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Comptroller General
of the United States

United States Government Accountability Office
Washington, DC 20548

Decision

Matter of: PGBA, LLC

File: B-292679.2; B-292679.3

Date: November 17, 2003

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Steven S. Diamond, Esq., Walter F. Zenner, Esq., Marc A. Stanislawcyzk, Esq., W. Susanne Addy, Esq., and Joseph M. Catoe, Esq., Arnold & Porter, for Wisconsin Physicians Service Insurance Corporation, an intervenor.
Ellen C. Bonner, Esq., and Michael E. Jonasson, Esq., Department of Defense, Tricare Management Agency, for the agency.
Glenn G. Wolcott, Esq., and Michael R. Golden, Esq., Office of the General Counsel, GAO, participated in the preparation of the decision.

DIGEST

1. Protest that awardee intends to improperly access proprietary Medicare information in performing claims processing function for Department of Defense (DOD) health care beneficiaries is denied where record shows that, rather than access Medicare databases, the awardee proposed to train its staff regarding Medicare requirements, coordinate communication with Medicare contractors and health care providers, and act as advocates for the DOD health care beneficiaries.

2. Where contract performance requires coordination of benefits available under both Medicare and DOD health care programs, and solicitation advised that proposals would be evaluated regarding the effectiveness of proposed approaches to timely and accurately resolve claims, offerors were reasonably on notice that the agency would consider the extent of an offeror's knowledge and experience regarding the Medicare program.

3. Agency reasonably concluded that protester's proposal to provide "one-on-one" assistance to a limited number of beneficiaries--selected on the basis of their status as "VIP beneficiaries," by virtue of a high call frequency, or due to having submitted a high volume of claims--did not provide the depth of service reflected in awardee's proposed approach to employ higher staffing levels of trained personnel to function as advocates for DOD beneficiaries.

4. Agency reasonably evaluated awardee's proposal regarding transitioning requirements as superior to protester's proposal, notwithstanding protester's incumbent status, where requirements of contract being competed have significant differences from prior contract requirements and awardee's proposal contained a detailed discussion of those new requirements, discussed anticipated risks, problems and potential disruptions, and identified potential strategies and solutions.

5. Agency reasonably evaluated awardee's proposal as superior to protester's regarding data access where awardee proposed to provide access to all points designated in the solicitation, identified two additional points where data access would be provided, and proposed to host semi-annual, customer focused, "discovery meetings" with government representatives to identify and discuss data access issues.

6. In evaluating protester's past performance, agency reasonably relied on content of performance reports that had been previously disclosed to, and discussed with protester, and for which protester had previously provided written comments; agency was not required to present the previously discussed information with protester again during discussions.

DECISION

PGBA, LLC protests the Department of Defense (DOD), Tricare Management Agency's (TMA) award of a contract to Wisconsin Physicians Service Insurance Corporation (WPS) under request for proposals (RFP) No. MDA906-02-R-0007. This solicitation sought proposals to provide health care claims processing and related services for military members, and their dependents, who are eligible for both Medicare and Tricare benefits. PGBA protests that the agency erred in evaluating proposals under various technical subfactors, failed to properly evaluate the offerors' past performance, failed to conduct meaningful discussions, and failed to perform an appropriate price/technical tradeoff.

We deny the protest.

BACKGROUND

DOD provides health care to active-duty and retired members of the seven uniformed services, and to their dependents, through an extensive network of military treatment facilities (MTFs), supplemented by a network of civilian health care providers operating under managed care support (MCS) contracts with DOD. In the early 1990s, DOD implemented the Tricare program, which provides three basic health care options: a managed care program, a preferred-provider option, and a fee-for-service option. The total number of beneficiaries currently eligible for Tricare coverage is approximately 8.7 million. A portion of these beneficiaries

(approximately 1.5 million) is also entitled to receive Medicare benefits due to their age (65 or older) or poor health; this portion of the beneficiary population is generally referred to as "dual eligible" beneficiaries.

Prior to October 2001, Tricare beneficiaries who became eligible for Medicare lost their eligibility for Tricare coverage. Effective October 2001, Congress enacted legislation, commonly referred to as "Tricare for Life" (TFL), which restored Tricare coverage for Tricare beneficiaries who are also eligible for Medicare. Under the statutory scheme, Medicare coverage is primary and Tricare coverage is secondary.[1]

In response to the TFL legislation, DOD modified the then-ongoing MCS contracts to incorporate claims processing services for the dual eligible beneficiary population. Pursuant to these modifications, PGBA, acting as a subcontractor to several MCS prime contractors, has been processing the majority of the dual eligible beneficiary claims; WPS, acting as a subcontractor to one MCS prime contractor, has been processing the remaining such claims.

The prior MCS contracts have expired or will expire soon, and have been or will be replaced by the "next generation" of Tricare contracts, frequently referred to as "T-Nex" contracts. In replacing the expiring contracts, and as a part of a broader transformation of DOD's military health care system, DOD has made various program changes, including consolidation of its current eleven Tricare regions into three regions. Further, unlike the prior MCS contracts that incorporated various unique services performed by specialized subcontractors, DOD has elected to "carve out" such services for separate, nationwide contracts. The contract at issue here, which requires performance of claims processing services for the "dual eligible" beneficiary population (generally referred to as the "Tricare Dual Eligible Fiscal Intermediary Contract" or "TDEFIC") is one such contract.

The TDEFIC solicitation was issued in September 2002 and sought proposals for a fixed-unit-priced requirements contract for a base period and five option periods. Agency Report, Tab 1, at 28. Among other things, the statement of work (SOW) calls for the successful offeror to timely and accurately verify beneficiary eligibility; adjudicate, process and pay beneficiaries' claims; accurately coordinate benefits available under Tricare and Medicare; correctly apply deductibles, caps and co-payments; and furnish the beneficiaries with explanations of the benefits provided. Agency Report, Tab 1, at 19-25.

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[1] Medicare and Tricare coverage differ in various ways. The Medicare program does not cover any costs for certain items of medical care covered by Tricare and, for much of the medical care provided, Medicare requires beneficiaries to share costs by means of co-payments and deductibles. Conversely, in a few instances, Medicare provides coverage where Tricare does not.

Section M of the solicitation provided that source selection would be based on the proposal offering the best overall value to the government and identified the following, equally weighted, evaluation factors--technical merit, past performance, and price--reminding offerors that the non-price factors combined were "significantly more important" than price. Agency Report, Tab 1, at 493.

With regard to technical merit, the solicitation established the following equally weighted subfactors: claims processing, beneficiary/provider satisfaction, management approach, transition in, and data access. Id. The solicitation also provided that technical proposals would be evaluated on the basis of how well the proposed procedures or methods "meet or exceed the Government's minimum requirement[s]"; offerors were advised that the agency would consider proposed enhancements exceeding the RFP's stated requirements, provided enhancements were clearly described, and offered--in the agency's judgment--"added benefit" to the government. Agency Report, Tab 1, at 493-94.[2]

With regard to past performance, the solicitation directed that:

> [t]he offeror . . . shall submit a past performance report . . . for each of their current top five overall accounts based on gross revenues. The offeror shall not include accounts from their own subsidiaries . . . or other team members.
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> If the offeror . . . w[as] formed for the purposes of proposing on this RFP and any of the parent corporations have relevant experience, the offeror shall submit their top five account information on its parent

[2] The agency's acquisition plan provided for evaluating proposals under each technical subfactor using an adjectival rating scheme of: blue/exceptional (exceeds specified standards in a manner beneficial to the government); green/acceptable (meets standards), yellow/marginal (fails to meet standards, significant but correctable weaknesses), and red/unacceptable (fails to meet standards, weaknesses are uncorrectable without major proposal revision). Agency Report, Tab 48 at 271. In addition, each subfactor was evaluated for proposal risk, that is, the risk associated with an offeror's proposed approach to performing the contract requirements, as high, moderate, or low. Agency Report, Tab 48, at 272.

> organizations. The offeror must document how the parent corporation's past performance is relevant to this solicitation.[3]

Agency Report, Tab 1, at 480.

Finally, with regard to price proposals, each offeror was required to propose, by contract period, fixed claims processing rates (separate rates for electronic and paper claims), a fixed price for administration, and fixed prices for transitioning in and transitioning out. Section B of the RFP provided estimated quantities, by contract period, regarding electronic and paper claims; section M of the RFP advised the offerors that the evaluated price for claims processing for each period would be calculated by multiplying the proposed rates by the corresponding volume estimates and that the offeror's total price would be calculated by summing the evaluated prices for each contract period. Agency Report, Tab 1, at 496.

The agency received initial proposals from PGBA, WPS and a third offeror by the February 12, 2003 closing date.[4] Each offeror subsequently made an oral presentation to the agency, relying on slides provided to the agency with the offeror's written proposal.

WPS's proposed approach contemplated significantly higher staffing levels than the staffing levels associated with PGBA's proposed approach.[5] Agency Report, Tab 16,

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[3] The record is clear that PGBA, LLC was formed in January 2002, Agency Report, Tab 5, at 98, and that, at the time initial proposals were submitted in February 2003, it had substantial past performance experience under the predecessor MCS contracts. Agency Report, Tab 77. Accordingly, PGBA, LLC was not "formed for the purposes of proposing on this RFP." Indeed, when the agency sought a corporate financial guarantee from PGBA's parent corporation, BlueCross BlueShield of South Carolina, PGBA's representatives resisted, arguing: "as part of establishing [PGBA LLC], the separate subsidiary company with its own government structure, its own dedicated resources . . . we attempted to put the necessary financial strength behind [PGBA, LLC] to not require a performance guarantee." Agency Report, Tab 100, at 89.

[4] The third offeror's proposal is not relevant to resolution of PGBA's protest. Accordingly, our decision here does not further discuss that proposal.

[5] The final evaluated staffing levels proposed by WPS under the contract line item numbers (CLINs) for claims processing and administration ranged from approximately [deleted] full time equivalent (FTE) staff years to approximately [deleted] FTEs. Agency Report, Tab 38, at 143; Tab 16, at 38. The final evaluated staffing levels proposed by PGBA under those CLINs ranged from approximately [deleted] FTEs to approximately [deleted] FTEs. Agency Report, Tab 38, at 143; Tab 10, at 142, 145, 149. At the hearing conducted by GAO in connection with this

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at 38; Tab 10, at 141-54. Further, WPS's proposal provided that WPS personnel would receive significant training regarding the Medicare program and emphasized that WPS staff would act as "advocates" for the Tricare beneficiaries, taking the lead in coordinating communication between the beneficiaries, health care providers, Medicare contractors, and other health insurance carriers. Agency Report, Tab 11, at 109, 126, 138, 143, 165. The agency's source selection evaluation team (SSET) viewed WPS's advocacy approach, along with the proposed training and higher staffing levels necessary to support that approach, as a proposal strength that exceeded the solicitation's requirements. Specifically, the SSET stated: "WPS' proposal to train customer service staff on Medicare benefits and to allow their customer service staff to deal with Medicare and [MCS] contractors on claims issues should increase beneficiary satisfaction." Agency Report, Tab 46, at 256. The SSET evaluated WPS's initial proposal as "blue/exceptional," with low proposal risk, under four of the five technical evaluation subfactors, noting that, overall, the proposal "was extremely comprehensive" and "exceeded RFP requirements in many aspects." Agency Report, Tab 43, at 208.

In contrast, the SSET evaluated PGBA's initial proposal as "yellow/marginal" under four of the five technical subfactors, stating: "the PGBA technical proposal was characterized by a number of omissions which gave the impression that there had been a lack of attention to detail."[6] Agency Report, Tab 43, at 206.

In evaluating initial proposals under the past performance factor, the performance risk assessment group (PRAG) assigned both PGBA's and WPS's proposals adjectival ratings of "confidence."[7] However, with regard to PGBA's proposal, the PRAG report

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protest, PGBA's cost/price consultant testified that WPS's proposed total staffing exceeded PGBA's proposed staffing by approximately [deleted] FTEs. Hearing Transcript (Tr.) at 708.

[6] More specifically, the SSET noted that PGBA's proposal neglected to "make any mention whatsoever of the Dual Eligible population under 65" (that is, beneficiaries that qualify for Medicare based on disability status rather than age); failed to acknowledge that this contract will cover services rendered in Guam, the U.S. Virgin Islands, American Samoa and the Northern Mariana Islands; failed to commit to meet all standards explicitly listed in the Tricare Operations Manual; and failed to adequately discuss training related to the data access evaluation subfactor. Agency Report, Tab 43, at 206-07.

[7] The agency applied an adjectival rating system with regard to evaluation of past performance in which it used the following ratings: "high confidence" (no doubt exists that offeror will successfully perform); "confidence" (little doubt exists that the offeror will successfully perform); "neutral" (no performance record identifiable); "little confidence" (substantial doubt exists that offeror will

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stated: "reservations exist as to [PGBA's] ability to perform the required effort without significant government oversight." Agency Report, Tab 22, at 98. In contrast, the PRAG report stated: "The PRAG is confident WPS can accomplish the required effort with minimal government oversight." Agency Report, Tab 23, at 103. Consistent with the PRAG report, at a hearing conducted by GAO in connection with this protest,[8] the PRAG chair testified that PGBA's rating was on the "lower side," and that WPS's rating was on the "high side," of the "confidence" rating. Tr. at 326.

The PRAG's past performance ratings were based, in large part, on consideration of contractor performance evaluations (CPEs) that TMA had conducted in connection with PGBA's and WPS's subcontract performance of claims processing activities under the prior MCS contracts, following enactment of the TFL legislation. The agency's final CPE reports reflect significantly more successful performance by WPS than by PGBA. Agency Report, Tabs 77, 78. Specifically, while recognizing that, due to the complexities involved, PGBA's efforts were "laudable," the CPE reports concluded that PGBA's actual accomplishments were not. Overall, TMA concluded that PGBA "fell short of ensuring an acceptable level of quality and accuracy" and that "many operation areas require critical re-evaluation, re-training, and re-thinking of work processes." Agency Report, Tab 77, at 4-5, 64-65, 144-45, 202-03.[9] Among other things, TMA noted that "millions of dollars in duplicate and incorrect payments were made" and that, even after PGBA attempted corrective action, "significant quality and accuracy issues still existed." Agency Report, Tab 77, at 5, 65, 145, 203. More specifically, the final CPE reports referenced PGBA's "overall operational problems," including "inaccurate payment determinations," "numerous violation[s] of privacy act requirements," "unclear, erroneous, or inappropriate letters," "improper aging of certain types of claims," and "inaccurate or non-existent deferrals for medical review." Id. The reports concluded, "These are the types of problems

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successfully perform); and "no confidence"(extreme doubt exists that offeror will successfully perform). Agency Report, Tab 49, at 296.

[8] In resolving this protest, our Office conducted a three-day hearing, on the record, during which testimony was provided by seven agency witnesses (the source selection authority, the source selection evaluation board (SSEB) chair, the PRAG chair, the SSET chair, an SSET evaluator, a requirements specialist, and the cost/price analyst), two protester witnesses (a cost/price consultant and an information technology specialist), and one intervenor witness (a corporate vice-president).

[9] Tab 77 of the Agency Report contains four separate CPE reports regarding PGBA's performance--one for each of the MCS contractors for whom PGBA functioned as a claims processing subcontractor. Because the conclusions discussed and quotations included in this decision appear in each of the four reports, we have provided separate citations to each report.

that should have been readily evident internally and addressed quickly [but were not]." Id. In contrast, the CPE report regarding WPS's performance reflected significantly fewer problems and complimented WPS and HealthNet Federal Services, Inc. (the MCS prime contractor) for working together to create documentation outlining their implementation of the TFL legislation. The report concluded that their efforts "resulted in a relatively smooth implementation of TFL."[10] Agency Report, Tab 78, at 258.

In evaluating PGBA's past performance, the PRAG also expressed concern that PGBA had not complied with the solicitation requirement that past performance information be submitted for the offerors' "top five" accounts.[11] The PRAG concluded that PGBA had omitted information for two of its "top five" accounts,[12] and had, instead, submitted past performance reports relating to PGBA's parent and sister corporations--which the PRAG considered to be not only irrelevant, but contrary to the solicitation directions.[13] Accordingly, the PRAG expressed concern

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[10] TMA issued the final CPE reports for WPS and PGBA on October 18, 2002. In performing this CPE effort, TMA used equal sample sizes of claims for each contractor. Agency/Intervenor's Joint Post-Hearing Comments, Nov. 3, 2003, at 176; Agency Report, Tab 77 at 9; Agency Report, Tab 78 at 259. As part of the CPE process, TMA provided copies of the draft CPEs to both WPS and PGBA, seeking their input and responses to the agency's preliminary findings/assessments. PGBA and WPS provided responses to TMA which were considered and, in some instances, included in the final CPE reports. Agency Report at 17.

[11] As noted above, the solicitation stated: "The offeror . . . shall submit a past performance report . . . for each of their current top five overall accounts based on gross revenues. The offeror shall not include accounts from their own subsidiaries . . . or other team members." Agency Report, Tab 1, at 480.

[12] PGBA did not submit past performance reports from TriWest Healthcare Alliance Corporation or Sierra Military Health Services, Inc., both of which were MCS contractors and among PGBA's "top five" accounts based on gross revenues.

[13] As noted above, PGBA, LLC was established as a subsidiary of BlueCross BlueShield of South Carolina (BCBSSC) in January 2002 and had significant past performance information related to its own performance of the claims processing function under the predecessor MCS contracts, including performance as a subcontractor for TriWest and for Sierra. The agency states that, in response to questions regarding this matter, BCBSSC's president acknowledged that the past performance information PGBA had submitted related to contracts that had been performed by BCBSSC and/or PGBA's sister corporations and that "[n]either PGBA, LLC, nor the former Tricare Division, PGBA, played a role in the performance of [these contracts]." Agency Report, Tab 22, at 99.

with "the inability of PGBA to accurately provide required information or the intentional omission of harmful information."[14] Agency Report, Tab 22, at 100.

Based on the evaluation of initial proposals, the agency determined that each of the three offerors were within the competitive range and that discussions would be required. Accordingly, discussions were thereafter conducted, during which multiple matters requiring correction, explanation, amplification, or clarification were brought to each offeror's attention. Agency Report, Tabs 99, 100.

Final proposal revisions (FPRs) were requested and submitted by April 28. These FPRs were subsequently evaluated by the SSET. In addition, all of the offerors' complete proposals were independently evaluated by TMA's source selection authority (SSA). Tr. at 27-33. In independently evaluating the proposals, the SSA made no changes to the SSET evaluations of WPS's proposal. However, in evaluating PGBA's proposal, the SSA increased the SSET rating with regard to one technical evaluation subfactor, data access, from "yellow/marginal" to "green/acceptable." Overall, the final agency ratings of PGBA's and WPS's proposals were as follows:

[14] Due to PGBA's omission of information from TriWest and Sierra, the PRAG contacted those companies and obtained past performance information from them. The information so obtained in connection with this procurement was provided to PGBA during discussions to provide PGBA an opportunity to respond. PGBA maintains that, because TriWest and Sierra are no longer intending to subcontract with PGBA, and are competing for the T-Nex MCS contracts using other subcontractors, the FAR conflict of interest provisions prohibit consideration of past performance information from them. At the GAO hearing, the SSA testified that she treated the information the PRAG obtained from TriWest and Sierra as "neutral." Tr. at 186. With regard to the CPEs, there is no conflict of interest issue since, at the time the CPEs were conducted, TriWest and Sierra were not competing for the T-Nex contracts. Further, as noted above, the agency's CPE findings, quoted in the decision above, were contained in the CPE reports relating to PGBA's subcontract performance under the other two MCS contractors, Health Net Federal Services, Inc. and Humana Military Healthcare Services, Inc., see Agency Report, Tab 77 at 61-148, 199-254, as well as in the CPE reports relating to TriWest and Sierra.

	WPS	PGBA
Technical Merit	Blue/Exceptional (low risk)	Green/Acceptable (low risk)
--Claims Processing	Blue/Exceptional (low risk)	Blue/Exceptional (low risk)
--Beneficiary/Provider Satisfaction	Blue/Exceptional (low risk)	Blue/Exceptional (low risk)
--Management Approach	Green/Acceptable (low risk)	Green/Acceptable (low risk)
--Transition In	Blue/Exceptional (low risk)	Green/Acceptable (low risk)
--Data Access	Blue/Exceptional (low risk)	Green/Acceptable (low risk)
Past Performance	Confidence	Confidence
Evaluated Price	$486,918,518	[deleted]

Agency Report, Tab 18, at 15; Tab 20, at 44.

Although WPS's and PGBA's proposals were both rated "blue/exceptional," with low risk, under the first two technical evaluation subfactors--claims processing and beneficiary/provider satisfaction--the SSA's source selection memorandum identifies various aspects of WPS's proposal which led her to conclude that it was superior under those two evaluation factors.[15] Among other things, the SSA referenced WPS's higher staffing levels and its "personalized approach" to achieve a higher level of beneficiary/provider satisfaction. Agency Report, Tab 18, at 20, 25. The SSA further documented her conclusions regarding strengths in WPS's proposal, stating:

> Get back money from Medicare Fiscal Intermediaries/Carriers that shouldn't have crossed over.
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> * * * * *
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> Training customer service staff on Medicare benefits and allowing customer service staff to deal with Medicare and MCS [contractors] on claims issues should increase beneficiary satisfaction.

[15] Both offerors proposed to exceed various aspects of the solicitation requirements regarding timeliness and accuracy of claims processing. The agency concluded that the two proposals were essentially equal with regard to timeliness and accuracy of claims processing. Tr. at 53-54.

> Will communicate to beneficiaries and providers if their claim was forwarded to Medicare for processing, rather than simply returning the claim for filing with Medicare, thus increasing satisfaction and better informing the beneficiary of the current status of their claim.

Agency Report, Tab 18, at 19, 20.

Similarly, although WPS's and PGBA's proposals received the same adjectival rating with regard to past performance, the SSA concluded "there is sufficient difference in WPS' past performance to rank WPS first." Agency Report, Tab 18, at 16. Referring to the TMA-prepared CPEs documenting WPS's and PGBA's immediately preceding claims processing performance, the SSA stated:

> PGBA had twice the number of findings (i.e. 34 findings for PGBA and 17 for WPS).[16] For WPS, most of the problems were of limited scope and had already been recognized by WPS. In many instances, changes were implemented by WPS to correct the problems and to preclude the inaccurate payment of broad categories of claims. The review performed at PGBA found systemic inaccuracies as well as individual faults that resulted in broad categories of overpayments. PGBA failed to recognize some of the errors until the TMA review team called them to their attention. In terms of both quantities of findings, as well as a delay by PGBA in identifying the problems, I find WPS' performance to be superior when compared to PGBA as it relates to the past performance within the category defined by "Confidence." WPS ranks the best in terms of past performance.

Agency Report, Tab 18, at 16-17.

The SSA then performed a price/technical tradeoff regarding WPS's and PGBA's proposals in which she specifically acknowledged the magnitude of PGBA's price advantage but, nonetheless, concluded, "I have determined the additional price that will be paid by the Government for WPS to perform the contract is more than justified by the superior technical performance, and WPS' outstanding past performance." Agency Report, Tab 18, at 25. Accordingly, a contract was awarded to WPS on July 29. This protest followed.

[16] As noted above, the CPE reports for both WPS and PGBA were based on equal numbers of sample claims.

DISCUSSION

PGBA first challenges the agency's evaluation of technical proposals, identifying alleged evaluation errors regarding the various technical subfactors. In short, PGBA maintains the agency improperly credited WPS with certain technical strengths and/or improperly failed to credit PGBA's proposal with various technical strengths. We find no merit in PGBA's assertions.

PGBA first complains that the agency "improperly credited WPS for leverage of its Medicare contract," complaining that, "to the extent that WPS' Customer Services staff use Medicare information provided to them by WPS' Medicare Operation to answer questions of Tricare beneficiaries, WPS could run afoul of various laws, as well as guidance . . . addressing disclosure of Medicare information." Protest at 8, 10. In short, PGBA maintains that WPS intends to inappropriately access proprietary Medicare information in performing the TDEFIC requirements.

WPS's proposal made various references to its claims processing experience under the Medicare program. Specifically, WPS noted that, in light of the relationship between Medicare and Tricare benefits under the TFL legislation,[17] knowledge and understanding of the Medicare program are valuable in effectively performing the TDEFIC requirements. In this regard, WPS's proposal states that WPS is "the largest [Medicare] Part B administrator in the national program," Agency Report, Tab 11, at 27, and repeatedly references the Medicare training WPS intends to provide for its staff, explaining that WPS staff will initiate and coordinate communication between the Tricare beneficiaries, the Medicare contractors, and the health care providers.

In response to PGBA's protest, both WPS and the agency maintain that nothing in WPS's proposal suggested, nor did the agency understand WPS's proposal to assert, that WPS staff would access proprietary Medicare databases to perform their TDEFIC responsibilities. Rather, they maintain that the record clearly shows that the Medicare-related "strengths" that WPS proposed, and as evaluated by the agency, related to training and/or experience of WPS staff regarding Medicare benefits and the Medicare program--not improper access to proprietary data. Specifically, the source selection decision memorandum describes the following proposed "strength" regarding Medicare knowledge:

[17] As noted above, under statute, Medicare coverage is primary and Tricare coverage is secondary. Thus, in general, beneficiary claims must first be submitted to Medicare for processing; these claims are then transmitted (usually electronically), or "crossed over," to the Tricare contractor for consideration of additional coverage.

> Training customer service staff on Medicare benefits and allowing customer service staff to deal with Medicare and [MCS] contractors on claims issues should increase beneficiary satisfaction.

Agency Report, Tab 18, at 20; Tab 20 at 54.

Consistent with this, WPS and the agency note that WPS's proposal repeatedly discussed its proposed proactive approach, under which WPS's trained staff will work as "advocates" for the Tricare beneficiaries, stating, for example:

> Training for our Customer Service staff will focus on becoming an advocate for the customer. Customers do not always understand that we are dependent on the processing and the information given by Medicare. In those situations where we are contacted because Medicare denied the claim or needs additional information, we will contact the appropriate Medicare contractor on behalf of the customer.

Agency Report, Tab 11, at 119.

Similarly, WPS's proposal states: "With each contact, the customer will be serviced by a Representative that has gone through six-weeks of training on Tricare and Medicare," Agency Report, Tab 11, at 126, and further elaborates:

> The training our Customer Service representatives receive will allow them to provide advocacy services such as claims payment information, benefit information, eligibility verification, program information, marketing material provided by TMA and duplicate explanation of benefits.

Agency Report, Tab 11, at 138.

Yet again, WPS's proposal states:

> We will forward all grievances that deal with Medicare contractors to them with a notification to the customer. We will be in close contact with the customer and if they have not received a response from Medicare, we will work with Medicare on their behalf to resolve the issue.

Agency Report, Tab 11, at 143.

The agency and WPS maintain, and we agree, that nothing in these portions of WPS's proposal suggests that WPS intends to improperly access proprietary Medicare information in performing the TDEFIC requirements. Further, in pursuing this protest, PGBA has not identified any other portions of WPS's proposal, or the agency

evaluation record, that suggests such an intent. Accordingly, we find no merit in PGBA's assertion that WPS's proposal was credited with improper "leverage" of WPS's Medicare contract.

Alternatively, PGBA asserts that it was improper for the agency to consider the extent of WPS's knowledge of, and/or experience under, the Medicare program, since such knowledge/experience was not a stated evaluation factor. Protester Comments on Agency Report, Oct. 7, 2003, at 5. We disagree.

Although solicitations must inform offerors of the bases on which proposals will be evaluated, and the evaluation must be based on such stated factors, a solicitation must also be read as a whole, with meaning given to every section, specifically including the statement of work. Irwin & Leighton, Inc., B-241734, Feb. 25, 1991, 91-1 CPD ¶ 208. While evaluation factors must be identified, an agency need not identify every possible consideration under each stated evaluation factor, provided such areas of consideration are reasonably related to, or encompassed by, the stated criteria. Avogadro Energy Sys., B-244106, Sept. 9, 1991, 91-2 CPD ¶ 229.

Here, as noted above, the solicitation directed that offerors would be responsible for, among other things, accurate coordination of benefits available under Tricare and Medicare, correct application of deductibles, caps and co-payments, and furnishing beneficiaries with explanations of the benefits provided. Agency Report, Tab 1, at 19-25, 476-77. Section M of the RFP stated that proposals would be evaluated, among other things, with regard to "the effectiveness of the [offeror's] approach for providing timely and accurate [claims] processing," and "the offeror's ability to establish and maintain beneficiary and provider satisfaction at the highest level."

In light of the these solicitation provisions alone, we believe the agency's consideration of an offeror's knowledge or experience with the Medicare program was reasonably subsumed in the stated evaluation factors. In any event, given the relationship between the Medicare and Tricare programs following enactment of the TFL legislation, along with the potential to minimize a "ping-pong" effect, where claims go back and forth between the two programs, the agency's consideration of an offeror's knowledge and/or experience regarding benefits provided and processes employed under each program was clearly related to and encompassed within the solicitation's various evaluation factors. Accordingly, we find no merit in PGBA's assertion that the agency improperly considered the knowledge that WPS staff would possess, either through training or experience, regarding the Medicare program or that the evaluation of this information was inconsistent with the stated evaluation criteria.

PGBA also complains that, to the extent WPS's proposal was credited for its approach to act as an advocate for Tricare beneficiaries, the agency erred in not similarly crediting PGBA's proposal for a similar approach. Specifically, PGBA maintains that it also proposed to provide "an additional level of dedicated customer

service by identifying TDEFIC beneficiaries who require one-on-one assistance," and "will make frequent proactive contact with their beneficiaries to assist with any TDEFIC-related issues." Protester Comments on Agency Report, Oct. 7, 2003, at 23; Agency Report, Tab 5, at 224-26.

In conducting discussions with PGBA, the agency noted PGBA's proposal to provide "one-on-one assistance," specifically questioning PGBA regarding the extent of its commitment and requesting information regarding the number of beneficiaries this was expected to involve. Agency Report, Tab 100, at 55-56. During discussions, PGBA's representative responded to these requests, stating: "I don't have an estimate right here with me. Certainly [can] provide that later on." Agency Report, Tab 100, at 57. In its FPR, PGBA did, in fact, provide a response, stating that this aspect of its proposal would "concurrently support up to 300 beneficiaries."[18] Agency Report, Tab 10, at 51. PGBA further clarified that the "up to 300 beneficiaries" selected for "one-on-one assistance" would be chosen based on their status as "VIP Beneficiaries,"[19] by virtue of a high frequency of calls, or due to having submitted a high volume of claims. Id.

In contrast, WPS did not narrowly limit its proposed advocacy to "VIP Beneficiaries," frequent callers, or those submitting a high volume of claims; nor did WPS suggest that its advocacy would be limited to a maximum of 300 beneficiaries at any given time. Rather, WPS's proposal provided that all of its customer service representatives would receive significant training focused on advocacy for the "dual eligible" population, and proposed sufficiently high staffing levels to accommodate a greater level of personal interaction with the beneficiary community. On this record, we find no basis to question the agency's determination that WPS's proposed approach, supported by more extensive training and higher staffing levels, offered a greater depth of service, more personal interaction, and increased advocacy for the "dual eligible" beneficiary population (which, the agency notes, is the oldest and frailest portion of the total Tricare beneficiary population) than the approach offered by PGBA, and that WPS's approach constituted a material benefit to the government.

PGBA next protests that the agency "erroneously credited WPS with potential costs savings that are unauthorized," complaining that WPS had proposed, and/or the SSA construed WPS as proposing, to recoup erroneous Tricare payments to beneficiaries from the Medicare Trust Fund. PGBA notes that "nothing . . . permits WPS to withdraw funds [from the Medicare Trust Fund] to reimburse Tricare." Protest at 11.

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[18] There are approximately 1.5 million dual eligible beneficiaries.

[19] PGBA further explained that "VIP Beneficiaries" would be "individual[s] identified through complex services issues, Congressional inquiries, etc." Id.

As noted above, beneficiaries must, generally, submit claims to Medicare for consideration prior to seeking additional recovery from Tricare. After processing a claim for Medicare benefits, the Medicare contractor forwards dual-eligible beneficiary claims to the Tricare contractor for processing.[20] A claim forwarded to the Tricare contractor by Medicare is known as a "crossover claim," and the Medicare contractor charges the Tricare contractor a fee for the administrative service of forwarding the claim, which is known as a "crossover fee." The Tricare contractor receives reimbursement from TMA for the crossover fees charged by the Medicare contractor.

Some of the "crossover claims" forwarded by Medicare contractors to Tricare contractors have been erroneously sent due to various errors on the part of the Medicare contractor. Referring to such erroneously transferred claims, WPS's proposal stated that "TMA shouldn't pay for these claims" and provided that WPS intended to negotiate agreements with the Medicare contractors "to recover charges on claims that should not have been crossed over." Agency Report, Tab 11, at 66. The agency evaluated this as a strength in WPS's proposal, noting in the source selection decision memorandum that "[WPS proposes] to get money back from Medicare Fiscal Intermediaries for claims that should not have crossed over when the benefit is a Medicare benefit but is not a Tricare benefit." Agency Report, Tab 18, at 13.

PGBA argues that this portion of WPS's proposal, and the agency's evaluation record, reflect WPS's intent, and/or the agency's understanding that WPS intended, to recover erroneous beneficiary payments from the Medicare Trust Fund. Protester Comments on Agency Report, Oct. 7, 2003, at 13.

At the GAO hearing, the SSA provided testimony regarding this issue, specifically testifying as follows:

> I identified [as a distinguishing strength of WPS's proposal] that they [WPS] could get money back from Medicare, fiscal intermediary carriers for claims that shouldn't have crossed over. And when I say get money back, we are talking about the crossover fees, not talking about benefit dollars, but crossover fees that are represented by those crossover claims.

Tr. at 54.

Based on our review of the entire record, we find no evidence that reasonably refutes the SSA's testimony. We conclude that WPS proposed to recover crossover

[20] Tricare contractors and Medicare contractors enter into "trading partner agreements" (TPA) that address their various responsibilities.

fees, and that the SSA understood the WPS proposal to be addressing only crossover fees. Accordingly, we find no merit in PGBA's assertion that WPS intended to recover beneficiary payments from the Medicare Trust Fund.

Next, PGBA protests that the agency's evaluation with regard to the technical subfactor, transition in, was unreasonable.[21] Specifically, PGBA maintains that, because PGBA has been performing more than 80 percent of the "dual eligible" claims under the prior MCS contracts,[22] it was "absurd" for the agency to evaluate PGBA's proposal as "green/acceptable" and WPS's proposal as "blue/exceptional under this subfactor." Protest at 14. PGBA's protest in this regard is based on the premise that PGBA has already "completed" transition tasks relating to 82 percent of the new contract's requirements, and that transition tasks will be "minimal" since they will "involv[e] only 18% of the work." Id.

The agency responds that, contrary to PGBA's assumption that transition tasks related to the claims processing it has been performing under the prior MCS contracts are "completed," the TDEFIC solicitation reflected a significant number of changes--affecting all claims processing--that will require the TDEFIC contractor to alter various aspects of its contract performance, even with regard to claims processing it has been performing under the MCS contracts. Accordingly, the agency states that, while PGBA's proposal--based on the premise that "most" of the transitioning requirements were "completed" and only "minimal" efforts would be required--minimally complied with the solicitations transitioning requirements, it offered nothing more.

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[21] With regard to transitioning in, section L of the RFP directed, among other things, that:

> The offeror shall present a comprehensive description of and timeline for all start-up activities. The description shall specifically address how the offeror will minimize disruption to beneficiaries.
>
> * * * * *
>
> The offeror shall provide their data transition plan. . . .
>
> The offeror shall demonstrate a commitment to engage in a collaborative and partnering manner with other Tricare contractors.

Agency Report, Tab 1, at 478.

[22] The record indicates that PGBA is currently performing approximately 82 percent of the required claims processing for dual eligible beneficiaries and that WPS is performing approximately 18 percent of that work.

With regard to changes between the TDEFIC's new requirements and the offerors' prior activities, the agency notes that, in addition to changing the basic contract relationship from that of an MCS subcontractor to a prime contractor relationship with TMA, negotiating new memoranda of understanding with the new T-Nex MCS contractors, adding the portion of claims processing not previously performed,[23] the TDEFIC contract contemplates implementation of system-wide automation changes, including changes to the payment system (generally referred to as the "TEDS" or "Tricare encounter data system") as well as to the automated system used to measure beneficiary eligibility (generally referred to as the new "DEERS" or "Defense enrollment and eligibility reporting system"). At the GAO hearing, Tricare's program manager responsible for implementing the new systems testified that the new DEERS system, alone, will add at least 75 to 100 new data elements to the existing system, will fundamentally change how contractors access data from and interface with Tricare beneficiary databases, and that implementation of the new system will involve modifications to contractors' existing systems and interfaces with Tricare systems that will require significant programming, testing and benchmarking. Tr. at 552-88.

PGBA's own witness, whom PGBA presented as being knowledgeable with regard to both information technology and the solicitation's transition requirements, acknowledged that the work associated with establishing interfaces between PGBA's existing/remaining systems and the new DEERS was significant. Specifically, she testified:

> There are certain pieces of data that must be checked against DEERS every step of the way throughout claims processing. Half of the work involves analysis of those [existing] systems themselves in order to understand where those interfaces must be, where they must be unhooked, and hooked into a new interface . . . and [we] have spent in excess of 13,000 hours doing [that] since the 1st of January [2003].

Tr. at 624.

With regard to the other "half of the equation," that is, analysis of the new DEERS, this witness further testified that, until PGBA personnel received more information, they did not feel "comfortable" establishing a detailed transition plan related to implementation of the new system. Tr. at 623, 626. Overall, consistent with PGBA's discomfort in addressing the new DEERS requirements and its assumption that

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[23] In addition to requiring the successful offeror to take over claims processing in the regions where it had not previously performed, the TDEFIC contract requires nationwide coverage for a new group of Tricare beneficiaries--those that that are under 65 but who qualify for Medicare due to their medical condition.

transition efforts would be minimal, the agency concluded that PGBA's proposal met, but did not exceed, the solicitation requirements regarding transitioning.

In contrast, WPS's proposal presented a transition plan that the agency viewed as significantly exceeding the solicitation requirements. In terms of detail, WPS's proposal contained 68 pages of annotated slides and a supplemental detailed plan that addressed how it intended to meet the transition requirements. Agency Report, Tab 11, at 220-87. The proposal identified and described 53 phased milestones, along with listing and describing all required tasks and timelines. Id. at 230. The plan showed the sequencing of the milestone tasks, which were annotated with appropriate "plan start" and "plan finish" dates. Id. at 231, 236, 238, 252, 277, 278. WPS also submitted a detailed phase-in plan. Id. at 354-500. These 155 pages displayed 1,302 sequenced tasks that WPS plans to follow to effect the transition. Finally, WPS's proposal addressed potential risks and problem areas and formulated specific solutions, in particular identifying potential disruptions in service to beneficiaries and providers and identifying proposed strategies to minimize their effect. Id. at 257-61. Overall, the agency found WPS's proposal to be comprehensive, detailed and proactive, and concluded that WPS's proactive approach exceeded the solicitation requirements. Agency Report, Tab 31, at 131. Accordingly, the agency rated WPS's proposal blue/exceptional.

In reviewing an agency's evaluation, GAO will not reevaluate offerors' proposals, but rather will examine the agency's evaluation to ensure that it was reasonable and consistent with the solicitation's stated evaluation criteria and with procurement statutes and regulations. Encorp-Samcrete Joint Venture, B-284171, B-284171.2, Mar. 2, 2000, 2000 CPD ¶ 55 at 4. The offeror has the burden of submitting a proposal that meets or exceeds the solicitation requirements, and mere disagreement with an agency's judgments regarding these matters is insufficient to establish that the agency acted unreasonably. PEMCO World Air Servs., B-284240.3 et al., Mar. 27, 2000, 2000 CPD ¶ 71 at 15.

Based on the record here we find no basis to question the agency evaluation of WPS's and PGBA's proposals with regard to the requirements for transitioning from the preceding MCS subcontracts to performing the TDEFIC requirements. The record establishes that there were significant aspects of the TDEFIC requirements that differed from the prior MCS contracts, thus requiring significant transition efforts--even for an incumbent contractor, and the record reasonably supports the agency's conclusion that WPS's proposal was significantly superior to PGBA's with regard to addressing the transition efforts that would be required. Accordingly, PGBA's protest that the agency unreasonably evaluated the offerors' proposals with regard to the transition requirement--including the assertion that PGBA's transition tasks would be "minimal"--is without merit.

PGBA next challenges the agency evaluation with regard to the technical subfactor for data access. As noted above, the final agency evaluation of PGBA's proposal

with regard to this subfactor was "green/acceptable," while WPS's proposal was rated "blue/exceptional." PGBA complains that the agency erred in failing to rate its proposal "blue/exceptional."

With regard to data access, the RFP contained the following requirements:

> The contractor shall . . . [provide] timely and reliable electronic access for Government-designated individuals. Minimum access shall include two authorizations at each MTF [military treatment facility], ten authorizations at each Surgeon General's Office, two authorizations at Health Affairs, two authorizations at TMA-Washington, two authorizations at TMA-Aurora, and authorization(s) (not to exceed two) for on-site Government representatives. Access requires ongoing user training and support. . . .

Agency Report, Tab 1, at 22.

The agency was concerned that PGBA's initial proposal did not adequately address the level and type of data access that would be provided. During discussions, the agency asked PGBA several specific questions regarding this matter. Agency Report, Tab 100, at 62-69. In its FPR, PGBA stated:

> It is up to the Government to determine which employees/agencies have [data] access . . . and PGBA will support your needs.
>
> PGBA will initially support access for up to 200 users. . . . Should the Government desire additional access rights, PGBA will work to accommodate the request.

Agency Report, Tab 10, at 58.

In evaluating PGBA's FPR, the agency concluded that PGBA met, but did not exceed, the solicitation's data access requirements, thereby warranting a "green/acceptable" rating.

Similar to PGBA's FPR, WPS's proposal provided that WPS would meet the solicitations requirements by providing data access to all of the specifically designated points identified in the solicitation. Agency Report, Tab 11, at 293. In addition to those specifically designated access points, WPS also proposed to provide data access to regional directors and intermediate services commands. Id. The agency viewed WPS's identification of these additional data access points as demonstrating a clear understanding of the contract requirements and evaluated this aspect of WPS's proposal as exceeding solicitation requirements in a manner that benefited the government. Additionally, WPS proposed to host "semi-annual discovery meetings with government representatives" in order to "address the usability of the existing tools, define desired enhancements and plan deliverables,"

further explaining that "[w]orking together we will be able to refine the portals, reports and query capabilities." Agency Report, Tab 11, at 310. Again, the agency viewed this proposed customer-oriented approach as exceeding the solicitation requirements in a way that benefited the government. Specifically, with regard to the "discovery meetings," one evaluator noted: "The fact that WPS offers to host semi-annual discovery meetings with government partners demonstrates their willingness to furnish ongoing customer support tailored to user needs that may evolve over the course of the contract." Agency Report, Tab 51, at 179.

As noted above, a protester's mere disagreement with the agency's judgment does not establish that the agency acted unreasonably. PEMCO World Air Servs., supra. Based on the record here, it is clear that PGBA's FPR revision, while meeting the solicitation requirements made no attempt to exceed those requirements.[24] In contrast, WPS's proposal did--and did so in a way which the agency viewed as providing a benefit. We find no basis to question the reasonableness of the agency's conclusions in this regard.

Next, PGBA protests the agency's evaluation regarding PGBA's past performance. As discussed above, the solicitation established that the agency would accord an offeror's past performance the same weight given to all five technical subfactors combined. Agency Report, Tab 1, at, 493. As also discussed above, the agency's past performance evaluation relied significantly on the information contained in the CPE evaluation reports which TMA completed in October 2002 and which were significantly more critical of PGBA's performance in performing claims processing for dual eligible beneficiaries under the prior MCS contracts.

In challenging the agency's evaluation of past performance, PGBA has not presented any argument or information that materially challenges the factual accuracy of the CPE reports. Indeed, PGBA acknowledges that the problems associated with PGBA's prior performance, as documented in the CPE reports, "were to be expected given the task confronting PGBA." Protester's Comments on Agency Report, Oct. 7, 2003, at 28. PGBA essentially maintains that the agency failed to consider the CPE reports in proper perspective, and specifically complains that, in comparing PGBA's performance to that of WPS, the agency failed to consider that PGBA was responsible for implementing a significantly greater volume of claims. Id. at 26.

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[24] PGBA makes much of the fact that, during discussions, PGBA's representatives verbally advised the agency that PGBA would provide access to whoever the government wanted, stating "every single employee could have access." Agency Report, Tab 100, at 62. However, the broad representations made during discussions were not repeated in PGBA's written responses to the agency's data access questions and, as discussed above, the express terms regarding data access in PGBA's FPR were substantially more limited. Agency Report, Tab 10, at 58.

The agency points out that the sample size of claims from which the CPE reports drew their findings were the same for both WPS and PGBA. Accordingly, to the extent PGBA criticizes the agency's consideration of the quantity of problems identified in each of the reports, the agency maintains that such consideration was appropriate. Cf. Green Valley Transport., Inc., B-285283, Aug. 9, 2000, 2000 CPD ¶ 133 (unreasonable for an agency to consider the absolute number of negative performance actions regarding an offeror without considering that number in the context of the total volume from which the number was drawn).

We agree. Since the sample size of claims from which problems were identified was the same for both PGBA and WPS, the agency's consideration of the number of problems identified within those samples was reasonable. More significantly, the agency's evaluation record establishes that, in addition to considering the relative number of problems, the SSA specifically considered the nature and significance of WPS's and PGBA's respective problems, along with the offerors' responses to them. Specifically, the source selection decision memorandum states:

> For WPS, most of the problems were of limited scope and had already been recognized by WPS. In many instances, changes were implemented by WPS to correct the problems and to preclude the inaccurate payment of broad categories of claims. The review performed at PGBA found systemic inaccuracies as well as individual faults that resulted in broad categories of overpayments. PGBA failed to recognize some of the errors until the TMA review team called them to their attention.

Agency Report, Tab 18, at 17.

On this record, we find no basis to question the agency's determination that WPS's past performance with regard to the claims processing for dual eligible beneficiaries was superior to that of PGBA.

PGBA also asserts that the agency was required to specifically discuss the content of the CPE reports with PGBA during the discussions TMA conducted in connection with the TDEFIC procurement. We disagree.

The Federal Acquisition Regulation (FAR) provides that an agency must discuss "adverse past performance information to which the offeror has not yet had an opportunity to respond." FAR §15.306(d)(3). Here, the record is clear that TMA specifically presented the draft CPE reports to PGBA at the time the evaluations were being conducted, that PGBA submitted written responses to TMA regarding the content of those reports, that TMA considered those responses and, in some instances, incorporated them into the final reports. To the extent PGBA asserts that TMA was required, in the context of the TDEFIC solicitation, to repeat that process,

we reject the assertion.[25] Accordingly, we find no merit in PGBA's protest that the agency's evaluation of PGBA's past performance was flawed.[26]

Finally, PGBA asserts that the SSA failed to perform a reasoned price/technical tradeoff, arguing that the record reflects an inadequate discussion of the qualitative distinctions between the two proposals. We disagree.

The propriety of a procuring agency's source selection decision turns, not on whether this Office agrees with the source selection official's judgment, but on whether that judgment is reasonable and is adequately documented. Cygnus Corp., B-275181, Jan. 29, 1997, 97-1 CPD ¶ 63 at 11. While adjectival ratings and point scores are useful guides, they generally are not controlling; rather, a price/technical tradeoff decision must be supported by documentation addressing the relative differences between proposals, their strengths, weaknesses and risks. Century Envtl. Hygiene, Inc., B-279378, June 5, 1998, 98-1 CPD ¶ 164 at 4.

Here, as discussed above, the solicitation advised offerors that, in making the source selection decision, past performance and the five technical evaluation subfactors combined would be "significantly more important than price." Accordingly, the SSA was obligated to give WPS's evaluated advantages with regard to the non-price factors significantly more weight than PGBA's price advantage. As discussed above, the evaluation record provides ample support for distinguishing between WPS's and PGBA's track records of past performance with regard to claims processing for dual eligible beneficiaries. Further, the record supports the agency conclusion that WPS's proposed approach, which contemplates higher staffing levels and more extensive training, will provide more personal interaction and greater support for the "dual eligible" population--the oldest and frailest portion of DOD's beneficiary population. Finally, the record reasonably supports the agency's assessment that WPS proposed

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[25] We note that, in pursuing this protest, PGBA has not factually challenged the content of the CPE reports, nor identified any portion of the substance of those reports that it would have refuted had the agency provided it with yet another opportunity to address those findings and conclusions.

[26] In addition to the various issues addressed elsewhere in this decision, PGBA's various protest submissions to this Office have challenged other aspects of the agency's evaluation and source selection process. These assertions include that various aspects of PGBA's proposal should have been considered "strengths"; that the agency misled PGBA and "coached" WPS during discussions; and that the agency failed to properly consider the cost realism of WPS's proposal (notwithstanding WPS's higher proposed price in this fixed-unit-price procurement). We have considered all of the issues raised by PGBA in pursuit of this protest and conclude that none of them constitute bases for sustaining the protest.

various business process improvements to promote fiscal accountability and limit unnecessary government expenditures. In making the source selection decision, the SSA specifically referenced each of these factors, recognized the magnitude of PGBA's price advantage, but concluded that WPS's higher price was "more than justified" by its superiority with regard to the more important non-price factors. Agency Report, Tab 18, at 25. On this record we find no basis to question the reasonableness of the source selection decision.

The protest is denied.

Anthony H. Gamboa
General Counsel