Comptroller General
of the United States

Washington, D.C. 20548

Decision

Matter of: Capital Health Services, Inc.; JSA Healthcare Corporation

File: B-281439.3; B-281439.4

Date: March 23, 1999

Victor G. Klingelhofer, Esq., and John J. O'Brien, Esq., Cohen Mohr, for the protesters.
Karl E. Hansen, Esq., TRICARE Management Activity, for the agency.
Ralph O. White, Esq., and Christine S. Melody, Esq., Office of the General Counsel, GAO, participated in the preparation of the decision.

DIGEST

1. The Military-Civilian Health Services Partnership Program, 10 U.S.C. § 1096 (1994)--which authorizes the use of resource sharing agreements between the military's medical treatment facilities and civilian health care providers to deliver health care services to active duty service personnel and other military-related beneficiaries--is not a procurement statute for purposes of General Accounting Office (GAO) bid protest jurisdiction. However, GAO will take limited jurisdiction over the award of such agreements where the protester alleges that the agreements have been improperly used to avoid the requirements of the procurement statutes.

2. Protesters' contention that resource sharing agreements were an improper attempt to avoid the requirements of the procurement statutes is denied where the agreements were clearly within the authority granted by the statute, and within the scope of the underlying contract for managed health care services.

DECISION

Capital Health Services, Inc. and JSA Healthcare Corporation protest a decision by the TRICARE Management Activity (TMA) to add the operation of two existing NAVCARE outpatient medical clinics in San Diego, California, to TMA's ongoing contract with Foundation Health Federal Services, Inc. The protesters argue that the operation of the two clinics is beyond the scope of Foundation's contract, that the agency was required to hold a competition for the operation of the clinics, and that the agency's use of resource sharing agreements to convey operation of the clinics to Foundation violated the regulations applicable to the use of such agreements.

We deny the protests.

BACKGROUND

The TRICARE Program

The Department of Defense (DOD) maintains an extensive network of military medical treatment facilities (MTF) to provide direct care to active duty service personnel and, on a space-available basis, to other military-related beneficiaries, including dependents of active duty personnel and military retirees and their dependents. The direct care provided by the MTFs is supplemented by care paid for by DOD, but provided in civilian facilities.

DOD has implemented a managed health care system, called the TRICARE program, to control the costs associated with providing health care to those eligible to receive it.[1] The TRICARE program uses a managed care contractor to coordinate the access of health care beneficiaries to MTFs and to supplemental civilian sector health care providers. 32 C.F.R. § 199.17(a)(1) (1998). TMA is the DOD office that directs the TRICARE program.

When the TRICARE program is implemented in a given area, the official announcement identifies the geographical area covered by the program. Id. at § 199.17(a)(5). The geographic area at issue in this case encompasses Southern California, and is referred to as TRICARE Region 9. Within TRICARE's Region 9 are a number of MTFs, each of which is responsible for providing health care (on a space-available basis, and with certain priorities) to all eligible beneficiaries within a geographical subset of the region, called the MTF's catchment area. Id. The most significant MTF within Region 9 is the Naval Medical Center San Diego (NMCSD). NMCSD's care, as well as that of the other Region 9 MTFs, is supplemented by the region's managed care support contractor, Foundation.

The TRICARE program offers three options for health care: (1) a health maintenance organization-type plan, called TRICARE Prime; (2) a network of preferred providers, called TRICARE Extra; and (3) a standard fee-for-service plan, called TRICARE Standard. All active duty military personnel are automatically enrolled under TRICARE Prime; all other TRICARE-eligible beneficiaries are

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[1]Prior to implementing the TRICARE program, DOD administered an insurance-like program for supplemental care called the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). CHAMPUS was a traditional fee-for-service program that allowed beneficiaries to obtain services from providers of their own choosing without preauthorization. See generally Defense Health Care: TRICARE Resource Sharing Program Failing to Achieve Expected Savings, (GAO/HEHS-97-130 Aug. 22, 1997) at 3-4; Foundation Health Fed. Servs., Inc.; QualMed, Inc., B-254397.4 et al., Dec. 20, 1993, 94-1 CPD ¶ 3 at 3.

automatically covered under the TRICARE Standard or Extra options, unless they select enrollment in the TRICARE Prime program. 32 C.F.R. § 199.17(a)(6).

Use of Resource Sharing Agreements

The TRICARE program, by statute and by regulation, as well as Foundation's contract for Region 9, anticipates the use of unique agreements for the sharing of medical resources between DOD and the managed care contractor, pursuant to the Military-Civilian Health Services Partnership Program, established at 10 U.S.C. § 1096 (1994). Specifically, a resource sharing agreement permits the sharing of personnel, equipment, supplies, and any other items necessary to provide health care, provided the Secretary determines that use of such an agreement would result in delivery of health care services to beneficiaries in a more effective, efficient, or economical manner. 10 U.S.C. § 1096(a), (b) (1994); 32 C.F.R. § 199.17(a)(6)(iii)(A).

In this regard, Foundation's managed care contract required it to:

> develop and implement a resource sharing program for seeking agreements with individual MTF Commanders for the provision of medical personnel . . . , equipment, and/or supplies by the contractor from the contractor's provider network and from private sources outside of the network for the purpose of enhancing the capabilities of MTFs to provide needed inpatient and outpatient care to beneficiaries.

Foundation Contract, MDA906-95-C-0007, § C-2a.(4).

The guidelines for resource sharing, also set forth in Foundation's contract, require "written agreements between the contractor and the MTF Commander and the appropriate Lead Agent,[2] and between the contractor and the resource sharing provider(s), support personnel, and/or equipment, and supply vendors." Id. at § C-2a.(4)(b)1. In addition, Foundation was required to develop a methodology for preparing a detailed cost analysis for each resource sharing proposal to estimate the net savings to the government and the contractor represented by the sharing approach. Id. § C-2a.(4)(a)2.a.

[2]To coordinate MTF and contractor services, and to monitor health care delivery, each TRICARE region is headed by a joint-service administrative organization called a lead agent. GAO/HEHS-97-130 at 4.

Previous Status of the Outpatient Clinics

The two NAVCARE outpatient clinics at the center of this dispute have been associated with NMCSD since 1984, prior to the implementation of TRICARE.[3] Both of the current clinic contracts were awarded by the Naval Medical Logistics Command, and neither provided for managed care. Now that TRICARE is implemented in the San Diego area, all TRICARE beneficiaries are eligible for care in these NAVCARE clinics. 32 C.F.R. § 199.17(l)(2). Capital Health has operated the NAVCARE clinic in the Clairemont Mesa area of San Diego since late 1993; the clinic currently handles approximately 104,000 visits annually. JSA has operated the NAVCARE clinic in the Chula Vista area of San Diego under its current contract since late 1996 (and continuously since 1986). The Chula Vista clinic currently handles approximately 114,000 visits annually.

In June 1997, the Navy's Fleet and Industrial Supply Center in Philadelphia, Pennsylvania issued request for proposals (RFP) No. N00140-97-R-2021, seeking offers for the operation of the Clairemont Mesa and Chula Vista clinics, and introducing some elements of managed care to the clinics. Two months later, on August 20, the Assistant Secretary of Defense, Health Affairs (ASD/HA), directed that all NAVCARE clinics be converted to TRICARE outpatient clinics in those regions where the TRICARE program was implemented. ASD/HA Policy Memorandum No. 97-062.[4] Both Capital Health and JSA submitted initial proposals and best and final offers in response to the RFP before it was canceled on May 7, 1998.

After the RFP was canceled in May, both protesters became aware that the TMA and NMCSD were considering using resource sharing agreements with Foundation to operate these clinics. After several months of negotiations, TMA, NMCSD and Foundation executed separate agreements for the sharing of resources to enable NMCSD to provide "a full scope adult and pediatric primary care clinic offering appointment[-]based outpatient primary care services, with limited pharmacy, laboratory, and radiology services to include mammography."[5]

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[3]TMA Request for Dismissal, Nov. 30, 1998, at 2.

[4]This direction is also set forth at 32 C.F.R. § 199.17(l)(1), which states that the NAVCARE clinics are "transitional entities" and that authorization for their operation will cease with the implementation of TRICARE, or on October 1, 1997, whichever is later.

[5]NAVCARE Prime, Chula Vista: Resource Sharing Agreement, Attach. A, § 2.2; NAVCARE Prime, Clairemont: Resource Sharing Agreement, Attach. A, § 2.2. Since these agreements are virtually identical, they will hereinafter be cited as the "Agreements."

The terms of the agreements show that the government will provide the clinic facility, as well as all "maintenance, telecommunications, security and utilities, housekeeping and laundry services, and central sterile supply support staff, emergency medical services and ambulance transport service, and office and medical supplies." Agreements, Attach. A, § 2.5. Foundation (or its vendor) will provide most of the required personnel, and medical equipment and clinic furniture. Id. §§ 2.2-2.4. In addition, Foundation is not compensated by the agreement for the resources it provides. Instead, compensation is pursuant to the negotiated rates for services provided for, or referenced in, Foundation's contract. Id. §§ 4.0-5.0.

DISCUSSION

The protesters argued initially that the addition of the Clairemont Mesa and Chula Vista NAVCARE outpatient clinics to Foundation's contract modified the contract beyond its anticipated scope. However, as explained by TMA, and as recognized by the protesters in their supplemental protests, a resource sharing agreement does not result in a modification to a contract, but is instead a bilateral, free-standing agreement between the MTF (together with TMA's Lead Agent), and the managed care contractor.[6]

In response, the protesters argue that the resource sharing agreements here are, nonetheless, beyond the scope of Foundation's contract, beyond the scope of any resource sharing agreement heretofore, and beyond the authority for such agreements authorized by the resource sharing agreement statute--in essence, arguing that the agreements here are disguised, improper sole-source awards. The protesters also argue that the resource sharing agreements here violate the requirement that such agreements be cost-effective for the government.

Jurisdiction and Extent of Review

As a preliminary matter, before we can address the protesters' allegations, we must first consider whether a resource sharing agreement falls within the bid protest jurisdiction of our Office.

Our jurisdiction to hear bid protests limits our review to alleged violations of procurement statutes or regulations by federal agencies in the award or proposed award of contracts for the procurement of goods and services, and solicitations leading to such awards. 31 U.S.C. §§ 3551(1), 3552 (1994). For the reasons set forth below, we conclude that the Military-Civilian Health Services Partnership

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[6]In fact, TMA's contract with Foundation explains that task order modifications to the contract requiring the contractor to provide personnel, medical equipment and supplies should only be used when resource sharing is not mutually beneficial to the government and the contractor. Foundation Contract, §§ C-2a.(4), C-13a.

Program, 10 U.S.C. § 1096, which authorizes resource sharing agreements, is not a procurement statute.

First, the statute, on its face, does not anticipate an acquisition of goods or services.[7] Rather, 10 U.S.C. § 1096(a) authorizes agreements "providing for the sharing of resources between facilities of the uniformed services and facilities of a civilian health care provider" with whom the government has a managed health care contract. In addition, the pool of eligible recipients of these agreements is expressly limited to those with whom the government already has a managed health care contract. Thus, nothing about the statute anticipates the award of new contracts. Further, the statute does not anticipate compensation of the civilian health care provider for the additional employees, equipment, or supplies provided. Rather, the statute clearly explains that beneficiaries will pay for the added services pursuant to the terms of their health care coverage. 10 U.S.C. § 1096(c). Finally, the statute underscores the shared nature of these endeavors by authorizing reimbursement of professional license fees for uniformed services members who must pay such a fee to provide health care at the facility of a civilian health care provider pursuant to one of these agreements. 10 U.S.C. § 1096(d). In short, none of the provisions of this statute support the protester's claim that the Military-Civilian Health Services Partnership Program is a procurement statute.

Nonetheless, while we do not agree that a generic resource sharing agreement is the equivalent of a procurement, our consideration of jurisdiction does not end there. As noted above, the protesters allege that the resource sharing agreements here are being used to avoid the procurement statutes and regulations. The fact that these NAVCARE clinics were previously operated pursuant to Navy-awarded procurement contracts supports the protesters' assertion. This case is thus analogous to those cases where we take limited jurisdiction over challenges to contract modifications, see MCI Telecomms. Corp., B-276659.2, Sept. 29, 1997, 97-2 CPD ¶ 90 at 7 (review limited to whether modification is beyond the scope of original contract, and would otherwise be subject to requirements for competition), and challenges to cooperative agreements under the Federal Grant and Cooperative Agreement Act, 31 U.S.C. § 6305, see Energy Conversion Devices, Inc., B-260514, June 16, 1995, 95-2 CPD ¶ 121 at 2 (review limited to whether cooperative agreement is consistent with the statutory guidance in the Act to ensure that agency is not attempting to avoid the requirements of procurement statutes or regulations). Accordingly, we will take

[7]The protesters here overstate the similarity between these resource sharing agreements and procurement contracts when they suggest that the agreements are being used to procure the operation of the NAVCARE clinics from Foundation, almost as if Foundation were providing a "turnkey" outpatient clinic. Under the previous Navy contracts, the protesters provided all aspects of the clinics, including the clinic building; as discussed above, the agreements here anticipate the sharing of resources necessary to operate a clinic.

jurisdiction over the issuance of these agreements for the limited purpose of considering whether they have been used to improperly avoid the requirements of the procurement statutes.[8] See MCI Telecomms. Corp., supra; Energy Conversion Devices, Inc., supra.

The Propriety of the Clairemont and Chula Vista Resource Sharing Agreements

In considering whether the agency improperly used resource sharing agreements where competitive procurements should have been conducted, we look to the authorizing statute for such agreements. See Spire Corp., B-258267, Dec. 21, 1994, 94-2 CPD ¶ 257 at 3. Here, the statute expressly anticipates the sharing of personnel, equipment, supplies, and any other items or facilities necessary to provide health care services. 10 U.S.C. § 1096(b). As explained above, the agreements here provide that the MTF is responsible for the clinic building and numerous facets of its operation (security, maintenance, supplies, etc.), while Foundation is responsible for ensuring that the facility is properly staffed, and for providing equipment and furniture. Thus, our review shows that these agreements are well within the parameters of the authorizing statute, and we have no basis to conclude that the agreements have been used improperly as a substitute for competitive procurements.

With respect to the protesters' contentions that the agreements here are beyond the scope of Foundation's contract, we look generally to whether there is evidence of a material difference between the agreement and the original contract, and whether the original contract adequately advised offerors of the potential for the type of change covered by the agreement. See MCI Telecomms. Corp., supra, at 7-8. In this area, we see no evidence to support a conclusion that the resource sharing agreements here are beyond the scope of Foundation's contract.

Foundation's contract anticipated that it would work with the MTF and TMA Lead Agent to provide managed care for all eligible beneficiaries within TRICARE's Region 9. Foundation Contract, § C.a. In addition, the contract directed the use of resource sharing agreements wherever possible, rather than task order modifications. Id. §§ C-2a.(4), C-13a. We also note that the operation of the NAVCARE clinics as separate non-managed care outpatient facilities, within the

[8]On the other hand, because our statutory grant of jurisdiction limits our review to awards or proposed awards of procurement contracts, we have no jurisdiction to review allegations that the agency performed an inadequate cost review to determine that the resource sharing agreements here will be cost-effective for the government. See Sprint Communications Co., L.P., B-256586, B-256586.2, May 9, 1994, 94-1 CPD ¶ 300 at 3, 5 (our limited review of cooperative agreements does not extend to an alleged conflict of interest in the award of a cooperative agreement).

NMCSD catchment area, was a redundant service left over from before the implementation of TRICARE.

Finally, we note the protesters' contention that the use of resource sharing agreements to provide for the operation of the Clairemont and Chula Vista clinics appears to be a broader use of such agreements than has been seen heretofore. We agree. Our review of the resource sharing agreements used to date by TRICARE, both as part of Foundation's Region 9 contract, and as part of our audit review of the use of such agreements, suggests that the agreements here may be the most significant use yet of the authority provided at 10 U.S.C. § 1096, and the TMA agrees. For example, our 1997 audit report describes the use of such an agreement simply to augment the internal medicine services at an MTF to reduce the need for referrals to outside internists. GAO/HEHS-97-130 at 29. Similarly, Foundation's Contract, § G, Exhibit 7, at 125-126 describes a possible resource sharing agreement to provide an echo-cardiogram technician to augment the MTF's cardiology capability.

On the other hand, as the discussion above concludes, there is nothing about the resource sharing agreements used here that provides for services beyond those anticipated by the statute authorizing these agreements. In addition, the agreements are clearly within the scope of Foundation's contract, and reflect a reasonable agency decision to delete the redundant non-managed care clinics from areas covered by the TRICARE managed care system. For these reasons, we see nothing unreasonable or improper about these agreements simply because they are larger or more significant than previous agreements.

The protests are denied.

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of the United States