STATE OF ILLINOIS

OFFICE OF THE AUDITOR GENERAL

MANAGEMENT AUDIT OF THE

STATE'S PROCUREMENT OF HEALTH INSURANCE VENDORS FOR THE STATE'S GROUP HEALTH INSURANCE PROGRAM

MARCH 2012

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To the Legislative Audit Commission, the Speaker and Minority Leader of the House of Representatives, the President and Minority Leader of the Senate, the members of the General Assembly, and the Governor:

This is our report of the Management Audit of the State's procurement of health insurance vendors for the State's group health insurance program.

The audit was conducted pursuant to Legislative Audit Commission Resolution Number 142, which was adopted May 11, 2011. This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

The audit report is transmitted in conformance with Section 3-14 of the Illinois State Auditing Act.

WILLIAM G. HOLLAND
Auditor General

Springfield, Illinois
March 2012

STATE OF ILLINOIS
OFFICE OF THE
AUDITOR GENERAL
William G. Holland, Auditor General

SUMMARY REPORT DIGEST

STATE'S PROCUREMENT OF HEALTH INSURANCE VENDORS FOR THE STATE'S GROUP HEALTH INSURANCE PROGRAM

MANAGEMENT AUDIT
Release Date: March 2012

SYNOPSIS

The Department of Healthcare and Family Services is responsible for procurement of health care contracts for State employees. Additionally, the Executive Ethics Commission has been given the responsibility of procurement oversight.

On April 6, 2011, the Department announced the Health Maintenance Organization award to BlueCross BlueShield (BCBS) for a total of **$6.6 billion**. On that same day, PersonalCare and HealthLink were awarded contracts totaling **$379 million** for the Open Access Plan administration services.

Our 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**.

Our 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, **we 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.

AUDIT CONCLUSIONS AND RECOMMENDATIONS

The Department was responsible for procuring health care contracts.

During the period covered by this audit, the Department of Healthcare and Family Services (Department) was the agency responsible for procurement of health care contracts. Additionally, the Executive Ethics Commission (Commission) has been given the responsibility, pursuant to Public Act 96-795, of procurement oversight, which includes the activities conducted on the procurement opportunities that form the basis of Legislative Audit Commission Resolution Number 142. (pages 8-10)

The Commission has procurement oversight responsibility.

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 percent to 436,000 participants. State employees and dependents comprise 81 percent of the total participation in the group health insurance program. (pages 6-7)

Procurement Process Conclusions

On April 6, 2011, the Department awarded a total of $7 billion in health care contracts to three vendors.

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 in the Illinois Procurement Bulletin to procure administrators for the State's two **managed care** health insurance programs, the HMO and OAP plans. The plans were **last bid** by the State in 2000. (pages 12-13)

On April 6, 2011, the Department announced the HMO award to both BlueCross BlueShield (BCBS) plans. BCBS was awarded a five-year contract that, with renewals, totaled $6.6 billion for the HMO administration services. On that same day, PersonalCare was awarded a contract totaling $179.7 million for the OAP administration services. HealthLink was also awarded a contract totaling $199.4 million for OAP services. (page 21)

The Department failed to include scoring criteria in the RFP and allowed a consultant that had business relationships with all the bidders to participate in the evaluation process.

Our review of the procurement process found **the Department**:

- **Failed to include** all relevant information, including scoring evaluation criteria, in the Request for Proposals (RFPs) for the State health insurance procurements.
- Utilized a 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.

The Department's evaluators did not meet during the process and failed to provide comments on scoring sheets, both violations of policy/procedure.

- 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.
- **Failed to comply** with its own evaluation policy/procedures by not having the evaluation teams for the State health insurance procurements meet during the evaluation process.
- 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 all scores given.
- 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.

The Department failed to address major scoring differences by evaluators, a violation of policy.

- 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**.
- 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**.

The Department developed a recommendation to award which was changed after a meeting with officials from the Governors Office.

- 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 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 after that meeting and the date the awards were announced on April 6, 2011, the recommendation was changed. While the Department indicated that the Chief Procurement Officer (CPO) could not support the initial

recommendation, documentation did not support that position.

- 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 State Purchasing Officer (SPO) was unaware that contracts had not been filed with the Comptroller for the emergency notices he posted in mid-June 2011. (pages 23-62)

The Department did not timely file contracts with the Comptroller.

Our review of the procurement process found **the Commission**:

Commission staff approved the RFP without ensuring all scoring information was included.

- Had staff review and approve the RFPs without ensuring all relevant information, including scoring evaluation criteria was included.
- Had staff with oversight responsibility that did not question the lack of compliance with evaluation procedures regarding the failure of the evaluation teams meeting during the process.
- Had staff responsible for the oversight of the procurements that did not question the violation of procedures regarding not providing thorough and appropriate comments to support all scores given.

Commission staff did not ensure that evaluation procedures were complied with.

- Had staff responsible for oversight of these procurements that did not ensure compliance with evaluation procedures prior to approving the award of the contracts regarding addressing major differences in scoring on the procurements.
- SPO for the Department did not approve the awards for the HMO plan administrator and OAP plan administrator procurements **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** 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.

The Commission has failed to develop policies for its oversight staff.

- Failed to develop policies and procedures for the activities of its staff that oversee State procurement functions. During our review of the procurement process followed in the solicitation and award of the State health insurance opportunities, we examined the role of the Commission and its staff in the oversight and review of the process. (pages 23-67)

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, we 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. (pages 63)

Networks, State Costs, and Savings Conclusions

The Department scored bidders that did not comply with RFP requirements for a minimum number of primary care physicians.

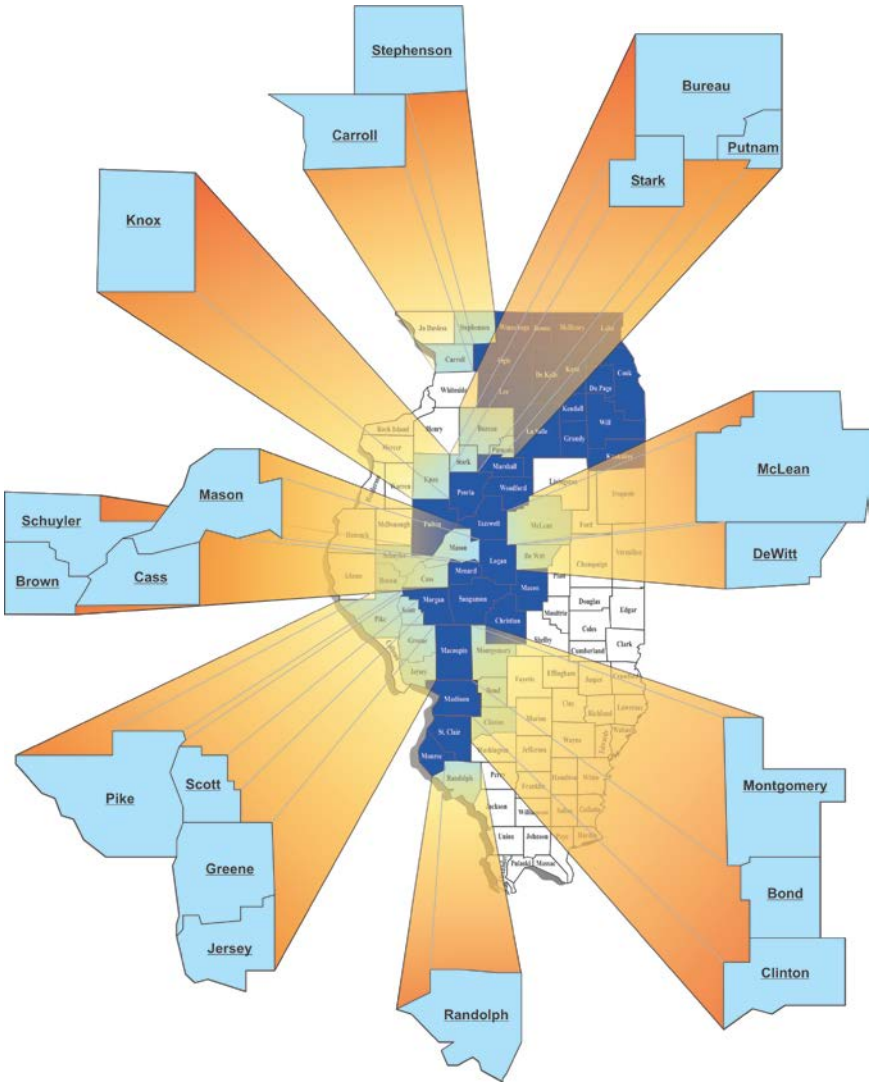
The Department allowed proposers to the State health insurance procurements to bid on counties where the number of primary care physicians (PCPs) was **not sufficient to meet requirements** laid out in the RFPs. Further, the Department awarded significantly more counties in the HMO procurement opportunity to the winner than they 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. Our review of provider network submissions showed:

- For the HMO Procurement:
  - The Department **awarded** BCBS 20 counties that BCBS **did not even bid on**.
  - BCBS network documentation showed that it had **zero PCPs in 24 counties that it was awarded**.
  - In five counties in which it bid, BCBS had **zero** PCPs on the network physician listing, yet the Department allowed the proposer to bid the counties.
  - 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.
  - 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.
  - In two counties in which it bid, Humana had **zero** PCPs on the network physician listing, yet the Department allowed the proposer to bid the counties.

Digest Exhibit 1 presents an analysis of BCBS awarded counties where the submitted network showed **no network presence.** (pages 73-76)

Digest Exhibit 1

COUNTIES AWARDED TO BCBS WITH NO BCBS NETWORK PRESENCE



Note: Network providers include primary care physicians, hospitals, OB/GYN, pediatricians and other specialists.

Source: OAG developed from vendor proposal.

- For the OAP Procurement: 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. (page 77)

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 2011, 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.

There were discrepancies in network documentation submitted by bidders.

Our review of the proposals and network information indicated that there were discrepancies on the network CDs submitted by the proposers. The major problem was that many physicians were listed multiple times for the same location. In September 2011 we researched on the proposer physician directory a sample of physicians that had been included in the proposals submitted by the vendors that were awarded State health insurance procurements. We found:

- **15 percent** of the BCBS Blue Advantage physicians in our sample (16 of 108) were **no longer** identified in the network.
- **12 percent** of the BCBS HMO-IL physicians in our sample (12 of 102) were **no longer** identified as a provider in the county listed in the network submission.
- **19 percent** of the HealthLink physicians in our sample (20 of 105) were **no longer** identified in the network.
- **14 percent** of the PersonalCare physicians in our sample (14 of 103) were **no longer** identified as a provider in the county listed in the network submission. (pages 80-82)

The Department publicized savings figures the day awards were announced.

The awards announced April 6, 2011 for State health insurance were estimated to cost nearly $7 billion over the first five years of the contract period. The Department reported that cost savings **was not a factor** in the selection and award of the health insurance contracts. While it was not a factor in the scoring criteria and point calculations, the Department did utilize savings figures generated by Mercer to request Best and Final Offer (BAFO) information from vendors for the HMO procurement. The day the HMO and OAP awards were announced, the Department issued a press release stating that *"the award of these four contracts will result in a savings of approximately $102 million in FY12, and a savings in excess of $1 billion over the life of the contracts."*

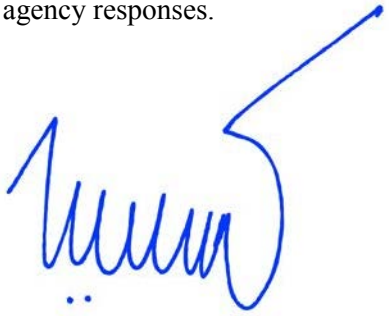
Based on the results and award of contracts, the Department significantly expanded the self-insured OAP program from what was previously utilized. This expansion was apparently considered as early as July 2010, but was not delineated in the RFP for the OAP procurement.

Department documentation 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. 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. The analysis was never

provided to auditors for review. The State picks up approximately 90 percent of the annual cost for the participant. It is difficult to know how Mercer calculations show the State saves money when the awards, as announced, migrate more HMO participants to OAP plans. No one from the Department validated the figures Mercer provided. Officials also reported that they did not even have the methodology that Mercer utilized when compiling the various scenarios. (pages 83-87)

RECOMMENDATIONS

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. Appendix E to the report contains the full agency responses.



WILLIAM G. HOLLAND
Auditor General

WGH:MJM

AUDITORS ASSIGNED: This Management Audit was performed by the Office of the Auditor General's staff.

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Chapter One

INTRODUCTION & BACKGROUND

REPORT CONCLUSIONS

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- 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.

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- 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 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 after that meeting and the date the awards were announced on April 6, 2011, the recommendation was changed. While the Department indicated that the Chief Procurement Officer (CPO) could not support the initial recommendation, documentation did not support that position.
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- Failed to develop policies and procedures for the activities of its staff that oversee State procurement functions. During our review of the procurement process followed in the solicitation and award of the State health insurance opportunities, we examined the role of the Commission and its staff in the oversight and review of the process.

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, we 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.

Networks, State Costs, and Savings Conclusions

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regarding the number of providers in counties yet still signed off on the procurement award. Our review of provider network submissions showed:

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  - 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.
  - In two counties in which it bid, Humana had **zero** PCPs on the network physician listing, yet the Department allowed the proposer to bid the counties.
- For the OAP Procurement: 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.

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 2011, 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.

Our review of the proposals and network information indicated that there were discrepancies on the network CDs submitted by the proposers. The major problem was that many physicians were listed multiple times for the same location. In September 2011 we researched on the proposer physician directory a sample of physicians that had been included in the proposals submitted by the vendors that were awarded State health insurance procurements. We found:

- **15 percent** of the BCBS Blue Advantage physicians in our sample (16 of 108) were **no longer** identified in the network.
- **12 percent** of the BCBS HMO-IL physicians in our sample (12 of 102) were **no longer** identified as a provider in the county listed in the network submission.
- **19 percent** of the HealthLink physicians in our sample (20 of 105) were **no longer** identified in the network.
- **14 percent** of the PersonalCare physicians in our sample (14 of 103) were **no longer** identified as a provider in the county listed in the network submission.

The awards announced April 6, 2011, for State health insurance were estimated to cost nearly $7 billion over the first five years of the contract period. The Department reported that cost savings **was not a factor** in the selection and award of the health insurance contracts. While it was not a factor in the scoring criteria and point calculations, the Department did utilize

savings figures generated by Mercer to request Best and Final Offer (BAFO) information from vendors for the HMO procurement. The day the HMO and OAP awards were announced, the Department issued a press release stating that *"the award of these four contracts will result in a savings of approximately $102 million in FY12, and a savings in excess of $1 billion over the life of the contracts."*

Based on the results and award of contracts, the Department significantly expanded the self-insured OAP program from what was previously utilized. This expansion was apparently considered as early as July 2010, but was not delineated in the RFP for the OAP procurement.

Department documentation 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. 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. The analysis was never provided to auditors for review. The State picks up approximately 90 percent of the annual cost for the participant. It is difficult to know how Mercer calculations show the State saves money when the awards, as announced, migrate more HMO participants to OAP plans. No one from the Department validated the figures Mercer provided. Officials also reported that they did not even have the methodology that Mercer utilized when compiling the various scenarios.

INTRODUCTION

On May 10, 2011, the Legislative Audit Commission adopted Resolution Number 142 (see Appendix A), 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. We were asked to determine:

- 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, dependants 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, dependants 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.

STATE EMPLOYEES GROUP INSURANCE ACT OF 1971

The State Employees Group Insurance Act of 1971 (Act) establishes the requirements for the State health insurance program related to the procurement opportunities the Auditor General was directed to examine in Resolution Number 142. The purpose of this Act is to provide a program of group life insurance, a program of health benefits and other employee benefits for persons in the service of the State of Illinois, employees of local governments, employees of rehabilitation facilities, employees of domestic violence shelters and services, and employees of child advocacy centers, and certain of their dependents (5 ILCS 375/2).

The General Assembly has declared "that it is the policy of the State and in the best interest of the State to assure quality benefits to members and their dependents under this Act. The implementation of this policy depends upon, among other things, **stability and continuity of coverage care and services** under benefit programs for members and their dependents. Specifically, but without limitation, members should have continued access, on substantially similar terms and conditions, to trusted family health care providers with whom they have developed long-term relationships through a benefit program under this Act. Therefore, the Director [of the Department of Healthcare and Family Services] must administer this Act consistent with that State policy, but may consider affordability, cost of coverage and care, and competition among health insurers and providers" (5 ILCS 375/5). The Act goes on to state that the "program of health benefits shall be designed by the Director…to provide benefits to the extent possible to members throughout the State, wherever located, on an equitable basis" (5 ILCS 375/6 (a)).

State Group Health Insurance Membership

The State's group health insurance program includes members and dependents enrolled in the **managed-care** health programs, either a Health Maintenance Organization (HMO) or the Open Access Plan (OAP), as well as the Quality Care Health Plan (QCHP). Members and dependents come from any of four groups: State employees, local government health plan, teachers retirement insurance program (TRIP), and college insurance program (CIP).

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 increased by 2 percent to 436,000 participants. State employees and dependents comprise 81 percent of the total participation in the group health insurance program.

Group Health Insurance Program

HMO – Members must select a primary care physician (PCP) from a network of participating providers. The PCP directs healthcare services and must make referrals for specialists and hospitalizations.

OAP – Provide three benefit levels broken into tier groups. Tier I and Tier II require the use of network providers and offer benefits with copayments and/or coinsurance.

QCHP – Medical plan that offers a comprehensive range of benefits. Participants can choose any physician or hospital for medical services. However, participants receive lower out-of-pocket costs when receiving services at a QCHP network provider.

Managed-care programs, those that were awarded by the Department in April 2011, are utilized more than QCHP. During FY11, managed-care participants totaled 262,634 from the four programs. Services were provided by up to seven vendors. Department figures for FY12 showed a three percent increase in managed-care enrollments. Exhibit 1-1 provides statistics for group insurance membership in FY11 and FY12 by program and provider.

Exhibit 1-1
GROUP INSURANCE MEMBERSHIP
FY11-FY12

	State Members – FY11			***State Members – FY12***		
	Members	*Dependents*	*Total*	*Members*	*Dependents*	*Total*
QCHP	80,763	40,096	120,859	79,234	39,775	119,009
Health Alliance HMO	37,386	41,379	78,765	38,261	43,062	81,323
Health Alliance IL	3,566	4,523	8,089	3,673	4,662	8,335
BCBS-HMO IL	29,784	30,043	59,827	30,125	30,916	61,041
Humana Health Plans	4,366	5,854	10,220	4,312	5,813	10,125
Humana Winnebago	797	801	1,598	780	778	1,558
PersonalCare HMO	13,367	13,332	26,699	13,463	13,698	27,161
HealthLink OAP	19,509	22,337	41,846	20,863	24,101	44,964
Group Total	189,538	158,365	347,903	190,711	162,805	353,516
	Local Government Members – FY11			***Local Government Members – FY12***		
	Members	*Dependents*	*Total*	*Members*	*Dependents*	*Total*
LCHP	1,156	594	1,750	1,038	530	1,568
Health Alliance HMO	1,549	767	2,316	1,413	808	2,221
Health Alliance IL	157	65	222	145	66	211
BCBS-HMO IL	309	257	566	271	215	486
Humana Health Plans	711	629	1,340	563	510	1,073
PersonalCare HMO	601	438	1,039	519	356	875
HealthLink OAP	699	348	1,047	536	268	804
Group Total	5,182	3,098	8,280	4,485	2,753	7,238
	TRIP Members – FY11			***TRIP Members – FY12***		
	Members	*Dependents*	*Total*	*Members*	*Dependents*	*Total*
TCHP	33,053	5,953	39,006	33,576	5,919	39,495
Health Alliance HMO	4,826	715	5,541	5,123	747	5,870
Health Alliance IL	829	134	963	898	150	1,048
BCBS-HMO IL	6,062	1,174	7,236	6,561	1,287	7,848
Humana Health Plans	2,352	360	2,712	2,431	381	2,812
PersonalCare HMO	1,770	264	2,034	1,953	293	2,246
HealthLink OAP	7,884	1,264	9,148	8,573	1,380	9,953
Group Total	56,776	9,864	66,640	59,115	10,157	69,272
	CIP Members – FY11			***CIP Members – FY12***		
	Members	*Dependents*	*Total*	*Members*	*Dependents*	*Total*
CCHP	3,669	628	4,297	3,860	610	4,470
Health Alliance HMO	283	59	342	303	59	362
Health Alliance IL	28	7	35	29	5	34
BCBS-HMO IL	320	63	383	339	63	402
Humana Health Plans	93	16	109	92	14	106
PersonalCare HMO	98	18	116	101	16	117
HealthLink OAP	364	77	441	403	80	483
Group Total	4,855	868	5,723	5,127	847	5,974
Overall Total	256,351	172,195	428,546	259,438	176,562	436,000

Source: OAG developed from Department information.

STATE HEALTH INSURANCE PROGRAM ADMINISTRATION

On April 1, 2005, Executive Order #2005-3 transferred the respective powers, duties, rights and responsibilities related to State healthcare purchasing from the Department of Central Management Services (CMS) to the Department of Healthcare and Family Services (Department). This transfer was effective July 1, 2005.

The Governor, on April 1, 2011, proposed to transfer that authority back to CMS through Executive Order #2011-1 if not disapproved by either house of the General Assembly. On May 22, 2011, the Illinois Senate disapproved, in a vote of 40-0-0, of the transfer of healthcare purchasing back to CMS. Senate Bill 178, which passed both houses on May 30, 2011, created the State Healthcare Purchasing Reorganization and Oversight Act, which again would have made CMS responsible for healthcare purchasing. This legislation was sent to the Governor on June 2, 2011. The Governor vetoed the legislation on July 29, 2011. The General Assembly failed to override the veto on October 26, 2011.

During the period covered by this audit, the Department was the agency responsible for procurement of health care contracts. Additionally, the Commission has been given the responsibility, pursuant to Public Act 96-795, of procurement oversight, which includes the activities conducted on the procurement opportunities that form the basis of Resolution Number 142.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

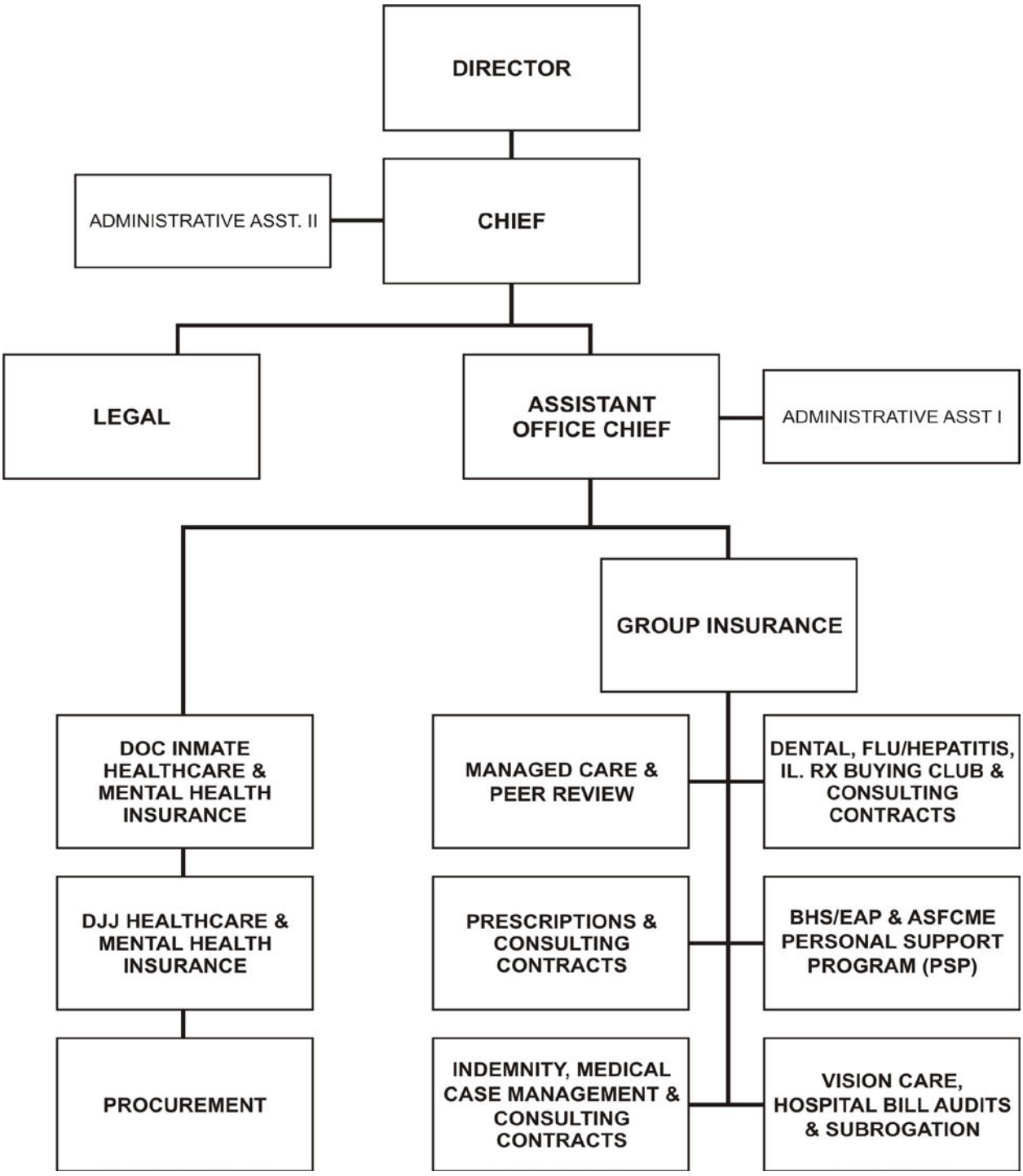
The Department utilizes a number of areas to procure healthcare services for the group insurance program. The major area is the **Office of Healthcare Purchasing** (Office).

The Office is responsible for the procurement of healthcare services for State government outside the Department's medical assistance programs. The Office reviews healthcare services previously procured through the Departments of CMS, Corrections, Human Services, and Veterans' Affairs.

The mission of the Office is four-fold:

1. To utilize best industry practices and efficiencies to eliminate redundancy, simplify organizational structure, and implement cost containment initiatives to realize savings.
2. To manage procurement functions to deliver fiscally responsible and high quality healthcare programs by utilizing the procurement process to ensure competitive selection and compliance.
3. To manage resources and services efficiently to minimize costs and assist in budget development and payment strategy for the vendor contracts and funds under HFS-Office control and responsibility.
4. To administer contracts operationally and for compliance with HFS and State requirements by establishing benchmarks, measures and service expectations and resolving issues among contracted parties. (Exhibit 1-2 presents the organizational chart for the Office at April 19, 2011.)

Exhibit 1-2
OFFICE OF HEALTHCARE PURCHASING ORGANIZATIONAL CHART
April 19, 2011



Note: DOC is the Illinois Department of Corrections. DJJ is the Department of Juvenile Justice.

Source: OAG developed from Department information.

The Office received appropriations for healthcare coverage for eligible members per the State Employees Group Insurance Act of 1971. Appropriations increased from $2.04 billion in FY10 to $2.10 billion in FY11.

Division of Finance (Division)

The Division reviews and provides comment on procurement documents to confirm that the Department has the budget and necessary appropriation authority, and to identify the federal reimbursement rate as applicable, for each request.

Office of Inspector General (OIG)

OIG reviews and provides comment on procurement documents to ensure program integrity and to prevent, detect and eliminate fraud, waste, abuse, misconduct and mismanagement in programs administered by the Department.

Office of General Counsel (OGC)

OGC reviews procurement documents and provides counsel to the procuring bureau regarding the Department procurement process, State and federal requirements, government legislation, and the procurement code and standard procurement rules.

Office of Procurement Management (OPM)

OPM reviews and provides comment on procurement documents in order to assist the procuring bureau in the management of the procurement processes. In addition, OPM assists the procuring bureau in the interpretation and implementation of changes to the procurement processes based on changes in Department policies, changes to the procurement code and standard procurement rules and in compliance with directives, processes and guidelines issued by CMS, the Procurement Policy Board and the Executive Ethics Commission specific to procurement.

EXECUTIVE ETHICS COMMISSION

The Commission is comprised of nine commissioners appointed by five executive branch constitutional officers. The Governor appoints five of the nine commissioners, and the Attorney General, Secretary of State, Treasurer, and Comptroller each appoint one. The Illinois Senate confirms commissioners, who serve staggered four-year terms. No more than five commissioners may be members of the same political party, and commissioners may not engage in any political activity during the term of their appointment. The duties and responsibilities of the Commission, pursuant to the Ethics Act, are detailed in Exhibit 1-3.

Exhibit 1-3 **COMMISSION DUTIES AND RESPONSIBILITIES**	
1	Promulgate rules governing the performance of commission duties and governing the investigations of the executive inspectors general.
2	Conduct administrative hearings on investigations brought before the commission by an executive inspector general.
3	Receive periodic reports from the executive inspectors general and the Attorney General regarding ongoing and completed investigations.
4	Prepare and publish manuals and guides and oversee training of executive agency employees.
5	Prepare public information materials to facilitate compliance, implementation, and enforcement of the Ethics Act.
6	Make rulings, issue recommendations and impose administrative fines, on ethics cases brought before it.
7	Issue subpoenas with respect to matters pending before the commission.
8	Appoint special executive inspectors general to investigate executive agency inspector generals or to pursue investigations of executive agency ethical misconduct allegations that have failed to be resolved within six-months.
9	Consider appeals of executive inspector general determinations concerning the revolving door prohibition.
10	Receive reports of *ex parte* communications that each agency and constitutional officer is required to file with the commission.
11	*Exercise jurisdiction over matters arising under the Illinois procurement code.*
Source: OAG developed from Commission information.	

Public Act 96-795 designated **responsibility for the oversight** of the purchase of State goods and services to the Commission. The General Assembly removed the authority to procure most goods and services from the State agencies under the Governor's control and tasked that responsibility to the Commission.

The Commission has appointed four CPOs, who, in turn, have appointed SPOs for the majority of State agencies. The four CPOs have the following jurisdictions:

- Department of Transportation,
- Capital Development Board,
- State Universities, and
- All other executive agencies under the Governor.

The SPOs must approve any applicable purchases sought by the agencies in advance of any contract being signed. The Commission has also appointed procurement compliance monitors (PCMs) for each State agency. The monitors oversee the procurements from inception to ensure that laws, rules and best practices are followed by State employees.

The CPO over the healthcare contract procurements referenced in Resolution Number 142 has responsibility for all executive agencies. The SPO that is assigned to the Department has reporting responsibility to the CPO at the Commission. The Commission has designated a PCM to the Department, but according to Commission organizational structure, has reporting responsibility to the chief procurement compliance monitor at the Commission.

HEALTH INSURANCE PROCUREMENTS

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 in the Illinois Procurement Bulletin to procure administrators for the State's two **managed care** health insurance programs, the HMO and OAP plans.

HMO Plan

HMO style plans require participants to **choose a doctor** from an HMO network to become the primary care physician (PCP). All routine medical care, hospitalizations and referrals for specialized care are coordinated under the direction of the PCP. Managed care plans, including HMOs, have restricted service areas. HMOs cover preventive health care needs. The State pays the vendor a fixed monthly premium in an HMO plan and the vendor pays all claims to medical providers and hospitals for health services to members. The vendor assumes all the risk of fluctuations in claims.

The HMO plan administrator was **last bid** by the State in October 2000. The resulting contract was for a period of five years with five one-year renewals. Seven vendors received the award for HMO services **from that 2000 procurement**: Unicare HMO, PersonalCare, OSF Winnebago, OSF Health Plans, HMO Illinois-BlueCross BlueShield of Illinois (BCBS), Health Alliance Medical Plans, and Health Alliance Illinois.

In a March 2011 report of liabilities of the State health insurance program, the Department reported to the Commission on Government Forecasting and Accountability (COGFA) that there would be an **increase** in the number and percentage of participants in HMO-style plans. The Department did warn that the number could change significantly due to the HMO contracts being rebid for FY12.

OAP Plan

OAP is a managed care plan that is a **combination** of an HMO and PPO. Members have access to a wide range of care, with **three benefits levels** from which to choose. According to Department documentation, Tier I of the OAP provides the richest benefit and the lowest co-payment for the member. Tier II, like Tier I, is considered "in-network" yet has a **higher co-payment** for providers of these services. Tier III providers are out-of-network with **significantly higher payments for the member**. PCPs in the OAP plan do not perform the gatekeeper function and the members can see specialists without referral from the PCP.

The OAP plan administrator was first offered by the State in FY02. The resulting contract was for a period of five years with five one-year renewals. The lone vendor selected for the award was HealthLink, Inc.

The main difference in an OAP compared to the HMO is that the State self funds the OAP plan. The State pays the vendor a small, fixed monthly administrative fee per member. Medical providers directly bill the State for services rendered to members. The State pays the providers a reduced amount based on discount percentages proposed in the vendor's response to the RFP. The State assumes the risk of fluctuations in claims.

During FY11, there were 44,085 participants in the OAP administered by HealthLink. That figure, according to figures the Department submitted to COGFA, was expected to grow by 2.61 percent in FY12 to 45,236 participants.

HMO PLAN ADMINISTRATOR PROCUREMENT

On October 5, 2010, the Department requested proposals for organizations to administer an insured HMO Plan for enrollees in the State Health Plan, Local Government Health Plan, Teachers' Retirement Insurance Program, and College Insurance Program. According to the RFP, the combined, current HMO Plan enrollment in these four plans was approximated to be 196,000 lives. Proposals were due November 8, 2010.

Four vendors bid on the HMO procurement: BCBS, PersonalCare, Health Alliance, and Humana. BCBS bid two networks in the same proposal. Proposals were evaluated and scored during November and December 2010. BAFOs were solicited from vendors in January and February 2011.

On April 6, 2011, the Department announced the HMO award to both BCBS plans. BCBS was awarded a five-year contract that, with renewals, totaled $6.6 billion for the HMO administration services. While the 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. Prices are typically lower due to increased competition, population size and number of medical providers. It was unclear whether the BCBS prices could be offered in other parts of the State. An evaluation analysis of the results is included in Exhibit 1-4.

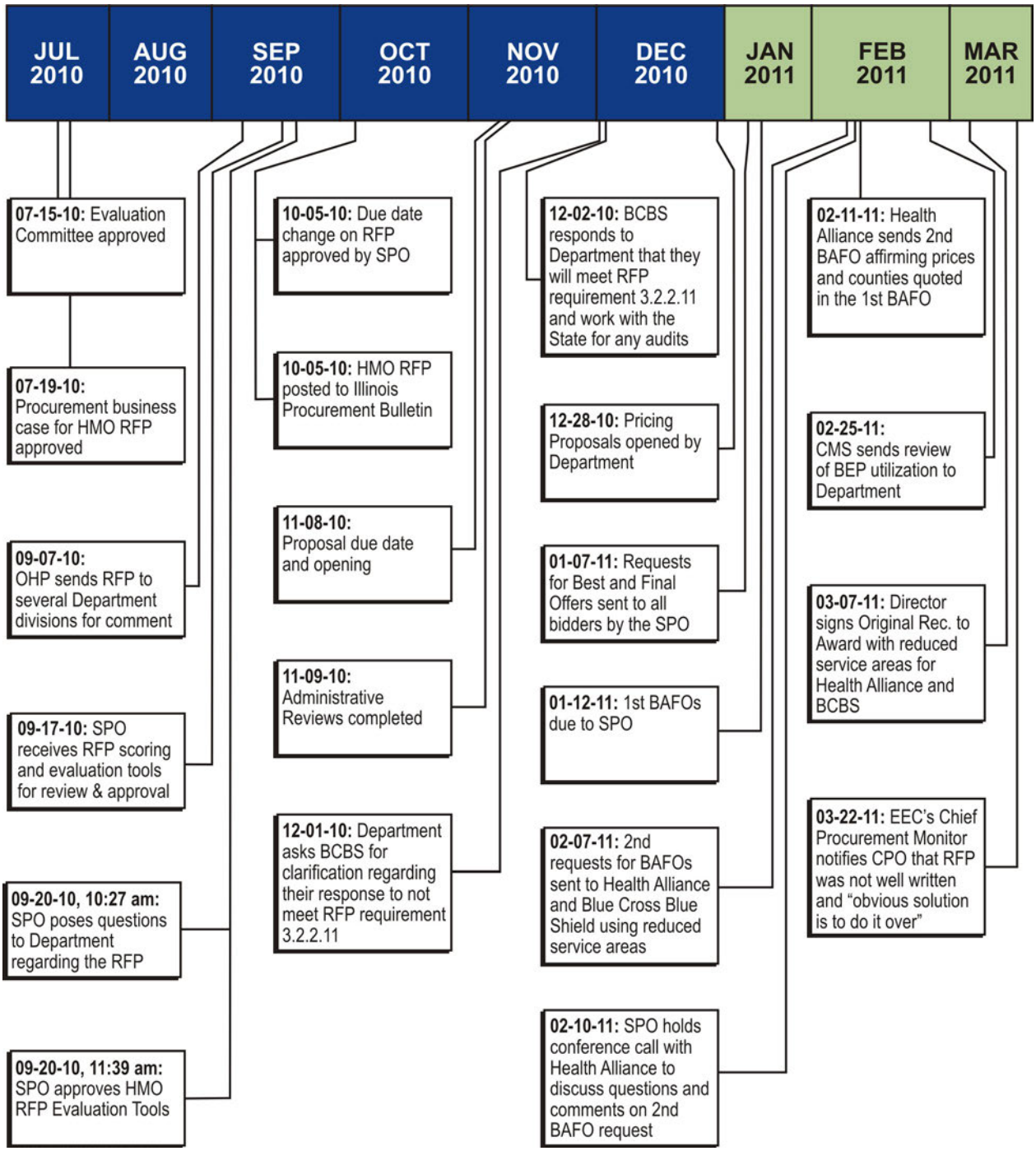
Exhibit 1-4
HMO PLAN ADMINISTRATOR FINAL EVALUATION ANALYSIS

Vendor	*Total Tech Pts*	*Total Price Pts*	*Final Score*	*FY12 Pricing*
BCBS/Blue Advantage	937	2,800	3,737	$1,375,100,000
BCBS/HMO IL	937	2,675	3,612	$1,439,600,000
PersonalCare	1,015	2,479	3,494	$1,552,900,000
Health Alliance	1,050	2,310	3,360	$1,666,800,000
Humana	998	2,174	3,172	$1,771,400,000

Source: Department information and Illinois Procurement Bulletin.

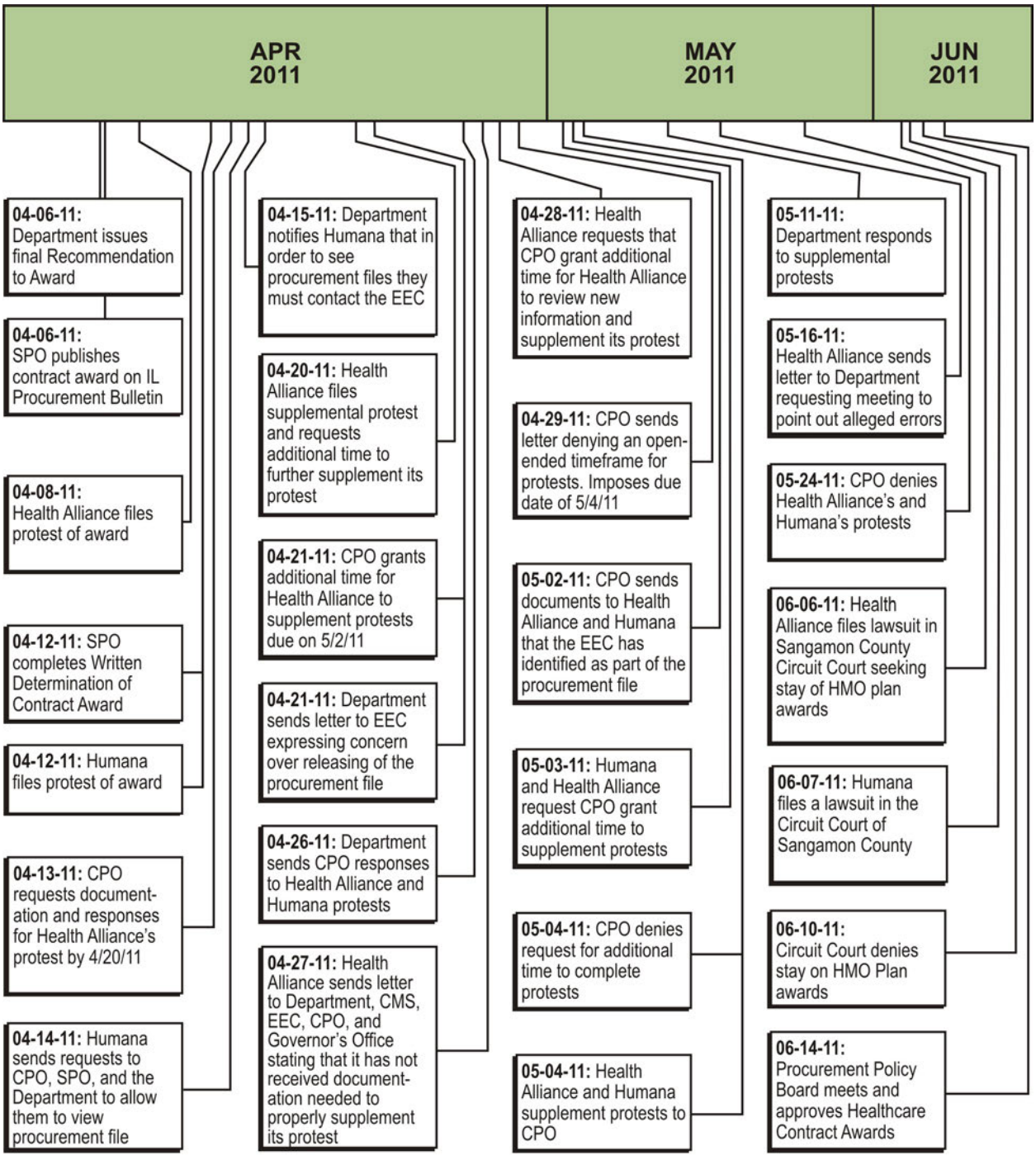
Health Alliance and Humana protested the awards. In June 2011, the two vendors then filed suit in Sangamon County Court requesting a stay of the HMO award. The Court ruled against Health Alliance and Humana. Exhibit 1-5 provides a timeline of activities associated with the HMO procurement.

Exhibit 1-5
TIMELINE OF ACTIVITIES
HMO PROCUREMENT



Source: OAG developed from Department and Commission information.

Exhibit 1-5
TIMELINE OF ACTIVITIES
HMO PROCUREMENT



Source: OAG developed from Department and Commission information.

OAP PLAN ADMINISTRATOR PROCUREMENT

On September 2, 2010, the Department requested proposals for organizations to administer a self-insured Open Access Plan for enrollees in the State Health Plan, Local Government Health Plan, Teachers' Retirement Insurance Program, and College Insurance Program. The combined, current Open Access Plan enrollment in these four plans is approximately 60,000 lives. Like the HMO procurement, this RFP was developed by a collaboration of groups, offered no vendor conference, and responses were due October 19, 2010.

The RFP, in Section 3.1, stated that the Department intended to provide benefits using self-insured plans and needed a vendor or vendors to administer the plans. The RFP states *"A key objective for this procurement is the ability to offer open access plans in every county in the state."* The Department reserved the right to make multiple awards by plan to meet its employee benefit program needs.

Four vendors bid on the OAP procurement: PersonalCare, Health Alliance, Humana, and HealthLink. On April 6, 2011, the Department announced the OAP award to both HealthLink and PersonalCare. An evaluation analysis of the results is included in Exhibit 1-6.

Exhibit 1-6
OAP PLAN ADMINISTRATOR FINAL EVALUATION ANALYSIS

Vendor	*Total Tech Pts*	*Total Price Pts*	*Final Score*	*FY12 Composite Price*
HealthLink	1,526	700	2,226	$14.24
PersonalCare	1,565	660	2,225	$15.05
Humana	1,555	476	2,031	$20.43
Health Alliance	1,368	638	2,006	$15.56

Source: Department information and Illinois Procurement Bulletin.

PersonalCare was awarded a contract totaling $179.7 million for the OAP administration services. HealthLink was also awarded a contract totaling $199.4 million for OAP services. Department staff indicated that the award to the top two vendors was due to them being separated by a single point and the statewide coverage of their proposals. Exhibit 1-7 provides a timeline of activities associated with the OAP procurement.

AUDIT SCOPE AND METHODOLOGY

This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310. The audit methodology for our fieldwork testing is presented in Appendix B. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The audit objectives for this audit were those as delineated in Resolution Number 142 (see Appendix A), 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. The audit objectives were to determine whether: all aspects of the procurement process were performed in accordance with laws, rules, regulations and policies; decisions were adequately documented; criteria was uniformly applied to all vendors; awardees were able to provide services to State health insurance members at the time of award and at the beginning of the contract period; impact on participants was considered; and cost and savings figures were fully supported. The majority of fieldwork for the audit was completed between August 1, 2011, and September 30, 2011.

In conducting the audit, we reviewed applicable State laws, administrative rules and Department and Commission policies pertaining to the procurement and oversight of State health insurance contracts. We reviewed compliance with those laws and rules to the extent necessary to meet the audit's objectives. Any instances of non-compliance we identified or noted are included in this report.

The State Employees Group Insurance Act of 1971 (Act) establishes requirements for the State health insurance program related to the procurement opportunities the Auditor General was directed to examine in Resolution Number 142 (5 ILCS 375). In addition to the Act, the Illinois Procurement Code (30 ILCS 500), Standard Procurement Rules (44 Ill. Adm. Code), applicable CPO Notices, Department evaluation procedures, and the solicitations themselves provided criteria as to the procurement for State health insurance contracts.

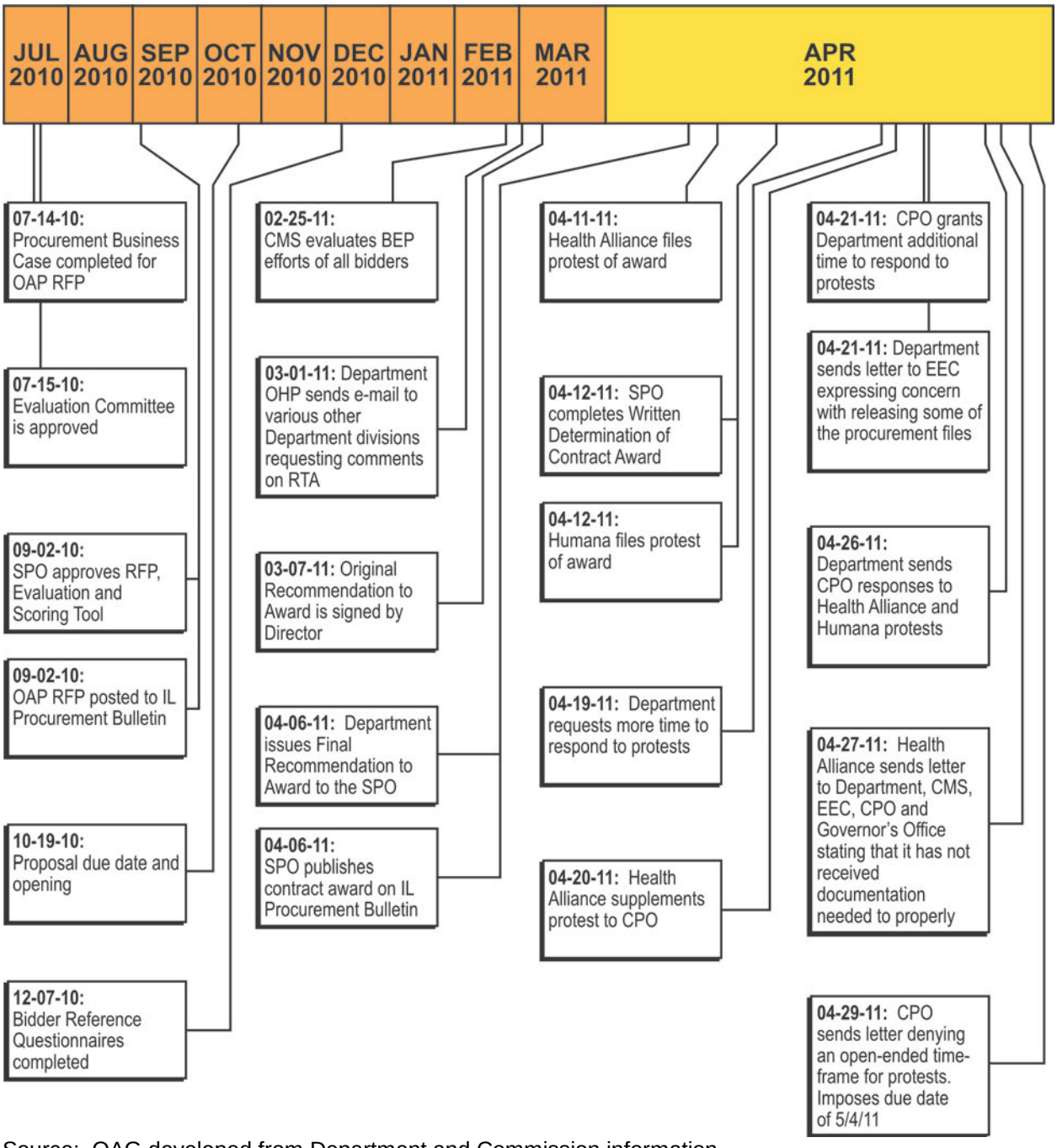
During the audit, we interviewed staff from both the Department and Commission relative to the two procurement opportunities for providing services for the State health insurance contracts. Additionally, we contacted **all** vendors that bid on the two procurement opportunities to see if they wanted to share their perspectives on the procurement processes utilized by the Department and the Commission for these procurements. We also interviewed the Department's consultant (Mercer) to gain an understanding of its role in the procurement and the cost savings calculations and scenarios it developed for use in the decision making process.

We examined all documentation maintained at the Department and Commission on the procurement activities undertaken for the procurement of the HMO and OAP plan administrators. Our review included documents submitted as part of legal proceedings brought by both losing vendors to the procurement.

We also reviewed internal controls and assessed audit risk relating to the audit's objectives. A risk assessment was conducted to identify areas that needed closer examination. Any significant weaknesses in those controls are included in this report.

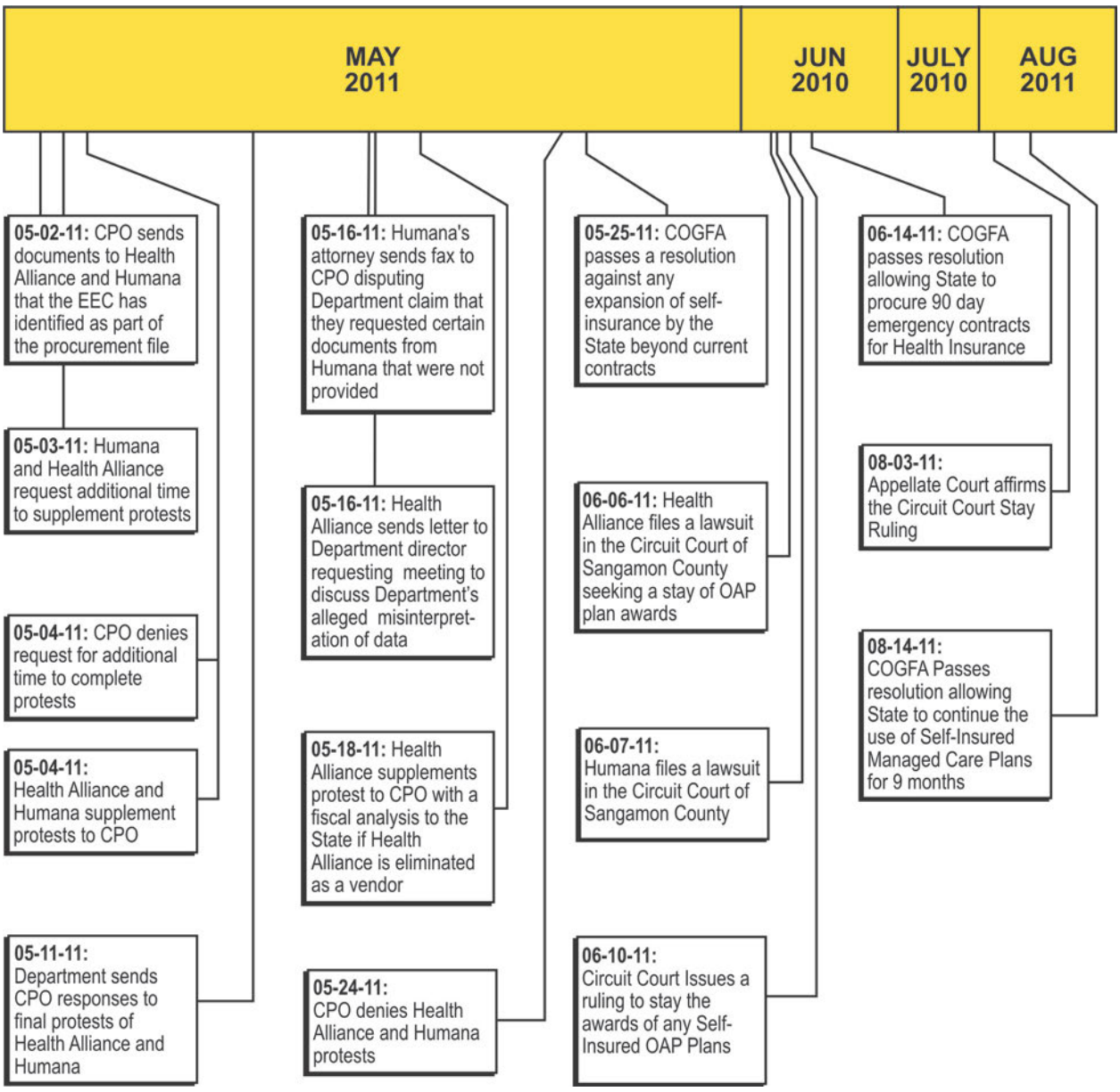
We conducted interviews with all evaluators for the two procurements, including evaluators from the Department of Central Management Services that served on the evaluation teams.

Exhibit 1-7
TIMELINE OF ACTIVITIES
OAP PROCUREMENT



Source: OAG developed from Department and Commission information.

Exhibit 1-7
TIMELINE OF ACTIVITIES
OAP PROCUREMENT



Source: OAG developed from Department and Commission information.

REPORT ORGANIZATION

The remainder of this report is organized into the following chapters:

- **Chapter Two** examines the procurement processes utilized by the Department and overseen by the Commission for the State health insurance procurements.
- **Chapter Three** examines the networks of winning vendors, the availability of those networks, and the cost savings estimated from the award decisions for the State health insurance contracts.
- **Appendices** presenting Resolution Number 142, our Audit Methodology, a listing of the Provider Network Access Points for the HMO procurement, a listing of the Provider Network Access Points for the OAP procurement, and Agency Responses are provided at the end of the report.

Chapter Two

PROCUREMENT PROCESS

CHAPTER CONCLUSIONS

On April 6, 2011, the Department announced the Health Maintenance Organization (HMO) award to both BlueCross BlueShield (BCBS) plans. BCBS was awarded a five-year contract that, with renewals, totaled $6.6 billion for the HMO administration services. On that same day, PersonalCare was awarded a contract totaling $179.7 million for the Open Access Plan (OAP) administration services. HealthLink was also awarded a contract totaling $199.4 million for OAP services.

Our review of the procurement process found **the Department**:

- **Failed to include** all relevant information, including scoring evaluation criteria, in the Request for Proposals (RFPs) for the State health insurance procurements.
- Utilized a 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.
- 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.
- Failed to comply with its own evaluation policy/procedures by not having the evaluation teams for the State health insurance procurements meet during the evaluation process.
- 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 all scores given.
- 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.
- 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**.

- 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**.
- 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 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 after that meeting and the date the awards were announced on April 6, 2011, the recommendation was changed. While the Department indicated that the Chief Procurement Officer (CPO) could not support the initial recommendation, documentation did not support that position.
- 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 State Purchasing Officer (SPO) was unaware that contracts had not been filed with the Comptroller for the emergency notices he posted in mid-June 2011.

Our review of the procurement process found **the Executive Ethics Commission (Commission)**:

- Had staff review and approve the RFPs without ensuring all relevant information, including scoring evaluation criteria was included.
- Had staff with oversight responsibility that did not question the lack of compliance with evaluation procedures regarding the failure of the evaluation teams meeting during the process.
- Had staff responsible for the oversight of the procurements that did not question the violation of procedures regarding not providing thorough and appropriate comments to support all scores given.
- Had staff responsible for oversight of these procurements that did not ensure compliance with evaluation procedures prior to approving the award of the contracts regarding addressing major differences in scoring on the procurements.
- SPO for the Department did not approve the awards for the HMO plan administrator and OAP plan administrator procurements **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** 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.

- Failed to develop policies and procedures for the activities of its staff that oversee State procurement functions. During our review of the procurement process followed in the solicitation and award of the State health insurance opportunities, we examined the role of the Commission and its staff in the oversight and review of the process.

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, we 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.

INTRODUCTION

Legislative Audit Commission Resolution Number 142 directed the Auditor General to examine the procurement process utilized to award health insurance contracts for the State's group health insurance program. Specifically, we were directed to determine: 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 Services' selection of vendors were adequate and uniformly applied to competing vendors; and, whether decisions concerning the selection of vendors and resolution of protests are adequately supported and documented.

PROCUREMENT PLANNING

The Requests for Proposals (RFP) for both managed care plans were developed through a collaboration of the Office of Healthcare Purchasing, Department of Central Management Services (CMS), Department of Insurance, Mercer, and other Department of Healthcare and Family Services (Department) internal staff.

Request for Proposals

The Department **failed to include** all relevant information, including scoring evaluation criteria, in the RFPs for the State health insurance procurements. Additionally, Commission staff reviewed and approved the RFPs without ensuring this information was included.

During fieldwork on this audit we 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. We 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. Those weighted averages were then put into the pricing formula that was shown in the RFP. The composite scoring methodology **was not delineated** in the RFP.
  - 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. This Department official added that Mercer did the scoring two or three **different ways** and came up with the same results.
  - 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. He stated all agencies need to do a better job explaining to vendors the State's goals.
- **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**. The method was also **not detailed** in the RFP. This method of applying statewide was also not acknowledged by the Department in its responses to the various vendor protests. The Department, in its May 11, 2011 response to the Commission regarding protests stated "Each responding bidder, as required by Section 7 of the RFP, provided a fixed premium rate (for each multiplier identified) that was applied **across all counties in their proposed service area**. Therefore, the relative scores for each bidder are the same in each individual county (emphasis added)."
- **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 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).
  - 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. Auditors also questioned the potential conflict of interest (discussed later in this Chapter). Had Mercer's role been identified in the RFPs, this issue may have been addressed by the Department much earlier. 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 our 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**. Summary scoring

sheets showed Mercer gave **exactly** the same score even though **one network did not include** all the same physicians and hospitals in the Chicago area. 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. As for scoring them as two separate networks, Mercer stated they are essentially the same from an internal perspective – it's the same company, **just without the same providers**. 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 is an aspect of the State Employees Group Insurance Act (Act) (5 ILCS 375/5). The CPO told auditors that due to the Act, this **should have been incorporated into the RFPs and scoring tools**. 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. Additionally, a former Department SPO, who then transferred to the Office of Healthcare Purchasing on August 16, 2010, told auditors that numerous individuals at the Department saw the RFP before it was published and no one suggested adding continuity of care or contiguous counties to the narrative.
- The HMO RFP included administrative service charges (ASCs) under Operational and Financial Issues**.** The RFP (section 3.2.10.1) stated *"The Agency is seeking a cost-effective open access provider partnership. A portion of Vendor's administrative service charges shall be placed at risk should costs exceed any guaranteed cap. Discuss your proposed methodology for establishing the cap amount and tracking performance against the cap. Do not include pricing in your response. Pricing should be submitted in a separate, sealed envelope or container section."* ASCs were part of the scoring for the self-funded OAP procurement; however, ASCs were not relevant to the HMO RFP. A Department official questioned in a July 12, 2010 email, why the HMO RFP would be issued that required "proposals that include administrative service charges (ASCs)?" This email was **prior to** the issuance of the RFPs for State health insurance procurements. This criteria was also included on the scoring tool for the HMO procurement with only PersonalCare, who had proposed for and eventually was awarded an OAP contract, receiving high evaluation marks from the evaluators.
- The OAP RFP contained a section (3.2.8.3) that asked the proposer to describe the referral process, indicating the method of communication that occurs between all parties (primary care physician, specialist, and medical management) prior to the issuance of a referral. Our understanding was that the self-funded OAP program did not require referrals. Mercer scored this criteria as part of its evaluation.

However, only Humana received any points for the criteria. The HMO RFP had the exact same section on referrals.

- The Commission reported that the SPO reviewed, commented and approved the RFPs.

The Illinois Procurement Code (30 ILCS 500/20-15(e)) states that requests for proposals shall state the relative importance of price and other evaluation factors. Additionally, procurement rules state that the RFP shall be prepared in accordance with Section 1.2010 (Competitive Sealed Bidding), provided that it shall also include a statement of when and how price should be submitted (44 Ill. Adm. Code 1.2015 (d)(2)). Procurement rules also state that the RFP shall state all of the evaluation factors, including price, and their relative importance. Evaluation subfactors, if any, and their relative importance must be finalized prior to the opening and made available for inspection and copying upon opening. However, all price subfactors and their relative ranking must be shown in the Request for Proposals (44 Ill. Adm. Code 1.2015 (f)(1)).

The Department stated the "composite scoring method is an accepted industry method that actuaries use to evaluate price for self insured benefit plans. During the allowable questions period, no vendors questioned the price scoring method. During the allowable procurement protest period (44 Ill. Adm. Code 1.5550(b) (1)), no vendors protested on this basis. Neither the Procurement Code, nor the applicable Administrative Rules require that the RFP contain this direction at the time the solicitation is advertised." We must note that vendors were not aware during the questions period, **because it was not contained in the RFP**, that the composite scoring would be utilized. For that matter, according to the evaluation team leader, **the Department did not know** that Mercer would utilize the composite scoring methodology.

Finally, the Department stated network disruption was not an evaluation criteria that was allowed to be scored in the RFP. Therefore the CPO informed the Department that he could not completely support the 1st Recommendation to Award (RTA). Thus, the SPO issued and posted the 2nd RTA. We did see documentation dated April 4, 2011, where the CPO indicated he could support the 1st RTA with reduced service areas based on his understanding of the continuity of care issues from the State Employees Group Insurance Act.

Regarding allowing BCBS to bid two networks but only score one network, the Department stated "answers to the technical questions would be the same, and given the fact the bidder proposed separate networks with a separate rate for price, the Procurement Coordinator instructed Mercer to proceed with reviewing and scoring the networks separately. Per Mercer, the networks were virtually the same, and therefore any difference in score would be minimal and would not change the outcome. In addition, the RFP did not prevent a vendor to propose only one network within the same proposal." We note that our review of the procurement file for the HMO procurement **did not find any documentation to support the instructions** reported by the Department to Mercer.

On October 12, 2011, the Department explained that in order to score pricing that could be compared on the same basis, the overall membership was used. Had this not been done, a vendor may have proposed on a limited geographic area where a limited potential membership resided. The result would have been that the overall cost of that vendor would have been lower

than that of a vendor with a much larger (or statewide) geographic bid proposal, even if that vendor had a lower overall unit price. Applying the underlying unit prices to the same total membership ensured that the pricing score was based upon the underlying price, and not the potential membership that may or may not be covered under a given vendor. We note this explanation **differs from the response to the Commission five months earlier** when the Department reported price scoring was based on counties bid by the vendors.

Failure to provide all information on how pricing will be scored violates Illinois Procurement Rules and **decreases the transparency** of the procurement process. Including elements of a self-insured health program in the HMO RFP **raises skepticism** that there was no effective review of the RFP.

REQUEST FOR PROPOSALS	
RECOMMENDATION NUMBER **1**	***The Department 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 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.***
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

(Commission Response continued)

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.

Auditor Comment #1

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.

(continued on next page)

(Auditor Comment #1 continued)

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.

(Commission Response continued)

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.

(Commission Response continued)	• 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.

Potential Conflict of Interest – Consultant Activity

The Department utilized a 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 our review of the procurement process utilized by the Department in selecting vendors to administer the State OAP and HMO contracts, we 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 (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).
- 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 contract states, *"These duties include, but are not limited to (1) financial analysis for group health initiatives including rate development, (2) health care procurement strategy and development and facilitation, (3) Medicare Part D practices, (4) research and analysis regarding healthcare purchasing best practices, (5) contract implementation and fiscal and compliance monitoring, (6) support for contract amendments and change orders, (7) purchasing and performance aspects of all health care plans administered by the State, (8) providing healthcare trend analysis, (9) analyzing claims data against industry standards and recommending effective strategies to control costs and increase efficiency, (10) providing ad hoc reports and (11) the ability to provide analysis of*

other actuarial assistance and consulting services as requested by the Agency/Buyer."

- The FY11 renewal to the Mercer contract, which would have been **in effect during the procurement period** for the State health insurance contracts, 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.
- Mercer reported to auditors *"Mercer does have business relationships with all of the vendors who participated in the Procurement Process."* These relationships, based on information from the procurement file and statements by Department officials, were 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. This evaluation, based on information from the procurement file and statements by HFS officials, was unknown to the Department.
- Mercer officials indicated that the Department **had not asked about any Mercer client relationships** in the past five years, a period under which Mercer was providing consulting services to the Department including those for the State health insurance procurements.

The Department's contract with Mercer, in FY10, added a section on Conflict of Interest which states, *"Conflict of interest shall mean an interest of Vendor, which may be direct or indirect, professional, personal, financial, or beneficial in nature that* ***in the sole discretion of the Agency, compromises, appears to compromise, or gives the appearance of impropriety*** *with regard to Vendor's duties and responsibilities under this Contract"* (emphasis added). Additionally, Department Policy/Procedure #302 – Compliance, Conflict of Interest, and Confidentiality Statement – 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.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires all State agencies, including the Department, to establish and maintain a system, or systems, of internal fiscal and administrative controls. These controls should include procedures where all business relationships that contractors who participate in the procurement process may have with potential proposers are disclosed and the Department documents a ruling on those disclosures.

If the Department does not require Mercer to disclose its business relationships with vendors that may bid on procurements the Department is utilizing Mercer's services for, it cannot discharge its duty to evaluate potential conflicts pursuant to its contract with Mercer. Also, the Department should seek to maintain transparency and avoid the appearance of potential conflicts of interest in procuring the services of providers to administer the State health insurance plan. Failure to ensure a fair and transparent procurement process may result in litigation which can influence the execution of needed health insurance services for the State.

POTENTIAL CONFLICT OF INTEREST – CONSULTANT ACTIVITY	
RECOMMENDATION NUMBER **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.***
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. ***Auditor Comment #2*** ***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.***

Evaluators' Access to Needed Materials

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 our review of the procurement files we found:

- **Evaluation procedures.** Several evaluators, including Mercer, **reported** they did not see the evaluation procedures yet we found that the team leader provided auditors with email correspondence showing he sent the document to the teams. If the evaluators did not follow those procedures it apparently must not have been because they did not have the procedures; it appears to be because they disregarded the direction of the Procedures.

- **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. As discussed later in this Chapter, several evaluators noted that certain information was not provided to them (see Exhibit 2-2).
- **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.
  - The team leader told auditors that after discussion with another Department official, and in the spirit of competition, the Department sent a letter to BCBS asking them if BCBS intend to meet the audit requirement in the RFP (section 3.2.2.11).
  - On December 1, 2010, the team leader sent an e-mail to BCBS requesting clarification to their response that they did not meet mandatory requirement 3.2.2.11.
  - On December 2, 2010, (date OHP received) BCBS sent back a response that it intended to meet requirement 3.2.2.11 and would cooperate with any audits the State conducts.
  - The team leader told auditors that he notified the evaluators of the result of his inquiry. However, we note that the question was asked of BCBS **after** the team members scored the category and submitted their scoring tools (which were dated November 16th, 18th, and 22nd of 2010; the other evaluator who was the team leader did not date his evaluation).
- **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. We note that:
  - For the OAP procurement, only two reference checks were dated and both of those were December 7, 2010, which was **after** the three evaluators that actually dated their scores completed their evaluations.
  - For the HMO procurement, we could not determine when the reference checks were made 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 by the Department.

Criteria we utilized in testing this issue included:

- Section 2.2.2 iii of the solicitation which stated "Other factors **that we may evaluate** to determine Responsibility include, but are not limited to: certifications, conflict of interest, financial disclosures, taxpayer identification number, past performance**, references** (including those found outside the Offer,) compliance with applicable laws, financial stability and the perceived ability to perform completely as specified" (emphasis added).

- Section 3.5.3 of the solicitation requires the proposers to "provide references from established private firms or government agencies, (four preferred; two of each type preferred) other than the procuring agency, that can attest to your experience and ability to perform the contract subject of this solicitation. You must provide the name, contact information and a description of the supplies or services provided. You must attach your references with the responsibility forms."
- Evaluation Policy/Procedure #303-Reference Contact and Experience Verification section, states that reference calls are to be completed during the technical proposal evaluation process and can be considered in scoring relevant technical proposal criteria. As noted above, for the two reference calls that were dated, both were after the individual evaluators scored the vendor proposals.
- Evaluation Policy/Procedure #303-Technical Evaluation Assignment of Evaluation Points section, states that should the team need to clarify statements or elements of a vendor's technical solution, the team can work with the RFP project contact, SPO, and Office of General Counsel to prepare and send the clarification letter to the vendor. The letters are for the purpose of clarifying what the vendor is proposing.
- The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires all State agencies, including the Department, to establish and maintain a system, or systems, of internal fiscal and administrative controls. These **controls should include** ensuring that all evaluators on a procurement have the necessary materials to make informed scoring decisions.
- Public Act 96-795 designated responsibility for the oversight of the purchase of State goods and services to the Commission.

The Department reported that the evaluation team was provided with, and had easy access to, all needed material. Additionally, the Department stated it "is the vendor's responsibility to ensure the correctness of the materials they submit, both in hardcopy and electronic format, and vendors should be held responsible for inaccuracies or errors in the submission. In this case, Health Alliance submitted a response on the hard copy but not on the CD. All vendors were informed in section 1.4 of the solicitation document to submit a signed original proposal and 8 copies of the proposal and 3 copies of the proposal on CD. Thus, a vendor is responsible for and should be scored upon the application that is before the reviewer."

The Department also stated that regarding the BCBS clarification, in 'the Administrative Compliance section of the Policy/Procedure 303, the Department has the right to ask for clarification. Therefore, the Procurement Coordinator suggested that the OHP staff obtain clarification. In the spirit of competition, the clarification was only to assure that the Team could proceed with scoring the proposal." We must again note that this clarification was made **after** the BCBS proposal was scored and **was not communicated** to other evaluators.

Regarding reference checks, the Department reported in the Reference Contact and Experience Verification section of the procedures, reference calls "**can** be considered in scoring relevant technical proposal criteria. References were, thus, not required to be scored....Thus, reference calls were made for all bidders, but the information received from these reference call was not shared with team members."

Evaluators need to have **all the necessary evaluation materials** to make sound decisions that will affect thousands of State employees. Failure to correct deficiencies after they are noted on scoring sheets creates skepticism that the procurement was conducted in a fair and transparent manner. The purpose of conducting reference checks, whether they will be conducted and how, should have been determined at the time the procedures were developed, prior to release of the RFP.

<table>
<tr><th colspan="2">EVALUATORS' ACCESS TO NEEDED MATERIALS</th></tr>
<tr><td>RECOMMENDATION NUMBER
3</td><td>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.</td></tr>
<tr><td>DEPARTMENT RESPONSE</td><td>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.

Auditor Comment #3

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.</td></tr>
</table>

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 ensure that all members of the Department's evaluation team had the needed materials to score the proposals. Specifically, the Auditor General determined the Department had evaluation procedures that were not provided to a consultant and some evaluators may have had incomplete vendor proposals. Additionally, the Auditor General determined the Department's team leader did not communicate to team members clarification of a vendor's proposal and did not share the results of reference checks with the team members. • In support of its findings against the Department, the Auditor General cites the Fiscal Control and Internal Auditing Act which requires all state agencies to establish and maintain a system of internal fiscal and administrative controls. The Auditor General emphasizes in bold that "**those controls should include** ensuring that all evaluators on a procurement have the necessary materials to make informed scoring decisions." Additionally, the Auditor General cites factors in the solicitation the Department may consider and references Department procedures. • In Legislative Audit Commission Resolution 142, the Auditor General was asked to determine amongst other things whether all aspects of the procurement process were conducted in accordance with applicable laws, rules, regulations and policies. • 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. • 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.

PROCUREMENT EVALUATION

Each evaluation team was comprised of three Department staff from the Office of Healthcare Purchasing, two CMS staff and staff from Mercer. The team leader for both procurements was from the Office of Healthcare Purchasing.

Section 2 of the RFPs delineated how the Department would evaluate offers. There were four categories of information: Administrative Compliance, Responsibility, Responsiveness, and Price. The Department indicated that if it found a failure or deficiency in the offer, it may have to reject the offer or reflect that in the evaluation.

Administrative compliance was the analysis of whether the offer complied with the instructions for submitting offers. **Responsibility** was a determination of whether HFS considered the vendor to be one that it wanted to do business with. **Responsiveness** was a determination whether the offer met the stated requirements of the RFP. **Price** was to be identified as the lowest priced offer that meets administrative, responsibility and responsiveness requirements. Where the HMO weighted price at 70 percent, the OAP price was only weighted at 28 percent of the overall points for the evaluation.

The **award** was to be to the offer that passed administrative review, was responsive, and submitted the best value as shown by a combination of responsiveness and price. The Department laid out the award process to be utilized for the procurement in the RFP. It would utilize a point ranking system (vendors that receive fewer than the minimum required points would not be considered for price consideration and point calculations). The point evaluation criteria are presented in Exhibit 2-1.

Exhibit 2-1
PROCUREMENT EVALUATION CRITERIA

HMO Procurement Points	*Criteria*	*OAP Procurement Points*
50	General Requirements	50
100	Organizational History, Structure & Accreditation	100
100	Account Implementation and Administration	100
550	Provider Network	250
N/A	Provider Network Contracting	900
90	Medical/Utilization Management	90
100	Customer Service	100
100	Operational and Financial Issues	100
100	System Capabilities	100
10	Health Management	10
2800	Price	700
4,000	Total	2,500

Source: OAG developed from Department documentation.

Lack of Evaluation Team Meetings

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 our review of the procurements to select administrators for the HMO and OAP health insurance contracts, we examined the procurement files for the two opportunities.

Additionally, we interviewed all 12 members of the two evaluation teams. Based on our testing we 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. The evaluator explained that on procurements she led, she would hold 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.

Team meetings may have been helpful to evaluators and allowed them to clarify issues. Exhibit 2-2 provides examples we found when reviewing the evaluation scoring documents.

Exhibit 2-2
CLARIFICATION ISSUES FROM EVALUATORS

Procurement	*Issue*
HMO	One evaluator explained his scoring 0/5 points for BlueCross BlueShield for section 3.2.4.6 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. The evaluator stated that **nobody approached him about this score.** A team meeting may have led to this evaluator being provided the information he needed to completely score the proposal.
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 (sections 3.2.7.16 and 3.2.7.30), questions which the consultant ultimately gave Health Alliance 0/140 points. Answers for these sections **were included** on the Health Alliance **hardcopy response**. A team meeting may have led to discussion where this was either discovered or clarified with the proposer.
OAP	Two evaluators on the OAP procurement scoring tools for section 3.2.10.10 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. A team meeting may have led to these evaluators being provided the information needed to adequately score the proposal.
OAP	An evaluator on the Health Alliance proposal scoring sheet indicated that the score of 0/20 for section 3.2.10.1 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**. A team meeting may have allowed these evaluators to obtain the information necessary to completely score the Health Alliance proposal.

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.

The Department utilized evaluation procedures to provide guidance to evaluators throughout the procurement evaluation. Under Attendance, procedures direct that ***"****Attendance of all Team members at all scheduled meetings is crucial to the quality of the evaluation process. Without all representatives present, meetings are not effective,* ***as not all opinions can be shared*** *in a group setting. Therefore, Team members should attend all meetings of the Team*" (emphasis added). The procedures also:

- Recommend "*that Team members meet to conduct discussions for the purpose of clarifying questions, identifying areas of clarification, and to discuss the strengths and weaknesses of each proposal."*
- State *"At the Pre-Evaluation Team meeting, the SPO will review the need for the procurement, the roles and responsibilities of the Team members and of the supporting areas (OSPO, OGC) and answer evaluation process questions. The OSPO will discuss briefly the Business Enterprise Program (BEP) subcontracting utilization goal initiative if a BEP goal applies to this procurement."*

Public Act 96-795 designated responsibility for the oversight of the purchase of State goods and services to the Commission. Additionally, the Procurement Code allows the procurement compliance monitor to: (i) review each contract or contract amendment prior to execution to ensure that applicable procurement and contracting standards were followed; and (ii) attend any procurement meetings. (30 ILCS 500/10-15(b))

The Department reported that Policy/Procedure 303 states that *"during a pre-meeting a review of the need for the procurement and the roles and responsibilities of the team and of the supporting areas will take place. It [Policy/Procedure 303] also stated that evaluation process questions will be answered and that team members should familiarize themselves with all documents in advance of receiving proposals. Although a* ***team pre-meeting was not conducted****, OHP conducted individual meetings with committee members during which HFS discussed its expectations of how the evaluation committees should conduct its evaluation process. OHP staff followed up with each committee member to determine if the committee member had any questions and later followed up again with each member to ensure that the member would meet the evaluation review timeline. No questions or concerns were raised by any committee member"* (emphasis added). We note that none of these individual meetings were **documented**, and as shown above, team members appear to have had questions **that were not answered**.

Failure to have evaluation team meetings decreases the ability of all team members to share questions, receive consistent guidance, or clarification of any proposal items and provide thorough and appropriate comments. Given the significant State financial impact, the HMO and OAP procurements over a five-year initial term, are estimated to cost **nearly $7 billion**, the procurement process should have been conducted in a complete manner in accordance with recommended evaluation procedures. Documenting meetings of the evaluation committee help to ensure the procurement process is transparent. Documenting that significant scoring differences are discussed by the evaluation team helps to ensure that the State receives the best proposed service.

LACK OF EVALUATION TEAM MEETINGS	
RECOMMENDATION NUMBER **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.***
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. ***Auditor Comment #4*** ***While the Department indicates the "team leader consistently contacted all members," this is <u>not supported</u> by documentation or testimonial evidence from the evaluators. Given the scoring differences among evaluators, there <u>clearly were issues</u> 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 as follows: • The Auditor General found the Department had a policy recommending evaluation committee members meet to conduct discussions for the purpose of clarification and to evaluate the strengths and weaknesses of proposals. • When meetings are held, the Department requires attendance at all meetings by all evaluation committee members. • The Auditor General found the Department failed to follow its internal policy/procedure by not having team meetings during the evaluation process. • In Legislative Audit Commission Resolution 142, the Auditor General was asked to determine amongst other things whether all aspects of the procurement process were conducted in accordance with applicable laws, rules, regulations and policies. • In its evaluation of the CPO's Office, the Auditor General cites the CPO's responsibility for the general oversight for state procurements

(Commission Response continued)	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.

Lack of Evaluation Comments

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 our review of the procurements to select administrators for the HMO and OAP health insurance contracts, we examined the evaluation scoring documents completed by each evaluation team. Additionally, we interviewed all 12 members of the two evaluation teams. Based on our testing we 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.
- Our analysis showed that **38 percent** (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.
- Our analysis showed that **17 percent** (176 of 1,036 categories) of the questions/criteria for the OAP evaluation **lacked thorough and appropriate**

comments. The vast majority of these exceptions were again due to a lack of comments or instances where evaluators simply put page numbers in the comments section.

- 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. 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.

The Department utilized Evaluation Policy/Procedure #303, to provide guidance to evaluators throughout the procurement evaluation. Under Assignment of Evaluation Points, procedures dictate that scores **"must be supported by thorough and appropriate comments"** (emphasis added). Points were to be consistent with comments. General comments such as good proposal without something to qualify the statement were not to be acceptable. The procedures further state, **"Evaluations which are not accompanied by thorough supporting comments should be returned to the evaluator for further consideration"** (emphasis added).

The procurement team leader from the Department explained to auditors that when evaluations were turned in from the State evaluation team, he **flipped through the total scores** and saw that the outcomes were so close that, he felt everything was okay. The leader stated that he **did not look at the individual points for individual criteria**.

The Department reported *"'Thorough and appropriate' are not defined in the procedures and are, thus, subjective terms. Evaluators responded to all questions."* We must point out that all questions were "scored" but not all contained thorough and appropriate comments. Also, **the Department's own procedures** state that general comments such as good proposal without something to qualify the statement were not acceptable.

Failure to provide thorough and appropriate comments is a **violation** of the evaluation procedures for these procurement opportunities. Given the significant State financial impact, the HMO and OAP procurements over a five year initial term, are estimated to cost **nearly $7 billion**, the procurement process should have been conducted in a complete manner in accordance with documented and approved evaluation procedures. Failure of Department and Commission officials to ensure that evaluation procedures were strictly followed **creates skepticism** that the procurements were conducted in fair and impartial fashion and could open the State to potential litigation from other proposers.

LACK OF EVALUATION COMMENTS	
RECOMMENDATION NUMBER **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.***
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 as follows: • The Auditor General found the Department had a policy requiring thorough and appropriate comments to support scores given by evaluation team members and for evaluations not supported by comments to be returned to evaluators. • The Auditor General found the Department failed to follow its procedures that required scores to be accompanied by thorough and appropriate comments. The Department further failed to return evaluations that were not supported by comments to evaluators. • In Legislative Audit Commission Resolution 142, the Auditor General was asked to determine amongst other things whether all aspects of the procurement process were conducted in accordance with applicable laws, rules, regulations and policies. • 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.

Scoring Evaluation Certification

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.

During our review of the procurement files we examined the scoring documentation for the two procurements. The following items are noted relative to certification of scoring by the evaluation teams:

- For the HMO procurement, 2 of 6 evaluators **failed to date** the evaluation scoring sheets. The other four evaluators **did provide evidence** as to when the evaluations were scored. Three of the evaluators that dated the scoring sheets completed scoring for all four proposals on the same day.
- For the OAP procurement, 3 of 6 evaluators **failed to date** the evaluation scoring sheets. The other three evaluators **did provide evidence** as to when the evaluations were scored. Two of the evaluators that dated the scoring sheets completed scoring for all four proposals on the same day.
- All evaluators were required to sign Department Policy/Procedure #302 – Compliance, Conflict of Interest, and Confidentiality Statement. Our examination of these forms found:
  - Policy/Procedure #302 has an area where the name of the project the individual is attesting to was to be placed. Only 1 of 21 forms actually **had this completed** (OAP project for a CMS evaluator). Absent this information it is **impossible to know** if these individuals signed the statement for the HMO/OAP procurements or other procurements.
  - The file for the HMO procurement contained a form signed by a Department employee that was not on the evaluation team.
  - Five Mercer staff completed the form.
- When evaluators do not provide the date on which they completed scoring sheets, it **is not possible to know** whether they scored the proposals **before or after they attested** to the compliance, confidentiality and conflict of interest disclosure.
- For the review of the HMO and OAP procurements we examined 24 evaluations in the procurement file. **None of the evaluations were signed** by the individual evaluators. Rather than having evaluator names or signatures, evaluators had numbers assigned to them in order to preserve the privacy of the evaluators, according to the Department. Our examination of the scoring sheets found:
  - Two of the scoring evaluations for the HMO procurement and four of the scoring evaluations for the OAP procurement had answers that were **typed** into the scoring sheets. Absent certified signatures it is impossible to know if the scores were **actually submitted by individuals assigned** to the evaluation team.
  - The network evaluations for both the HMO and OAP procurements were filled out by "consultant." There were five Mercer staff who signed the Policy/Procedure #302 form. Absent a certified signature it is **impossible to**

know if the network scores were provided by an individual that was authorized to do so based on the contract between Mercer and the Department.

- The Information Technology (IT) evaluation for the HMO procurement was filled out by "system." The evaluation for the OAP procurement was unsigned. This was supposed to be an official from CMS. Absent a certified signature it is **impossible to know** if the scores were actually submitted by an individual assigned to the evaluation team.

- For the PersonalCare OAP proposal, Mercer needed clarification to the provider file submitted due to Tier I and Tier II physicians being included together. Email documentation showed that Mercer **received the updated information** on December 9, 2010, yet Mercer signed the PersonalCare evaluation, which would have included the network scoring based on the old file on December 3, 2010 – **six days prior** to receiving the updated file.
- Evaluation team members told auditors that there was no meeting after they completed their scoring sheets. The scores were turned into the team leader.

The Illinois Administrative Code (44 Ill. Adm. Code 1.2005(u)(5)) details the documentation of procurement actions and requires each SPO to maintain in the procurement or associated contract file all substantive documents and records of communications that pertain to the procurement and any resulting contract. This shall include evaluation materials (e.g., scoring guidelines and forms; completed score sheets for individual evaluators, including notes; evaluation committee's combined score sheets; evaluation committee's recommendation; and management's decision). Additionally, the Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires all State agencies, including the Department, to establish and maintain a system, or systems, of internal fiscal and administrative controls. These **controls should include evidence** to support that the individual members of the evaluation team signed and dated the evaluations to not only create an audit trail but assure that the scores were actually completed by the members of the evaluation team.

The Department reported that the evaluation procedures **did not require** the sheets to be signed and dated. However, since the sheets had a place for the names, each committee member was directed to sign with their assigned number. Assigned numbers were given in order to **preserve the privacy of the evaluators**.

Evaluations **not being certified** by the members of the evaluation team increase the likelihood that the results of the scoring could be considered arbitrary and potentially opening the State to legal action by non-winning proposers.

SCORING EVALUATION CERTIFICATION	
RECOMMENDATION NUMBER **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.***
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

(Department Response continued)	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.

Procurement Scoring Irregularities

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.

Our review of the scoring conducted for the two procurements involved comparing evaluator scores to proposals and to identify any major scoring differences. We 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. Our 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. Our 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. Our review of the HMO evaluations showed:
  - For criteria 3.2.7.2-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 percent and they received 25/25 points. Humana, with 87 percent and BCBS with 85 percent both received 22/25 points. PersonalCare had 79 percent board-certified and received 20/25 points.
  - For criteria 3.2.7.3-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 criteria 3.2.7.10-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 percent, 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 percent for HMO-IL and 8.79 percent for Blue Advantage. For 2010, the percentages were 1.45 percent and 1.72 percent respectively. PersonalCare received 15/25 points from Mercer for percentages of 5.5 percent and 3.4 percent in the two years. Finally, Health Alliance received 10/25 points for a rate of 8.42 percent in 2009 and 6.35 percent in 2010.
  - We saw **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 Evaluation Policy/Procedure #303, in the Phase 2 Technical Evaluation section under Assignment of Evaluation Points, dictate, **"Any major differences in scores should be**

discussed to determine if an error was made or an evaluator missed or misinterpreted a vendor's proposal" (emphasis added). The procedures further state, **"Adjustments to scores may be made if warranted"** (emphasis added). In the Phase 2 Technical Evaluation section, procedures state "With the exception of cost, proposals and statements of qualifications are to be rated on their individual merits **not relative to one another**" (emphasis added).

According to the Department, regardless of whether the evaluators compared the proposals to each other, all evaluators were expected to and did evaluate the proposals on their individual merits. The Department also stated the scores were reviewed by OHP staff, the Procurement Coordinator, and Procurement Compliance Staff prior to the posting of the first RTA. OHP staff reviewed each section as a whole, and determined the final scoring results were comparable.

Failure to discuss major differences in scoring is a violation of Department procedure and **increases the possibility** that the vendors selected for the awards may have not been the true top score. Allowing evaluators to rate proposals against one another is a violation the Department's policy. When the State will be expected to pay nearly $7 billion for the health insurance contracts, the **Department would have a responsibility** to ensure that all evaluators understood all proposals before final scores were completed.

PROCUREMENT SCORING IRREGULARITIES	
RECOMMENDATION NUMBER **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.***
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 as follows:

(Commission Response continued)	• The Auditor General found the Department had a policy recommending discussion of major scoring differences by evaluation team members to determine if errors were made or whether an evaluator was misinterpreting a vendor's proposal. • The Auditor General found the Department failed to follow its procedures that required discussion of scoring differences. • In Legislative Audit Commission Resolution 142, the Auditor General was asked to determine amongst other things whether all aspects of the procurement process were conducted in accordance with applicable laws, rules, regulations and policies. • 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.

Inappropriate Communications

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 our review of the Department's procurement files for the managed care procurement opportunities, we 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. We 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"*** (emphasis added). 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.
- The SPO reported to auditors that he did not give his approval for any of the evaluators to contact any of the vendors.

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 (referenced in bullet #3 above). 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. The procedures also state *"Team members **must not communicate** with proposers about this project outside of any scheduled and sanctioned evaluation activity without the knowledge and approval of the SPO"* (emphasis added).

Mercer officials first indicated they had not seen the evaluation procedures that contained the direction on how to clarify responses and placed a restriction on communication outside of regularly scheduled evaluation activity. The officials later reported that the Department did send them the procedures. Mercer officials also indicated that **a Department official instructed them** to make the contact (referenced in bullet #3 above). The Department official told auditors that a superior directed him to instruct Mercer to reach out to the carriers.

The Department should ensure that its evaluators comply with evaluation procedures and not contact vendors. The Department should not direct contractors to violate procurement evaluation procedures, or should document why the decision was made.

When an evaluator, during the course of evaluating a procurement opportunity, seeks information from a proposing vendor to that procurement opportunity that will financially help the evaluators' business operations, it **gives the appearance of a lack of objectivity** and creates skepticism that the procurement was fair and transparent. Given the estimated dollar value of the health insurance contracts, $6.6 billion for HMO administration and $379 million for OAP administration, a clean procurement process is vital for public interest that the procurement was conducted in an open and transparent manner.

INAPPROPRIATE COMMUNICATIONS	
RECOMMENDATION NUMBER **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.***
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.

RECOMMENDATION TO AWARD

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 after 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.* (emphasis added)

The SPO notified the CPO on March 4, 2011, that we "expect to post awards **today or Monday** for state employee health insurance contracts. Thousands of Illinoisans and several large companies will be upset with the awards. This is likely to receive protests, media coverage, and potential legal action. The award decision itself was somewhat unusual." 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 percent. 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.

Written Determination of Contract Award

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**.

Our review of the procurement file showed that the awards of the State health insurance contracts were announced April 6, 2011, in the Illinois Procurement Bulletin by the SPO. The *SPO Written Determination of Contract Awards* was not signed by the SPO **until 6 days later**, on April 12, 2011.

The Illinois Procurement Code requires that the procurement file shall contain the basis on which the award is made, all submitted bids and proposals, all evaluation materials, score sheets and all other documentation related to or prepared in conjunction with evaluation, negotiation, and the award process. The procurement file **shall contain a written determination**, signed by the chief procurement officer or State purchasing officer, setting forth the reasoning for the contract award decision (30 ILCS 500/20-155 (b)) (emphasis added).

CPO Notice #37 requires that all competitive procurements "be **preceded** by a written determination recommending the award of a contract to a specific vendor" (emphasis added). Commission personnel (CPO and SPO) stated they utilize the Procurement Code, standard procurement rules, and CPO Notices in the conduct of their performance of job duties.

The SPO recognized he did not complete the written determination in a timely manner. Additionally, on June 8, 2011, a Commission official indicated that the various CPOs were still awaiting final approval from the Joint Committee on Administrative Rules and the Secretary of State on the transfer of rules and that once the transfer was made, new notices, policies and procedures would be issued. The official added that ideally "the written determination should have been made at or before the time of the contract award." Additionally, the Commission stated that *"[A]lthough the official written determination form was signed six days after the publication of the award on the Bulletin, the decision making process completed by the SPO was compliant with the requirements of the Code and the intent of CPO Notice #37. The CPO and SPO recognize, however, that the written determination should have been completed in a more timely fashion. Subsequently, the CPO has established a new SPO Determination Form and related process to ensure that SPO written determinations occur at appropriate times."*

There is a significant State financial impact for the HMO and OAP procurements, estimated to cost **nearly $7 billion** over a five year initial term. Failure to timely approve written determinations for the two health insurance awards is a **violation** of guidance of the CPO. Approving the rationale for selecting vendors **after** the awards have already been publicly announced increases skepticism about the fairness of the procurement processes and creates the appearance that awards were made in an arbitrary and capricious manner.

WRITTEN DETERMINATION OF CONTRACT AWARD	
RECOMMENDATION NUMBER **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.***
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

(Commission Response continued)	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.

Protest Independence

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.

Our review of the procurement documents for the State health insurance found that the CPO was involved in the procurement process:

- The SPO for the Department has a direct-line reporting relationship to the CPO for executive agencies. The PCM for the Department, **while required by law** to report to the CPO for executive agencies, **actually reports to another official** within the Commission.
- The CPO was part of the procurement process through updates from the SPO. The CPO told auditors he fielded questions from the SPO regarding the Procurement Code or any other **application of law** and the actual award. The majority of questions were about award methodology and what the law allowed or prohibited the Department to do regarding the procurement.

- The CPO ruled on the procurement process credibility, including the solicitation itself, when his staff **had not verified** that the Department sufficiently and accurately conducted the procurement.
- CPO staff were responsible for the oversight of the procurement process but **failed to determine** whether Department policies and procedures were followed in the evaluation process.
- Department documentation indicated that its first recommendation to award (RTA), and the RTA that the SPO was pushing to implement, was **not supported by the CPO** and so changes were made. In a correspondence dated February 17, 2011, to the evaluation team leader, the SPO stated (**relative to the 1st RTA** that included reduced service areas for Health Alliance and BCBS), *"Following our earlier conversation and in-depth review of the RFP and related addendums, I no longer have concerns with OHP's plans. I think the anticipated awards are consistent with the RFP, so we should be on solid footing to defend a protest."*
- Further, in a March 4, 2011 correspondence to the CPO, which was three days **before** the 1st RTA was signed by the Director, the SPO reported, *"We expect to post awards **today or Monday** for state employee health insurance contracts. Thousands of Illinoisans and several large companies will be upset with the awards. This is likely to receive protests, media coverage, and potential legal action"* (emphasis added).
- In his protest rulings, the CPO stated, *"arguments were considered only to the extent they were raised as a challenge to whether HFS's actions were consistent with the requirements of the Procurement Code. The CPO makes no opinion as to the arguments made from a public policy standpoint."*

The Illinois Procurement Code (Code) requires the CPO to establish, by rule, 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) Procurement rules state an actual or prospective bidder, offeror, or vendor that may be aggrieved in connection with a procurement action may file a protest provided the aggrieved party has evidence of a **violation** of the Illinois **Procurement Code or other law, any associated rules, or the solicitation** itself, **including evaluation** or award (44 Ill. Adm. Code 1.5550(a)) (emphasis added).

The Code also requires the Commission to appoint procurement compliance monitors **to oversee and review the procurement processes**. Each 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). The Code requires the chief procurement officer to appoint a State purchasing officer for each agency that the chief procurement officer is responsible for under Section 1-15.15. A State purchasing officer shall be located in the State agency that the officer serves **but shall report to** his or her respective chief procurement officer (30 ILCS 500/10-10(a)) (emphasis added).

The CPO told auditors that there is a significant challenge involved in the protest process as there is a lot of weight placed on the fact of an independent protest process when it is actually more separated than it is independent.

Having the superior of the individuals responsible for ensuring the procurement process followed State procurement laws rule on protests of that process lacks independence and increases skepticism about the fairness and objectivity of the procurement processes and creates the appearance that awards were made in an arbitrary and capricious manner.

PROTEST INDEPENDENCE	
RECOMMENDATION NUMBER **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.***
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

(Commission Response continued)	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. ***Auditor Comment #5*** ***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.***
(Commission Response continued)	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.

CONTRACTS

After the HMO and OAP awards were announced on April 6, 2011, losing vendors began the protest process. Health Alliance protested the HMO award on April 8, 2011, and protested the OAP award on April 11, 2011. Humana protested both awards on April 12, 2011. Additional actions included:

- On April 20, 2011, Health Alliance supplemented both of its protests to the CPO. On April 27, 2011, Health Alliance sent a letter to the Department, CMS, Commission and CPO stating it did not receive documentation needed to properly supplement the protest.
- On May 24, 2011, the CPO denied the protests by Health Alliance and Humana for both HMO and OAP awards. Following this denial, COGFA passed a resolution against any expansion of self-insurance by the State, beyond the current contracts.
- On June 6, 2011, Health Alliance filed a lawsuit in the Circuit Court of Sangamon County. One day later on June 7, 2011, Humana also filed a lawsuit. These lawsuits were combined on June 8, 2011.
- On June 10, 2011, the Circuit Court issued a ruling to stay the awards of any self-insured OAP Plans. Four days later, on June 14, 2011, the Commission on Government Forecasting and Accountability (COGFA) passed a resolution allowing the State to procure 90-day emergency contracts for health insurance. On August 3, 2011, the Appellate Court affirmed the Circuit Court stay ruling. COGFA then, on August 16, 2011, passed the resolution allowing the State to continue the use of self-insured managed care plans for 9 months.

Contract Deficiencies

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.

During our review of the documentation for the awards of the State health insurance procurements we noted the following:

Contract Filing

On April 6, 2011, the Department announced the award of HMO contracts totaling $6.6 billion to BlueCross BlueShield. Additionally, the Department awarded OAP contracts totaling $379 million to HealthLink and PersonalCare. Subsequently, protests were filed to the awards and legal action was initiated by losing vendors.

COGFA would not provide consent to expansion of self-funded insurance program. A decision was made to execute 90-day emergency contracts for health insurance coverage. The emergency period was from July 1, 2011 through September 28, 2011.

On June 15, 2011, the Department, through the SPO, published on the Illinois Procurement Bulletin five emergency procurement notices for the following:

- Health Alliance HMO ($126.9 million),
- PersonalCare HMO ($41.6 million),
- HealthLink ($2.3 million),
- PersonalCare OAP ($1.3 million), and
- Health Alliance Illinois ($547,000).

On August 1, 2011, the SPO reported to auditors that he was **unaware** that the emergency contracts had yet to be filed with the Comptroller. On August 11, 2011, 41 days after the beginning of the emergency period, the Department reported to auditors that the contract late execution waivers had been sent to the SPO on that day. The contracts could not be filed without the late filing affidavit.

Contracts were eventually filed on September 6, 2011, just **22 days prior to the end of the emergency contract period**. The contracts had been signed by the vendors, Department director and the CPO from mid to late June 2011.

Contractual Pricing

The HMO contract with BCBS contained pricing (premium) figures for the State employees health plan that **did not match** to prices submitted by the vendor. Some premiums were **higher** than those proposed by BCBS in the 1st Best and Final Offer (BAFO).

The five-year contract signed with BCBS for HMO services, in Section 3.2 Type of Pricing, indicated the **pricing was for "HMOI FY 2012 (METRO)"** with a like heading for the contract for the Blue Advantage plan offered by BCBS and awarded by the Department. The METRO rates would have referred to just the eight counties that BCBS was asked to price in the 2nd BAFO – an **offer which was not part of the final award** given that the Department awarded many more than eight counties to BCBS. The rates in the contract **were not those proposed** by BCBS in the 2nd BAFO.

The Department awarded the HMO contract **based on the pricing proposed by BCBS in the 1st BAFO** from January 2011. The rates in that 1st BAFO are provided in Exhibit 2-3, for BCBS HMO Illinois plan, with the rates that were eventually set out in the contract by the

Exhibit 2-3
CONTRACTUAL RATE DISCREPANCIES
HMO AWARD

Rate Category	*BCBS HMO-IL 1st BAFO*	*Contract*
Active Employees	$545.53	$545.54
Medicare-Primary Retiree	$354.59	$354.60
Non-Medicare Primary Retiree	$807.38	$807.40
1 Dependent not Primary w/Medicare	$458.25	$458.24
2 or more Dependents	$785.56	$785.58
Medicare-Enrolled Dependent	$354.59	$354.60

Source: OAG developed from Department information.

Department.

Likewise, for the BCBS Blue Advantage contract, there were **two prices that were incorrect** in the contract when compared to the 1st BAFO for this plan. The premium for **1 dependent not primary with Medicare** for the State plan and the **no Medicare age 65 and over** for the Teachers Retirement plan were both a cent higher in the contract than what was bid by BCBS in the 1st BAFO. We calculated that the State would pay $116,000 more to the vendor than necessary.

Contractual Provisions

Section 7 of the Department's contracts for health insurance contain **Disclosures and Conflicts of Interes**t. Sub-section 3, which had to be completed by all vendors, contained information on Debarment/Legal Proceeding Disclosures. BCBS did not complete the disclosures required in this part of the contract. Vendors for all other health insurance contracts **did complete** the disclosures.

The Illinois Procurement Code requires contract liabilities exceeding $10,000 to have the contracts filed with the Comptroller within 15 days (30 ILCS 500/20-80 (b)). The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires all State agencies, including the Department, to establish and maintain a system, or systems, of internal fiscal and administrative controls. These controls should include the timely filing of emergency contracts with the Comptroller for health insurance.

Public Act 96-795 designated responsibility of the oversight of the purchase of State goods and services to the Commission. The Commission appointed a PCM and the CPO appointed an SPO to the Department to ensure that laws and rules are followed in procurement activities.

On the Late Execution Waiver Request the Department indicated it was *"not aware of the January 2010 revision to section 15.10.40 of the SAMS Manual interpreting contract execution to include the CFO and Chief Legal Counsel (CLC) signatures, when required."* After being notified of contract filing as a report issue, the Department failed to provide an answer in its October 12, 2011 response to auditors.

On August 2, 2011, the SPO reported that fiscal staff in the Department explained that they had yet to see the contracts and concluded that the contracts must have been held in the Director's office. The Commission further stated that the filing of contracts with the Comptroller for obligation purposes occurs within the Department's fiscal and accounting processes that occur after execution of a contract and are outside of the Code and thus not within the CPO's jurisdiction.

Failure to file contracts in a timely manner is a violation of State statute. The contracts not on file total a significant amount of money - **$172.8 million** for the five published 90-day emergency period contracts. Additionally, the HMO contracts for BlueCross BlueShield totaled **$6.6 billion**, as published in the Illinois Procurement Bulletin. Filing of the agreements with the Comptroller would create a sense of transparency in the process utilized by the Department and overseen by the Commission.

Failure to include the correct premium rate in the contract increases the amount the State will pay for health insurance premiums over the life of the contract. While a few cents' difference may not appear to be significant, $116,000 would be **overpaid** to the vendor for this State contract.

CONTRACTS	
RECOMMENDATION NUMBER 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.***
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 as follows: • The Procurement Code requires contracts in excess of $10,000 to be filed within 15 days with the Comptroller. 30 ILCS 500/20-80(b). • The Auditor General found the Department did not timely file 90 day emergency contracts with the Comptroller's Office. • 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.

PROCUREMENT CONCLUSION

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, we 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.

Lack of Policies and Procedures for Procurement Review

Both the SPO and PCM guided the procurement process for the healthcare contracts that are part of the audit directed by Resolution Number 142. The SPO and PCM assigned to the Department started with the Commission in July 2010. The **$7 billion** RFP procurements were the **first RFP procurements** these two individuals worked on. The Commission also reported that the CPO and another Commission employee provided guidance to the SPO and the Department as to specific questions or issues raised during the course of the procurement. Exhibit 2-4 details the activities the CPO, SPO and PCM provided during this procurement.

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

Public Act 96-795 designated responsibility of the oversight of the purchase of State goods and services to the Commission. The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires all State agencies, including the Commission, to establish and maintain a system, or systems, of internal fiscal and administrative controls. These controls should provide assurance that: (1) resources are utilized efficiently, effectively, and in compliance with applicable law; and (2) obligations and costs are in compliance with applicable law. These controls **should include policies and procedures** for Commission staff (SPO and PCM) to follow when providing oversight to procurement processes at the agencies

The Commission stated that the CPO's office received authority for procurements beginning September 1, 2010. This procurement began months in advance of the transfer of authority and independent CPO/SPO review, and coming into the procurement at such a late date, did not give the CPO's office opportunity to bring forth issues earlier in the process. Auditors do note that the SPO reported he was assigned to the Department on August 1, 2010, one month prior to the advertisement of the OAP procurement on September 2, 2010, and two months prior to the advertisement of the HMO procurement on October 5, 2010.

Given the sheer dollar volume of procurements the Commission staff have oversight responsibility for, **including $7 billion for these two procurements alone**, the development of policies and procedures for staff activities would help ensure that State resources are adequately monitored. The recent changes in procurement oversight pursuant to Public Act 96-795 has created **new positions** at the Commission with **staff new to these roles** as evidenced by the SPO and PCM working on their first RFP procurements associated with the health insurance procurements. Policies and procedures would provide direction for those new staff, direction that should provide the basis for effective monitoring of the procurement of State goods and services.

LACK OF POLICIES AND PROCEDURES FOR PROCUREMENT REVIEW	
RECOMMENDATION NUMBER **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.***
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

(Commission Response continued)	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.

Chapter Three

NETWORKS, STATE COSTS, AND SAVINGS

CHAPTER CONCLUSIONS

The Department allowed proposers to the State health insurance procurements to bid on counties where the number of primary care physicians (PCPs) was **not sufficient to meet requirements** laid out in the Requests for Proposals (RFPs). Further, the Department awarded significantly more counties in the HMO procurement opportunity to the winner than they actually bid on. Finally, an Executive Ethics Commission (Commission) official **was aware of the lack of compliance** regarding the number of providers in counties yet still signed off on the procurement award. Our review of provider network submissions showed:

- For the HMO Procurement:
  - The Department **awarded** BlueCross BlueShield (BCBS) 20 counties that BCBS **did not even bid on**.
  - BCBS network documentation showed that it had **zero PCPs in 24 counties that it was awarded**.
  - In five counties in which it bid, BCBS had **zero** PCPs on the network physician listing, yet the Department allowed the proposer to bid the counties.
  - 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.
  - 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.
  - In two counties in which it bid, Humana had **zero** PCPs on the network physician listing, yet the Department allowed the proposer to bid the counties.
- For the OAP Procurement: 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.

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 2011, 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.

Our review of the proposals and network information indicated that there were discrepancies on the network CDs submitted by the proposers. The major problem was that many physicians were listed multiple times for the same location. In September 2011 we researched on the proposer

physician directory a sample of physicians that had been included in the proposals submitted by the vendors that were awarded State health insurance procurements. We found:

- **15 percent** of the BCBS Blue Advantage physicians in our sample (16 of 108) were **no longer** identified in the network.
- **12 percent** of the BCBS HMO-IL physicians in our sample (12 of 102) were **no longer** identified as a provider in the county listed in the network submission.
- **19 percent** of the HealthLink physicians in our sample (20 of 105) were **no longer** identified in the network.
- **14 percent** of the PersonalCare physicians in our sample (14 of 103) were **no longer** identified as a provider in the county listed in the network submission.

The awards announced April 6, 2011, for State health insurance were estimated to cost nearly $7 billion over the first five years of the contract period. The Department reported that cost savings **was not a factor** in the selection and award of the health insurance contracts. While it was not a factor in the scoring criteria and point calculations, the Department did utilize savings figures generated by Mercer to request Best and Final Offer (BAFO) information from vendors for the HMO procurement. The day the HMO and OAP awards were announced, the Department issued a press release stating that *"the award of these four contracts will result in a savings of approximately $102 million in FY12, and a savings in excess of $1 billion over the life of the contracts."*

Based on the results and award of contracts, the Department significantly expanded the self-insured OAP program from what was previously utilized. This expansion was apparently considered as early as July 2010, but was not delineated in the RFP for the OAP procurement.

Department documentation 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. 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. The analysis was never provided to auditors for review. The State picks up approximately 90 percent of the annual cost for the participant. It is difficult to know how Mercer calculations show the State saves money when the awards, as announced, migrate more HMO participants to OAP plans. No one from the Department validated the figures Mercer provided. Officials also reported that they did not even have the methodology that Mercer utilized when compiling the various scenarios.

INTRODUCTION

Legislative Audit Commission Resolution Number 142 directed the Auditor General to examine the networks, State costs and savings applicable to the award of health insurance contracts for the State's group health insurance program. Specifically, we were directed to determine: whether the vendors selected by the Department demonstrated the capacity to provide quality, adequate and timely health care services for State employees, dependants 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, dependants 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.

PROVIDER NETWORKS

Each bidder to the HMO and OAP procurement opportunities submitted a bid for a certain number of Illinois counties. Exhibit 3-1 presents the service areas proposed by bidders to the HMO procurement. Exhibit 3-2 presents the service areas proposed by bidders to the OAP procurement.

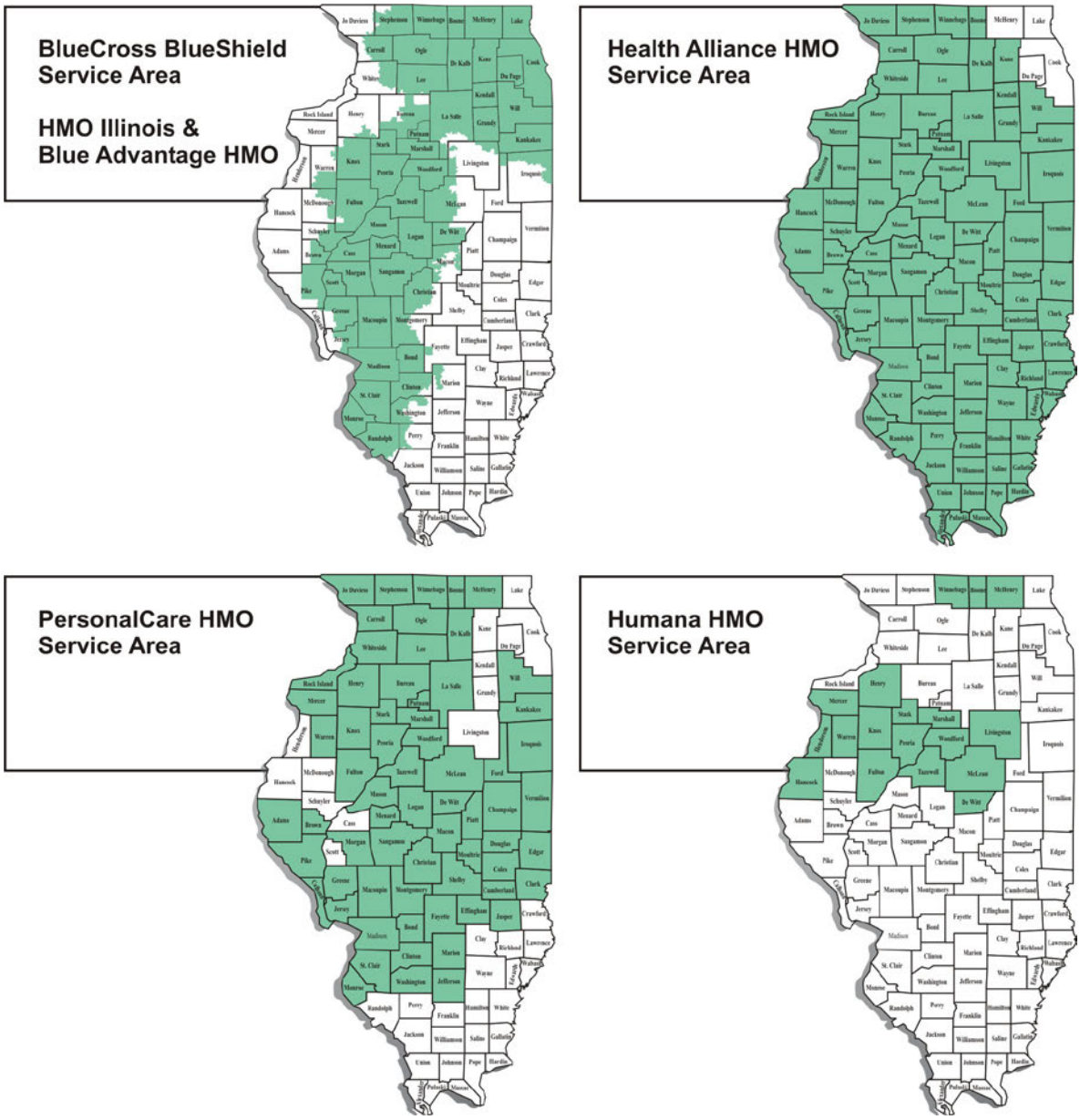
The RFPs for the two procurements required the bidders to submit information on their networks. Two of those sections which reference Primary Care Physicians (PCPs) were:

- Section 3.2.7.12 of the RFP requires each vendor to submit a **list and count** of PCPs by county.
- Section 3.2.7.13 of the RFP requires the vendors to submit a **text file on cd** containing contracted PCPs, specialists, and hospital names and locations for the networks proposed to offer.

We found several bidders that had two files with a different number of PCPs per county. For example, the Humana list it provided for 3.2.7.12 had 71 PCPs in McLean County, but the text file for 3.2.7.13 had zero PCPs for McLean County.

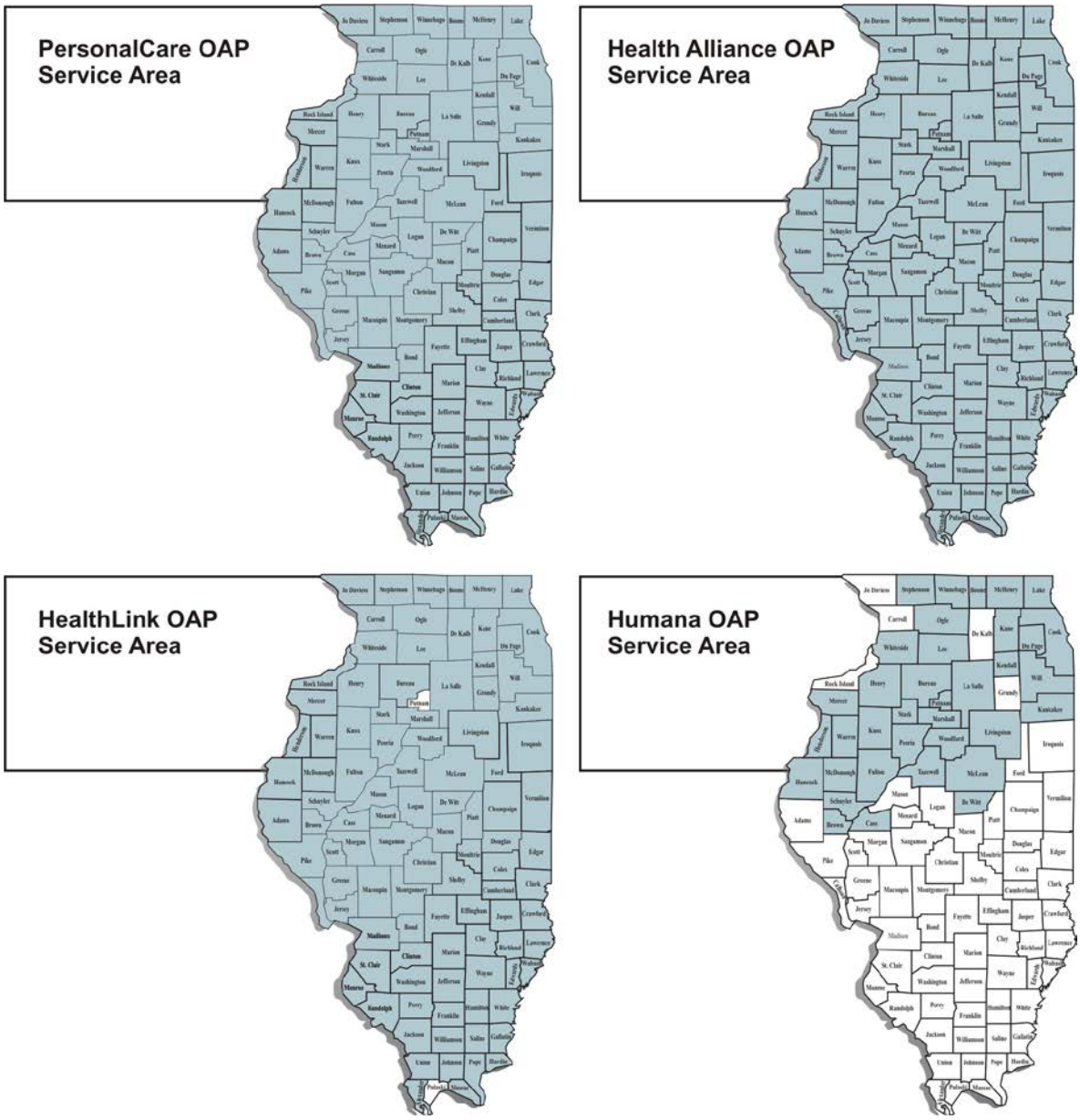
We asked the Department why the discrepancy existed. The Department responded that *"We cannot speculate as to why there may be a difference in a vendor's response."* Additionally, the Department replied *"The provider file was also used for exhibits of provider counts, but to our knowledge, were [sic] not used in the scoring of the RFP anywhere else."* We must note that both section 3.2.7.12 and section 3.2.7.13 of the RFP **were included** in the evaluation scoring tools for the procurement opportunities. Given that the files differed, and apparently no reconciliation was performed, it calls into question how points were distributed for these two criteria.

Exhibit 3-1
HMO PROPOSED SERVICE AREAS



Source: OAG developed from vendor proposals.

Exhibit 3-2
OAP PROPOSED SERVICE AREAS



Source: OAG developed from vendor proposals.

Counties Bid and Awarded

The Department allowed proposers to the State health insurance procurements 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.

During fieldwork on this audit we examined the procurement files for the two health insurance procurement opportunities, including the RFPs to determine whether all counties bid by proposers had the requisite number of physicians as required by the RFPs and whether the counties awarded by the Department to proposers were actually counties the proposers bid on. Our review included analysis on proposer-provided files of physicians in the networks. We examined those files, removed physicians that were listed more than once, and compared the result to the counties which the proposers bid.

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"* (emphasis added). We 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 percent** 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 percent** 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.
- BCBS had at least five PCPs in **65 percent** of the counties it bid (20 of 31). In five counties in which it bid, BCBS had **zero** PCPs on the network physician listing, yet the Department allowed the proposer to bid the counties.
- Humana had at least five PCPs in **78 percent** of the counties it bid (14 of 18). In two counties in which it bid, Humana had **zero** PCPs on the network physician listing, yet the Department allowed the proposer to bid the counties.

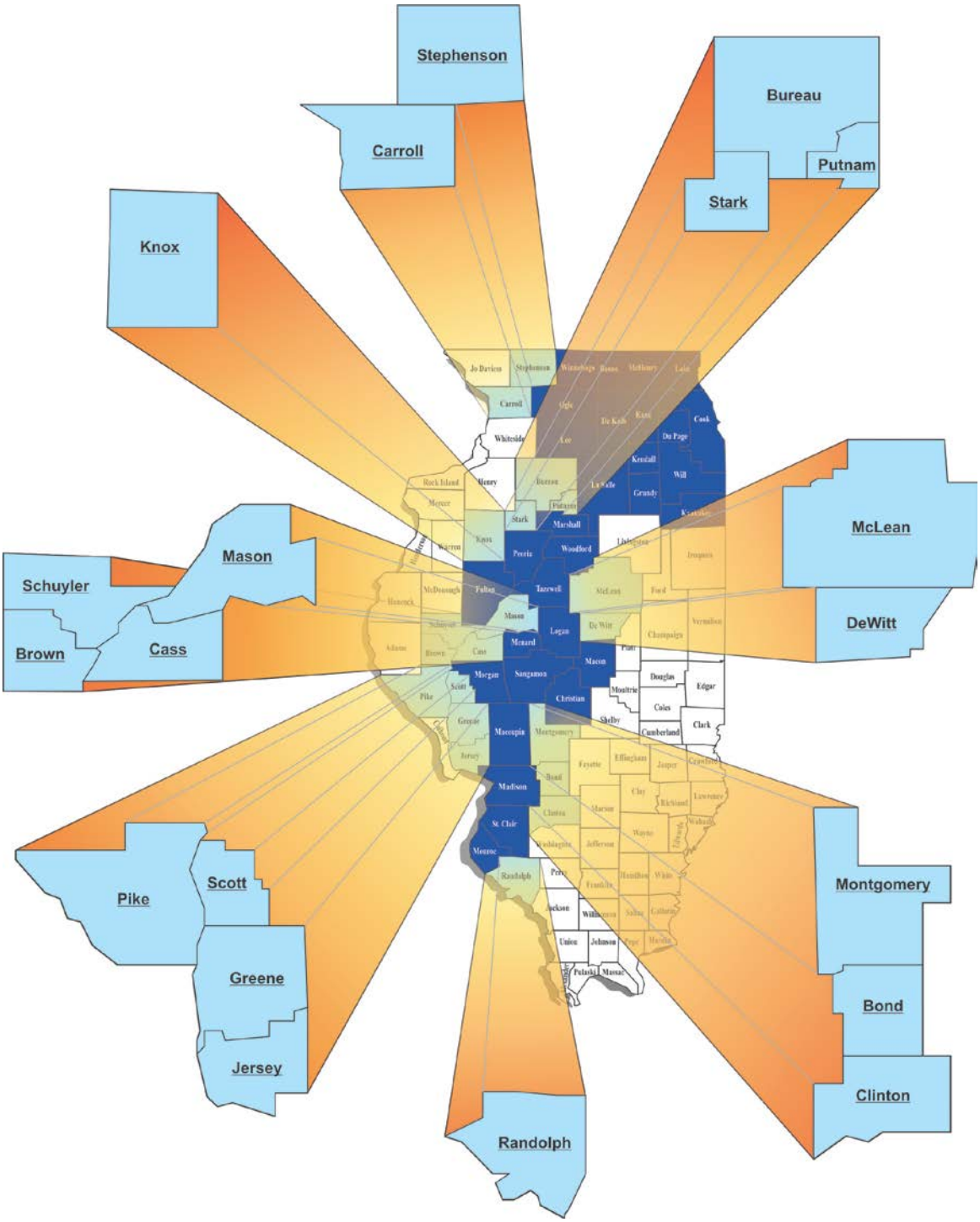
HMO Procurement – Counties Awarded

The Department awarded two BCBS networks 50 counties for the HMO procurement opportunity. The 50 counties were the same for both BCBS networks. An analysis of BCBS awarded counties where the submitted network showed **no network presence** is presented in Exhibit 3-3. A review of the awards showed:

- 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.

Exhibit 3-3

COUNTIES AWARDED TO BCBS WITH NO BCBS NETWORK PRESENCE



Note: Network providers include primary care physicians, hospitals, OB/GYN, pediatricians and other specialists.

Source: OAG developed from vendor proposal.

- 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. Exhibit 3-4 presents an analysis of PCPs in counties where BCBS was awarded the HMO contract versus the other vendors that did not receive the award.

Exhibit 3-4
NUMBER OF PRIMARY CARE PHYSICIANS IN PROVIDER NETWORKS COUNTIES AWARDED TO BCBS FOR HMO PROCUREMENT

County	*BCBS*	*Health Alliance*	*Humana*	*PersonalCare*
Grundy	0	21	N/A	6
Carroll	0	0	N/A	3
Lee	0	0	N/A	16
Stephenson	0	3	N/A	14
Bureau	0	16	N/A	12
Knox	0	25	17	16
LaSalle	1	55	N/A	47
Marshall	1	6	0	4
Putnam	0	2	N/A	2
Stark	0	3	2	3
Woodford	2	42	8	27
Brown	0	0	N/A	2
Cass	0	9	N/A	N/A
Christian	0	14	N/A	10
Macon	0	83	N/A	55
Macoupin	1	20	N/A	11
Mason	0	6	N/A	6
Menard	2	3	N/A	0
Pike	0	5	N/A	10
Schuyler	0	1	N/A	N/A
Scott	0	0	N/A	2
DeWitt	0	12	7	3
Kankakee	1	12	N/A	47
McLean	0	147	0	49
Bond	0	12	N/A	10
Clinton	0	23	N/A	19
Greene	0	7	N/A	12
Jersey	0	19	N/A	10
Montgomery	0	15	N/A	14
Randolph	0	26	N/A	20

Note: N/A indicates the vendor did not bid on the county.
Source: OAG developed from Department bid information.

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"* (emphasis added). We 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. This violated the RFP. In our analysis we counted all Tier I and Tier II physicians that were PCPs in our totals.
- Health Alliance had at least five PCPs in **84 percent** 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, yet the Department allowed the proposer to bid the counties.
- PersonalCare had at least five PCPs in **70 percent** of the counties it bid (71 of 102). In six counties in which it bid, PersonalCare had **zero** PCPs on the network physician listing, yet the Department allowed the proposer to bid the counties.
- HealthLink had at least five PCPs in **90 percent** of the counties it bid (90 of 100).
- Humana had at least five PCPs in **78 percent** of the counties it bid (28 of 36). In two counties in which it bid, Humana had **zero** PCPs on the network physician listing, yet the Department allowed the proposer to bid the counties.

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"* (emphasis added).

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)"* (emphasis added). 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 Minimum Mandatory Administrative Requirements section of the RFPs contains a requirement (3.2.2.14) 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. The Department reserved the right to change this requirement based on the size of the county, the specific locations of PCP offices, and particular circumstances.

The Illinois Procurement Code dictates that awards shall be made to the responsible offeror whose proposal is determined in writing to be the most advantageous to the State, taking into consideration price and the evaluation factors set forth in the request for proposals. The contract file shall contain the basis on which the award is made (30 ILCS 500/20-15(g)).

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. We 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.

When Department and Commission officials are aware that requirements of the RFP were not met and continue to let the procurement process proceed, it raises questions about the fairness and accuracy of the award process. The health insurance contracts were valued at **$7 billion**. Allowing proposers to bid on, and then award, counties in violation of the requirements in the RFP increases the possibility that the various health insurance services (HMO/OAP) **would not be offered** in certain areas of the State. Awarding counties to a HMO proposer that did not even bid on the counties, or even have any PCPs in the county, makes it impossible to meet one of the key objectives listed in the RFP (HMO access in every county in the State) and creates skepticism that the Department actually wanted to offer HMO services in all counties.

COUNTIES BID AND AWARDED	
RECOMMENDATION NUMBER **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.***
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

(Department Response continued)	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. ***Auditor Comment #6*** ***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

(Commission Response continued)	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.

Network Monitoring

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.

We 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. Based on our testing we found:

Vendor proposals for the **HMO** procurement, including the required network physicians, were due November 8, 2010. Networks were scored on December 17, 2010 – 14 days prior to the RFP required date of January 1, 2011, for a fully credentialed network. Vendor proposals for the **OAP** procurement, including the required network physicians, were due October 19, 2010. Networks were scored on December 3, 2010 – 28 days prior to the RFP required date of January 1, 2011 for a fully credentialed network.

Our review of the proposals and network information indicated that there were discrepancies on the network CDs. The major problem was that many physicians were listed multiple times for the same location.

Our review of the documentation contained in the procurement files uncovered a number of items relative to network monitoring. Specifically:

- The RFPs required vendors to respond to a Minimum Mandatory Administrative Requirements Matrix. The Matrix provided a structure that enabled both the Vendor and the Department to determine readily whether each requirement had been addressed. The vendor had to clearly commit to comply with every item in the Matrix that is identified as a requirement.
- In the HMO procurement BCBS responded to this requirement that *"We are in agreement that we shall have a network of fully credentialed providers in counties specified in this solicitation by January 1, 2011."* A Mercer official stated Mercer did not define "counties specified in this solicitation." The official added they did not evaluate this portion of the RFP, whether a vendor could bid on the county. We note that the State employees that scored a portion of the proposals were responsible for the scoring points applied to this requirement.

- The above proposal due dates were the **last time** anyone from the Department or Mercer performed any type of **review** on the network information.
- Both Department and Mercer officials reported that provider networks were fluid. For instance Mercer explained that for the BCBS network, previously the Advocate health system was not a part of BCBS but did join after the evaluations were completed. The Rush health system group had been a part of BCBS during the evaluation but was out according to the Mercer official when he reported it to us in August 2011.
- An additional problem with the BCBS network data was that even though the RFP required a unique identifier for the PCPs (for example, National Provider ID number or tax ID number), BCBS **did not provide** those identifiers. The RFP allowed the Department to reject the entire proposal for this submission, yet the Department selected not to. There was **no documentation** in the procurement file to show why this decision was made.

Auditor Review

Given that no one from the Department or Mercer evaluated the networks after scoring prior to January 1, 2011, in September 2011, we 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. We found:

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

Also, in September 2011, we also 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. We found:

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

Section 3.2.2.12 of the solicitations required vendors to "have a network of fully credentialed providers in counties specified in this solicitation by **January 1, 2011.** Additionally, Section 3.2.7.13 of 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"** (emphasis added).

The Department stated that it does not "believe that a finding approximately 9 months after the evaluation period that 12% to 19% of physicians are no longer in a network is unusual or indicative of a flawed network or evaluation process. Over time, physicians leave networks for a number of reasons such as death, retirement, relocation, mergers and business decisions. The RFP process did not require or include a facility to evaluate scoring dimensions after the

award was made. If some or all of the scoring dimensions were continuously or periodically evaluated and/or reviewed, the procurement process could potentially never be completed." Auditors note that Resolution Number 142 directed the Auditor General to determine whether networks were able to provide services to participants at January 1 and July 1. **Absent the Department knowing the answer** to these questions auditors had to test networks for themselves.

Failure to verify if networks were the same at the date required in the RFP as those networks that were scored by evaluators, calls into question the point totals provided for those networks.

NETWORK MONITORING	
RECOMMENDATION NUMBER 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.***
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. ***Auditor Comment #7*** ***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.***

Other Network Issues

When we examined the subcontractor agreements that winning vendors submitted in their bids, we found that two subcontractors were **still in negotiations** with a vendor (Healthlink) that won a State contract to provide OAP services in the Rockford area. Healthlink's provider network was scored by Mercer even though the agreements with the subcontractors were not executed.

One subcontractor for HealthLink, HFN, was not reduced to finalized writing until November 2011, **more than four months after** HealthLink was supposed to begin providing services to State membership. HFN provides a wrap-up network of physicians for HealthLink largely in north and northwestern Illinois. The Department reported there was a "verbal agreement" between HealthLink and HFN to administer the network effective July 1, 2011 until final negotiations could be completed.

Migration Report

At the August 16, 2011, Commission on Government Forecasting and Accountability (COGFA) hearing a migration report was provided to the Commission members. The report detailed how the State membership had moved into other plans based on the awards announced April 6, 2011. Mercer officials told auditors that the Department authored the report. The officials indicated the report was different from what Mercer was expecting, but the **award was also different than what they expected**.

STATE COSTS AND SAVINGS

The awards announced April 6, 2011, for State health insurance were estimated to cost nearly $7 billion over the first five years of the contract period. BCBS was awarded a five-year contract totaling $6.6 billion for the HMO administration services. PersonalCare was awarded a five-year contract totaling $179.7 million for the OAP administration services and HealthLink was also awarded a five-year contract totaling $199.4 million for OAP services.

The Department reported that cost savings **was not a factor** in the selection and award of the health insurance contracts. While it was not a factor in the scoring criteria and point calculations, the Department did utilize savings figures generated by Mercer to request Best and Final Offer (BAFO) information from vendors for the HMO procurement.

The day the HMO and OAP awards were announced, the Department issued a press release stating that "the award of these four contracts will result in a savings of approximately $102 million in FY12, and a savings in excess of $1 billion over the life of the contracts."

Expansion of Self-Insurance Plan

Based on the results and award of contracts, the Department significantly expanded the self-insured OAP program from what was previously utilized. This expansion was apparently considered as early as July 2010, but was not delineated in the RFP for the OAP procurement.

The OAP is a self-insured program whereby the State pays an administrative fee to a vendor for each participant in the program. Responsibility for the payment of the claims is then borne by the State. The State assumes the risk of an enrollee getting ill and requiring medical services.

According to Department staff, the Department made a decision to increase the self-funded OAP **after the proposals were scored** for the FY12 bid opportunity. These proposals were scored in December 2010. These officials may have not been entirely accurate in this claim.

In fact, as late as March 2011, the Department was asserting, in a report of liabilities of the State health insurance program, to COGFA, that there would be an increase in the number and percentage of participants in HMO-style plans. The Department did warn that the number could change significantly due to the HMO contracts being rebid for FY12. Those figures, by plan, are provided in Exhibit 3-5.

Exhibit 3-5
HMO PARTICIPATION ANALYSIS
FY11-FY12

Plan	*FY11 Participants*	*FY12 Participants*	*Percentage Change*
Health Alliance HMO	80,782	83,055	2.81 %
Health Alliance IL	8,239	8,416	2.15 %
HMO IL	60,928	61,893	1.58 %
Humana of IL	10,116	10,350	2.31 %
PersonalCare	26,989	27,711	2.68 %
Humana Winnebago	1,571	1,613	2.67 %
Totals	188,625	193,038	2.34 %

Source: March 2011 report on FY12 Liabilities of State Health Insurance Program.

In the July 14, 2010 Procurement Business Case for the OAP procurement, which was developed almost two months prior to RFP release, it states "The Department's consultant, Mercer, suggests that self-insuring is effective because the Department currently pays the managed care vendor a premium often referred to as the retention cost for assuming the risk of the unknown healthcare costs for enrollees. By internally managing and funding Open Access vendors the Department will achieve the best healthcare value for its enrollees."

The RFP for the OAP procurement stated there were approximately 60,000 lives in the OAP program. This is the figure bidders were relying on when putting together price bids. In the end, based on Mercer figures from the award of the contracts, the number of enrollees went from 41,000 to over 137,000. Exhibit 3-6 provides the enrollment impact in FY12 estimated by Mercer for the expansion of the self-funded program.

Exhibit 3-6
FY12 ENROLLMENT IMPACT OF AWARD DECISION
For Awards Announced April 6, 2011

	Plan Type		*Enrollment*		
Vendor	*Current*	*Proposed*	*Current*	*Proposed*	*Change*
Health Alliance	HMO	HMO	73,769	0	(73,769)
BCBS	HMO	HMO	53,195	66,278	13,083
HealthLink	OAP	OAP	41,131	75,077	33,946
PersonalCare	HMO	OAP	23,354	62,092	38,738
Humana	HMO	N/A	11,998	0	(11,998)
Total			203,447	203,447	0

Source: OAG developed from Mercer information.

In May 2011, COGFA took steps to stop the Department from expanding the OAP program by not giving its advice and consent for the expansion.

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 percent 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.

Given that Department data show OAP plans' cost are higher, it is difficult to know how Mercer calculations show the State saves money when the awards, as announced, migrate more HMO participants to OAP plans. 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 scenarios.

Mercer Scenarios

The Department had Mercer develop 14 spend scenarios utilizing different configurations. These scenarios would show the financial impact to the State when comparing to the current status quo versus the projected award. If there was less spent under the new configuration, or scenario, then the State would "save" a calculation amount. These projections were based on multiple assumptions, the least of which was the migration pattern for the announced awards.

The Department **first considered a scenario** where continuity of care coverage for existing members would have resulted in an award of HMO contracts to BCBS and Health Alliance with reduced service areas and the OAP contracts to HealthLink and PersonalCare. This scenario was abandoned when Health Alliance refused to bid on the lesser service area because it contended that the areas the State told it to bid on were not its core markets. This scenario showed the State would spend $39 million less on insurance under this plan. This Mercer projection, in a report dated February 16, 2011, is presented in Exhibit 3-7.

Exhibit 3-7
FINANCIAL IMPACT OF REDUCED SERVICE AREAS FOR HMO AWARDS
FY12

	Plan Type		*Enrollment*		
Vendor	*Current*	*Proposed*	*Current*	*Proposed*	*Change*
Health Alliance	HMO	HMO	73,769	58,051	(15,718)
BCBS	HMO	HMO	53,195	46,446	(6,749)
HealthLink	OAP	OAP	41,131	61,570	20,439
PersonalCare	HMO	OAP	23,354	37,380	14,026
Humana	HMO	N/A	11,998	0	(11,998)
Total			203,447	203,447	0
	Plan Type		*Projected Spend (in millions)*		
Vendor	*Current*	*Proposed*	*Current*	*Proposed*	*Change*
Health Alliance	HMO	HMO	$510.4	$400.0	($110.4)
BCBS	HMO	HMO	$303.5	$264.6	($38.9)
HealthLink	OAP	OAP	$302.1	$433.4	$131.3
PersonalCare	HMO	OAP	$139.7	$197.9	$58.2
Humana	HMO	N/A	$79.1	$0.0	($79.1)
Total			$1,334.8	$1,295.9	($38.9)

Source: OAG developed from Mercer documentation.

Department documentation showed and the SPO told auditors that when the scenario with reduced service areas for the HMO providers was discussed with the Governor's Office of Management and Budget (GOMB) the Department was told to go with the award that could be supported by the Commission and offered the higher savings to the State. While the decision to award was not based solely on savings, documentation does show that savings were part of the decision making process. Exhibit 3-8 provides the savings based on State spend that was actually awarded on April 6, 2011.

Exhibit 3-8
FY12 FINANCIAL IMPACT OF AWARD DECISION
For Awards Announced April 6, 2011

	Plan Type		*Projected Spend (in millions)*		
Vendor	*Current*	*Proposed*	*Current*	*Proposed*	*Change*
Health Alliance	HMO	HMO	$510.4	$0.0	($510.4)
BCBS	HMO	HMO	$303.5	$377.9	$74.4
HealthLink	OAP	OAP	$302.1	$521.8	$219.7
PersonalCare	HMO	OAP	$139.7	$332.6	$192.9
Humana	HMO	N/A	$79.1	$0.0	($79.1)
Total			$1,334.8	$1,232.3	($102.5)

Source: OAG developed from Mercer information.

Subsequent Event

Documentation obtained by auditors showed that on July 1, 2011, Champaign County provider Christie Clinic received notice that PersonalCare was unilaterally terminating its contract with Christie Clinic. The contract would terminate on January 1, 2012. Christie Clinic reported that "because of the business practices of PersonalCare and serious differences over the past decade, Christie will not renegotiate or reenter a contract with PersonalCare that includes any Open Access, HMO or PPO [Preferred Provider Option] Products."

The Department awarded PersonalCare an OAP for Champaign County on April 6, 2011. The Department reported that CMS does not track membership by providers; therefore the Department was unable to supply a figure for how many State participants this affected. Given that Mercer projected that PersonalCare would have **an increase of 39,000 participants** as part of the awards, losing providers such as Christie Clinic would appear to have to have an impact on the $102.5 million savings figure calculated by Mercer. Participants that utilized Christie would now have to select another OAP plan provider or move to a premium based HMO or the Quality Care Health Plan (QCHP), with possibly different costs to the State.

Monitoring Consultant Activity

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 our review of the procurements to select administrators for the HMO and OAP health insurance contracts, we 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. Based on our review we 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 Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires all State agencies, including the Commission, to establish and maintain a system, or systems, of internal fiscal and administrative controls. These controls should provide assurance that resources are utilized efficiently, effectively, and in compliance with applicable law. These controls **should include sufficient monitoring and documentation of decisions** that impact State resources relative to State health insurance procurements.

The State Records Act requires the head of each agency "shall cause to be made and preserved records containing adequate and proper documentation of the organization, functions, policies, **decisions,** procedures, and essential transactions of the agency designed to furnish

information to protect the legal and financial rights of the State and of persons directly affected by the agency's activities" (5 ILCS 160/8) (emphasis added).

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 with 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. We 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.

The Department stated that projected cost savings were not part of the evaluation process and were not considered in the determination of the final Recommendations to Award (RTAs). According to the Department, the request to Mercer to formulate various scenarios was made in an effort to minimize disruption to members.

The responsibility for State health insurance procurement rests with the Department. Allowing its consultant to conduct a large part of those procurements without guidance or monitoring is in derogation of that responsibility.

MONITORING CONSULTANT ACTIVITY	
RECOMMENDATION NUMBER **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.***
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

(Commission Response continued)	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.

APPENDICES

APPENDIX A
LEGISLATIVE AUDIT COMMISSION
RESOLUTION 142

RESOLUTION NO. 142
Presented by Representatives Brauer and Mautino

WHEREAS, the Department of Healthcare and Family Services (the "Department") announced in April the selection of health insurance vendors to provide benefits to government employees, dependents and retirees effective July 1, 2011; and

WHEREAS, according to the Department, the contracts will result in savings to the State of approximately $102 million in FY12 and over $1 billion over the life of the contracts; and

WHEREAS, as a result of the procurement process, Health Alliance and Humana HMOs that currently insure about 115,000 people will be eliminated; and

WHEREAS, protests filed by Health Alliance and Humana are currently pending before the Executive Ethics Commission; and

WHEREAS, legislators and others have expressed concerns about the procurement process and results; therefore,

BE IT RESOLVED, BY THE LEGISLATIVE AUDIT COMMISSION that the Auditor General is directed to conduct a management audit of the State's procurement of health insurance vendors for the State's group health insurance program; and be it further

RESOLVED, that the audit include, but not be limited to, the following determinations:

- 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's 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, dependants 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, dependants 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;

- 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; and be it further

RESOLVED, that the Department of Healthcare and Family Services, the Executive Ethics Commission and any other State agency or other entity that may have relevant information pertaining to this audit cooperate fully and promptly with the Auditor General's Office in the conduct of this audit; and be it further

RESOLVED, that the Auditor General commence this audit as soon as possible and report his findings and recommendations upon completion in accordance with the provisions of Section 3-14 of the Illinois State Auditing Act.

Adopted this 10th day of May, 2011.

Senator Chris Lauzen
Co-Chair

Representative Frank J. Mautino
Co-Chair

APPENDIX B
AUDIT METHODOLOGY

Appendix B

AUDIT METHODOLOGY

This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The audit objectives for this audit were those as delineated in Resolution Number 142 (see Appendix A), 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. The audit objectives were to determine whether: all aspects of the procurement process were performed in accordance with laws, rules, regulations and policies; decisions were adequately documented; criteria was uniformly applied to all vendors; awardees were able to provide services to State health insurance members at the time of award and at the beginning of the contract period; there was an impact on participants; and cost and savings figures were fully supported. The majority of fieldwork for the audit was completed between August 1, 2011, and September 30, 2011.

In conducting the audit, we reviewed applicable State laws, administrative rules and Department of Healthcare and Family Services (Department) and Executive Ethics Commission (Commission) policies pertaining to the procurement and oversight of State health insurance contracts. We reviewed compliance with those laws and rules to the extent necessary to meet the audit's objectives. Any instances of non-compliance we identified or noted are included in this report.

The State Employees Group Insurance Act of 1971 (Act) establishes requirements for the State health insurance program related to the procurement opportunities the Auditor General was directed to examine in Resolution Number 142 (5 ILCS 375). In addition to the Act, the Illinois Procurement Code (30 ILCS 500), Standard Procurement Rules (44 Ill. Adm. Code), applicable Chief Procurement Officer (CPO) Notices, Department evaluation procedures, and the solicitations themselves provided criteria as to the procurement for State health insurance contracts.

During the audit, we interviewed staff from both the Department and Commission relative to the two procurement opportunities for providing services for the State health insurance contracts. Additionally, we contacted **all** vendors that bid on the two procurement opportunities to see if they wanted to share their perspectives on the procurement processes utilized by the Department and the Commission for these procurements. We also interviewed the Department's consultant (Mercer) to gain an

understanding of its role in the procurement and the cost savings calculations and scenarios it developed for use in the decision making process.

We examined all documentation maintained at the Department and Commission on the procurement activities undertaken for the procurement of the HMO and OAP plan administrators. Our review included documents submitted as part of legal proceedings brought by both losing vendors to the procurement.

We also reviewed internal controls and assessed audit risk relating to the audit's objectives. A risk assessment was conducted to identify areas that needed closer examination. Any significant weaknesses in those controls are included in this report.

We conducted interviews with all evaluators for the two procurements, including evaluators from the Department of Central Management Services that served on the evaluation teams.

Provider Access Points

To prepare the provider access points appendices (Appendices C and D) we examined the networks that were submitted by vendors in their proposals in response to both the HMO and OAP Requests for Proposals. We examined each network and manually reviewed the data provided for primary care physicians to remove duplicate entries and used Microsoft Excel to remove duplicate entries for hospitals, OB/GYNs, pediatricians and other providers. We manually reviewed data provided for primary care physicians because of the primary care physician requirement in each of the RFPs. Providers were removed if they appeared twice at the same address and the results were entered into the appendix.

Vendor Network Confirmations

To verify that the vendors awarded contracts for the HMO and OAP procurements had sufficient networks in place, we took the primary care physicians provided by the vendors in their proposals and verified that they were still available. We judgmentally selected counties and verified that the primary care physicians in those counties were still available by using each of the vendors' websites to conduct a provider search. The results were summarized and any providers not available were noted.

APPENDIX C
PROVIDER NETWORK ACCESS POINTS

HMO PROCUREMENT

NETWORKS SUBMITTED
WITH PROPOSALS
NOVEMBER 8, 2010

Appendix C PROVIDER ACCESS POINTS – HMO PROCUREMENT							
BlueCross/BlueShield – HMO Illinois							
Region		*PCP*	*Hospital*	*OB/GYN*	*Pediatrician*	*Other*	*Total*
Chicagoland		3179	66	1093	1057	8078	13473
East Central		1	0	1	0	8	10
Greater Peoria		51	1	27	12	181	272
Greater Rockford		68	2	8	14	101	193
Greater St. Louis		58	5	25	3	143	234
Southern		0	0	0	0	0	0
West Central		59	5	29	22	287	402

BlueCross/BlueShield – HMO Illinois							
Region	*County*	*PCP*	*Hospital*	*OB/GYN*	*Pediatrician*	*Other*	*Total*
Chicagoland	Cook	2243	45	691	646	5684	9309
Chicagoland	DeKalb	6	2	3	0	16	27
Chicagoland	DuPage	381	7	181	168	1112	1849
Chicagoland	Grundy	0	0	0	0	3	3
Chicagoland	Kane	94	3	43	25	328	493
Chicagoland	Kendall	19	0	7	7	18	51
Chicagoland	Lake	251	4	71	113	445	884
Chicagoland	McHenry	67	3	49	37	217	373
Chicagoland	Will	118	2	48	61	255	484
Greater Rockford	Boone	11	0	0	0	3	14
Greater Rockford	Carroll	0	0	0	0	0	0
Greater Rockford	JoDaviess	N/A	N/A	N/A	N/A	N/A	N/A
Greater Rockford	Lee	0	1	0	0	0	1
Greater Rockford	Ogle	11	0	0	0	0	11
Greater Rockford	Stephenson	0	0	0	0	0	0
Greater Rockford	Whiteside	N/A	N/A	N/A	N/A	N/A	N/A
Greater Rockford	Winnebago	46	1	8	14	98	167
Greater Peoria	Bureau	0	0	0	0	0	0
Greater Peoria	Fulton	5	0	0	0	2	7
Greater Peoria	Hancock	N/A	N/A	N/A	N/A	N/A	N/A
Greater Peoria	Henderson	N/A	N/A	N/A	N/A	N/A	N/A
Greater Peoria	Henry*	N/A	N/A	N/A	N/A	1	1
Greater Peoria	Knox	0	0	0	0	0	0
Greater Peoria	LaSalle	1	0	0	0	0	1
Greater Peoria	Marshall	1	0	0	0	0	1
Greater Peoria	Mercer	N/A	N/A	N/A	N/A	N/A	N/A
Greater Peoria	Peoria	31	1	23	8	162	225
Greater Peoria	Putnam	0	0	0	0	0	0
Greater Peoria	Rock Island	N/A	N/A	N/A	N/A	N/A	N/A
Greater Peoria	Stark	0	0	0	0	0	0
Greater Peoria	Tazewell	11	0	4	4	16	35
Greater Peoria	Warren	N/A	N/A	N/A	N/A	N/A	N/A
Greater Peoria	Woodford	2	0	0	0	0	2
West Central	Adams	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Brown	0	0	0	0	0	0
West Central	Cass	0	0	0	0	0	0
West Central	Christian	0	1	1	0	3	5
West Central	Logan	7	1	0	0	1	9

West Central	Macon	0	0	0	0	1	1
West Central	Macoupin	1	1	0	0	2	4
West Central	Mason	0	0	0	0	0	0
West Central	McDonough	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Menard	2	0	0	0	1	3
West Central	Morgan	8	1	3	3	15	30
West Central	Moultrie	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Pike	0	0	0	0	0	0
West Central	Sangamon	41	1	25	19	264	350
West Central	Schuyler	0	0	0	0	0	0
West Central	Scott	0	0	0	0	0	0
West Central	Shelby	N/A	N/A	N/A	N/A	N/A	N/A
East Central	Champaign	N/A	N/A	N/A	N/A	3	3
East Central	Coles	N/A	N/A	N/A	N/A	N/A	N/A
East Central	DeWitt	0	0	0	0	0	0
East Central	Douglas	N/A	N/A	N/A	N/A	N/A	N/A
East Central	Edgar	N/A	N/A	N/A	N/A	N/A	N/A
East Central	Ford	N/A	N/A	N/A	N/A	N/A	N/A
East Central	Iroquois	N/A	N/A	N/A	N/A	N/A	N/A
East Central	Kankakee	1	0	1	0	5	7
East Central	Livingston	N/A	N/A	N/A	N/A	N/A	N/A
East Central	McLean	0	0	0	0	0	0
East Central	Piatt	N/A	N/A	N/A	N/A	N/A	N/A
East Central	Vermilion	N/A	N/A	N/A	N/A	N/A	N/A
Greater St. Louis	Bond	0	0	0	0	0	0
Greater St. Louis	Calhoun	N/A	N/A	N/A	N/A	N/A	N/A
Greater St. Louis	Clinton	0	0	0	0	0	0
Greater St. Louis	Greene	0	0	0	0	0	0
Greater St. Louis	Jersey	0	0	0	0	0	0
Greater St. Louis	Madison	25	2	11	0	35	73
Greater St. Louis	Monroe	10	1	1	0	2	14
Greater St. Louis	Montgomery	0	0	0	0	0	0
Greater St. Louis	Randolph	0	0	0	0	0	0
Greater St. Louis	St. Clair	23	2	13	3	106	147
Greater St. Louis	Washington	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Alexander	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Clark	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Clay	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Crawford	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Cumberland	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Edwards	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Effingham	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Fayette	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Franklin	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Gallatin	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Hamilton	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Hardin	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Jackson	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Jasper	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Jefferson	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Johnson	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Lawrence	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Marion	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Massac	N/A	N/A	N/A	N/A	N/A	N/A

Southern	Perry	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Pope	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Pulaski	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Richland	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Saline	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Union	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Wabash	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Wayne	N/A	N/A	N/A	N/A	N/A	N/A
Southern	White	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Williamson	N/A	N/A	N/A	N/A	N/A	N/A
NOTE: Counties in RED were awarded by the Department to BCBS in April 2011.							
NOTE: Counties with N/A were not bid on by the vendor.							
NOTE: *Henry County was bid on by BCBS, but was not awarded by the Department.							
Source: OAG developed from vendor proposal information.							

Appendix C
PROVIDER ACCESS POINTS – HMO PROCUREMENT

BlueCross/BlueShield – BlueAdvantage HMO

Region		*PCP*	*Hospital*	*OB/GYN*	*Pediatrician*	*Other*	*Total*
Chicagoland		2781	60	1025	892	6837	11595
East Central		1	0	1	0	8	10
Greater Peoria		51	1	27	12	181	272
Greater Rockford		68	2	8	14	101	193
Greater St. Louis		58	5	25	7	143	238
Southern		0	0	0	0	0	0
West Central		59	5	29	22	286	401

BlueCross/BlueShield – BlueAdvantage HMO

Region	*County*	*PCP*	*Hospital*	*OB/GYN*	*Pediatrician*	*Other*	*Total*
Chicagoland	Cook	1932	40	646	547	4622	7787
Chicagoland	DeKalb	6	2	3	0	16	27
Chicagoland	DuPage	363	7	175	151	1045	1741
Chicagoland	Grundy	0	0	0	0	2	2
Chicagoland	Kane	94	3	43	25	328	493
Chicagoland	Kendall	19	0	7	6	18	50
Chicagoland	Lake	185	3	54	65	352	659
Chicagoland	McHenry	67	3	49	37	217	373
Chicagoland	Will	115	2	48	61	237	463
Greater Rockford	Boone	11	0	0	0	3	14
Greater Rockford	Carroll	0	0	0	0	0	0
Greater Rockford	JoDaviess	N/A	N/A	N/A	N/A	N/A	N/A
Greater Rockford	Lee	0	1	0	0	0	1
Greater Rockford	Ogle	11	0	0	0	0	11
Greater Rockford	Stephenson	0	0	0	0	0	0
Greater Rockford	Whiteside	N/A	N/A	N/A	N/A	N/A	N/A
Greater Rockford	Winnebago	46	1	8	14	98	167
Greater Peoria	Bureau	0	0	0	0	0	0
Greater Peoria	Fulton	5	0	0	0	2	7
Greater Peoria	Hancock	N/A	N/A	N/A	N/A	N/A	N/A
Greater Peoria	Henderson	N/A	N/A	N/A	N/A	N/A	N/A
Greater Peoria	Henry*	N/A	N/A	N/A	N/A	1	1

Greater Peoria	Knox	0	0	0	0	0	0
Greater Peoria	LaSalle	1	0	0	0	0	1
Greater Peoria	Marshall	1	0	0	0	0	1
Greater Peoria	Mercer	N/A	N/A	N/A	N/A	N/A	N/A
Greater Peoria	Peoria	31	1	23	8	162	225
Greater Peoria	Putnam	0	0	0	0	0	0
Greater Peoria	Rock Island	N/A	N/A	N/A	N/A	N/A	N/A
Greater Peoria	Stark	0	0	0	0	0	0
Greater Peoria	Tazewell	11	0	4	4	16	35
Greater Peoria	Warren	N/A	N/A	N/A	N/A	N/A	N/A
Greater Peoria	Woodford	2	0	0	0	0	2
West Central	Adams	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Brown	0	0	0	0	0	0
West Central	Cass	0	0	0	0	0	0
West Central	Christian	0	1	1	0	2	4
West Central	Logan	7	1	0	0	1	9
West Central	Macon	0	0	0	0	1	1
West Central	Macoupin	1	1	0	0	2	4
West Central	Mason	0	0	0	0	0	0
West Central	McDonough	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Menard	2	0	0	0	1	3
West Central	Morgan	8	1	3	3	15	30
West Central	Moultrie	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Pike	0	0	0	0	0	0
West Central	Sangamon	41	1	25	19	264	350
West Central	Schuyler	0	0	0	0	0	0
West Central	Scott	0	0	0	0	0	0
West Central	Shelby	N/A	N/A	N/A	N/A	N/A	N/A
East Central	Champaign	N/A	N/A	N/A	N/A	3	3
East Central	Coles	N/A	N/A	N/A	N/A	N/A	N/A
East Central	DeWitt	0	0	0	0	0	0
East Central	Douglas	N/A	N/A	N/A	N/A	N/A	N/A
East Central	Edgar	N/A	N/A	N/A	N/A	N/A	N/A
East Central	Ford	N/A	N/A	N/A	N/A	N/A	N/A
East Central	Iroquois	N/A	N/A	N/A	N/A	N/A	N/A
East Central	Kankakee	1	0	1	0	5	7
East Central	Livingston	N/A	N/A	N/A	N/A	N/A	N/A
East Central	McLean	0	0	0	0	0	0
East Central	Piatt	N/A	N/A	N/A	N/A	N/A	N/A
East Central	Vermilion	N/A	N/A	N/A	N/A	N/A	N/A
Greater St. Louis	Bond	0	0	0	0	0	0
Greater St. Louis	Calhoun	N/A	N/A	N/A	N/A	N/A	N/A
Greater St. Louis	Clinton	0	0	0	0	0	0
Greater St. Louis	Greene	0	0	0	0	0	0
Greater St. Louis	Jersey	0	0	0	0	0	0
Greater St. Louis	Madison	25	2	11	4	35	77
Greater St. Louis	Monroe	10	1	1	0	2	14
Greater St. Louis	Montgomery	0	0	0	0	0	0
Greater St. Louis	Randolph	0	0	0	0	0	0
Greater St. Louis	St. Clair	23	2	13	3	106	147
Greater St. Louis	Washington	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Alexander	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Clark	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Clay	N/A	N/A	N/A	N/A	N/A	N/A

Southern	Crawford	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Cumberland	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Edwards	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Effingham	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Fayette	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Franklin	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Gallatin	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Hamilton	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Hardin	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Jackson	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Jasper	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Jefferson	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Johnson	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Lawrence	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Marion	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Massac	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Perry	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Pope	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Pulaski	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Richland	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Saline	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Union	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Wabash	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Wayne	N/A	N/A	N/A	N/A	N/A	N/A
Southern	White	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Williamson	N/A	N/A	N/A	N/A	N/A	N/A
NOTE: Counties in RED were awarded by the Department to BCBS in April 2011.							
NOTE: Counties with N/A were not bid on by the vendor.							
NOTE: *Henry County was bid on by BCBS, but was not awarded by The Department..							
Source: OAG developed from vendor proposal information.							

Appendix C
PROVIDER ACCESS POINTS – HMO PROCUREMENT

Health Alliance

Region		*PCP*	*Hospital*	*OB/GYN*	*Pediatrician*	*Other*	*Total*
Chicagoland		74	17	30	22	871	1014
East Central		416	16	94	106	2879	3511
Greater Peoria		523	21	113	138	3264	4059
Greater Rockford		81	5	41	19	950	1096
Greater St. Louis		469	20	90	101	2162	2842
Southern		338	29	94	45	2058	2564
West Central		294	18	61	81	2739	3193

Health Alliance

Region	*County*	*PCP*	*Hospital*	*OB/GYN*	*Pediatrician*	*Other*	*Total*
Chicagoland	Cook	N/A	N/A	N/A	N/A	N/A	N/A
Chicagoland	DeKalb	13	2	7	5	353	380
Chicagoland	DuPage	N/A	N/A	N/A	N/A	N/A	N/A
Chicagoland	Grundy	21	1	10	5	110	147
Chicagoland	Kane	18	4	12	8	261	303
Chicagoland	Kendall	0	0	0	0	0	0

Chicagoland	Lake	N/A	N/A	N/A	N/A	N/A	N/A
Chicagoland	McHenry	N/A	N/A	N/A	N/A	N/A	N/A
Chicagoland	Will	22	10	1	4	147	184
Greater Rockford	Boone	7	1	2	0	56	66
Greater Rockford	Carroll	0	0	0	0	3	3
Greater Rockford	JoDaviess	0	0	0	0	0	0
Greater Rockford	Lee	0	0	1	0	17	18
Greater Rockford	Ogle	3	1	5	0	38	47
Greater Rockford	Stephenson	3	0	6	2	40	51
Greater Rockford	Whiteside	0	0	2	0	10	12
Greater Rockford	Winnebago	68	3	25	17	786	899
Greater Peoria	Bureau	16	2	5	2	103	128
Greater Peoria	Fulton	18	1	2	1	84	106
Greater Peoria	Hancock	19	1	4	0	49	73
Greater Peoria	Henderson	0	0	0	0	1	1
Greater Peoria	Henry	28	1	3	2	101	135
Greater Peoria	Knox	25	1	4	2	127	159
Greater Peoria	LaSalle	55	5	23	7	321	411
Greater Peoria	Marshall	6	0	1	1	6	14
Greater Peoria	Mercer	3	1	0	0	40	44
Greater Peoria	Peoria	130	3	37	74	985	1229
Greater Peoria	Putnam	2	0	2	0	5	9
Greater Peoria	Rock Island	97	3	24	31	1011	1166
Greater Peoria	Stark	3	0	0	0	18	21
Greater Peoria	Tazewell	63	1	6	14	257	341
Greater Peoria	Warren	16	1	1	1	35	54
Greater Peoria	Woodford	42	1	1	3	121	168
West Central	Adams	34	1	5	3	230	273
West Central	Brown	0	0	0	0	10	10
West Central	Cass	9	0	0	0	24	33
West Central	Christian	14	2	0	2	69	87
West Central	Logan	10	1	2	1	29	43
West Central	Macon	83	2	7	7	408	507
West Central	Macoupin	20	3	0	4	57	84
West Central	Mason	6	1	0	1	36	44
West Central	McDonough	15	1	6	2	170	194
West Central	Menard	3	0	0	0	2	5
West Central	Morgan	12	1	3	3	132	151
West Central	Moultrie	5	0	0	0	9	14
West Central	Pike	5	1	0	0	55	61
West Central	Sangamon	66	3	38	57	1478	1642
West Central	Schuyler	1	1	0	0	9	11
West Central	Scott	0	0	0	0	0	0
West Central	Shelby	11	1	0	1	21	34
East Central	Champaign	98	2	44	47	1169	1360
East Central	Coles	11	1	5	6	65	88
East Central	DeWitt	12	1	0	1	39	53
East Central	Douglas	11	0	1	0	13	25
East Central	Edgar	7	1	0	0	25	33
East Central	Ford	11	1	2	0	78	92
East Central	Iroquois	16	1	3	1	77	98
East Central	Kankakee	12	2	1	6	108	129
East Central	Livingston	44	1	5	5	148	203
East Central	McLean	147	3	22	31	784	987

East Central	Piatt	6	1	2	0	13	22
East Central	Vermilion	41	2	9	9	360	421
Greater St. Louis	Bond	12	1	5	3	30	51
Greater St. Louis	Calhoun	6	0	0	0	7	13
Greater St. Louis	Clinton	23	1	5	4	123	156
Greater St. Louis	Greene	7	0	0	2	4	13
Greater St. Louis	Jersey	19	1	2	1	40	63
Greater St. Louis	Madison	173	6	37	55	820	1091
Greater St. Louis	Monroe	18	0	2	3	74	97
Greater St. Louis	Montgomery	15	2	1	0	85	103
Greater St. Louis	Randolph	26	4	5	0	183	218
Greater St. Louis	St. Clair	163	4	32	33	754	986
Greater St. Louis	Washington	7	1	1	0	42	51
Southern	Alexander	8	0	2	1	11	22
Southern	Clark	6	1	0	0	9	16
Southern	Clay	8	1	0	1	11	21
Southern	Crawford	9	1	4	0	19	33
Southern	Cumberland	2	0	0	0	4	6
Southern	Edwards	3	0	0	1	4	8
Southern	Effingham	24	1	4	2	146	177
Southern	Fayette	4	2	1	1	29	37
Southern	Franklin	28	2	6	2	121	159
Southern	Gallatin	4	0	0	0	5	9
Southern	Hamilton	3	1	0	0	22	26
Southern	Hardin	5	1	0	0	6	12
Southern	Jackson	44	2	19	6	357	428
Southern	Jasper	4	0	0	0	3	7
Southern	Jefferson	34	3	11	5	231	284
Southern	Johnson	1	0	0	0	16	17
Southern	Lawrence	5	1	2	0	22	30
Southern	Marion	36	2	5	4	198	245
Southern	Massac	6	1	4	0	20	31
Southern	Perry	7	2	4	0	94	107
Southern	Pope	4	0	0	3	4	11
Southern	Pulaski	0	0	0	0	2	2
Southern	Richland	8	1	3	3	46	61
Southern	Saline	21	2	5	4	112	144
Southern	Union	11	1	5	1	102	120
Southern	Wabash	8	1	1	0	21	31
Southern	Wayne	8	0	5	3	33	49
Southern	White	7	0	0	2	33	42
Southern	Williamson	30	3	13	6	377	429
NOTE: Counties with N/A were not bid on by the vendor.							
Source: OAG developed from vendor proposal information.							

Appendix C
PROVIDER ACCESS POINTS – HMO PROCUREMENT

Humana

Region		*PCP*	*Hospital*	*OB/GYN*	*Pediatrician*	*Other*	*Total*
Chicagoland		147	2	60	57	890	1156
East Central		29	2	4	5	125	165

Greater Peoria		262	10	54	95	1748	2169
Greater Rockford		187	2	62	56	893	1200
Greater St. Louis		0	0	0	0	0	0
Southern		0	0	0	0	0	0
West Central		0	0	0	0	0	0

Humana							
Region	*County*	*PCP*	*Hospital*	*OB/GYN*	*Pediatrician*	*Other*	*Total*
Chicagoland	Cook	N/A	N/A	N/A	N/A	N/A	N/A
Chicagoland	DeKalb	N/A	N/A	N/A	N/A	N/A	N/A
Chicagoland	DuPage	N/A	N/A	N/A	N/A	N/A	N/A
Chicagoland	Grundy	N/A	N/A	N/A	N/A	N/A	N/A
Chicagoland	Kane	N/A	N/A	N/A	N/A	N/A	N/A
Chicagoland	Kendall	N/A	N/A	N/A	N/A	N/A	N/A
Chicagoland	Lake	N/A	N/A	N/A	N/A	N/A	N/A
Chicagoland	McHenry	147	2	60	57	890	1156
Chicagoland	Will	N/A	N/A	N/A	N/A	N/A	N/A
Greater Rockford	Boone	26	0	8	3	26	63
Greater Rockford	Carroll	N/A	N/A	N/A	N/A	N/A	N/A
Greater Rockford	JoDaviess	N/A	N/A	N/A	N/A	N/A	N/A
Greater Rockford	Lee	N/A	N/A	N/A	N/A	N/A	N/A
Greater Rockford	Ogle	N/A	N/A	N/A	N/A	N/A	N/A
Greater Rockford	Stephenson	N/A	N/A	N/A	N/A	N/A	N/A
Greater Rockford	Whiteside	N/A	N/A	N/A	N/A	N/A	N/A
Greater Rockford	Winnebago	161	2	54	53	867	1137
Greater Peoria	Bureau	N/A	N/A	N/A	N/A	N/A	N/A
Greater Peoria	Fulton	19	1	3	4	61	88
Greater Peoria	Hancock	6	1	1	0	5	13
Greater Peoria	Henderson	2	0	0	0	0	2
Greater Peoria	Henry	12	0	0	1	50	63
Greater Peoria	Knox	17	1	3	2	121	144
Greater Peoria	LaSalle	N/A	N/A	N/A	N/A	N/A	N/A
Greater Peoria	Marshall	0	0	0	0	0	0
Greater Peoria	Mercer	6	1	0	0	9	16
Greater Peoria	Peoria	118	4	36	68	1146	1372
Greater Peoria	Putnam	N/A	N/A	N/A	N/A	N/A	N/A
Greater Peoria	Rock Island	N/A	N/A	N/A	N/A	N/A	N/A
Greater Peoria	Stark	2	0	0	0	0	2
Greater Peoria	Tazewell	58	1	9	18	294	380
Greater Peoria	Warren	14	1	1	2	30	48
Greater Peoria	Woodford	8	0	1	0	32	41
West Central	Adams	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Brown	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Cass	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Christian	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Logan	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Macon	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Macoupin	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Mason	N/A	N/A	N/A	N/A	N/A	N/A
West Central	McDonough	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Menard	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Morgan	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Moultrie	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Pike	N/A	N/A	N/A	N/A	N/A	N/A

West Central	Sangamon	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Schuyler	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Scott	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Shelby	N/A	N/A	N/A	N/A	N/A	N/A
East Central	Champaign	N/A	N/A	N/A	N/A	N/A	N/A
East Central	Coles	N/A	N/A	N/A	N/A	N/A	N/A
East Central	DeWitt	7	1	0	1	11	20
East Central	Douglas	N/A	N/A	N/A	N/A	N/A	N/A
East Central	Edgar	N/A	N/A	N/A	N/A	N/A	N/A
East Central	Ford	N/A	N/A	N/A	N/A	N/A	N/A
East Central	Iroquois	N/A	N/A	N/A	N/A	N/A	N/A
East Central	Kankakee	N/A	N/A	N/A	N/A	N/A	N/A
East Central	Livingston	22	1	4	4	114	145
East Central	McLean	0	0	0	0	0	0
East Central	Piatt	N/A	N/A	N/A	N/A	N/A	N/A
East Central	Vermilion	N/A	N/A	N/A	N/A	N/A	N/A
Greater St. Louis	Bond	N/A	N/A	N/A	N/A	N/A	N/A
Greater St. Louis	Calhoun	N/A	N/A	N/A	N/A	N/A	N/A
Greater St. Louis	Clinton	N/A	N/A	N/A	N/A	N/A	N/A
Greater St. Louis	Greene	N/A	N/A	N/A	N/A	N/A	N/A
Greater St. Louis	Jersey	N/A	N/A	N/A	N/A	N/A	N/A
Greater St. Louis	Madison	N/A	N/A	N/A	N/A	N/A	N/A
Greater St. Louis	Monroe	N/A	N/A	N/A	N/A	N/A	N/A
Greater St. Louis	Montgomery	N/A	N/A	N/A	N/A	N/A	N/A
Greater St. Louis	Randolph	N/A	N/A	N/A	N/A	N/A	N/A
Greater St. Louis	St. Clair	N/A	N/A	N/A	N/A	N/A	N/A
Greater St. Louis	Washington	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Alexander	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Clark	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Clay	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Crawford	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Cumberland	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Edwards	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Effingham	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Fayette	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Franklin	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Gallatin	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Hamilton	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Hardin	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Jackson	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Jasper	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Jefferson	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Johnson	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Lawrence	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Marion	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Massac	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Perry	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Pope	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Pulaski	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Richland	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Saline	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Union	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Wabash	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Wayne	N/A	N/A	N/A	N/A	N/A	N/A

Southern	White	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Williamson	N/A	N/A	N/A	N/A	N/A	N/A
NOTE: Counties with N/A were not bid on by the vendor.							
Source: OAG developed from vendor proposal information.							

Appendix C
PROVIDER ACCESS POINTS – HMO PROCUREMENT

PersonalCare

Region		*PCP*	*Hospital*	*OB/GYN*	*Pediatrician*	*Other*	*Total*
Chicagoland		1522	45	509	794	9482	12352
East Central		233	12	45	61	1625	1976
Greater Peoria		382	19	73	88	1751	2313
Greater Rockford		292	10	84	61	1340	1787
Greater St. Louis		298	29	63	74	863	1327
Southern		187	18	56	26	609	896
West Central		252	16	48	44	1302	1662

PersonalCare

Region	*County*	*PCP*	*Hospital*	*OB/GYN*	*Pediatrician*	*Other*	*Total*
Chicagoland	Cook	686	28	195	355	5569	6833
Chicagoland	DeKalb	16	2	10	2	143	173
Chicagoland	DuPage	272	3	101	135	1453	1964
Chicagoland	Grundy	6	N/A	4	1	86	97
Chicagoland	Kane	95	2	56	31	381	565
Chicagoland	Kendall	20	N/A	12	6	43	81
Chicagoland	Lake	174	3	66	145	755	1143
Chicagoland	McHenry	107	3	36	54	423	623
Chicagoland	Will	146	4	29	65	629	873
Greater Rockford	Boone	30	1	8	6	72	117
Greater Rockford	Carroll	3	0	0	0	10	13
Greater Rockford	JoDaviess	6	1	0	0	10	17
Greater Rockford	Lee	16	1	3	2	81	103
Greater Rockford	Ogle	33	1	7	0	37	78
Greater Rockford	Stephenson	14	1	3	7	128	153
Greater Rockford	Whiteside	20	2	3	5	77	107
Greater Rockford	Winnebago	170	3	60	41	925	1199
Greater Peoria	Bureau	12	2	5	4	40	63
Greater Peoria	Fulton	35	1	4	19	75	134
Greater Peoria	Hancock	2	N/A	N/A	N/A	5	7
Greater Peoria	Henderson	N/A	N/A	N/A	N/A	N/A	N/A
Greater Peoria	Henry	24	1	1	1	52	79
Greater Peoria	Knox	16	1	4	5	73	99
Greater Peoria	LaSalle	47	4	10	10	160	231
Greater Peoria	Marshall	4	0	0	1	3	8
Greater Peoria	Mercer	3	1	1	0	20	25
Greater Peoria	Peoria	70	3	29	9	713	824
Greater Peoria	Putnam	2	0	0	0	1	3
Greater Peoria	Rock Island	87	3	14	25	279	408
Greater Peoria	Stark	3	0	0	0	3	6
Greater Peoria	Tazewell	46	1	4	8	237	296
Greater Peoria	Warren	4	1	1	0	22	28

Greater Peoria	Woodford	27	1	0	6	68	102
West Central	Adams	43	1	8	7	208	267
West Central	Brown	2	0	0	0	4	6
West Central	Cass	N/A	N/A	N/A	N/A	4	4
West Central	Christian	10	2	1	0	26	39
West Central	Logan	0	1	0	0	26	27
West Central	Macon	55	4	11	10	307	387
West Central	Macoupin	11	2	1	3	41	58
West Central	Mason	6	1	0	1	8	16
West Central	McDonough	N/A	N/A	N/A	N/A	8	8
West Central	Menard	0	0	0	0	1	1
West Central	Morgan	4	1	3	0	48	56
West Central	Moultrie	3	0	0	0	13	16
West Central	Pike	10	1	0	2	23	36
West Central	Sangamon	99	2	24	18	529	672
West Central	Schuyler	N/A	N/A	N/A	N/A	4	4
West Central	Scott	2	N/A	N/A	N/A	1	3
West Central	Shelby	7	1	0	3	51	62
East Central	Champaign	38	1	14	11	384	448
East Central	Coles	16	1	5	4	128	154
East Central	DeWitt	3	1	0	1	20	25
East Central	Douglas	5	0	0	1	17	23
East Central	Edgar	6	1	1	1	14	23
East Central	Ford	11	1	1	1	67	81
East Central	Iroquois	18	1	1	5	58	83
East Central	Kankakee	47	2	9	15	284	357
East Central	Livingston	15	N/A	N/A	2	79	96
East Central	McLean	49	1	6	16	358	430
East Central	Piatt	3	1	0	0	47	51
East Central	Vermilion	22	2	8	4	169	205
Greater St. Louis	Bond	10	1	4	2	23	40
Greater St. Louis	Calhoun	4	0	0	0	6	10
Greater St. Louis	Clinton	19	1	4	1	38	63
Greater St. Louis	Greene	12	1	0	0	3	16
Greater St. Louis	Jersey	10	1	0	1	14	26
Greater St. Louis	Madison	93	8	25	39	326	491
Greater St. Louis	Monroe	11	1	3	3	41	59
Greater St. Louis	Montgomery	14	3	0	0	33	50
Greater St. Louis	Randolph	20	3	5	1	69	98
Greater St. Louis	St. Clair	101	9	19	27	293	449
Greater St. Louis	Washington	4	1	3	0	17	25
Southern	Alexander	3	N/A	1	N/A	1	5
Southern	Clark	6	0	0	0	19	25
Southern	Clay	1	N/A	N/A	1	9	11
Southern	Crawford	7	1	3	N/A	17	28
Southern	Cumberland	2	0	0	0	8	10
Southern	Edwards	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Effingham	28	1	4	6	129	168
Southern	Fayette	6	1	0	1	7	15
Southern	Franklin	12	1	6	1	33	53
Southern	Gallatin	1	N/A	N/A	N/A	N/A	1
Southern	Hamilton	N/A	N/A	N/A	N/A	7	7
Southern	Hardin	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Jackson	32	2	8	5	55	102

Southern	Jasper	2	0	0	1	2	5
Southern	Jefferson	20	2	8	5	109	144
Southern	Johnson	N/A	N/A	N/A	N/A	3	3
Southern	Lawrence	N/A	N/A	N/A	N/A	2	2
Southern	Marion	15	2	6	4	81	108
Southern	Massac	N/A	N/A	3	N/A	3	6
Southern	Perry	8	2	N/A	N/A	39	49
Southern	Pope	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Pulaski	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Richland	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Saline	11	2	3	N/A	17	33
Southern	Union	N/A	2	N/A	N/A	8	10
Southern	Wabash	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Wayne	4	N/A	4	N/A	9	17
Southern	White	N/A	N/A	N/A	N/A	4	4
Southern	Williamson	29	2	10	2	47	90
NOTE: Counties with N/A were not bid on by the vendor.							
Source: OAG developed from vendor proposal information.							

APPENDIX D
PROVIDER NETWORK ACCESS POINTS

OAP PROCUREMENT

NETWORKS SUBMITTED
WITH PROPOSALS
OCTOBER 19, 2010

Appendix D
PROVIDER ACCESS POINTS – OAP PROCUREMENT

HealthLink

Region		*PCP*	*Hospital*	*OB/GYN*	*Pediatrician*	*Other*	*Total*
Chicagoland		9259	110	3637	5511	50021	68538
East Central		1524	16	281	468	5855	8144
Greater Peoria		1532	23	221	978	4811	7565
Greater Rockford		718	12	140	154	2219	3243
Greater St. Louis		700	20	159	185	3339	4403
Southern		571	25	122	91	2749	3558
West Central		632	18	137	206	3337	4330

HealthLink

Region	*County*	*PCP*	*Hospital*	*OB/GYN*	*Pediatrician*	*Other*	*Total*
Chicagoland	Cook	6164	78	2251	3630	31691	43814
Chicagoland	DeKalb	83	3	29	30	459	604
Chicagoland	DuPage	1067	11	546	734	7934	10292
Chicagoland	Grundy	39	1	12	7	293	352
Chicagoland	Kane	412	4	193	152	2110	2871
Chicagoland	Kendall	59	0	21	14	249	343
Chicagoland	Lake	695	6	330	538	3542	5111
Chicagoland	McHenry	283	4	125	141	1559	2112
Chicagoland	Will	457	3	130	265	2184	3039
Greater Rockford	Boone	64	1	8	11	102	186
Greater Rockford	Carroll	4	0	0	0	25	29
Greater Rockford	JoDaviess	3	2	0	0	24	29
Greater Rockford	Lee	29	1	10	5	134	179
Greater Rockford	Ogle	43	1	15	1	84	144
Greater Rockford	Stephenson	48	1	8	17	355	429
Greater Rockford	Whiteside	36	2	5	5	111	159
Greater Rockford	Winnebago	491	4	94	115	1384	2088
Greater Peoria	Bureau	28	2	7	3	85	125
Greater Peoria	Fulton	61	1	4	40	165	271
Greater Peoria	Hancock	18	1	2	0	29	50
Greater Peoria	Henderson	2	0	0	0	1	3
Greater Peoria	Henry	60	2	4	6	135	207
Greater Peoria	Knox	80	2	17	16	259	374
Greater Peoria	LaSalle	99	4	19	41	320	483
Greater Peoria	Marshall	23	0	2	7	25	57
Greater Peoria	Mercer	17	1	1	1	31	51
Greater Peoria	Peoria	565	3	113	573	2149	3403
Greater Peoria	Putnam	4	N/A	2	2	3	11
Greater Peoria	Rock Island	151	3	25	60	643	882
Greater Peoria	Stark	4	0	0	0	6	10
Greater Peoria	Tazewell	242	2	23	167	684	1118
Greater Peoria	Warren	24	1	0	0	34	59
Greater Peoria	Woodford	154	1	2	62	242	461
West Central	Adams	82	1	15	11	367	476
West Central	Brown	2	0	0	0	8	10
West Central	Cass	11	0	0	0	15	26
West Central	Christian	24	2	3	4	136	169
West Central	Logan	15	1	4	2	60	82

West Central	Macon	115	2	17	23	506	663
West Central	Macoupin	27	3	1	6	92	129
West Central	Mason	10	1	0	2	11	24
West Central	McDonough	19	1	4	5	109	138
West Central	Menard	3	0	0	0	9	12
West Central	Morgan	18	1	5	6	125	155
West Central	Moultrie	9	0	0	0	8	17
West Central	Pike	11	1	0	4	63	79
West Central	Sangamon	266	3	88	140	1779	2276
West Central	Schuyler	5	1	0	0	16	22
West Central	Scott	2	0	0	0	5	7
West Central	Shelby	13	1	0	3	28	45
East Central	Champaign	563	3	143	204	2294	3207
East Central	Coles	73	1	23	28	347	472
East Central	DeWitt	28	1	0	1	63	93
East Central	Douglas	19	0	0	2	22	43
East Central	Edgar	12	1	0	1	24	38
East Central	Ford	29	1	2	1	105	138
East Central	Iroquois	18	1	1	12	92	124
East Central	Kankakee	87	2	21	42	607	759
East Central	Livingston	148	1	9	44	236	438
East Central	McLean	391	2	44	88	1424	1949
East Central	Piatt	51	1	11	15	162	240
East Central	Vermilion	105	2	27	30	479	643
Greater St. Louis	Bond	18	1	5	3	47	74
Greater St. Louis	Calhoun	7	0	0	0	7	14
Greater St. Louis	Clinton	37	1	6	5	143	192
Greater St. Louis	Greene	14	1	3	5	16	39
Greater St. Louis	Jersey	21	1	5	2	62	91
Greater St. Louis	Madison	229	6	64	97	1375	1771
Greater St. Louis	Monroe	41	0	5	3	123	172
Greater St. Louis	Montgomery	25	2	0	0	113	140
Greater St. Louis	Randolph	40	3	8	3	202	256
Greater St. Louis	St. Clair	259	4	62	67	1184	1576
Greater St. Louis	Washington	9	1	1	0	67	78
Southern	Alexander	10	0	3	2	14	29
Southern	Clark	11	0	0	0	21	32
Southern	Clay	8	1	0	1	35	45
Southern	Crawford	11	1	7	0	38	57
Southern	Cumberland	6	0	0	0	8	14
Southern	Edwards	4	0	0	2	6	12
Southern	Effingham	37	1	3	10	299	350
Southern	Fayette	13	1	3	4	28	49
Southern	Franklin	40	1	13	3	143	200
Southern	Gallatin	2	0	0	0	5	7
Southern	Hamilton	5	1	0	0	34	40
Southern	Hardin	6	1	0	0	6	13
Southern	Jackson	108	2	20	12	459	601
Southern	Jasper	5	0	0	0	5	10
Southern	Jefferson	50	2	8	14	365	439
Southern	Johnson	6	0	1	0	19	26
Southern	Lawrence	14	1	4	0	18	37
Southern	Marion	41	2	9	8	299	359
Southern	Massac	6	1	8	0	30	45

Southern	Perry	20	2	2	0	124	148
Southern	Pope	4	0	0	4	5	13
Southern	Pulaski	N/A	N/A	N/A	N/A	4	4
Southern	Richland	10	1	3	3	34	51
Southern	Saline	25	2	8	2	138	175
Southern	Union	28	1	2	2	71	104
Southern	Wabash	6	1	0	0	19	26
Southern	Wayne	21	1	6	4	65	97
Southern	White	10	0	0	5	34	49
Southern	Williamson	64	2	22	15	423	526
Note: The Department awarded HealthLink all 102 Illinois counties in April 2011.							
Source: OAG developed from vendor proposal information.							

Appendix D
PROVIDER ACCESS POINTS – OAP PROCUREMENT

PersonalCare							
Region		*PCP*	*Hospital*	*OB/GYN*	*Pediatrician*	*Other*	*Total*
Chicagoland		3257	89	1072	1465	16272	22155
East Central		360	15	279	98	1937	2689
Greater Peoria		449	21	80	102	1787	2439
Greater Rockford		289	11	87	63	1196	1646
Greater St. Louis		372	33	80	91	1014	1590
Southern		332	26	65	42	740	1205
West Central		364	15	58	66	1399	1902

PersonalCare							
Region	*County*	*PCP*	*Hospital*	*OB/GYN*	*Pediatrician*	*Other*	*Total*
Chicagoland	Cook	2066	55	732	854	10202	13909
Chicagoland	DeKalb	14	2	10	2	139	167
Chicagoland	DuPage	416	12	0	215	2653	3296
Chicagoland	Grundy	13	1	7	5	87	113
Chicagoland	Kane	154	5	77	51	623	910
Chicagoland	Kendall	22	0	14	8	57	101
Chicagoland	Lake	268	6	144	177	1184	1779
Chicagoland	McHenry	118	3	39	59	512	731
Chicagoland	Will	186	5	49	94	815	1149
Greater Rockford	Boone	26	1	6	5	60	98
Greater Rockford	Carroll	0	0	0	0	5	5
Greater Rockford	JoDaviess	7	1	0	0	11	19
Greater Rockford	Lee	13	1	3	3	71	91
Greater Rockford	Ogle	28	1	7	0	29	65
Greater Rockford	Stephenson	14	1	7	4	104	130
Greater Rockford	Whiteside	24	2	3	4	77	110
Greater Rockford	Winnebago	177	4	61	47	839	1128
Greater Peoria	Bureau	12	2	5	4	45	68
Greater Peoria	Fulton	31	1	5	20	75	132
Greater Peoria	Hancock	5	0	0	0	8	13
Greater Peoria	Henderson	0	0	0	0	0	0
Greater Peoria	Henry	32	1	1	4	64	102
Greater Peoria	Knox	22	1	4	6	73	106
Greater Peoria	LaSalle	42	4	10	9	135	200

Greater Peoria	Marshall	4	0	0	1	3	8
Greater Peoria	Mercer	4	1	1	0	16	22
Greater Peoria	Peoria	76	4	30	13	548	671
Greater Peoria	Putnam	2	0	0	0	2	4
Greater Peoria	Rock Island	122	3	19	28	484	656
Greater Peoria	Stark	3	0	0	0	3	6
Greater Peoria	Tazewell	56	2	4	10	231	303
Greater Peoria	Warren	6	1	1	1	19	28
Greater Peoria	Woodford	32	1	0	6	81	120
West Central	Adams	46	1	7	8	223	285
West Central	Brown	2	0	0	0	2	4
West Central	Cass	1	0	0	0	2	3
West Central	Christian	14	2	1	2	20	39
West Central	Logan	10	1	0	0	23	34
West Central	Macon	63	4	10	10	294	381
West Central	Macoupin	16	1	1	2	32	52
West Central	Mason	7	1	0	1	9	18
West Central	McDonough	0	0	0	0	9	9
West Central	Menard	3	0	0	0	3	6
West Central	Morgan	14	1	3	4	44	66
West Central	Moultrie	1	0	0	0	6	7
West Central	Pike	10	1	0	2	22	35
West Central	Sangamon	165	2	36	34	693	930
West Central	Schuyler	1	0	0	0	3	4
West Central	Scott	2	0	0	0	1	3
West Central	Shelby	9	1	0	3	13	26
East Central	Champaign	126	3	16	36	768	949
East Central	Coles	21	1	6	14	127	169
East Central	DeWitt	2	1	0	0	23	26
East Central	Douglas	6	0	226	2	19	253
East Central	Edgar	4	1	1	0	10	16
East Central	Ford	16	1	1	1	54	73
East Central	Iroquois	14	1	1	4	38	58
East Central	Kankakee	53	2	9	13	226	303
East Central	Livingston	18	0	0	2	65	85
East Central	McLean	63	1	8	17	408	497
East Central	Piatt	7	1	0	1	19	28
East Central	Vermilion	30	3	11	8	180	232
Greater St. Louis	Bond	11	1	4	4	13	33
Greater St. Louis	Calhoun	4	0	0	0	8	12
Greater St. Louis	Clinton	19	1	5	4	41	70
Greater St. Louis	Greene	15	1	0	2	2	20
Greater St. Louis	Jersey	13	1	2	1	19	36
Greater St. Louis	Madison	120	10	30	49	377	586
Greater St. Louis	Monroe	12	2	2	3	50	69
Greater St. Louis	Montgomery	8	2	0	0	25	35
Greater St. Louis	Randolph	27	3	6	0	86	122
Greater St. Louis	St. Clair	129	11	30	28	373	571
Greater St. Louis	Washington	14	1	1	0	20	36
Southern	Alexander	2	0	1	2	7	12
Southern	Clark	2	0	0	0	16	18
Southern	Clay	4	1	0	1	8	14
Southern	Crawford	8	1	4	0	16	29
Southern	Cumberland	2	0	0	0	6	8

Southern	Edwards	2	0	0	1	0	3
Southern	Effingham	28	1	3	8	102	142
Southern	Fayette	8	1	1	2	7	19
Southern	Franklin	21	1	7	1	39	69
Southern	Gallatin	1	0	0	0	0	1
Southern	Hamilton	1	1	0	0	10	12
Southern	Hardin	0	1	0	0	1	2
Southern	Jackson	69	2	10	5	85	171
Southern	Jasper	0	0	0	1	0	1
Southern	Jefferson	33	2	7	5	105	152
Southern	Johnson	1	0	0	0	6	7
Southern	Lawrence	5	1	2	0	12	20
Southern	Marion	26	2	7	4	79	118
Southern	Massac	2	1	3	0	13	19
Southern	Perry	10	2	0	0	52	64
Southern	Pope	1	0	0	1	1	3
Southern	Pulaski	0	0	0	0	1	1
Southern	Richland	3	1	0	1	8	13
Southern	Saline	19	2	4	0	25	50
Southern	Union	11	2	0	2	19	34
Southern	Wabash	5	1	1	0	16	23
Southern	Wayne	8	1	4	3	13	29
Southern	White	2	0	0	2	7	11
Southern	Williamson	58	2	11	3	86	160
Note: The Department awarded PersonalCare all 102 Illinois counties in April 2011.							
Source: OAG developed from vendor proposal information.							

Appendix D
PROVIDER ACCESS POINTS – OAP PROCUREMENT

Humana

Region		*PCP*	*Hospital*	*OB/GYN*	*Pediatrician*	*Other*	*Total*
Chicagoland		4402	74	1194	1347	15712	22729
East Central		128	6	28	35	541	738
Greater Peoria		304	17	59	59	1287	1726
Greater Rockford		231	7	54	57	843	1192
Greater St. Louis		0	0	0	0	0	0
Southern		18	0	4	4	10	36
West Central		6	2	1	1	32	42

Humana

Region	*County*	*PCP*	*Hospital*	*OB/GYN*	*Pediatrician*	*Other*	*Total*
Chicagoland	Cook	2947	51	816	862	10524	15200
Chicagoland	DeKalb	N/A	N/A	N/A	N/A	N/A	N/A
Chicagoland	DuPage	543	7	162	156	2185	3053
Chicagoland	Grundy	N/A	N/A	N/A	N/A	N/A	N/A
Chicagoland	Kane	198	4	49	52	779	1082
Chicagoland	Kendall	27	0	2	8	59	96
Chicagoland	Lake	316	6	99	133	1129	1683
Chicagoland	McHenry	124	3	30	47	398	602
Chicagoland	Will	247	3	36	89	638	1013
Greater Rockford	Boone	21	0	1	3	18	43

Greater Rockford	Carroll	N/A	N/A	N/A	N/A	N/A	N/A
Greater Rockford	JoDaviess	N/A	N/A	N/A	N/A	N/A	N/A
Greater Rockford	Lee	17	1	3	2	41	64
Greater Rockford	Ogle	16	1	3	0	11	31
Greater Rockford	Stephenson	27	1	6	7	60	101
Greater Rockford	Whiteside	22	2	2	3	32	61
Greater Rockford	Winnebago	128	2	39	42	681	892
Greater Peoria	Bureau	15	2	4	1	35	57
Greater Peoria	Fulton	17	1	3	1	40	62
Greater Peoria	Hancock	5	1	1	0	5	12
Greater Peoria	Henderson	2	0	0	0	0	2
Greater Peoria	Henry	16	1	1	1	29	48
Greater Peoria	Knox	15	1	4	1	72	93
Greater Peoria	LaSalle	51	4	10	7	151	223
Greater Peoria	Marshall	3	0	0	1	2	6
Greater Peoria	Mercer	7	1	0	0	8	16
Greater Peoria	Peoria	99	3	26	38	740	906
Greater Peoria	Putnam	4	0	0	0	1	5
Greater Peoria	Rock Island	N/A	N/A	N/A	N/A	N/A	N/A
Greater Peoria	Stark	2	0	0	0	3	5
Greater Peoria	Tazewell	46	1	8	7	166	228
Greater Peoria	Warren	15	1	1	2	23	42
Greater Peoria	Woodford	7	1	1	0	12	21
West Central	Adams	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Brown	0	0	0	0	0	0
West Central	Cass	0	0	0	0	0	0
West Central	Christian	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Logan	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Macon	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Macoupin	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Mason	N/A	N/A	N/A	N/A	N/A	N/A
West Central	McDonough	4	1	1	1	31	38
West Central	Menard	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Morgan	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Moultrie	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Pike	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Sangamon	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Schuyler	2	1	0	0	1	4
West Central	Scott	N/A	N/A	N/A	N/A	N/A	N/A
West Central	Shelby	N/A	N/A	N/A	N/A	N/A	N/A
East Central	Champaign	N/A	N/A	N/A	N/A	N/A	N/A
East Central	Coles	N/A	N/A	N/A	N/A	N/A	N/A
East Central	DeWitt	6	1	0	1	7	15
East Central	Douglas	N/A	N/A	N/A	N/A	N/A	N/A
East Central	Edgar	N/A	N/A	N/A	N/A	N/A	N/A
East Central	Ford	N/A	N/A	N/A	N/A	N/A	N/A
East Central	Iroquois	N/A	N/A	N/A	N/A	N/A	N/A
East Central	Kankakee	51	2	9	12	155	229
East Central	Livingston	20	1	2	2	56	81
East Central	McLean	51	2	17	20	323	413
East Central	Piatt	N/A	N/A	N/A	N/A	N/A	N/A
East Central	Vermilion	N/A	N/A	N/A	N/A	N/A	N/A
Greater St. Louis	Bond	N/A	N/A	N/A	N/A	N/A	N/A
Greater St. Louis	Calhoun	N/A	N/A	N/A	N/A	N/A	N/A

Greater St. Louis	Clinton	N/A	N/A	N/A	N/A	N/A	N/A
Greater St. Louis	Greene	N/A	N/A	N/A	N/A	N/A	N/A
Greater St. Louis	Jersey	N/A	N/A	N/A	N/A	N/A	N/A
Greater St. Louis	Madison	N/A	N/A	N/A	N/A	N/A	N/A
Greater St. Louis	Monroe	N/A	N/A	N/A	N/A	N/A	N/A
Greater St. Louis	Montgomery	N/A	N/A	N/A	N/A	N/A	N/A
Greater St. Louis	Randolph	N/A	N/A	N/A	N/A	N/A	N/A
Greater St. Louis	St. Clair	N/A	N/A	N/A	N/A	N/A	N/A
Greater St. Louis	Washington	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Alexander	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Clark	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Clay	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Crawford	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Cumberland	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Edwards	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Effingham	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Fayette	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Franklin	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Gallatin	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Hamilton	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Hardin	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Jackson	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Jasper	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Jefferson	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Johnson	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Lawrence	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Marion	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Massac	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Perry	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Pope	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Pulaski	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Richland	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Saline	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Union	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Wabash	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Wayne	N/A	N/A	N/A	N/A	N/A	N/A
Southern	White	N/A	N/A	N/A	N/A	N/A	N/A
Southern	Williamson	18	N/A	4	4	10	36
NOTE: Counties with N/A were not bid on by the vendor.							
Source: OAG developed from vendor proposal information.							

Appendix D
PROVIDER ACCESS POINTS – OAP PROCUREMENT

Health Alliance

Region		*PCP*	*Hospital*	*OB/GYN*	*Pediatrician*	*Other*	*Total*
Chicagoland		4957	117	1483	1858	18070	26485
East Central		534	35	105	143	3151	3968
Greater Peoria		783	39	159	202	4508	5691
Greater Rockford		253	9	59	76	1568	1965
Greater St. Louis		502	28	117	123	3102	3872
Southern		424	39	134	62	2456	3115

West Central		505	28	82	107	3387	4109

Health Alliance							
Region	*County*	*PCP*	*Hospital*	*OB/GYN*	*Pediatrician*	*Other*	*Total*
Chicagoland	Cook	3312	64	881	1160	11119	16536
Chicagoland	DeKalb	21	4	11	12	428	476
Chicagoland	DuPage	534	14	195	251	2770	3764
Chicagoland	Grundy	31	4	11	6	119	171
Chicagoland	Kane	219	7	98	79	953	1356
Chicagoland	Kendall	39	0	12	6	103	160
Chicagoland	Lake	329	6	146	150	1183	1814
Chicagoland	McHenry	182	5	60	72	475	794
Chicagoland	Will	290	13	69	122	920	1414
Greater Rockford	Boone	16	1	2	1	76	96
Greater Rockford	Carroll	3	0	0	0	19	22
Greater Rockford	JoDaviess	3	0	0	0	7	10
Greater Rockford	Lee	24	1	4	6	115	150
Greater Rockford	Ogle	28	1	7	3	66	105
Greater Rockford	Stephenson	30	2	14	15	258	319
Greater Rockford	Whiteside	32	2	5	13	189	241
Greater Rockford	Winnebago	117	2	27	38	838	1022
Greater Peoria	Bureau	22	3	6	2	134	167
Greater Peoria	Fulton	27	1	4	1	124	157
Greater Peoria	Hancock	22	2	4	0	57	85
Greater Peoria	Henderson	0	0	0	0	0	0
Greater Peoria	Henry	36	5	5	6	125	177
Greater Peoria	Knox	37	4	5	8	170	224
Greater Peoria	LaSalle	67	8	26	10	373	484
Greater Peoria	Marshall	11	0	1	1	9	22
Greater Peoria	Mercer	4	1	0	0	41	46
Greater Peoria	Peoria	210	5	53	105	1636	2009
Greater Peoria	Putnam	3	0	2	0	5	10
Greater Peoria	Rock Island	128	7	36	39	1189	1399
Greater Peoria	Stark	4	0	0	0	18	22
Greater Peoria	Tazewell	121	1	12	20	441	595
Greater Peoria	Warren	16	1	2	1	35	55
Greater Peoria	Woodford	75	1	3	9	151	239
West Central	Adams	66	1	13	8	405	493
West Central	Brown	3	0	0	0	13	16
West Central	Cass	9	0	0	0	19	28
West Central	Christian	18	4	1	3	67	93
West Central	Logan	10	1	3	1	37	52
West Central	Macon	108	3	7	10	446	574
West Central	Macoupin	26	5	0	6	61	98
West Central	Mason	10	1	0	2	39	52
West Central	McDonough	19	3	6	2	186	216
West Central	Menard	3	0	0	0	3	6
West Central	Morgan	18	1	3	3	148	173
West Central	Moultrie	8	0	0	0	10	18
West Central	Pike	13	2	0	3	64	82
West Central	Sangamon	180	5	49	68	1853	2155
West Central	Schuyler	1	1	0	0	10	12
West Central	Scott	2	0	0	0	2	4
West Central	Shelby	11	1	0	1	24	37

East Central	Champaign	127	10	50	64	1280	1531
East Central	Coles	12	3	5	6	71	97
East Central	DeWitt	12	1	0	1	43	57
East Central	Douglas	14	1	1	0	10	26
East Central	Edgar	8	1	0	0	28	37
East Central	Ford	11	3	2	0	78	94
East Central	Iroquois	17	1	3	1	78	100
East Central	Kankakee	12	3	1	5	119	140
East Central	Livingston	60	2	5	7	159	233
East Central	McLean	213	5	27	50	887	1182
East Central	Piatt	6	1	2	0	14	23
East Central	Vermilion	42	4	9	9	384	448
Greater St. Louis	Bond	12	1	5	3	32	53
Greater St. Louis	Calhoun	7	0	0	0	6	13
Greater St. Louis	Clinton	26	1	5	4	152	188
Greater St. Louis	Greene	11	0	0	2	4	17
Greater St. Louis	Jersey	20	1	6	1	53	81
Greater St. Louis	Madison	181	6	44	67	1164	1462
Greater St. Louis	Monroe	19	0	4	4	136	163
Greater St. Louis	Montgomery	17	2	1	0	90	110
Greater St. Louis	Randolph	27	6	7	0	223	263
Greater St. Louis	St. Clair	171	10	44	42	1190	1457
Greater St. Louis	Washington	11	1	1	0	52	65
Southern	Alexander	12	0	4	2	22	40
Southern	Clark	7	1	0	0	15	23
Southern	Clay	9	2	0	1	13	25
Southern	Crawford	13	1	5	0	21	40
Southern	Cumberland	4	0	0	0	5	9
Southern	Edwards	3	0	0	1	4	8
Southern	Effingham	31	1	5	2	167	206
Southern	Fayette	8	1	0	1	28	38
Southern	Franklin	43	3	10	3	134	193
Southern	Gallatin	6	0	0	0	6	12
Southern	Hamilton	3	2	0	0	28	33
Southern	Hardin	9	3	0	0	14	26
Southern	Jackson	53	6	25	11	469	564
Southern	Jasper	4	0	0	0	3	7
Southern	Jefferson	40	3	16	8	274	341
Southern	Johnson	2	0	0	0	17	19
Southern	Lawrence	5	1	2	0	13	21
Southern	Marion	41	2	7	4	214	268
Southern	Massac	6	1	10	0	36	53
Southern	Perry	10	2	5	0	123	140
Southern	Pope	5	0	0	5	7	17
Southern	Pulaski	0	0	0	0	10	10
Southern	Richland	9	1	3	2	47	62
Southern	Saline	25	3	9	5	130	172
Southern	Union	11	2	7	1	107	128
Southern	Wabash	8	1	2	1	22	34
Southern	Wayne	11	0	5	3	39	58
Southern	White	6	0	0	2	36	44
Southern	Williamson	40	3	19	10	452	524
Source: OAG developed from vendor proposal information.							

APPENDIX E
AGENCY RESPONSES

ILLINOIS DEPARTMENT OF
Healthcare and
Family Services

Pat Quinn, Governor
Julie Hamos, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-1200
TTY: (800) 526-5812

February 3, 2012

Honorable William G. Holland
Auditor General
State of Illinois

Dear Auditor General Holland:

I appreciate the work performed by your office in the management audit of the State's health insurance procurement. Enclosed with this letter are detailed responses that address each of the recommendations for the Department.

While your audit identified technical weaknesses in the process, the Department continues to believe that the overall procurement was executed in a fair and competitive manner. It is imperative to state that this was the first large-scale, competitive and complex procurement for the managed care contracts in ten years, and it was the first major endeavor under Senate Bill 51 coinciding with this procurement timeframe. Regrettably, not all policies and procedures had been developed to implement the new procurement requirements. Your audit, therefore, is a useful blueprint to our agency and others to strengthen the internal procedures that are necessary. As we have indicated in our responses, several of them have been implemented in a new procurement that is currently pending.

The Department also feels it is necessary to put into context your auditor's statement of the physicians no longer in the vendors' proposed networks as of September 2011. 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. Knowledge of these market reactions caused the Department to request updated network figures from the same vendors as of November 2011. The Department found that, upon taking into account all additions and deletions of providers, all networks increased between 5% and 10% compared to their proposed networks in place on January 1, 2011.

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In addition, your report identifies issues noted with the oversight of the consultant used in the development and the evaluation of the RFP. The Department did in fact monitor and oversee the performance of the consultant's participation in the process and was fully aware of the consultant's communications with some bidders. It was determined by the Department that the communications were appropriate and did not conflict with their contracted services. It should be further noted that the complex, actuarial nature of the consultant's work is an expertise that the Department has no staff to validate. As a result, there is a level of reliance that must be placed on the consultant's work; otherwise there would not have been a need for their services. As stated in our response, we do, however, recognize the need to improve on the documentation that supports the Department's oversight and monitoring of consultants.

If you have any questions or comments about our responses to the recommendations, please contact Jamie Nardulli, External Audit Liaison, at (217) 558-2527 or through email at jamie.nardulli@illinois.gov.

Sincerely,

Julie Hamos
Director

Attachment Response
Report: LAC Resolution #142

Recommendation 1: The Department should ensure that all evaluation scoring information, required by the Illinois Procurement Code, is included in the RFPs. Further, the Department should provide guidance to vendors that want to propose more than one network in its 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.

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.

Recommendation 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 potential 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 review work to be performed for State procurement opportunities.

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.

Auditor Comment #2:

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.

Recommendation 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.

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.

Auditor Comment #3:

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.

Recommendation 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 interest of the State.

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.

Auditor Comment #4

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.

Recommendation 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.

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.

Recommendation 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.

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.

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

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.

Recommendation 8: The Department should take steps to monitor and ensure that all evaluators comply with Departmental procedures regarding communications 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.

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.

Recommendation 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.

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.

Recommendation 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. A dditionally, the Department should not award counties for health insurance coverage to proposers that did not bid on the counties.

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.

Auditor Comment #6:

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."

Recommendation 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.

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.

Auditor Comment #7:

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.

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

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.

EXECUTIVE ETHICS COMMISSION

STATE OF ILLINOIS

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February 3, 2012

Mr. Mike Maziarz
Audit Manager
Office of the Auditor General
Iles Park Plaza
740 East Ash
Springfield, Illinois 62703-3154

Re: Legislative Audit Commission #142 Audit

Dear Mr. Maziarz:

Enclosed please find the Executive Ethics Commission's responses to the Auditor General's findings and recommendations for the above described audit. The responses are being submitted both electronically and in hard copy by mail. Please don't hesitate to contact us should there be any questions.

Very truly yours,

Chad Fornoff
Executive Director

REQUEST FOR PROPOSALS

Recommendation Number 1

The Department 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 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.

Department Response

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.

Auditor Comment #1:

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.

EVALUATORS' ACCESS TO NEEDED MATERIALS

Recommendation Number 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.

Department Response

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 ensure that all members of the Department's evaluation team had the needed materials to score the proposals. Specifically, the Auditor General determined the Department had evaluation

procedures that were not provided to a consultant and some evaluators may have had incomplete vendor proposals. Additionally, the Auditor General determined the Department's team leader did not communicate to team members clarification of a vendor's proposal and did not share the results of reference checks with the team members.

- In support of its findings against the Department, the Auditor General cites the Fiscal Control and Internal Auditing Act which requires all state agencies to establish and maintain a system of internal fiscal and administrative controls. The Auditor General emphasizes in bold that "**those controls should include** ensuring that all evaluators on a procurement have the necessary materials to make informed scoring decisions." Additionally, the Auditor General cites factors in the solicitation the Department may consider and references Department procedures.
- In Legislative Audit Commission Resolution 142, the Auditor General was asked to determine amongst other things whether all aspects of the procurement process were conducted in accordance with applicable laws, rules, regulations and policies.
- 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.
- 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.

LACK OF EVALUATION TEAM MEETINGS

Recommendation Number 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.

Department Response

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 had a policy recommending evaluation committee members meet to conduct discussions for the purpose of clarification and to evaluate the strengths and weaknesses of proposals.
- When meetings are held, the Department requires attendance at all meetings by all evaluation committee members.
- The Auditor General found the Department failed to follow its internal policy/procedure by not having team meetings during the evaluation process.
- In Legislative Audit Commission Resolution 142, the Auditor General was asked to determine amongst other things whether all aspects of the procurement process were conducted in accordance with applicable laws, rules, regulations and policies.
- 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.

LACK OF EVALUATION COMMENTS

Recommendation Number 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.

Department Response

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 had a policy requiring thorough and appropriate comments to support scores given by evaluation team members and for evaluations not supported by comments to be returned to evaluators.
- The Auditor General found the Department failed to follow its procedures that required scores to be accompanied by thorough and appropriate comments. The Department further failed to return evaluations that were not supported by comments to evaluators.
- In Legislative Audit Commission Resolution 142, the Auditor General was asked to determine amongst other things whether all aspects of the procurement process were conducted in accordance with applicable laws, rules, regulations and policies.
- 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.

PROCUREMENT SCORING IRREGULARITIES

Recommendation Number 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.

Department Response

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 had a policy recommending discussion of major scoring differences by evaluation team members to determine if errors were made or whether an evaluator was misinterpreting a vendor's proposal.
- The Auditor General found the Department failed to follow its procedures that required discussion of scoring differences.
- In Legislative Audit Commission Resolution 142, the Auditor General was asked to determine amongst other things whether all aspects of the procurement process were conducted in accordance with applicable laws, rules, regulations and policies.
- 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.

WRITTEN DETERMINATION OF CONTRACT AWARD

Recommendation Number 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.

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.

PROTEST INDEPENDENCE

Recommendation Number 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.

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.

Auditor Comment #5:

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.

CONTRACTS

Recommendation Number 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.

Department Response

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 Procurement Code requires contracts in excess of $10,000 to be filed within 15 days with the Comptroller. 30 ILCS 500/20-80(b).
- The Auditor General found the Department did not timely file 90 day emergency contracts with the Comptroller's Office.
- 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.

LACK OF POLICIES AND PROCEDURES FOR PROCUREMENT REVIEW

Recommendation Number 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.

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.

COUNTIES BID AND AWARDED

Recommendation Number 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.

Department Response

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.

MONITORING CONSULTANT ACTIVITY

Recommendation Number 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.

Department Response

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.