

REDACTED VERSION*

Matter of: Foundation Health Federal Services, Inc.;
QualMed, Inc.

File: B-254397.4; B-254397.6; B-254397.7;
B-254397.8; B-254397.10

Date: December 20, 1993

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DIGEST

Protests are sustained where, in procurement for managed health care services, the agency did not follow the evaluation scheme for technical and cost proposals as provided in the solicitation by failing to evaluate the effectiveness of the offerors' proposed managed health care approaches or the likely impact of their approaches on the total health care costs that would be incurred by the government.

*The decision issued on December 20, 1993, contained proprietary and source selection information subject to a General Accounting Office protective order. This version of the decision has been redacted. Deletions in text are indicated by "[deleted]."

TABLE OF CONTENTS

	<i>Page</i>
I. Background	
A. Traditional CHAMPUS Program	3
B. The CHAMPUS Reform Initiative (CRI)	3
II. The Solicitation	
A. Requirements	4
B. Technical Evaluation Factors	
1. General	5
2. Utilization Management and Quality Assurance (UM/QA)	6
C. Cost/Price Factors	7
1. Trend Factors	8
2. Risk-Sharing Corridors	9
III. Initial Proposals	10
A. Lewin's Evaluation of Initial Business Proposals and Use of Independent Government Cost Estimate (IGCE)	10
B. Business Proposal Evaluation Team (BPET) Evaluation and Recommendations	13
C. Source Selection Advisory Council (SSAC) Recommendations	14
D. Source Selection Evaluation Board (SSEB) Evaluation	
1. Overall Evaluation	14
2. Evaluation of UM/QA	15
IV. Discussions and Other Actions Prior to Best and Final Offers (BAFO)	
A. Effect of Anticipated UM/QA Revision	16
B. Discussions	16
C. BAFO Cost Evaluation Methodology	17
D. Request for Proposals (RFP) Amendment No. 10	22
V. BAFO Evaluation	
A. BAFO Technical Evaluation	23
B. BAFO Cost Evaluation	25
VI. Source Selection	33
VII. Discussion	
A. The Evaluation of Proposals	34
B. Prejudice	42
VIII. Conclusion and Recommendation	43

DECISION

Foundation Health Federal Services, Inc. and QualMed, Inc. protest the award of a contract by the Office of the Civilian Health and Medical Program of the Uniformed Services to Aetna Government Health Plans, Inc. under request for proposals (RFP) No. MDA906-91-R-0002. The RFP sought proposals to provide managed health care services for CHAMPUS beneficiaries in California and Hawaii, who include more than 800,000 military service retirees, their dependents, and dependents of active duty members. Foundation and QualMed protest that the agency failed to properly evaluate the business and technical proposals.²

We sustain the protests.

I. BACKGROUND

A. Traditional CHAMPUS Program

Under the traditional CHAMPUS program, health care services are obtained by beneficiaries from providers of their choosing without preauthorization; claims are subsequently submitted, and the government makes an after-the-fact determination regarding the extent to which the charges incurred are covered by the CHAMPUS program. In this environment, CHAMPUS contractors process claims, receive funds from the government, and disburse those funds to the appropriate recipients, thus functioning merely as "fiscal intermediaries."

B. CHAMPUS Reform Initiative

In 1986, due in part to concerns over dramatically increasing health care costs, Congress directed the Secretary of Defense to:

"conduct a project designed to demonstrate the feasibility of improving the effectiveness of the [CHAMPUS program] through the competitive

¹Throughout this decision, we refer to the program as CHAMPUS, and the agency as OCHAMPUS.

²The protesters have also raised other ancillary issues concerning, for example, alleged deficiencies in Aetna's proposal and allegedly improper post-award contract modifications by OCHAMPUS. While we have reviewed these matters and conclude that the allegations are without legal merit, it would not serve any purpose to address them in this decision in view of our disposition of the protests.

selection of contractors to financially underwrite the delivery of health care services under the program." National Defense Authorization Act for Fiscal Year 1987, P.L. 99-661, Title VII, § 702(a), 100 Stat. 3899, codified at 10 U.S.C. § 1073, note (1988).

The program resulting from this legislation is known as the "CHAMPUS Reform Initiative" (CRI). Reflecting the direction of Congress, contracts awarded under the CRI program require the contractor to participate in, and share the financial risk associated with, delivering health care services to CHAMPUS beneficiaries.

The first CRI contract was awarded to Foundation Health Corporation in 1988;³ that contract covered CHAMPUS beneficiaries in California and Hawaii. The RFP at issue in these protests is for the recompetition of that initial CRI contract.⁴

II. THE SOLICITATION

A. Requirements

The RFP was issued in January 1992, and sought proposals for "the development, implementation and operation of a health care delivery and support system to continue the . . . CRI health care demonstration project in California and Hawaii" during a base period and five 1-year options. As under the initial CRI contract, offerors were required to propose three health care options, featuring increasingly managed health care accompanied by decreasing costs to the beneficiary. Specifically, the RFP required offerors to propose a health care system under which CHAMPUS

³The contract was subsequently novated to a subsidiary, Foundation Health Federal Systems, Inc., one of the protesters here.

⁴The Department of Defense is currently in the process of expanding the CRI program to various other parts of the country, including, in the near future, the states of Washington, Oregon, and Texas. Because there has been concern over the costs associated with Foundation's current CRI contract, Congress enacted legislation prohibiting the Secretary of Defense from proceeding with the proposed expansion of CRI until the Secretary certified that CRI "has been demonstrated to be more cost-effective than [traditional CHAMPUS] or any other health care demonstration program being conducted by the Secretary." National Defense Authorization Act for Fiscal Year 1991, Pub. L. No. 101-510, Title VII, § 715, 104 Stat. 4739 (1990).

beneficiaries could opt to obtain services: (1) from providers of their own choosing on a fee-for-service basis (Standard CHAMPUS); (2) from members of the offeror's preferred provider organization (PPO) (CHAMPUS Extra); or (3) from a contractor-established health maintenance organization (HMO) (CHAMPUS Prime).⁵

B. Technical Evaluation Factors

1. General

The solicitation stated that, in the selection of an awardee, technical factors would receive a weight of 60 percent and cost/price factors would receive a weight of 40 percent. Technical evaluation factors covered the 12 tasks included in the statement of work, as well as experience/performance. Section M of the RFP grouped those 13 items into 8 evaluation factors and ranked them in descending order of importance, as follows:

- (1) Health care services and health care providers
- (2) Claims processing and program integrity
- (3) Management and startup/transitions
- (4) Contractor responsibilities for coordination and interface with military treatment facilities
- (5) Enrollment/beneficiary services
- (6) Fiscal management/controls, support services, and automatic data processing
- (7) Experience/performance
- (8) Contingencies for mobilization

The most important evaluation factor encompassed two tasks-- health care services and health care providers; section M indicated that an offeror's utilization management program was relevant to both tasks. Although not disclosed to the

⁵The beneficiary's contribution is highest, through deductibles and copayments, under Standard CHAMPUS; the beneficiary's cost is more limited under CHAMPUS Extra; and the beneficiary's cost is lowest in the CHAMPUS Prime context, where the beneficiary generally does not pay a deductible and contributes only nominal copayments. Under CHAMPUS Prime, health care is most "managed" in that the beneficiary is in an HMO environment and has a "primary care manager" assigned who coordinates access to specialists and inpatient services.

offerors, these combined tasks were assigned [deleted] percent of the technical points available under the evaluation scheme.

2. UM/QA

As explained in the RFP, utilization management and quality assurance (often referred to as one term, UM/QA) essentially represented the twin faces of the CHAMPUS Reform Initiative: on the one hand, utilization management covered the contractor's ability to "manage" the utilization of health care services--that is, oversee decisions about provision of health care services in order to avoid unnecessary services; while, on the other hand, quality assurance required the contractor to ensure that quality health care was provided and appropriate care was never denied to beneficiaries.

Utilization management is the element which distinguishes this procurement from other procurements for health care services: in the words of the source selection evaluation board (SSEB) chair, utilization management is "the heart of any managed care program." In the same vein, the consultant from Lewin-VHI (Lewin), an outside entity that OCHAMPUS retained to assist with the evaluation of business proposals, said that "whether a given bidder can control costs" is "the whole idea behind the CRI concept." Transcript (Tr.) at 295.

Utilization management is the contractor's opportunity to contain health care costs by preventing expenditures on services, such as tests, prescriptions, hospitalizations, and referrals to specialists, where those services are not medically necessary. The RFP listed, as examples of

⁶[deleted]

⁷Transcript citations refer to the transcript of the hearing conducted by our Office in connection with these protests.

⁸Other ways in which contractors could control costs included obtaining greater discounts (from individual practitioners and institutions) and resource sharing (use of contractor-provided medical personnel, equipment, or supplies for the purpose of enhancing the capabilities of military treatment facilities to provide care to beneficiaries). Although those additional avenues of savings do not technically involve utilization management, and the RFP treated them independently, our discussion of utilization management applies essentially equally to those other mechanisms, and we therefore do not address them separately.

potential cost savings resulting from effective utilization management, a decrease in the number of office visits and hospital admissions, shorter hospital stays, and the use of less intensive settings or providers. As explained in the RFP, utilization management may be implemented through programs for preauthorization requirements prior to use of the services, concurrent review of decisions involving use of services, and intensive case management for high-cost cases.

Section M of the RFP emphasized the importance of the particular technical approach proposed by each offeror, advising that offerors "must not merely commit to offering to provide services in accordance with the requirements . . . but . . . must submit a 'definitive approach' in their technical proposal for achieving the required results." Consistent with this, section M advised offerors that each offeror's utilization management program "will be evaluated on how the proposed program . . . promotes appropriate utilization." Section M provided that the agency would evaluate proposals with respect to how the offerors propose to meet the requirement that the contractor "ensure the medical necessity and appropriateness of health care services provided to beneficiaries," and that "quality patient care is delivered in the most cost-effective manner. With regard to mental health services, section M further advised that OCHAMPUS would evaluate "the adequacy of the means by which adequate access [to those services] is assured, but controlled." Finally, section M advised offerors that the agency would evaluate "[t]he offeror's capability to develop and implement a system for monitoring and controlling the care and expenses of high-cost cases"

C. Cost/Price Factors

The RFP required that business proposals be divided into two parts: one part addressing the administrative functions, under which offerors proposed a firm, fixed price, including profit;⁹ and another part addressing health care services, under which offerors proposed a "fixed price" that was subject to subsequent adjustments. The RFP required offerors to submit cost and pricing data.

⁹Administrative costs were associated largely with claims processing and support services.

1. Trend Factors

The proposed price for health care for each period of contract performance consisted principally of the proposed cost for 11 specified categories of health care services (such as inpatient medical, inpatient surgical, inpatient psychiatric, and similar categories for outpatient services), each of which was subdivided into several pairs of subcategories (active duty dependents and non-active duty dependents, Prime enrollees and non-enrollees, California and Hawaii). Additional elements in health care price were proposed profit (distinct from the profit for administrative services) and a catch-all category for other health care costs.

The proposed costs for the 11 categories of health care were to be calculated by applying cost and utilization "trend factors" proposed by the offeror to baseline data drawn on the experience under the current contract and provided to offerors by the agency. Proposals were to include the offeror's expectations for all of these trend factors, as well as for the expected percentage of eligible beneficiaries in the various subcategories (such as active duty dependents in Hawaii) that would enroll in the Prime program.

Of the eight trend factors, four were considered to be essentially outside the control of the offerors: price inflation, cost sharing (relating only to changes in health care costs due to the government's modification of cost-sharing requirements), intensity (referring to changes in case mix or available medical technology), and utilization per eligible (referring to utilization rates as affected by the type of population included in the universe of CHAMPUS beneficiaries as well as the impact on that population of economic and other general factors, as distinct from the contractor's utilization management efforts).¹⁰

The remaining four trend factors, however, would be affected by the offeror's approach to managed health care: utilization management, provider discounts, coordination of benefits and third-party liability (referring to collection of insurance benefits from a party outside of CHAMPUS), and resource sharing. At least as to those trend factors, therefore, each offeror's expected health care costs would thus reflect that offeror's projections of the effect of its

¹⁰It is not clear why OCHAMPUS had offerors make estimates in areas over which the offerors had no control. Ultimately, the agency included in the RFP the government's estimate for at least some of the uncontrollable variables.

particular technical approach, as those variables applied to various segments of the beneficiary population and various types of health care services in each contract period.

2. Risk-Sharing Corridors

In the RFP as it stood at the time that initial proposals were submitted, offerors were also required to propose three risk-sharing tiers or "corridors" for both gains and losses.¹¹ In the first tier, which covered initial overruns relative to the contract health care cost figure, the contractor would absorb 100 percent of the overrun; in this tier, the contract would maintain its fixed-price character. In the second tier, the government and the contractor would share the risk, without either side absorbing the entire cost overrun. In the third tier, the contract would convert to a cost-reimbursement mode, with the government absorbing all further cost overruns.

In initial proposals, offerors were free to propose the point at which the contract would shift from the first to the second tier. One offeror could thus propose to absorb the first 1 percent overrun over the contract health care cost figure, while another offeror could propose to absorb the first 3 percent. Similarly, the offerors could propose any loss-sharing ratios within the second tier, thus permitting a government/contractor ratio of 75 to 25, or 50 to 50, or any other split.

For losses, the shift from the second tier to the third--the shift from shared responsibility to total government responsibility--was to be determined by the amount of equity each offeror put at risk. The RFP stated that the government would not agree to pay 100 percent of any overrun until the contractor had lost its cumulative profit on health care services and an additional, unspecified amount of equity which the contractor was to place at risk. The point at which the contractor had lost health care profits and its equity at risk through the loss-sharing provisions under the first and second tiers was referred to as the point of total government responsibility (POTGR), and represented the threshold of the third tier.¹² At the time

¹¹Because only the loss-sharing provisions are relevant to the protest, we do not discuss the gain-sharing provisions here.

¹²The risk-sharing corridors would be based on a yearly calculation, and a contractor could thus revert to the second tier (risk shared by the contractor and the government) in a year following one in which it passed the POTGR.

initial proposals were submitted, the RFP allowed offerors discretion in proposing the amount of equity at risk both in each period of performance and cumulatively.

Regarding the evaluation of business proposals, section M of the RFP stated that the agency would evaluate "the impact of the [trend and utilization] factors proposed by each offeror utilizing cost models to determine the actual cost impact and mutual risk of individual offers." Section M also provided that the agency would evaluate "each proposal to determine whether all proposed costs and factors affecting costs are reasonable, realistic, and affordable." In addition, Section M stated that a "sensitivity analysis" would be performed "to evaluate the contract cost to the Government that will result by assuming various percentages of health care cost overruns or underruns."

III. INITIAL PROPOSALS

On August 24, 1992, proposals were submitted by [deleted] offerors, including Aetna, Foundation and QualMed.¹³

[The remainder of page 10 and all of pages 11 through 21 contain proprietary and source-selection-sensitive information, and have therefore been deleted.]

¹³[deleted]

[deleted]

D. RFP Amendment No. 10

On March 2, the agency issued amendment No. 10, which revised the UM/QA requirements by mandating that the CHAMPUS contractor coordinate quality assurance tasks with outside entities: a regional review center (RRC), a quality monitoring contractor (QMC), and the CHAMPUS record center (CRC). Specifically, amendment No. 10 provided that the contractor must enter into memoranda of understanding (MOU) with the appropriate RRC and QMC which delineated the roles and responsibilities of each entity. Each RRC and QMC would be responsible, among other tasks, for reviewing the CHAMPUS contractor's denials of requests for certain health care services. The QMC would handle mental health care, while the RRC would be responsible for other care. Amendment No. 10 did not materially change the other UM/QA requirements in the RFP.

Amendment No. 10 also revised the risk-sharing provisions in the RFP by specifying uniform risk-sharing corridors and setting minimum levels of equity at risk that each offeror was required to offer in its business proposal. Specifically, amendment No. 10 mandated the following terms with regard to the three tiers of the loss-sharing corridors. The first tier, in which the offeror was entirely responsible for absorbing overruns, would extend through the first 1 percent of overrun relative to the proposed health care cost. The second tier, in which

overruns were shared, would extend from that 1-percent overrun through the POTGR, and in that tier the government would bear 80 percent of the overrun, while the contractor would absorb 20 percent. The POTGR would be determined by the contractor's exhausting its equity at risk, which the amendment required be a minimum of \$20 million for each period of performance and \$65 million over the life of the contract. Beyond the POTGR, the government would be responsible for all costs.

During the last week of April, the agency met with the offerors to discuss the revisions to the RFP. Again, the agency deliberately refrained from discussing any strengths or weaknesses of the initial proposals with regard to the UM/QA requirements. Tr. at 889; 1015-1019.

V. BAFO Evaluation

A. BAFO Technical Evaluation

[The remainder of page 23 and all of pages 24 through 33 contain proprietary and source-selection-sensitive information, and have therefore been deleted.]

[deleted], and the SSA selected Aetna as the successful offeror on July 21; a contract with Aetna was subsequently executed.⁴²

VII. DISCUSSION

A. The Evaluation of Proposals

Our Office will not question an agency's evaluation of proposals unless the agency deviated from the solicitation evaluation criteria or the evaluation was otherwise unreasonable. Payco American Corp., B-253668, Oct. 8, 1993, 93-2 CPD ¶ _____. In these protests, Foundation and QualMed contend that the agency's evaluation of business and technical proposals was unreasonable and inconsistent with the stated evaluation criteria upon which they based the contents of their proposals. They assert that the agency failed to evaluate the offerors' approaches to managed care and, in particular, the proposed means for controlling health care costs.

Based on our review of the record in these protests, which included nearly 40 hours of testimony during a 4-day hearing, we conclude that OCHAMPUS's evaluation of proposals under this procurement did not comport with the RFP evaluation criteria.

The terms of this solicitation repeatedly advised offerors that each proposal would be evaluated to assess the degree to which each offeror's proposed approach would effectively achieve the solicitation's twin goals, that is, to provide quality health care and contain health care costs. Section M advised offerors that each proposal would be evaluated with regard to the realism of proposed costs and the assumptions related to cost. Section M also provided that proposals would be evaluated to assess how the offerors

⁴²On August 13, the agency authorized Aetna to continue performance notwithstanding the protests, based on a determination that performance of the contract was in the government's best interest and that urgent and compelling circumstances significantly affecting the interest of the United States would not permit waiting for the decision of our Office.

propose to meet the requirement that the contractor "ensure the medical necessity and appropriateness of health care services provided to beneficiaries," and that "quality patient care is delivered in the most cost-effective manner." Thus, the RFP committed the agency to evaluating the merits of the proposed methods for managing health care and the realism of the claimed cost impact of the different methods, and offerors, in preparing their proposals, reasonably relied on the agency's commitment to do so.

Consistent with the agency's undertaking to evaluate each offeror's approach to providing quality health care and controlling costs, the RFP assigned the greatest technical weight to the evaluation factor, "health care providers and health care services," under which an offeror's approach to UM/QA was to be assessed. In fact, as this solicitation was structured, utilization management was critical to both the technical and cost evaluation, since it would provide the key mechanism for containing health care costs. An evaluation of an offeror's ability to contain health care costs thus necessitated a judgment about whether the offeror's proposed cost savings were reasonably supported by a feasible utilization management approach which would reduce health care expenses such as referrals to specialists, hospital stays, tests, and prescriptions when they are unnecessary.

Nonetheless, despite the RFP's plain statements, the documentation in the extensive record of this procurement clearly demonstrates that OCHAMPUS never formed any meaningful judgment regarding any offeror's proposed utilization management. The technical evaluators never incorporated any judgment about the offerors' proposed utilization management approaches into their evaluation. The SSEB limited itself to summarizing offerors' technical approaches to managing care, and declined to evaluate them.⁴³ The SSEB evaluators therefore scored proposals based on their clarity and comprehensiveness, but not on

⁴³This appeared to be a matter of principle, as illustrated by the following colloquy at the hearing between the SSA and one of the GAO hearing officials:

GAO: Wasn't it incumbent upon the technical evaluators to decide, "We believe this guy is probably going to succeed [in avoiding unnecessary use of health care services] by using second opinions" or "We're not convinced"?

SSA: No. The technical evaluation team is going to say, "This is how they're going to do it."
Tr. at 1337.

the substantive merit of the proposed managed-care approach--that is, whether it would control access to health care services such that only appropriate services would be provided.⁴⁴ Indeed, although the SSEB chair recognized that [deleted] proposed approach could lead to higher Prime enrollment, fewer hospitalizations, and fewer tests, he did not consider that relevant to the technical evaluation. Tr. at 839-43.

Even when the contracting officer sent his June 29 memorandum to the SSEB chair expressly seeking the SSEB's opinion about whether [deleted] technical proposals supported claimed health care savings, the SSEB chair did not view it as "appropriate" to express an opinion, responding: "It is not possible nor appropriate to say if [deleted] UM/QA philosophy will account for more savings than a more conservative approach."⁴⁵ The SSEB chair "felt the SSAC [would] be in a better position to make that overall assessment." Tr. at 846. When asked at the hearing what basis the SSAC had to make such an assessment, however, the SSEB chair conceded that he did not know of anything that the SSAC could rely on except the SSEB report, and that the report provided nothing relevant in this regard. Tr. at 847-48.

Notwithstanding the SSEB chair's view, the SSAC chair did not believe that it was the SSAC's responsibility to reach a determination regarding the merit of offerors' technical approaches to managing health care. At the hearing, the SSAC chair testified that the SSAC was not, and should not be, involved in evaluating proposals, and that the SSEB was the "appropriate body." Tr. at 725-26. Similarly, the contracting officer testified that his role was limited to

⁴⁴As explained in the factual discussion, there was one exception. One of the evaluators who reviewed initial technical proposals did consider it relevant to evaluate whether offerors' proposed utilization management approaches might contain health care costs by, for example, inducing physicians to modify their behavior. As detailed above, that evaluator found that [deleted] technical approach was "promising" and "more than satisfactory." That evaluator did not participate in evaluation of BAFOs, and the individuals who did evaluate BAFOs apparently did not consider views about particular proposals' utilization management approaches to be relevant.

⁴⁵The SSEB chair stated that he believed the SSEB's role was limited to advising the SSAC that [deleted], for example, was proposing "a very unique way of doing business."

administrative and procedural decisions, Tr. at 1079-80, and the SSA testified that he did not perform any independent analysis of the technical proposals. Tr. at 1190-91.

In short, neither the SSEB, the SSAC, the contracting officer nor the SSA was willing to include in the evaluation an opinion about the relative merits of the proposed utilization management approaches. The failure to evaluate technical proposals in this regard was inconsistent with section M, which required that proposed utilization management approaches be evaluated on their technical merits.

Evaluation of this critical issue--what the SSEB chair called "the heart of managed care"--was left, by default, to the Lewin consultant who had constructed the agency's independent cost estimate. However, the consultant did not view himself as in a position to make an authoritative judgment in this area, and he expected the SSAC to make the definitive evaluation. Tr. at 491.

Clearly, the cost evaluators (and their consultant) were obligated to evaluate the merit of the individual offerors' differing methods of cost containment, such as utilization management, in evaluating the realism of the offerors' proposed trend factors. This is because health care costs were based on the assumed trend factors and other variables (such as utilization management, Prime enrollment, and provider discounts), and those variables reflected each offeror's unique technical approach, just as the IGCE reflected Lewin's estimate of the variables applicable to a typical contractor. Involvement of the cost evaluators in judging the realism of the claimed cost impact of an offeror's technical approach was consistent with the section M provision that, in the cost evaluation, the agency would "evaluate each proposal to determine whether all proposed costs and factors affecting cost are reasonable, realistic, and affordable." Accordingly, we will address Lewin's evaluation of cost proposals at length before returning to the general question of the evaluation of offerors' technical approaches.

As explained above, Lewin's sensitivity analysis calculated the expected cost to the government under each proposal on the premise that the proposal's claimed cost savings would not occur. In the calculation of total expected cost, the consultant "plugged in" the IGCE trend factors and other cost variables, not those proposed by the offerors. Doing so without consideration of offerors' proposed variables was clearly inconsistent with the basis on which the RFP directed offerors to prepare their proposals. The consultant and agency personnel testified that some consideration was given to adjusting the sensitivity

analysis by adopting offerors' variables, but nothing in the written record supports that position. As discussed above, Lewin's memorandum of February 20 indicated that all offerors would be assumed to incur the same health care costs; that approach was again documented in Lewin's June 3 memorandum, which stated that Lewin would "assume that the actual health care costs incurred by [each] contractor correspond to different percentages of the IGCE health care costs."

Just as in the detailed examples included in those two memoranda, Lewin calculated each offeror's total expected cost to the government based on the premise that all variables, and therefore actual health care costs, would be identical for each offeror. It thus appears that there was an a priori decision made, even if never formally approved by OCHAMPUS officials, to base the sensitivity analysis of BAFOs on the IGCE variables in lieu of offerors' proposed variables. That decision meant that the calculation of total expected cost to the government under each proposal was based on health care costs being identical for every offeror.⁴⁶

Even if consideration was at some point given to accepting offerors' proposed variables as realistic, the Lewin consultant was not "persuaded" that any of the offerors' trend assumptions were more likely than those he relied on in creating the IGCE. See, e.g., Tr. at 429.⁴⁷ Regardless

⁴⁶Lewin apparently viewed the credibility adjustment as crucial to any realism evaluation. That adjustment was clearly designed to give an offeror at least some credit for proposing health care costs lower than the IGCE, where the offeror was willing to stand behind its proposed costs by placing extra equity at risk. Thus, that adjustment benefitted [deleted], which proposed low health care costs and [deleted] million of equity at risk above the RFP minimum. Even the credibility adjustment, however, did not take into account whether the technical merit of the proposed methodology for controlling costs justified the claimed cost savings. In any event, the credibility adjustment was rejected by the SSAC and deleted from the final evaluation.

⁴⁷For example, the consultant testified that [deleted] resource sharing assumption was rejected because it failed to provide "specific information about resource sharing opportunities that [deleted] would follow," such as "we've identified that, at San Diego Naval Hospital, we think in the neonatal intensive care unit, there's an opportunity to do [resource sharing]." Tr. at 427-28. Similarly, Lewin maintains that [deleted] discussion of utilization management failed to recognize [deleted].

of whether it resulted from Lewin's review of proposals or from a pre-BAFO decision to use only the IGCE variables, the use of those numbers, with the concomitant rejection of all offerors' proposed variables, was inconsistent with the RFP evaluation criteria, which required OCHAMPUS to evaluate cost assumptions, including the trend factors and other variables, for realism. See The Jonathan Corp., B-251698, May 17, 1993, 93-2 CPD ¶ 174; Bendix Field Eng'g Corp., B-246236, Feb. 25, 1992, 92-1 CPD ¶ 227. In effect, OCHAMPUS shifted the driving considerations in the cost evaluation to proposed administrative costs and the amount of equity each offeror placed at risk. Had the offerors known this, they might have significantly altered their proposals. Because offerors reasonably rely on a solicitation's terms in preparing their proposals, agencies are required to evaluate proposals based on the RFP criteria. See Federal Acquisition Regulation § 15.608(a).

There is a suggested defense to the agency's actions in the record that should be addressed: that the agency reasonably concluded that each offeror's proposed technical approach would actually result in the same health care costs (the IGCE) as every other offeror's approach. Our rejection of this argument is not based on any disagreement with the technical judgment of the agency. In resolving a bid protest, our Office would not second-guess the agency's reasoned judgment about the likely level of health care costs under one or another proposal's technical approach. Rather, we conclude that the substitution of common variables and common health care costs for those upon which offerors based their proposals is unsupported by any analysis in the contemporaneous record, and it cannot be reconciled with Lewin's and the agency's view of the impact on costs of differing technical approaches.

Specifically, Lewin's judgment, as documented in the February 16 memorandum, was that "[i]t is unrealistic to assume that all of the bidders are equal in their ability to manage health care costs." Lewin pointed this problem out as a disadvantage of option No. 3, yet the BAFO methodology ultimately used was, in effect, that option. The final evaluation of proposals involved neither substantive SSAC review (the only step distinguishing option No. 4 from option No. 3) nor the credibility adjustment (central to the methodology set forth in the February 20 and June 3 memoranda). The consultant did not expect that Lewin's initial judgment about the supportability of cost variables

would be adopted without meaningful review by the SSEB and SSAC; yet those two bodies effectively abdicated their responsibilities, and the result was precisely the unrealistic assumption that the February 16 memorandum had rejected.

Not surprisingly, in view of the consultant's expectation that the SSEB and SSAC would reach the definitive evaluation as to the achievability of offerors' proposed cost variables, Lewin's report does not provide an adequate basis to reject those variables as unrealistic. Thus, the report nowhere expresses an opinion regarding the realism of the individual offerors' proposed costs, nor did the consultant ever state, during three extensive sessions of hearing testimony, that any offeror's proposed variables were unrealistic. [deleted]⁴⁸ Lewin also found that at least some of the offerors' proposed cost savings were "potentially achievable." Tr. at 431. Given the evaluation scheme upon which offerors designed their proposals, without a finding that the offerors' proposed variables were unreasonable, unrealistic, or unachievable,⁴⁹ it was improper for Lewin, and OCHAMPUS, to reject them.

Even if the record somewhere stated that Lewin (or, more importantly, OCHAMPUS) found a particular offeror's specific cost variable unrealistic--and the record does not so state--that finding would only be reasonable if it were

⁴⁸[deleted]

⁴⁹We also note that, in one area relevant here, Lewin's analysis appeared internally illogical. The consultant's approach did not even take into account whether a given offeror's proposed trend factor was more aggressive or less aggressive than the corresponding IGCE trend assumption. Even where offerors proposed an approach which Lewin thought would drive health care costs higher than the IGCE--that is, the offeror's technical approach was inferior, Lewin continued to assume that the offeror's health care costs would be those reflected in the IGCE. See, e.g., Tr. at 430, 452-53. In those areas, Lewin was assuming that the offeror's technical approach would work better than the offeror itself claimed, and the justification for this unusual conclusion was that the offeror had failed to persuade Lewin that the proposal was as weak as the offeror claimed.

supported. Here, notwithstanding the agency officials' testimony that there were oral discussions in this area, nothing in the voluminous record explains, or even acknowledges, the agency's rejection of every variable proposed by every offeror. This lack of documentary support is another ground for our finding the rejection of all offerors' proposed cost variables unreasonable. See Department of the Army--Recon., B-240647.2, Feb. 26, 1991, 91-1 CPD ¶ 211; American President Lines, Ltd., B-236834.3, July 20, 1990, 90-2 CPD ¶ 53.

The agency's use of Lewin's cost analysis was also inconsistent with the OCHAMPUS officials' understanding of the evaluation process. Lewin's analysis meant that expected health care costs were identical, regardless of which offeror won the contract. For example, [deleted] were thus expected to lead to identical health care costs; and the same percentage of CHAMPUS beneficiaries was expected to enroll in the Prime program, regardless of whether [deleted] or [deleted] became the contractor. We not need address the plausibility of such scenarios; of far more relevance is the fact that OCHAMPUS officials testifying on this issue unanimously stated that they did not find the scenarios plausible.

For example, the SSA testified that he believed that the evaluators had concluded that health care costs would probably be different, depending on which offeror became the contractor. Tr. at 1208-09.⁵⁰ The SSA further testified that, if someone had told him prior to award that the calculation of total expected cost to the government for each proposal was based on health care costs being identical for all offerors, he would have been troubled. Tr. at 1212.

In sum, because the cost analysis was inconsistent with the ground rules upon which offerors prepared their proposals, the evaluation on which it was based was improper. OCHAMPUS failed to reasonably evaluate the merit of the offerors' technical approaches as they related to the task of containing health care costs. Indeed, the agency failed to evaluate the differing approaches in any meaningful way.⁵¹

⁵⁰ Similarly, the contracting officer testified that he believed that the evaluators' conclusion was that actual health care costs would probably be different under different offerors' proposals. Tr. at 1093.

⁵¹ The protesters also assert that the agency was obligated to conduct discussions regarding the UM/QA requirements, presenting two arguments: (1) award on the basis of the offerors' first submission following the revision of the UM/QA requirement was improper because the solicitation did not permit award on the basis of initial proposals; and
(continued...)

B. Prejudice

The agency and Aetna argue that, even if we find that the agency acted improperly, the protests should be denied for lack of prejudice, because none of the defects in the procurement process prejudiced Foundation or QualMed. We reject this argument, both because we will deny an otherwise meritorious protest for lack of prejudice only where the absence of prejudice is clear beyond cavil, Moon Eng'g. Co., Inc.--Recon., B-251698.6, Oct. 19, 1993, 93-2 CPD ¶ _____, and because the agency's failure to meaningfully evaluate offerors' proposals to manage health care costs effectively undermined the entire proposal evaluation process.

Thus, while the agency and Aetna point out, accurately, that the agency's improper normalization of health care costs to the IGCE [deleted], we cannot conclude, on the basis of the current inadequate evaluations, that [deleted] health care costs would actually be greater or lesser than any other offeror's. Similarly, while [deleted] might suggest that the offeror would not have been in line for award, even if the cost evaluators had given [deleted] credit for its [deleted],

⁵¹ (...continued)

(2) the agency was required to discuss areas of their proposals that were not affected by the UM/QA revisions. Regarding the first issue, we believe the notice provided in this solicitation permitted award on the basis of initial proposals. See Warren Pumps, Inc., B-248145.2, Sept. 18, 1992, 92-2 CPD ¶ 187. Regarding the second issue, our review indicates that [deleted] proposal was downgraded in areas which remained essentially the same in both its initial proposal and BAFO, and which were not affected by the new RFP requirements. [deleted] argues that failure to discuss these areas had a significant impact on [deleted] technical rating. See Price Waterhouse, 65 Comp. Gen. 205 (1986), 86-1 CPD ¶ 54, aff'd, B-220049.2, Apr. 7, 1986, 86-1 CPD ¶ 333; American Dev. Corp., B-251876.4, July 12, 1993, 93-2 CPD ¶ 49. It clearly would have been more prudent for the agency to have conducted discussions regarding all of the UM/QA requirements, both to assure that it fully understood the proposals and to give the offerors an opportunity to improve what they proposed to provide the government. However, in light of our conclusion and recommendation here, we need not determine whether the agency's manner of conducting discussions provides an independent legal basis for sustaining the protests.

the failure to evaluate utilization management in a meaningful way tainted the technical evaluation as well as the cost evaluation, thus rendering it impossible to predict which offeror might be in line for award if the evaluation had been performed as represented.

As previously discussed, had the solicitation advised offerors that the agency intended to substitute its calculation of expected health care costs for those proposed by offerors, thus shifting the driving considerations in the cost competition to proposed administrative costs and the amount of equity placed at risk, offerors might have significantly altered their proposals. Accordingly, we have no basis to conclude that the deficiencies both in the conduct of discussions and in the evaluation process did not prejudice either protester.

VIII. CONCLUSION AND RECOMMENDATION

Judgments about how best to determine which offeror will most successfully meet governmental needs are largely reserved for the procuring agencies, subject only to such statutory and regulatory requirements as full and open competition and fairness to potential offerors. We recognize that OCHAMPUS was unsure about how to perform the task it committed to perform--evaluating the extent to which proposed technical approaches would actually contain health care costs. Consequently, we make two alternative recommendations in this case. If OCHAMPUS desires to modify its approach to selecting a contractor, it should revise the solicitation so that offerors are clearly informed about the bases for evaluating technical and cost proposals, and obtain revised proposals. On the other hand, if the agency elects to proceed with the evaluation as described in the RFP, it should reopen discussions with all competitive range offerors, request revised proposals, and proceed with the source selection process based on appropriate evaluations.

If, as a result of the evaluation of revised proposals, Aetna's proposal is no longer considered to represent the best value to the government, the agency should terminate Aetna's contract for the convenience of the government, if practicable, and award to the successful offeror. If termination is not practicable, Aetna's option should not be exercised, and the next option period should be awarded to the successful offeror. We also find that the protesters are entitled to recover their reasonable costs of filing and pursuing these protests, including attorneys' fees.

4 C.F.R. § 21.6(d)(1) (1993). The protesters' certified

claims for such costs, detailing the time expended and costs incurred, must be submitted directly to OCHAMPUS within 60 days after receipt of this decision.

The protests are sustained.

Comptroller General
of the United States