RFTOP Issuance Date: April 01, 2008
Deadline for Questions: April 14, 2008
08:00 A.M. Addis time
RFTOP Closing Date: May 6, 2008
08:00 A.M. Addis Ababa time

To: TASC3 - IQC CONTRACTORS

SUBJECT: Request for Task Order Proposal No. 663-P-08-014
Health Sector Financing Reform in Ethiopia

USAID/Ethiopia would like to acquire technical services to support the implementation of the Health Sector Financing Reform project in accordance with the attached Statement of Work.

This letter invites TASC3 IQC holders to submit a Task Order Proposal containing the following minimum information:

1. A Technical Proposal of no more than twenty (20) pages (page limit does not include resumes, graphs, and past performance information) for accomplishing the requirement described in the SOW. If an offer is pre-selected or selected, USAID reserves the right to ask for a more detailed proposal.
2. Resumes of proposed personnel and their specific duties and responsibilities.
3. A Certification that the proposed personnel were not initially suggested or requested by USAID
4. A Cost proposal that will provide:
   a. Name and Title; Fixed Daily Rate; Number of workdays and Total Estimated Cost for each individual who will perform directly under the task order,
   b. Detailed breakdown of Other Direct Costs, which are considered necessary for completion of work. Details should include the rationale/basis for the estimated costs.
   c. Current Negotiated Indirect Cost Rate Agreement (NICRA)

As notified in the pre-solicitation notice, USAID plans to award a contract with a total estimated cost of about **$15 millions** covering **a 5 years period**, subject to availability of funds.

Procedures specified in IQC section F.5.2.2.3 will be utilized to determine which contract to order against. Revealing the cost range for the contract does not mean that offerors should necessarily strive to meet the maximum amount; the offeror must propose costs that it believes are realistic and reasonable for the work. As detailed in Attachment 2 – Selection/Evaluation Criteria, the Cost proposal will be evaluated as part of a Best Value determination for contract award, including cost containment and effective approaches to achieve the results.

The Offerors should submit the proposal either:

i) electronically – proposal by email compatible with MS WORD and Excel to caddis@usaid.gov and request for acknowledgement without attachment to mcsow@usaid.gov and fasfawossen@usaid.gov. NOTE: Facsimile of the entire proposal is not authorized; or

ii) hand delivery (including commercial courier) of 3 paper copies of a technical proposal and one original and 2 copies of a cost proposal to the A&A Office, USAID, Riverside Building, Off Haile Gebereselasie/ Olympia Road, tel 251-11-5510088.

Regardless of the method used, the Technical Proposal and the Cost Proposal must be kept separate from each other. Technical Proposals must not make reference to pricing data in order that the technical evaluation may be made strictly on the basis of technical merit.

All offerors shall submit a proposal directly responsive to the terms and conditions of this RFTOP. If an offeror chooses to submit an alternative proposal, it shall also submit a proposal directly responsive to the RFTOP to be considered.

Offerors are advised that funds are not yet available for award at this time, and this letter in no way obligates the USAID to award a task order, nor does it commit USAID to pay for any costs incurred in the preparation and submission of a proposal in response hereto.

Any questions concerning this RFTOP should be submitted in writing via email to caddis@usaid.gov with a copy to Ms. Marie-Claire Sow at mcsow@usaid.gov and Mr. Fitih Asfawossen at fasfawossen@usaid.gov no later than April 14, 2008 08:00am Addis time. The responses and RFTOP Amendment if needed will be released by April 18, 2008 at the latest.

Please acknowledge receipt of this letter.

Yours sincerely,

Marie-Claire Sow
Senior A&A Specialist

Attachments: 1. Statement of Work
2. Evaluation Criteria

ATTACHMENT 1 - STATEMENT OF WORK

HEALTH SECTOR FINANCING REFORM PROGRAM IN ETHIOPIA

1. BACKGROUND

The Ethiopia's Third National Health Accounts, 2004/2005 indicated that the total per capita health expenditure from all sources, including the government, is only $7 compared to an average of $12 per person in the African region. Ethiopia spends only 20% of the $34 per person recommended by the World Health Organization to provide a minimum package of essential health services. Limited public resources are used to support costly tertiary care, which is only available to a small segment of the population; more affordable and cost-effective health care services remain under-funded. Health care professionals are underpaid and the participation of the private sector in the delivery of health services is low. These structural problems of the health system, coupled with high fertility and population growth, contribute to unacceptably high child and maternal mortality and morbidity with wide differences by region and by wealth (EDHS 2005). Neonatal mortality, infant mortality and under-five mortality stand at 39, 77, and 123 per 1,000, respectively (EDHS 2005). In Ethiopia, only 7% of women receive delivery assistance from a health professional (EDHS, 2005). Ethiopia has one of the world's highest rates of maternal deaths and disabilities (Save the Children/USA 2006). The maternal mortality ratio for the period 1998-2004 is estimated at 673 for every 100,000 live births (EDHS 2005). This means 19,000 Ethiopian women die of causes related to childbirth each year (EDHS 2005, PRB 2006). One of the major causes for these low coverage and poor health status is lack of financial resources.

Ethiopia's existing public health cost recovery and user fee policies were established in the early 1950s. Flawed in design and ineffectively implemented, the policies need to be revisited. Revenues collected at health facilities are rarely available for use by the facilities, instead going to the government's Regional Finance Bureaus and the Ministry of Finance and Economic Development. A waiver system, established to ensure services are available to economically vulnerable individuals and families, is not benefiting the poor, leaving many families without access to health care services. Health service utilization per capita per annum of 0.36 is extremely low by any standard. As mentioned above, though the fees are not retained in the facilities; it is a very long established tradition and practice that households/patients pay for health care in Ethiopia. Since there is not prepayment scheme/insurance, patients/ users are paying out-of-pocket at the time of sickness, which creates prohibitive and in some cases catastrophic situation for individuals and their families. Out-of-pocket spending accounts for 31% of the total spending in health in 2004/5.

In view of addressing the growing need of health services and ensuring sustainable health financing, the Ethiopian Ministry of Health has embarked on health sector financing reform (HSFR). The HSFR is one of the major components of the Ethiopian Health Sector Development Program. The HSFR promotes alternative options for financing, allocating, organizing, and managing health resources and services; it emphasizes cost sharing and an expanded role of the private sector and health insurance. USAID has worked with the Federal Ministry of Health in the development and implementation of the on-going HSFR activities. The reform activities resulted in major changes in health financing policy that are currently being implemented, particularly in the three regions (SNNPR, Oromia and Amhara). Regions differ in their progress with reform; for those regions that are at the implementation phase, USAID provides support to strengthen implementation capacity while expanding financing reform to new regions. The reform is building a health financing system that accommodates diverse financing and decentralized management mechanisms. The Reform Proclamation encourages local retention and utilization of user fees by the collecting facilities (hospitals and health centers) for use at those facilities to improve quality of health services. The retention of user fees by the collecting facilities will result in a net increase in

resources available to these health care facilities as the user fees are additive to the budget they receive from existing federal and regional block grants.

The reform package also:

- Ensures that people pay for health services according to their ability and protects the poorest from financial barriers to health care services;
- Provides greater authority and accountability to hospitals and health centers to manage service delivery through establishment of management boards;
- Creates opportunities for hospitals to outsource non-clinical services to the private sector for efficiency gains, etc

USAID proposes to continue supporting the Federal Ministry of Health and the Regional Health Bureaus in the strengthening and rollout of the Reform package. However, there are still tasks remaining to be done to further improve access and quality in health service delivery. While the current level of user fee is far below the actual cost of service delivery, its revision (after quality improvement) to better reflect cost of the service is inevitable. One consequence of raising user fees, even with improved quality of service, is that the sick will face higher financial barriers to obtaining the needed health service. Hence the need for complementary policy to spread individual financial risk over the general population is needed. This is to be addressed through the implementation of health insurance schemes. As stated earlier there is huge financing gap when comparing current level of expenditure on health and the amount required delivering essential health services and achieving the MDGs. Raising the total spending on health substantially requires using a mix of alternative and complementary financing mechanisms. The traditional health financing mechanisms such as public financing through the general tax system, mobilizing more resources from development partners and mobilizing from other alternative sources need to be strengthened and maintained. Introduction of health insurance will enable to mobilize additional resources to the health sector. More importantly, substantially pooling risks between the poor and the better off as well as the sick and healthy will enhance equity in health service delivery. In addition, as health insurance schemes remove or substantially reduce cash requirement at the point of getting services, members will be encouraged to seek service when it is needed. This will ultimately increase the demand for health care and utilization of the service.

Background on Ethiopia and USAID programs in Ethiopia is available at "Ethiopia" in USAID's Development Experience System (DEXS) at www.dec.org. Background on the Ethiopian health programs and information is available on www.dagethiopia.org and www.moh.gov.et .

2. PROGRAM OBJECTIVES

The purpose of this award is to implement the Health Sector Financing Reform (HSFR) and the health insurance programs at the national, regional, zonal/Woreda, and health facility levels. The program will begin on or about October 1, 2008 and end no later than September 30, 2013.

The Contractor will focus on the consolidation of the reform in those regions that started the implementation of the reform, expansion of the reform to all other regions, support the FMOH in the implementation of the health insurance and generate evidence to inform policy changes.

The implementation of the HSFR and the health insurance are key priorities for the Ethiopian Ministry of Health.

3. SCOPE OF WORK

The HSFR and the Health Insurance will build upon the existing health sector organizational management system, mainly the federal Planning and Program Department of the Ministry of Health, the regional

health bureaus, woreda health management institutions, hospital and health center management bodies as well as the new health insurance management institution.

The HSFR will support the regional health bureaus, woreda health offices and facilities in

- The local retention and utilization of resources
- The establishment and functioning of health center/hospital management boards
- The establishment and functioning of protection mechanisms for the poor
- The promotion of outsourcing of non-clinical services
- The promotion of private health providers

The HSFR will also support the FMOH in

- Establishing the social health insurance
- Piloting and evaluation of Community Based Health Insurance,
- Scaling up of the Community Based Health Insurance
- Establish the health insurance institution
- Create legal instruments for the health insurance.

USAID will also build the Woreda health planning, budgeting and financial management capacity in the context of the HSDP and Ethiopia's decentralization.

HSFR will make use of the already existing experiences and documentation and will draw upon lessons learned from these programs to build on successes and maintain the momentum of health reforms.

5. DETAILED TECHNICAL REQUIREMENTS, GOALS AND EXPECTED RESULTS

The HSFR will provide technical assistance to:

1) The Federal Ministry of Health,
2) Eleven regional Health Bureaus,
3) Woreda Health offices,
4) Health facility managing boards, and
5) Health insurance institutions in a phased manner.

The following are the goals and expected results of the program.

a) Goals

The below goals are interrelated and anticipated to complement each other:

- Enhanced quality and equity of essential health services in public health centers and hospitals.
- Expansion of HSFR policy frameworks, legal and operational guidelines
- Improved access to health insurance mechanisms.
- Systematic program learning to inform policy and program investment.

b) Expected Results

USAID's strategy to expand HSFR and health insurance will consolidate the achievements of the FMOH's reforms to improve the quality of health services. The following are the key expected outcomes:

- Health service utilization in target regions increased to 0.6 from its current level of 0.36
- Per capita health expenditure increased to 12 USD from its current level of 7.10 USD
- At least 20% of the Ethiopian population covered by health insurance at the end of the fifth year.

Proposals will explain how these program goals and expected results will be achieved through their strategies and implementation approaches. Proposals will also define related milestones and targets that will be achieved over the contract period.

There is a wealth of information and materials available through USAID partners and it is expected that the contractor will take full advantage of these resources during the implementation of this program. Where possible, proposals are also expected to link their activities including with but not limited to, the new FP-MNCH, PEFFAR/Ethiopia, the President's Malaria Initiative, and other USAID health activities in the target regions.

c) Targeted Beneficiaries and Geographic Areas

Building on prior USAID investments in health reforms, the HSFR program will continue consolidating the achievements of the reform in Oromia, SNNP and Amhara regions.
The support currently being provided in Tigray, Addis Ababa and Benshangul -Gumuz will also be strengthened and deepened. It is expected, that geographic scope and program coverage in the major regions will expand over the first two years of the project to cover the whole country. The
support to health insurance will be expanded based on the experiences gained in the implementation of social health insurance and the piloting of community based health insurance. The following table outlines a national time table

	Major Activities	SNNPR	Amhara Oromia, and Tigray	Addis Ababa and Benshangul	Dire Dawa And Harari	Pastoralist regions (Gambella,Afar and Somale)
1	Consolidation of the on – going HSFR	2009, 2010	2009,2010, 2011	2010, 2011	2010, 2011	2011, 2012
2	Legal Frameworks for HSFR	Completed	Completed	2009	2009	2010
3	Legal instruments for Health Insurance at FMOH level (National)	2009	2009	2009	2009	2009
4	Implementation of Social Health Insurance	2009	2009	2009	2009	2009
5	CBHI Pilot	2010	2010			
6	CBHI Expansion	2012	2012	2012		

Major Activities by Regions

Regions are expected to graduate from technical assistance. Criteria for graduation will need to be established in partnership with GFDRE, Regional Health Bureaus, USAID and other key stakeholders. The proposal is expected to develop graduation and exit strategies that ensure public ownership of the HSFR.

d) Tasks and Indicators

The tasks for each HSFR goal are outlined below:

(d1) Enhanced quality and equity of essential health services: Enhancing the quality and equity of essential health services requires key quality health delivery inputs and functioning protection mechanisms for the poor. In SNNPR, Amhara and Oromia hospitals and health centers are allowed to retain and use their revenue, as additive to the subsidy (budget) they get from the government regularly.

This is a break through in the Ethiopian health system. The Regional governments also clearly stated in their laws that the retained revenue is meant for quality improvement, and that health facilities are expected to utilize their revenue exclusively for improving quality. However, at the health centers, hospitals and district levels the experience in planning quality improvement, budgeting and financial management is very low. The new waiver system under the reform started to protect indigents requires follow-up and technical support at the Woreda and regional levels.

The HSFRP will work to strengthen the capacity of the health facilities, Woreda health offices and regional health bureaus for effective utilization of retained revenues for quality improvements. This includes strengthening capacity in financial management, planning and budgeting and decentralized decision making. This also requires institutionalization of financial management at the regional, and Woreda levels to provide supportive supervision to facility based health financial management. The contractor is expected to strengthen supportive supervision and appropriate M& E system to ensure transparency and accountability in health facility resource management.
The HSFR will support the effective targeting of the waiver beneficiaries (the poor) and waver management to enhance equity through minimization of leakages and under serving.

Applicants should propose activities and define related milestones and targets to achieve the goals and outcomes through staged interventions for wider coverage.

Indicators:

- Increase in health service utilization (national & regional).
- Increase in the share of non-salary operational budget in health facilities.
- Number of people benefiting from the waiver system.
- Number of health centers and hospitals with functioning management boards

Illustrative activities

- Training modules for Health Facility Management board developed
- Quality improvement inputs identified and implemented
- Training on planning and budgeting undertaken
- Supportive supervision for HSFR prepared
- Technical assistance in HSFR management provided

(d2) Expansion of HSFR Policy Frameworks, Legal and Operational Guidelines: As stated earlier, regions are at different levels in the implementation of HSFR. This task focuses on the expansion of the reforms to all regions and supports the FMOH in its effort to formulate a comprehensive reform package that introduces health insurance. Successful contractors are expected to formulate efficient approaches to ensure formulation and adoption of all necessary policy instruments in all regions. This will be done at federal and regional levels in close collaboration and leadership of the Federal Ministry of Health and Regional Health Bureaus. Introduction of the HSFR to new regions requires dialogue, consultation and active participation of different stakeholders and high level regional officials. Thus, there is a need to organize various consultative workshops and review meetings at district level, and similar forums need to be organized at regional and Federal levels. Through this intervention technical assistance will be provided to prepare directives and guidelines on health revenue retention, revenue utilization, on outsourcing of non-clinical activities, management of the waiver system and hospital and health center board administration as well as health insurance. It is to be noted that once regions have put in place the policy and legal frameworks they will graduate into the next stage of the reform.

Indicators:

- Number of policy documents revised/drafted
- Number of legal instruments developed

- Number of consultations organized to review policy and legal documents
- Number of people participating in consultations.

Illustrative Activities

- Consensus building workshops conducted
- Policy dialogue undertaken
- Training on HSFR provided
- TA on the health financing reform policies provided
- Policy and legal documents prepared and distributed.

(d3) Improved Access to Health Insurance Schemes in Ethiopia: The Ethiopian government is instituting health insurance to provide basic package of essential health service to all Ethiopians and to establish financial protection against catastrophic medical expenses in an equitable, efficient and sustainable manner. As the experience in health insurance is limited in the country, adequate capacity in designing, implementation and monitoring of health insurance is lacking. Hence, capacity building will be considered as essential area of intervention in the development of health insurance in Ethiopia. The capacity building activities may include (i) capable human resource, (ii) systems, procedures and operational tools, and (iii) directorial structures at all levels. Based on the Health Insurance Strategy and the implementation plan of the FMOH, the priorities of the Ministry of Health and in harmony with other components of the HSFR, the applicants are expected to come out with innovative and feasible strategies and activities that will help the FMOH achieve its goals. The approach is also required to promote the involvement of the private health service providers in the health insurance schemes. The approaches are expected to also consider global experiences to bring meaningful changes in the health delivery and increase access to modern health services and able to achieve the outputs outlined below.

Indicators:

- Increase in the number of people enrolled in the health insurance
- Increase in health services utilization
- Number of poor people protected with health insurance.

Illustrative Activities:

- Technical assistance in the design of Health Insurance provided
- Technical assistance in the designing of Piloting Community Based Health Insurance Provided
- Technical assistance in the implementation of CBHI piloting provided,
- Technical assistance in the evaluation of CBHI piloting provided,
- Technical assistance to CBHI scale-up of CBHI provided
- Training to the Managers and implementers of health insurance provided

(d4) Systematic Program Learning To Inform Policy and Program Investment: The HSFR is the Federal Ministry of Health led reform process to address the long-standing structural problems of the health financing system and introduce efficient and expanded alternative financing mechanisms. This task under this objective is anticipated to promote a culture of evidence based policy decision. It is designed to learn from its own experience and to share evidence-based information to inform policy and the reform process. The contractor, in collaboration with the FMOH and the RHBs is required to develop and refine key unresolved health financing problems and newly emerging implementation issues affecting the health delivery system. One of these issues is to gain a more complete understanding of the processes that motivate health workers and communities. Understanding behavioral and implementation barriers will enable the program to take action that addresses various health financing reform interventions and reshape programs. These could also be done through piloting and documenting and promotion of best practices. At the same time, institutionalizing best practices that can be brought to scale while making needed

refinements is key particularly in the area of health insurance and the waiver system. The contractor is expected to formulate practical and innovative activities and approaches that will generate technically defensible evidence useful for advocacy and will influence health financing policy and programming adjustment and expansion. The implementing partner will be mandated to collect, analyze and manage a knowledge base to determine what works, and identify best or promising practices. The program will build on existing GFDRE platforms, be flexible, innovative in approaches and sufficiently large with typical program conditions so that the evidence generated is accepted as relevant to larger program operations in a scaled up version. Coordination of this intervention with USAID bilateral programs is critical. The study includes but not limited to global and Ethiopian best practices and lessons learned in the areas of health care financing and health insurance.

Indicators:

- Number of policies or guidelines developed or changed to improve the health financing system.
- Number of new studies successfully conducted and accepted by the FMOH.
- Number of policies or guidelines developed or changed to improve the health financing system.
- Number of new studies successfully conducted and accepted by the FMOH.

Illustrative Activities

- Health systems assessment undertaken
- key study areas identified
- Technical assistance to conduct the study provided
- The Study Findings published and disseminated
- Policy Dialogue conducted

e. Key Outputs

The key outputs that the contractor is required to deliver by the end of the fifth year are:

- Legal framework, directives and guidelines prepared in all regions
- Health financing management units that promotes and manages HSFR established in all regions and woredas
- Percentage of health centers with functioning management committee reaching 100% through out the country.
- Percentage of hospitals with functioning management board reaching 100% throughout the country.
- Percentage of health centers that are retaining fees collected at their facilities reaching 100% through out the country.
- Percentage of hospitals that are retaining fees collected in their facilities reaching 100% through out the country.
- 80 % of the Woredas covered with established waiver system.
- Number of individuals trained in Community based health insurance schemes management at the woreda levels (targets to TBD).
- Number of Community based health insurance schemes supported (targets TBD)

f. Special considerations

The HSFR Program is leveraging funding from PEPFAR Ethiopia to support the Ethiopian Ministry of Health's efforts to strengthen the health system. Therefore, the successful contractor is expected to report on a quarterly basis on the following PEPFAR indicators as it seems appropriate.

- Number of local organizations provided with technical assistance for HIV/-related policy development

- Number of local organizations provided with technical assistance for HIV/AIDS related institutional capacity building
- Number of individuals trained in HIV/AIDS related policy development
- Number of individuals trained in HIV/AIDS-related institutional capacity.

ATTACHMENT 2 – EVALUATION/SELECTION CRITERIA – RFTOP

Potential Offerors should note that the criteria presented below serve to: (a) identify the significant matters which offerors should address in their proposals and (b) set the standard against which all proposals will be evaluated. The award may/will be made based on the ranking of proposals according to the selection criteria identified below. To make an objective evaluation possible, proposals must clearly demonstrate how the organization and the proposal meet these criteria.

NOTE: USAID encourages the participation of small business concerns and disadvantaged enterprises in this project. Accordingly, every reasonable effort will be made to identify and make use of such organizations. All evaluation criteria being found equal, the participation of such organizations may become a determining factor for selection.

Evaluation Process, Factors and Weighted Values

Technical, cost and other factors will be evaluated relative to each other, as described herein:

a) The technical proposal will be scored by a technical evaluation committee using the criteria shown in this Attachment.

b) The cost proposal will not be scored. The cost proposal of all offerors submitting a technically acceptable proposal will be opened and costs will be evaluated for general reasonableness, allowability, and allocability.

c) The criteria below are presented by major category, with relative order of importance, so that offerors will know which areas require emphasis in the preparation of proposals. The criteria below reflect the requirements of this particular solicitation. To facilitate the review, offerors should organize the narrative sections of their proposals in the same order as the selection criteria.

TECHNICAL VERSUS COST CONSIDERATIONS: For this RFTOP, technical considerations are more important than cost.

A Task Order may be awarded to the responsible offeror whose proposal, conforming to the solicitation, represents the best value, cost and other factors considered, and is the most advantageous to the Government. To the extent that they are necessary, if award is not made based on initial proposals, negotiations will be conducted with all offerors whose proposals have a reasonable chance of being selected for award. The competitive range of offerors with whom negotiation will be conducted (if necessary) will be determined by the Contracting Officer based on the below technical and cost evaluation factors. Only one offeror may be determined to be within the competitive range and discussions, if any, will be pursued with the selected offeror.

TECHNICAL EVALUATION CRITERIA: The following criteria will be used by the technical evaluation committee (TEC) to evaluate the proposals. The TEC members will assign values totaling 100 points to score the various components of the proposal as set forth below:

1. Technical Approach 40 points

- Extent to which the proposed program approach and strategies are well conceived and realistic to accomplish the objectives of the project. Does the application demonstrate a thorough understanding of the current Ethiopian health financing context and policy environment, constraints and advantages at the regional and federal levels (15 points)

- Does the application offer a program that is built on achievements to date to ensure the continuity of the reform, including policy changes and ensure the wider coverage both geographically and in technical areas (15 points)

- Does the application describe effective approaches to work with the Ministry of Health , the Regional Health Bureaus , woreda health Offices to strengthen their capacity to manage the health care financing reform in more sustainable way – including the involvement of private sector (10 points)

2. Personnel 40 points

- Does the application propose appropriate organizational and management structure that fits the Ethiopian decentralization structure and ensures national and regional links? (15 points)
- Does the application propose full time personnel with the professional qualifications, relevant experience needed to manage and achieve results? (15 points)

- Does the application propose appropriate, professionally qualified consultants and local expert at federal and regional levels with relevant experience with the Health Care Financing Reform in Ethiopia to support the implementation of the program? (10 points)

3. Institutional Capacity and Past Performance 20 points

- Demonstrated that the project management structure provides cost-effective approach (expatriate vs. local experts) to achieve the desired results of the program. (10 points)

- Demonstrated success in implementing and managing outputs and activities similar to those described in the scope of work, which have achieved significant results. (5 points)

- Provided evidence of an ability to develop and implement management procedures and systems: i) for control of all Contract resources and activities; and ii) to keep USAID/Ethiopia accurately and continuously informed of financial, administrative, personnel and technical issues. (5 points)

COST EVALUATION CRITERIA: Cost Effectiveness and Realism - Proposed costs will be analyzed for cost realism, reasonableness, completeness, and allowability. In its analysis USAID will assess if: the costs are realistic for the effort, if the proposed costs demonstrate that the offeror understands the RFTOP requirements, and if the costs are consistent with the technical proposal.