LEGISLATIVE AUDIT COMMISSION

Management Audit
Of the
State's Procurement of
Health Insurance Vendors for the
State's Group Health Insurance Program
March 2012

622 Stratton Office Building
Springfield, Illinois 62706
217/782-7097

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RECOMMENDATIONS – 15

Background

The Department of Healthcare and Family Services is responsible for procurement of health care contracts for State employees, and others such as employees of local governments, rehabilitation facilities, domestic violence shelters, child advocacy centers and certain of their dependents. Additionally, the Executive Ethics Commission has been given the responsibility of procurement oversight.

According to Department figures, in FY11, 428,546 participants and their eligible dependents were part of the State's group insurance program. During FY12, total membership was projected to increase by 2% to 436,000 participants. State employees and dependents comprise 81% of the total participation in the group health insurance program.

Prior to July 1, 2011, the State Employees Group Health Program offered up to four options for coverage, based on geographic location: a self-insured plan preferred provider organization (PPO) option; an insured health maintenance organization (HMO) option; a self-insured HMO option; and, a self-insured open access plan (OAP) option. In September and October 2010, the Department publicly advertised to procure administrators for the State's two managed care health insurance program, the HMO and OAP plans. The HMO plan administrator was last bid in October 2000 when seven vendors received the award for HMO services. The OAP plan administrator was first offered in FY02 and only one vendor was selected. The main difference in an OAP compared to the HMO is the State self funds the OAP plan.

On April 6, 2011, the Department announced the Health Maintenance Organization award to BlueCross BlueShield (BCBS) for a total of $6.6 billion over a five-year period plus a five-year renewal. On that same day, PersonalCare and HealthLink were awarded contracts totaling $379 million for the Open Access Plan administration services. While BCBS proposals received the least amount of technical points, the prices were lower than the other proposers. The rates offered by BCBS were for the pricing it receives in the Chicago area. It was unclear whether the BCBS prices could be offered in other parts of the state. Health Alliance and Humana protested the awards. In May, COGFA passed a resolution against any expansion of self-insurance beyond the current contracts. In June 2011, Health Alliance and Humana filed suits in Sangamon County Court requesting a stay of the HMO award and a stay of the OAP plan awards. The Court ruled against Health Alliance and Humana and allowed the HMO award to move forward. However, the Court issued a ruling to stay the awards of any self-insured OAP plans. Since COGFA would not provide consent to expansion of self-funded insurance program, 90-day contracts for health insurance coverage were executed to Health Alliance and Humana.

Management Audit
State's Procurement of Health Insurance Vendors
For the State's Group Health Insurance Program

On May 10, 2011, the Legislative Audit Commission adopted Resolution Number 142, which directed the Auditor General to conduct a management audit of the State's procurement of health insurance vendors for the State's group health insurance program to determine the following:

- Whether all aspects of the procurement process were conducted in accordance with applicable laws, rules, regulations and policies;
- Whether the evaluative criteria guiding the Department of Healthcare and Family Service's (Department) selection of vendors were adequate and uniformly applied to competing vendors;
- Whether decisions concerning the selection of vendors and resolution of protests are adequately supported and documented;
- Whether the vendors selected by the Department demonstrated the capacity to provide quality, adequate and timely health care services for State employees, dependents and retirees at the time of the award;
- Whether the vendors selected by the Department demonstrated the capacity to provide quality, adequate and timely health care services for State employees, dependents and retirees no later than at the beginning of the contract period (July 1, 2011);
- Whether estimates of cost savings to the State are reasonable and fully supported; and,
- Whether, in the course of the procurement process or resolution of protests, the potential cost impact on participants in the group health insurance program was taken into consideration.

Report Conclusions

The auditors' review of the procurement process found **the Department of Healthcare and Family Services**:

- **Failed to include** all relevant information, including scoring evaluation criteria, in the RFPs.
- Utilized a consulting firm to have a **major participation role** in the procurements even though the firm **had business relationships** with all the firms that proposed on the two State procurement opportunities.
- Failed to ensure that all members of the evaluation team **had all needed materials** to score the proposals.
- **Failed to comply** with policy by not having the evaluation teams meet during the evaluation process.
- Allowed 10 of 12 evaluators to violate the evaluation procedures by **not providing** appropriate comments.
- Failed to **address major differences in scoring** by evaluators, a violation of evaluation procedures.
- Within the period of one month, March 7, 2011 to April 6, 2011, had developed and the Director had signed **two different recommendations to award** the State healthcare contracts.
- The Department **awarded** BCBS 20 counties it **did not even bid on**. Also, network documentation showed that BCBS had **zero primary care physicians in 24 counties that it was awarded**.

The review of the procurement process found **the Executive Ethics Commission**:

- Had staff review and approve the RFPs without ensuring all relevant information was included.
- Had staff that did not question lack of compliance with evaluation procedures.
- SPO did not approve the awards **until after the awards were publicly announced**.
- Utilized a protest review process where the protest officer basically rules on the procurement process that his staff guided and approved, a **process that lacks independence**.
- Failed to develop policies and procedures for the activities of its staff that oversee procurement functions.

Given the serious deficiencies in the procurement activities, including the disregard for following evaluation procedures and lack of documentation to support how the recommendation to award changed, **the auditors are unable to conclude whether the State's best interests were achieved** by the Department for the awards for the State health insurance procurements. Additionally, oversight of these procurements by the Commission lacked adequate review prior to approving the award of the contracts. These are serious problems given that this involved **over 400,000 enrollees and eligible dependents** and **$7 billion** in taxpayer monies.

This audit report contains 15 recommendations directed towards the Department and/or the Commission. The Department generally agreed with the recommendations. While the Chief Procurement Officer agreed with the recommendations directed towards the Commission, the Commission does not feel it has the authority to direct the oversight of procurement activities.

RECOMMENDATIONS

1. The Department of Healthcare and Family Services should ensure that all evaluation scoring information, required by the Illinois Procurement Code, is included in RFPs. Further, the Department should provide guidance to vendors that want to propose more than one network in their proposals to State procurement opportunities and score all networks proposed. Additionally, the Department should consider any potential conflicts based on its use of a consultant, which may require disclosure of the consultant's identity in the RFP so that proposers can respond by describing any relationship.

The Executive Ethics Commission should ensure that any concerns it may have relative to all information being included in an RFP are addressed prior to approving the RFP for publishing.

Findings: The Department of Healthcare and Family Services failed to include all relevant information, including scoring evaluation criteria, in the RFPs for the State health insurance procurements. Additionally, Executive Ethics Commission staff reviewed and approved the RFPs without ensuring this information was included.

During fieldwork auditors examined the procurement files for the two health insurance procurement opportunities, including the RFPs to determine whether all relevant materials, including procurement scoring tactics, were identified to potential proposers and found:

- **OAP Price Scoring**. The Department's consultant (Mercer) that scored the network and pricing components of the RFP for the OAP Plan Administrator procurement utilized a "composite" price to assign points for the proposals.

  - Mercer officials described the composite score as a weighted average of the proposers' prices.
  - The evaluation team leader told auditors the Department was not aware Mercer was going to use composite scoring, but that Mercer informed him it was industry standard.
  - The CPO agreed that the "composite" score was not mentioned in the RFP. He stated the fact that the scoring matrix was unknown to the vendors is cause for concern since they should know what the agency is looking for so they can adjust their proposal and processes to better meet the needs of the State.
- **HMO Price Scoring**. For the HMO proposals, Mercer applied the proposers' pricing to all members statewide **when the vendors did not bid on all counties**.
- **Make Up of the Evaluation Team**. The RFPs for both procurements failed to identify that an outside consultant under contract to the Department would evaluate the vast majority of the proposals.
  - Mercer evaluated and scored 86% of the total evaluation points for the HMO procurement (3,440 of 4,000).
  - Mercer evaluated and scored 78% of the total evaluation points for the OAP procurement (1,940 of 2,500).
  - The evaluation team leader told auditors there was no conscious decision to leave out language that Mercer and CMS would be scoring part of the evaluations.
  - As part of its protest and subsequent legal proceeding, Health Alliance alleged that Mercer had business relationships with proposing vendors. Department officials indicated they became aware of the possible conflict when Health Alliance made it part of their protest and then asked Mercer, who responded on May 6, 2011 – approximately five months after scoring was completed.
- **Other Issues**. From the review, other RFP omissions were:
  - The RFP for the HMO made no mention that a vendor could propose more than one network. BCBS bid two networks yet evaluators, including Mercer for network evaluation, provided the same scores for each bid. Mercer officials told auditors that BCBS Blue Advantage is a subset of HMO Illinois and that outside of Cook county and the collar counties, the networks are the same. Auditors note that Cook and the collar counties are the main BCBS service areas. In the end the Department awarded contracts to both BCBS networks when only one was evaluated, but they were given the exact same score.
  - The RFPs failed to inform providers that the pricing, while needing to be submitted separately, would not be provided to those scoring the technical portion of the responses. This had an effect on some proposers that answered the State's questions in the RFPs by referring the evaluator to pricing information, information the technical evaluators apparently did not have access to because they provided zero points for those responses.
  - Continuity of care. The RFPs were silent on the continuity of care issue. Continuity of care may have been part of the Department's initial recommendation to award when it wanted to award HMO contracts to both BCBS and Health Alliance.
- The Commission reported that the SPO reviewed, commented and approved the RFPs.

Department Response: The Department accepts the recommendation. The Department has already moved to ensure that future RFPs clearly state evaluation scoring information, proposal requirements and Department expectations in as much detail as possible. The Department will ensure that network analysis required in an RFP will be scored in accordance with specifications included in the RFP. Consultants are being identified in current healthcare purchasing RFPs so

that bidders will have the opportunity to disclose any relationships that may pose a potential conflict with the consultant.

Commission Response: This recommendation and many others contained in this report are based upon a premise that the General Assembly has directed the Executive Ethics Commission (Commission) to make procurement-related decisions and become involved in the details of particular procurement matters. This premise is at odds with a number of statutory provisions contained in the State Officials and Employees Ethics Act (5 ILCS 430/1) and the Illinois Procurement Code (30 ILCS 500/1).

The Commission's statutory authority with respect to procurement activity is limited to matters for which the Commission is given explicit authority in the Procurement Code. 5 ILCS 430/20-5(d-5). The Commission's explicit authority in the Procurement Code relates to conflicts of interest, communication reporting, and appointment and removal powers with respect to certain officers. In contrast to the EEC's limited and specific authority with respect to specific procurement matters, the Code provides that"[t]he chief procurement officer shall exercise all procurement authority created by this Code." 30 ILCS 500/10-5.

Furthermore, the chief procurement officers are State officers, not employees of the Commission or any other agency. The Commission appoints or approves the appointment of chief procurement officers. They are described in statute as "independent" (30 ILCS 500/10-20), and also owe a fiduciary duty to the State. 30 ILCS 500/10-20(d). They, not the Commission, have been empowered to promulgate rules to exercise their authority to make procurements under the Code. (30 ILCS 500/5-25(a)).

To the extent that this recommendation and others offer a means for improving future procurement activities, the Commission welcomes this report of the Office of the Illinois Auditor General. For the reasons described above, however, it believes that the recommendations should be directed to those responsible for making procurement decisions and to those who can implement the recommendations. The Commission has requested a written opinion from the Office of the Illinois Attorney General to resolve this matter of statutory interpretation.

Auditors' Comment: *Under the State Officials and Employees Ethics Act (the Act), the Executive Ethics Commission (the Commission) is given "jurisdiction over all chief procurement officers and procurement compliance monitors and their respective staffs." 5 ILCS 430/20-5 (d-5). Further, according to the Procurement Code (the Code), "a chief procurement officer shall be responsible to the Executive Ethics Commission. . ." 30 ILCS 500/10-20 (a).*

We recognize that the Chief Procurement Officers and Procurement Compliance Monitors have specifically enumerated day-to-day duties under the Procurement Code. However, in areas where findings indicate that those duties may not have been fulfilled or may not have been fulfilled in compliance with applicable laws, the auditors believe the fact that the Commission is explicitly given statutory "jurisdiction over all chief procurement officers and procurement compliance monitors" and the chief procurement officers are statutorily made "responsible to the Executive Ethics Commission" common sense makes it appropriate for the audit recommendations to be directed to the Commission.

Further, in addition to the 4 Chief Procurement Officers, there were 19 Procurement Compliance Monitors as of November, 2011. The Procurement Code states that "[e]ach procurement compliance monitor. . .shall report to the appropriate chief procurement officer." 30 ILCS 500/10-

15 (a). However, according to the Commission in its response to this audit's recommendation 10, "CPOs have no authority to direct the PCMs. . ." To sum up its interpretation of the Code, the Commission believes it has no oversight of the CPOs and the CPOs, in turn, have no oversight of the PCMs. Under the Commission's interpretation, if the auditors were to detect a systemic problem with the procurement process, it could only be addressed in a piecemeal basis over an extended period of time through multiple audits, multiple findings and multiple recommendations directed to several different individuals. We do not find this practical, efficient or necessary given the Act's clear grant of jurisdiction to the Commission.

The Chief Procurement Office responds as follows:

- On July 16, 2010, the Chief Procurement Office appointed a State Purchasing Officer (SPO) to the Department of Healthcare and Family Services (Department); the appointee began his placement as SPO at the Department on August 1, 2010.
- On July 16, 2010, the Executive Ethics Commission appointed a Procurement Compliance Monitor (PCM) to the Department; similarly that appointee began at the Department on August 1, 2010.
- The transfer of procurement authority from the agency/Governor's Office to an independent CPO was not complete until September 1, 2010. 30 ILCS 500/10-20(g).
- The RFPs for the managed health insurance programs had been developed by the Department over a period of several months prior to the arrival of the SPO and PCM.
- The RFPs were developed through a collaboration of the Department, Central Management Services (CMS), the Illinois Department of Insurance, and a consultant (Mercer Health & Benefits LLC) (see page 23 of management audit).
- The plans were last bid by the State in 2000 and contracts for the State's health care contracts were set to expire on June 30, 2011. Pursuant to 30 ILCS 500/20-60(a), extensions of the prior contracts was prohibited by the Code.
- In September 2, 2010 (OAP), and October 5, 2010 (HMO), RFPs for the State's two managed care health insurance programs were published to the Illinois Procurement Bulletin.
- The Auditor General states the CPO's Office should have ensured any concerns it had relative to all information being included in the RFP should have been addressed prior to publication of the RFP on the Illinois Procurement Bulletin.
- The CPO's Office agrees with the Auditor General's Office that any concerns a SPO has with solicitations being prepared in accordance with the requirements of the Code and procurement rules be addressed by State agencies prior to posting of the solicitation on the Illinois Procurement Bulletin. With additional time, clarifications could have been suggested by the CPO's Office to the Department to make clearer the solicitation requirements of the RFP.

2. The Department should ensure that all consultants disclose any relationships that may, even if only in appearance, impair the integrity of the procurement process that the consultants participate in. The Department should then document that it has considered any such potentials conflicts and the results of that consideration. Additionally, the Department should complete a statement of work for its contract with Mercer to identify specific scope of service work to be performed for State procurement opportunities. The Department should ensure that all consultants disclose any

relationships that may, even if only in appearance, impair the integrity of the procurement process that the consultants participate in. The Department should then document that it has considered any such potentials conflicts and the results of that consideration. Additionally, the Department should complete a statement of work for its contract with Mercer to identify specific scope of service work to be performed for State procurement opportunities.

Findings: The Department utilized the consulting firm, Mercer, to have a major participation role in the development of the RFP through the evaluation of proposers to the State health insurance procurements. The consulting firm had business relationships with all the firms that proposed on the two State procurement opportunities, relationships that the Department failed to have identified.

During a review of the procurement process utilized by the Department in selecting vendors to administer the State OAP and HMO contracts, auditors examined the procurement files and interviewed the consultant utilized by the Department in the process. The following items were noted:

- The Department utilized a consultant, Mercer, to help develop the RFP and scoring instrument, and evaluate the responses to the RFP.
- Mercer evaluated and scored 86% percent of the total evaluation points for the HMO procurement.
- Mercer evaluated and scored 78% of the total evaluation points for the OAP procurement.
- Mercer officials that participated in the project signed the Compliance, Conflict of Interest, and Confidentiality Statement.
- The contract with Mercer originally executed on September 20, 2006, (and filed with the Comptroller seven days later) described the services required of Mercer. These services did not include the evaluation and scoring of proposals. This contract and the associated renewals make no mention of major evaluations of State health care procurement proposals.
- The FY11 renewal to the Mercer contract had no scope of services section added to include the evaluation of proposals for the OAP and HMO procurement opportunities.
- Mercer officials reported that they had participated in other evaluation scoring opportunities for the Department – on the dental and behavioral health RFPs.
- Unknown to the Department, Mercer reported to auditors *"Mercer does have business relationships with all of the vendors who participated in the Procurement Process."*
- Unknown to the Department, Mercer officials reported that Mercer conducted an evaluation of BCBS health management programs during calendar 2009. Mercer was paid for this work by BCBS and a number of other smaller Mercer clients that requested the evaluation.
- Mercer officials indicated that the Department had not asked about any Mercer client relationships in the past five years.

The Department's contract with Mercer, in FY10, added a section on Conflict of Interest, and Department policy requires members of the project team to notify the project manager immediately if a situation arises where a conflict of interest or the appearance of a conflict of interest may exist.

Department Response: The Department accepts the recommendation. The Department required, in its contract with Mercer and as part of the evaluation procedures given to all team members, disclosure of any potential conflicts. Future statements of work and evaluation

procedures issued by the Department will specifically require consultants used for RFP development and/or evaluation to disclose any business relationships with bidders. If any relationships are disclosed, the Department will work with the State Purchasing Officer to develop procedures that allow for Department review of the disclosures, referral to the State Purchasing Officer, and appropriate documentation of the issues and conclusion. The Department will complete a statement of work with Mercer if they are consulted or used as evaluators in future RFPs.

Auditors' Comment: *While the Department states the contract with Mercer and the evaluation procedures required the disclosure of any potential conflicts, the fact is that the Department did not know of the business relationships that Mercer had with vendors that proposed on the State health procurements.*

3. The Department should ensure that all evaluation materials in the Department's possession are provided to all evaluators. Additionally, the Department should ensure that reference checks are timely conducted for all vendors that propose and that information obtained from the reference checks be provided to all members of the evaluation team.

The Commission should instruct its staff to review scoring evaluations to ensure that evaluators had complete information prior to giving approval for the award of State contracts.

Findings: The Department failed to ensure that all members of the evaluation team had all needed materials to score the proposals submitted for the State health insurance procurements. While the evaluators clearly acknowledged the lack of needed materials, the Department failed to correct the problem and let the evaluation process continue. Additionally, the procurement team leader conducted reference checks on the proposers to the two procurements but did not share any of that information with the other evaluators.

During the review of the procurement files auditors found:

- **Evaluation procedures.** Several evaluators, including Mercer, reported they did not see the evaluation procedures yet the team leader provided auditors with email correspondence showing he sent the document to the teams.
- **Lack of needed materials noted in evaluation scoring.** Evaluators either noted the lack of materials on their individual evaluation sheets or the evaluator thought there was an issue with uncompleted proposal responses, issues the evaluator did not follow up on.
- **Clarification not communicated to evaluation team.** The team leader for the HMO procurement followed up with a proposer but failed to notify the other evaluators of the clarification until after they had already scored the vendor's proposal. There was no indication that any revisions to the scoring were made.
- **References**. The team leader conducted reference checks containing questions related to level of satisfaction with vendor performance; whether the vendor met the goals and expectations of the reference in the work the vendor performed; whether there were any problems with the vendor; and what the strengths and weaknesses were for the vendor. Auditors note that:

- For the OAP procurement, only two reference checks were dated and both were dated after the three evaluators that actually dated their scores completed their evaluations.
- For the HMO procurement, when the reference checks were made could not be determined because the team leader that conducted the checks failed to date any of the forms. Additionally, while the team leader made three calls for Humana, Health Alliance, PersonalCare, and HMO Illinois, he did not make any reference checks of the BCBS Blue Advantage proposal, which was eventually awarded part of the HMO contract.

Department Response: The Department partially accepts the recommendation. The Department, with assistance and approval of the State Purchasing Officer, has revised its evaluation Procedures to distinctly identify all evaluation materials to be provided to evaluators. The evaluation procedures and all relevant evaluation materials will be distributed to team members at the pre-evaluation team meeting. Evaluators will continue to have open access to the project lead and project contact to ensure that they have all information necessary to perform a complete and proper evaluation. However, consistent with the auditor's recommendation, the Department agrees to provide evaluators those materials in the Department's possession. As noted in the auditor's report, Health Alliance failed to follow the requirements of the RFP and did not provide consistent hard and CD copies. The Department will continue to require in future RFPs that bidders assume responsibility for the materials they submit. The Department agrees that reference checks, if required to evaluate responsiveness, will be relayed to the evaluation team. However, in this RFP, the Department did not require the evaluators to score or to consider references as part of the responsiveness criteria. There were no requirements in either the solicitation or the evaluation procedures which required the reference calls to be considered in scoring. Thus, reference checks were conducted but were not required to be shared with the team.

Auditors' Comment: *In this $7 billion procurement, there was no "pre-evaluation meeting" held. Nor were there any team meetings held or evaluation scores reviewed to ensure that the team had all required materials to make sound scoring decisions. Reference checks, even if not required in the scoring criteria, may provide important information on a bidder that should be shared with evaluators so that informed scoring decisions can be made.*

Commission Response: The Executive Ethics Commission incorporates its response to Recommendation #1 as its response to this Recommendation. The Chief Procurement Office responds, in part, as follows:

- In its evaluation of the CPO's Office, the Auditor General cites the CPO's responsibility for the general oversight for State procurement and the need to be vigilant with the Department.

- The CPO's Office agrees with the Auditor General's Office that all relevant evaluation materials should be provided to evaluation team members and that mandatory provisions of the evaluation criteria be followed by the Department. Further, the CPO's Office agrees its staff should ensure evaluations are conducted in accordance with the Code, rules, procedures and provisions of the solicitation. Subsequently, the CPO's Office has provided additional guidance to its staff on conducting evaluations.

Furthermore, additional guidance as to the process of overseeing evaluations has been provided to the procurement compliance monitors for use in efforts to ensure evaluations are conducted in accordance with the Code, rules, procedures and provisions of the solicitation.

4. The Department should comply with its own policy/procedure and ensure that evaluation teams meet to discuss clarifying questions, identifying areas of clarification, and to discuss the strengths and weaknesses of each proposal so that all evaluators have all relevant information to make adequate scoring decisions that are in the best interests of the State.

The Commission should require its staff, during the conduct of its procurement oversight, to determine whether team discussions, which are a recommended part of the evaluation procedures, are being utilized by the Department to clarify questions or identify areas of clarification for evaluators.

Findings: The Department failed to comply with its own evaluation policy/procedure by not having the evaluation teams for the State health insurance procurements meet during the evaluation process. Commission staff with oversight responsibility also did not question this lack of compliance with evaluation procedures.

During a review of the procurements to select administrators for the HMO and OAP health insurance contracts, auditors examined the procurement files for the two opportunities, and interviewed all 12 members of the two evaluation teams and found:

- The evaluation teams did not meet to discuss any issues relative to the proposals, evaluations, or procurement process.
- The team leader for the procurements indicated he delivered all the materials to the team members and individually asked each member if they had any questions. While he stated there were some questions, there was no documentation to show what those questions were or whether they were shared with any other members of the evaluation team.
- An evaluator (Department employee) from the HMO procurement told auditors that she was not part of any meeting where the evaluation team would have met to discuss who should be awarded the State contract. She added that she was not shown the 1st Recommendation to Award (signed March 7, 2011, by the Director) and that she did not give any recommendation besides the scores she provided. The evaluator also stated that other than hearing of the award no one ever notified her of the result of the procurement or the selection.
- Another HMO evaluator, a CMS employee that explained these evaluations were not part of his normal duties and was working on his first health insurance RFP, stated that he was asked if he had any questions when the team leader dropped off the proposals. The only instructions were to fill out the scoring tool. He stated that no team meetings were held.
- Another HMO evaluator (Department employee) stated that when she is team lead on a procurement she always holds team meetings once a week and identify outlying scores to try and provide clarification. She stated that sometimes the scores would remain the same, but at least the team was on the same page and clarification was provided.
- An OAP evaluator (Department employee) also stated that no team meetings were held, but that nobody had any questions. It is unclear how this evaluator would have known what the other team members thought absent team meetings.

- Another OAP evaluator, a CMS employee that had worked on one previous RFP, stated the team leader gave him verbal instructions and that there was only talk about meetings at the beginning of the process, but they never had any.
- An evaluator that worked on both procurements (CMS employee) stated that to her knowledge she was not given any instructions on how to complete the scoring.

Exhibit 2-2
CLARIFICATION ISSUES FROM EVALUATORS

Procurement	*Issue*
HMO	One evaluator explained his scoring 0/5 points for BlueCross BlueShield for a section as its response referenced a CD and that he was not provided the CD for the evaluation. All the other evaluators scored BCBS at the maximum for this category.
OAP	The consultants that scored the network part of the proposals indicated that they wondered why the electronic version of the Health Alliance OAP proposal did not contain responses to two questions, which the consultant ultimately gave Health Alliance 0/140 points. Answers for these sections were included on the Health Alliance hardcopy response.
OAP	Two evaluators on the OAP procurement of the Humana proposal indicated the response referred to a CD, a CD that they did not have. These two evaluators scored Humana lower for the lack of information while the other two evaluators scored Humana a perfect 10 for the criteria.
OAP	An evaluator on the Health Alliance proposal scoring sheet indicated that the score of 0/20 for a section was because "Did not provide any information regarding proposed methodology, only referred to pricing binder." Another evaluator commented that "Included ACS risk in pricing binder. No info given in this portion." The evaluator scored Health Alliance 10/20 for the criteria. A third evaluator stated his 10/20 score for the criteria was due to "Supplied but didn't respond to questions." The fourth evaluator explained her 0/20 score with "Not provided." The technical (non-network) scoring committee was not provided with the pricing information
Source: OAG developed from Department documentation.	

The Commission reported that its SPO reviewed, commented and approved the evaluation procedures. However, there was no documentation in the procurement files or Commission staff files to indicate the SPO or Procurement Compliance Monitor (PCM) questioned the lack of team meetings for these two procurements.

Department Response: The Department accepts the recommendation. The Department acknowledges that while there were no group team meetings, the team leader consistently contacted all members to identify questions or concerns and to ensure timelines were met. At no time did evaluators express that there were issues needing group discussion. The Department, with the assistance of State Purchasing Officer, has already ensured that team meetings are being held for RFPs to discuss and clarify any concerns raised by evaluators.

Auditors' Comment: *While the Department indicates the "team leader consistently contacted all members," this is not supported by documentation or testimonial evidence from the evaluators. Given the scoring differences among evaluators, there clearly were issues that needed group discussion.*

Commission Response: The Executive Ethics Commission incorporates its response to Recommendation #1 as its response to this Recommendation. The Chief Procurement Office responds, in part, as follows:

- In its evaluation of the CPO's Office, the Auditor General cites the CPO's responsibility for the general oversight for State procurements and the need to be vigilant with the Department in ensuring team meetings took place.
- The CPO's Office agrees its staff should ensure evaluations are conducted in accordance with the Code, rules, procedures and provisions of the solicitation. Subsequently, the CPO's Office has provided additional guidance to its staff on conducting evaluations.

Furthermore, additional guidance as to the process of overseeing evaluations has been provided to the procurement compliance monitors for use in efforts to ensure evaluations are conducted in accordance with the Code, rules, procedures and provisions of the solicitation.

5. The Department should take the necessary steps to ensure that procurement evaluation criteria are followed by all evaluators when awarding State contracts. These steps would include ensuring that the Department follow evaluation procedures and return evaluations to team members that fail to provide thorough and appropriate comments to specific criteria.

The Commission should require its staff, during the conduct of its procurement oversight, to determine whether evaluation procedures were followed prior to approving an award of a State contract.

Findings: The Department allowed 10 of 12 evaluators that scored the proposals for the State health insurance procurements to violate the evaluation procedures by not providing thorough and appropriate comments to support the scores given. Additionally, Commission staff responsible for the oversight of the procurements did not question the violation of procedures.

During the review of the procurements to select administrators for the HMO and OAP health insurance contracts, auditors examined the evaluation scoring documents completed by each evaluation team, and interviewed all 12 members of the two evaluation teams, and found:

HMO Procurement

- The six evaluators that scored the HMO procurement had a total of 964 questions/criteria to score.
- Five of the six HMO evaluators failed to provide thorough and appropriate comments for all the scores they marked on the scoring tool. There was wide variation in the comments provided on evaluation forms by the evaluators. Only the consultant, Mercer, provided thorough and appropriate comments for all questions/criteria.
- The analysis showed that 38% (368 of 964 categories) of the questions/criteria for the HMO evaluation lacked thorough and appropriate comments. The vast majority of these exceptions were due to a lack of comments or instances where evaluators simply put page numbers in the comments section.

- Evaluators for the HMO procurement did provide thorough and appropriate comments for 596 of the questions/criteria on the scoring tool.

OAP Procurement

- The six evaluators that scored the OAP procurement had a total of 1,036 questions/criteria to score.
- Five of the six OAP evaluators failed to provide thorough and appropriate comments for all the scores they marked on the scoring tool. Again, only the consultant, Mercer, provided thorough and appropriate comments for all questions/criteria.
- The analysis showed that 17% (176 of 1,036 categories) of the questions/criteria for the OAP evaluation lacked thorough and appropriate comments.
- Evaluators for the OAP procurement **did provide** thorough and appropriate comments for 860 of the questions/criteria on the scoring tool.

None of the evaluators interviewed that had failed to include thorough and appropriate comments reported the scoring tools had been returned by the team leader, contrary to Department policy. One evaluator, who was a Department employee, when asked if comments were needed for all scores, told auditors that a former Department procurement official said she did not need to comment for each question/criteria. Another evaluator, a CMS employee, stated that it was her understanding that she only needed to provide comments if she did not give a specific response a full score.

Public Act 96-795 designated responsibility for the oversight of the purchase of State goods and services to the Commission. The Commission reported that its PCM reviewed the evaluation tool and procedures. Additionally, the PCM reported he reviewed the scoring for consistency. Additionally, the Commission reported that its SPO reviewed, commented and approved the evaluation procedures.

Department Response: The Department accepts the recommendation. The Department, with the assistance and approval of the State Purchasing Officer, has revised its evaluation procedures to stress the importance of complete and thorough comments. These procedures now require that in the event an evaluator submits insufficient comments, the Department will work with the State Purchasing Officer to determine appropriate resolution including, but not limited to, convening team meetings and/or returning individual scoring tools to members for clarification.

Commission Response: The Executive Ethics Commission incorporates its response to Recommendation #1 as its response to this Recommendation. The Chief Procurement Office responds, in part, as follows:

- In its evaluation of the CPO's Office, the Auditor General cites the CPO's responsibility for the general oversight for state procurements and the need to be vigilant with the Department in ensuring comments support evaluator's scores and internal procedures are followed by the Department.
- The CPO's Office agrees its staff should ensure evaluations are conducted in accordance with the Code, rules, procedures and provisions of the solicitation. Subsequently, the CPO's Office has provided additional guidance to its staff on conducting evaluations.

Furthermore, additional guidance as to the process of overseeing evaluations has been provided to the procurement compliance monitors for use in efforts to ensure evaluations are conducted in accordance with the Code, rules, procedures and provisions of the solicitation.

6. The Department should ensure that all evaluation scoring tools include certification by the individual evaluator and are also dated to indicate when the scoring actually took place. Additionally, the Department should ensure that evaluations are not scored until after all clarifications are received.

Findings: The Department failed to have evaluation team members for the HMO Plan Administrator and OAP Plan Administrator procurements certify their evaluation scores. Additionally, some of the evaluation scoring sheets were undated making it impossible to know when they were completed. In another instance, it appears that a technical scoring clarification was provided after the Department's consultant had already scored a proposal.

Department Response: The Department accepts the recommendation. The Department would like to note that the evaluation procedures for this RFP did not require the evaluation scoring tools to be signed and dated. Each member of the evaluation team was issued a personal identification number (PIN) to be used instead of their names in order to maintain anonymity. All score sheets were delivered by the timeline given to each evaluator and contained the certification required in the form of the evaluator's PIN. Recognizing the importance of identifying evaluators, however, in the future, the Department will require evaluators to sign an acknowledgement sheet when receiving their PINs so that scorers can be identified. The Department will also require that evaluators certify the date the scoring is completed.

7. The Department should require its evaluation teams to comply with Department policy/procedure by reviewing, identifying and discussing major scoring differences. Additionally, the Department should either ensure that evaluators follow evaluation procedures and score each proposal on its own merits and refrain from comparing one proposal to another in scoring, or change its procedures to allow for such a comparison.

The Commission should require its staff to review whether policies and procedures regarding scoring were followed before approving the award of State procurements.

Findings: The Department failed to address major differences in scoring by evaluators of the procurement for the State health insurance contracts, a violation of the Department's own evaluation procedures. Additionally, the Department allowed evaluators to score proposals against each other, again a violation of the Department's own evaluation procedures. Commission staff responsible for oversight of these procurements did not ensure compliance with evaluation procedures prior to approving the award of the contracts.

The review of the scoring conducted for the two procurements involved comparing evaluator scores to proposals and to identify any major scoring differences. Auditors noted the following:

- For the **HMO procurement**, given the five proposals evaluated, there were 225 criteria/categories for the four State employee evaluators to score. The review showed:

  - 67 instances where the difference between the highest and lowest scores was 50 percent or more;
  - 71 instances where three evaluators scored the criteria/category the same and the other evaluator had a different score;
  - 21 instances where one evaluator gave the proposal criteria/category zero points and another evaluator gave the same criteria/category the total maximum points available; and,
  - 7 instances where one evaluator gave a criteria/category zero points yet all other evaluators gave the same criteria/category the total maximum number of points available.
- The Executive Summary for the HMO procurement stated "the committee chair did a thorough review to determine if there were any noticeable scoring differences. No key differences in scoring between committee members were identified." This representation is not supported by the facts provided above.
- **For the OAP procurement**, given the four proposals evaluated, there were 180 criteria/categories for the four State employee evaluators to score. The review showed:
  - 36 instances where the difference between the highest and lowest scores was 50 percent or more;
  - 50 instances where three evaluators scored the criteria/category the same and the other evaluator had a different score; and,
  - 3 instances where one evaluator gave the proposal criteria/category zero points and another evaluator gave the same criteria/category the total maximum points available.
- The Executive Summary for the OAP procurement also stated "the committee chair did a thorough review to determine if there were any noticeable scoring differences. No key differences in scoring between committee members were identified." This representation is again not supported by the facts provided above.
- The consultant (Mercer) that scored the network portion of the HMO evaluation had instances where they compared proposals to one another when assigning points. The review of the HMO evaluations showed:
  - For a criteria—what percentage of contracted physicians is board certified, Mercer based its scores on the percentages that were self-reported in the proposals. Health Alliance's percentage of board-certified physicians was 88% and they received 25/25 points. Humana, with 87% and BCBS with 85% both received 22/25 points. PersonalCare had 79% board-certified and received 20/25 points.
  - For a criteria–current PCP to specialist ratio, Mercer again based its scores on the ratios that were self-reported in the proposals. Humana, with a ratio of 1:1.8, and BCBS, with a ratio of 1:1.58, both received 10/10 points. Health Alliance, with a ratio of 1:3 received 9/10 points and PersonalCare with a ratio of 1:0.359 received 8/10 points.
  - For a criteria—provider turnover rate in calendar 2009 and 2010 to date, Mercer also scored based on the self-reported percentages. Humana gave a rate of 1.5%, did not specify whether 2009 or 2010, and received 25/25 points. BCBS provided percentages for two networks, HMO-IL and Blue Advantage and received 20/25 points. The 2009 rates were 8.38% for HMO-IL and 8.79% for Blue Advantage. For 2010, the percentages were 1.45% and 1.72% respectively. PersonalCare received 15/25 points from Mercer for percentages of 5.5% and 3.4% in the two years. Finally, Health Alliance received 10/25 points for a rate of 8.42% in 2009 and 6.35% in 2010.
  - There was no documented scoring legend to show how many points should be attributed to where a proposer ranked in comparison to other proposers. The

consultant followed the same pattern with its review and scoring for the OAP procurement.

- An evaluator for the HMO procurement told auditors as she evaluated the proposals she reviewed one question at a time, comparing the four proposals to each other, and based her evaluation scores on those comparisons against each other. The evaluator stated that she had asked Commission personnel if her way of evaluating was okay and was informed that they were fine with it.
- Members of the evaluation teams told auditors that differences in their scoring were not returned to them or discussed.
- The Commission reported that the Procurement Compliance Monitor reviewed the scoring for consistency. The facts above question that review.

Department Response: The Department accepts the recommendation. Each evaluator will provide individual comments to support each score assigned, and when major scoring differences are identified, they will be addressed by the Department, along with the State Purchasing Officer, in accordance with evaluation procedures. As to the recommendation to score proposals on their own merits, the Department is considering whether complex procurements such as this would benefit from a side by side comparison as it may yield better results. The Department will work with the State Purchasing Officer in an attempt to allow side by side comparisons to be conducted in procurements of this nature. The Department will ensure that evaluators score the proposals on their own merits until evaluation procedures are modified to allow for a side by side comparison.

Commission Response: The Executive Ethics Commission incorporates its response to Recommendation #1 as its response to this Recommendation. The Chief Procurement Office responds, in part, as follows:

- In its evaluation of the CPO's Office, the Auditor General cites the CPO's responsibility for the general oversight for state procurements and the need to be vigilant with the Department in ensuring scoring differences are discussed.
- The CPO's Office agrees its staff should ensure evaluations are conducted in accordance with the Code, rules, procedures and provisions of the solicitation. Subsequently, the CPO's Office has provided additional guidance to its staff on conducting evaluations.

Furthermore, additional guidance as to overseeing evaluations has been provided to the procurement compliance monitors for use in efforts to ensure evaluations are conducted in accordance with the Code, rules, procedures and provisions of the solicitation.

8. The Department should take steps to monitor and ensure that all evaluators comply with Departmental procedures regarding communication with vendors. Additionally, the Department should consider revising its conflict statements to include a requirement that evaluators not contact proposers to a procurement soliciting additional business opportunities.

Findings: The Department failed to monitor the evaluation team for the procurement of vendors to administer the State health insurance contracts. As a result, one of the evaluators, the consultant hired to assist in the development of the RFP and scoring of proposals, had communications with vendors which violated Departmental evaluation procedures. Additionally, the consultant had an

inappropriate communication with one of the vendors that proposed on the managed care procurements. A Department official directed this communication.

During the review of the Department's procurement files for the managed care procurement opportunities, auditors reviewed documentation which showed that one evaluator, the Mercer consultants, had communications with two of the vendors that proposed on the procurement opportunities without notifying the SPO and found:

- On November 2, 2010, Mercer contacted Health Alliance to clarify the vendor OAP proposal specifically regarding the provider network listing. The contact resulted in a telephone conversation between Mercer and Health Alliance officials.
- A telephone communication between Mercer and Humana the week of November 1, 2010, requested a conversation to discuss: (1) validation of the OAP networks that Humana was proposing, and (2) to request an updated file for OAP and HMO RFP submissions.
- On November 1, 2010, at a time when Mercer was involved in the evaluation of proposals for the OAP procurement, one of the Mercer evaluators sent Health Alliance an email requesting to *"have a discussion with Health Alliance to talk to Health Alliance about submitting data to NetPiC, Mercer's discount database"*. A Health Alliance official reported that Health Alliance chose not to participate in the submission of database discount information to Mercer. According to Mercer officials, many vendors submit data for the database and they are not paid for the information. However, Mercer does utilize the database as a tool in generating revenue for Mercer.
- Mercer staff told auditors on August 24, 2011, that they did not contact any vendor, due to the strict policy. Documentation did not support this claim.
- The SPO reported to auditors that he had no knowledge of Mercer staff, or any evaluators, contacting any vendor for clarification purposes.

Mercer staff provided auditors with email correspondence, dated October 18, 2010, showing that a Department official, who was the evaluation team leader for the health insurance procurements, instructed Mercer to "reach out" to the carriers. The decision to have Mercer contact Health Alliance was due to the procurements being "on the streets." This directive conflicts with Department evaluation procedures. Department evaluation procedures outline how to clarify statements or elements of a vendor's technical solution. The procedures direct evaluators to work with the RFP project contact, SPO, and Office of General Counsel to send needed clarification letters to vendors.

Department Response: The Department partially accepts the recommendation. While the Department may have failed to document the circumstances regarding the communication in question, it did not fail to monitor the evaluation team for this procurement. The Department has always had procedures and will continue to follow procedures to prohibit inappropriate conversations between evaluators and bidders. The Department monitored the consultant and determined that the State Purchasing Officer did not need to be notified as the communication with the bidder was appropriate and was unrelated to the procurement in question. The Department will also agree to consider the propriety of evaluators soliciting additional business opportunities from bidders in future RFPs.

9. The Commission should ensure that its State Purchasing Officers comply with State guidance and approve written determinations of contract awards prior to the public announcement of the awards.

Findings: Within the period of one month, March 7, 2011 to April 6, 2011, the Department had developed and the Director had signed two different recommendations to award the State healthcare contracts. The Department took the first recommendation to a meeting with officials from the Governor's Office and the Governor's Office of Management and Budget in late March 2011. Sometime between that meeting and the date the awards were announced on April 6, 2011, the recommendation was changed. While the Department indicated that the CPO could not support the initial recommendation, documentation did not support that position.

On March 7, 2011, a recommendation to award was developed and signed by the Director and the acting chief of the Office of Healthcare Purchasing. This recommendation would award HMO contracts to BCBS and Health Alliance with reduced service areas from their original proposals. The recommendation stated it had been reviewed and approved by the Office of General Counsel, Office of Procurement Management, Procurement Compliance Monitor, the State Purchasing Officer, Division of Finance and Office of Inspector General.

The justification/reason for selection was:

> *The BCBS/Blue Advantage and BCBS/HMO Illinois plans received the highest combined scores, respectively, for technical responsiveness and price. PersonalCare received the third highest combined score. PersonalCare proposed OAP services under a separate procurement that offered the same network as their HMO proposal, in addition to a PPO network, at a substantially lower cost. PersonalCare is being recommended for award of a contract for OAP services, which will provide access to their network. A key objective of the RFP (section 3.1) was the "ability to offer access in every county in the State." Awarding a second contract to PersonalCare for the same network would not further the State's access objectives, but would increase costs to the State. Therefore, it was determined that a separate HMO award would not be a cost effective option, and PersonalCare is not recommended for contract award. Health Alliance had the highest technical score, but fell to fourth when both technical and price were combined.*
>
> *However, since Health Alliance has the major providers in central Illinois, and currently provides HMO services to a significant portion of enrollees in the covered plans/programs, reduction of disruption for such a large group of enrollees became an overriding factor to keep Health Alliance. To achieve the maximum savings from each proposal, the committee reviewed each proposal on a county level. This process reduced each vendor's proposed service area. Therefore, it is recommended that contracts be awarded to BCBS/HMO Illinois, BCBS/Blue Advantage, and Health Alliance Medical Plans.*

The SPO notified the CPO on March 4, 2011, that we "expect to post awards today or Monday for state employee health insurance contracts". The CPO questioned the Department's recommendation because it was giving PersonalCare an OAP award and bypassing them for the HMO award in favor of Health Alliance.

Department officials met with staff from the Governor's Office regarding the recommendation to award the HMO to BCBS and Health Alliance with reduced service areas. After this meeting, which was not documented by any meeting minutes, a 2nd recommendation was developed that was eventually announced April 6, 2011. Department officials indicated that the reason was the CPO could not support the reduced services areas 100%. However, in an email correspondence dated April 4, 2011, the CPO informed the Department that he could support an award that included reduced service areas due to the continuity of care issues.

The SPO, an employee of the Commission, did not approve the awards for the HMO Plan Administrator and OAP Plan Administrator procurements until after the awards were publicly announced. The *SPO Written Determination of Contract Awards* was not signed by the SPO until 6 days later, on April 12, 2011.

Commission Response: The Executive Ethics Commission incorporates its response to Recommendation #1 as its response to this Recommendation. The Chief Procurement Office responds as follows:

- The Auditor General found the CPO's Office did not sign the written determination of award for the health insurance plans until six days after the awards were posted to the Illinois Procurement Bulletin.
- The Auditor General found the failure to sign the written determination of award prior to the posting of the award to the Bulletin to be a violation of the Procurement Code which requires the procurement file to "contain a written determination, signed by the chief procurement officer or the State purchasing officer, setting forth the reasoning for the contract award decision." 30 ILCS 500/20-155(b).
- In further support, the Auditor General found CPO Notice #37 requires all competitive procurements awards to be preceded by a written determination recommending the award of a contract to a specific vendor.
- Administrative rules provide that an award shall be made by a procurement officer pursuant to a written determination which shows the basis for the award. 44 Ill. Admin. Code §1.2015(h)(1).
- As to the timing of when a written determination is required, the Code and rules are silent as to whether the written determination is required prior to posting the notice of intent to award to the Bulletin. Former CPO Notice #37, on the other hand, directs completion of the written determination prior to award.
- While the SPO did not sign the written determination to award until after the award posting to the Bulletin, the SPO reviewed and provided e-mail approval of the recommendation to award and was the individual who posted the award to the Bulletin. In sum, the SPO approved the award determination in writing prior to the posting of award to the Bulletin, but did not complete the formal written determination form until six days after the Bulletin posting.
- The CPO's Office agrees its staff should ensure written determinations of award be timely documented in accordance with the Code, rules, and procedures. Subsequently, the CPO established a new SPO Determination Form and related process to ensure the written determination of award occurs in an appropriate order.

10. The Commission should establish in its procurement rules a protest process where the protest officer is independent of, or at minimum, not directly responsible for, the procurement being protested. Additionally, the Commission should either change its reporting relationship for procurement compliance monitors to comply with the Procurement Code or seek a change to the Code if it feels the monitors should report to a Commission official other than the Chief Procurement Officer.

Findings: The Commission utilizes a protest review process where the protest officer basically rules on the procurement process that his staff guided and approved, a process that lacks independence when the protest officer is involved in guidance for the procurement oversight by his staff. The Commission has not created rules to guide its oversight responsibility, including rules on protest review. The Commission, during the procurement process for the State health insurance procurements, was in the process of developing an independent protest office. However, the employee assigned these duties was only to be responsible for gathering the required documents. The CPO for the applicable area (i.e., executive agencies, Illinois Department of Transportation, universities, Capital Development Board) was still responsible for the protest ruling.

Commission Response: The Executive Ethics Commission incorporates its response to Recommendation #1 as its response to this Recommendation and further states:

The Illinois Procurement Code provides that "[e]ach procurement compliance monitor shall have an office located in the State agency that the monitor serves but shall report to the appropriate chief procurement officer." 30 ILCS 500/10-15(a). Procurement compliance monitors (PCMs) do report their findings to chief procurement officers, and this is clarified at 30 ILCS 500/10-15(b)(iv). This recommendation implies, however, that PCMs should be subject to the supervision and direction of the chief procurement officers. Such an arrangement is problematic for two reasons.

First, PCMs are directed to "oversee and review the procurement processes," (30 ILCS 500/10-15(a), but these processes are established by the CPOs. For example, "[a]ll actions of a State purchasing officer are subject to review by a chief purchasing officer in accordance with procedures and policies established by the chief procurement officer." (30 ILCS 500/10-10(a)). Also, the Code gives CPOs the power to promulgate rules to carry out the authority to make procurements under the Code (30 ILCS 500/5-25(a)). Further, CPOs shall also "by rule establish procedures to be followed in resolving protested solicitations and awards and contract controversies, for debarment or suspension of contractors, and for resolving other procurement-related disputes." 30 ILCS 500/20-75. The supervisory relationship implied in this recommendation would necessitate the PCM evaluating procurement process decisions made and implemented by his or her supervisor.

Second, while "the actions of a State purchasing officer are subject to the review by the appropriate chief procurement officer," (30 ILCS 500/10-10(a)), no such language exists permitting the CPO to direct the activities of PCMs. Further, PCMs are appointed by the Commission, serve five-year terms and their salaries may not be diminished during their terms. 30 ILCS 500/10-15. Also, only the Commission may remove a PCM for cause following a hearing by the Commission. Consequently, CPOs have no authority to direct the PCMs and have no authority or wherewithal to discipline a PCM who does not follow a CPO's direction.

Auditors' Comment: *In its response, the Commission did not feel the legislation in the Illinois Procurement Code was adequate to address the reporting relationship of the procurement compliance monitors. The Code requires "[e]ach procurement compliance monitor shall have an office located in the State agency that the monitor serves but shall report to the appropriate chief procurement officer" (30 ILCS 500/10-15(a)) (emphasis added). As opposed to seeking changes in the Code, the Commission simply created a new position for the procurement compliance monitors to report to, a position and function that is not provided in State law.*

The Chief Procurement Office responds as follows:

- The Auditor General disagrees with the protest review process employed after the contract award, citing it for lacking independence as the SPO had a direct-line reporting relationship to the CPO.
- The Auditor General correctly cites the Code which requires the CPO to establish by rule procedures for the resolutions of protests. 30 ILCS 500/20-75.
- Procurement rules, promulgated through the process outlined with the Illinois Administrative Procedure Act, are found at 44 Ill. Adm. Code §1.5550.
- The CPO followed the protest rules found at 44 Ill. Adm. Code §1.5550.
- While the Auditor General does not believe the rules adequately provide for independence, the CPO's Office believes it was required to address protests in accordance with the Code and approved rules.

The CPO's Office agrees improvements to the administrative rules for protests are needed. Subsequently, the CPO has filed proposed rules with the Illinois Secretary of State for improved processes. Those proposed rules provide for a separate protest review officer to perform the protest review and analysis as well as to draft a recommendation. The recommendation is presented to the CPO for review and a final determination by the CPO consistent with the authority provided by statute and rule. The protest review officer is an attorney in the Executive Ethics Commission's legal department and reports to the Commission's general counsel and not the respective CPO. Once adopted, the revised protest rule will address many of the Auditor General's concerns.

11. The Department should timely file completed copies, including all required disclosures, of the health insurance contracts in compliance with State law. Additionally, the Department should ensure that contractual premium prices are those that the vendor actually bid for the services awarded.

The Commission should instruct its oversight staff to ensure that contracts are filed by agencies in a timely manner.

Findings: The Department failed to timely file with the Comptroller, completed copies of emergency health insurance contracts as well as the HMO insurance contracts awarded four months earlier. Additionally, the HMO contract contained pricing for monthly premiums that was greater than what the winning vendor bid on the procurement. Further, the Department did not require one vendor to provide information on debarment/legal proceeding disclosures in the final contract with the State. Finally, 31 days after the start of the emergency contract period, the SPO was unaware that contracts had not been filed with the Comptroller for the emergency notices he posted in mid-June 2011.

Department Response: The Department accepts the recommendation. The Department agrees that all contracts should be filed with the Comptroller in a timely manner. The rates in the contracts were adjusted to make the dollar amounts divisible by two due to the inability to re-program the State employee payroll deduction system. Given this inability, the Department will ensure, in future procurements that are subject to the payroll deduction system, that bidders submit rates divisible by two.

Commission Response: The Executive Ethics Commission incorporates its response to Recommendation #1 as its response to this Recommendation. The Chief Procurement Office responds, in part, as follows:

- In its evaluation of the CPO's Office, the Auditor General cited the SPO for not knowing the Department had failed to timely file the contracts with the Comptroller.
- The CPO's Office agrees the Department should ensure contracts are timely filed in accordance with State law. The CPO's Office will strive to advise agencies regarding the necessity of timely filing of contracts where feasible, and will remind the Department that contract filing is a fiscal and accounting function for which the Department bears responsibility.

Furthermore, additional guidance as to advising agencies regarding the necessity of timely filing of contracts has been provided to the procurement compliance monitors.

12. The Commission should develop policies and procedures to guide its staff in overseeing State procurements. These policies and procedures should address the review of scoring by Commission staff prior to reviewing and approving procurement awards.

Findings: The Commission has failed to develop policies and procedures for the activities of its staff that oversee State procurement functions. During the review of the procurement process followed in the solicitation and award of the State health insurance opportunities auditors examined the role of the Commission and its staff in the oversight and review of the process and found:

- The Commission was aware of its procurement oversight responsibilities when legislation (Senate Bill 51) was signed into law on November 3, 2009 (Public Act 96-795).
- The Commission has had oversight responsibility for procurement activities since July 1, 2010.
- State health insurance procurements were the 1st RFP procurements for the SPO and PCM.
  - The SPO started with the Commission on July 16, 2010 and was assigned to the Department on August 1, 2010. The SPO reported he primarily followed the Procurement Code, administrative rules and CPO notices, although he did not have a good handle on the notices. The SPO stated this was the 1st RFP he had ever gone through and he was confused looking at the RFP wondering how it would be reviewed and evaluated.
  - The PCM started with the Commission July 16, 2010. The PCM stated that these were the first RFPs he had ever worked on and that he did some review. He stated that he reviewed the RFPs for consistency and also compared the two.

Exhibit 2-4
COMMISSION ACTIVITIES IN THE PROCUREMENT OF STATE HEALTHCARE VENDORS

Procurement Compliance Monitor	*State Purchasing Officer*	*Chief Procurement Officer*
Reviewed RFP for consistency prior to posting.	Reviewed, commented and approved RFP, scoring tool, evaluation procedures and addendums.	Consulted with SPO and PCM regarding Department recommendation to award.
Attended proposal opening, reviewed opening sheet and administrative compliance check.	Reviewed and approved draft and final recommendations to award developed by Department. Discussions with Department and CPO before approval.	Phone conference with Department and Mercer regarding methodology of calculations in the RFP evaluation process.
Reviewed evaluation tool and procedures.	Published contract award notice on Bulletin.	Internal Commission discussions to vet process used by Department.
Reviewed procurement file and scoring for consistency.	Assisted in organization of procurement file.	Decision on what was public in the procurement file.
Reviewed request to award, executive summary posting, and addendums.	Sent 1st Best and Final Offer (BAFO) to all responsive offerors and forwarded responses to Department.	Reviewed protests to awards to determine whether a violation of the Procurement Code, procurement rules, the solicitation, or other law had occurred.
Discussions with CPO, SPO and HFS regarding award decision.	Sent 2nd BAFO to Health Alliance and BCBS-spoke with Health Alliance.	
Reviewed BAFOs.	Participated in discussions subsequent to notice to award.	

Source: OAG summary of Commission information.

- Commission staff were on site and part of the oversight process at the Department for the procurement of the State health insurance procurements.
- The SPO participated in certain activities in the procurement process including: reviewed, **commented and approved RFP scoring tool evaluation procedures** and addendums; reviewed and approved the recommendation to award that was developed by Department; sent best and final opportunities to proposers.
- The PCM participated in certain activities in the procurement process including: reviewing RFP for consistency with each other; attended proposal opening and performed administrative compliance check; **reviewed evaluation tool and procedures**; reviewed scoring file and scoring for consistency; reviewed request to award and best and final offers.

- Based on documentation reviewed by auditors, neither the SPO or PCM identified any of the procurement deficiencies discovered by auditors during the review including: failure to follow evaluation procedures by Department evaluation team, and scoring irregularities.
- Actual oversight by the Commission **should include** ensuring that the procurement was scored correctly and policies and procedures were followed before approving the recommendation to award.
- The CPO told auditors that he **doesn't believe it is the Commission's responsibility to push the procurement review down to the level of checking scoring**, that this function would be something that was for an entity like the Auditor General to review. He indicated the Commission staff were not there to duplicate work by checking the agency's work but to "press down" to a level of satisfaction for the PCM and SPO. It should be noted that the satisfaction level is being obtained for two first-time staff working on their first RFPs, all **without policies and procedures** from their superiors.
- The CPO also told auditors that there are not policies and procedures and Commission staff only operate under their job description and the Procurement Code. He stated on the policy side of the question, most of the work of the SPOs and PCMs is based on the Procurement Code and not much falls outside of that or the standard procurement rules which had recently been transferred to the Commission. He stated there isn't a lot to their duties that "falls outside" of the Code and believes policies wouldn't be very useful.

Commission Response: The Executive Ethics Commission incorporates its response to Recommendation #1 as its response to this Recommendation. The Chief Procurement Office responds as follows:

- The Auditor General cites the Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) as requiring state agencies to establish systems of internal fiscal and administrative controls, including in this instance policies and procedures for CPO staff to follow when providing oversight to procurement processes at state agencies.
- The Auditor General cites passage of SB 51/P.A. 96-795 on November 3, 2009, as providing notice to the Executive Ethics Commission (Commission) of its procurement oversight responsibility.
- P.A. 96-795 provided for the Commission, with the advice and consent of the Senate, to appoint four chief procurement officers, who are charged with the exercise of all procurement authority under the Code.
- The Commission solicited CPO applicants in February 2010; interviews of applicants were conducted by the Commission in April and May 2010.
- The Commission appointed Matt Brown as Chief Procurement Officer for General Services on May 16, 2010.
- The effective date of P.A. 96-795 was July 1, 2010. Procurement authority under the Code was not transferred to the CPO until September 1, 2010. 30 ILCS 500/10-20(g).
- P.A. 96-795 provided for the appointment by the Governor of an Executive Procurement Officer (EPO). The powers and purpose of the EPO were:
  1) to recommend policies and procedures to ensure consistency between the CPO and their staffs, provided that each CPO shall have the final and exclusive authority over particular procurement decisions;
  2) to assist CPO in the development of and revisions of policies that decisions on procurement related matters remain free from political and other inappropriate extrinsic influence;

3) to provide guidance to CPOs and staff on conducting procurements in a manner responsive and sensitive to the needs of vendors and the business community; and
4) to assist with the implementation of policies mandated by statute or executive order that promote diversity amongst state contractors. 30 ILCS 500/10-25.

- The EPO established under the Code was never appointed by the Office of the Governor; the statutory provision establishing the EPO sunsetted on January 1, 2011. Failure of the Governor to appoint an EPO to assist in the formulation of policies and procedures and assist in an orderly transition of procurement functions from CMS to an independent CPO has hindered the establishment of policies and procedures, as well as the proper understanding of various stakeholders' responsibilities under the Code.
- Absent the EPO assistance contemplated by the Code, in the first full year of implementation of P.A. 96-795, the Commission and CPO's Office have:
  1) appointed SPOs and PCMs and hired additional central office and support staff;
  2) learned the structure, personnel, missions, and intricacies of each state agency subject to the CPO's jurisdiction;
  3) learned state agencies' pre-SB 51 procurement processes for determination of compliance with the Code;
  4) became familiar with state agency contracts and the needs for future contracts; and
  5) transferred the Standard Procurement Rules from CMS to the CPO's Office.
- CPO staff was guided in these procurements by reference to the Code and standard procurement rules (44 Ill. Admin. Code 1). Additionally, CPO notices issued prior to P.A. 96-795 were maintained to provide guidance and assistance to staff as procurement functions were transferred to the new CPO.
- The CPO's Office agrees additional policies and procedures to guide its staff in overseeing State procurements are needed. Subsequently, the CPO has filed proposed rules with the Illinois Secretary of State for improved procurement rules and processes that reflect the changes made in P.A. 96-795. Additional staff assigned exclusively to the development of rules, policies and procedures is planned. The CPO's Office continues to work on developing additional policies and procedures to guide staff and state agencies on the proper conduct of procurements.

Furthermore, the procurement compliance monitors agree additional policies and procedures to guide the overseeing of State procurements are needed. The procurement compliance monitors continue to work on developing additional policies and procedures to guide staff and state agencies on the proper conduct of procurements.

13. The Department should follow the directive of its own RFPs and not allow proposers to bid on counties in which they do not have the requisite number of PCPs. Additionally, the Department should not award counties for health insurance coverage to proposers that did not bid on the counties.

The Commission should ensure that if its staff question whether requirements were satisfied, those questions should be answered and documented prior to approving the award of State health insurance contracts.

Findings: The Department allowed proposers to bid on counties where the number of primary care physicians was not sufficient to meet requirements laid out in the RFPs. Further, the Department awarded significantly more counties in the HMO procurement opportunity to the winner

than it actually bid on. Finally, a Commission official was aware of the lack of compliance regarding the number of providers in counties yet still signed off on the procurement award.

HMO Procurement – Counties Bid

Four proposers bid on the HMO procurement opportunity. One of those proposers, BlueCross BlueShield (BCBS), bid two different networks (the HMO-IL network contained more PCPs than the Blue Advantage network). Section 3.1 of the RFP stated that *"A key objective for this procurement is the ability to offer access in every county in the state. HFS [Healthcare and Family Services] reserves the right to make multiple awards by plan to meet its employee benefit program needs"*. Auditors found:

- Health Alliance bid on 98 counties; PersonalCare bid on 66 counties; BCBS bid on 31 counties for both of its bids; and Humana bid on 18 counties.
- The Department allowed proposers to bid on counties even though they did not have the required number of primary care physicians in some counties. This violated the RFP. The RFP required that for a vendor to include a county in its service area, a minimum of five PCPs must be available and practicing in that county.
- Health Alliance had at least five PCPs in 76% of the counties it bid (74 of 98). In nine counties in which it bid, Health Alliance had zero PCPs on the network physician listing, yet the Department allowed the proposer to bid the counties.
- PersonalCare had at least five PCPs in 74% of the counties it bid (49 of 66). In two counties in which it bid, PersonalCare had zero PCPs on the network physician listing, yet the Department allowed the proposer to bid the counties.

HMO Procurement – Counties Awarded

The Department awarded two BCBS networks 50 counties for the HMO procurement opportunity.

- The Department awarded BCBS 20 counties that BCBS did not even bid on. These counties were: Bond, Brown, Bureau, Carroll, Cass, Clinton, DeWitt, Greene, Jersey, Knox, Mason, McLean, Montgomery, Pike, Putnam, Randolph, Schuyler, Scott, Stark, and Stephenson.
- BCBS network documentation showed that it had zero PCPs in 24 counties that it was awarded. These counties were: Bond, Brown, Bureau, Carroll, Cass, Christian, Clinton, DeWitt, Greene, Grundy, Jersey, Knox, Lee, Macon, Mason, McLean, Montgomery, Pike, Putnam, Randolph, Schuyler, Scott, Stark, and Stephenson.
- BCBS did bid on one county (Henry) that the Department did not award to BCBS. However, the network information submitted by BCBS showed no PCPs in Henry County.

OAP Procurement – Counties Bid

Four proposers bid on the OAP procurement opportunity. Section 3.1 of the RFP stated that *"A key objective for this procurement is the ability to offer open access plans in every county in the state. HFS reserves the right to make multiple awards by plan to meet its employee benefit program needs"*. Auditors found:

- Health Alliance bid on all 102 counties in the State; PersonalCare also bid on all 102 counties; HealthLink bid on 100 counties (did not bid on Pulaski and Putnam counties); and Humana bid on 36 counties.
- The Department allowed proposers to bid on counties even though they did not have the required number of primary care physicians in some counties, which violated the RFP.
- Health Alliance had at least five PCPs in 84%of the counties it bid (86 of 102). In two counties in which it bid, Health Alliance had zero PCPs on the network physician listing.
- PersonalCare had at least five PCPs in 70% of the counties it bid (71 of 102). In six counties in which it bid, PersonalCare had zero PCPs on the network physician listing.
- HealthLink had at least five PCPs in 90% of the counties it bid (90 of 100).
- Humana had at least five PCPs in 78% of the counties it bid (28 of 36). In two counties in which it bid, Humana had zero PCPs on the network physician listing.

OAP Procurement – Counties Awarded

The Department awarded all 102 counties to both HealthLink and PersonalCare for the OAP procurement opportunity. The Department awarded HealthLink the entire State when it did not bid on the entire State. While HealthLink did not bid on Pulaski and Putnam counties, the Department still awarded those counties to HealthLink even though network information showed that HealthLink only had four PCPs in Putnam County and none in Pulaski County.

Acknowledged Shortcomings

The Department evaluation team leader for the procurements provided the State Purchasing Officer (SPO) the proposed service areas for the HMO and OAP awards in a correspondence on March 16, 2011 – approximately three months after evaluations were completed. The Department official stated *"Now keep in mind, there are some counties where the vendor says they have access, when they have no providers in the counties"*.

The SPO, in a correspondence dated March 15, 2011, again approximately three months after the proposals were scored, suggested to the Department evaluation team leader *"I don't know what your arrangements are with Mercer, but if it is feasible, it may be helpful to get two additional groups of scenarios: 1. Scenarios based on entire service areas…2. Same as #1, but remove counties from the proposed service areas where the plan does not meet RFP requirements (e.g. not enough providers)"*. It should be noted that this correspondence came eleven days after the SPO informed the Chief Procurement Officer (CPO) that awards were ready to be posted, and eight days after the Director approved the first Recommendation to Award, awards that included counties where the plans did not meet RFP requirement for number of providers.

The Department reported that the RFP clearly stated that it had the right to change this requirement. Additionally, all the bidders were aware of this right and no one questioned or protested it during the time which questions and protests were allowed. Auditors note that the Department did not provide any documentation to support that it changed the requirement or what any changed requirement may have been for scoring purposes.

Department Response: The Department partially accepts the recommendation. The Department adhered to the requirements of the RFP. The RFP contained language that "The Agency reserves the right to change this requirement based on the size of the county, the specific locations of the PCP offices, and particular circumstances." This language permitted the

Department to award more counties based on the bidder's service area and not solely on the number of primary care physicians per county. The Department retained this discretion, because Illinois consists of 102 counties with wide demographic variations. Thus, this approach recognized that the service area may be larger than the locations of the PCPs and allowed for greater flexibility in member access. Bidders were aware of this requirement and did not question or protest it during the time when questions and protests were allowed. However, the Department agrees that it should give more detail in future RFPs in terms of the specific determinations that will be made to award counties.

Auditors' Comment: *The Department has stated in multiple forums, including to the auditors, that no requirements from the RFP were waived. Based on its response and its action in awarding 24 counties to BlueCross BlueShield that the vendor did not bid on, we do not agree that the Department "adhered to the requirements of the RFP."*

Commission Response: The Executive Ethics Commission incorporates its response to Recommendation #1 as its response to this Recommendation. The Chief Procurement Office responds as follows:

- The Auditor General found the Department allowed vendors to bid on counties where the number of primary care physicians was not sufficient to meet requirements outlined in the RFP.
- The Auditor General also found the Department awarded more counties in the HMO procurement to the winning vendor than was actually bid on by that vendor.
- The Auditor General cites the CPO's Office as being aware of the lack of compliance regarding the number of providers, yet still signing off on the contract award.
- According to Department staff, Department of Insurance and Department of Public Health regulations require servicing of "contiguous counties" under certain conditions. This was addressed and explained by the Department to potential vendors in the definition of "Service Area" in section 1 of the RFPs.
- In the RFPs' administrative requirements for vendors, language was include requiring a minimum of five primary care physicians be available and practicing in the county. The RFPs also included language indicating the Department reserved the right to change this requirement based on the size of the county, the locations of the physicians' offices and particular circumstances.
- The CPO's Office agrees its staff should ensure evaluations of procurements and awards of contracts be conducted in accordance with the Code, rules, procedures and provisions of the solicitation. Subsequent to these solicitations, CPO staff has been instructed to direct agencies to more clearly distinguish between mandatory and desirable specifications, both in solicitations and evaluation documents.

Furthermore, additional guidance as to overseeing evaluations has been provided to the procurement compliance monitors for use in efforts to ensure evaluations are conducted in accordance with the Code, rules, procedures and provisions of the solicitation.

14. The Department should take the steps necessary to ensure that the vendors that are awarded State health insurance contracts have the same or similarly credentialed networks in place to comply with RFP requirements and are available once the contract period begins.

Findings: The Department required proposers to have a network of fully credentialed providers in place by January 1, 2011, but the Department failed to evaluate the proposed networks on that date. Further, the Department received information on proposer networks in mid-October and early November 2010, without verification to know how the networks had evolved by the required date in the RFP and when the awards were to go into effect on July 1, 2011.

Auditors examined the procurement files for the two opportunities including the networks the vendors proposed. The solicitations required the vendors to have a network of fully credentialed providers in counties specified in the solicitation by January 1, 2011. While all vendors had a network, they were not necessarily networks that complied with the RFP requirements for the minimum number of PCPs in order to be awarded the county. The major problem was that many physicians were listed multiple times for the same location.

Auditor Review

Given that no one from the Department or Mercer evaluated the networks after scoring prior to January 1, 2011, in September 2011, auditors researched on the proposer physician directory a sample of physicians that had been included in the proposal submitted by BCBS, as the award winner for the HMO procurement, to determine whether those physicians were still part of the BCBS network and found:

- 15% of the BCBS Blue Advantage physicians in the sample (16 of 108) were no longer identified in the network.
- 12% of the BCBS HMO-IL physicians in the sample (12 of 102) were no longer identified as a provider in the county listed in the network submission.

Also, in September 2011, auditors researched on the proposer physician directory, a sample of physicians that had been included in the proposals submitted by the award winners for the OAP procurement, to determine whether those physicians were still part of the networks and found:

- 19% of the HealthLink physicians in the sample (20 of 105) were no longer identified in the network.
- 14% of the PersonalCare physicians in the sample (14 of 103) were no longer identified as a provider in the county listed in the network submission. The sample did not include physicians from Champaign County.

By January 1, 2011, the solicitations required each vendor to provide a CD with contracted PCPs, specialists, and hospital names and locations for the network(s) you propose to offer. All PCPs must have a unique identifier. Inaccurate or incomplete submission of the above requested data may cause rejection of the entire proposal".

Department Response: The Department disagrees with the recommendation. In November 2010, the Department evaluated the networks to be in place on January 1, 2011. As provider network contracts are typically calendar year contracts, this evaluation was through December 2011. Further, the Department identifies the changes to the provider networks/service areas on an annual basis as part of either contract renewal or benefits choice. Provider networks are constantly evolving and fluid, reacting to a number of demographic and economic forces. Just as an employer's workforce has regular turnover, so does a medical vendor's provider networks. Over time, physicians are added to networks and leave networks for a number of reasons such as aging population, increase in utilization, death, retirement, relocation, mergers, and business decisions. Based on the Auditor's review of networks in September 2011, the Department requested updated network figures from the same vendors in November 2011. After review of this

information, the Department determined that upon taking into account all additions and deletions of providers, all networks increased between 5.46% and 9.78% compared to their proposed networks in place on January 1, 2011.

Auditors' Comment: *Auditors provided the Department with our network monitoring concerns on November 7, 2011. Over 80 days later, at the exit conference on January 27, 2012, the Department indicated that it identifies changes to the networks on an annual basis. It further stated, as it does in its response to the audit, that the networks actually increased based on its analysis. We cannot comment on the Department's figures or its statement that it identifies changes to provider networks/service areas annually because no documentation was ever provided for this analysis to the auditors.*

15. The Department should document the monitoring of consultants with which it contracts that assist in the development and evaluation of procurement opportunities.

The Commission should, in instances where consultants have major roles in procurement activity, ensure its staff have an understanding of the work the consultant conducts prior to approving the award of State contracts.

Findings: The Department failed to provide written guidance to its consultant, a consultant that conducted a large percentage of the procurement activity for the State health insurance procurements. Additionally, the Department failed to monitor the consultant by not reviewing the work product or having the methodology that the consultant utilized in developing calculations of spends.

During the review of the procurements to select administrators for the HMO and OAP health insurance contracts, auditors examined the procurement files for the two opportunities and interviewed Department staff and officials from Mercer to determine what direction was provided by the Department and the extent of consultant monitoring by the Department and found:

- The Department provided Mercer no written guidance on what Mercer's role/responsibility was to be on the procurements for the State health insurance procurements. A Mercer official indicated the scope of services in the Mercer contract with the Department was very wide.
- The Mercer contract in effect during the procurement process contained no scope of services section directly towards the State health insurance procurements.
- Mercer staff helped develop the RFP and scoring instrument, and evaluated the responses to the RFP. Mercer evaluated and scored 86 percent of the total evaluation points for the HMO procurement (3,440 of 4,000). Mercer evaluated and scored 78 percent of the total evaluation points for the OAP procurement (1,940 of 2,500).
- No one from the Department or the Commission had the methodology on how Mercer calculated spend data or reviewed any of the Mercer scoring on the procurement for either the HMO or OAP procurements. The Department was unaware that Mercer would be utilizing a composite scoring methodology for the OAP procurement evaluation.
- A Mercer official told auditors that Mercer was directed to do additional spend scenarios after Mercer did the first three or so scenarios. The official said Mercer received emails and calls from Department staff, but another Mercer official thought the requests came from others, down to those two, because they would say, *"Someone just asked us…."*

These email communications occurred in mid January 2011, some of which were while the 1st BAFO responses were outstanding.

- A Department official told auditors that the spend scenarios were mostly used as a tool to help look at the service areas of each of the bidders, and that the costs saving projections attached were not reviewed and he barely looked at them. This is the same Department official that sent the email direction to Mercer to adjust or develop specific scenarios.
- The SPO stated he presumed the Department did a cursory check of Mercer evaluation scoring, but was not sure. He also stated that the Procurement Compliance Monitor (PCM) for the Department reviewed the scoring conducted by State employees. The SPO stated that he made one phone call to Mercer in late February 2011 to generally go over the methodologies but that he never got a clear grasp on that nor was he able to get an answer to what Mercer had been directed to do by the Department.
- On July 7, 2011, the PCM told auditors that the Commission did not conduct a review of the Mercer documents and he wasn't sure if anyone at the Department had.
- On April 6, 2011, the SPO published the award of the State health insurance procurements to the Illinois Procurement Bulletin.

The Department reported the Budget Chief for the Office of Healthcare Purchasing met with members of the Mercer group that provided the costing analysis of the RFP. Many questions were asked regarding the methodology, individual data elements of the analysis, and the manner in which the data elements were used. In each instance, either questions were answered to the satisfaction of the Budget Chief, or resulted in additional questions. According to the Department, Mercer's oversight of the scoring documents was appropriate because the scoring required actuarial expertise. The Department competitively procured and relied upon Mercer's actuarial expertise. Auditors note there was no documentation to support these meetings in the procurement files, and this official indicated at the entrance conference that he stepped in and out of the process.

Department Response: The Department accepts the recommendation. The Department has required and will continue to require the use of nationally recognized actuarial consultants to provide actuarially sound and defensible analyses in complex healthcare purchasing procurements. The Department agrees to document the monitoring of its consultants to ensure they have complied with the scope and tasks set forth in the future statements of work.

Commission Response: The Executive Ethics Commission incorporates its response to Recommendation #1 as its response to this Recommendation. The Chief Procurement Office responds as follows:

- The Auditor General found the Department failed to provide written guidance to a consultant who conducted or was involved with a large percentage of procurement activity.
- The Auditor General cites the Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) as requiring state agencies to establish systems of internal fiscal and administrative controls, including in this instance controls to provide sufficient monitoring and documentation of decisions that impact State resources relative to the health insurance procurements.
- The CPO's Office agrees it should ensure staff understand consultant's roles in evaluations, that the role be appropriate, and the decisions or recommendations be properly documented.

Furthermore, the procurement compliance monitors should understand consultant's roles in evaluations, that the role be appropriate, and the decisions or recommendations be properly documented.

Costs and Savings

Mercer projected that in FY12 the State would spend $102.5 million less on health insurance given the awards announced on April 6, 2011. This figure was based on many assumptions, the most significant of which was how the participants that were previously in HMO style plans migrated to the expanded OAP plans. The savings figure appears to become irrelevant given that the State created emergency contracts to continue HMO plans under vendors from the previous procurement.

In a report to COGFA, information supplied by the Department showed that the average cost of a participant in the health plans was higher for OAP programs than HMO programs by over $1,200 per year. The State picks up approximately 90% of the annual cost for the participant. The report showed:

- FY12 Average Annual Cost:
  - HMO plans: $5,467 for 193,038 participants
  - OAP plan: $6,699 for 45,236 participants
- FY11 Average Annual Cost:
  - HMO plans: $5,341 for 186,669 participants
  - OAP plan: $6,534 for 44,085 participants

A Department official reported that an analysis of OAP costs versus some HMO plans (for example, Health Alliance Illinois) showed lower costs for the OAP plan. The official admitted that this was not true for all HMO plans. Additionally, the analysis was never provided to auditors for review. It is important to note that the Department reported no one validated the figures Mercer provided. Officials also reported that they did not even have the methodology that Mercer utilized when compiling the various cost scenarios.