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Comptroller General
of the United States

Washington, D.C. 20548

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Decision

Matter of: QualMed, Inc.

File: B-254397.13; B-257184

Date: July 20, 1994

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DIGEST

1. Solicitation provisions requiring that healthcare utilization review be conducted in a particular way are reasonably related to the agency's need to protect beneficiaries' access to appropriate health care.

2. Although solicitations must provide sufficient information to enable offerors to compete intelligently and on an equal basis, they are not required to disclose the government cost estimate or the precise details of the proposal evaluation process.

DECISION

QualMed, Inc. protests the terms of two requests for proposals (RFP) issued by the Office of the Civilian Health and Medical Program of the Uniformed Services.[1] RFP No. MDA906-91-R-0002 covers managed health care services for CHAMPUS beneficiaries in California and Hawaii, while RFP No. MDA906-92-R-0005 covers the same services in Washington and Oregon.[2] CHAMPUS beneficiaries include military service retirees, their dependents, and dependents of active duty members. QualMed contends that the two solicitations (1) establish requirements that exceed the agency's minimum needs, (2) include unreasonable specifications, and (3) fail to adequately explain how the agency will evaluate proposals.[3]

We deny the protests.

We briefly describe here the relevant aspects of the solicitations as of the time QualMed filed the instant protests.[4] Offerors are required to propose three health care options, featuring increasingly managed health care accompanied by decreasing costs to the beneficiary. Specifically, the RFPs require offerors to propose a health care system under which CHAMPUS beneficiaries could opt to obtain services: (1) from providers of their own choosing on a fee-for-service basis (referred to as TRICARE

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[1] We refer to the program as CHAMPUS and the agency as OCHAMPUS.

[2] Although they cover two separate procurements, the solicitation provisions are essentially identical in the areas challenged.

[3] QualMed's protests initially raised a number of additional issues. Following telephone conferences conducted by our Office both before and after the agency filed its reports, QualMed withdrew those additional protest grounds, and we therefore do not discuss them here.

[4] The solicitations at issue in these protests reflect changes implemented by the agency following our Office's decision that an earlier award decision under the California/Hawaii solicitation was inconsistent with the RFP evaluation criteria. Foundation Health Fed. Servs., Inc.; QualMed, Inc., B-254397.4 et al., Dec. 20, 1993, 94-1 CPD ¶ 3. The relevant background and statutory framework are set forth in that decision, and are not repeated here.

Standard), (2) from members of the contractor's preferred provider organization (TRICARE Extra), or (3) from a contractor-established health maintenance organization (HMO) (TRICARE Prime).

The RFPs require the contractor to operate a comprehensive utilization management program to ensure that medically necessary care is provided in the most cost effective manner. Among the key aspects of the required utilization management program is utilization review, which is the review by the contractor of treating physicians' requests for care, an issue of particular importance in the case of such high-cost care as hospital admissions and the services of specialist physicians.[5]

The RFPs require the contractor to maintain two tiers of utilization review; the first-tier review is to be staffed by nurses or doctors, and may either approve the treating physician's determination or forward the matter to second-tier review, which must be performed by a doctor. Where the treating physician is a specialist, the second-tier reviewer must be a specialist in the same field. Reviewers are required to use sets of criteria published by InterQual, Inc., a private company, although those criteria sets need not be applied rigidly and reviewers are free to use professional judgment in their decisions. If both tiers of the contractor's reviewers conclude that the care requested by the treating physician is not appropriate, the care is denied, unless the treating physician or the beneficiary successfully appeals to certain independent bodies, under procedures set forth in the solicitations.

The RFPs state that the government intends to award a fixed-price contract subject to later price adjustment based on certain criteria. Two of the limits on the fixed-price nature of the contract are at issue in these protests. One is a solicitation provision stating that the price paid to the contractor will be reduced as the number of "nonavailability statements" (NAS) per capita for inpatient services declines. An NAS is issued by a military treatment facility (MTF), where the MTF is unable to timely provide health care services needed by a beneficiary; the NAS permits the beneficiary to go to a civilian health care provider. The agency's rationale for reducing the contract price as the number of NASs per capita drops is that, because an NAS represents an instance of the contractor

[5]As discussed in a recent report by our Office, this sort of external utilization review is nearly universal in managed care arrangements. See Managed Health Care: Effect on Employers' Costs Difficult to Measure, GAO/HRD-94-3, October 1993.

having to pay a civilian provider for services, a decline in NASs can be expected to translate into lower costs for the contractor, since care will either be provided by the MTF or not at all (that is, a beneficiary, or his or her doctor, may decide the treatment initially requested is not necessary).

The second modification to the fixed-price nature of the contract that is relevant to this protest is the risk-sharing arrangement, a key characteristic of these solicitations. Under that arrangement, in the event of health care cost overruns, the government will at some point absorb part of the excess cost. Once the contractor has absorbed overruns equaling the amount of equity that the company put at risk in its proposal (and certain other conditions, not relevant here, are met), the contract will begin to function as a cost-reimbursement contract, with the government paying for all additional health care costs. An offeror's putting more equity at risk thus postpones the time at which the contract would convert to a cost-reimbursement arrangement.

We first address QualMed's contention that the RFPs exceed the government's needs by imposing OCHAMPUS's particular approach to utilization management. QualMed alleges that this approach will force the contractor to incur unnecessary costs (costs which QualMed suggests will be passed on to the government through higher proposed prices) and will prevent the contractor from effectively managing health care.

Specifically, the protester points out that, while two-tier review is common, some utilization review organizations, including QualMed, use a single-tier review structure, with physicians performing the review. The RFPs require any offeror that normally uses one-tier review to add an extra level of review, thus increasing costs. In addition, QualMed argues that, under the RFP scheme, treating physicians' requests that services be provided are shielded from meaningful review, and the RFPs thus skew the review process in favor of approving those services. The first tier is expected to approve a request if it is consistent with the InterQual review criteria; in any event, the first tier is not allowed to deny the request but may, at most, forward the request for second-tier review; and the second-tier reviewer must practice in the same specialty as the treating physician, where similarity in approach will allegedly increase the likelihood that the request will be approved. Overall, QualMed is in essence arguing that, while the RFP recognizes that utilization management involves both ensuring access to medically appropriate care and containing costs, OCHAMPUS is so zealously protecting beneficiaries' access to the care their treating physician

recommends that it has effectively abandoned the goal of cost containment.

The governing statutes and regulations allow contracting agencies broad discretion in determining their minimum needs and the appropriate method for accommodating them. See 10 U.S.C. § 2305(a)(1) (1988); Federal Acquisition Regulation (FAR) §§ 6.101(b), 7.103(b). However, because full and open competition is generally required, agencies may include provisions restricting competition in solicitations only to the extent necessary to satisfy the legitimate needs of the agency. 10 U.S.C. § 2305(a)(1)(B)(ii). See National Customer Eng'g, 72 Comp. Gen. 132 (1993), 93-1 CPD ¶ 225. Where a protester challenges a solicitation's provisions as unduly restrictive of competition, our Office will review the record to determine whether the provisions are reasonably related to the agency's legitimate minimum needs. Tek Contracting, Inc., B-245454, Jan. 6, 1992, 92-1 CPD ¶ 28.

OCHAMPUS contends that, in requiring a two-tiered review process and mandating the use of InterQual criteria and same specialty second-tier reviewers, the RFP reflects the agency's need to ensure that CHAMPUS beneficiaries are not denied appropriate medical care. The agency does not deny that QualMed as well as other companies routinely use a one-tiered structure for utilization review and that such a structure may be adequate for other users; nor does it deny that forcing such companies to establish a two-tiered system for OCHAMPUS may result in increased staffing and administrative costs. OCHAMPUS also does not dispute that its insisting on a second tier of review, reliance on InterQual review criteria, and use of same-specialty reviewers may decrease the number of instances in which treating physicians' requests for care are ultimately denied. The RFP requirements may thus affect the ability of the contractor to contain health care costs.

While the fixed-price structure and other provisions of the RFPs demonstrate the agency's commitment to reduce costs, the challenged requirements in the solicitations do indicate that OCHAMPUS may have elected, in the area of utilization review, to sacrifice some potential cost savings in order to avoid inappropriate denials of health care. QualMed views this choice as an unwise policy decision that will increase health care costs without ensuring better health care for OCHAMPUS beneficiaries. Our Office's role in considering protests of solicitation provisions, however, is not to review contracting agencies' policy choices, but solely to determine whether the challenged provisions, which may result from those choices, restrict competition and, if so, whether the specifications are reasonably related to a legitimate need of the agency.

Here, QualMed has not established that the specifications at issue restrict competition. QualMed argues, at most, that those specifications force companies to incur unnecessary administrative costs which erode their ability to limit health care costs. QualMed concedes, however, that it was able to, and did, submit proposals that it believes fully comply with the solicitation provisions that it challenges. The restrictions thus did not preclude QualMed from competing, and any impact on QualMed's competitive position appears marginal and, in any event, speculative.

Indeed, QualMed scarcely mentioned the question of prejudice to itself in its submissions to our Office; instead, it focused primarily on the company's views about government health care policy. For example, while QualMed argued that reliance on InterQual review criteria is unwise, it did not explain how the company's chances of winning this competition could be adversely affected by the agency's insistence on the use of those criteria.[6] Similarly, it is not clear how QualMed believes that the company would suffer any disadvantage as a result of the RFP requirement that second-tier reviewers practice the same specialty as the attending physician.

Even if the cumulative impact of the challenged RFP provisions were considered to restrict competition, those provisions are still proper if they are reasonably related to a legitimate agency requirement. We find that they are.

There is no dispute that OCHAMPUS has a legitimate need to protect beneficiaries' access to appropriate medical care. Rather, the dispute concerns whether the constraints that OCHAMPUS has placed on the contractor's ability to manage utilization of health care services are arbitrary, or whether they are reasonably related to the need to ensure the access of CHAMPUS beneficiaries to necessary health care. Put another way, the dispute concerns the risks and benefits of having an outside contractor reviewing the treating physician's judgment about the appropriate treatment for a CHAMPUS beneficiary.

[6]We should note that OCHAMPUS initially appeared to be treating the InterQual criteria as definitive, thus supplanting the professional judgment of reviewers, and QualMed's protest focused on this aspect. Subsequently, however, the agency changed its position and agreed that the InterQual criteria were to serve as guidelines, which could be supplemented by the reviewers' medical judgment. QualMed did not withdraw this protest ground, however, and appears to contend that the RFP should not mandate any use of InterQual criteria.

Utilization review is a sensitive and controversial area: advocates argue that it can lead to substantial cost savings, while critics respond that utilization review interferes with treating physicians' clinical decision-making and may impede patients' access to care. "Managed Health Care: Effect on Employers' Costs Difficult to Measure", supra. Moreover, it is not clear that utilization review necessarily leads to large savings, particularly in light of the higher administrative costs required to implement that review. Id. In light of the sensitiveness of this area, we find reasonable the agency's concern that its contractor may so aggressively review and manage utilization as to unduly restrict beneficiaries' access to health care. The challenged RFP restrictions are thus reasonably related to the agency's need to protect beneficiaries' access to appropriate health care.

Specifically, the requirement that a two-tiered review structure be used is reasonably related to that need. While QualMed correctly points out that some utilization review organizations rely on a single-tier review structure, the fact is that most do not. "Utilization Review: Information on External Review Organizations", GAO/HRD-93-22FS, November 1992. In any event, it is not unreasonable for the agency to prohibit the contractor from denying the care recommended by the attending physician unless two tiers of reviewers agree that the care is inappropriate. While QualMed may feel that this approach demonstrates excessive caution, the decision about how much caution is appropriate in utilization review is properly left to the agency's discretion.

With respect to the requirement that second-tier reviewers practice in the same specialty field as the attending physician, QualMed is not alone in its concern that same-field specialists may approve care more readily than generalists or related-field practitioners, whether out of similarity of approach or other reasons. Nevertheless, it is not unreasonable for the agency to decline to permit a doctor outside the specialty field to deny care that a specialist has determined is appropriate. In this regard, we note that accepted practice appears to be use of same-specialty practitioners to perform review, particularly in higher levels of review or appeal, based on the expectation that a specialist in the same field as the attending physician will be knowledgeable in the area of expertise at issue and thus will be able to provide an informed opinion about the appropriateness of the recommended care. Id. We therefore conclude that the requirement for same-specialty review is reasonably related to the agency's legitimate needs.

Concerning the requirement that InterQual criteria sets be used in the review process, OCHAMPUS argues that it has a legitimate need to have a uniform set of criteria used throughout the country. Although there will be differences in care recommended by attending physicians and approved (or denied) by reviewers due to the differing judgments of individual practitioners, it is reasonable for the agency to require that all reviewing personnel initially turn to the same guidelines. Doing so may be expected to facilitate the supervision of the contractor, the handling of appeals of denials (which, as explained above, are adjudicated by personnel independent of the CHAMPUS contractor), and the defense of decisions challenged by dissatisfied beneficiaries.

Among criteria sets, the choice of InterQual appears reasonable. While some review organizations have developed their own criteria for making utilization review decisions, commercially available criteria sets are widely relied upon, and InterQual appears to be among the most widely used of those commercial products. Id. We therefore conclude that mandating reliance on one criteria set is reasonably related to the agency's need for uniformity nationwide and that, among such sets, the choice of InterQual is reasonable.

We next turn to the question of nonavailability statements and the RFP methodology for reducing the contract price as the number of NASs issued per capita for inpatient services declines. As explained above, NASs are issued when care is needed that an MTF is unable to provide either because it does not offer that care at all or because, while it generally offers the care, its work load does not allow it to provide the care to the beneficiary at the time needed. QualMed alleges that the bulk of the reduction in the number of NASs will be due to the contractor's utilization management efforts, and that it is "perverse" for OCHAMPUS to punish the contractor for such efforts by reducing its compensation.

The protester and agency agree that, at least in theory, reduction in the number of NASs issued could be due to the efforts of either the contractor or the MTFs. The parties also agree that, in the past, MTFs have performed little utilization management and that reducing the contract price due to a decline in NASs assumes that MTFs will now be responsible for progress in this area. OCHAMPUS defends its expectation of a change in MTF practice by explaining that it has shifted from a system under which MTF budgets were tied to work load (thus removing budgetary constraints on the amount of care provided) to a system of capitation under which the MTF must live within a fixed budget (thus creating an incentive for effective utilization management). The agency also notes that MTFs provide approximately two-thirds

of the care to CHAMPUS beneficiaries, and that the MTFs, not the contractor, are in the best position to implement utilization management for that care.

QualMed does not advocate simply increasing the compensation to the contractor for each decrease in the number of NASs. Instead, the protester argues that OCHAMPUS should establish a mechanism to keep track of each NAS that is avoided and decide, as to each "avoidance," whether the contractor or the MTF should receive credit for it; the contract price will be adjusted accordingly (upwards, if the contractor deserves credit; downwards, if the MTF's efforts led to the reduction). When pressed by the agency to explain how this mechanism would work, QualMed stated that "an independent professional (e.g., a major accounting firm) could decide (this would be a binding, nonchallengeable determination) how much of the reduction should be credited to the MTF and the awardee."

Based on our review of the record, we conclude that reducing the contract price where the number of NASs drops is reasonable, since NASs can be expected to translate into contractor costs for health care provided by civilian providers, and fewer NASs should thus mean lower costs for the contractor. Irrespective of who was responsible for the decrease in the number of NASs, the decrease should result in lower costs to the contractor. The resulting reduction in the contract price will thus not reduce the contractor's net income and will, at most, pass through to the government savings that may be attributable to the contractor's efforts. Although QualMed argues that reducing the contract price due to a reduction in the number of NASs will "punish" a contractor for effective utilization management, the protester has not shown that the provision will, in fact, penalize the contractor in any way.

What we are left with, again, is QualMed's disagreement with the agency's approach to utilization management. Based on Department of Defense policy decisions designed to encourage MTFs to engage in more aggressive utilization management, OCHAMPUS chose a particular mechanism to link the number of NASs to the contract price adjustment process. QualMed's skepticism about future MTF utilization management is speculative and cannot serve as the basis for finding the challenged RFP provision unreasonable. Moreover, the alternative mechanism that QualMed advocates--having an outside accounting firm review reductions in NASs to decide who should receive credit for them--risks making the process yet more complicated, without necessarily reaching a more

equitable result or satisfying any party.[7] We conclude that the challenged NAS provision in the RFPs is not improper.

Finally, we turn to QualMed's contention that the RFP fails to adequately explain how the agency will evaluate proposals. In particular, the protester alleges that the RFP does not identify the relative importance, for purposes of proposal evaluation, of the amount of equity that offerors agree to put at risk, and does not disclose the independent government cost estimate (IGCE) for health care costs, detail the way in which the IGCE was calculated, or explain when the agency evaluators will base their evaluated cost for a proposal on the offeror's estimate of expected health care costs rather than the IGCE.

A solicitation must clearly advise offerors of the broad scheme of scoring to be employed and give reasonably definite information concerning the relative importance of the various evaluation factors. This does not mean, however, that a solicitation must disclose the precise numerical weights that will be used in the evaluation. A.J. Fowler Corp.; Reliable Trash Serv., Inc., B-233326; B-233326.2, Feb. 16, 1989, 89-1 CPD ¶ 166. Rather, the solicitation must contain sufficient information to enable offerors to compete intelligently and on an equal basis. University Research Corp., 64 Comp. Gen. 273 (1985), 85-1 CPD ¶ 210.

In our view, the RFP language provides offerors with sufficient information relating to the evaluation factors, the relative importance of those factors, and the evaluation methodology. The agency concedes that the RFPs do not precisely identify the weight that will be assigned to an offeror's proposed amount of equity at risk, and that the importance of equity at risk will vary, depending on the agency's determination of the proposal's cost realism.[8] Whatever the uncertainty about the precise weight to be assigned, however, we find that, in the context of these

[7]For example, QualMed does not explain why, under the scheme it advocates, the contractor will be precluded from challenging the independent professional's determination about how much of the credit for reducing NASs should go to the contractor.

[8]That is, where the agency judges a proposal to be realistic as to anticipated health care costs, the amount of equity that the offeror proposes to put at risk may play a minor role in proposal evaluation; while the amount of equity put at risk may be significantly more important where the agency has concern about the proposal's cost realism.

procurements, the solicitations provide adequate guidance about the evaluation of equity at risk to allow offerors to prepare proposals intelligently.

As for the IGCE and its use in the evaluation of proposals, we note initially that there is no obligation that an agency make public its estimate of expected costs, or explain precisely how it was calculated, and that such information is generally not disclosed in solicitations. These RFPs do detail the cost factors that form the components of the IGCE and explain that the IGCE will be constructed based on the government's estimate of those cost factors, including the ones over which the contractor is likely to have control as well as those over which the contractor is likely to have little or no control. The RFPs also commit the government to evaluating the realism of each proposal's cost estimates for factors under the contractor's control, based on a comparison with the government estimate for those factors and the government's judgment about "the likely trends under the offeror's approach." That is, the government will not simply substitute its IGCE figure for cost factors for the offeror's; instead, the government will judge the realism of each proposal's estimates for the various controllable cost factors based on the technical approach set forth in the proposal.[9] In the context of these solicitations and their description of the evaluation factors and subfactors, this guidance should enable offerors to compete intelligently and on an equal basis.

The protests are denied.

/s/ Ronald Berger
for Robert P. Murphy
Acting General Counsel

[9]One of the grounds for our sustaining the earlier protests in the California/Hawaii procurement was the agency's unexplained rejection of offerors' estimates for all cost factors, and their replacement by the government's estimates in the calculation of expected overall health care costs; this represented an unsupported assumption that total health care costs would be identical for every offeror. Foundation Health Fed. Servs., Inc.; QualMed, Inc., supra.