to an unstable financial environment within the DHP. Year of execution decrements to the RM program continue to plague the DHA as the topline budget becomes more and more constrained. In addition, shortfalls in the Private Sector Care budget and Information Technology (IT) budget and the onset of the coronavirus disease 2019 pandemic in FY 2020 have further restricted DHA’s ability to reduce the current backlog. DHA experienced another budget crisis in FY 2021. We had to prioritize the Pandemic Response, which required DHA to source funding from other areas to cover those expenses, including further decrementing R&M and exacerbating the backlog.

Funding Constraints Bottom Line

The DHP under the department’s zero-based budget does not offer growth to current programs without a cut in other programs. Based on BUILDER modeled funding levels for FSRM shown in Figure 2 below, DHP is unable to buy down the DM&R backlog and the backlog will continue to grow. As noted in Table 24 showing the historical FSRM, DHA requires a steady and reliable FSRM funding stream to execute valid requirements in a timely manner via contracts and to avoid increasing the DM&R backlog.

The graph at Figure 2 shows the modeled DM&R backlog growth/reduction based on the different total FSRM funding scenarios described in this response.



FY	Modeled					
Total	\$2,861,916,380		\$5,429,957,086		\$8,476,011,988	
7 Year Avg	\$408,845,197		\$775,708,155		\$1,210,858,855	

Figure 2 – Modeled DM&R Backlog Amounts for three FSRM Funding Scenarios

** Modeled Funding projections for FY 2023 – FY 2027 are based on 2 percent inflation growth*

The orange bar in Figure 2 represents the growth of backlog at current FSRM funding levels. The grey bar represents the FSRM funding needed to maintain the existing backlog level (status quo) with no further backlog growth. The yellow bar represents a scenario in which FSRM funding is increased by the amount requested in the model to show the resultant backlog buy down, similar to the figures requested in the model scenario. The dollar amounts in the Figure 2 table indicate the DM&R backlog amount under each scenario.

Contract Capacity Constraints

An additional constraint to reducing the DM&R backlog is contract capacity for project execution. Contracting agents need to ensure there is also enough capacity on contracts so that when there is an increase in projects that are funded, they can be executed in a timely manner.

Appendix: List of the Six Installations (and 24 MTFs) the DoD OIG Visited

FORT CAMPBELL, KENTUCKY AND TENNESSEE

- BLANCHFIELD ARMY COMMUNITY HOSPITAL
- BYRD ADKINS HEALTH CLINIC
- CAMPBELL AIRFIELD MEDICAL HOME
- LAPOINTE MEDICAL HEALTH CLINIC

FORT RILEY, KANSAS

- IRWIN ARMY COMMUNITY HOSPITAL
- CALDWELL CLINIC
- CUSTER HILL HEALTH CLINIC
- DENTAL CLINIC NO. 2

NAVAL AIR STATION PENSACOLA, FLORIDA

- NAVAL HOSPITAL PENSACOLA
- PRIMARY CARE CLINIC
- PRIMARY CARE CLINIC-BRANCH

MARINE CORPS BASE CAMP PENDLETON, CALIFORNIA

- NAVAL HOSPITAL CAMP PENDLETON
- DENTAL CLINIC – AREA 13
- PRIMARY CARE CLINIC – AREA 43
- PRIMARY CARE CLINIC – AREA 52

EGLIN AIR FORCE BASE, EGLIN, FLORIDA

- 96TH MEDICAL GROUP, U.S. AIR FORCE HOSPITAL
- SATELLITE PHARMACY
- DENTAL CLINIC
- AEROSPACE MEDICINE FACILITY
- CENTRAL ENERGY PLANT

NELLIS AIR FORCE BASE, NEVADA

- MIKE O'CALLAGHAN FEDERAL MEDICAL CENTER
- MEDICAL ANNEX
- MEDICAL LOGISTIC WAREHOUSE
- BIOENVIRONMENTAL ENGINEERING