
August 1995**DEFENSE HEALTH
CARE****Despite TRICARE
Procurement
Improvements,
Problems Remain**

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United States
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Health, Education, and
Human Services Division

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Chairman
The Honorable Ronald V. Dellums
Ranking Minority Member
Committee on National Security
House of Representatives

The Honorable Hank Brown
The Honorable Ben Nighthorse Campbell
United States Senate

The Honorable Scott McInnis
The Honorable Patricia Schroeder
House of Representatives

As federal and state medical programs move to managed care, competitively bid contracting with private health care companies is increasingly being used. Under the Medicaid program, states are using such contracts as part of their overall strategy to control rapidly escalating medical costs. In the federal sector, the Department of Defense (DOD) has been a leader in using these contracts. As part of its implementation of a nationwide managed health care program for military beneficiaries called TRICARE,¹ DOD has begun to award large, complex, competitively bid contracts to supplement and support the health care provided in military medical facilities. These 5-year contracts are estimated to cost a total of about \$17 billion.

In response to concerns about DOD's difficulties with an early contract award covering California and Hawaii for which GAO² sustained³ a protest of the award, you asked that we review (1) procurement process problems identified by the bid protest experiences, (2) DOD's actions to improve and help ensure the fairness of the procurement process, and (3) what problems and concerns remain and whether further actions are needed.

¹Defense Health Care: Issues and Challenges Confronting Military Medicine (GAO/HEHS-95-104, Mar. 22, 1995).

²Under the Competition in Contracting Act of 1984 (31 U.S.C. 3551-56 (1988)), GAO is required to consider bid protests and determine whether a challenged federal government solicitation, contract award, or proposed award complies with applicable statutes and regulations.

³Foundation Health Federal Services, Inc.; QualMed, Inc., B-254397.4 et al., Dec. 20, 1993, 94-1 CPD ¶ 3.

In doing our work, we examined pertinent procurement regulations and the agency files for several DOD procurements. We also had many discussions with officials responsible for (1) developing solicitation requirements; (2) conducting the procurements; (3) evaluating offerors' proposals; and (4) ensuring that the procurements are conducted in a legal, fair, and equitable manner. In addition, we contacted health care companies and regional military officials that had participated in recent procurements for information on their experiences with these procurements as well as their views of the procurements. For a more complete discussion of our scope and methodology, see appendix I.

Results in Brief

In sustaining the protest of DOD's California/Hawaii contract award, GAO cited several problems, including DOD's failure to evaluate offerors' proposed prices according to solicitation criteria, lack of communication between DOD evaluators performing technical and price evaluations, and failure to properly evaluate offerors' cost containment approaches such as their proposed methods for controlling health care service use. In response, DOD changed its managed care procurement processes in several ways to correct these and other problems. For example, DOD has revised its methodology for evaluating proposed prices, added new requirements for discussions between boards evaluating the technical and price proposals, revised its utilization management requirements and evaluation criteria, and made other changes.

In our view, DOD's changes should improve future procurements and ensure more equitable and fair treatment of offerors. They are unlikely, however, to eliminate future protests. On two subsequent protests, one challenging the revised solicitation terms and another contesting the contract award following the California/Hawaii protest, GAO ruled in DOD's favor. Protests are likely to continue, however, given the vast sums of money at stake and the relatively small added expense involved in lodging them.

Despite these improvements, several matters remain that concern both those administering and those responding to the procurements. For example, the procurements thus far have taken more than twice as long as originally planned. Unless DOD can avoid delays such as those due to numerous changes in solicitation requirements, it may not meet the congressional deadline for awarding all contracts by September 30, 1996. Also, because the procurements are broad, complex, involve huge sums, and have been lengthy, unsuccessful offerors incur substantial expense to

participate, which may sharply narrow future competition to only a few providers. But DOD could consider alternative award approaches for the next round of procurements.⁴

Also, offerors maintain that solicitation requirements are so prescriptive that offerors cannot fully propose innovative and cost-saving managed care techniques or the best practices now available in the private sector. DOD, while seeking system uniformity so that similar benefits are provided no matter where beneficiaries live, acknowledges offerors' concerns and has expressed interest in making requirements less process and more outcome based.

Further, DOD has tried to make up for procurement delays by reducing its 8-month transition period after contract award for contractors to prepare to deliver health care. By doing so, however, DOD has introduced significant risk that contractors will not complete all the tasks needed to deliver health care on time.

Finally, evaluation board members are now selected without DOD having set forth their needed qualifications. Because the tasks they evaluate are so specialized and because the boards have grown in number and members are less familiar to selecting officials, DOD needs to better ensure that prospective evaluators are appropriately qualified.

Background

Since the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) began in 1956 and was expanded in 1966,⁵ it functioned much like a fee-for-service insurance program. Beneficiaries⁶ have been free to select providers and required to pay deductibles and copayments, but, unlike with most insurance programs, they have not been required to pay premiums. CHAMPUS has approximately 5.7 million beneficiaries and, as part of a larger Military Health Services System (MHSS), these beneficiaries are also eligible for care in the MHSS' 127 hospitals and 500 clinics worldwide. Of the approximately \$15.2 billion budgeted for the MHSS in

⁴The current round of procurements consists of seven contracts covering the 12 TRICARE regions. The next round will begin after the first 5-year managed care support contract expires in February 2000.

⁵CHAMPUS was established initially by the Dependents' Medical Care Act of 1956 (P.L. 84-569) and expanded by the Military Medical Benefits Amendments of 1966 (P.L. 89-614).

⁶Beneficiaries eligible for CHAMPUS include dependents of active-duty members, retirees and their dependents, and dependents of deceased members. They include those from the Army, Navy, Air Force, Marines, Coast Guard, and the Commissioned Corps of the Public Health Service and of the National Oceanic and Atmospheric Administration.

fiscal year 1995, the CHAMPUS share is about \$3.6 billion or about 24 percent.

Because of escalating costs, claims paperwork demands, and general beneficiary dissatisfaction, DOD initiated, with congressional authority, a series of demonstration projects in the late 1980s designed to more effectively contain costs and improve services to beneficiaries. One of these projects, the CHAMPUS Reform Initiative (CRI), a forerunner of TRICARE managed care support contracts, was one of the first to introduce managed care features to CHAMPUS. Included as part of a triple-option health benefit were a health maintenance organization choice, a preferred provider choice, and the existing standard CHAMPUS choice. Managed care features introduced included enrollment, utilization management,⁷ assistance in referral to the most cost-effective providers, and reduced paperwork.

The first CRI contract, awarded to Foundation Health Corporation,⁸ covered California and Hawaii. Foundation delivered services under this contract between August 1988 and January 1994. Before the contract expired, DOD began a new competitively bid procurement for California and Hawaii that resulted in DOD's awarding a 5-1/2 year (1 half-year plus 5 option years), \$3.5 billion contract to Aetna Government Health Plans, Inc. in July 1993. Because a bid protest was sustained on this procurement, it was recompeted, although Aetna's contract was allowed to proceed until a new one was awarded.

In late 1993, in response to requirements in DOD's Appropriation Act for Fiscal Year 1994, the Department announced plans for restructuring the entire MHSS program, including CHAMPUS. The restructured program, known as TRICARE, is to be completely implemented by May 1997. To implement and administer TRICARE, DOD reorganized the military delivery system into 12 new, joint-Service regions. DOD also created a new administrative organization featuring lead agents in each region to coordinate among the three Services and monitor health care delivery.

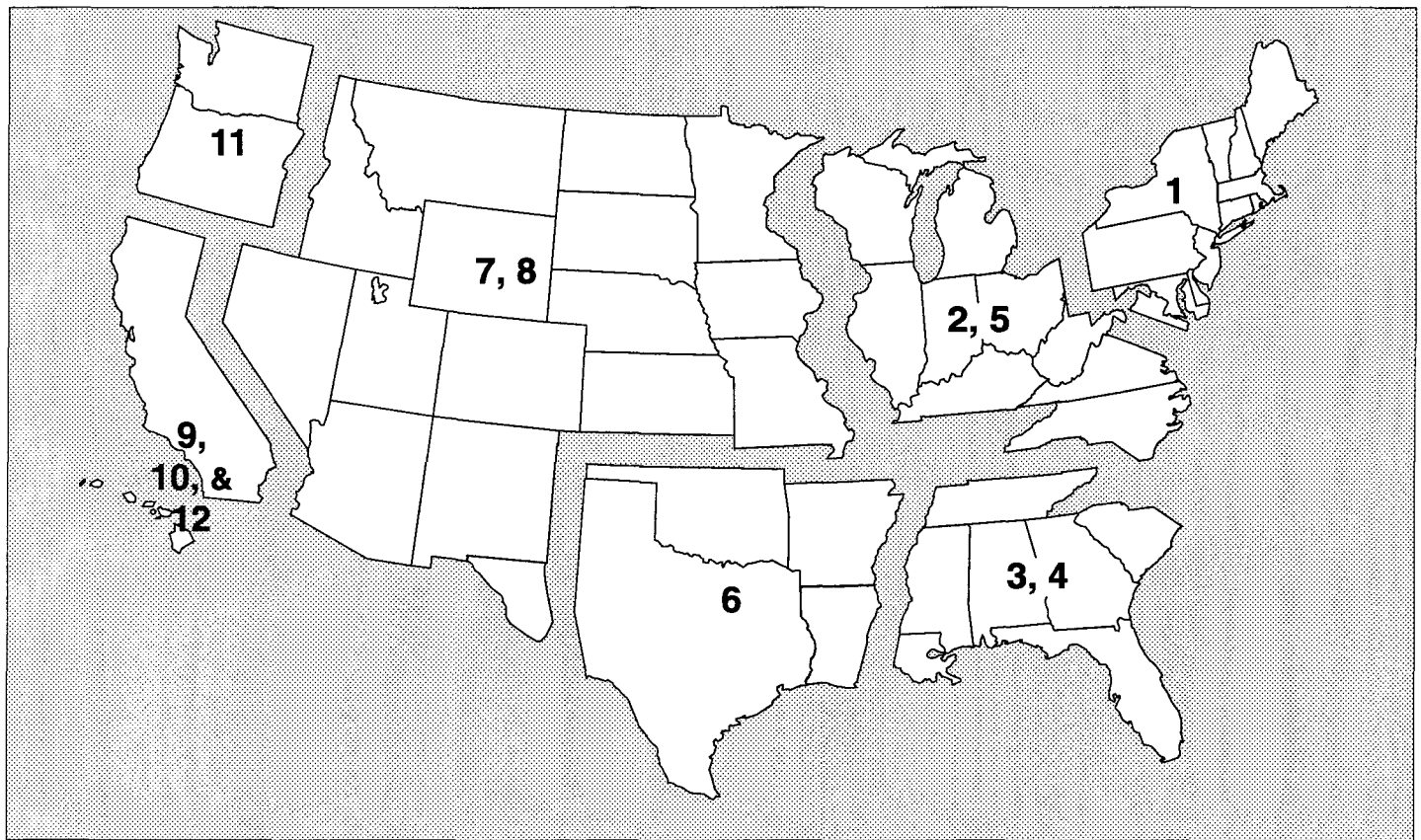
For medical care the military medical facilities cannot provide, seven managed care support contracts will be awarded to civilian health care

⁷Utilization management involves the use of such techniques as preadmission hospital certification, concurrent and retrospective reviews, and case management to determine the appropriateness, timeliness, and medical necessity of an individual's care.

⁸Foundation later created a subsidiary to administer this contract called Foundation Health Federal Services, Inc.

companies covering DOD's 12 health care regions. These contracts, much like the former CRI contracts, retain the fixed-price, at-risk,⁹ and triple-option health benefit that CRI featured. An important difference, however, is the addition of lead agent requirements—tasks to be performed by the contractor specific to military medical facilities in the region. Figure 1 shows the regions covered by the seven contracts.

Figure 1: Managed Care Support Contract Regions



Note: Managed care support for Alaska will be addressed separately from these regions.

⁹At-risk features of the contract provide for the sharing of gains and losses between the contractor and the government. For example, contractors are at risk for health care cost overruns up to 1 percent of health care prices. Beyond that, the contractor and the government share in losses until an amount prepledged by the contractor, called contractor equity, is totally depleted, at which time the government assumes full responsibility for further losses.

Since the December 1993 decision sustaining the protest of the California/Hawaii (regions 9, 10, and 12) contract award, three managed care support contracts have been awarded and all have been protested. Also, a protest was filed on the solicitations for the California/Hawaii recompetition and that for Washington/Oregon (region 11).¹⁰ GAO has denied the protests on these solicitations and the Washington/Oregon contract award¹¹ and has yet to decide on the other two award protests. Information on the procurements awarded to date appears in table 1.

Table 1: Managed Care Support Contracts Awarded Since 1993

Region	Date of contract award	Awardee	Amount of award	Number of final offerors	Protest status
11	9/94	Foundation Health Federal Services, Inc.	\$650 million	3	Denied
9, 10, and 12	3/95	QualMed, Inc. ^a	\$2.5 billion	4	Pending
6	4/95	Foundation Health Federal Services, Inc.	\$1.8 billion	5	Pending

^aThe recompeted contract award stemming from the successful protest of the first California/Hawaii contract award.

For more information on the transition to managed care support contracts and the offerors submitting proposals for these contracts, see appendixes II and III, respectively.

The Office of CHAMPUS, an organization within the Office of the Assistant Secretary of Defense (Health Affairs), administers the procurements. The procurement process involves the issuance of a request for proposal (RFP) that has the detailed specifications and instructions offerors are to follow in responding. Offerors are required to submit both a technical and a business (price) proposal.

Upon receipt of the offerors' proposals, a Source Selection Evaluation Board (SSEB) evaluates the technical proposals according to detailed

¹⁰QualMed, Inc., B-254397.13; B-257184, July 20, 1994, 94-2 CPD ¶33.

¹¹QualMed, Inc., B-257184.2, Jan. 27, 1995, 95-1 CPD ¶94.

evaluation criteria, and a Business Proposal Evaluation Team (BPET) evaluates the proposed prices. A Source Selection Advisory Council (SSAC) reviews the work of the two boards and consults with them. Following discussions with offerors about weaknesses and deficiencies in their proposals, DOD requests offerors to submit "best and final offers." The two boards again evaluate changes to proposals, complete final scoring, and prepare reports on the evaluations. A senior executive designated as the source selection authority uses these reports in selecting the winning offeror. As part of the evaluation process, evaluators are asked to identify ways to improve the process. For a complete description of the procurement process and the tasks performed, see appendix IV.

Problems Identified During Award Protests

GAO sustained the protest of the July 1993 California/Hawaii award primarily because DOD failed to evaluate offerors' proposals according to the RFP criteria. The RFP provided that each offeror's proposed approach to attaining health care cost estimates would be individually evaluated. However, in evaluating the proposals, DOD evaluators rejected the contractors' cost estimates and assigned the same government cost estimates to all offerors' proposals. By so doing, the BPET did not consider offerors' individual cost-containment approaches, such as their utilization management approaches, upon which the success of managed care contracting to contain costs largely rests. In effect, the evaluators' action made this part of the evaluation methodology meaningless.

Also, the process did not allow the price evaluators to discuss with the technical evaluators possible inconsistencies between the price and technical proposals nor otherwise discuss the technical information that supported the price estimates. Such discussions may have highlighted the need to analyze offerors' individual cost containment approaches.

During the protest of the Washington/Oregon award, the offeror protested nearly a dozen of DOD's technical ratings of its proposal. In its decision, GAO recognized that DOD made mathematical errors that affected scoring, but these errors were not limited to the protesting offeror, and correcting them did not affect the procurement's final outcome.

DOD Actions to Improve and Help Ensure Fairness of the Procurement Process

DOD has made several changes that should improve future procurements. Major changes due to the protest experiences include (1) revising the price evaluation methodology and providing offerors more complete RFP information on how the methodology will be used in evaluating bid prices, (2) adding requirements for discussions between price and technical evaluation boards, and (3) revising both the requirements and the technical evaluation criteria for utilization management. Also, DOD is developing a computer spreadsheet to automate the technical scoring process and, thus, address mistakes made during the Washington/Oregon evaluation process.

DOD's other changes include providing more training for proposal evaluators, collocating the technical evaluation boards, and providing more feedback to offerors on their proposals' weaknesses. A final change requires that DOD approve the bid price evaluation methodology before evaluating prices.

Price Evaluation Methodology Revised

DOD significantly changed its methodology for evaluating the health care cost portion of the offerors' business proposals. While details of the new methodology are procurement sensitive and cannot be disclosed, the changes essentially involve evaluating the reasonableness of the offerors' estimates for cost factors over which the contractor has some control, such as utilization management and provider discounts. The evaluation includes comparing the offerors' cost estimates with the government's estimates and considering the offerors' justification and documentation.

Also, DOD rewrote portions of the RFP to provide more explicit information to offerors so they can better understand the new evaluation methodology and the factors to be considered in evaluating prices. This more complete guidance should facilitate offerors' ability to furnish the information DOD needs to evaluate their proposals.

Discussions Between Price and Technical Evaluators

DOD instituted a process requiring discussions between the technical and the price evaluators. Previously, discussions between the two boards were prohibited, and knowledge possessed about offerors' proposals by one group was not shared with the other. Under the new procedures, the SSEB briefs the BPET and responds to BPET questions on offerors' proposed technical approaches. This should enable the BPET to better judge whether offerors can achieve the health care costs that they have bid. Conversely,

the SSEB can request information from the BPET to assist in its technical evaluation.

Utilization Management Requirements Revised

DOD significantly revised its RFP utilization management requirements and utilization management criteria used in evaluating offerors' proposals. DOD incorporated these revisions in the solicitations for the then ongoing Washington/Oregon procurement as well as the post-protest recompetition of the California/Hawaii procurement. The revised utilization management requirements place additional responsibilities on the contractor and establish specific utilization management procedures. Also, while the previous evaluation criteria basically involved checking whether offerors' proposed approaches addressed requirements, the revised criteria require evaluators to judge the effectiveness of the cost-containment approaches.

Other Procurement Improvements

Among other DOD improvements is the provision of more training for evaluators and team leaders who oversee the evaluation of specific tasks. Training for the California/Hawaii evaluators had been limited to about one-half day, but training on more recent procurements has been increased to nearly 1 week. The new training includes more detailed information on the (1) procurement cycle, (2) technical and price evaluation boards, (3) evaluation of proposals, and (4) use of personal computers to record evaluation information.

Another change involves collocating at Aurora, Colorado, the SSEB staff who had been split between Aurora and Rosslyn, Virginia. SSEB members evaluating managed care tasks were located in Rosslyn, and those evaluating claims processing and related tasks were in Aurora. The dual locations caused the board chair to travel frequently to the Rosslyn location to review work and provide guidance to board members there. Also, DOD lost time awaiting information arriving from the Rosslyn site to Aurora and retyping and reformatting information submitted from the Rosslyn site. More significantly, some rating procedures differed between the two locations.

A further change in the process is that DOD, along with providing offerors the questions evaluators raise on their proposals, is also providing information on proposal weaknesses. As a result, offerors are better assured that they are addressing the specific concerns that prompted the questions. Offerors told us, moreover, that DOD is now providing them more information about their proposals, responding more quickly to their

questions, and providing more complete information after initial evaluations and debriefings following contract award.

A final procedural change is that DOD now formally approves the price evaluation methodology prepared by a contractor before the proposal evaluation begins. On the California/Hawaii procurement awarded to Aetna, DOD had not approved the evaluation methodology before the proposals had been evaluated. The methodology had been prepared by a consultant who submitted it to DOD for review, received no formal response, and proceeded to use it to evaluate proposals. Late in this process, DOD determined that the methodology improperly skewed the evaluation and ordered it changed at that time. DOD's new procedure eliminates the possibility of changing the evaluation methodology during the process, thus removing any such possible appearance of impropriety.

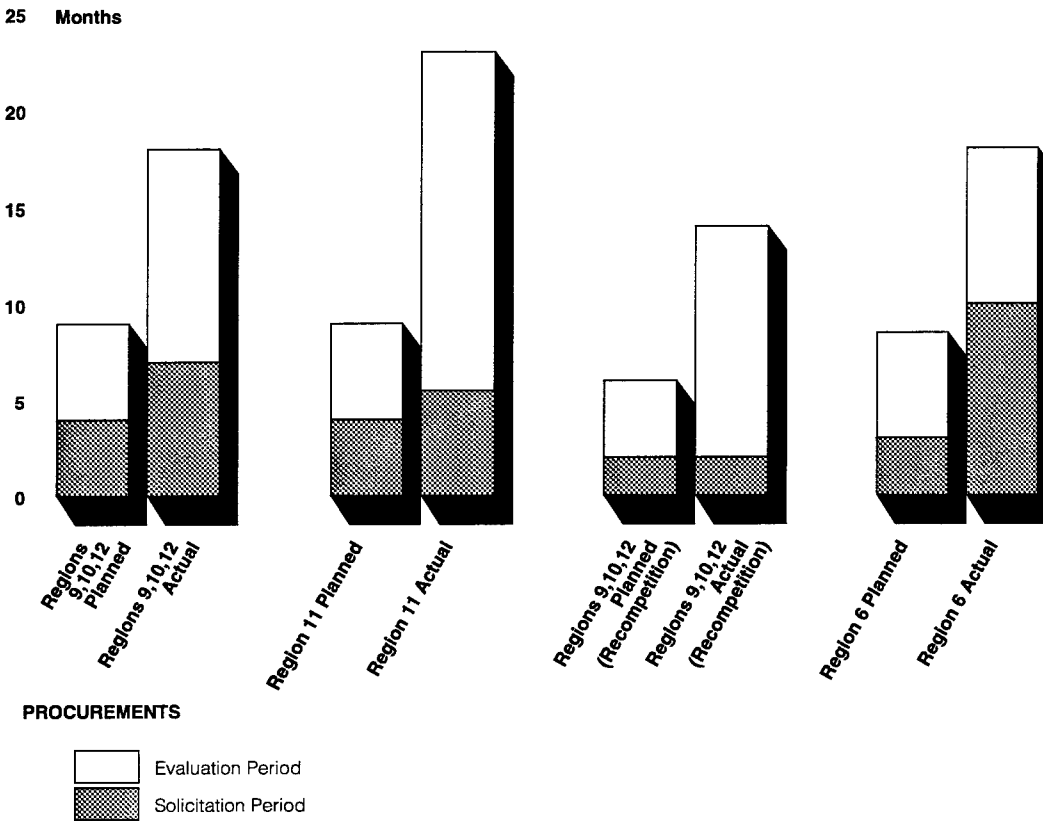
Remaining Problems and Concerns

Despite DOD's process improvements, several matters remain that concern both those administering and those responding to the procurements. First, unless DOD can avoid further delays in this round of procurements, it may not meet the congressional deadline for awarding all contracts by September 30, 1996. Also, the substantial expense that offerors incur to participate may further limit future competition. Also, the specificity of solicitation requirements may work against offerors proposing innovative, cost-saving managed care techniques. Further, by reducing the length of transition periods, DOD has introduced significant risk that all the tasks needed to deliver health care will not be completed on time. Finally, DOD needs to better ensure that prospective evaluators are properly qualified.

Lengthy Procurements Jeopardize Meeting Congressional Award Deadline

For each of the four contracts awarded thus far, the procurement lengths, on average, have been 18 months or more than twice as long as originally planned. Figure 2 compares the planned and actual procurement times for the contracts.

Figure 2: Planned Versus Actual Procurement Times



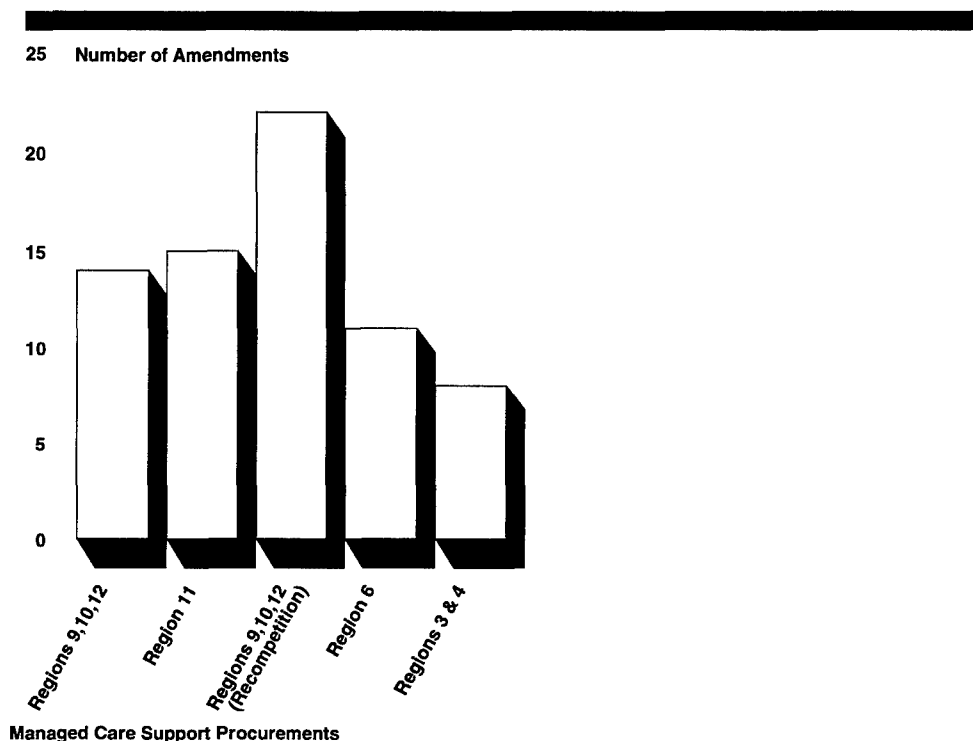
Note: The solicitation period for region 11's actual procurement time includes both the initial solicitation period plus an additional period for a major amendment that resulted in offerors' submitting completely new proposals.

If the remaining procurements encounter similar delays, DOD will have difficulty in meeting the congressional mandate for awarding all contracts by September 30, 1996. The current schedule allows about 1 month of slippage for the remaining procurements to have all contracts awarded on time.

A primary cause of delays has been the many changes DOD has made to solicitation requirements. For example, as shown in figure 3, the California/Hawaii (regions 9, 10, and 12) recompetition procurement had

22 RFP amendments, and the Washington/Oregon (region 11) procurement had 15 amendments.

Figure 3: Number of RFP Amendments Issued on DOD Managed Care Procurements



Note: The regions 3 and 4 procurement is ongoing and more amendments could be added.

Some of the changes resulted from such new requirements as the lead agent concept and a new uniform benefits package¹² to replace previous beneficiary cost-sharing requirements that differed across the country. Other changes resulted from major revisions to such existing requirements as utilization management. When such changes occur, extra time is needed to issue solicitation amendments, for offerors to analyze the changes and revise their proposals, and often for evaluation boards to review the changes. Offerors have expressed extreme displeasure about the

¹²Section 731 of the National Defense Authorization Act for fiscal year 1994 required the establishment of a health maintenance organization benefit option to provide reduced out-of-pocket costs and a benefit structure that is as uniform as possible nationwide. This benefit will be included in all DOD's future managed health care initiatives.

continually changing program requirements that make it more costly for them to participate in the protracted procurements.

On the other hand, procurements have been delayed to allow offerors to correct errors in their cost proposals and as a result of bid protests. While these actions have not caused major delays so far, because DOD normally can proceed with the procurements, protests can add additional time to the overall schedule.

DOD has acted to shorten the procurement process by increasing the size of evaluation boards and changing the way proposals are evaluated. The enlarged boards can divide evaluation tasks among more members, and members have narrower spans of review responsibility.

Regarding RFP changes, some offerors maintain that DOD did not adequately plan the program before beginning the procurements. While DOD officials acknowledge planning problems, particularly for the lead agent concept, they told us that RFP changes will become less of a problem as their experience with the managed care support contracts grows. Also, DOD officials are concerned that if needed changes are not added before contract award, it will be more costly to implement them after award in the form of contract change orders when competition no longer exists.

Currently, the administration is strongly encouraging simplifying federal procurements by, among other things, adopting commercial best practices to reduce costs and expedite service delivery. DOD recognizes that its process is extremely costly, complex, and cumbersome for all affected and acknowledges the need to simplify and shorten it. DOD can take advantage of the administration initiative's momentum and seek ways to simplify and streamline its health care procurements by considering, among other things, the private sector's best practices.

Costs to Participate May Narrow Future Competition

Because the procurements are broad, complex, lengthy, and involve huge sums of money, offerors incur substantial expense to participate. As a result, participation thus far has been limited to large companies with vast resources. For example, the California/Hawaii procurement required that offerors be in a position to risk losing a minimum of \$65 million should they incur losses during the contract's performance. Competition is further limited because only a small number of available subcontracting firms can now knowledgeably process CHAMPUS claims.

Moreover, several offerors told us that it cost them between \$1 and \$3 million to develop their proposals. Planning and preparing bid proposals and responding to amendments require them to divert their most able people from their regular duties to work months preparing offers. One offeror, in illustrating the procurement's size, complexity, and resources needed to participate, told us that its proposal consisted of 33,000 pages. The offeror told us that if it did not win a then ongoing procurement, it would not participate again unless it could develop a proposal for no more than \$100,000. Another offeror said its firm could not afford to continue bidding if it did not win a contract soon.

DOD incurs substantial costs as well. The evaluation process, in particular, requires tremendous time, effort, and costs. A DOD official estimated that 54,000 hours were spent on evaluating a recent procurement. In addition to evaluation duties, many staff must continue to perform their regular duties. Many commonly spend weekends performing evaluation duties involving a considerable amount of overtime expense. Further, many of the evaluators travel from all over the country and are on travel status for 5 to 6 weeks.

DOD recognizes that in the next round of the seven regional procurements, the number of offerors may further narrow and consist only of those who won awards in the first round. While DOD has chosen to award large contracts on a regional basis, it may be advisable in the next round to consider such alternatives as awarding smaller contracts covering smaller geographic areas, awarding to more than one offeror in a region, or simplifying the contracts by removing the claims processing function and awarding it separately.

Prescriptive Requirements May Bar Innovative, Cost-Saving Techniques

DOD's RFP requirements are extremely specific and prescriptive because, the Department has stated, it desires a uniform program nationwide in which beneficiaries and providers are subject to the same requirements and processes regardless of residence. Offerors, on the other hand, maintain that if DOD's RFP stated minimum requirements but emphasized the health care outcomes desired and allowed offerors more flexibility in devising approaches to achieve such outcomes, costs could be reduced without adversely affecting the quality of care delivered.

In specifying its requirements, DOD has sought to ensure that beneficiaries not be denied necessary care and that care be provided by appropriate medical personnel in the appropriate setting. DOD's concern has been that

allowing contractors to use different processes and criteria might jeopardize these ends. Offerors maintain that those objectives can be met by allowing them more freedom to use innovative approaches, drawing on their private-sector managed care expertise.

In comparing DOD's managed care procurements with private-sector procurements, private corporations interested in contracting for managed care have far less specific requirements and normally only request general information about offerors such as corporate background, financial capability, health care performance, and utilization management/quality assurance strategies. Offerors told us that DOD does not ask for the kind of information on private-sector experience that would allow them to adequately compare performance among offerors. Also, many corporations use managed care consulting firms to help identify their requirements and select awardees.

Offerors often cite utilization management as the area in which more relaxed DOD requirements would enable them to implement equally or more effective techniques than DOD requires but with greater cost savings. Among the most objectionable requirements is the use of a two-level review process for determining care appropriateness/necessity, a specific company's utilization management criteria, and reviewers with the same specialty as the providing physician. DOD has maintained that its utilization management requirements are based on its extensive review of the literature and are reasonable, though perhaps not the most cost-effective. Also, DOD has maintained that because the military environment differs from the private sector, it warrants different requirements.

Nevertheless, DOD has acknowledged that offerors have some legitimate concerns. In recent discussions, DOD told us that, while it has no plans yet, for the next round of procurements it may begin considering ways of making the requirements less onerous to offerors while ensuring that beneficiaries receive adequate access to care. DOD officials said that they may begin seeking to simplify the requirements by making them less process and more outcome driven, while respecting, to the extent practicable, their overall system goals.

Shortening Post-Award Transition Creates Significant Risk

Because of procurement delays occurring before contract award, DOD has tried to recover lost time by reducing to 6 months its scheduled 8- to 9-month transition period during which contractors prepare to deliver health care. But by doing so, DOD has introduced significant risk that

contractors will not complete the many tasks needed to begin health care delivery on time.

We have reported that DOD has experienced serious problems in the past both with fiscal intermediary¹³ contractors¹⁴ and the CRI contractor¹⁵ being unable to begin processing claims by the start work date because the 6-month transition period was too short. As a result, beneficiaries faced considerable difficulties getting services and providers getting reimbursement. The managed care transitions are more complex and involved than the prior transitions.

Most offerors we contacted told us that 6 months was too short and that about 8 months was needed to accomplish the tasks required to be ready on time. The transition tasks include signing up network providers, establishing service centers, hiring health care finders, preparing information brochures, bringing the claims processing system on line, resolving database problems, enrolling beneficiaries, and many other tasks. Offerors also told us that even a contractor with CRI experience would have difficulty meeting the 6-month transition requirement. DOD contracting officials and evaluators also have expressed the same concerns.

While DOD, in reducing the transition periods, is driven to adhere to its individual procurement schedules and thus respond to internal and external pressures to bring services on line, we believe the risk introduced far outweighs the small potential time savings due to shorter transition periods. As demonstrated in the fiscal intermediary and CRI transitions, inadequate transition periods can overly tax contractors to the point of failure and result in substantial additional time and expense to recover.

Evaluators' Needed Qualifications Not Specified

DOD has so far selected evaluation board members in a relatively informal way, either allowing board chairs to do so, on the basis of their knowledge of the individuals, or military services headquarters or lead agents to do so, on the basis of general guidelines. To date, DOD, relying on this less formal appointee approach, has not set forth general qualification

¹³Private organizations under contract with DOD to pay claims for health care services provided to beneficiaries under standard CHAMPUS. This arrangement was used before regions converted to TRICARE and is still used where such contracts have yet to be awarded.

¹⁴CHAMPUS Has Improved Its Methods for Procuring and Monitoring Fiscal Intermediary Services to Process Medical Claims (GAO/HRD-85-56, Aug. 23, 1985).

¹⁵Implementation of the CHAMPUS Reform Initiative (GAO/T-HRD-89-25, June 5, 1989).

requirements for evaluators such as experience or subject area knowledge. But, because the tasks they evaluate are so specialized and because the boards have expanded and members are increasingly less familiar to selecting officials, specifying evaluator qualifications—as has been suggested by offerors and board members alike—seems prudent.

Some offerors expressed concern to us that DOD evaluators have had little or no experience with private-sector managed care plans and thus have difficulty distinguishing among offerors who can perform effectively in the private sector and those who are less effective in ensuring quality care and controlling costs. Evaluation board team leaders for recent procurements told us that qualification requirements would be helpful to ensure that people with appropriate experience and knowledge can adequately evaluate specific tasks. One board member, as input to DOD's internal improvement process, stated that some SSEB members seemed to lack (by their own admission) the prerequisite experience and background to serve most effectively as subject matter experts on the SSEB. He went on to state that, given the potential impact of these contracts in dollars and health care service, it seems critical that only experienced evaluators be put in a position to make the essential judgment calls inherent in the technical review process.

On more recent procurements, DOD has requested that evaluator nominees submit resumes to assist selection decisions and facilitate their assignment to various tasks. While this is a step in the right direction, it does not ensure that prospective evaluators with appropriate skills are nominated in the first place and are selected on the basis of the requisite qualifications.

Conclusions

DOD has improved the procurement process since the protest on the California/Hawaii award to Aetna was sustained, to the extent that offerors can be more assured of equitable and fair treatment. While the dollar value of the contracts will likely cause offerors to protest in the future, DOD improvements have reduced the chance of protests being sustained.

Despite improvements in the process, several areas of concern remain, particularly regarding the next round of procurements. The procurement process is extremely costly, complex, and cumbersome for all affected, and DOD acknowledges the need to simplify it. We agree and see an opportunity for DOD to draw upon the administration's current initiative for

simplifying federal procurements as it seeks ways to streamline its processes. Further, because of the costs of participating, the number of offerors in the next procurement round may be limited to only those who received contracts in the first round. We think that DOD should consider alternative procurement approaches to help preserve the competitiveness of the process. Along with these measures, DOD needs to address whether its solicitation requirements can be less prescriptive and still achieve their overall health care goals.

Though DOD was driven by internal and external pressures to bring health care services on line, we do not agree with the Department's decision to reduce transition times to make up for time lost in awarding the contracts. The potential time saved by shortening transition periods, in our view, does not justify the risk of contractors not being able to prepare to deliver services on time. Finally, given the increasing size of the evaluation boards, their specialized tasks, and members' increasing lack of familiarity to selecting officials, we believe that DOD needs to develop qualification requirements for evaluator appointees.

Recommendations

We recommend that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to

- weigh, in view of the potential effects of such large procurements on competition, alternative award approaches for the next procurement round;
- determine whether and, if so, how the next round's solicitation requirements could be simplified, incorporating the use of potentially better, more economical, best-practice managed care techniques while preserving the system's overall health care goals;
- adhere to the 8- to 9- month scheduled transition period and discontinue, whenever possible, reducing such periods to make up for delays incurred before contracts are awarded; and
- establish general qualification requirements for evaluator appointees.

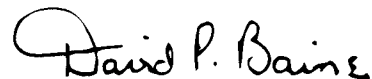
Agency Comments

In commenting on the draft report, DOD fully agreed with the first three of our recommendations and agreed in part that qualifications for evaluation board appointees need to be established. DOD pointed out that, while it could improve the evaluator selection process, it now tasks lead agents and the Services with nominating qualified individuals and the contracting officer and board chairs with reviewing their resumes. We continue to

believe that establishing general qualification requirements would more appropriately equip responsible DOD officials to nominate and select the best qualified evaluators and assign them the most suitable tasks. DOD made other comments and suggested changes that we incorporated in the report as appropriate. DOD's comments are included as appendix V.

As arranged with your staff or offices, unless you announce its contents earlier, we plan no further distribution of this report until 7 days after its issue date. At that time, we will send copies to the Secretary of Defense; the Director, Office of Management and Budget; and interested congressional committees. We will also make copies available to others upon request.

If you have any questions concerning the contents of this report, please call me at (202) 512-7101. Other major contributors to this report are Stephen P. Backhus and Daniel M. Brier, Assistant Directors, Donald C. Hahn, Evaluator-in-Charge, and Robert P. Pickering and Cheryl A. Brand, Senior Analysts.



David P. Baine
Director, Federal Health Care
Delivery Issues

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Abbreviations

BPET	Business Proposal Evaluation Team
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
	Services
CRI	CHAMPUS Reform Initiative
DOD	Department of Defense
MHSS	Military Health Services System
RFP	request for proposal
SSAC	Source Selection Advisory Council
SSEB	Source Selection Evaluation Board

Scope and Methodology

We examined in detail the complete California/Hawaii procurement file for the contract that was awarded to Aetna as well as selected portions of more recent procurements' files. These files were from the California/Hawaii recompetition procurement, the Washington/Oregon procurement, and the region 6 procurement. We also reviewed agency files and discussed with agency officials various aspects of the procurement process.

Also, we reviewed pertinent regulations governing the procurement processes in the Federal Acquisition Regulation, the Defense Federal Acquisition Regulation Supplement, and the Office of CHAMPUS Acquisition Manual. We held discussions with contract management personnel who conduct the procurements, officials who develop solicitation requirements, staff involved in the evaluations, and agency legal staff who ensure that the procurements are conducted according to applicable laws and regulations and in an equitable manner.

Our review of procurement documents included (1) documents related to the planning of the CHAMPUS Reform Initiative and managed care support procurements, (2) procurement schedules showing planned and actual dates, (3) RFPS and amendments to the RFPS, (4) questions raised by offerors and agency responses, (5) documents relating to evaluation methodology, (6) evaluation criteria and scoring sheets, (7) reports of discussions with offerors, (8) internal reports, (9) reports of the evaluation boards, (10) selection reports, and (11) preaward survey reports.

Because of agency concerns about compromising future procurements, we are not presenting specific information on the evaluation methodology or on the scoring and weighting systems used. Nor are we presenting information on the criteria used in the rating and scoring process. We examined proposals of individual offerors to only a limited extent and are not providing information on these proposals because it is proprietary.

We interviewed the Source Selection Evaluation Board, Business Proposal Evaluation Team (BPET), and Source Selection Advisory Council chairmen involved in recent procurements as well as the selecting officials. We also interviewed several team leaders involved in evaluating the technical proposals of the California/Hawaii recompetition procurement and several members of the BPET. In addition, to assess the qualifications of evaluation members, we reviewed their resumes.

Appendix I
Scope and Methodology

In conducting our review, we examined GAO bid protest decisions involving these managed care procurements and coordinated our efforts with GAO's Office of General Counsel, which handles these bid protests. In addition to the protest decisions, we reviewed much of the supporting documentation for decisions, including the offerors' protests, agency reports, offerors' comments on the agency reports, videotapes of the protest hearings, and post-hearing comments.

To obtain information on their experiences with DOD managed care procurements and their views of the overall procurement process and the solicitation requirements, we interviewed officials from four offerors who had participated in recent procurements. The officials interviewed were from Aetna Government Health Plans, Inc., California Care Health Plan (Blue Cross of California), Foundation Health Federal Services, Inc., and QualMed, Inc. We also interviewed the lead agents and their staffs for regions 9 and 11 to obtain similar information.

Our work was conducted at the Office of CHAMPUS, Aurora, Colorado, and at the Office of the Assistant Secretary of Defense (Health Affairs), Washington, D.C. In addition, we visited the offerors at their headquarters offices and the lead agents at their military treatment facilities.

We conducted our review between March 1994 and June 1995 in accordance with generally accepted government auditing standards.

Transition to TRICARE Managed Care Support Contracts

CHAMPUS provides funding for health care services from civilian providers for uniformed services beneficiaries.¹⁶ CHAMPUS began in 1956 and was expanded in 1966 to include additional classes of beneficiaries and more comprehensive benefits.¹⁷ These beneficiaries eligible for CHAMPUS include dependents of active-duty members, retirees and their dependents, and dependents of deceased members. CHAMPUS has approximately 5.7 million eligible beneficiaries and has traditionally functioned much like a fee-for-service insurance program. Beneficiaries are free to select providers and are required to pay deductibles and copayments, but, unlike with most insurance programs, they are not required to pay premiums.

CHAMPUS is part of the overall Military Health Services System (MHSS) that serves active- and nonactive-duty members and includes 127 hospitals and over 500 clinics worldwide. CHAMPUS beneficiaries can also obtain medical care services in military medical facilities on a space-available basis. In fiscal year 1995, the MHSS was budgeted at over \$15 billion, of which \$3.6 billion, or about 24 percent, was budgeted for CHAMPUS.

Because of escalating costs, claims paperwork demands, and general beneficiary dissatisfaction, DOD initiated in the late 1980s, with congressional authority, a series of demonstration projects designed to more effectively contain costs and improve services to beneficiaries. One of these, known as the CHAMPUS Reform Initiative (CRI), was designed by DOD in conjunction with a consulting company. Under CRI, a contractor provided both health care and administrative-related services, including claims processing.

The CRI project was one of the first to introduce managed care features to the CHAMPUS program. Beneficiaries under CRI were offered three choices—a health maintenance organization-like option called CHAMPUS Prime that required enrollment and offered enhanced benefits and low-cost shares, a preferred provider organization-like option called CHAMPUS Extra that required use of network providers in exchange for lower cost shares, and the standard CHAMPUS option that continued the freedom of choice in selecting providers and higher cost shares and deductibles. Other features of CRI included use of health care finders for referrals and the application of utilization management. The project also

¹⁶Uniformed service beneficiaries include those from the Air Force, Army, Marine Corps, Navy, Coast Guard, and Commissioned Corps of the Public Health Service and the National Oceanic and Atmospheric Administration.

¹⁷Dependents' Medical Care Act of 1956 (P.L. 84-569) and Military Medical Benefits Amendments of 1966 (P.L. 89-614).

Appendix II
Transition to TRICARE Managed Care
Support Contracts

contained resource sharing features whereby the contractor, to reduce overall costs, could provide staff or other resources to military treatment facilities to treat beneficiaries in these facilities.

Although DOD's initial intent under CRI was to award three competitively bid contracts covering six states, only one bid—made by Foundation Health Corporation—covering California/Hawaii was received.¹⁸ Because of the lack of competition, DOD ended up awarding a negotiated fixed-price, at-risk contract with price adjustment features to Foundation. Although designated as fixed price, the contract contained provisions for sharing risks between the contractor and the government. Foundation delivered services under this contract between August 1988 and January 1994.

Before the contract expired, DOD began a new procurement for the CRI California/Hawaii contract that resulted in the competition's narrowing down to four bidders. In July 1993, DOD awarded a 5-1/2 year (1 half-year plus 5 option years), \$3.5 billion contract to Aetna Government Health Plans, with health care services beginning on February 1, 1994. Because a bid protest was sustained on this procurement, this contract was recompleted, although Aetna was allowed to proceed with its contract until a new contract was awarded.

In late 1993, in response to requirements in the DOD Appropriation Act for Fiscal Year 1994, the Department announced plans for implementing a nationwide managed care program for the MHSS that would be completely implemented by May 1997. Under this program, known as TRICARE, the United States is divided into 12 health care regions. An administrative organization, the lead agent, is designated for each region and coordinates the health care needs of all military treatment facilities in the region.

Under TRICARE, seven managed care support contracts will be awarded covering DOD's 12 health care regions. DOD estimates that over a 5-year period these contracts will cost about \$17 billion. The TRICARE managed care support contracts retain the fixed-price, at-risk, and triple-option health benefit features of CRI as well as many other CRI features. An important change, however, involves including in the contract tasks to be performed by the contractor that are specific to military treatment facilities in the regions, in addition to the standard requirements.

¹⁸Foundation later created a subsidiary to administer this contract called Foundation Health Federal Services, Inc.

Appendix II
Transition to TRICARE Managed Care
Support Contracts

Since the announcement of DOD's plan for implementing managed care contracts nationwide, three contracts have been awarded, as shown in table II.1.

Table II.1: Managed Care Support Contracts Awarded Since 1993

Region	Date of contract award	Awardee	Amount of award	Number of final offerors	Protest status
11	9/94	Foundation Health Federal Services, Inc.	\$650 million	3	Denied
9,10, and 12	3/95	QualMed, Inc. ^a	\$2.5 billion	4	Pending
6	4/95	Foundation Health Federal Services, Inc.	\$1.8 billion	5	Pending

^aThe recompeted contract award stemming from the successful protest of the first California/Hawaii contract award.

The current schedule for awarding the remaining four contracts appears in table II.2.

Table II.2: Contract Award Schedule for Managed Care Support Contracts

Region(s)	RFP issue date (actual or planned)	Planned award date	Scheduled health care delivery date
3,4	8/1/94	third quarter 1995	5/1/96
7,8	3/24/95	first quarter 1996	11/1/96
1	9/15/95	third quarter 1996	5/1/97
2,5	9/15/95	third quarter 1996	5/1/97

Organizations Submitting Best and Final Proposals

Region	Organizations submitting best and final proposals
9,10, and 12	<ol style="list-style-type: none"> 1. Aetna Government Health Plans, Inc. 2. BCC/PHP Managed Health Company 3. Foundation Health Federal Services, Inc. 4. QualMed, Inc.
11	<ol style="list-style-type: none"> 1. CaliforniaCare Health Plans (Blue Cross of California) 2. Foundation Health Federal Services, Inc. 3. QualMed, Inc.
9,10, and 12 (recompetition)	<ol style="list-style-type: none"> 1. Foundation Health Federal Services, Inc. 2. Aetna Government Health Plans, Inc. 3. Blue Cross of California 4. QualMed, Inc.
6	<ol style="list-style-type: none"> 1. Aetna Government Health Plans, Inc. 2. Blue Cross Blue Shield of Texas 3. Foundation Health Federal Services, Inc. 4. Humana Military Health Care Services, Inc. 5. Prudential Uniformed Services Administrator

The TRICARE Managed Care Support Procurement Process

The Office of CHAMPUS, an organization within the Office of the Assistant Secretary of Defense (Health Affairs) conducts the managed care support procurements. In conducting these procurements, DOD must follow the requirements in the Federal Acquisition Regulation and the Defense Federal Acquisition Regulation Supplement. In addition, the Office of CHAMPUS Acquisition Manual provides further guidance for conducting procurements. The major steps in the procurement process are described in this appendix.

Issuance of the RFP

The request for proposal (RFP) contains the detailed specifications, instructions to offerors in responding to the RFP, and evaluation factors that DOD will consider in making the award. The RFP requires that offerors submit both a technical and a business (price) proposal, and offerors are told that the technical content will account for 60 percent of the scoring weight and the price, 40 percent.

In preparing the technical proposal, offerors are required to address 13 different tasks: (1) health care services; (2) contractor responsibilities for coordination and interface with the lead agent and military treatment facilities; (3) health care providers' organization, operations, and maintenance; (4) enrollment and beneficiary services; (5) claims processing; (6) program integrity; (7) fiscal management and controls; (8) management; (9) support services; (10) automatic data processing; (11) contingencies for mobilization; (12) start-up and transitions; and (13) resource support program.

Experience and performance are other evaluation factors. Offerors must describe the approaches they would take in accomplishing these tasks. While offerors are not told the specific weights assigned the individual tasks, they are told their order of importance.

In preparing the business proposal, offerors must provide support for both their administrative and health care prices and justify their health care prices by addressing seven cost factors over which the offerors have some control: (1) HMO option penetration rates (enrollment), (2) utilization management, (3) provider discounts, (4) coordination of benefits/third-party liability, (5) resource sharing savings, (6) resource sharing expenditures, and (7) enrollment fee revenues. Offerors must also provide trend data for costs that the offeror is considered likely to have little or no control over such as price inflation. In evaluating proposals, since these factors are considered uncontrollable, the government

substitutes its own estimates for the offerors' so that all offerors are treated equally. Offerors must also pledge an equity amount to absorb losses if health care costs exceed the amount proposed. In evaluating proposals, DOD determines whether offerors have the financial resources to meet this pledge, and the equity amount is also applied as part of the methodology in evaluating prices.

Before the proposals' due date, offerors are free to submit questions on clarification of requirements or further program information. Offerors can continue to submit questions up until the close of discussions before best and final offers are due.

Evaluation of Proposals

Upon receipt of the offerors' proposals, a Source Selection Evaluation Board (SSEB) evaluates the technical proposals according to detailed evaluation criteria. The board size depends on the number of offerors and, in recent procurements, has numbered about 80 people. Board members are selected from offices such as the Assistant Secretary of Defense (Health Affairs), the military Surgeons General, the military treatment facilities, and the Office of CHAMPUS. A chairperson heads the board, which is divided into teams to review the various tasks and subtasks. The worksheets used in these evaluations contain both the specifications and the criteria upon which to base a judgment.

A Business Proposal Evaluation Team (BPET) evaluates the business proposals. A chairperson also heads this team, which comprises about 10 people, divided between a team that primarily evaluates administrative costs and another that primarily evaluates health service costs. The team evaluating administrative costs is supported by the Defense Contract Audit Agency, which performs a cost analysis of the administrative costs bid. The team evaluating health service costs consists primarily of consultants, some of whom are actuaries. In their evaluation, they use specially developed criteria as well as a government-developed cost estimate. Another consultant ensures the financial viability of the offerors, including whether they have the fiscal capacity to absorb the amount of equity offered, which would be at risk if losses were to be incurred under the contract.

A Source Selection Advisory Council (SSAC) is an oversight board that reviews the work of the SSEB and BPET and provides consultation advice to the two teams. The SSAC comprises about six executive-level personnel.

Best and Final Offers

DOD does not normally award a contract after the initial evaluations, although nothing precludes an award at that time. Instead, DOD notifies offerors in writing of weaknesses and deficiencies identified in the initial evaluation and prepares questions relating to them. This gives the offerors an opportunity to correct the weaknesses and deficiencies and improve their proposals. In addition to the questions provided offerors, DOD holds face-to-face discussions to clarify and resolve any outstanding issues. DOD then requests best and final offers, and offerors submit their revised proposals, including any desired price revisions.

Upon receipt of the best and final offers, the SSEB and BPET evaluate revisions to the initial proposals, and the SSAC reviews the work of the two boards. DOD then completes final scoring and prepares reports of the evaluations.

Preaward Survey

DOD can conduct preaward surveys before award if outstanding issues remain to be resolved. This survey can include an on-site visit to an offeror or subcontractor.

Selection of Offeror

A senior official, designated as the Source Selection Authority, selects the winning offeror using reports prepared by the SSEB, BPET, and SSAC. The official prepares a written report justifying the final selection.

Debriefing of Unsuccessful Offerors

Following selection of the winning offeror, unsuccessful offerors can learn why they were not selected. Offerors are individually told of the deficiencies and weaknesses in their proposals. This can serve as the basis for preparing improved proposals for subsequent procurements.

Transition Period

The period between contract award and the start of health care delivery is referred to as the transition period. During this period, the contractor must perform many tasks, including assembling a provider network, establishing service centers, getting the claims processing system operational, and beginning the process of enrolling beneficiaries into the HMO-like option.

Lessons Learned

Throughout the evaluation process, evaluators are requested, as part of the "lessons learned" process, to identify problems or suggest potential

**Appendix IV
The TRICARE Managed Care Support
Procurement Process**

changes to improve future procurements. The lessons learned can be as minor as correcting specification references or as major as changing evaluation procedures.

Comments From the Department of Defense



HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

JUN 28 1995

Mr. David P. Baine
Director, Federal Health Care
Delivery Issues
Health, Education, and Human Services Division
U.S. General Accounting Office
Washington, DC 20548

Dear Mr. Baine:

This is the Department of Defense (DoD) response to the General Accounting Office (GAO) draft report, "DEFENSE HEALTH CARE: Despite TRICARE Procurement Improvements Problem Areas Remain," dated May 31, 1995, (GAO Code 101450/OSD Case 9953). The Department partially concurs with the report.

The DoD agrees that the procurement process should be continuously monitored for improvement. A number of alternatives are being considered with the intent of enhancing the competitive environment of the TRICARE procurement process. The DoD partially concurs with the recommendation that general qualification standards need to be established for evaluation boards. It is the current practice, in the letter calling for nominees to evaluation boards, to require that only persons who are generally qualified be nominated. Current practice meets the requirements of the Federal Acquisition Regulations (FAR) and the Defense Federal Acquisition Regulations (DFAR). The DoD agrees that improvements to the selection process may be possible; however, the current methodology does not compromise the procurement program.

Detailed DoD comments on the report recommendations are provided in the enclosure. The DoD appreciates the opportunity to comment on the draft report.

Sincerely,

Edward D. Martin /for
Stephen C. Joseph, M.D., M.P.H.

Enclosure:
As stated

GAO DRAFT REPORT - DATED MAY 31, 1995
(GAO CODE 101450) OSD CASE 9953

“DEFENSE HEALTH CARE: DESPITE TRICARE PROCUREMENT
IMPROVEMENTS PROBLEM AREAS REMAIN”

DEPARTMENT OF DEFENSE COMMENTS

RECOMMENDATIONS

RECOMMENDATION 1: The GAO recommended that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to weigh, in view of the potential effects of such large procurements on competition, alternative award approaches for the next procurement round. (pp. 25-26/GAO Draft Report)

Now on p. 19.

DoD RESPONSE: Concur. The DoD is aware of the potential effects of large procurements on competition and Health Affairs is continuously assessing the Managed Care Support (MCS) procurements for ways to improve. The DoD is looking at the potential benefits of awarding smaller contracts in small geographic areas, conferring multiple awards per contract, and unbundling contracts as discussed in the draft report. Another possibility under consideration is the outcomes oriented Request for Proposal (RFP) which would give the offerors the opportunity to propose existent state of the art commercial practices. This would serve to simplify proposal development and contract implementation. Competition is an essential procurement program element if the government's objective of providing quality health care to our beneficiaries within a cost controlled environment is to be realized. The DoD desires to minimize actions on the government's behalf which contribute to the length of the procurement process and increase the effort required of the offerors. As stated, the DoD is also looking at a number of ways to reduce costs offerors incur in the development of proposals. This in turn will improve potential offerors' opportunity to participate in these procurements and benefit the government by way of the advantages associated with open competition. The DoD has enhanced competition by increasing the participation of variably sized organizations with local market influence as well as large, mature organizations which can accommodate more risk. Directly impacting the way the DoD has designed the current TRICARE procurement process is the Congressional direction in Section 8025 of the Defense Appropriations Act of 1994. This legislation directed the DoD to procure region-wide, at-risk, fixed price managed care contracts similar to the CHAMPUS Reform Initiative in California and Hawaii.

RECOMMENDATION 2: The GAO recommended that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to determine whether and, if so, how the next round's solicitation requirements could be simplified, incorporating the use of potentially better, more economical, best-practice managed care techniques while preserving the system's overall health care goals. (p. 27/GAO Draft Report)

Now on p. 19.

Appendix V
Comments From the Department of Defense

DoD RESPONSE: Concur. As stated in the response to Recommendation 1, the DoD agrees that solicitation requirements may be simplified and is continuously reviewing the MCS procurements for improvement.

RECOMMENDATION 3: The GAO recommended that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to hold to the 8 to 9 month scheduled transition period, and discontinue, whenever possible, reducing such periods to make up for delays incurred before contracts are awarded. (p. 27/GAO Draft Report)

DoD RESPONSE: Concur. The current schedule for the remaining TRICARE procurements establishes an eight month transition period post-award to allow time to react to contingencies. The Department intends to maintain a minimum transition period of 6 months.

RECOMMENDATION 4: The GAO recommended that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to establish general qualification requirements for appointees to the evaluation boards. (p. 27/GAO Draft Report)

DoD RESPONSE: Partially concur. It is the current practice, in the letter calling for nominees to evaluation boards, to require that only persons who are generally qualified be nominated. Current practice meets the requirements of the FAR and the DFAR. The DoD agrees that improvements to the selection process may be possible; however, the current methodology does not compromise the procurement program. The evaluation criteria are prepared by subject matter experts. The Department in turn tasks the Lead Agents and Services to nominate to the contracting officer evaluators and team leaders with educational and professional backgrounds specific to the areas of evaluation. The nominees' backgrounds are reviewed by the contracting officer and the chairman of the Source Selection Evaluation Board and the Business Proposal Evaluation Team to ensure the closest possible match of evaluator to RFP task. Also, prior to commencement of proposal review, the evaluators and team leaders are provided process oriented training.

Now on p. 19.

Now on p. 19.