TSG Task Force Update

To: Arkansas Health Reform Task Force

Re: Follow up from previous Task Force Discussions and Meetings

Date: December 16, 2015

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UPDATE

TSG review of the Gartner Report

TSG reviewed the Gartner "IBM Cúram Eligibility and Enrollment Framework (EEF) Program Assessment and Go Forward Strategy and Recommendations Project Final Report: Go Forward Strategy, Recommendations and Roadmap" dated November 10, 2015. In the Introductory section of their 162-page power point presentation, Gartner described the project background, project objectives, and critical questions to answer. The key components of their recommendations are:

- The State should not move forward with additional development work on the eligibility or benefits management work until better governance and vendor management is in place.
- The State should put on hold further deployment of the Cúram solution.
- The State should write an RFP and move forward to procure a Systems Integrator to be singularly responsible for the eligibility and benefits management solution implementation. This procurement should identify Cúram COTS as the "preferred solution" but specify the State is open to vendors presenting compelling justification for migration to a different solution.

Gartner proceeds to recommend 7 projects DHS should complete in the near term. These are:

- Halting Cúram Deployment until Foundational Capabilities and Infrastructure are in place
- Define/Ratify and Promote State's Health and Human Services Vision
- Enhance Investment and Program Governance Management
- Develop Strategic Sourcing and Vendor Management Capabilities
- Define and Implement Architecture Vision, Standards and Methodologies
- Competitive Procurement Systems Integration Services
- Enhance Communications and Organizational Change Management Processes

Gartner provides a description of each of these projects, suggested duration, proposed resource levels, metrics, deliverables, key risks, mitigation plan to address the risks, any tasks completed to date, and a high-level project plan with key milestones. They summarize the overall project plan and show activities in the short term, mid-term, and long term timeframes. The overall timeline runs through December 2018.

In the appendix to the report, Gartner provides a risk assessment of the proposed strategy. They "score" the risks in a green/yellow/red scheme where "green" means the approach meets or exceeds established best practices. "Yellow" means the current approach is not clearly defined

or consistently executed. "Red" means the current approach presents serious risks to the program and requires the State's immediate attention. Using this categorization, Gartner concludes that Governance and Management is between red and yellow, the Solution Fit is yellow, Vendor Management is red, Solution Development Practices is yellow, and Technical Environment is yellow.

Gartner also includes a detailed discussion of 4 alternatives for going forward with part or all of the Cúram Solution.

In alternative A, the Cúram software would be used for modified adjusted gross income (MAGI) Medicaid Eligibility, Traditional Medicaid Eligibility, SNAP Eligibility, SNAP benefits management, and Other DHS programs. In Alternative B, Cúram would be used for all eligibility work but a new platform would be used for SNAP benefits management and all other DHS programs. In Alternative C, Cúram is used only to support MAGI Medicaid Eligibility and in Alternative D, a new platform is used to support all eligibility and benefits management requirements.

Gartner proposes a relative importance for how well each of those alternatives meets the State's business needs, supports the State's ability to manage the complexity of the project, minimizes the total cost of ownership for the technology components, leverages the existing investment, and reduces the time to deploy a complete vision. Based on this analysis, they score Alternative A slightly higher than Alternative D followed by Alternative B. Alternative C scores significantly less than the other alternatives.

TSG met with Mark White and Tim Lampe from DHS to discuss the Gartner report. As the Governor's memo indicated, DHS is moving forward with all of Gartner's recommendations. They are working on all 7 projects identified in the report and have engaged Gartner to advise them on this work. TSG discussed the following challenges with DHS leadership.

1) The Gartner report stopped short of recommending whether DHS continue to use Cúram or switch to an alternate product or approach. Gartner suggested the State invite vendors to propose what they believe will be the best value option for the State. Unfortunately, this approach transfers this critical decision to the Proposal Evaluation team when they score the technical responses. It is reasonable to assume at least two vendors in this marketplace will propose a non-Cúram approach and that at least one vendor will propose Cúram. The State team will have to decide who gets the higher score for technical solution. TSG discussed with DHS a potential approach for making this decision before the RFP is issued.
2) The Gartner report considered "total cost of ownership" from a technical perspective. This term typically is used to measure the life cycle costs of choosing a particular technology from development through maintenance and operations costs. What is not

included is the cost to the business of the schedule delays. There is an impact to program of not delivering the software support at the pace requested.

TSG recommends the Task Force continue to monitor the status of the DHS work in this area. In particular, the Legislature will need to consider whether the timing for implementation of any recommended changes to the Health Care Independence Program and the traditional Medicaid program will be impacted by the ability of the DHS computer systems to support changes in direction.

Ideally, technology should support the agency's mission and direction. However, the delays in implementing the eligibility and benefits management work today, as well as the current recommendations, may create some challenges for DHS in meeting future implementation timelines.

Managed Care Premium Tax Question

On behalf of the Task Force, TSG submitted an inquiry to the Arkansas Insurance Department (AID) Commissioner Allen Kerr, regarding a recent article in California where CMS was questioning the legality of the California Medicaid managed care premium tax. The issue concerned the State of California requiring managed care plans serving Medi-Cal recipients to pay a special health care tax that was not levied across all similar non-Medicaid insurance providers. A previous Center of Medicaid and Medicare Services letter addressed the health care-related taxes (provider taxes) and their effect on federal matching funding under Medicaid and the Children's Health Insurance Program (CHIP). The letter stressed compliance and provided the history and details regarding changes to definitions and applications. The letter along with information related to the California program was forwarded to AID for review.

On December 11, 2015, AID provided TSG with its written response and TSG discussed the issue during a phone conference with AID staff. The conclusion is that Arkansas does not have a special health care tax in the state code and does not single out plans that serve Medicaid recipients or specifically and expressly to Medicaid MCOs in assessing its premium tax. Thus, it would appear that the CMS concern over the tax would not be applicable to Arkansas.

AID, does, suggest that should the Task Force decided to recommend any managed care solution that requires a state insurance license to operate, and, thus, the premium tax would apply, that the Task Force seek further review by legal tax experts at the Department of Finance and Administration. (See attached AID letter to TSG, dated December 11, 2015).

Arkansas Pharmacy Association (APA) Insights and Perspectives in Response to TSG Recommendations

At previous Task Force meetings, TSG released a draft report that included recommendations for actions that the State of Arkansas should take regarding vaccinations and the pharmacy program.

The following provides a summary of these recommendations, many of which the DHS has already initiated:

- Expand the State Preferred Drug List (PDL) and consider joining a multi-state rebate pool (DHS has already initiated this effort).
- Re-procure the contract for the retail pharmacy provider network to secure discounts in ingredient cost and dispensing fees and to establish discounting tiers to incentivize pharmacy participation and maintain access by Medicaid patients in rural and underserved areas of the State (DHS is currently completing a dispensing fee survey in the State as required by CMS).
- Undertake activities to address the over-prescribing and overuse of opioids
    - Expand the current pharmacy lock-in program which limits a beneficiary to filling all of his/her opioid prescriptions at one pharmacy
    - Implement a prescriber lock-in program wherein a beneficiary could secure opioid prescriptions from one prescriber only
    - Permit clinicians to access the State's Opiate Prescription Drug Monitoring Program (allowing clinician access is underway)
- Restructure monthly prescription limits for maintenance medications. Implementation of this recommendation would require the development of a list of medications to be considered "maintenance drugs"
    - Further examine and consider restructuring the monthly prescription limit for non-maintenance drugs
- Undertake activities to improve vaccination rates
    - In State Medicaid reimbursement guidelines for adult vaccines, divorce reimbursement for product from reimbursement for administration fees. This would enable providers to better evaluate participation and to better assess the costs and benefits of program participation
    - Examine Vaccines for Children (VFC) administration fees and establish a new rate schedule if advised

Over the course of its engagement, TSG has met with numerous groups to present and validate findings, refine recommendations, and to seek feedback from stakeholders regarding its recommendations.

APA Consultations

Among these stakeholders, The Arkansas Pharmacists Association (APA) has provided important perspective to TSG especially as it relates to recommendations for improving vaccination rates and pharmacy services. TSG has sought APA insights at several points in the months prior and weeks subsequent to the delivery of its draft report.

On November 24th, TSG representatives visited APA offices in Little Rock to discuss recommendations and on December 2nd, TSG and APA engaged in a follow-up conference call to further discuss TSG recommendations. The following provides a summary of discussion

points from these consultations including an articulation of APA perspectives and concerns as well as TSG responses to these concerns.

APA Perspectives/Concerns

Topic	APA Perspective	TSG Response
Expand the PDL,	Recommends an expansion of the program to examine and expand the State's preferred drug list (PDL) and inform the identification of additional supplemental rebates at Evidenced-based Prescription Drug Program (EBRx) at the University of Arkansas for Medical Sciences (UAMS) College of Pharmacy	TSG supports this recommendation. It is noted however that there exist a variety of evidence-based drug class reviews in addition to the EBRx Program at UAMS. These include the Oregon Drug Effectiveness Review Project (DERP), Magellan, as well as multi-state pools. DHS should evaluate all potential partner/vendors to determine best alignment of strategy, potential rebate return, ability to support therapeutic class reviews (potentially eliminating costs for Oregon DERP program), and the possibility of consolidating call centers once a new partner is in place.
Pharmacist-provided, appointment-based medication synchronization program (ABMS)	Recommends the expansion of the ABMS with the removal of arbitrary prescription limits on maintenance medications for chronic diseases. APA further asserts that ABMS can be expanded and can conservatively enroll 10,000 Medicaid chronic disease patients within the first year and that chronic disease savings from prior adherence studies have demonstrated upwards of $2200 in savings per Chronic Obstructive Pulmonary Disease (COPD) patient per year for patients who achieve a proportion of days covered (PDC) value greater than 80%. Further, APA asserts that the performance network	TSG supports the ABMS recommendation in principle but with reservation. TSG has followed closely the evolution of appointment-based medication synchronization programs in retail pharmacies across the country. In response to widely reported adherence problems, small pockets of these programs have emerged. In Arkansas, 70 pharmacies participated in a study that demonstrated improvements in adherence as measured by PDC. Another study examined COPD patients and demonstrated annual healthcare cost savings of $2,200 per patient after a modest increase in drug spend due to improved adherence. We are not comfortable extrapolating such savings to all chronic disease patients, so we are not comfortable supporting the saving estimate, nor are we comfortable supporting the enrollment estimate of 10,000 patients in the first year. Of the over 800 retail pharmacies in Arkansas, only the 70 pharmacies that participated in the study would be immediately ready to enroll patients. Moreover, there are significant prescription processing issues to overcome, such as refill-too-soon edits and short filling certain prescriptions. There are companies with software programs to assist in

	of retail pharmacies in Arkansas exceeded the 80% number. Based upon these assumptions, APA estimates an annual savings of $22 million, minus a Per Member Per Month (PMPM) administrative expense of $10, or $1.2 million, equating to a total projected savings of ~$20.8M.	ABMS programs but these programs cannot be implemented without significant upfront investment. Finally, to realize such savings would also require resources to enroll individual beneficiaries. In summary, TSG believes that this is a good idea for the future, but that current data does not support the estimation of savings. Moreover, that the infrastructure required by DHS to administer and oversee the program does not justify the anticipated savings compared to the costs.
Vaccine Reimbursements	Recommends an examination and restructuring of the current reimbursement model to improve vaccination rates for influenza, pneumococcal, shingles, tdap and other diseases and encourage preventative health.	TSG supports this recommendation including the separation of ingredient reimbursement from the profession administration fee and reevaluating the administration fees for adult vaccinations Further, TSG recommends reevaluating the professional administration fee for the free vaccines distributed in the VFC program. TSG views this measure as an important means to reduce hospitalizations, emergency room visits and overall medical expenses.
Therapeutic Substitution	Recommends the institution of program opportunities to take advantage of Arkansas' existing therapeutic substitution law to maximize the EBRx PDL using the clinical expertise of the APA to assist in drug selection.	TSG supports the recommendation that prescribers be allowed to permit a dispensing pharmacist to substitute a less expensive, different, but therapeutically equivalent drug and dose to the one prescribed. We believe this provision provides an important means to improve compliance to the expanded PDL, generate ingredient cost savings, and secure additional supplemental rebates. However, TSG would not support a recommendation for any additional fees for this activity.
Timing of Dispensing Reimbursement Restructure	Recommends the postponement of product and professional service reimbursement decisions until the State concludes its ongoing cost of dispensing analysis and NADAC impact analysis so that a thoughtful approach to reimbursement may be explored that focuses on	TSG supports this recommendation. CMS requires a dispensing fee survey prior to any changes which DHS has already begun. The survey results should be available to DHS from the survey vendor sometime in January 2016. Further, there is more than one ingredient cost benchmark available for use in retail pharmacy reimbursement formulae. DHS is currently evaluating several benchmarks including AWP, WAC, and NADAC. These are important considerations in evaluation and planning of retail pharmacy reimbursement changes. APA

	appropriate incentives and total reduction of drug expenditures, not just the portion of the reimbursement pharmacist retain as gross margin.	reports Arkansas retail pharmacy reimbursement to be 20th best of 50 states. TSG reported earlier, that Arkansas was in the middle tier of all states for retail pharmacy reimbursement. TSG recommends a range of potential program savings in brand drug ingredient cost, and brand and generic drug dispensing fees available by re-contracting the retail pharmacy network. During our November 24th meeting, we asked APA if they could offer an alternative to our recommendation in this area that could generate similar savings, but we have been unable to identify such an alternative that TSG is comfortable in recommending to the Task Force. However, we appreciate the review and response generated by APA.
Prescription fill Limits per month	Recommends removal of arbitrary prescription limits on maintenance medications for chronic diseases	TSG supports this recommendation and recognizes that limits on non-maintenance medications may need to be reevaluated.

Conclusion

TSG's responsibility to the Task Force is to help it identify opportunities for program improvement and cost savings. While TSG has considered and will continue to consider the valuable feedback from all stakeholders, including APA, at this time we anticipate no changes to the recommendations TSG previously offered even as we recognize that some of our recommendations may not be fully endorsed by all stakeholders.

Health Care Independence Program Breakout

During past Task Force hearings, TSG has been asked questions related to the number of HCIP beneficiaries in each of the FPL categories and whether any are currently receiving any unemployment, TANF and SNAP benefits, as well as higher educational assistance. TSG had previously made a data request to DHS for detailed information related to HCIP beneficiaries and was provided an additional data set recently that it was able to analyze for the Task Force. The following consists of a result of that analysis.

Private Option / Health Care Independence Breakout

FPL Categories	Total	% total	Higher Ed	% total	UI Benefits	% total	SNAP	% total	TANF	% total	SNAP & TANF	% total
0-50%	148,849	59.1%	1,216	0.5%	2,336	0.9%	57,276	22.8%	558	0.2%	404	0.2%
50-100%	61,169	24.3%	758	0.3%	1,316	0.5%	22,174	8.8%	229	0.1%	179	0.1%
100-138%	39,517	15.7%	452	0.2%	920	0.4%	7,822	3.1%	93	0.0%	69	0.0%
Over 138%	2,135	0.8%	15	0.0%	44	0.0%	285	0.1%	4	0.0%	3	0.0%
TOTAL	251,670	100.0%	2,441	1.0%	4,616	1.8%	87,557	34.8%	884	0.4%	655	0.3%

Categories	Total	% of column	Higher Ed	% of column	UI Benefits	% of column	SNAP	% of column	TANF	% of column	SNAP & TANF	% of column
0-50%	148,849	59.1%	1,216	49.8%	2,336	50.6%	57,276	65.4%	558	63.1%	404	61.7%
50-100%	61,169	24.3%	758	31.1%	1,316	28.5%	22,174	25.3%	229	25.9%	179	27.3%
100-138%	39,517	15.7%	452	18.5%	920	19.9%	7,822	8.9%	93	10.5%	69	10.5%
Over 138%	2,135	0.8%	15	0.6%	44	1.0%	285	0.3%	4	0.5%	3	0.5%
TOTAL	251,670	100.0%	2,441	100.0%	4,616	100.0%	87,557	100.0%	884	100.0%	655	100.0%

Notes:

1 *330 members live in households of between 9 and 12 people (.001%), and are not included in the above breakout.*

2 *The Over 138% category could include beneficiaries who are being disenrolled upon renewal or beneficiaries enrolled through the Federal Portal and not yet reviewed.*

3 *Monthly Income DOES include UI benefits, but does NOT include SNAP or TANF benefits.*

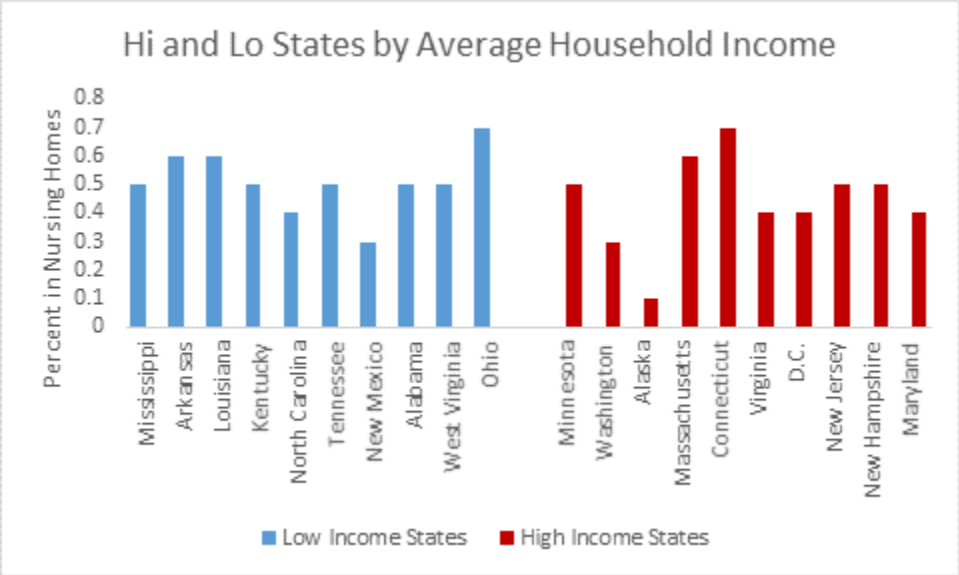
4 *Only taxable student aid is counted as Income for Higher Ed students. There are other policy constraints on what student aid or scholarship income can be considered.*

5 *There are a small number of records which apparently have data entry errors (~80 records). DHS/DCO has or is fixing these errors.*

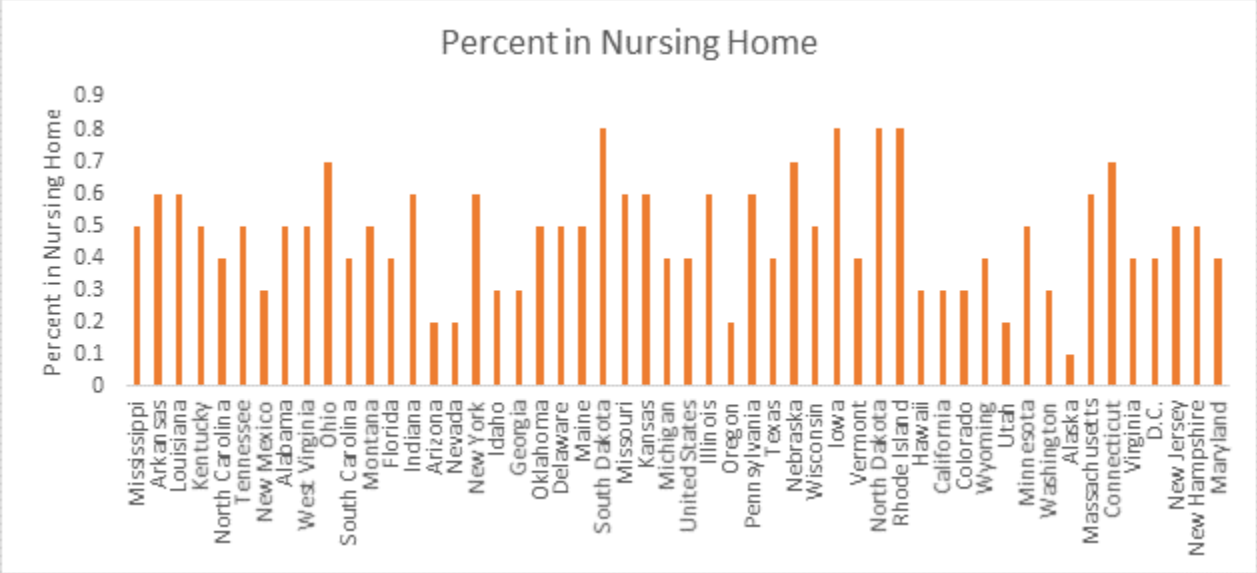
Nursing Home Population Data Presented to Task Force on November 24, 2015 Accounted for State Per Capita Income

As part of the November 24, 2015 Task Force update, TSG presented national nursing home data from the 2013 CMS nursing home compendium showing that population in Arkansas that resides in nursing homes as a percent of the total population is higher than the national average, and that those with low level of acuity is also higher than the national average. The Task Force asked if TSG could further compare this data to national census bureau income data. We did such a comparison and used the same year income data.
https://www.census.gov/hhes/www/income/data/statemedian/

The graph below shows the percent of population in a nursing home for the ten states with the highest household income, compared to the lowest. The data reveals that the percent in nursing homes seems to vary by something other than income. The highest percent is 0.7% in both Ohio (low income) and Connecticut (high income). Alaska is an outlier. Other than that, the lowest percent is 0.3% (New Mexico and Washington).

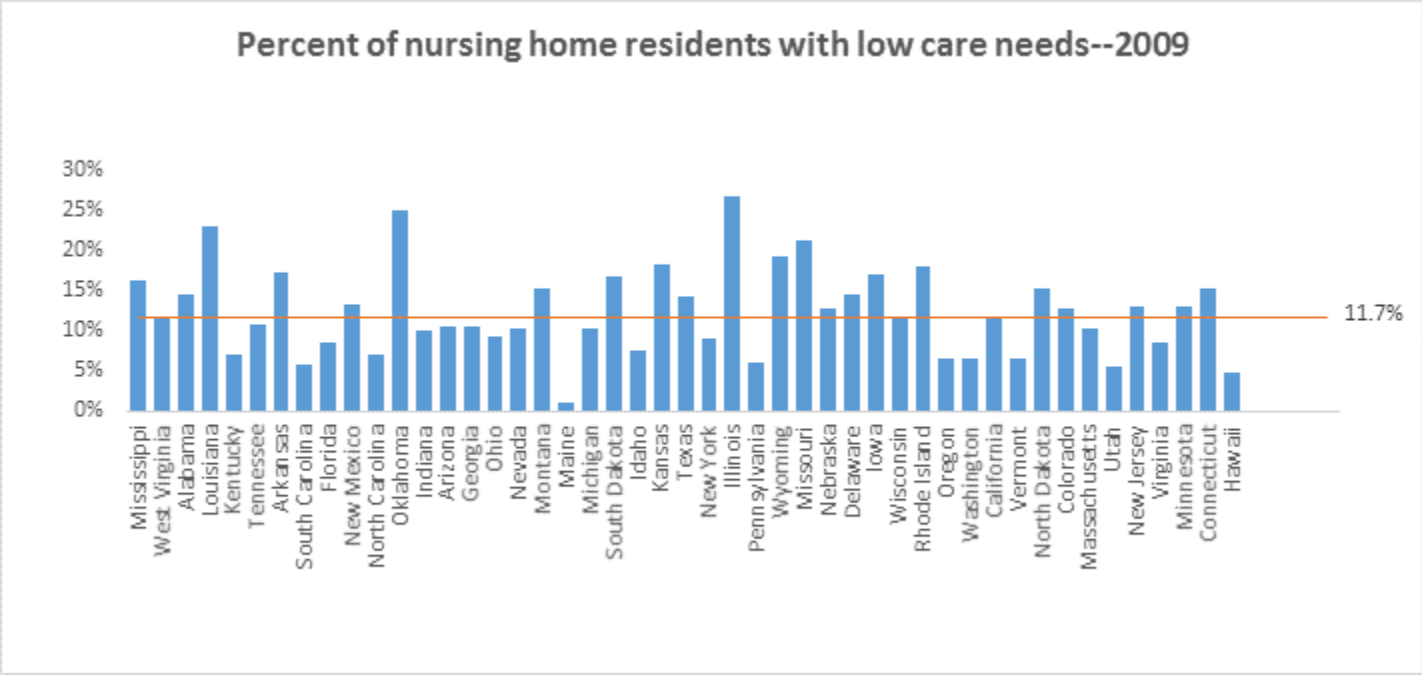


Other than Alaska (clearly an outlier), Arizona and Nevada are the lowest % nursing home, and are relatively low income. Nevada, North Dakota and Iowa are on the higher half of incomes, yet they compare with South Dakota for the highest nursing home percentage. The conclusion is that something else besides income is explaining nursing home percentage.

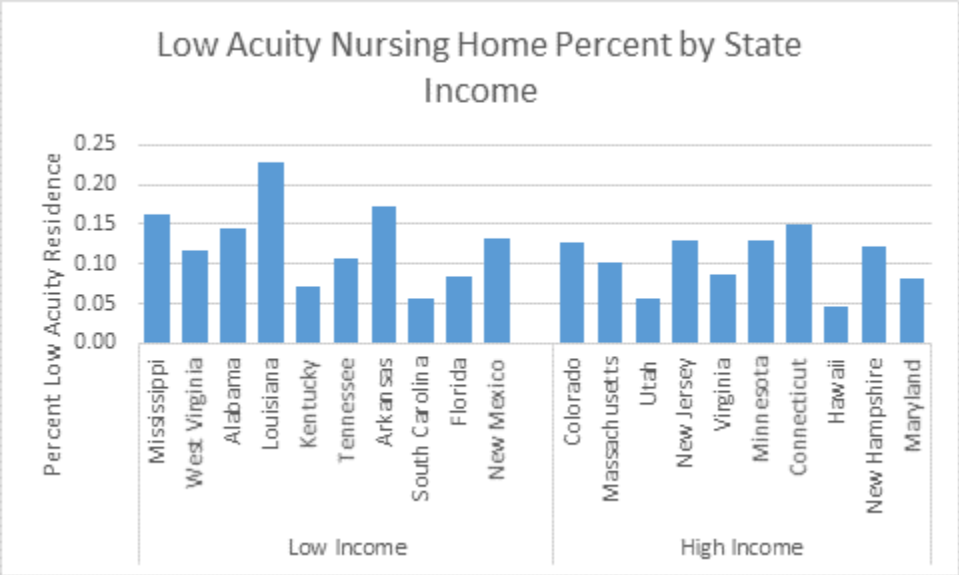


With regard to the number of states with higher than average residents in nursing homes with lower acuity, the data are also unambiguous. That is, state household income does not explain the difference in low-acuity nursing home use.

The first graph shows all states arranged by state household income—lowest to highest. If income were driving nursing home use, then the bars would trend down from left to right. They do not. Oklahoma and Illinois are the two highest low-acuity use—one on either side of the middle. Of the 12 lowest, 6 are large income and 6 low.



The second graph repeats this data, showing only the highest and lowest income states. Again, there is no obvious trend. Louisiana is the largest and is small income, but other than that, low and high income states are pretty similar. One state does not make a trend. The variance is more significant than the average.



DHS Meeting with Arkansas Certified Insurance Agents

On December 8, 2015, DHS leadership met with Dolores Chitwood with NAIFA and a group of Certified Insurance Agents to discuss ways to improve enrollment services to their clients in the Private Option of the Affordable Care Plan. The Insurance Agents had requested the presence of TSG at the meeting.

The main issues highlighted by the Insurance Agents were:

- Authorized Agents: Agents would like to be officially recognized as authorized representatives who can act on behalf of their clients in matters of eligibility determination and enrollment. As part of that they ask to be included in notifications sent to clients by DHS regarding eligibility and enrollment. They also requested viewing access to the DHS system.
- Communication: Agents would like written documentation of regulations and definitions guiding DHS decisions so that they can better help their clients correctly and minimize issues that will cause delays for DHS. Agents also requested regular update bulletins on details and changes in policy and processes pertinent to the eligibility and enrollment process.
- Contact at DHS: Agents are frustrated because all issues and problems are routed back to the county offices, who are still resolving backlogs, causing additional delays. They requested a DHS contact to turn to with questions and problems.

DHS responses can be summarized as:

- DHS cited federal guidelines as the reason for not allowing agents to speak on behalf of their clients. They also said there was no way in the current system to include agents in notifications.
- DHS referred agents to county offices to resolve all issues and problems

During the meeting, Dolores Chitwood repeatedly confirmed with Mary Franklin of DHS that their concerns are heard and understood and would be considered in future decision-making on improving the eligibility and enrollment system.

TSG appreciated the time spent with the agents will continue to monitor the issues raised by the agents and will raise them to the Health Care Task Force.

Lock Out Pennsylvania Response

At previous Task Force hearings TSG identified the State of Pennsylvania as one of the states that made an earlier waiver request of CMS to entertain a similar lockout provision that was accepted in the Indiana Medicaid Expansion Waiver and was not pursued by Pennsylvania after waiver discussion with CMS. Task Force members asked TSG to contact the State of Pennsylvania to determine why the lockout provision was not pursued.

On December 4, 2015, TSG received Pennsylvania's response as follows:

"Per the Deputy Secretary, CMS did not provide a reason for not approving a waiting period before re-enrollment. She believes it may be because it would be inconsistent with current policies regarding all individuals having access to health care."

Current Address Validation Process at DHS

Because the issue of address verification has been discussed at length and a key part of the TSG program integrity recommendations, TSG sought an update from Arkansas DHS as to any changes to the current address verification process in light of the TSG recommendations and concerns voiced during hearings by a number of Task Force members. According to DHS Deputy Director Mark White, below is an explanation of the address validation process DHS is now using on eligibility determinations:

"Previously, the EEF did not validate addresses entered in to the system via any outside validation source. In early October, we instituted a real time address validation through the Arkansas Geographic Information Systems. This is an online validation. When a client or caseworker enters an address, we match with the service to determine if the address entered is a valid Arkansas address. If the service does not find an exact match, the service returns a 'suggested' address. The client is then prompted to select the best address. This works somewhat like 'Google' when it asks, 'did you mean....?' This is a free service provided by the state of Arkansas and should greatly reduce the incidence of returned mail for invalid addresses. This

service only validates that the address exists in Arkansas. This service does not validate that the person resides at that address."

Furthermore, according to Mark White, DHS is exploring future service through either an existing vendor or new vendor that "provides validation through a series of data warehousing that the client actually resides at the address entered." The vendor would use a "series of national databases (utility companies, property records, online delivery services, etc.) to provide a score of the likelihood that the applicant/recipient actually resides at the address entered." If done routinely to determine if individual continue to reside at the address identified at application, this service would appear to meet the intent of the TSG recommendation on routine address verification.

DHS has indicated that any long term solution, such as integrating address verification through the EEF, is awaiting a decision on "whether or not the state will pursue a cross-agency verification system."

Presentation to the Joint Review Committee Regarding Best Practices in Procurement

TSG presented to the Joint Review Committee on Best Practices in Procurement on December 10, 2015. The following is a recap of testimony prepared by Martha Tuthill, Stephen Group Senior Consultant:

Discussion involved the importance of starting with a good RFP and the typical challenges State agencies have with this process. The typical state agency leader in charge of an area requiring services may have never seen or written an RFP. They are a subject matter expert in their area, but typically, are not experienced in procurement. To compound this situation, they usually are required to maintain their normal job responsibilities while writing the RFP. It's not surprising that a lot of state RFP's are copied and pasted from others without really thinking through what's unique about each situation.

A good RFP should attract a wide number of qualified vendors to bid to maximize competition. It should clearly specify what work the agency requires the vendor to do and what performance levels are acceptable. It should provide complete information to allow a vendor to price the work accurately. It should also build in flexibility to allow vendors to be creative where that drives the cost down.

The scope of a good RFP should match what's available in the marketplace. The State can save money by conforming its requirements to marketplace standards. For example, if the State wishes to procure accounting services and legal services, the State could write a single RFP asking for vendors to provide both. There may be some vendors who respond. However, it the State packaged the RFP separately for each type of service, there would be many more vendors responding since more firms are in just the accounting business or just the legal business.

The State should consider how much innovation and risk they are interested in taking. It may be cheaper and easier to be a fast follower than to be on the absolute cutting edge – particularly with technology contracts.

The State should consider the duration of the contract and balance the desire not to be continuously in the procurement mode with the realistic ability to forecast the needs in the future. Commercial organizations have tended to use a 3-4 year duration for their contracts as it becomes difficult to forecast changing requirements beyond that period.

The RFP should also outline what happens at the end of the contract. The State should own as much intellectual property as possible and should require the vendor to cooperate with whatever transition plan the State requires upon their departure.

Requirements should specify not only WHAT the State wants but how it should be done, when it should be done, how robust the solution must be, and who decides whether the solution is "good enough." The State should not confuse high level requirements with being flexible. Flexibility is a conscious process accomplished through designating an agency person empowered to authorize cost neutral changes.

Performance Indicators should motivate vendors and not be overly punitive. The State wants vendors to do this work. The worst outcome is to bankrupt a vendor – then the State has no solution and has to start the procurement process all over again. Performance indicators should be clear and they should be things the vendor has control over. Typically contracts have between 5 and 20 performance indicators. Liquidated damages vary between performance indicators based on relative importance of the measure.

The Committee was given an example of how one contract spread the liquidated damage amounts across a contract to put the maximum emphasis on the things most important to the State. The example illustrated how the total fees at risk can be capped at one amount while the sum of the individual liquidated damage amounts may be two or three times that amount. The example also illustrated that vendors rarely miss all the performance indicators. They tend to have trouble with the same small number of measures over and over again. Some vendors will assume they consistently miss some indicators and build the liquidated damage amounts into their pricing.

The final slide discussed the concept of three levels of performance. One level is that performance level necessary to avoid paying a liquidated damage. Another performance level that could be defined in the RFP and contract is the level necessary to avoid invoking the corrective action plan clause in the contract. The last level that could be defined is the level that allows a vendor to "earn back" the liquidated damage amount previously incurred. This concept motivates the vendor to fix their problems quickly. For example, if a vendor is responsible for

processing 5,000 transactions per month, that's the level they must do to avoid a liquidated damage. If they fall below 5,000, they owe the state, in this example, $9,000. If they really mess up and drop below 4,500 transactions per month, the agency will require a corrective action plan. However, if they "rebound" from one month of poor performance and process 6,000 transactions the following month, the State would refund the $9,000 liquidated damage amount paid. The idea behind "earn backs" is that the State really wants the work done more than they want the small amount of money associated with an individual liquidated damage.

At the end of the TSG presentation, Rep. Hammer asked for questions from members and comments from Ms. Thompson from the Office of State Procurement (OSP). Rep. Hammer asked OSP if she thought that most state agencies have the capability to follow these best practices. She indicated they did.

OSP is planning an RFP class on January 12, 2016 where they expect 100 procurement professionals from state agencies and universities to be trained on writing RFP's and performance standards. She indicated that her office assists on the most complex RFP's and those above a particular dollar threshold. She talked about the new quarterly vendor performance management process and the ability to have more insight into how well all State vendors are performing.

Rep. Hammer asked if the training class should be a requirement rather than an option to attend. He asked if the TSG recommendations were consistent with OSP direction. Ms. Thompson indicated "yes" with the exception that OSP had not looked at using the concept of "earn backs." Lastly, Rep. Hammer asked if it would be helpful to require a checklist to ensure complete RFPs. The TSG response was to use the existing review process to make sure skilled people were looking at the details. Our experience with the existing contracts we have seen is that they would pass the checklist but still don't necessarily have the rigor needed for the complexity of the situation.