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Decision

Matter of: UnitedHealth Military & Veterans Services, LLC

File: B-401652.8; B-401652.9; B-401652.10; B-401652.11

Date: June 14, 2011

Thomas C. Papson, Esq., Jason A. Carey, Esq., Jason N. Workmaster, Esq., Luke W. Meier, Esq., and John W. Sorrenti, Esq., McKenna Long & Aldridge LLP; and Paul F. Khoury, Esq., and Brian G. Walsh, Esq., Wiley Rein, LLP, for the protester. Peter L. Wellington, Esq., Thomas P. Barletta, Esq., Paul I. Lieberman, Esq., and Michael J. Navarre, Esq., Steptoe & Johnson, LLP, for Humana Military Healthcare Services, Inc., an intervenor.

Rhonda L. Bershok, Esq., Roger K. Corman, Esq., Kenneth S. Lieb, Esq., Michael Bibbo, Esq., and David R. Smith, Esq., Department of Defense, for the agency. Scott H. Riback, Esq., and David A. Ashen, Esq., Office of the General Counsel, GAO, participated in the preparation of the decision.

DIGEST

Protest that agency miscalculated awardee's proposal and made an unreasonable source selection decision is denied where record shows that agency's evaluation and source selection was reasonable and consistent with the terms of the solicitation and applicable procurement laws and regulations.

DECISION

UnitedHealth Military & Veterans Services, LLC (UMVS), of Minnetonka, Minnesota, protests the Department of Defense (DOD), TRICARE Management Activity's (TMA) award of a contract to Humana Military Healthcare Services, Inc. (HMHS), of Louisville, Kentucky, under request for proposals (RFP) No. H94002-07-R-0007, for TRICARE managed health care support services for the south region. UMVS maintains that the agency miscalculated proposals and made an irrational source selection decision.

We deny the protest.

BACKGROUND

TRICARE is a managed health care program implemented and administered by DOD, principally for active duty and retired members of the military, their dependents and survivors. Managed care support (MCS) contractors assist the military health system in operating an integrated health care delivery system, combining the resources of the military's direct medical care system (government-operated military treatment facilities (MTF)) and the MCS contractor's network of civilian health care providers to deliver health, medical and administrative support services to eligible beneficiaries. TMA is the DOD field activity responsible for procuring and managing contracts for these services; this protest concerns the contract awarded for the south region.¹

The RFP contemplates the award of a contract for a base transition-in period, five 1-year option periods of actual health care delivery, and a 270-day transition-out option period. Award was to be made to the firm submitting the proposal representing the "best value" to the government, considering price/cost, and a number of non-price/cost considerations. RFP § M.4. The RFP set forth three evaluation factors listed in descending order of importance: (1) technical approach, which included seven equally weighted subfactors (network development and maintenance, referral management, medical management, enrollment, beneficiary satisfaction/customer service, claims processing, and management functions); (2) past performance; and (3) price/cost. Offerors were advised that the agency would assign a merit and a proposal risk rating to each of the technical evaluation subfactors. RFP §§ M.5.1, M.6. Additionally, the RFP advised that the agency would consider price realism in connection with the fixed-price elements of the contract in order to assign an overall performance risk rating to the proposal. RFP § M.8.4.3. The technical approach and past performance factors, combined, were significantly more important than the cost/price factor. RFP § M.4.

The solicitation advised offerors to submit a technical proposal demonstrating their understanding of the solicitation's requirements and providing a successful technical solution for the prospective contract. RFP § L.6.1. In addition, offerors were encouraged to propose features that exceeded the government's minimum requirements; where an offeror proposed such a feature, it was to be included in a separate list, along with an explanation of how the offeror proposed to exceed the RFP's requirements. *Id.*, RFP § M.5.1.

The RFP provided that, for purposes of preparing price/cost proposals, total evaluated price/cost would be comprised of a number of elements. First, firms were

¹ The south region includes: Alabama, Arkansas, Florida, Georgia, part of Kentucky, Louisiana, Mississippi, Oklahoma, South Carolina, Tennessee, and most of Texas.

required to propose fixed prices for a number of contract services relating to the initial transition and administrative aspects of the overall requirement (for example, claims processing). Second, firms were required to propose what the RFP refers to as “health care fixed fees” that represented a percentage of total health care and disease management costs. Third, total disease management and health care costs were estimated by the agency; these are cost reimbursable elements of the contract for which the agency provided estimates to be used in proposal preparation. Finally, offerors were required to propose a transition-out cost. See generally RFP section B.

In July, 2009, TMA awarded a contract for this requirement to UMVS, finding that the proposals submitted by UMVS and HMHS were essentially equal from a technical approach and past performance standpoint, and concluding that, because UMVS’s proposal enjoyed an evaluated price/cost advantage relative to HMHS’s proposal of \$[deleted], its proposal represented the best overall value to the government. Agency Report (AR) 1, exh. 1, at 7; exh 100, at 5².

Upon learning of the agency’s 2009 award to UMVS, HMHS filed a protest raising various contentions challenging that award decision. We sustained HMHS’s protest, concluding that the agency’s technical evaluation improperly failed to consider certain discounts (discussed in detail below) that could have been available if HMHS had been awarded the contract. Humana Military Healthcare Servs, B-401652.2, et al., Oct. 28, 2009, 2009 CPD ¶ 219. In particular, we found that, because HMHS was the incumbent contractor and already had in place a network of civilian health care providers from which it was obtaining an average overall discount of approximately [deleted] percent, and because its proposal showed that it potentially could realize discounts from its existing civilian provider network of as much as \$[deleted] over the life of the contract, the failure of the agency’s source selection decision to account for such potential savings was unreasonable. Id. at 8, 9, 12, 16. We recommended that the agency reevaluate proposals and make a new source selection decision consistent with our decision. Id. at 16.

Following our decision, the agency issued a series of amendments to the solicitation and provided the offerors an opportunity to engage in discussions and revise their proposals in certain areas. The amendments sought information that would enable the agency to quantify and evaluate the potential discounts that might be available

² This is the second occasion where we have considered a protest in connection with this acquisition. References to the record developed during the first protest are to AR 1; references to the record developed in connection with the current protest are to AR 2.

from the offerors.³ In this connection, the costs associated with care provided by the MCS contractor's civilian health care providers are subject to TRICARE maximum allowable charges (TMACs), such that the providers will be paid no more than the TMAC for any given service.⁴ The discounts are reductions in the charges to be paid to the civilian health care providers below the TMACs for any given service. These reductions, or discounts, are negotiated by the offerors with their respective networks of health care providers

The agency advised that it would confine its consideration of any proposed discount to the technical evaluation of proposals (that is, any proposed discount would not be factored in to the agency's calculation of an offeror's evaluated price/cost). Additionally, the RFP required that any proposed network discount had to be unconditionally guaranteed by the offeror. The amended RFP provided:

Offerors are advised that the Government will factor, as an offered element exceeding minimum standards/requirements, into the technical evaluation and subsequent best value analysis, any network provider discounts. However, this will occur only if an offeror commits to incorporating such network provider discounts as a *guarantee* into the awarded contract and the offered guarantee is otherwise determined to be a strength by the government pursuant to the solicitation.

* * * * *

The best value decision will not consider any projected health care cost savings associated with any proposed network provider discounts as an adjustment within the Price/Cost Volume.

RFP amend. 13, AR 2, exh. 10, at 4-5 (*italics in original*). Offerors were further advised that they could amend their technical proposals, but any change had to be confined to that portion of their technical proposals relating to the network development and maintenance subfactor, and could not exceed 15 pages, exclusive of supporting spreadsheets and analysis. Id. at 4.

³ The series of amendments also revised the periods of performance for the contract, the quantities for the administrative services and the estimates of the cost of health care services.

⁴ As noted, the agency provided the offerors with estimates of the total health care costs that the agency anticipated would be incurred during contract performance; these total costs were calculated based on the TMACs.

Offerors were free to amend any aspect of their proposed price/cost, but were specifically advised that any price/cost changes could not be the result of a change to their technical approach outlined in the remaining portions of their technical proposal that previously had been submitted and evaluated. Specifically, revisions to proposed price/cost had to be related either to the offer of a guaranteed discount, to changes made by the amendments (changes to the period of performance, administrative services quantities or estimated health care costs), or to the introduction of new estimating assumptions or methodologies. The amended RFP provided:

If the offeror revises unit prices, or introduces new estimating assumption[s]/methodologies, it shall be fully described consistent with instructions under L.8. Such revisions will not be counted in the page limitation in response to the corrective action of this amendment. The offeror's previously evaluated technical approach not encompassed within the corrective action cannot be changed; therefore, any revisions to the offered prices shall not be the result of any changes to the offeror's previously evaluated technical approach.

RFP amend. 13, AR 2, exh. 10, at 4. Furthermore, the amended RFP advised that the agency did not necessarily intend to change the "risk tolerance" assumed by the offerors in their prior proposals, but that, to the extent that the offer of a guaranteed network discount impacted the offerors' pricing strategy, that impact was to be confined to changes to the offeror's health care fixed fees. RFP amend. 13, AR 2, exh. 10, at 4.

In response to the amended RFP, UMVS and HMHS submitted revised proposals (final proposal revisions (FPRs) 2). The agency then conducted discussions with the offerors and afforded them an opportunity to submit revised proposals (FPRs 3). The agency made its source selection based on the FPRs 3.

Both offerors proposed guaranteed network discounts. HMHS proposed [deleted]. AR 2, exh. 22, at 51.⁵ UMVS offered [deleted]. AR 2, exh. 28, at 26.

HMHS offered an additional proposed discount stated as a dollar amount (referred to by HMHS as its annual healthcare savings guarantee) for each option year as follows: option year 1 (OP1) [deleted].OP2; [deleted]; OP3 [deleted]; OP4 [deleted]; and OP5 [deleted]. AR2, exh. 22, at 53, 55.⁶

⁵ The proposed primary guarantee offered by HMHS [deleted]. AR 2, exh. 22, at 51.

⁶ Although the sum of these amounts is approximately [deleted]. AR 2, exh. 22, at 55.

[deleted].⁷ [deleted].

In evaluating these proposed discounts, the agency assigned an additional strength to both proposals under the network development and maintenance subfactor and also assigned both proposals a low proposal risk rating. However, the agency determined that, because of the additional potential monetary value of the discount offered by HMHS, its proposal was slightly superior to the proposal of UMVS in this area. AR 2, exh. 5, at 10-12; exh. 7, at 12; exh. 8, at 10. Specifically, the agency assigned an expected monetary value to the HMHS discount of approximately \$[deleted], and assigned an expected monetary value of approximately \$[deleted]. AR 2, exh. 5, at 10-12. In concluding that the discount proposed by HMHS was more valuable, the chairman of the source selection evaluation board (SSEB) stated:

A comparison can be made of HMHS's Network Provider Discount Guarantee to UMVS's [deleted]. My finding is based on the expected value of HMHS's Network Provider Discount Guarantee which is approximately \$[deleted] more than UMVS's [deleted]. In addition HMHS's Network Provider Discount Guarantee is approximately \$[deleted].

AR 2, exh. 5, at 12.

Apart from HMHS's evaluated advantage with respect to its proposed guaranteed network discount, the record shows that the HMHS proposal was evaluated as superior because it offered more strengths than UMVS's proposal, and also had a lower proposal risk rating than UMVS's proposal. The chairman of the SSEB found:

There are quantitative differences [under the technical factor] in that HMHS had 16 (15 in FPR 1) strengths compared to UMVS's 14 (13 in FPR 1) strengths[.] I found HMHS had an advantage in 5 subfactors compared to UMVS's advantages in 2 subfactors which supports my finding that when viewed as a whole HMHS's proposal is superior in Technical Merit. HMHS was assessed Low proposal risk ratings for each of the seven subfactors. As discussed in the FPR 1 report UMVS was assessed a Moderate proposal risk rating in Subfactor 6 and the rating remains unchanged for the FPR 3 evaluation. UMVS was assessed Low proposal risk ratings in the other six subfactors.

⁷ [deleted]. RFP § H.2.3.1.

AR 2, exh. 5, at 14. The agency also found that the proposals were essentially equal under the past performance evaluation factor, and that HMHS's proposal had a price/cost advantage over UMVS's of approximately \$[deleted]. Id. Finally, the chairman of the SSEB assigned a slight performance risk to HMHS based on certain aspects of its fixed prices, but concluded that this slight risk was outweighed by the slightly superior technical proposal and lower price/cost offered in the HMHS proposal. Id. The SSEB chairman therefore recommended award to HMHS, concluding that its proposal offered the best overall value to the government. Id. at 15. The agency's source selection advisory council (SSAC) concurred in the recommendation of the SSEB chairman. AR 2, exh. 4.

After reviewing the proposals and all of the evaluation and source selection materials prepared in connection with this round of the competition, as well as the evaluation and source selection materials prepared during the prior round of competition, the source selection authority (SSA) determined that HMHS's proposal represented the best value to the government. AR 2, exh. 3 (Source Selection Decision Document (SSDD)). After being advised of the agency's award decision and receiving a debriefing, UMVS filed this protest with our Office.

DISCUSSION

UMVS has raised a large number of protest allegations. In considering protests challenging an agency's evaluation of proposals, we will not reevaluate proposals; rather, we will examine the record to determine whether the agency's evaluation conclusions were reasonable and consistent with the terms of the solicitation and applicable procurement laws and regulations. Engineered Elec. Co. d/b/a/ DRS Fermont, B-295126.5, B-295126.6, Dec. 7, 2007, 2008 CPD ¶ 4 at 3-4. A protester's mere disagreement with a procuring agency's judgment is insufficient to establish

that the agency acted unreasonably. CIGNA Gov't. Serv's., LLC, B-401068.4, B-401068.5, Sept. 9, 2010, 2010 CPD ¶ 230 at 16.

We have carefully reviewed all of UMVS's assertions and find them to be without merit. We discuss UMVS's principal protest grounds below.

Right of First Refusal

UMVS asserts that HMHS's proposal impermissibly deviated from a requirement of the solicitation relating to how referrals are handled between the MTFs and civilian providers. The RFP described the interrelationship between the civilian providers and the MTFs, and requires appropriately-identified referrals from the civilian provider to be presented to the MTF first, in order to provide the MTF a right of first refusal (ROFR). RFP amend. 7, AR 1, exh. 62, at 22. The TRICARE operations manual (TOM), Ch. 8, § 5, in turn, establishes timeframes and procedures relating to

the handling of these referrals. Under technical subfactor 2, referral management, offerors were to describe how their procedures for handling referrals between the MTFs and civilian providers complied with the solicitation and the TOM. RFP amend. 7, AR 1, exh. 62, at 100. Briefly, when a referral is submitted to an MTF, the MTF generally is required to respond to the referral within one business day. TOM, Ch. 8, § 5, ¶ 6.2.2. Where the MTF fails to respond to the referral within one business day, the TOM requires the referral to be handled as if the MTF had declined the referral. Id. These so-called “passive denials” occur because the MTF does not actively decline the referral.

HMHS offered as a proposed enhancement in this area an approach that the firm used successfully while it was the incumbent contractor for these requirements. Specifically, HMHS proposed as follows:

[deleted].

AR 1, exh. 66, at 162. As further explained in the HMHS proposal, this approach [deleted]. Id.

UMVS asserts that this proposed approach is inconsistent with the requirements of the TOM, which provides that: [deleted].

We dismiss this aspect of UMVS’s protest. The record here shows that, during HMHS’s protest against the initial award to UMVS, UMVS specifically addressed the agency’s evaluation of the ROFR issue in its pleadings. In particular, the record during the prior protest showed that the SSEB identified HMHS’s handling of the ROFR issue as a significant strength, but the SSA disagreed. In commenting on this aspect of the agency’s evaluation, UMVS stated as follows:

Consequently, where the SSA disagreed with the SSEB Report, he was well prepared and had a sound basis for doing so. The SSA explained his reasons for disagreeing with the advantage that the SSEB Report identified for HMHS in Subfactor 2, referral management. *Id.* [hearing transcript] at 1238-42. He explained that the HMHS Subfactor 2 strength involved situations where the government failed to take advantage of its Military Treatment Facility (“MTF”) Right of First Refusal (“ROFR”). *Id.* at 1239-40. He further explained that he viewed this problem as one that is properly fixed from the Government side, and therefore concluded that HMHS’s strength--although it remained a strength--did not merit the significance that the SSEB Report placed on it. *Id.* at 1240-41.

UMVS’s Post-Hearing Comments, Oct. 8, 2009, at 72-73.

UMVS's position in the current litigation is that the ROFR enhancement offered by the HMHS proposal should have rendered it unacceptable for award, or at least should have been deemed a significant weakness. E.g., Protester's Comments, Apr. 28, 2011, at 20. However, the record clearly shows that during the earlier litigation, after having examined the record in connection with this very aspect of the HMHS proposal--including the testimony of the SSA on the subject--UMVS did not assert that HMHS's approach in this area rendered the HMHS proposal unacceptable, but, rather, simply argued that the proposal was properly assigned the emphasis (treatment as a strength) to which it was entitled by the SSA.

Where, as here, the record demonstrates that, during an earlier round of the litigation, the protester had all of the information necessary to make an argument, but instead made a very different argument--asserting that this aspect of the HMHS proposal was a strength (albeit not a significant one) rather than a significant weakness--we will not consider the subsequently advanced assertion. Techniarts Eng'g, B-238520.5, B-238520.6, Dec. 31, 1991, 92-1 CPD ¶ 20 at 3. Allowing the protester to argue--after agency corrective action--in a manner flatly contradicted by arguments in the earlier proceeding undermines the overriding goals of our bid protest forum to produce fair and equitable decisions based on consideration of all parties' arguments on a fully developed record. Id. Accordingly, such subsequently raised arguments will not be considered by our Office, whether presented in a request for reconsideration, or in a new protest.⁸ Id.

Page Limit for Proposal Revisions

As noted above, during the agency's corrective action on this procurement, it limited revisions to the offerors' technical proposals to those provisions relating to the network development and maintenance subfactor. Offerors were further advised that any revisions to their technical proposals were limited to 15 pages, exclusive of spreadsheets and narratives containing information supporting the offeror's proposed guaranteed network discount. RFP Amend. 13, AR 2, exh. 10, at 4-7. With respect to these spreadsheets and narratives, the RFP stated that they could include any other supporting information the offeror wanted to supply and provided examples of information that could be included. Among the examples of information that could be included in the spreadsheets and narratives were a detailed

⁸ In any case, we conclude that the agency properly accepted this aspect of the HMHS proposed approach. As noted, the RFP specifically provided that offerors could propose enhancements to the basic requirements of the RFP, and the agency properly could accept those enhancements where it found them beneficial to the government. RFP §§ L.6.1, M.5.1. HMHS's proposal relating to its treatment of the ROFR requirement was such an enhancement, and was properly accepted by the agency.

explanation of the assumptions and calculations used to generate to the proposed network discount; the proportion of health care costs that the offeror expects would be provided by civilian network providers; an analysis of the average discounts the offeror has already negotiated with the proposed network providers; or, alternatively, where such discounts had not already been negotiated, an analysis of how the negotiated reimbursement rates in the offeror's commercial network compare to the TRICARE Standard allowable rates. RFP Amend. 13, AR 2, exh. 10, at 6.

The RFP also included directions regarding what information was subject to the 15 page limit. As is pertinent here, the RFP provided:

Included in the page limit, an acknowledgement and discussion of the risks assumed by the offeror for the guaranteed network provider discounts, given that the Outpatient Prospective Payment System (OPPS) was implemented by TRICARE in May 2009 and reduced reimbursement levels to hospitals and that TRICARE reimbursement rates are generally tied to Medicare rates by law and Medicare rates may be highly uncertain during the option periods of the awarded contract[.]

RFP amend. 13, AR 2, exh. 10, at 6.

The record shows that both offerors included a narrative that was limited to the 15 pages allowed,⁹ and also submitted additional information in the form of spreadsheets and appendices that were not subject to the 15-page limit. AR 2, exhs. 22, 28.

UMVS asserts that HMHS failed to follow the RFP's instructions because the firm's narrative relating to its acknowledgement and discussion of the risks assumed by HMHS relating to implementation of OPPS and the uncertainty of Medicare rates was not included in the 15 pages of narrative, but instead was included in one of its

⁹ After receiving the HMHS FPR 3, the contracting officer concluded that there were several lines among the 15 pages presented that included cost information that should not have been included in HMHS's technical proposal. AR 2, exh. 21, at 48. Additionally, the contracting officer concluded that an extensive footnote on page 3 of HMHS's FPR 3 was in a font that was smaller than permissible under the RFP's instructions. Id. at 49. Accordingly, the contracting officer, using an electronic version of the HMHS proposal, redacted the cost information and changed the font size of the footnote. Id. Since the narrative of the HMHS proposal as reformatted went beyond the 15 page limit, the contracting officer also redacted the narrative beyond the 15th page. Id. It was this redacted version of the HMHS technical proposal revision that was provided to the technical evaluators. Compare AR 2, exh. 22 (the redacted narrative) with AR 2, exh. 23 (the unredacted narrative).

additional appendices. UMVS further asserts that this additional information was relied upon by the agency in its source selection decision. See AR 2, exh. 3, at 6-7. The protester contends that, since the additional information was not included in the 15 pages but was relied on by the agency in making its source selection, the agency's actions were improper.

We find no merit to this aspect of UMVS's protest. An examination of the HMHS proposal shows that the firm met the proposal instruction requirement to acknowledge and discuss the risks associated with implementation of OPSS and the uncertainty of Medicare rates within the 15 page narrative. While the record also shows that the subject of Medicare rates was further discussed in an appendix to the narrative materials in order to provide the agency with supporting information relating to the firm's business strategy, this supporting information was not required to be within the 15 page limit.

Within the 15 page limit of the HMHS proposal narrative are the following passages:

[deleted]

AR 2, exh. 22, at 51, 65 (emphasis supplied). These passages demonstrate that HMHS made explicit reference to the risks assumed by HMHS for rate changes (which would occur if there were changes to the Medicare rates that impacted the TRICARE rates during the term of the contract) and also explicitly discussed its implementation of OPSS under the heading "acknowledgement and discussion of risk." Simply stated, HMHS satisfied the requirement in the proposal instructions to include within the 15 page limit ". . . an acknowledgement and discussion of the risks assumed by the offeror for the guaranteed network provider discounts." RFP amend. 13, AR 2, exh. 10, at 6.

UMVS is correct that the HMHS proposal also included narrative materials in an appendix relating to its underlying business strategy of offering a guaranteed discount that [deleted]. AR 2, exh. 22, at 72.) This, however, was precisely the sort of supporting information explaining HMHS's assumptions that was permitted to be outside of the 15 page limitation. As stipulated in the solicitation, offerors could include information outside of the 15 pages to detail:

Any other supporting information. For example, a working spreadsheet (with formulas intact and clear labels) and text narrative that presents a detailed explanation of the [offeror's] assumptions and calculations that build up to the proposed network discounts.

RFP amend. 13, AR 2, exh. 10, at 6 (emphasis supplied). The narrative materials referenced by UMVS, AR 2, exh. 22, at 72, simply provide the underlying explanation of HMHS's assumptions and overall approach relating to possible

changes to the Medicare rates, and thus properly were included in an appendix not subject to the 15 page limitation. We therefore deny this aspect of UMVS's protest.

RFP Requirements Relating to Medicare Rate Uncertainty

UMVS maintains that the HMHS's proposal fails to comply with the requirement added by amendment 13 relating to Medicare rates, which required offerors to "acknowledge and discuss" that: "TRICARE reimbursement rates are generally tied to Medicare rates by law and Medicare rates may be highly uncertain during the option periods of the awarded contract[.]" RFP amend. 13, AR 2, exh. 10, at 6. According to the protester, this solicitation provision required HMHS to acknowledge or recognize the risk posed by a decline in Medicare rates, and [deleted].

As UMVS notes, the RFP required offerors to "acknowledge and discuss" the fact that Medicare rates might be highly uncertain during the term of the contract. However, there is nothing in this language that dictated a particular response to the solicitation's observation that Medicare rates might be uncertain. In effect, UMVS's position is that the RFP required offerors to assume that Medicare rates would decrease during the term of the contract, and to [deleted].

As set forth below, UMVS's reading of the solicitation is unreasonable. First, UMVS's interpretation requires the phrase "acknowledge and discuss" to dictate that the offerors base their proposals on the certainty that Medicare rates will be reduced during the contract term. Second, UMVS's interpretation ignores the balance of the clause that provides only that Medicare rates "may be highly uncertain." Use of the words "may be" clearly shows that UMVS's interpretation of the phrase "acknowledge and discuss" is unreasonable, inasmuch as the certainty insisted upon by UMVS regarding a decline in Medicare rates is absent. Moreover, the phrase "highly uncertain" does not indicate whether Medicare rates will go up or down, only that they may be uncertain. We therefore have no basis to interpret the language of the RFP in the manner insisted upon by UMVS.¹⁰

Evaluation of The HMHS Proposed Guaranteed Network Discount

¹⁰ UMVS suggests that this solicitation language created a latent ambiguity because it interpreted the language as it maintains it should be read. However, for a latent ambiguity to exist, there must be more than one reasonable interpretation. LS3, Inc., B-401948.11, July 21, 2010, 2010 CPD ¶ 168 at 2-3. As discussed, UMVS's proposed interpretation of the solicitation language is unreasonable; consequently there is no basis to find that the RFP contained a latent ambiguity.

UMVS asserts that the agency unreasonably evaluated the proposal risk associated with HMHS's proposed guaranteed network discount. In this connection, UMVS points out that, as noted above, HMHS [deleted]. The protester maintains that this is a significant risk and that it was unreasonable for HMHS [deleted]. Correspondingly, UMVS asserts that it was unreasonable for the agency to assign a low risk rating to the HMHS proposal in its evaluation under this subfactor.

In support of its position, UMVS notes that, as part of the Balanced Budget Act of 1997, Congress created what is referred to as the sustainable growth rate (SGR) formula applicable to Medicare payment rates for physician services. See 42 U.S.C. § 1395w-4 (2006). These Medicare payment rates are to be updated annually based upon actual cost experience as compared to a projected expenditure rate or path calculated using the SGR formula; in effect, the objective of the SGR formula is to keep Medicare costs for physician services at a level that, as the name implies, is sustainable over time. Protest, Mar. 7, 2011, at 52; Agency Legal Memorandum, Apr. 18, 2011, at 42. If, for example, actual cost growth exceeds the target path established by the SGR formula, then Medicare payment rates are to be reduced the following year in order to keep actual cost experience in line with the target path identified by the formula.

Every year since 2002, Medicare costs have grown, such that the SGR formula would require a reduction in Medicare rates. However, Congress consistently has passed measures that effectively suspend implementation or application of the SGR formula dictated rate reductions. As a result, to date there is an accumulated reduction of approximately 20 percent below the current Medicare rates. The latest suspension of the SGR rate reductions extends until January 2012. Medicare and Medicaid Extenders Act of 2010, Pub. L. No. 111-309, 124 Stat. 3285.¹¹

UMVS asserts that it was unreasonable for HMHS to prepare its proposal [deleted]. UMVS notes that, should that occur, both the accumulated (approximately 20 percent) rate reductions that previously were suspended would take effect, as would any additional rate reductions that would be dictated by the SGR formula. UMVS points out that any reduction in the Medicare rates would impact the TMACs which, by statute, are generally tied to the Medicare rates. UMVS asserts that, should this occur, the ability of HMHS to achieve the discounts it has proposed below the TMACs would be virtually eliminated because HMHS's network of civilian providers would be unwilling to agree to discounts in light of such a substantial

¹¹ UMVS points out that there have been several instances during which the suspension of the application of the SGR formula has lapsed before the suspension was reenacted (for example, the suspension lapsed for a 2 week interval between April 1 and April 15, 2010). Protest, Mar. 7, 2011, at 52. We see nothing in this fact that would alter our conclusions.

reduction in the TMACs. UMVS further asserts that the effects of such an eventuality would be [deleted] for HMHS, based on the firm's having guaranteed more than [deleted] in discounts over the life of the contract.

UMVS also asserts that, even if Congress does continue suspension of the SGR formula rate reductions, there is a substantial chance that Medicare rates, and hence TMACs, will be reduced during the life of the contract. UMVS points out, for example, that, pursuant to section 3403 of the Patient Protection and Affordable Care Act, Pub. L. 111-148 124 Stat. 119, 489 (2010), there was created the Independent Payment Advisory Board (IPAB), whose mandate is to control the growth of Medicare costs. The IPAB is to make recommendations relating to reducing the costs of Medicare, either through implementation of the SGR formula, or through other means, and it is designed to work on a "fast track" basis. See generally, 42 U.S.C. § 1395kkk. UMVS asserts that the potential rate reductions from the above considerations, along with such other potential factors as the possibility that future inflation will hinder HMHS's ability to achieve its projected guaranteed network discount, call into question the likelihood that HMHS will, in fact, be able to achieve its proposed guaranteed network discount.

UMVS further asserts that the agency's evaluation of HMHS's proposed guaranteed network discount was unreasonable because it failed to take into consideration the substantial risk introduced by its approach. According to the protester, HMHS's inability to achieve its promised discount rates could have serious adverse impacts on the firm's ability to deliver a stable, high quality network that meets the RFP's access to care requirements. UMVS concludes that the agency unreasonably failed to take these considerations into account in evaluating the risk associated with the HMHS proposal.

We find no merit to this aspect of UMUV's protest. The record shows that HMHS provided the agency with detailed information in its proposal relating to its decision [deleted]. As noted in our earlier decision, the starting point for HMHS's approach is the fact that, as discussed in its previous proposal, it is the incumbent for the requirement and has a preexisting network of providers from which it was achieving an average network-wide discount from the TMACs of approximately [deleted] percent. See, e.g., AR 1, exh. 66, at 74. Further, HMHS was the incumbent at the time that OPPTS¹² was implemented in 2009, and the firm presented information in its proposal showing that, even in the wake of that implementation, it was achieving an average network-wide discount of [deleted] percent from the TMACs. AR 2, exh. 22, at 56. In contrast, HMHS proposed discounts no higher than [deleted]. Id. at 51.

¹² OPPTS or the Outpatient Prospective Payment System was implemented by TRICARE in May 2009 and reduced reimbursement levels to hospitals.

The record shows that the agency technical evaluators carefully reviewed the HMHS proposed guaranteed network discount. The evaluators noted that HMHS's starting point for its analysis was the average [deleted], AR 2, exh. 7, at 6, and that HMHS had [deleted]. AR 2, exh. 7, at 7. They further noted that HMHS has been a TRICARE contractor since 1996 and has extensive experience in estimating health care costs and implementing major changes to reimbursement rates that impacted discount levels.

The evaluators concluded that HMHS likely would achieve its proposed guaranteed network discounts, and therefore assigned the HMHS proposal a low risk rating under this subfactor. According to the evaluators:

Their [HMHS's] stated ability to provide a managed, stable, high-quality network within access standards with discount guarantees is based on [deleted]. HMHS also states they will continue to provide high levels of service and quality, minimize administrative burdens, and ensure the network is of sufficient size and diversity to meet access standards. These methods will likely be effective because a large, diverse network provides flexibility and options for directing network care, and provides some assurance that discount guarantees will be achieved because of the large number of available providers, [deleted]. A stable network, with providers [deleted]. All of these contribute to ensuring HMHS's ability to provide a managed, stable, high-quality network within access standards[.]

AR 2, exh. 7, at 11.

The record thus shows that HMHS presented considerable detail relating to the establishment of its proposed discounts, showing in particular that its proposed discounts were based on its historical experience, and accounted for contingencies that could affect its ability to achieve its proposed discount. In turn, the agency evaluators carefully reviewed the HMHS proposal and concluded that HMHS could achieve its proposed discounts given the totality of circumstances considered and accounted for in the firm's establishment of its discount rates.

On the specific subject of HMHS's decision [deleted], HMHS explained that it relied on the [deleted] into its proposed discount. In this regard, the HMHS proposal provided:

[deleted]

AR 2, exh. 22, at 72.

The agency's technical evaluators found HMHS's conclusion in this regard reasonable, noting that:

[deleted]

AR 2, exh. 7, at 7-8. The SSA, in turn, considered the conclusions of the technical evaluators and concurred in their finding that HMHS's decision [deleted] discount possible changes to Medicare rates was reasonable, especially in light of the fact that, not only had [deleted]. AR 2, exh. 3, at 6-7.

In sum, the record shows that HMHS provided in its proposal a detailed explanation regarding how it had calculated its proposed discounts. The agency, in turn, reviewed HMHS's assumptions and calculations and concluded that HMHS's proposed discount was reasonable in light of the totality of circumstances, including its decision [deleted] potential changes to Medicare rates.

UMVS offers numerous reasons and opinions from various experts to the effect that HMHS's calculations pose a significant risk to successful contract performance, and that the agency's failure to factor this risk into its evaluation of the HMHS proposal was unreasonable. However, in our view, the record reflects two offerors proposing differing business solutions, one of whom (HMHS) has historical experience and offers detailed calculations showing the underlying rationale for its proposal.¹³

While the protester believes that its proposed business strategy is the most appropriate in light of all circumstances, this belief, ultimately, is a disagreement as to business judgment. In the final analysis, UMVS's experts are no more able to predict the future than HMHS's experts or those of the agency. Simply stated, none of the parties knows with certainty whether Medicare rates will be dramatically reduced during the term of the contract, or whether any other eventuality will affect the relative success of the HMHS approach.

The disagreement of one offeror with the business strategy proposed by another, in the face of a reasonable evaluation by the agency, and without an objective showing that the questioned strategy is inherently unreasonable, does not provide a basis for our Office to object to the agency's evaluation. CAE USA, Inc., B-293002, B-293002.2, Jan. 12, 2004, 2004 CPD ¶ 25 at 15 (differing approaches that merely reflect the differing business judgments of competing offerors in a best value procurement do not provide a basis for our Office to object to the agency's evaluation). We therefore deny this aspect of UMVS's protest.

¹³ In addition to the extensive materials in the contemporaneous record relating to this question, HMHS also has noted in its briefs that [deleted]. By way of example, HMHS notes that, [deleted]. HMHS Comments, Apr. 28, 2011, at 12, n. 8.

HMHS's Underwriting Fees

UMVS protests the agency's evaluation of HMHS's proposed price based on the amount of its underwriting fees (also referred to in the record as underwritten health care fixed fees (HCFF)). The underwriting fee aspect of the contractor's reimbursement is intended to represent both an earned fee or profit for the successful performance of the contract, as well as a risk mitigation cushion against potential losses under the contract (obviously, the more the fee is required to defray losses, the less it represents a profit).

UMVS's arguments in this aspect of its protest mirror the arguments it made in connection with the agency's evaluation of HMHS's proposed guaranteed network discounts. Specifically, UMVS asserts both that the terms of the RFP prohibited the reduction made by HMHS in its underwriting fees from FPR 1 to FPR 3, and also that its FPR 3 underwriting fees introduce an element of performance risk not adequately accounted for in the agency's price evaluation. We address these contentions in order below.

UMVS asserts that the terms of the corrective action amendments prohibited offerors from reducing their proposed underwriting fees in their FPR 3 proposals. In this connection, UMVS directs our attention to the following solicitation language:

The Government does not intend to change the offeror's risk tolerance beyond that already assumed within their prior FPR. Thus, it is not intended that any impact of any proposed guaranteed network provider discount be reflected elsewhere in the offeror's proposal *except*, if an offeror determines that any guaranteed discount impacts its pricing strategy; such impact should be specifically identified and only be reflected in a revision to the appropriate Underwritten Health Care Fixed Fee(s) in Section B.

RFP amend. 13, AR 2, exh. 10, at 4. According to the protester, this language precluded the offerors from lowering their underwriting fees in submitting their respective FPR 3 proposals, and, thus, the agency improperly accepted HMHS's proposal which substantially reduced its underwriting fees from what it proposed in its FPR 1. (As with its assertion relating to the language concerning the proposed guaranteed network discounts, UMVS also asserts that this language created a latent ambiguity.)

We find no merit to this aspect of the protest. First, we agree that it is clear from the revised solicitation language that permitting the offerors to propose guaranteed network discounts could introduce an element of risk that was not present when proposals had been prepared in the absence of a guaranteed discount. Second, we also agree it is clear that, to the extent that offerors wanted to incorporate an

ameliorating offset to any increased risk assumed by proposing a guaranteed discount, they were to allocate that offset to their underwriting fees, rather than to any other element of their proposed price/cost.

Beyond these conclusions, however, we find no basis to read the language in the manner suggested by the protester. While it is true that the agency announced its position that it did not “intend to increase the offerors’ risk tolerance beyond that already assumed in their previous proposal,” RFP amend. 13, AR 2, exh. 10, at 4, there is absolutely nothing in the language that would preclude an offeror from assuming additional risk as part of its business strategy. We therefore deny this aspect of UMVS’s protest.

UMVS further asserts that HMHS dramatically reduced its underwriting fees in FPR 3 as compared to the fees proposed in FPR 1, and that this reduction introduced an element of performance risk not accounted for in the agency’s price evaluation. In this connection, the RFP required the agency to perform a price realism evaluation of the fixed price CLINs to assess performance risk. RFP § M.8.4.3. The record shows that, in its FPR 3, HMHS reduced its total proposed underwriting fee from its FPR 1 fee (HMHS’s FPR 1 proposed an underwriting fee for estimated health care costs of \$[deleted]), while its FPR 3 proposed an underwriting fee for estimated health care costs of \$[deleted], for a difference between the proposals of \$[deleted]). AR 2, exh. 9, at 11-12.¹⁴

According to the protester, it was unreasonable for the agency not to assign HMHS’s proposal a significant performance risk based on this reduction to HMHS’s underwriting fees because HMHS assumed significant risk on account of its proposed guaranteed network discounts. In this regard, UMVS asserts that HMHS failed to include an adequate financial cushion to account for what UMVS characterizes as the inevitable cost overruns that will occur should HMHS be unable to meet its proposed discount and have to pay the government to make good on its guarantee.

As discussed in detail above, we find that the agency reasonably concluded both that the guaranteed network discount proposed by HMHS was reasonable under the circumstances--principally because of the fact that the firm had a large, stable preexisting provider network under which it historically achieved larger discounts than it had proposed--and that it was reasonable for the firm [deleted] in calculating

¹⁴ UMVS focuses principally on HMHS’s underwriting fee for estimated health care costs, but offerors also proposed an underwriting fee that represented a percentage of estimated disease management costs. HMHS’s total underwriting fees for FPR 1 were \$[deleted], while its total underwriting fees for FPR 3 were \$[deleted], for a difference of \$[deleted]. AR 2, exh. 9, at 11.

its proposed discount. Thus, the underlying premise of this aspect of UMVS's protest, that HMHS inevitably will sustain losses on this contract because of the size of its proposed guaranteed discounts, was reasonably discounted by the agency.

Furthermore, the record shows that the agency carefully considered the reductions made by HMHS in its proposed underwriting fees from FPR 1 to FPR 3, accounted for that reduction in its evaluation of HMHS's proposed price, and ultimately assigned a slight performance risk to the HMHS proposal based on that reduction. This slight risk was weighed by the agency's evaluators and SSA, and ultimately they concluded that this slight risk was acceptable and did not outweigh the advantages associated with award to HMHS.

The agency's price/cost team (P/CT) analyzed HMHS's proposal in this area, noting that there were two principal drivers, or risks, that should have been considered by HMHS in establishing its underwriting fees--the risk associated with disallowed health care costs, and the risk associated with HMHS's ability to meet its proposed guaranteed network discount.

As to the risk regarding disallowed health care costs, the P/CT noted that HMHS had an average of [deleted] percent disallowed health care costs under its current contract, but that it had only included [deleted] percent of the estimated health care costs in its underwriting fee to cover this risk. However, HMHS represented in its proposal, and the agency independently verified, that, [deleted]. Thus, the agency concluded that the [deleted] percent figure included in its underwriting fee was reasonable in light of HMHS's proposal to [deleted], and the fact that, [deleted] disallowed health care costs. AR 2, exh. 9, at 20.

As for the risk associated with HMHS's ability to achieve its guaranteed network discount, the record shows that the P/CT concluded that the firm likely had included more than an adequate amount in its underwriting fee to cover this risk because the technical evaluators had concluded that it was highly likely that HMHS would achieve its proposed guaranteed network discount. AR 2, exh. 9, at 20.

Nonetheless, the P/CT was concerned with the amount of HMHS's underwriting fee as compared to the underwriting fees proposed by other offerors in both this competition, as well as the competitions for the other regions. The P/CT concluded that:

There is risk of contractor loss on the delivery of healthcare regardless of the proposed HCFF [underwriting fee]. However, with the separate award fee incentive pool in the contract, which is [deleted] of the option period 1-5 administrative line items, contractors can earn a positive award fee based on good performance in other areas which further mitigates a risk of loss on the contract. Considering [that] HMHS's HCFF, with and without the

network discount risk premium, is significantly lower than all other offerors, it appears HMHS is assuming a comparatively higher degree of risk of delivering health care at a net loss.

AR 2, exh. 9, at 20. This overall conclusion relating to the amount of HMHS's proposed underwriting fee as compared to the fees proposed by other offerors, coupled with another comparative performance risk identified by the P/CT (discussed below), led the P/CT to assign a slight performance risk to the HMHS proposal in their evaluation. Id. at 31. The SSEB Chairman likewise concurred in the assessment of a slight performance risk for the HMHS price proposal in light of the considerations outlined above, as did the SSAC. AR 2, exh. 5, at 13; AR 2, exh. 4 at 1-2.

In his source selection decision, the SSA acknowledged the risk posed by the adequacy of HMHS's proposed underwriting fee and concluded as follows:

Nonetheless, I recognize that there is slight risk associated with the amount of HMHS's Health Care Fixed Fee[,] however, I also note there are other sources of revenue available to the contractor, such as Award Fees, should the network provider discount guarantee not be achieved. I also note in the FPR 3 TET report that it is likely that HMHS will meet [its] proposed network provider discount guarantee and I agree with the SSEB Chair that this will mitigate the risk. I attribute the proposed low Health Care Fixed Fee offered by HMHS to [its] being very aggressive in a very competitive environment in an effort to keep the TRICARE South Region contract. HMHS has been the South Region contractor for seven years, has a mature provider network where they have been receiving network provider discounts which I believe will continue and they fully understand the risk they are accepting by proposing a low Health Care Fixed Fee. I do not believe that the lower prices as identified above will have an appreciable impact on the risks to the government or to HMHS's overall ability to perform the contract.

AR 2, exh. 3, at 10-11. Based on these considerations, coupled with the fact that its parent entity guaranteed HMHS's performance of the contract, see, AR 2, exh. 26, at 1617-18, the SSA concluded that the slight performance risk associated with the HMHS proposal was outweighed by its slightly superior technical proposal and lower price. AR 2, exh. 3, at 11.

As shown above, the record demonstrates that, as with its proposed network guarantee, HMHS provided a detailed explanation of the underlying basis for its proposed underwriting fee and the agency carefully evaluated the HMHS proposal. The agency recognized that there was a slight performance risk associated with HMHS's proposed underwriting fee, but nonetheless concluded that this slight risk

was mitigated by other contract revenue considerations (such as potential award fees), as well as HMHS's experience in performing the requirement, and its offer of a corporate guarantee. As with HMHS's proposed guaranteed network discount, the record shows that UMVS made a different business judgment in connection with the establishment of its underwriting fee. Nonetheless, as noted, the disagreement of one offeror with the business strategy proposed by another, in the face of a reasonable evaluation by the agency, and without an objective showing that the questioned strategy is inherently unreasonable, does not provide a basis for our Office to object to the agency's evaluation. CAE USA, Inc., supra. We therefore deny this aspect of UMVS's protest.

HMHS's Subcontractor

UMVS asserts that the agency failed to adequately evaluate the performance risk associated with the proposal of one of HMHS's subcontractors, Palmetto Government Benefits Administrator (PGBA), that was responsible for part of the proposed claims processing effort. First, the protester points out that PGBA made a reduction in its proposed staffing between FPR 1 and FPR 3 to perform [deleted] claims processing. According to the protester, this proposed reduction in staffing introduces a performance risk not adequately considered by the agency in its price evaluation. In this regard, UMVS principally challenges PGBA's claimed [deleted] as the underlying basis for its staffing reductions, maintaining that the data presented in its subcontract proposal is misleading. UMVS also maintains that any reduction in PGBA's proposed staffing to account for [deleted] ignores net increases in the number of claims over the course of the contract. Finally, UMVS compares its proposed staffing and HMHS's proposed staffing [deleted] claims processing area in an attempt to show that the proposed approach offered by PGBA involves significant performance risk.

The record shows that PGBA, the incumbent for these services, proposed a reduction in its full time equivalent (FTE) staff of approximately [deleted] percent between its FPR 1 and FPR 3 submissions. According to PGBA's subcontract proposal, the reduction was based on three factors, [deleted],¹⁵ [deleted]. AR 2, exh. 24, at 694-95. Additionally, PGBA included information in its subcontract proposal showing historical [deleted] during its performance of the predecessor contract, [deleted] that it projected would continue under the current requirement. Id. at 696.

We find no basis to object to the agency's evaluation in this respect. First, the record shows that the P/CT gave careful consideration to all three of these variables

¹⁵ Total claims includes both electronic and paper claims, and the record shows that, over the course of the contract, [deleted].

in evaluating the likelihood that PGBA could support its proposed reductions in staffing. To that end, it also obtained the assistance of the technical evaluation team (TET). With respect to the first factor [deleted], the P/CT, with the assistance of the TET, concluded that: “the changes that PGBA made between FPR 1 and FPR 3, including changes to claims volume, are reasonable assumptions in applying their recent experience to the updated FPR3 Government estimated claims volume.” AR 2, exh. 9, at 13. With respect to the second factor [deleted], the P/CT found:

PGBA’s second [deleted] refers to improvements that HMHS and PGBA have made on their [deleted] claims processed. PGBA states that the reduction in [deleted]. This assumption is supported in PGBA’s proposal and considered acceptable to the P/CT.

Id. Finally, with respect to the third variable [deleted], the P/CT found:

The P/CT requested assistance from the T-3 TET on the third [deleted] since the P/CT had uncertainties as to whether the proposed [deleted] and resulting [deleted] reduction in [deleted] FTEs could be achieved by PGBA without a performance risk. The T-3 TET performed an analysis of the percentage reduction in the [deleted] and concluded that PGBA’s reduction in direct labor hours from FPR1 to FPR3 is reasonable. (see Attachment 4 to this report). Although the TET concluded that the reduction in direct labor hours is reasonable, the P/CT still has some uncertainty as to whether PGBA can achieve its goal for [deleted] throughout the T-3 contract.

Id., at 13-14. The record thus shows that the underlying rationale offered by PGBA for its [deleted], and therefore lower staffing, was broadly accepted by the agency’s P/CT, but that they had some limited reservations with respect to decreases in the number of claims [deleted]. As a consequence, the P/CT assigned a slight performance risk to the HMHS proposal for this reason, as well as for the considerations relating to its proposed underwriting fees discussed above, and a second reason relating to the PGBA proposal discussed below.

Id. at 30-31.

UMVS’s protest disagrees with the rationale and assumptions offered by PGBA in support of its claimed ability [deleted], and, correspondingly, reduce its staffing. Instead, UMVS urges our Office to focus on the [deleted] claims contemplated under the RFP. UMVS points out that the RFP contemplates a net overall increase in claims over the life of the contract of approximately 18.5 percent. UMVS Comments, Apr. 28, 2011, at 60. The protester would have us conclude that PGBA’s reduction in its proposed staffing from FPR 1 to FPR 3 ignores this overall increase in claims.

However, the record shows that HMHS (and PGBA as its subcontractor) increased its proposed [deleted] claims staffing from option year 1 to option year 5 by

approximately [deleted], thereby accounting for the overall increase in claims. AR 2, exh. 9, at 26. In contrast, UMVS [deleted] over the life of the contract. Id. Thus, it would appear either that UMVS overstaffed the contract in the early years of performance, or failed to account for the net increase in claims over the life of the contract.

Finally, UMVS urges our Office to compare its proposed staffing for this element of the requirement with that of HMHS (and PGBA). However, such a comparison ignores the fact that HMHS's staffing is based on a comparatively minor reduction in PGBA's proposed staffing (approximately [deleted]percent) below the staffing used by PGBA to actually perform the requirement as the incumbent contractor. In contrast, UMVS's proposed staffing is based exclusively on its estimates and projections for the requirement, without the benefit of actual historical data to support those estimates and projections.

In sum, the record shows that the agency assigned a minor performance risk to the HMHS proposal related to its proposed reduction of [deleted] claims processing staff. Although UMVS makes various challenges to this evaluation conclusion, it has not demonstrated that it was unreasonable, but only that UMVS disagrees with the significance of the risk assigned. UMVS's disagreement, without more, does not provide an adequate basis for our Office to object to this aspect of the agency's evaluation. CIGNA Gov't Serv's., LLC, supra.

Finally, UMVS points to the fact that the PGBA subcontract proposal included a [deleted] of approximately \$[deleted], or approximately [deleted] percent of the total amount of the PGBA proposal. Since this [deleted] in the PGBA proposal, AR 2, exh. 9, at 30, UMVS asserts that PGBA intends to perform its portion of the contract [deleted]. According to the protester, the agency improperly failed to take this [deleted] into consideration in evaluating the performance risk associated with the PGBA subcontract proposal.

We find no merit to this aspect of UMVS's protest. The record shows that the agency's P/CT reviewed this aspect of the PGBA subcontract proposal and factored it into its overall assessment of performance risk for the HMHS proposal. The P/CT specifically noted that PGBA's proposal explained the considerations that went in to its proposed [deleted].

Nevertheless, in view of the lack of detailed supporting financial information regarding PGBA's [deleted], the P/CT concluded that it "had some uncertainty as to whether [deleted] could be achieved without a performance risk." AR 2, exh. 9, at 30. The P/CT further noted that, although PGBA was an experienced claims processing contractor with nearly 30 years of experience, and, thus, it understood the requirements of the contract, it nonetheless appeared that PGBA had been "aggressive" with its proposed price [deleted]. Id. These considerations, along with those relating to PGBA's proposed [deleted] claims processing staffing and HMHS's

reduction in its underwriting fees are what led, ultimately, to the overall assignment of a “slight” performance risk to the HMHS proposal. Id. at 31. The SSEB chairman, in his report, however, concluded that the risk associated with the PGBA proposal was mitigated because PGBA had been performing these services for an extended time, its past performance in this area had been exceptional, and PGBA [deleted]. AR 2, exh. 5, at 14.

Finally, the SSA, in making award to HMHS, specifically concluded that the PGBA proposal explained the underlying rationale for the [deleted], and that of HMHS and its parent company, to [deleted]. AR 2, exh. 3, at 8. The SSA further observed:

[deleted]

Id.

In sum, the record shows that PGBA’s [deleted] was thoroughly reviewed by the agency’s evaluators and found to pose only a slight performance risk when considered in conjunction with the other reservations highlighted by the P/CT (PGBA’s [deleted] claims processing staffing and HMHS’s reduction in its underwriting fees). The agency’s SSEB chair concluded that the risk was mitigated by the considerations outlined in his report. And, finally, the SSA also concluded that the risk was mitigated, and used, [deleted].

UMVS has not shown that the agency’s determination as to the risk posed by this aspect of the PGBA proposal was unreasonable, only that it would have assigned a different level of risk. This, without more, does not provide a basis for our Office to object to this aspect of the agency’s evaluation. We therefore deny this aspect of UMVS’s protest.

CONCLUSION

For the reasons discussed in detail above, we conclude that UMVS’s protest lacks merit. While we understand that UMVS disagrees both with the approach offered by HMHS in its proposal, as well as the agency’s evaluation of that approach, such disagreement does not provide a basis for our Office to object to the agency’s evaluation or resulting source selection decision.

The protest is denied.

Lynn H. Gibson
General Counsel