MED.01 - Reduction of PERM Rate

available to the state.

4. Reduction of CDDO Facilities – Based on recent audit findings and projected census changes—the general shift to larger populated cities and counties—A&M recommends the state consider eliminating seven Community Developmental Disability Organizations thereby reducing administration costs.

5. Review opportunities to implement Healthy Birth Outcome Initiatives – Through partnerships with state health care providers, A&M recommends the state implement healthy birth outcome initiatives, to improve women and child health care outcomes and manage costs.

6. Centralize all Medicaid Support Functions within KDHE – A&M recommends that state officials consider consolidating all Medicaid support services with Health Care Finance, thereby improving overall operating efficiency, and potentially reducing administrative costs.

Recommendations – State General Fund Savings / Revenue

		Target Savings and Revenue Estimate (All values in 2014 dollars, in 000s)					
Rec #	Recommendation Name	FY17	FY18	FY19	FY20	FY21	Total
1	Reduction of PERM Rate	$-	$34,084	$34,084	$34,084	$34,084	$136,336
2	Increase Oversight of MCO Program Integrity Units	$4,000	$4,000	$4,000	$4,000	$4,000	$20,000
3	Expansion of Federal Grants	$1,462	$1,462	$1,181	$1,091	$1,091	$6,287
4	Reduction of CDDO facilities	$1,011	$1,011	$1,011	$1,011	$1,011	$5,055
5	Implement Healthy Birth Outcome Initiatives	$2,052	$3,408	$4,748	$6,056	$6,521	$22,785
6	Centralize all Medicaid Support Functions within KDHE	$-	$-	$-	$-	$-	$-
KDHE & KDADS Totals		**$8,525**	**$43,965**	**$45,024**	**$46,242**	**$46,707**	**$190,463**

Recommendation #1 – The agencies should institute broad operational improvements to lower the state's Medicaid eligibility error rate

The Improper Payments Information Act (IPIA) of 2002 (amended in 2010 by the Improper Payments Elimination and Recovery Act or IPERA) requires the heads of federal agencies to annually review programs they administer, and identify those that may be susceptible to significant improper payments. They are expected to then estimate the amount of improper payments, to submit those estimates to Congress as well as a report on actions the agency is taking to reduce the improper payments. The Federal Office of Management and Budget (OMB) has identified Medicaid and the Children's Health Insurance Program (CHIP) as programs at risk for significant improper payments. As a result, the Centers for Medicare and Medicaid Services (CMS) developed the Payment Error Rate Measurement (PERM) program to comply with the IPIA and related guidance issued by OMB.

The PERM program measures improper payments in Medicaid and the Children's Health Insurance Program (CHIP) and produces error rates for each program. The error rates are based on reviews of the Fee-For-Service (FFS), managed care, and eligibility components of Medicaid and CHIP in the fiscal year under review. CMS conducts PERM reviews in 3-year cycles consisting of 17 states (including the District of Columbia) in each cycle. In the most recent 2012 review, Kansas' PERM error rates were the highest in the country with an overall error rate of 17.8 percent, which was 5.8 percentage points, or 48 percent, higher than the next highest state. Moreover, Kansas' eligibility error rate of 12.8 percent was nearly four times the national average eligibility error rate of 3.3 percent. An eligibility error occurs when a potential beneficiary is not eligible for the program or for a specific service and a payment for the service, or a capitation payment covering the date of the service, has been made.

The state's 2012 error rates deteriorated when compared to the 2009 PERM report, which cited an overall error rate of 10.35 percent and an eligibility error rate of 9.59 percent. At that time, the national overall and eligibility averages were 8.98 percent and 7.60 percent, respectively, indicating a wider divide and worsening between the state's performance and the national average.

The Governor and KDHE have recently taken several important steps to improve the error rate especially with respect to eligibility. The Governor issued Executive Reorganization Order (ERO) No. 43, which transfers oversight responsibility of Medicaid eligibility from KDCF to KDHE effective January 1, 2016. The ERO, when combined with KDHE's implementation of the Kansas Eligibility and Enforcement System (KEES), is expected to reduce eligibility error rates and the overall PERM error rate by 2 percent in FY17. The 2 percent reduction is budgeted to reduce KanCare costs by $59 million (based on 2 percent of total Medicaid spend of $2.95B), including $26 million from the State General Fund in FY17.

Kansas' 2012 17.8% overall error rate by category as measured by CMS follows:

Fee-For-Service: 7.7%

Managed Care: 0.0%

Eligibility: 12.8%

As Kansas has migrated to a managed care delivery model, the eligibility error rate is the most concerning, since the managed care entities are potentially being paid a monthly capitation rate for beneficiaries that may not be eligible for Medicaid benefits. A&M's review of the 2012 PERM report found that of the 112 findings that resulted in payment errors (from a sample size of 972 active cases) the majority (73) involved potential resources—Veteran Administration (VA) benefits, income errors, application processing, excess resources, program specific and general eligibility errors. While all eligibility errors could potentially result in Medicaid waste that is funded by taxpayers, A&M considers application errors to be clerical processing mistakes that still would have resulted in a beneficiary being eligible for Medicaid benefits. After accounting for the application errors, the eligibility error rate was reduced by a third to 8.3%—still significantly above the national average.

It is KDHE's position, that the VA benefit errors would have still resulted in applicants being eligible for Medicaid. However, CMS specifically cited that "the agency failed to require elderly and disabled applicants to apply for potential Veteran Administration (VA) benefits as required by KEESM 2124-2124.2. This requirement is a condition of eligibility in Kansas." It is uncertain whether potential applicants would have been eligible for Medicaid if VA benefits were considered, but absent a detailed file review, KDHE's position, while considered, is not incorporated in our analysis. Moreover, as Medicaid is a payer of last resort, even if the applicants were still eligible for Medicaid, certain VA benefits would be applied towards medical care prior to Medicaid. It is therefore incumbent upon the state that under the current MCO structure, that the MCOs aggressively pursue any potential VA benefits available to these enrollees.

While the 2.0 percent 2017 budgeted decrease in the eligibility error rate will be beneficial to the state, it will still result in Kansas' adjusted (8.3% - 2.0%) eligibility error rate being more than three percentage points higher than the national average. Through more aggressive actions and commitment to driving down eligibility errors, the state can reduce the error rate by an additional three percent beginning in FY18. Reducing the eligibility error rate by three additional percentage points (from 6.3 to 3.3 percent)—which is in line with the national average—will result in approximately $33.3 million in savings per year to the State General Fund. Although the ERO and KEES initiatives will provide critical benefits to improve eligibility management, we recommend that the state consider taking the following additional measures to improve eligibility accuracy:

- The state currently outsources certain eligibility functions to PSI/Maximus who's performance exceeds that of the state, based on the 2012 PERM report. In order to improve controls associated with payment error rates, consideration should be given to outsourcing all eligibility responsibilities to a third-party vendor whose portion of compensation is directly linked to improving the PERM eligibility error rate.

- If the state elects not to outsource the eligibility function, the state should review opportunities to implement the following:

  - » Maximize the use of state and federal databases to obtain eligibility verification with-

out client contact.

- » Review and potentially enhance existing workflows, case workloads and procedures to increase edibility verification accuracy.
- » Review practices from other states with low eligibility PERM rates, obtain best practices and implement in Kansas.
- » Increase the state's investment in training to ensure accurate and timely completion of eligibility forms.
- » Consider establishing career ladders for eligibility personnel, managers and examiners based on performance.
- » Establish standardized performance protocols and internal controls for managers and train managers to establish and use operating metrics to measure performance.
- » Exam communication mechanisms between supervisors and staff to improve frequency and clarity of communication.
- » Implement a standard supervisory control for supervisory review of eligibility files prior to approval.
- » Leverage existing agency or state audit departments to conduct timely reviews of eligibility files, records, policies and procedures.

Recommendation #1 - (dollars in 000's)				
FY17	FY18	FY19	FY20	FY21
$0	**$34,084**	**$34,084**	**$34,084**	**$34,084**

Recommendation #2 – Improved oversight and training of the MCO program integrity (PI) units will increase fraud, waste and abuse recoveries

According to the U.S. Government Accountability Office, in federal fiscal year 2014, CMS reported an estimated improper payment rate of 6.7 percent or $17.5 billion of the federal government's total Medicaid spend. As Medicaid spending at the state level is partially funded by the federal government, Section 1936(d) of the Social Security Act directs the Secretary of Health and Human Services to establish a comprehensive plan for ensuring the integrity of the Medicaid program by combatting Fraud, Waste and Abuse (FW&A). All states are therefore required to maintain a PI function and federal regulations further require that managed care organizations (MCOs) have similar administrative and management arrangements and procedures that are designed to safeguard against FW&A.

Moreover, traditional PI efforts emphasized a "pay and chase" model that required states to recover overpayments after the fact. Operational experience shows that collecting funds that are incorrectly paid to providers is very difficult to recover. Further, with managed care approaches like KanCare, the state has little or no relationship with the MCO provider network, further exacerbating PI efforts at the state level. CMS and states have begun migrating to a PI model that emphasizes keeping unscrupulous providers out of Medicaid through the use of risk-based provider screening, periodic revalidation of provider enrollment and temporary suspension of payments before FW&A occurs. Moreover, PI efforts are increasingly relying on "cost avoidance" techniques through the use of sophisticated data analysis models and software applications to minimize FW&A.

In Kansas, the contracted MCOs are required to submit quarterly reports on their FW&A efforts and attest to the accuracy and completeness of the reports. Based on a summary provided by KDHE personnel, the three MCOs reported total FW&A recoveries of $0.2 million and $1.7 million for FY14 and FY15, respectively. In addition, the MCOs reported total costs avoided from their prepayment review efforts (excluding Medicare and third-party liability) of $1.2 million and $1.0 million for FY14 and FY15, respectively. For the two years prior to the implementation of KanCare (2011 and 2012), KDHE's Surveillance and Utilization Review (SUR) unit within PI averaged $2.9 million per year in FW&A recoveries.

To encourage the MCOs to improve overall recoveries, A&M recommends that KDHE take the following measures to improve its oversight and effectiveness of the MCO PI units:

- Develop reports with standardized Key Performance Indicators (KPIs) to measure the effectiveness of the PI units.
- Perform periodic audits and reviews of the MCOs to ensure compliance with state and federal guidelines and the overall effectiveness of the PI units.

MED.02 - Increase Oversight of MCO Program Integrity Units

out client contact.

- » Review and potentially enhance existing workflows, case workloads and procedures to increase edibility verification accuracy.
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2012	Total Expenditures	PI Collections	% Collected
Kansas	***$2,667***	***$34***	***1%***
Missouri	$8,727	$106	1%
Nebraska	$1,722	$46	3%
Iowa	$3,478	$78	2%
Oklahoma	$4,644	$244	5%
Utah	$1,903	$33	2%
Arkansas	$4,155	$55	1%
Nevada	$1,739	$8	0%
New Mexico	$3,430	$10	0%
Idaho	$1,452	$31	2%
Peer Group Average	$3,472	$68	2%
Peer Group Median	$3,430	$46	1%
National	$416,898	$8,048	2%

2013	Total Expenditures	PI Collections	% Collected
Kansas	***$2,578***	***$33***	***1%***
Missouri	$8,951	$88	1%
Nebraska	$1,834	$43	2%
Iowa	$3,709	$86	2%
Oklahoma	$4,796	$314	7%
Utah	$2,130	$43	2%
Arkansas	$4,207	$50	1%
Nevada	$1,823	$26	1%
New Mexico	$3,295	$14	0%
Idaho	$1,672	$30	2%
Peer Group Average	$3,602	$77	2%
Peer Group Median	$3,295	$43	1%
National	$440,213	$7,103	2%

- Establish uniform measurements across all three MCOs to quantify cost avoidance prepayment efforts. One potential measure is reviewing provider claim submissions six months prior to the MCOs putting providers on prepay review and claim submissions one year after prepay review. The difference, if any, would be considered cost avoidance savings, that would be reported to the state.
- Review the effectiveness of MCO data analytic technologies and techniques for identifying and mitigating improper claim payments.
- Require that the MCOs properly document fraud recoveries in future rate setting determinations to ensure that the state is properly credited for such recoveries by the MCOs.
- Increase training of KDHE personnel in state-of-the-art FW&A techniques and encourage active participation in the National Association for Medicaid Program Integrity annual conference to obtain FW&A best practices of other states.

Recommendation #2 - (dollars in 000's)				
FY17	FY18	FY19	FY20	FY21
$4,000	**$4,000**	**$4,000**	**$4,000**	**$4,000**

Benchmarking Comparison

A&M reviewed PI collection efforts of comparable states and overall national efforts for FY12 and FY13 (the most recent public information available). The collections outlined below, represent a broader swath of recoveries and includes third-party liability recoveries from insurance carriers and Medicare A&B in addition to FW&A.

Based on our review, Kansas is lower than the peer group average, peer group median and overall national collection rates. While the percentage point differential is not material, when applied to total expenditures, the benefit to the state in dollar terms is significant. Each additional 10 basis point (0.1 percent) improvement in the collection rate, would result in approximately $2.95 million in additional recoveries, which gets shared between the state and federal government—assuming total Medicaid expenditures of $2.95 billion per year. Increasing total collections to the overall national average of 1.61 percent, the KanCare and State General Fund benefit would be in excess of $9 million and $4 million per year, respectively.

In addition, as Oklahoma has achieved significantly higher recovery rates than the peer group in 2012 and 2013, the state should consult with Oklahoma officials to gain an understanding of the practices the state employs to achieve such high collection rates.

Other Considerations for Oversight of MCOs

Based on A&M's review of the MCO contracts and discussions with KDHE personnel, A&M recommends the state consider amending the existing contracts and/or implementing the following oversight measures that will derive additional benefits to the state:

- Program Integrity Recoveries – As outlined in the above table, Kansas recovered $33.5 million in PI collections in FY13. The contracts with the MCOs stipulate that the MCO retains any recoveries, but adjusts the subsequent years' capitation rates based on the amounts collected. Kansas should consider amending its MCO contracts so that it has immediate access to the funds when received. Based on our review of other state MCO agreements, Tennessee has such a provision in its MCO contract.
- State Audits of MCOs – In June 2015, citing states' increased use of MCOs—CMS proposed that states audit their MCOs at least every three years. Based on A&M's discussions with Medicaid personnel, Kansas currently does not audit its MCOs. A&M recommends that Kansas audit the MCOs on a three-year rotating basis resulting in one MCO being audited every year. Such audits will ensure compliance of contract requirements, federal and state statutes, and accuracy and completeness of the encounter and financial data submitted to the state.
- Minimum Medical Loss Ratio (MLR) – Kansas' current contract with the MCOs does not impose a minimum MLR. Instead, Kansas uses an MLR for risk sharing purposes only. While the MLR helps ensure that appropriate measures are enforced for its MCO risk corridors, it does not impact excess profits that an MCO may make. CMS proposed to include a minimum MLR of 85 percent in its proposed rules. Kansas should amend its contracts to impose a minimum MLR. Doing so would ensure that the Kansas MCOs continue to provide appropriate services, and quality performance activities, at a level (85 percent) commensurate with what they are being paid. If an MCO furnishes less than 85 percent of its payments for services to its enrollees, the MCO would pay back to the state and federal governments the difference between what it expended for services and quality activities and the 85 percent level (based on its Medicaid premiums).

Recommendation #3 – The state should pursue additional Medicaid and healthcare Federal grant funding that it could be eligible for

The United States Department of Health and Human Services (DHHS) is the largest grant-making agency in the nation, with most grants being provided to states, territories, and education and community organizations. Both KDHE and KDADS oversee various federal grants that enhance the services that are provided to Kansans. All federal grants are listed with the Catalog of Federal Domestic Assistance (CFDA), which contains financial and nonfinancial assistance programs

CFDA Code	Program Title	# of Benchmark States Receiving Grant	Avg Grant Awarded	Assume 30% Probability of Obtaining
93	Occupational Safety and Health Program	9	$1,511	$453
94	PPHF - Community Transfromation Grants and National Dissemination and Support for Community Transformation Grants	6	$1,357	$407
94	The Affordable Care Act - Medicaid Adult Quality Grants	3	$939	$282
93	Teenage Pregnancy Prevention Program	8	$537	$161

Sources: Catalog of Federal Domestic Assistance, 2013 and 2014 Kansas Single Audits

KDCF.03 - Children's Initiative Fund Optimization

Scott. Program staff can be redistributed to one of these two offices, or to Independence.

  - » Three offices are proposed to remain open to minimize impact on clients:
    - – Colby and Pratt will absorb FTE and/or clients from the proposed closures above. Once the implications on staff and clients of the closures are clear, these two offices should be reviewed to determine whether additional action, such as reduction of space or additional subleasing is appropriate.
    - – For Concordia, there are no field offices in bordering counties to absorb clients and staff, so closure is not recommended.

- The remaining eight offices hold more than 15 FTE. Given their size, closure may put undue burden on clients.
  - » Fort Scott will take in FTE relocated from Iola.
  - » Conditions in Atchison, El Dorado, Lawrence, Leavenworth, Newton, Ottawa and Phillipsburg should be reviewed to determine whether the square footage can be reduced or additional space can be sublet.

Recommendation #2 - (dollars in 000's)				
FY17	FY18	FY19	FY20	FY21
$735	**$692**	**$659**	**$620**	**$590**

Key Assumptions

- All direct service positions will be transferred to nearby offices, thus consolidating the footprint but not reducing service capacity.
- Administrative and temporary staff positions in the closed offices will be eliminated, with non-temporary incumbents offered comparable vacancies in other offices if available.
- SGF currently funds 60.5% of the facilities costs in the offices planned for closure. The table above represents only the SGF savings, and does not include savings of Federal funds.

Critical Steps to Implement

- Create a staff transfer plan and work with staff on relocation
- Develop and execute an outreach plan for clients and communities near closed offices
- Terminate leases

The expected time to implement the recommendation is six months. This will allow for time to work with staff, clients and communities on the transition. The recommendation is not expected to require statutory or regulatory changes, as the Secretary has the authority to determine the number and locations of field offices.

Recommendation #3 – Improve the targeting of CIF funding and diversify the funding mix

The Children's Initiative Fund (CIF) is overseen by the Kansas Children's Cabinet and Trust Fund. The CIF supports children's health, child care, and early childhood education programs. Such programs, if well designed, can result in significant long term savings for the State. For example, a study of The Opportunity Project (TOP) in Sedgwick County, which provides early education to children living in poverty, showed a savings of $4.5 million just from avoiding K-12 special education placement for students enrolled in the program for two years – an 11 percent annual return on investment.[13]

Every CIF-funded program is evaluated annually based, in part, on the extent to which it is supported by empirical evidence. As such, CIF-funded programs are held to a higher standard of evaluation than many State programs. These evaluations can be used to focus further improvements to the returns on the CIF investments.

A&M recommends that CIF-funded programs which consistently received low Evidence Based Practice (EBP) scores be reviewed, and the agencies executing each program either:

- Establish a plan to improve EBP performance, or
- Redesign or replace the program with new programs that have a stronger evidence basis.

13 "Little Footprints Have a Big Impact," Kansas Children's Cabinet Report, December 3, 2015.

To the extent possible, redesigned and new programs should be designed to retain and/or expand federal and private funding.

In addition, with the expected drop in CIF funding due to the reduction in Tobacco Settlement revenues after 2017 and with new leadership in place in multiple agencies, A&M recommends that the Children's Cabinet facilitate joint planning for 2018 to to further evaluate and align funding priorities and strategies across relevant agencies.

Background and Findings

The Kansas Children's Cabinet and Trust Fund, known as the Children's Cabinet, was created by the Legislature in 1999. It is comprised of voting members appointed by the Governor and Legislature, and non-voting ex-officio members from KDCF, KDSE, KDHE, the Kansas Board of Regents, and the Kansas Supreme Court. These are the statutory responsibilities of the Children's Cabinet[14]:

- Advising the Governor and the legislature regarding the uses of the moneys credited to the Children's Initiatives Fund
- Evaluating programs which utilize Children's Initiatives Fund moneys
- Assisting the Governor in developing and implementing a coordinated, comprehensive delivery system to serve children and families of Kansas
- Supporting the prevention of child abuse and neglect through the Children's Trust Fund

The Children's Initiatives Fund was established by the Legislature in 1999 to support programs promoting the health and welfare of the children of Kansas.

- The CIF is funded by the Tobacco Master Settlement agreement.
- Settlement monies flow into the Kansas Endowment for Youth (KEY) Fund
- The CIF is funded with annual transfers from the KEY Fund.
- The Children's Cabinet then recommends transfers from the CIF to specific programs for children. These include programs managed directly by the Children's Cabinet, as well as multiple programs which are administered by KDCF, KDHE, KDADS, and KSDE.
- In some cases, the CIF funds bring in additional federal funding. A portion of the CIF funds supporting the following programs represents state match and/or Maintenance of Effort (MOE) for federal grants:
  - » KDCF's Family Preservation and Child Care Assistance programs
  - » KDADS' Children's Mental Health Waiver program
  - » KDHE's Healthy Start Home Visitor and KIDS Network Grant programs
  - » The Children's Cabinet's Early Childhood Block Grant program.
- However, the majority of CIF funds are not used as state match to bring in Federal or other grant funds.

Tobacco Settlement Funds are expected to drop by approximately 25 percent after 2017 - States and grantees are beginning to plan for the transition.

- The Children's Cabinet has stressed the importance of diversifying funding to its grantees, given the projected reduction in Tobacco Settlement funds.
- The Children's Cabinet and related agencies should also diversify the funding of early childhood programs by continuing to seek private funding and pursuing a wider range of federal grants.
- Many states are also choosing to take future Tobacco Settlement funds as a lump sum at a discount to allow for more flexibility in the timing of the spend. Alabama, Alaska, South Dakota, and South Carolina took lump sums before 2003, and several other states have since followed suit. [15]

The Children's Cabinet undertakes an annual Accountability Process in which programs are evaluated and priorities set for the coming year. The program evaluation results are published in Annual Investment Impact Report (AIIR) and are included in the benchmarking section above.

14 http://kschildrenscabinet.org/mission/, accessed Dec 2, 2015.

15 "Securitization Of Tobacco Settlement Funds," Report, Connecticut Office of Legislative Research, 2002-R-0736.

- The 2015 Annual Investment Impact Report (AIIR) demonstrates strong program governance.
  - » Funding is clearly tied to strategic objectives outlined in the Children's Cabinet's Blueprint for Early Childhood.
  - » Programs are evaluated based on a clear set of criteria, and several programs improved their evaluation scores from 2014 to 2015.
  - » Four programs that were funded in 2014 were not funded in 2015, representing a willingness to adapt funding as needs change.
- However, five programs received Evidence Based Practice (EBP) scores of "1" (on a scale of 1-3) in both 2014 and 2015 and are still being funded in 2016.
  - » In some cases, a low EBP is the result of innovation – newer approaches have not been in place long enough to build up the evidence required.
  - » In other cases, differences between the existing evaluation method for a long standing program and the EBP evaluation method may result in a delay in accurate EBP scoring.
  - » To account for these factors, and to further measure the quality of programs, every program will be required to report on at least one approved outcome measure in 2016.
- In addition, financial efficiency and agency alignment are not systematically evaluated.
  - » Although select CIF-funded programs have been evaluated for financial return, the Accountability Process does not systematically review financial efficiency.
  - » Although the AIIR demonstrates how the CIF funding priorities align to the Children's Cabinet's Blueprint for Early Childhood, it is not clear that the Blueprint and the individual Department strategies for children's programs are explicitly aligned. Agency leadership input is obtained through ex-officio membership on the Children's Cabinet, but the Agencies strategic planning and the Children's Cabinet's planning process are not formally connected.

A&M recommends that CIF-funded programs which consistently received low Evidence Based Practice (EBP) scores develop a plan to improve EBP or be redesigned or replaced with new programs that have a stronger evidence basis.

To the extent possible, redesigned and new programs should be designed to retain and/or expand federal and private funding.

- Three low-EBP programs (Autism Diagnosis, Healthy Start Home Visitor, KIDS Network Grant) currently receive significant federal and private funding. EBP improvement plans and redesigns should be undertaken in such a way as to retain the outside funding while improving evidence based practice.
- Two low-EBP programs are currently entirely CIF-funded. (Child Care Quality Initiative, Kansas Preschool Program). Redesigned or replacement programs may qualify for federal or private grants.

For example, TANF Block Grant funds can be applied to new or substantially redesigned programs in the following areas:[16]

- Preschool and other early childhood education programs which are means tested or designed to reduce out of wedlock births by reducing drop-out rates
- Abuse prevention programs
- Child care programs.[17]

The Kansas TANF Fund[18] includes $3.5 million of uncommitted funds each year from 2017-2020. The TANF Fund is funded by the Federal TANF Block Grant, which is designed to support needy children and their families.

- KDCF administers the TANF fund, as well as administering multiple programs supported by TANF.
- If a new or redesigned program meets the TANF eligibility requirements, it must be included in the state TANF plan and specific Federal reporting requirements must be fulfilled in order to claim the funds.
- With the exception of the Children's Cabinet itself, the agencies which administer the CIF-fund-

16 HHS Program Instruction TANF-ACF-PI-2001.

17 Note: the Child Care Quality Initiative is designed, in part, to improve the identification of child abuse and neglect..

18 "TANF and CCDF Fund Report, FY2016-FY2020 Submitted Budget with Approved Policies, 11/24/2015," report provided by KDCF.

ed programs have extensive expertise in federal funds management and reporting, and therefore should have the capabilities in place to establish the fiscal reporting required for TANF.

Savings resulting from agencies bringing in new Federal or Private funds for redesigned or replacement programs will free up CIF funds, which can then be transferred to core children's programs currently funded by SGF, such as the Infants and Toddlers program or Child Care Assistance.

In addition to addressing low-EBP programs, with the projected reduction in Tobacco Settlement Funds after 2017 and new leadership in place in multiple agencies, an overall review of children's program priorities and funding strategies is in order.

- The above recommendation is a first step, and should be executed jointly by the relevant agencies and the Children's Cabinet, consistent with both Agency strategies and the Children's Cabinet's Blueprint for Early Childhood.
- To further the Children's Cabinet's mandate of "assisting the Governor in developing and implementing a coordinated, comprehensive delivery system to serve children and families of Kansas", A&M recommends that the Children's Cabinet facilitate joint planning for FY18 funding cycle to ensure that priorities are aligned and the impact of funding decisions on both the Blueprint for Early Childhood and Agency objectives are considered and addressed.
- To the extent feasible, the common measures under development by the Children's Cabinet should be expanded to cover additional children's programs so that funding tradeoffs may consider relative impact on child welfare across program types.

Recommendation #3 - (dollars in 000's)				
FY17	FY18	FY19	FY20	FY21
$0	$3,500	$3,500	$3,500	$3,500

Key Assumptions

- All existing programs will continue until redesigned or new programs are in place.
- Current KDCF, KDHE, and/or KDSE staff have the capability to execute the recommendations outlined above with minimal additional administrative cost.
- At least one major new or redesigned program will be eligible for TANF funding, and the TANF surplus, which is projected at $3.5 million per year from FY17 through FY20, will also be at least $3.5 million in FY21.
- Savings resulting from the application of TANF funds to redesigned or replacement programs will free up CIF funds, which can then be transferred to core children's programs currently funded by SGF. The table in this section represents the resultant SGF savings.
- Savings may be higher if needs can be met with programs that are less costly than the current set of programs, or if additional Federal or private funding can be obtained.

Critical Steps to Implement

- Determine which programs will implement a plan to improve EBP, which will be redesigned, which replaced.
- Determine whether the proposed new or redesigned programs meet TANF objectives and/or are eligible for other federal grants or private funding.
- Develop the program policies, documentation, and reporting required.
- Communicate changes to key stakeholders, and engage them in the new program designs as appropriate.
- Update the State TANF plan and obtain federal approval.
- Execute fund transfers.
- Implement the program changes.

A preliminary draft of steps one and two above can be completed within one month. However, depending on the extent of the proposed program changes, the remaining steps may take six to twelve months. Program redesigns and replacements will therefore be implemented for the FY18 grant cycle. This recommendation is not expected to require statutory or regulatory changes.

Appendix - KDCF

The Federal Office of Child Support Enforcement monitors five measures of effectiveness for Child Support Services. The definitions of these measures are provided below. For the first measure—Paternity Establishment Percentage, States have two choices. They may consider only those children born out of wedlock who are IV-D eligible, or they may consider all children born out of wedlock in the state.

CSPIA INCENTIVE MEASURE FORMULAS	
INCENTIVE MEASURE	**FORM AND LINE NUMBERS**
PATERNITY ESTABLISHMENT PERCENTAGE (PEP): IV-D	
Number of Children in the Caseload in the FY or as of the End of the FY Who Were Born Out-of-Wedlock with Paternity Established or Acknowledged / Number of Children in the Caseload as of the End of the Preceding FY Who Were Born Out-of-Wedlock	OCSE-157, Line 6 / OCSE-157, Line 5a
PATERNITY ESTABLISHMENT PERCENTAGE (PEP): STATEWIDE	
Number of Minor Children in the State Born Out-of-Wedlock with Paternity Established or Acknowledged During the FY / Number of Children in the State Born Out-of-Wedlock During the Preceding FY	OCSE-157, Line 9 / OCSE-157, Line 8a
SUPPORT ORDER ESTABLISHMENT	
Number of IV-D Cases with Support Orders / Number of IV-D Cases	OCSE-157, Line 2 / OCSE-157, Line 1
CURRENT COLLECTIONS	
Amount Collected for Current Support in IV-D Cases / Amount Owed for Current Support in IV-D Cases	OCSE-157, Line 25 / OCSE-157, Line 24
ARREARAGE COLLECTIONS	
Number of IV-D Cases Paying Toward Arrears / Number of IV-D Cases with Arrears Due	OCSE-157, Line 29 / OCSE-157, Line 28
COST-EFFECTIVENESS	
Total IV-D Dollars Collected / Total IV-D Dollars Expended	OCSE-34A, Lines 4b+ 4c + 8+ 11 of column (G) / OCSE-396A, Line 7 columns (A) + (C) less Line 1(c) columns (A) + (C)
STATE COLLECTION BASE	
2 times (Current Assistance + Former Assistance Collections + Medicaid Assistance) + Never Assistance Collections + Fees Retained by Other States	OCSE-34A: 2 times ((Line 4b,columns A+B+C+D+E) + (Line 8, columns A+B+C+D+E)) + Line 4b, column F + Line 8, column F + Lines 4c + 11 of column G

Source: "Office of Child Support Enforcement Preliminary Report FY 2014," US Department of Health and Human Services, 2015.

TEC.03 - Consolidate Service Desk and EUC

recommendation include:

- **Labor Costs** – There are currently 72.46 FTEs providing network and telecommunications support representing $5.2 million of annual labor costs. Consolidation (considering the part-time commitment of these resources) could generate between 10% and 15% in total savings or $525,000 to $786,000 in annual savings.
- **AVPN Costs** – There are 411 AVPN circuits costing the state $2.8 million annually. A mix of AVPN renegotiating and resolutioning (e.g., cable modems; Ethernet alternatives) should achieve between 40% and 60% in savings. This equates to annual savings of $1.1 million to $1.6 million.
- **AT&T Contract Renegotiation** – The AT&T contract is due for renegotiation in June of 2016. The potential savings associated with this event is included in the Procurement chapter as a Strategic Sourcing event.

Recommendation # 3 - Service Desk and End User Computing Services Consolidation

Background

State agencies staff their Service Desk individually with internal resources that are not leveraged across other agencies. Some agencies do not have dedicated service desk staff and use cross-functional IT resources from their internal IT departments.

There is no standardization on the service desk ticketing system (service management tool) used across the agencies.

There are currently 134 FTEs providing Service Desk and End User Computing (EUC) support across OTIS and the cabinet agencies.

More than half of the EUC users are outside of Topeka. They are supported through a mix of Topeka based support staff and a regional dispatch model.

Recommendation

A&M recommends consolidating Service Desk operations (Level 1 support) and EUC support across all of EBIT. EBIT should also develop standardization on a single service desk ticketing system and evaluate opportunities to improve remote user support through a regional depot system with adequate spares. This will lower costs, reduce duplication of effort and can lead to improved service (e.g. coverage hours, answer rate, First Call Resolution).

Recommendation #3 - (dollars in 000's)				
FY17	FY18	FY19	FY20	FY21
$2,400	$2,400	$2,400	$2,400	$2,400

As part of the consolidation planning, the state should consider outsourcing the Service Desk and EUC support as a way to further reduce costs; accelerate consolidation; gain access to skills that are in short supply and enhance support for the large number of remote EUC users.

Savings Potential

The key components of savings associated with this recommendation include:

- **Labor Costs** – There are currently 134.24 FTEs providing Service Desk and EUC support representing $8 million of annual labor costs. Consolidation could generate between 30% and 50% in total savings or $2.4 million to $4 million in annual savings.
- **PC Purchasing** – PC purchasing is not leveraged across agencies and there are no standard configurations defined. EBIT should implement a strategic PC purchasing capability and enforce standard configurations to not only lower the purchase price but lower the lifetime support costs as well. The potential savings associated with this recommendation is included in the Procurement chapter as a Strategic Sourcing event.

Recommendation #4 - Application Development and Maintenance Consolidation

Background

There are 248 FTEs currently performing Application Development and Maintenance (ADM) and database administration activities across EBIT. Approximately 20% of these resources are performing database management while the remaining resources are engaged in application development and maintenance tasks.

Historically, each agency managed its own develop-

TEC.04 - Consolidate ADM

recommendation include:

- **Labor Costs** – There are currently 72.46 FTEs providing network and telecommunications support representing $5.2 million of annual labor costs. Consolidation (considering the part-time commitment of these resources) could generate between 10% and 15% in total savings or $525,000 to $786,000 in annual savings.
- **AVPN Costs** – There are 411 AVPN circuits costing the state $2.8 million annually. A mix of AVPN renegotiating and resolutioning (e.g., cable modems; Ethernet alternatives) should achieve between 40% and 60% in savings. This equates to annual savings of $1.1 million to $1.6 million.
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State agencies staff their Service Desk individually with internal resources that are not leveraged across other agencies. Some agencies do not have dedicated service desk staff and use cross-functional IT resources from their internal IT departments.

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There are currently 134 FTEs providing Service Desk and End User Computing (EUC) support across OTIS and the cabinet agencies.

More than half of the EUC users are outside of Topeka. They are supported through a mix of Topeka based support staff and a regional dispatch model.

Recommendation

A&M recommends consolidating Service Desk operations (Level 1 support) and EUC support across all of EBIT. EBIT should also develop standardization on a single service desk ticketing system and evaluate opportunities to improve remote user support through a regional depot system with adequate spares. This will lower costs, reduce duplication of effort and can lead to improved service (e.g. coverage hours, answer rate, First Call Resolution).

Recommendation #3 - (dollars in 000's)				
FY17	FY18	FY19	FY20	FY21
$2,400	$2,400	$2,400	$2,400	$2,400

As part of the consolidation planning, the state should consider outsourcing the Service Desk and EUC support as a way to further reduce costs; accelerate consolidation; gain access to skills that are in short supply and enhance support for the large number of remote EUC users.

Savings Potential

The key components of savings associated with this recommendation include:

- **Labor Costs** – There are currently 134.24 FTEs providing Service Desk and EUC support representing $8 million of annual labor costs. Consolidation could generate between 30% and 50% in total savings or $2.4 million to $4 million in annual savings.
- **PC Purchasing** – PC purchasing is not leveraged across agencies and there are no standard configurations defined. EBIT should implement a strategic PC purchasing capability and enforce standard configurations to not only lower the purchase price but lower the lifetime support costs as well. The potential savings associated with this recommendation is included in the Procurement chapter as a Strategic Sourcing event.

Recommendation #4 - Application Development and Maintenance Consolidation

Background

There are 248 FTEs currently performing Application Development and Maintenance (ADM) and database administration activities across EBIT. Approximately 20% of these resources are performing database management while the remaining resources are engaged in application development and maintenance tasks.

Historically, each agency managed its own develop-

ment resources with little sharing across agencies. There is no formal process in place to track skills/capabilities and no attempt to optimize ADM resources across EBIT.

Recommendation

A&M recommends consolidating ADM and database administration across all of EBIT.

A first step in this consolidation effort should include a review of the personnel roles, responsibilities and competencies of the staff associated with this function.

Recommendation #4 - (dollars in 000's)				
FY17	FY18	FY19	FY20	FY21
$1,900	$1,900	$1,900	$1,900	$1,900

As part of the consolidation planning, the state should consider outsourcing ADM and database support as a way to further reduce costs, accelerate consolidation, and gain access to skills that are in short supply.

Savings Potential

The key components of savings associated with this recommendation include:

- **Labor Costs** – There are currently 248.83 FTEs providing ADM and database support services representing $18.9 million of annual labor costs. Consolidation could generate between 10% and 15% in total savings or $1.9 million to $2.8 million in annual savings.

Recommendation #5 – Consolidate Project Management, Security, Management and "Other" activities

Background

In addition to the FTEs addressed in the four previous recommendations, Excipio identified the following FTEs performing IT activities across EBIT:

Total :	230.55	$19.373 million

Recommendation

A&M recommends consolidating these activities across all of EBIT to the extent possible.

As part of the consolidation planning, the state should consider implementing a complete organization redesign for EBIT that addresses organizational structure, span of control and centralized vs. decentralized activities.

The decisions regarding what activities to retain in-house vs. which activities should be performed by external organizations, will be a key driver in the organizational design. ITIL process implementation and contract management requirements will also be significant contributors to the design effort.

Savings Potential

The key components of savings associated with this recommendation include:

- **Labor Costs** – There are currently 230.55 FTEs providing Project Management, Security, Management and "Other" representing $19.4 million of annual labor costs. Consolidation could generate between 5% and 10% in total savings or $968,000 to $1.9 million in annual savings.

Summary

Executive Branch IT (EBIT) has made good progress laying the foundation for consolidating common IT functions under the leadership of the newly appointed Executive Branch CITO. The establishment of the Core Leadership Team (CLT) and the four Working Groups represent a good start down the path of consolidation.

- Finance/Measures
- People
- Performance/Process/ITIL
- Architecture/Standards

However, there have been repeated attempts to tackle consolidation in the past with very few results gained. Consistent focused leadership and good planning are prerequisites for a successful consolidation effort.

EBIT should look to augment the existing staff with external subject matter experts when and where necessary to move the recommendations forward.

Critical Steps to Implement

The critical steps necessary to complete the implementation of the consolidation recommendations include:

TEC.01 - Consolidate Data Center

  - » Application Development and Maintenance (ADM)
  - » Project Management, Security, Management and Other

- Conduct a "make/build" vs. "buy" decision analysis for each consolidation opportunity listed above, to determine whether to deliver an IT service using internal resources or use outside service providers

Develop a consolidation/outsourcing roadmap for each consolidation opportunity to maximize savings while minimizing risk. Some IT functions can be outsourced prior to consolidation while others are better suited for consolidation prior to outsourcing.

Recommendation #1 – Data Center Consolidation

Background

There have been numerous prior proposals to consolidate data centers in Kansas. In 2013, IBM conducted a comprehensive study of the data center environment for the state of Kansas with the following key findings:

- Kansas data center infrastructure is highly dispersed across agencies leading to added complexity and limited economies of scale.
- Server virtualization is done within agencies silos limiting overall potential for efficiencies (average server utilization at 14%).
- Server and storage hardware is aging and requires update (over 70% are more than four years old).
- Need to drive to higher levels of standardization and automation (over 120 variations of servers in use).
- Lack of service level definitions aligned to business requirements.
- Lack of comprehensive and integrated toolset to support management and monitoring of storage infrastructure.

Following the IBM study, the EBTM project was launched to provide private cloud services to state agencies, in order to resolve the aging server environment and other IBM findings.

Excipio completed a review of the EBTM project and concluded that "the current data center/cloud strategy is not appropriate for the state." Several factors led to that conclusion:

- Project was not properly scoped (e.g., under-provisioned memory and storage configurations but excess server capacity).
- Flawed assumptions led to an overpriced solution (e.g. synchronous replication, limited virtualization, solution complexity).
- Lack of internal skills to design, implement, and manage a private cloud environment.

Existing Data Centers

OITS utilizes two primary data centers. The lager of the two is located in the Landon building and consists of 14,000 ft^2 of floor space with approximately 150 racks. The State Historical Society houses another data center consisting of 1,200 ft^2 and approximately 55 racks. In addition to these data centers, the Department of Transportation (DOT) and other agencies maintain a mix of data centers and server closets. The CITA data center consolidation study conducted in 2010, estimated approximately 50,000 ft^2 of total space was being used by agencies across the state to host computing equipment.

The states computing infrastructure is currently housed in buildings that were not originally designed as data centers and therefore do not conform to industry standards for resiliency and redundancy (e.g., single point of failure).

Mainframe Environment

The state operates a single IBM mainframe with 718 MIPS and 32 GB of memory. The mainframe currently supports applications for DCF, DOT, DOL and DOR. All agencies are currently pursuing strategies to migrate away from the mainframe. The state spends $6.383 million per year to support the mainframe environment. As agencies migrate their application away from the mainframe, most of the state's mainframe costs will not decrease. Given the chargeback structure, the last agency utilizing the mainframe will bear all of the costs associated with the mainframe.

Server Environment

Excipio found that there are 2,183 servers in the Topeka area. While 71% of the Topeka area servers were virtualized the current VM to Host ration of 8.2:1 is

significantly below the industry target of 20:1 to 30:1. The Topeka area servers utilize approximately 1.4 PBs of storage.

The agencies have deferred refresh of the server and storage environment. Currently 71% of the servers are older than five years, while 74% of server storage devices are older than four years and in critical need of refresh.

Recommendation

As stated earlier, A&M recommends a "make vs. buy" analysis be conducted for each IT function being consolidated. Given the current condition of the state's data center infrastructure (age, condition and capacity of the existing data centers as well as the significant capital requirement needed to refresh the server and storage environment) A&M believes that Kansas should strongly consider outsourcing all existing state-owned data centers (mainframe, server and storage) to an external IT service provider utilizing consumption based pricing and industry standard service levels.

Data Center consolidation and outsourcing would replace the existing EBTM project and provide all state agencies (including colleges and universities) with access to secure compute utility on commercial terms. This has the potential to lower operating costs, lower the CapEx budget—associated with replacing an aging server environment, increase availability, and provide a means to recoup some of the EBTM hardware investment. Below is a listing of some of the current data centers (in addition, there are several locations with server closets scattered across the state):

Consolidating and outsourcing the data centers represents a relatively low risk solution that can successfully address several of the state's current issues, including:

- Aging servers, storage and need for greater server virtualization
- Allow the state's mainframe costs to ramp down as agencies migrate away from the mainframe

Recommendation #1 - (dollars in 000's)				
FY17	FY18	FY19	FY20	FY21
$1,820	$1,820	$1,820	$1,820	$1,820

- Lack of resilient data center strategy and DR capability
- CapEx requirements over the next 18 months for equipment refresh

Savings Potential

The key components of savings associated with this recommendation include:

- **Mainframe Costs** – There are currently 39.44 FTEs supporting the mainframe environment representing $2.4 million of annual labor costs. Additionally, there are $4 million of annual non-labor costs (HW maintenance and SW) for a total of $6.4 million of mainframe related costs. If bundled with a comprehensive data center outsourcing initiative, the state could generate between 15% and 25% in total savings or $960,000 to $1.6 million in annual savings.
- **Server & Storage Costs** – There are 59.68 FTEs supporting the server, storage and data center environment representing $4.3 million of annual labor costs. The annual non-labor costs (HW maintenance and SW) for the server and storage component of the data centers is not known due to the lack of accurate budget data. Organizations with decentralized data center support generally achieve between 20% and 30% in savings through consolidation and outsourcing data center support. This equates to annual labor savings of $860,000 to $1.3 million.
- **Space Related Costs** – Outsourcing the data centers would free up 50,000 ft^2 of floor space according to the CITA data center consolidation study and result in utility savings as well as support equipment costs for Power Supplies (UPS), Power Distribution Units (PDUs) and chillers.
- **Capital Avoidance** – OITS and the agencies have delayed refresh of the server environment in anticipation of the EBTM project. Currently more than 70% of the server and storage environment is operating beyond the useful asset life (more than five years old). This places the systems running in that environment at increased risk of failure. The Power Distribution Units (PDUs) and Uninterruptible Power Supplies (UPSs) are also significantly past their useful life (15 years old at the Landon data center) and place the data cen-

ters at increased risk for outages.

The state has already spent $18.6 million of the budgeted $33 million on the EBTM project. Excipio estimates that the actual cost to complete the EBTM project will exceed $55 million. The Executive Branch CIO has halted this project.

A conservative estimate of the capital required to refresh the server and storage hardware and the power equipment for the two primary data centers is $10 million. This investment has not been budgeted.

Thus the recommendation is to outsource all existing state-owned data centers (mainframe, server and storage) to a Tier 1 external IT service provider. Utilizing consumption-based pricing and industry standard service levels will eliminate the need to fund the capital necessary to refresh the server and storage environment. This would provide all state agencies (including universities) with access to secure compute utility on commercial terms (consumption-based pricing and committed service levels) and provide a means to recoup some of the EBTM hardware investment.

Recommendation # 2 - Network Services Consolidation

Background

OITS provides the core Wide Area Network (WAN) to most state agencies. OTIS provides centralized voice services to some state agencies and local government entities. Most agencies provide their own Local Area Network (LAN) capability and voice systems. Additionally, the Kansas Department of Transportation (KDOT)

Component	Quantity	Useful Life (years)	% At or Past Useful Life
WAN Devices	675	5	74%
LAN Devices	1,835	6	75%

manages its own fiber and radio network.

Most of the state's network and telecommunications hardware is past its useful life and in need of refresh. The cost for the necessary refresh has not been estimated or budgeted for.

Source: Excipio Consulting, LLC

There are currently 144 people supporting network and telecommunications across OTIS and the agencies. Many of the people supporting the network and telecommunications environment do so only as part of their job as evidenced by the fact that 72.46 FTEs support the network and telecommunications environment representing $5.2 million of annual labor costs.

Excipio identified $11.6 million in telecommunications contract spending across the cabinet agencies and OTIS. Of that amount, the state spends $7.2 million on long distance services.

There are 411 small (less than 7 Mbps) data circuits provided through AT&T's Virtual Private Network (AVPN) at a cost of $2.8 million annually ($6,813 per circuit per year).

Many agencies still maintain local private branch exchange (PBX) equipment and phone systems. Of the PBX equipment used by these agencies, 92% of them are past their end of life, and in need of refresh.

Recommendation

A&M recommends consolidating all network services, including Network Operations Center (NOC), Wide Area Network (WAN), Local Area Network (LAN), voice and data services across the state agencies.

Additionally, the state should evaluate alternatives for the expensive AVPN data circuits and the aging PBX phone solutions.

As part of the consolidation planning, the state should consider outsourcing the network and telecommunications support as a way to:

- Further reduce costs
- Accelerate consolidation
- Gain access to skills that are in short supply

Recommendation #2 - (dollars in 000's)				
FY17	FY18	FY19	FY20	FY21
$1,625	$1,625	$1,625	$1,625	$1,625

- Convert much of the fixed cost to variable (consumption-based) costs

A&M recommends bundling the Network Services and Data Center outsourcing evaluations together to gain greater leverage and better pricing.

Savings Potential

The key components of savings associated with this

TEC.02 - Consolidate Network Services

ters at increased risk for outages.

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There are currently 134 FTEs providing Service Desk and End User Computing (EUC) support across OTIS and the cabinet agencies.

More than half of the EUC users are outside of Topeka. They are supported through a mix of Topeka based support staff and a regional dispatch model.

Recommendation

A&M recommends consolidating Service Desk operations (Level 1 support) and EUC support across all of EBIT. EBIT should also develop standardization on a single service desk ticketing system and evaluate opportunities to improve remote user support through a regional depot system with adequate spares. This will lower costs, reduce duplication of effort and can lead to improved service (e.g. coverage hours, answer rate, First Call Resolution).

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$2,400	$2,400	$2,400	$2,400	$2,400

As part of the consolidation planning, the state should consider outsourcing the Service Desk and EUC support as a way to further reduce costs; accelerate consolidation; gain access to skills that are in short supply and enhance support for the large number of remote EUC users.

Savings Potential

The key components of savings associated with this recommendation include:

- **Labor Costs** – There are currently 134.24 FTEs providing Service Desk and EUC support representing $8 million of annual labor costs. Consolidation could generate between 30% and 50% in total savings or $2.4 million to $4 million in annual savings.
- **PC Purchasing** – PC purchasing is not leveraged across agencies and there are no standard configurations defined. EBIT should implement a strategic PC purchasing capability and enforce standard configurations to not only lower the purchase price but lower the lifetime support costs as well. The potential savings associated with this recommendation is included in the Procurement chapter as a Strategic Sourcing event.

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Background

There are 248 FTEs currently performing Application Development and Maintenance (ADM) and database administration activities across EBIT. Approximately 20% of these resources are performing database management while the remaining resources are engaged in application development and maintenance tasks.

Historically, each agency managed its own develop-

MED.03 - Expansion of Federal Grants

Other Considerations for Oversight of MCOs

Based on A&M's review of the MCO contracts and discussions with KDHE personnel, A&M recommends the state consider amending the existing contracts and/or implementing the following oversight measures that will derive additional benefits to the state:

- Program Integrity Recoveries – As outlined in the above table, Kansas recovered $33.5 million in PI collections in FY13. The contracts with the MCOs stipulate that the MCO retains any recoveries, but adjusts the subsequent years' capitation rates based on the amounts collected. Kansas should consider amending its MCO contracts so that it has immediate access to the funds when received. Based on our review of other state MCO agreements, Tennessee has such a provision in its MCO contract.
- State Audits of MCOs – In June 2015, citing states' increased use of MCOs—CMS proposed that states audit their MCOs at least every three years. Based on A&M's discussions with Medicaid personnel, Kansas currently does not audit its MCOs. A&M recommends that Kansas audit the MCOs on a three-year rotating basis resulting in one MCO being audited every year. Such audits will ensure compliance of contract requirements, federal and state statutes, and accuracy and completeness of the encounter and financial data submitted to the state.
- Minimum Medical Loss Ratio (MLR) – Kansas' current contract with the MCOs does not impose a minimum MLR. Instead, Kansas uses an MLR for risk sharing purposes only. While the MLR helps ensure that appropriate measures are enforced for its MCO risk corridors, it does not impact excess profits that an MCO may make. CMS proposed to include a minimum MLR of 85 percent in its proposed rules. Kansas should amend its contracts to impose a minimum MLR. Doing so would ensure that the Kansas MCOs continue to provide appropriate services, and quality performance activities, at a level (85 percent) commensurate with what they are being paid. If an MCO furnishes less than 85 percent of its payments for services to its enrollees, the MCO would pay back to the state and federal governments the difference between what it expended for services and quality activities and the 85 percent level (based on its Medicaid premiums).

Recommendation #3 – The state should pursue additional Medicaid and healthcare Federal grant funding that it could be eligible for

The United States Department of Health and Human Services (DHHS) is the largest grant-making agency in the nation, with most grants being provided to states, territories, and education and community organizations. Both KDHE and KDADS oversee various federal grants that enhance the services that are provided to Kansans. All federal grants are listed with the Catalog of Federal Domestic Assistance (CFDA), which contains financial and nonfinancial assistance programs

CFDA Code	Program Title	# of Benchmark States Receiving Grant	Avg Grant Awarded	Assume 30% Probability of Obtaining
93	Occupational Safety and Health Program	9	$1,511	$453
94	PPHF - Community Transfromation Grants and National Dissemination and Support for Community Transformation Grants	6	$1,357	$407
94	The Affordable Care Act - Medicaid Adult Quality Grants	3	$939	$282
93	Teenage Pregnancy Prevention Program	8	$537	$161

Sources: Catalog of Federal Domestic Assistance, 2013 and 2014 Kansas Single Audits

that are administered by departments and establishments of the federal government.

A&M reviewed the grants and awards provided by the DHHS and determined that Kansas is potentially eligible for certain awards that it currently does not receive funding for. A&M also received confirmation from both KDADS and KDHE personnel that the agencies have not applied for the grants.

A&M's analysis was performed by comparing the CFDA as outlined in Kansas' 2013 and 2014 Single Audits, against the CFDAs of various benchmark states (Arkansas, Iowa, Indiana, Missouri, Nebraska, New Mexico, Nevada, Oklahoma and Utah). A&M then calculated the average size of each grant received by the benchmark states. As there is no assurance that DHHS will approve a grant when submitted and the size of grants vary by state, A&M applied a conservative 30 percent probability factor to determine the potential amount Kansas can receive. Based on our review, Kansas is potentially eligible to receive additional federal grant funds (which do not have any state matching requirement) for the following six programs:

- Occupational and Health Program – The purpose of this grant is to increase worker safety and health as well as to "help develop specialized professional and paraprofessional personnel in the occupational safety and health field with training in occupational medicine, occupational health nursing, industrial hygiene, occupational safety, and other priority training areas." Of the nine benchmark states reviewed, all nine receive this grant with the average size award of $1.5 million.

- PPHF – Community Transformation Grants and National Dissemination and Support for Community Transformation Grants – The purpose of this grant is to "reduce death and disability from the five leading causes of death through the prevention and control of the conditions and their risk factors. Recipients will select from a menu of interventions across the health and wellness spectrum, each of which can prevent or control chronic conditions." Of the nine benchmark states reviewed, six receive this grant with the average size award of $1.36 million.

- The Affordable Care Act – Medicaid Adult Quality Grants – the purpose of this grant is to "support State Medicaid agencies in testing, collecting, and reporting the Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid to CMS. Additionally, the grant funding will also support States' efforts to use this data for improving the quality of care for adults covered by Medicaid." Of the nine benchmark states reviewed, five receive this grant with the average size award of $.94 million. This grant can only be renewed for one year.

- Teenage Pregnancy Prevention Program - the purpose of this grant is to (1) replicate evidence-based teen pregnancy prevention program models that have been shown to be effective through rigorous evaluation and (2) research and demonstration projects to develop and test additional models and innovative strategies to prevent teen pregnancy. Of the nine benchmark states reviewed, five receive this grant with the average size award of $.54 million.

- Birth Defects and Developmental Disabilities – Prevention and Surveillance – the purpose of this grant is to assist in "planning, implementing, coordinating or evaluating programs, research or surveillance activities related to improved birth outcomes, prevention of birth defects, and the improvement of infant and child health and developmental outcomes." Of the nine benchmark states reviewed, six receive this grant with the average size award of $.23 million.

- Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Programs – the purpose of this grant is to "help ensure that evidence-based self-management education programs are embedded into the nation's health and long-term services and supports systems." Of the nine benchmark states reviewed, four receive this grant with the average size award of $.3 million. This grant can only be renewed for two additional years.

The financial benefit for FY17 to FY21 is outlined below:

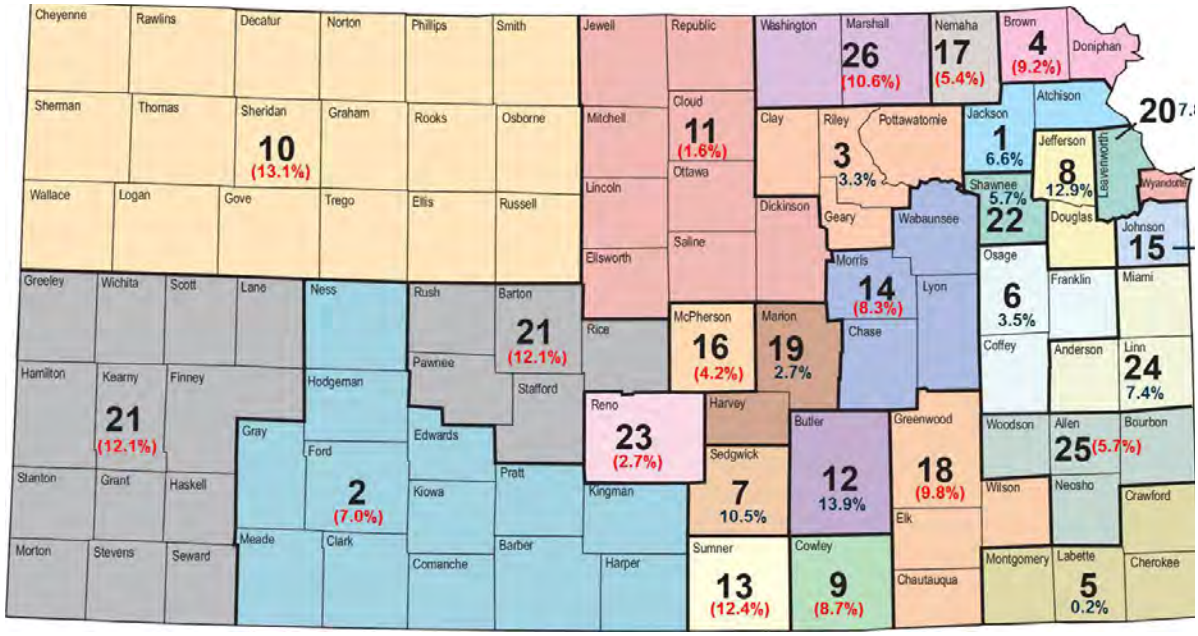
Recommendation #3 - (dollars in 000's)				
FY17	FY18	FY19	FY20	FY21
$1,462	$1,462	$1,181	$1,091	$1,091

MED.04 - Reduction of CDDO facilities

Recommendation #4 – KDADS should move to consolidate operations of certain regions thereby reducing its field footprint and operational costs

KDADS has a network of 27 CDDOs throughout the state that are responsible for i) determining whether an indivdual qualifies for services, ii) working with indivduals or families in choosing service options, and iii) referring the potential beneficiary or family member to other agencies, if necessary. CDDOs serve a critical role by providing a single point of entry, eligibility determination, and referral for potential beneficiaries and their families. Moreover, CDDOs provide a wide aray of developmental disability services including residential, employment, targeted case management, and family supports for indivduals. For FY14, the 27 CDDO regions were projected to receive $360 million in funding with a signficant portion being matched with federal Medicaid funding.

In 2012, the Wichita State University Center for Economic Development and Business Research projected population trends for the state. Based on the study, A&M developed an analysis and visualization that shows the expected population for 2025 and compared the results to current census data for each of the 27 regions. Of the 27 CDDO regions, 15 are projected to have lower populations over the next ten years with the reductions ranging from 1.6 percent to 13.1 percent. The growth rates of the remaining 12 regions range from 0.2 percent to 21.6 percent. A map of the 27 regions and projected population change from 2014 to 2025 is outlined below:



The findings are consistent with national trends that show similar urban population growth trends. Based on A&M's review, we recommend the state consider consolidating the 27 facilities down to 20, thereby reducing annual operating costs by $1.0 million per year. The operating costs are based on cost allocations provided by KDADS personnel. A&M recommends the state consider closing the following seven facilities. which would be the least disruptive to potential beneficaires by minimizing the increase in travel times associated with the consolidation:

Region #	CDDO Facility
4	Brown County Developmental Services, Inc.
9	Cowley County Community Dev. Disability Organization in Cowley County
13	Future Unlimited, Inc
14	Helinger Developmental Services, Inc
23	Training & Evaluation Center of Hutchinson, Inc.
25	Tri-Valley Developmental Services, Inc.
26	Twin Valley Developmental Services, Inc.

Moreover, although three regions with the western most facilities (Southwest Developmental Services, Inc., Arrowhead West, Inc., and Developmental Services of Nothwest Kansas, Inc.) are projected to experience higher population declines, A&M does not recommend consolidating the offices due to the large territories the facilities already serve.

Our analysis relied solely on census data and population trends as operating metrics and key performance indicators are not traacked or produced by KDADS. To more accurately determine which regions to consolidate, A&M recommends that KDADS develop reports and analyses that will track key operational metrics and performance data of the 27 CDDOs. Utilizing performance and activity-based reports will augment A&M's analysis, thereby pinpointing which facilities to potentially consolidate. Examples of operating metrics to measure effectiveness and efficiency include:

- Staffing ratios – computing a ratio of staffing to a particular function such as customer volume or case workloads.
- Response time – the amount of time to respond to a request for service.
- Backlog – Measure the amount of time work is waiting to be processed.
- Quality measurements – error rates, complaints to total services provided, staff turnover and customer satisfaction.

While development and utilization of operating reports will impact the timing of implementation, it will allow the agency to make a more detailed and informed decision.

Oversight of CDDOs

The state does not own the CDDOs. Instead, KDADS contracts with the CDDOs, which are responsible for gatekeeping functions and oversight of service providers. However, KDADS is ultimately responsbile for adminstering the overall development disability system, so it is critical that KDADS have the staff, tools, and controls in place to monitor the CDDOs. Based on a March 2014 Legislative Division of Post Performance Audit, KDADS was cited for failure to provide proper oversight in four distinct areas:

- Not reviewing or approving extraordinary funding requests from the CDDOs
- Inconsistent peer review teams and a process to follow up on deficincies
- Lack of a formal complaint tracking system
- The inability to verify whether an indivduals assessment of receving developmenmtal disability services is accurate

The report further cited that KDADS's oversight of the CDDOs is hindered by a "cumbersome and ambiguous" contracting process whereby KDADS negotaites individual contracts with each of the CDDOs each year. This process stretches KDADS's staff and adds extra oversight and adminstration requirements. The process is made worse by the fact that 50 to 70 representatives from the CDDOs and their respective service providers, participate in contract negotiations thereby making it impossible to reach a consensus on oversight and monitoring controls. A&M recommends that the state consider consolidating all the CDDOs under one master agreement with measurable operating and performance targets which will provide clear, consistent controls across all regions.

Lastly, the CDDOs provide services to approximately 8,700 indivduals a year. The audit report also cites that of the 8,700 indivduals, 1,750 were receiving some, but not all of the services. and an additional 3,250 indivduals were not receiving any servcies. In com-

parison, the state's 11 Aging and Disability Resource Centers provide assessment and eligibility services for 13,000 Kansans for the frail elderly, physical disability and traumatic brain injury waivers. While a direct comparison of the two programs is difficult to measure, the fact that the ADRC's adminster a larger population with less than half the number of facilities, further warrants the development and implementation of operating metrics and key performance indicators as outlined above to measure the efficacy of the CD-

Table 1

Kansas Live Birth Statistics	CY 2013	CY 2014	CY 2015 YTD *
All Kansas Live Births	38,805	39,193	NA
Medicaid Total Live Births	11,938	13,363	7,832
Percent of Medicaid Live Births	31%	34%	NA
All Medicaid Delivery Costs (000's)	$50,670	$59,840	$35,500
Average Medicaid Delivery Costs Per Member	$4,244	$4,478	$4,533
Medicaid Hospital Live Births	11,791	13,154	7,711
Medicaid Hospital Costs (000's)	$50,546	$59,643	$35,371
Average Medicaid Hospital Costs per Member	$4,287	$4,534	$4,587
Percent of Medicaid Hospital Births	99%	98%	98%

Source: Kansas Department of Health & Environment - as of September 2015*

Table 2

Kansas Live Birth Statistics	Total Births (2010):	% of Medicaid Births (2010):
Kansas	40,439	33%
Missouri	76,718	42%
Nebraska	25,916	31%
Iowa	38,514	41%
Arkansas	38,224	67%
Colorado	66,349	37%
Oklahoma	51,798	64%
National	4,018,554	45%

Source: Kaiser Foundation

Table 3

Live Births and Costs by Delivery Type	CY 2013	CY 2014	CY 2015 YTD *
Medicaid C-Section Delivery Counts	3,738	4,029	2,292
Medicaid C-Section Delivery Costs (000's)	$20,098	$22,950	$12,905
Average Medicaid C-Section Costs Per Member	$5,377	$5,696	$5,630
Medicaid Vaginal Delivery Counts	8,200	9,334	5,540
Medicaid Vaginal Delivery Costs (000's)	$30,546	$36,889	$22,595
Average Medicaid Vaginal Delivery Costs	$3,725	$3,952	$4,079
Percent of C-Sections Deliveries	31%	30%	29%
Percent of C-Sections Deliveries	69%	70%	71%

Source: Kansas Department of Health & Environment - As of September 2015*

Table 4

	CY 2014 Kansas - Weeks Gestation				
Method of Delivery	< 36	36-38	39 & over	Not Stated	Grand Total
Vaginal	1,013	7,486	19,009	13	27,521
C-Section, not elective	186	936	2,583	1	3,706
C-Section, elective	893	2,420	4,652	-	7,965
Not Stated	-	-	1	-	1
Grand Total	2,092	10,842	26,245	14	39,193

Note: per definitions given by KDHE epidemiologists, C-sections are considered elective if there if there was no trial of labor residence data

DOs footprint. The combination of census projections and operating performance will provide the state with the necessary tools and data to determine the optimal CDDO structure.

Recommendation #4 - (dollars in 000's)				
FY17	FY18	FY19	FY20	FY21
$1,011	**$1,011**	**$1,011**	**$1,011**	**$1,011**

Recommendation #5 – Implement healthy birth outcome initiatives to improve women and child health care outcomes and manage costs

Background and Findings

Together, maternal and newborn care represent the largest single category of hospital expenditures for Kansas Medicaid, and the hospitalization phase of childbirth accounts for the vast majority of all maternal and newborn care costs. In 2014, Kansans spent more than a half billion dollars in birth related costs including more than $160 million in birth related costs through Kansas Medicaid and state employee healthcare.[1]

In 2014, there were 39,193 births recorded in Kansas for which Medicaid paid approximately 34 percent of the birth costs (See Table 1). In comparison, based on 2010 data, 32.5 percent of the births in Kansas were Medicaid funded compared to a national average of 44.9 percent.[2] (See Table 2)

In Kansas, hospital and facility costs for a vaginal birth is on average $11,180 per birth, and hospital and facility costs for cesarean births is on average $17,391 per birth (preterm birth rates are calculated as the number of preterm births divided by the number of live births with known gestational age multiplied by 100).[3]

In review of live births by delivery type, the Kansas Department of Health and Environment reported the statistics seen in Table 3.

Percentage of Induced Deliveries or C-Sections Before 39 Weeks	
National Average	7%
Kansas	28%
Oklahoma	16%
Missouri	5%
Iowa	7%
Colorado	2%
Arkansas	6%
Mississippi	34%

Our research also found that more than 25 percent of Kansas births fewer than 39 weeks in gestation were elective C-sections. (See Table 4).

Part I: Managing Early Birth Costs and Risks for Pre-Term Births

The National Institute of Health states that "almost one of every ten infants born in the United States are premature, and a premature birth is defined as a baby being born before 37 completed weeks of pregnancy (a full-term pregnancy is 40 weeks)."[4] Infants born preterm are at greater risk than infants born at term for mortality, health, and developmental problems, therefore, a multitude of health complications can arise. Complications can include "behavioral, social-emotional, health and growth problems (examples include: increased Neonatal Intensive Care Unit admissions, and increased ventilator support)."[5] Additionally, the "birth of a preterm infant brings economic costs to families and has implications for public-sector services (i.e. health insurance, education, and other social support systems)."[6] Among the main recommendations that the National Institute of Health offers to reduce and improve preterm birth in the United States, is for the study and informing of public policy.

The US preterm birth rate ranks among the worst in

1 Childbirth Connection. Average Facility Labor and Birth Change by Site and Method of Birth, United States, 2009-2011. Retrieved from: transform.childbirthconnection.org.

2 Kaiser Foundation - http://kff.org/medicaid/state-indicator/births-financed-by-medicaid/

3 Behrman RE, Butler AS. (2007). Preterm Birth: Causes, Consequences, and Prevention. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/20669423

4 National Institute of Health. Retrieved from: https://www.nlm.nih.gov/medlineplus/prematurebabies.html

5 Behrman RE, Butler AS. (2007). Preterm Birth: Causes, Consequences, and Prevention. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/20669423

6 Behrman RE, Butler AS. (2007). Preterm Birth: Causes, Consequences, and Prevention. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/20669423

TEC.05 - Consolidate Project Management, Security, Management and Other

ment resources with little sharing across agencies. There is no formal process in place to track skills/capabilities and no attempt to optimize ADM resources across EBIT.

Recommendation

A&M recommends consolidating ADM and database administration across all of EBIT.

A first step in this consolidation effort should include a review of the personnel roles, responsibilities and competencies of the staff associated with this function.

Recommendation #4 - (dollars in 000's)				
FY17	FY18	FY19	FY20	FY21
$1,900	$1,900	$1,900	$1,900	$1,900

As part of the consolidation planning, the state should consider outsourcing ADM and database support as a way to further reduce costs, accelerate consolidation, and gain access to skills that are in short supply.

Savings Potential

The key components of savings associated with this recommendation include:

- **Labor Costs** – There are currently 248.83 FTEs providing ADM and database support services representing $18.9 million of annual labor costs. Consolidation could generate between 10% and 15% in total savings or $1.9 million to $2.8 million in annual savings.

Recommendation #5 – Consolidate Project Management, Security, Management and "Other" activities

Background

In addition to the FTEs addressed in the four previous recommendations, Excipio identified the following FTEs performing IT activities across EBIT:

Total :	230.55	$19.373 million

Recommendation

A&M recommends consolidating these activities across all of EBIT to the extent possible.

As part of the consolidation planning, the state should consider implementing a complete organization redesign for EBIT that addresses organizational structure, span of control and centralized vs. decentralized activities.

The decisions regarding what activities to retain in-house vs. which activities should be performed by external organizations, will be a key driver in the organizational design. ITIL process implementation and contract management requirements will also be significant contributors to the design effort.

Savings Potential

The key components of savings associated with this recommendation include:

- **Labor Costs** – There are currently 230.55 FTEs providing Project Management, Security, Management and "Other" representing $19.4 million of annual labor costs. Consolidation could generate between 5% and 10% in total savings or $968,000 to $1.9 million in annual savings.

Summary

Executive Branch IT (EBIT) has made good progress laying the foundation for consolidating common IT functions under the leadership of the newly appointed Executive Branch CITO. The establishment of the Core Leadership Team (CLT) and the four Working Groups represent a good start down the path of consolidation.

- Finance/Measures
- People
- Performance/Process/ITIL
- Architecture/Standards

However, there have been repeated attempts to tackle consolidation in the past with very few results gained. Consistent focused leadership and good planning are prerequisites for a successful consolidation effort.

EBIT should look to augment the existing staff with external subject matter experts when and where necessary to move the recommendations forward.

Critical Steps to Implement

The critical steps necessary to complete the implementation of the consolidation recommendations include:

- Begin with the end in mind—develop a "future state" operating model and organizational design for EBIT and ensure that EBIT customers understand the model.
- Using the Excipio report as a starting point, gather additional FTE and IT costs data to support a comprehensive and detailed IT budget for each IT function. Understanding the true total cost of IT by functional area will allow for comparative analysis (benchmarking) and is a prerequisite for the "make vs. buy" analysis that A&M recommends for each consolidation recommendation.
- Prioritize and implement key ITIL processes across EBIT with an initial focus on Service Operation processes (i.e., Incident Management; Problem Management; Event Management; Request Fulfillment and Access Management) as the first wave of ITIL process implementation across EBIT.
- Provide ITIL training to all EBIT staff. A&M recommends that ITIL Foundations certification be a requirement for all EBIT staff, with the initial focus on training the infrastructure and network staff. A&M further recommends that EBIT have two or three ITIL Experts within the organization to act as champions for the implementation of common processes across EBIT.
- Implement qualitative metrics and use them to proactively manage the business of IT across the Executive Branch. The metrics should be published regularly (as least monthly) and should be reviewed with stakeholders. Suggested metrics include:
  - » **Data Center** - server availability; incident resolution; batch schedule completion; utilization (servers and storage)
  - » **Network** - availability (end-to-end; VPN; ISP; Access Link); response times; throughput; security (intrusion detection)
  - » **End User Computing** - MAC (moves, add, changes); release deployment; procurement and installation; workstation break fix (time to respond / time to resolve)
  - » **Service Desk** - % of call answered in 30 seconds; abandon rate; first call problem resolution; user satisfaction
  - » **Applications Development & Maintenance** - milestones on time; estimation accuracy; Severity 1 and 2 Problems in Production; application outages; defect rates
- Develop detailed project plans for each consolidation work stream (ensure a "make vs. buy" analysis for each consolidation work stream is included).
- Develop a detailed business case for each work stream.
- Develop a detailed consolidation roadmap, prioritizing all of the consolidation efforts required to achieve the future state operating model, balancing organizational readiness, risk and reward.
- Ensure that the overall consolidation plan include a change management program and leader.
- Rigorously track progress of each work stream against the business case at regular intervals.
- Celebrate and communicate interim successes.

Recommendation #5 - (dollars in 000's)				
FY17	FY18	FY19	FY20	FY21
$968	$968	$968	$968	$968

KDCF.02 - KDCF Regional Facility Consolidation

on employers who fail to report.[11]

- Many other states, including Nebraska, New Mexico and Arkansas, highlight their authority to impose penalties in their employer communications.[12]

KDCF and KDOL recently announced a partnership to increase new-hire reporting. They implemented web-enabled reporting for new hires and gave employers online access to lists of EWOs. In addition, CSS staff members are reaching out to employers who have not reported, educating them about the process and legal requirements.

Building on this effort, Kansas should:

- Impose a penalty for non-reporting at the maximum level allowed by federal statue, and include the potential penalty in employer communications.
- Require reporting of independent contractors.
- Coordinate with the Kansas Department of Revenue to deny issuances or renewal of car, boat, or recreational vehicle registration until an EWO or payment plan is in place.
- Coordinate with the Kansas Department of Revenue to establish inter-local agreements with neighboring states.

In addition, A&M recommends that Kansas monitor and report on operational metrics for the collections program (e.g., rates of employer compliance with new hire reporting, number of EWOs instituted) and for the new web-based employer tools (e.g., site hits, abandonment rates), and adjust CSS's employer outreach program accordingly.

Recommendation #1 - (dollars in 000's)				
FY17	FY18	FY19	FY20	FY21
$121	**$121**	**$121**	**$121**	**$121**

11 US Department of Health and Human Services. http://www.acf.hhs.gov/programs/css/resource/new-hire-reporting-answers-to-employer-questions. Accessed December 8, 2015

12 State new hire reporting websites. Accessed December 8, 2015

Key Assumptions

- An 8 percent increase in revenue from child support collections over the baseline budget.
- KDCF has already budgeted and planned for efforts to improve performance on the five measures of child support services performance. These recommendations will help focus those efforts and will not require significant additional investment.

Critical Steps to Implement

The critical steps necessary to complete the implementation of the child support collections recommendation include:

- Establish a requirement for employers to report independent contractors as part of their new hire reporting.
- Establish penalties for non-reporting of new hires and communicate these potential penalties to employers
- Develop agreements with the Kansas Department of Revenue and neighboring states on the improvements outlined above
- Establish new operational metrics as outlined above

Imposing penalties for employers who do not report new hires on a timely basis and requiring reporting of independent contractors may require statutory or regulatory changes. However, the remaining recommendations can be implemented in parallel with this change. The expected time to implement the recommendation is six months, exlusive of time needed for regulatory or legal changes.

Recommendation #2 – Close Three Service Centers

A&M recommends that Kansas close three service centers and move the direct service staff to nearby facilities:

- Goodland (Sherman County) – move program staff to Colby
- Greensburg (Kiowa County) – move program staff to Dodge City or Pratt
- Iola (Allen County) – redistribute program staff to

Fort Scott, Independence, or Chanute

The lease for the Greensburg office ends in February 2016, and the Goodland and Iola leases end in July 2016. After the leases end, they can be shifted to a month to month basis.

Additional closures may be possible in 2018 based on:

- Additional Business Process Management and technology improvements, resulting in greater efficiency and therefore reduced regional staffing needs.
- Changes in office traffic patterns and staffing needs following the transfer of Medicaid eligibility to KDHE.
- Trends in citizen's choices on how to contact KDCF (shift from office visits to internet based service).

A&M recommends that KDCF establish metrics that enable an annual review of the footprint. KDCF should specifically monitor demand and capacity utilization at the office level, breaking out back office versus front office work (e.g., foot traffic in the office, local work in the community such as court visits).

Background and Findings

KDCF has service centers in the field, serving multiple purposes:

- Citizens can visit to apply for, and ask questions about, KDCF's services.
- In addition to working with visiting citizens, staff members in the service centers perform a range of back office duties, such as processing applications for benefits.
- Many field staff travel regularly to execute their duties. For example, social workers make home visits and travel to court appointments throughout the region.

As Kansas' population and needs change, so do the needs for individual offices in the field.

- Kansas' population and KDCF's client base are both shifting.
- A rising percentage of applications and inquiries that once came in person, at a service center, are now being handled online.
- With the implementation of Business Process Management and technology improvements, many back office duties can be performed in any office, not just in the office where the beneficiary applied.
- As population served declines in many areas of the state, many service centers have (and need) fewer FTE than they were originally designed to hold.

As a result, Kansas has the opportunity to revisit the need for individual offices.

- Current operating metrics do not track demand and capacity utilization at the office level. Therefore, our recommendation used FTE by office and persons served (i.e., KDCF program beneficiaries) by county as proxies for current demand for a local service center.
- Square footage per FTE was used as a proxy for service center capacity utilization and as an indicator of decreasing demand. Empty offices indicate that the office no longer needs as many staff members as they once needed when leases were signed.

Every office with more than 500 square feet of space per FTE was reviewed—fourteen offices fell into this category:

- Six of these offices hold 15 or fewer FTE—of those:
  - » Three are proposed for closure. Program staff positions can be relocated to another office in the next county. All three offices are in counties projected to experience population declines over the next five years.
    - – Goodland was built for 15 staff members, but currently only has three staff members. Program staff can be relocated to Colby.
    - – The Greensburg office was rebuilt after a devastating tornado but the town did not rebuild. The office only has one staff person—a social worker who travels frequently in her role. This position can be relocated to Dodge City or Pratt.
    - – Iola is located within 20 miles of the larger Chanute office, and 40 miles from Fort

Scott. Program staff can be redistributed to one of these two offices, or to Independence.

  - » Three offices are proposed to remain open to minimize impact on clients:
    - – Colby and Pratt will absorb FTE and/or clients from the proposed closures above. Once the implications on staff and clients of the closures are clear, these two offices should be reviewed to determine whether additional action, such as reduction of space or additional subleasing is appropriate.
    - – For Concordia, there are no field offices in bordering counties to absorb clients and staff, so closure is not recommended.

- The remaining eight offices hold more than 15 FTE. Given their size, closure may put undue burden on clients.
  - » Fort Scott will take in FTE relocated from Iola.
  - » Conditions in Atchison, El Dorado, Lawrence, Leavenworth, Newton, Ottawa and Phillipsburg should be reviewed to determine whether the square footage can be reduced or additional space can be sublet.

Recommendation #2 - (dollars in 000's)				
FY17	FY18	FY19	FY20	FY21
$735	**$692**	**$659**	**$620**	**$590**

Key Assumptions

- All direct service positions will be transferred to nearby offices, thus consolidating the footprint but not reducing service capacity.
- Administrative and temporary staff positions in the closed offices will be eliminated, with non-temporary incumbents offered comparable vacancies in other offices if available.
- SGF currently funds 60.5% of the facilities costs in the offices planned for closure. The table above represents only the SGF savings, and does not include savings of Federal funds.

Critical Steps to Implement

- Create a staff transfer plan and work with staff on relocation
- Develop and execute an outreach plan for clients and communities near closed offices
- Terminate leases

The expected time to implement the recommendation is six months. This will allow for time to work with staff, clients and communities on the transition. The recommendation is not expected to require statutory or regulatory changes, as the Secretary has the authority to determine the number and locations of field offices.

Recommendation #3 – Improve the targeting of CIF funding and diversify the funding mix

The Children's Initiative Fund (CIF) is overseen by the Kansas Children's Cabinet and Trust Fund. The CIF supports children's health, child care, and early childhood education programs. Such programs, if well designed, can result in significant long term savings for the State. For example, a study of The Opportunity Project (TOP) in Sedgwick County, which provides early education to children living in poverty, showed a savings of $4.5 million just from avoiding K-12 special education placement for students enrolled in the program for two years – an 11 percent annual return on investment.[13]

Every CIF-funded program is evaluated annually based, in part, on the extent to which it is supported by empirical evidence. As such, CIF-funded programs are held to a higher standard of evaluation than many State programs. These evaluations can be used to focus further improvements to the returns on the CIF investments.

A&M recommends that CIF-funded programs which consistently received low Evidence Based Practice (EBP) scores be reviewed, and the agencies executing each program either:

- Establish a plan to improve EBP performance, or
- Redesign or replace the program with new programs that have a stronger evidence basis.

13 "Little Footprints Have a Big Impact," Kansas Children's Cabinet Report, December 3, 2015.

MED.06 - Centralize all Medicaid Support Functions within KDHE

Recommendation #6 – Have all Medicaid support services under one unit to improve operating efficiency and potentially reduce adminstrative costs

Since the beginning of 2013, Medicaid has primarily been administered through KanCare to over 400,000 Kansans. Both KDHE and KDADS oversee KanCare with KDHE providing financial management and contract oversight and KDADS administering the Medicaid waiver programs for disability services, mental health and substance abuse. In addition, KDADS operates the Larned State Hospital and Osawatomie State Hospital and Parsons State Hospital and Training Center and Kansas Neurological Institute for individuals with intellectual and learning disabilities.

The shift from a fee-for-service model to a managed care structure has provided new opportunities and challenges. Kansas, similar to other states that have transitioned to a managed care structure, is faced with retooling and redefining itself, just as private corporations do when entering new markets. This paradigm shift has resulted in Kansas being a purchaser of health care through the MCOs with an emphasis on enrolling and educating beneficiaries, overseeing health plans, and contract management. The shift also involves moving from a provider-centric environment to one that is beneficiary-centric and requires a staff with contract management and strong analytical skills. For KDHE and KDADS, the shift to a delivery model that's more than 95 percent provided by the MCOs, offers an opportunity to consider combining all Medicaid support services and administration under one umbrella, while combining Medicaid related functions under a single budget structure.

A&M recommends combining the strengths and resources of both agencies to improve operational effectiveness and efficiency, eliminate redundancy and promote cross-agency communication and cooperation. The existing dual structure is fragmented and the ever-increasing—regulations, program changes, reporting and compliance requirements—warrant centralizing all Medicaid support services under one agency. Moreover, as the Federal government continues its efforts of supporting and encouraging the use of data analytics, quality measurement, performance improvement, payment modeling and financial simulations, a greater emphasis is required to hire and train employees with the requisite skills.

A&M recommends transferring all support functions to Health Care Finance within KDHE. Having the core support services such as finance, budgeting, data analytics, legal, HR and IT under one umbrella will improve operating efficiency. This will eliminate certain overlapping tasks (ex. budget and rate setting) while strengthening areas that share common skill requirements (ex. Data, analytics, and legal).

To properly determine the optimal organizational structure would require an in-depth review of process flows, employee workloads, job descriptions, skill sets, and interviews with staff. In August 2015, KDHE contracted with Navigant Consulting to perform a more detailed review, in order to identify the organizational structure and resource requirements in a managed care environment. A&M views KDHE's effort to perform a detailed review as an important step in determining the optimal organizational structure in the new MCO environment.

In connection with centralizing support services, A&M also recommends the state invest in a training program that will allow for employees to meet the skill requirements associated with a managed care environment. As transition to a managed care structure is primarily driven by cost-containment and budgetary pressures, allocating resources to a well-trained staff is not a priority. The typical outcome is that management staff has extensive Medicaid experience, but relatively little training in the skills necessary to oversee managed care, namely; managing contracts or analyzing MCO performance. Absent an investment in MCO training, Kansas will have to import managed care specialists with the contract oversight and analytic qualifications to effectively manage the MCOs. Investing in a robust training program will ensure that the combined Medicaid agency is adequately staffed to meet the necessary contract and analytical demands.

MED.05 - Implement Healthy Birth Outcome Initiatives

DOs footprint. The combination of census projections and operating performance will provide the state with the necessary tools and data to determine the optimal CDDO structure.

Recommendation #4 - (dollars in 000's)				
FY17	FY18	FY19	FY20	FY21
$1,011	**$1,011**	**$1,011**	**$1,011**	**$1,011**

Recommendation #5 – Implement healthy birth outcome initiatives to improve women and child health care outcomes and manage costs

Background and Findings

Together, maternal and newborn care represent the largest single category of hospital expenditures for Kansas Medicaid, and the hospitalization phase of childbirth accounts for the vast majority of all maternal and newborn care costs. In 2014, Kansans spent more than a half billion dollars in birth related costs including more than $160 million in birth related costs through Kansas Medicaid and state employee healthcare.[1]

In 2014, there were 39,193 births recorded in Kansas for which Medicaid paid approximately 34 percent of the birth costs (See Table 1). In comparison, based on 2010 data, 32.5 percent of the births in Kansas were Medicaid funded compared to a national average of 44.9 percent.[2] (See Table 2)

In Kansas, hospital and facility costs for a vaginal birth is on average $11,180 per birth, and hospital and facility costs for cesarean births is on average $17,391 per birth (preterm birth rates are calculated as the number of preterm births divided by the number of live births with known gestational age multiplied by 100).[3]

In review of live births by delivery type, the Kansas Department of Health and Environment reported the statistics seen in Table 3.

Percentage of Induced Deliveries or C-Sections Before 39 Weeks	
National Average	7%
Kansas	28%
Oklahoma	16%
Missouri	5%
Iowa	7%
Colorado	2%
Arkansas	6%
Mississippi	34%

Our research also found that more than 25 percent of Kansas births fewer than 39 weeks in gestation were elective C-sections. (See Table 4).

Part I: Managing Early Birth Costs and Risks for Pre-Term Births

The National Institute of Health states that "almost one of every ten infants born in the United States are premature, and a premature birth is defined as a baby being born before 37 completed weeks of pregnancy (a full-term pregnancy is 40 weeks)."[4] Infants born preterm are at greater risk than infants born at term for mortality, health, and developmental problems, therefore, a multitude of health complications can arise. Complications can include "behavioral, social-emotional, health and growth problems (examples include: increased Neonatal Intensive Care Unit admissions, and increased ventilator support)."[5] Additionally, the "birth of a preterm infant brings economic costs to families and has implications for public-sector services (i.e. health insurance, education, and other social support systems)."[6] Among the main recommendations that the National Institute of Health offers to reduce and improve preterm birth in the United States, is for the study and informing of public policy.

The US preterm birth rate ranks among the worst in

1 Childbirth Connection. Average Facility Labor and Birth Change by Site and Method of Birth, United States, 2009-2011. Retrieved from: transform.childbirthconnection.org.

2 Kaiser Foundation - http://kff.org/medicaid/state-indicator/births-financed-by-medicaid/

3 Behrman RE, Butler AS. (2007). Preterm Birth: Causes, Consequences, and Prevention. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/20669423

4 National Institute of Health. Retrieved from: https://www.nlm.nih.gov/medlineplus/prematurebabies.html

5 Behrman RE, Butler AS. (2007). Preterm Birth: Causes, Consequences, and Prevention. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/20669423

6 Behrman RE, Butler AS. (2007). Preterm Birth: Causes, Consequences, and Prevention. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/20669423

high-resource countries, ranking a "C" on the report card assigned and distributed by the March of Dimes, with a birth rate of 9.6 percent in 2014, according to the National Center of Health Statistics ("C" rating is preterm birth rate of 9.3 percent to 10.3 percent). The state of Kansas earned a "B" in 2015.

According to the Institute of Medicine, the annual social economic burden and cost of premature births nationally is $26.2 billion a year. The breakdown is as follows:

- $16.9 billion in medical costs for the baby
  - » $611 million for early intervention services, birth to age three
  - » $1.1 billion for special education services, ages three to twenty one
  - » $5.7 billion in lost work and pay for people born prematurely
- NICU admissions—average payments for babies in NICU exceed average payments for all newborns and both types of birth (vaginal and cesarean)[7]
- Increased average payment levels for NICU care: Medicaid paid $13,875 for newborns with vaginal births and NICU care and $19,971 for newborns with cesarean births and NICU care [8]

According to the Medicare Economic Index (MEI), "In 2015 commercial insurers are incurring costs of $18,961 for vaginal births and $28,826 for cesarean births, while Medicaid programs are paying $9,446 and $14,058 respectively."[9] To offer perspective—if there were "472,000 fewer cesareans, Medicaid and Commercial insurers would have saved nearly $3.5 billion in 2013."[10]

A March 2014 study by the Commonwealth Fund and Whynotthebest.org—an organization providing a full spectrum of healthcare assessment and improvement services—reported that early scheduled deliveries could cause serious complications for newborn babies. As shown below (study indicated 2013 data reported), Kansas was one of the highest states with early term deliveries for both private pay and state Medicaid funded births.[11]

Many states across the US have implemented Healthy Birth Outcome initiatives and formed partnerships between the state hospital associations, the March of Dimes, managed care providers, insurance companies and stakeholders, in order to improve the health outcomes for newborns not only in the Medicaid program but throughout the state's population. One of the early implementers of state Medicaid Early Birth Initiatives has been the State of South Carolina.

South Carolina Department of Health and Human Services (SCDHHS)

In July 2011, South Carolina Department of Health and Human Services (SCDHHS) launched its partnership program called South Carolina Birth Outcomes Initiative (SCBOI). The program had three interconnected goals to work together in order to improve birth outcomes throughout the state, including:

- Reducing the number of low birth weight babies
- Reducing NICU admissions
- Reducing racial disparities in birth outcomes

The members of the SCBOI worked to achieve the three core objectives through various initiatives while serving on a series of workgroups. Examples of initiatives include:

- Eliminating elective inductions for non-medically indicated deliveries prior to 39 weeks gestation.
- Reducing the number of admissions and the average length of stay in neonatal intensive care units.
- Reducing health disparities.
- Making 17 Alpha-hydroxyprogesterone caproate (17P)—a compound that helps prevent pre-term births—available to all at-risk pregnant women with a no "hassle factor."
- Implementing a universal screening and referral tools like, Screening, Brief Intervention, and Re-

7 Perelman, Nicole. Using Education, Collaboration, and Payment Reform to Reduce Early Elective Deliveries: A Case Study of South Carolina's Birth Outcomes Initiative. Retrieved from: www.milbank.org/uploads/documents/reports/South_Carolina_Birth_Outcomes_Case_Study.pdf.

8 Childbirth Connection. Average Facility Labor and Birth Change by Site and Method of Birth, United States, 2009-2011. Retrieved from: transform.childbirthconnection.org.

9 7. American College of Nurse-Midwives (2015, November). The Midwifery Model of Care-A Value Proposition [PowerPoint slides].

10 7. American College of Nurse-Midwives (2015, November). The Midwifery Model of Care-A Value Proposition [PowerPoint slides].

11 WhyNotTheBest.org, March 2014

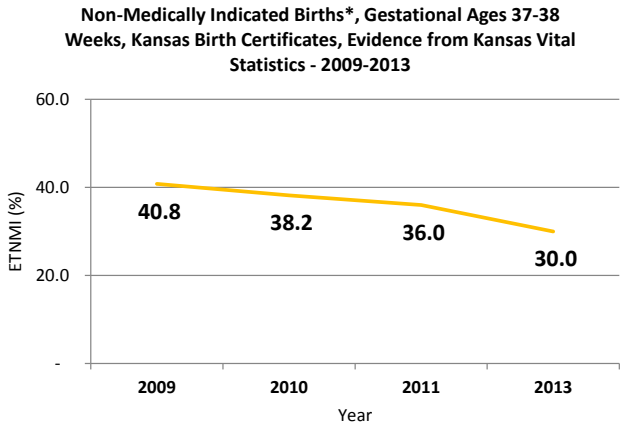
ferral to Treatment (SBIRT)—an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. The SBIRT model was incited by an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use.[12] In SC, the physician's office screens pregnant women and 12 months post-delivery for tobacco use, substance abuse, alcohol, depression, and domestic violence.

- Promoting Baby Friendly Certified Hospitals and Breast Feeding.

- The concept of this initiative is to reduce the number of elective early births. Babies born before 39 weeks of pregnancy have much higher rates of low birth weight and infant mortality. SCHHS—which administers Medicaid in the state—asked South Carolina's hospitals to reduce early induction births except for medical reasons. All of the state's hospitals complied and signed agreements to do so in 2011. HHS and BlueCross—which together pay for nearly 85 percent of births in the state—also stopped paying for voluntary early births.[13]

The Catalyst Payment Reform Study entitled "Using Education, Collaboration, and Payment Reform to Reduce Early Elective Deliveries: A Case Study of South Carolina's Birth Outcomes Initiative" reported in 2013 that the number of unwarranted early inductions in the state had been cut by 50 percent and the number of babies in neonatal intensive care units had dropped. Babies born before 39 weeks of pregnancy generally have lower birth weights and higher rates of infant mortality.[14]

Prior to the SCBOI program start, the state had the fourth highest percentage of babies born prematurely



in the nation. Data gathered over several years show that approximately one in every ten babies born in South Carolina will be admitted to a NICU. South Carolina's rate of early elective delivery was 9.62 percent or more than annual 6,000 births. Researchers estimate that eliminating the practice of early elective deliveries in South Carolina will generate more than $1 million a year in delivery costs and an additional $7 million in reduced hospitalizations for babies. In the first quarter of 2013, the SCDHHS reported saving over $6 million through the initiative. This savings was attributed to decreased NICU admissions and Average Length of Stay (ALOS) in the NICU among babies born at 37 and 38 weeks to mothers with Medicaid coverage.[15]

Other states have voluntary programs, and some other state health agencies have stopped paying for non-emergency early deliveries but South Carolina is the first Medicaid agency and its major insurer and hospitals have collaborated on this type of program. Governor Haley indicated that the "Birth Outcomes Initiative is a wonderful example of leaders in the health community working together as a team in South Carolina's fight against premature birth."[16]

SCDHHS has been able to significantly reduce these non-medically necessary inductions over a two-year period. With the mindset that infant mortality and low birth weight babies are two of the state's most pressing health problems, SCDHHS, SC Hospital Association and the South Carolina Chapter of the March of Dimes joined with other community partners to create the

12 http://www.integration.samhsa.gov/clinical-practice/SBIRT (Note - Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

13 2013 Catalyst Payment Reform Study "Using Education, Collaboration, and Payment Reform to Reduce Early Elective Deliveries: A Case Study of South Carolina's Birth Outcomes Initiative

14 2013 Catalyst Payment Reform Study "Using Education, Collaboration, and Payment Reform to Reduce Early Elective Deliveries: A Case Study of South Carolina's Birth Outcomes Initiative

15 2013 Catalyst Payment Reform Study "Using Education, Collaboration, and Payment Reform to Reduce Early Elective Deliveries: A Case Study of South Carolina's Birth Outcomes Initiative

16 http://www.thestate.com/news/business/health-care/article13828319.html

now nationally recognized SCBOI.

In August 2011, SCBOI successfully secured a BOI-sponsored commitment from all 43 birthing hospitals in the state to end non-medically necessary inductions by 39 weeks with a specific focus on preventing early term births, delivered at 37 and 38 weeks. In 2013, SCDHHS and BlueCross BlueShield of South Carolina (BCBSSC) strengthened the effort by stopping reimbursement to hospitals and physicians for elective inductions or non-medically indicated deliveries prior to 39 weeks gestational age.

In 2013, SCDHHS implemented Centering Pregnancy, a group model of prenatal care shown to decrease pre-term birth, and "Race to the Date," a program providing financial incentive payments to hospitals who achieved the certification of "Baby Friendly" by September 2013.

As a second phase of the early elective delivery initiative, SCDHHS is also working with SCBOI stakeholders to reduce the number of C-sections performed on first-time, low risk moms in South Carolina through a signed commitment from all birthing hospitals in the state, simulation education training, webinars and provider education materials.[17] The March of Dimes reports that progress in the US preterm birth rate comes through the implementation of programs and policies by state and local health departments, hospitals, and health care providers.

As shown in the below graph, the State of Kansas has made progress over the past seven years to address the importance of full term births for the mother and newborn health and addressing early non-medically induced births.[18]

Kansas Healthy Birth Outcome Initiatives[19]

KDHE Bureau of Family Health is responsible for administering the federally funded Title V Maternal and Child Health (MCH) Services Block Grant for the State of Kansas [Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA), U.S. Department of Human and Health Services (HHS)]. The Title V MCH Block Grant plays a key role in the provision of maternal and child health services in Kansas. The State has implemented a number of family health initiatives and activities underway for a comprehensive approach, focusing on the life course, crosscutting efforts (through collaboration), and service/systems integration. Some of the initiatives include:

- Baby Friendly Hospitals
  - » KDHE reported that in July 2015, Wesley Medical Center in Wichita achieved Baby Friendly hospital status (6,300 or 14.7 percent of Kansas births are now served by a Baby Friendly hospital). The Kansas Breastfeeding Coalition, Inc. (KBC) Continuity of Care Project assisted Wesley in developing a resource list for breastfeeding follow up assistance to distribute to mothers. The Continuity of Care model is being used by other communities to develop resources for follow up care. A total of five Kansas hospitals are now involved in the CDC EmPower project and are working on becoming Baby Friendly by 2017.
- High 5 for Mom & Baby
  - » KDHE has implemented a program called "High 5 for Mom & Baby." Under this initiative, hospital policies and procedures are pivotal to mothers successfully initiating breastfeeding and continuing to breastfeed after leaving the facility. The High 5 steps are based on the most crucial of the 10 steps to successful breastfeeding specified for the Baby Friendly Hospital program. Since initiation of High 5 in 2012, twenty hospitals have completed the required education and the policies necessary to implement the five High 5 steps.
  - » KDHE indicated that there were 69 eligible hospitals/birthing facilities, excluding Wesley Medical Center—which is already designated as Baby Friendly—and 83 percent of those are enrolled or recognized in the High 5 program. Based on 2013 statistics, High 5 impacts 96 percent of Kansas births (excluding Wesley's 6,300 births).
- Communities Supporting Breastfeeding
  - » KDHE in partnership with Kansas Breastfeeding Coalition (KBC), called the Communities Supporting Breastfeeding (CSB) project, is collectively improving breastfeeding rates for infants at three and six months of age in Kansas. The objective of this project is to assist communities with achieving the CSB designation by the Kansas Breastfeed-

17 www.scdhhs.gov/boi.

18 Kansas HealthCare Collaborative - American Hospital Association 2015 Quality and Effectiveness Roadmap 2015 Quality and Equity Roadmap

19 December 31, 2015 Briefing Report from KDHE Division of Public Health-Bureau of Family Health

ing Coalition (KBC) as defined by six criteria needed to provide multifaceted breastfeeding support across several sectors. With support from KDHE and KBC, six communities reached the CSB designation in 2015: Liberal, Winfield, Salina, Lawrence, Great Bend and Hays. An additional five communities are receiving support to achieve the CSB designation in 2016: Wichita, Abilene, Emporia, Garden City and Gove County.

- Early Elective Delivery Programs
  - » KDHE has indicated that they have worked collectively with the March of Dimes in Kansas to address the reduction of early elective delivery. In 2008, the March of Dimes introduced the 39-week toolkit and the issues related to early elective deliveries as part of the fall Prematurity Conference. More than 250 health care professionals received toolkits and participated in this professional development opportunity. Over the next two years, hospitals in the bi-state Kansas City area examined their policies and procedures related to inductions and elective deliveries and implemented a variety of internal programs to reduce the occurrence with varying results.
  - » In 2011, the March of Dimes awarded a grant to the seven hospitals in the Saint Luke's Health System to pilot the 39-week toolkit system in collaboration with their obstetric providers and develop an evaluation system for continuous quality improvement. This pilot was expanded to include the Health Corporation of America (HCA) and Shawnee Mission Medical Center systems in 2012 with the goal of sharing best practices and data. Collectively, these three hospital systems delivered the majority of babies in Kansas City and represented the greatest opportunity to reduce the preterm birth and infant mortality rates associated with early elective deliveries.
  - » March of Dimes is currently partnering with the Kansas Hospital Association and the Kansas Health Collaborative (KHC) to support their work launching a statewide EED reduction initiative as part of the Health Engagement Network (HEN) funded through a three-year grant from the Center for Medicare and Medicaid Services.
- Early Elective Delivery QI Collaborative (Kansas Healthcare Collaborative)
  - » KDHE indicated that in July 2012, the Kansas Healthcare Collaborative (KHC) initiated a quality improvement collaborative in 49 birthing hospitals (later expanded to 52 birthing hospitals) with the goal of reducing early elective delivery (EED) to less than 3 percent. Collaborative work included measurement of clinical process interventions designed to reduce EED (standardized scheduling tools, documentation of indication for EED and record review of scheduled C-sections), and promotion of "hard stop" policies in hospitals (a policy intervention endorsed by the American Congress of Obstetricians and Gynecologists, to administratively prevent early elective deliveries from being scheduled).
  - » After 18 months, the collaborative demonstrated widespread adoption of scheduling and clinical review processes to reduce early elective delivery. One hundred percent of participating hospitals reported through an online survey administered by KHC that they had a "hard stop" policy in place—most were adopted since the start of the project in 2012. Along with these clinical process and policy changes, participating hospitals reported a 73 percent reduction in EED rates from the baseline.
- Infant Mortality Collaborative Improvement & Innovation Network (CoIIN)
  - » KDHE, along with several partners and organizations including the March of Dimes (MOD), the Kansas Infant Death and SIDS Network, and American Academy of Pediatrics, is actively engaged in the Infant Mortality Collaborative Improvement & Innovation Network (CoIIN) initiative, launched by the U.S. Department of Health & Human Services in 2012 and expanded in 2014 to include Kansas and other Region VII states. The National Institute for Children's Health Quality (NICHQ) is hosting the national project and facilitating cross-state and region collaborative work involving learning networks/sessions for six identified CoIIN strategies.

Each participating state selected strategies to focus on as part of the national platform. Kansas' selections include:

- Reducing pre and early term birth rates through improved risk identification, increased and appropriate utilization of progesterone, and eliminating EED.

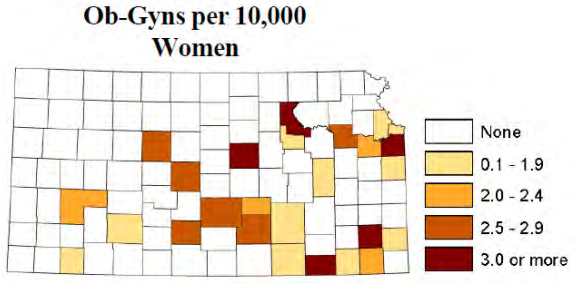
- Reducing smoking rates before, during, and after pregnancy. KDHE is approaching the CoIIN work through a collaborative model bringing together providers, payers, and public health professionals. Evidence-based interventions, practice change, data analysis, and quality improvement are key components.
- Becoming a Mom/Comenzando bien® Program
  - » In 2010, following the release of the Kansas Blue Ribbon Panel on Infant Mortality recommendations, the March of Dimes Kansas Chapter began the development of a community collaborative bringing prenatal education and clinical prenatal care together to create the comprehensive Becoming a Mom (BAM) program.
  - » The program is components of the March of Dimes Healthy Babies are Worth the Wait model, which focuses on the 39 weeks initiative and eliminating EED. The Kansas BAM program is targeted to communities with demonstrated birth outcome and infant mortality disparities, both racial/ethnic and socioeconomic.
  - » KDHE indicated that this model is driven by private and public partnerships across the state and local levels including: Title V MCH (public health), Medicaid, private foundations, local health departments, federally qualified health centers, clinical providers, local hospitals, and community-based organizations. The community collaborative model brings:
    - Permanent Maternal and Child Health infrastructure
    - Leveraged and shared resources
    - Change in the prenatal care delivery system
    - A vehicle to identify community needs
    - A standardized evaluation system
    - New funding opportunities for achieving community collective impact and improved birth outcomes

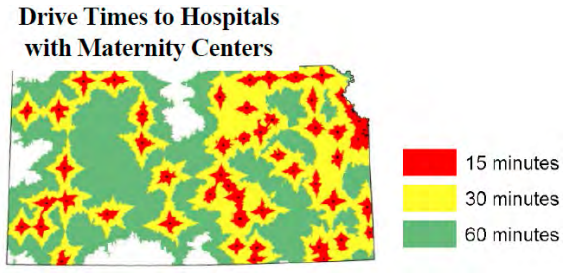
The work of KDHE and its health partners has been successful in addressing the needs of woman and children Healthily Birth outcomes. A&M recommends that the State move forward with its planned efforts to reduce Pre and Early Term Birth Plan including its Early Elective Deliveries across the State. The strategies are currently being piloted in a private Wichita OBGYN clinic. Officials indicated that expansion is planned for early 2016.

Part II: Enhance options for delivery venues of low risk births

A&M found that the state has a shortage of current practicing obstetrical physicians for women's health care services. The American Congress of Obstetricians and Gynecologists (ACOG) reported that in 2014, 77 of the 105 Kansas counties lacked an OB-GYN provider.[20]

Comparison of Kansas OB-GYN Providers and Hospital Maturity Centers





Kansas has portions of the state that currently do not have available obstetric services or significant drive times to hospitals with maturity centers. (See Table 1)

One solution to address the shortage of physicians is to expand the use of certified nurse midwives to address the shortages of available trained birth professionals and alternatives to managing the cost of in-hospital births.

Our research found that in Kansas only one percent of

20 American Congress of Obstetricians and Gynecologists, 2014 ACOF Workforce Fact Sheet: Kansas.

Table 1

Analysis Available OB-GYN Physicians and Medicaid Costs:	US Average	*Kansas*	Iowa	Nebraska	Colorado	Missouri	Oklahoma	Arkansas
Number of OB-GYN Physicians		***273***	239	190	645	596	286	244
Woman Population		***1,149,898***	1,251,057	739,146	2,045,728	2,480,157	1,530,437	1,205,102
Physicians per 10,000 women	3	***2***	2	3	3	2	2	2
Physicians per 10,000 women added 15 to 45	5	***5***	4	5	4	5	4	4
% of Counties that do not have OB-GYNS		***73%***	67%	90%	50%	57%	62%	61%
% of Female Population to Increase by 2030	18%	***4%***	2%	3%	19%	9%	8%	13%
Number of Residency Programs		***2***	1	2	2	5	2	1
Number of Graduating OB-GYN physicians per year		***9***	5	8	15	34	11	4
Percent of Births Financed through Medicaid	45%	***33%***	40%	31%	37%	42%	64%	67%

Source: The Amercian Congress of Obstetricians and Gunccologists 2014 Workforce Fact Sheets

Table 2

Kansas Medicaid Birthing Centers to Hospital Births	CY 2013	CY 2014	CY 2015 YTD *
Medicaid Total Live Births	11,938	13,363	7,832
Percent of Medicaid Live Births	31%	34%	NA
Average Medicaid Delivery Costs Per Member	4,244	4,478	4,533
Medicaid Hospital Live Births	11,791	13,154	7,711
Medicaid Hospital Costs	$50,545,596	$59,642,794	$35,371,010
Average Medicaid Hospital Costs per Member	$4,287	$4,534	$4,587
Percent of Medicaid Hospital Births	99%	98%	98%
Medicaid Birthing Center Births	147	209	121
Medicaid Birthing Center Costs	$124,755	$196,507	$128,681
Average Medicaid Birthing Center Costs Per Member	$849	$940	$1,063

*As of September 2015

the births took place in non-hospital settings in2012. Of that amount, 65 percent occurred in home settings and 28 percent occurred in licensed birth centers. The cost for a low-risk birth at a birthing center ranges between $5,000 and $8,000 (including birth education and risk screening) versus the average vaginal birth cost of $11,180 per birth.

Our research found that slightly less than 2 percent of Kansas births in 2012 were performed in non-hospital settings, primarily for low risk births.

KDHE further reported that Medicaid costs for a hospital birth totals $4,587 during the first nine months in 2015 compared to birthing center Medicaid birth costs of $1,063. (See Table 2)

The U.S. Department of Health and Human Services Centers for Disease Control and Prevention National Center for Health Statistics reported the following birth in out-of-hospital settings in 2012:[21]

21 CDC - http://www.cdc.gov/nchs/data/databriefs/db144_table.pdf

Live Births by Place of Birth, Kansas Residents, 2012-2014				
Place of Birth	2012	2013	2014	Grand Total
Hospital	39,562	37,936	38,396	115,894
Free-standing Birthing Center	309	466	356	1,131
Home Birth	421	393	431	1,245
Other	12	10	10	32
Grand Total	40,304	38,805	39,193	118,302

Source: Kansas Department of Health and Environment, Bureau of

Kansas	2%	Arkansas	1%
Missouri	2%	Colorado	2%
Nebraska	1%	Oklahoma	1%
Iowa	1%	National Average	1%

Note: Out-of-hospital births include those occurring in a home, birthing center, clinic or doctor's office, or other location.

The U.S. Centers for Disease Control and Prevention (CDC) reported that in 2013 there were 3,932,181 births in the US of which 3,553,581 were Physician Assisted and 320,983 were Certified Nurse Midwife Assisted (8.8 percent). If you exclude the 1,284,339 births that were performed through a C-Section, the percent of Midwife vaginal assisted births increased to 12.1 percent due to Midwifes performing only vaginal deliveries. [22]

The American College of Nurse Midwives reported that in 2013, majority of CNM/CM-attended births occurred in hospitals (94.6 percent), while 2.8 percent occurred in freestanding birth centers, and 2.6 percent occurred in homes.[23]

KDHE reported in the Annual Summary of Vital Statistics, there were 38,805 live births to residents of Kansas. Vaginal delivery was the most common final route of delivery for most Kansas resident live births in 2013 (27,064 live births, or 69.8 percent of all live births for which the final route of delivery was known). "Most vaginal deliveries were 'spontaneous,' meaning no mechanical procedures like forceps or vacuum extraction were required (25,804 deliveries, or 66.5% of live births for which the final route was stated). Other vaginal deliveries (forceps assisted or vacuum extraction) accounted for 1,260 live births (3.2 percent). Cesarean deliveries accounted for 11,735 live births (30.2 percent)." [24]

The 2012 Kansas Journal of Medicine reported that in 2012 there were 63 licensed CNMs in Kansas. These CNMs practice in a variety of settings including hospitals, freestanding birth centers, homes, and military bases. CNM's are able to prescribe medications, having obtained prescription writing privileges. It was reported that in 2009, CNMs attended 1,902 births, approximately 4.5 percent of all births in Kansas.[25]

In comparison, our research found that Georgia, midwives deliver about 18 percent of all vaginal births and New Mexico has the county's highest rate, at 24 percent or all births. [26]

Approximately 11 percent of all spontaneous vaginal births and 7 percent of all births are attended by certified nurse-midwives, according to the National Center for Health Statistics, 2007. Approximately 97 percent of CNM-attended births occur in hospitals, 2 percent in freestanding birth centers and 1 percent at home (ACNM, 2008).[27]

According to the American Association of Birth Center, and the U.S. Agency for Healthcare Research and Quality, the National Average Charge for varying births in 2011 for a birth center vaginal birth is $2,277, a hospital vaginal birth with no complications $10,657, a hospital vaginal birth with complications $13,749, a hospital cesarean birth with no complications $17,859, and a hospital cesarean birth with complications was

22 National Vital Statistics http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_01.pdf

23 http://www.midwife.org/acnm/files/ccLibraryFiles/Filename/000000005464/CNM-CMAttendedBirthStatisticsJune2015.pdf

24 http://www.kdheks.gov/hci/as/2013/AS_2013.pdf

25 Kansas Journal on Medicine 2012. Midwifery in Kansas Astrid McDaniel, B.A. , Lynette R. Goldberg, Ph.D. , Nancy G. Powers, M.D.

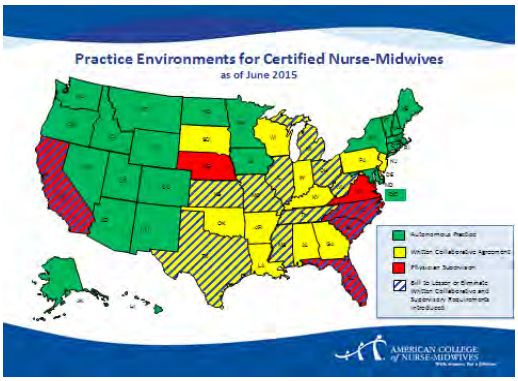
26 http://healthland.time.com/2012/06/25/midwife-mania-more-u-s-babies-than-ever-are-delivered-by-midwives

27 http://nursing.kumc.edu/nurse-midwifery-education-program.html

$23,923.[28]

Washington State gives Medicaid clients the option of receiving prenatal care from a CNM and delivering at home or in a free-standing birth center. In a 2005-2006 analysis of over 1,000 women participating in the Washington Medicaid home birth program, it was found that even though 36 percent ended up delivering in a hospital, per-delivery costs were reduced by an average of $1,341 (2014 dollars) over what they would have been had hospital births been planned.[29]

One of the hurdles for enhanced use of Certified Nurse Midwives to increase outcomes for Healthy Birth Outcomes is the current licensing requirement for a signed physician collaborative agreement. Many States have removed the requirement for a signed physician collaborative practice agreement as a condition of licensure. As shown below, many States have already removed the requirement or are in process of removing requirements for a signed physician collaborative practice agreement as a condition of licensure.[30]



Recommendation #6 - Kansas should review the opportunities to implement the following measures to enhance its efforts to achieve greater outcomes to manage lower state-wide costs for Healthy Birth Outcomes

Part I: Manage costs and risks for pre-term births

- Eliminate elective inductions for non-medically indicated deliveries prior to 39 weeks gestation.
- Reduce the number of admissions and the average length of stay in neonatal intensive care units and number of low birth weight babies.
- Implement a universal screening and referral tool (SBIRT) in the physician's office to screen pregnant women and 12 months post-delivery for tobacco use, substance abuse, alcohol, depression, and domestic violence.
- Continue to promote Baby Friendly Certified Hospitals and Breast Feeding.

Part II: Enhance options for delivery venues of low risk births

A&M also recommends that the State improve the licensing and authorization legislation to allow for increased utilization of non-hospital settings for low risk pregnancy births and address the shortage of OB-GYNs. Receiving pre-natal care from Certified Nurse Midwives (CNM) is a cost-effective option for low-risk mothers that have been shown to produce birth outcomes at least as favorable as those of hospital delivery.

28 Childbirth Connection. Average Facility Labor and Birth Change by Site and Method of Birth, United States, 2009-2011. Retrieved from: transform.childbirthconnection.org.

29 Research using the state of Washington's Medicaid database revealed that providing maternity care to Medicaid patients through certified nurse midwives saved the state $473,000 in averted C-sections and $3.1 million in overall maternity costs. Cost savings from Medicaid fee for service for averted caesareans exceeded the cost of the program by 180 percent and savings to Washington state's healthcare system overall exceeded the cost of the program by over ten fold.

Midwifery Licensure and Discipline Program in Washington State: Economic Costs and Benefits. Health Management Associates. October 31, 2007 http://www.illinoismidwifery.org/blog/wp-content/uploads/2012/04/Washington-State-Midwifery_Cost_Study_10-31-07.pdf

30 American College of Nurse Midwives Presentation on Practice Environments for Certified Nurse-Midwives (June 2015)

	FY 17	FY 18	FY 19	FY 20	FY 21	Total
Eliminate Medicaid Funded Elective Per 39 week Induced Births						
Costs of Pre-39 Week Elective Induced Birth Costs ($ 000's)	$34,657	$34,657	$34,657	$34,657	$34,657	$173,284
% Medicaid Funded	33%	33%	33%	33%	33%	
Estimated Reduction in Payments	30%	50%	75%	90%	90%	
Reduced Medicaid Payments for Level II to IV NIC-B Births						
Level II- III- IV NIC-U Births (2014 Costs)	$36,965	$36,965	$36,965	$36,965	$36,965	$184,824
% Medicaid Funded	33%	33%	33%	33%	33%	
Estimated Savings from BOI	5%	10%	10%	15%	20%	
Increase % of Out-of-Hospital Births	2%	3%	4%	5%	5%	

CNM's are Advance Practice Registered Nurses with specialized training in normal pregnancy and childbirth that provides women's health care through the lifespans.

In July 2014, The American Congress of Obstetricians and Gynecologists reported that "Ob-Gyns and CNMs are experts in their respective fields of practice and are educated, trained, and licensed, independent providers who may collaborate with each other based on the needs of their patients...to provide highest quality and seamless care, ob-gyns and CNMs should have access to a system of care that fosters collaboration among licensed, independent providers."[31]

Kansas should allow CNMs to provide a written plan that describes how they collaborate, manage, refer, and consult with local physicians in the community. CNM's already carry malpractice insurance as determined by the Health Care Stabilization Fund.

Kansas can increase utilization alternative care to increase Healthy Birth Outcomes to lower cost birthing options in Medicaid by:

- Encouraging the expansion of use of Certified Nurse Midwives in proliferation of all birthing centers (both in and out of hospital settings).
- Conducting outreach and education to Medicaid maternity care clients.
- Educating mothers about their birthing options and dispelling misinformation about the risks, both physical and legal, of a normal delivery by a CNM.

Critical to the success of these initiatives is the continued partnership between KDHE and the health care provider partners across the State.

Recommendation #6 - (dollars in 000's)					
Fund Impact	FY17	FY18	FY19	FY20	FY21
Part I	**$1,751**	**$3,007**	**$4,246**	**$5,253**	**$5,518**
Part II	**$301**	**$401**	**$502**	**$803**	**$1,003**
Total	**$2,052**	**$3,408**	**$4,748**	**$6,056**	**$6,521**

Key Assumptions

Part I: Manage costs and risks for pre-term births

- Cost savings initiative includes two cost components (a) reduced elective inductions for non-medically indicated deliveries prior to 39 weeks gestation and (b) reduced neonatal costs from reduced pre-gestation period births.
- Gradual reduction in Medicaid paid elective non-medically necessary induced births to 90 percent by 2021.
- All data is based on medical claims data. Medical claims data uses national standardized coding to describe a medical event. Therefore, newborns are categorized as full term infants (gestational age of 37 weeks and over) and premature infants (less than 36 weeks of gestational age).

31 Joint Statement of Practice Relations between Obstetrical Gynecologists and Certified Nurse-Midwives

- Assumes 32.5 percent of claims are Medicaid births.
- Kansas FMAP for Federal CMS funding at 56 percent compared to State General Fund costs of 44 percent.
- Assumes NIC-U Level II to Level IV birth costs.
- Gradual increase in reduced NIC-U days and related costs due to Healthy Birth Outcome Initiatives.

Part II: Enhance options for delivery venues of low risk births

Part II of this recommendation promotes the enhanced use of Certified Nurse Midwives including legislative changes modifying the existing full practice requirement, public education, and partnerships with Kansas health care community. The cost savings target over the five years is based on the following assumptions:

- Annual growth in the number of non-hospital settings from current 1.0 percent to 5.0 percent by FY 2021. The growth is factored from the current number of Medicaid funded births of 13,142.
- Cost savings differential of $3,470 between the current Medicaid In-Hospital costs of $4,533 to the Birthing Center Medicaid cost of $1,063 or an averaged $3,470 cost different per birth. We noted however that the minimum Kansas Medicaid reimbursement for a birthing center facility delivery is actually $1,295.
- Kansas FMAP for Federal CMS funding at 56 percent compared to State General Fund costs of 44 percent.

Critical Steps to Implement

Kansas should—like other states that have been successful in the implementation of healthy birth outcome initiatives—strategically develop an implementation plan that partners with key stakeholders to lower measures and in turn lower state-wide costs.

Part I. Managing costs and risks for pre-term births

Critical steps in the implementation of Medicaid funding for early elective non-medically induced births would include:

- Create costing structure and policy and procedures for early birth outcome initiative program initiatives including the elimination of State Medicaid funding for elective, non-medically non-medically indicated deliveries prior to 39 weeks gestation.
- Create incentives for evidence-based delivery of health care, including labor and delivery services.
- Create costing structure and policy and procedures for early birth outcome initiative program initiatives.
- Continued collaboration between all agencies and stakeholders—Hospital Associations, March of Dimes, Kansas Medicaid Managed Care Organizations, etc.

Part II. Enhance options for delivery venues of low risk births

For Kansas to be effective in changing its maturity and birth model, the state would have to adopt new regulatory policies and changes in statutes that modify the licensing requirements for NMs. The state would also need to expand the availability of mid-wives in Kansas with targeted attention and/or incentive to areas where obstetric services are not being provided or there are significant drive times to birthing locations.

Kansas should define the role of CNM's and protect public safety by defining the scope of midwifery while recognizing and enabling full practice authority for CNM's. Kansas could allow CNMs to provide a written plan that describes how they collaborate, manage, refer, and consult with local physicians in the community. Other implementation tasks should include:

- Adopt policies and statutes that would remove barriers to CNMs indecently practicing within their full scope.
- Encourage physicians and CNM to collaborate to increase the provider workforce in the inner city and rural health care shortage areas.
- Encourage more CNM centers to practice in Kansas with targeted incentives to obstetric-deserts within the state.
- Create public education on opportunities for normal, low-risk births to be performed by licensed CNM's.

KDCF.01 - Child Support Collection

approximately $700 thousand a year of increased revenue to the state. Higher collections rates will also help Kansas families by ensuring that children and custodial parents have the financial support they are owed.

- **Regional Facility Consolidation (KDCF):** Close three service centers and move program staff to nearby offices.
- **Children's Initiatives Fund (CIF) Optimization (Children's Cabinet):** Improve the targeting of funding and diversify funding sources.
  - » A&M recommends that CIF-funded programs which consistently received low Evidence Based Practice (EBP) scores develop a plan to improve EBP, or be redesigned or replaced with new programs that have a stronger evidence basis. To the extent possible, redesigned and new programs should be designed to retain and/or expand federal and private funding.
  - » In addition, the Children's Cabinet's should facilitate joint planning to further improve the targeting of funding and alignment of priorities among agencies serving children.

Recommendations

		Target Savings and Revenue Estimate (All values in 2015 dollars, in 000s)					
Rec #	Recommendation Name	FY17	FY18	FY19	FY20	FY21	Total
1	Child Support Collections	$735	$692	$659	$620	$590	$3,297
2	Regional Facility Consolidation	$121	$121	$121	$121	$121	$605
3	Children's Initiatives Fund Optimization	$0	$3,500	$3,500	$3,500	$3,500	$14,000
DCFS Total		**$856**	**$4,313**	**$4,280**	**$4,241**	**$4,211**	**$17,901**

Recommendation #1 – Raise Kansas' Child Support Collections to Peer State Levels

KDCF has improved the Cost-Effectiveness Ratio for the Child Support Services (CSS) program by 60% since 2011, putting Kansas 8% above the national average. Now the department is turning its focus to improving collections. Adopting proven practices from other states can accelerate this effort.

Specifically, Kansas should:

- Coordinate with the Kansas Department of Labor (KDOL) to take further steps to increase the number of employers self-reporting new hires—including imposing a penalty for non-reporting and requiring the reporting of independent contractors—so that additional Employment Withholding Orders (EWOs) can be established to collect court-ordered child support payments.
- Coordinate with the Kansas Department of Revenue to deny issuances or renewal of car, boat, or recreational vehicle registration until an EWO or payment plan is in place.
- Coordinate with the Kansas Department of Revenue to establish an inter-local agreement with neighboring states—many people work in Missouri and owe child support to a child living in Kansas, or vice versa. Kansas can increase collections by using Missouri's Set-Off program and other collections tools.
- Kansas should continue current efforts to optimize the full range of collections measures currently in place.

Background and Findings

KDCF's Child Support Services (CSS) help children receive child support:

- Services include establishing parentage and orders for child and medical support, locating noncustodial parents and their property, enforcing child and medical support orders, and modifying

support orders as appropriate.

- CSS automatically serves families receiving Temporary Assistance for Needy Families (TANF), foster care, food assistance, and child care assistance. Assistance from CSS is also available to any family regardless of income or residency. [7]

The federal Office of Child Support Enforcement monitors five measures of effectiveness for CSS programs.

- The measures are:
  - » Establishment of paternity
  - » Establishment of support orders
  - » Collection of current support due
  - » Collection of arrears
  - » Cost effectiveness
- Incentive payments are provided to states based on performance of these five measures.
- CSS has set a goal of being #20 in the nation across all measures.

As outlined in the operational benchmarks above, Kansas is performing below its peers in the collection of current child support owed and arrearage on behalf of custodial parents.

- As of the end of FY15, $980.4 million of child support receivables were outstanding, of which $813.9 million was more than 365 days in arrears. [8]

Increased collections benefit Kansas' children, custodial parents, and the State and Federal governments. When CSS collects child support, the majority of the funds go directly to the custodial parent. However, when the child is receiving TANF in foster care, or in juvenile justice custody, the child support goes to state and federal funds. Of Kansas' total Child Support collections in 2015, 5.79% represented state funds.[9]

In addition, Kansas receives incentive payments from the Federal government based, in part, on collections rates. Higher collections rates, all else being equal, can increase Kansas' incentive payment.

On average, child support represents 45 percent of family income, for poor custodial families that receive it.[10] Therefore, increasing child support collections will improve the financial stability of Kansas' custodial parents, improving children's lives and potentially reducing the rate of children requiring foster care and other services.

Kansas already has a broad range of mechanisms in place for collecting child support. In FY15:

- 75.6% of child support collections came through Employment Withholding Orders (EWOs) (consistent with the national average of 75%)
- 13.7% came from the non-custodial parent sending a check or money order
- 10.4% through the US Treasury Offset Program
- 1.86% through the Kansas Debt Recovery Program

Measures such as placing restrictions on driver's licenses, denying recreational licenses, withholding lottery winnings, obtaining liens on property, and offsetting bank accounts through the Financial Institute Data Match help drive collections.

Employers are legally required to report new hires in order to facilitate the implementation of EWOs. However, Kansas has had challenges in enforcing this requirement.

- Of the nearly 80,000 private employers in Kansas, only approximately 20,000 self-report new hires.
- Kansas does not impose a penalty on employers for non-compliance with the reporting requirement.
- Federal law allows for civil penalties for non-reporting—up to $25 per newly hired employee, or up to $500 per newly hired employee, if the state shows a conspiracy between the employer and employee not to report. States also have the option of imposing non-monetary civil penalties

7 KDCF website

8 KDCF FY2015 Accounts Receivables Report. Note that because the child support is owed to custodial parents, these receivables are not treated in the same way that State receivables are treated.

9 Ibid.

10 "Child Support 2014: More Money for Families," Infographic, Federal Office of Child Support Enforcement.

on employers who fail to report.[11]

- Many other states, including Nebraska, New Mexico and Arkansas, highlight their authority to impose penalties in their employer communications.[12]

KDCF and KDOL recently announced a partnership to increase new-hire reporting. They implemented web-enabled reporting for new hires and gave employers online access to lists of EWOs. In addition, CSS staff members are reaching out to employers who have not reported, educating them about the process and legal requirements.

Building on this effort, Kansas should:

- Impose a penalty for non-reporting at the maximum level allowed by federal statue, and include the potential penalty in employer communications.
- Require reporting of independent contractors.
- Coordinate with the Kansas Department of Revenue to deny issuances or renewal of car, boat, or recreational vehicle registration until an EWO or payment plan is in place.
- Coordinate with the Kansas Department of Revenue to establish inter-local agreements with neighboring states.

In addition, A&M recommends that Kansas monitor and report on operational metrics for the collections program (e.g., rates of employer compliance with new hire reporting, number of EWOs instituted) and for the new web-based employer tools (e.g., site hits, abandonment rates), and adjust CSS's employer outreach program accordingly.

Recommendation #1 - (dollars in 000's)				
FY17	FY18	FY19	FY20	FY21
$121	**$121**	**$121**	**$121**	**$121**

11 US Department of Health and Human Services. http://www.acf.hhs.gov/programs/css/resource/new-hire-reporting-answers-to-employer-questions. Accessed December 8, 2015

12 State new hire reporting websites. Accessed December 8, 2015

Key Assumptions

- An 8 percent increase in revenue from child support collections over the baseline budget.
- KDCF has already budgeted and planned for efforts to improve performance on the five measures of child support services performance. These recommendations will help focus those efforts and will not require significant additional investment.

Critical Steps to Implement

The critical steps necessary to complete the implementation of the child support collections recommendation include:

- Establish a requirement for employers to report independent contractors as part of their new hire reporting.
- Establish penalties for non-reporting of new hires and communicate these potential penalties to employers
- Develop agreements with the Kansas Department of Revenue and neighboring states on the improvements outlined above
- Establish new operational metrics as outlined above

Imposing penalties for employers who do not report new hires on a timely basis and requiring reporting of independent contractors may require statutory or regulatory changes. However, the remaining recommendations can be implemented in parallel with this change. The expected time to implement the recommendation is six months, exlusive of time needed for regulatory or legal changes.

Recommendation #2 – Close Three Service Centers

A&M recommends that Kansas close three service centers and move the direct service staff to nearby facilities:

- Goodland (Sherman County) – move program staff to Colby
- Greensburg (Kiowa County) – move program staff to Dodge City or Pratt
- Iola (Allen County) – redistribute program staff to

PRINT.01 - Electronic Communication and Documentation

assign a state employee(s) to manage the central accounts.

Critical Steps to Implement:Consolidate all agency accounts into a single account for each provider.

- Issue an RFQ/P for a Telecom Expense Management service provider.
- Develop and effectively communicate the standard operating procedures to the user group.

RECOMMENDATION #8 - Implement a Managed Print Services Model at Universities and Evaluate Agencies

Conduct a statewide assessment to identify which universities/colleges should move to network-based multi-function devices and away from distributed individual printers to reduce procurement and maintenance costs.

Findings/Rationale

There is no university-wide Managed Print Services (MPS) contract setup at Kansas State University and Wichita State University. In both locations, the departments primarily utilize local desk printers and copiers for their needs. Typically, large organizations that take a decentralized approach to managing print services, experience increased costs to the organization to procure printing supplies and equipment, to maintain the equipment, and to run the equipment due to higher energy usage.

Some state agencies have already moved to a networked multi-function device model. Additionally, the University of Kansas has moved to networked-based multi-function devices. They were able to achieve millions in costs savings over four years by prohibiting the use of unauthorized local printers, centralizing IT technicians and setting up an MPS contract. These savings are in line with the 10%-30% savings potential noted by Gartner and various MPS case studies.

A&M recommends that the State of Kansas conduct a statewide printing and copying assessment to identify where to deploy or redeploy an MPS model. The universities spend approximately $7.8 million for print services, supplies and equipment, combined. A&M estimates that they could save approximately $673,000 annually by switching to network-based multi-function devices. This savings estimate does not include the reduction in energy usage or refining existing MPS programs at other agencies or universities to drive higher savings or leveraging the consolidated spend statewide to get more favorable contract pricing from MPS providers.

Reccomendation #8 - (dollars in 000's)				
FY 17	FY 18	FY 19	FY 20	FY 21
$673	$673	$673	$673	$673

Key Assumptions

- University departments and colleges will participate in the assessment.
- The University of Kansas and the University of Kansas Medical Center have already implemented an MPS program.
- Some state agencies have implemented networked print services but have not entered into statewide MPS programs.

Critical Steps to Implement

- Initiate a statewide printing and copying assessment to outline all agencies/universities that should be part of the program and gather functional requirements.
- Work with the Office of Information and Technology Services and affected agencies/universities to outline technical requirements, approach, and address challenges.

RECOMMENDATION #9 – Optimize Facility Operations to Reduce Energy Usage

Conduct a comprehensive review of facility operations and control systems at state agency, university and school district buildings, in order to identify and implement control systems and operational changes that will significantly reduce energy usage and cost.

Findings and Rationale

A&M analyzed detailed natural gas and electricity data from a select group of high usage agency and university facilities. The data from these facilities came from

B&C.01 - Organize B &C’s under industry structures

Boards and Commissions

Agency Overview

Boards and commissions are governmental authorities tasked with the regulation and support of various industries and their member professionals throughout the state. Kansas employs 141 boards and commissions. Their breadth of influence spans from broad financial regulation to focused industry groups—such as those themed solely in nursing or cosmetology.

These boards and commissions are led by gubernatorial and senatorial appointed professionals within a relevant field. According to the Office of Appointments within the Office of the Governor, the governor will appoint over 1,000 individuals.[1] Appointments occur on an as-needed basis all year long and are subject to public disclosure. Additionally, boards and commissions routinely meet quarterly and service is generally voluntary.

In addition to appointed leadership and board members, these organizations are staffed with a cadre of professionals. The budgets and organizational structures of nineteen sample boards and commissions focusing on public health, financial institutions and technical professions were analyzed. This particular group was chosen for their subject matter similarities.[2]

These organizations average 6.83 full-time employees per executive director and/or management level employees. Additionally, boards and commissions average 8.2 board members per organization.

As it stands, these disparate organizations lack significant strategic shared resources or consolidated leadership and budgetary oversight. There are precedents in other states—such as Utah, Iowa and Virginia—that align boards and commissions thematically, in order to optimize resources and prevent needless redundancies in services. In particular, Virginia's State Corporation Commission and Department of Professional and Occupational Regulation are separately responsible for those boards and commissions related to financial institutions and professional industries, respectively. This industry-specific oversight allows for strategic planning and shared resources between various boards.

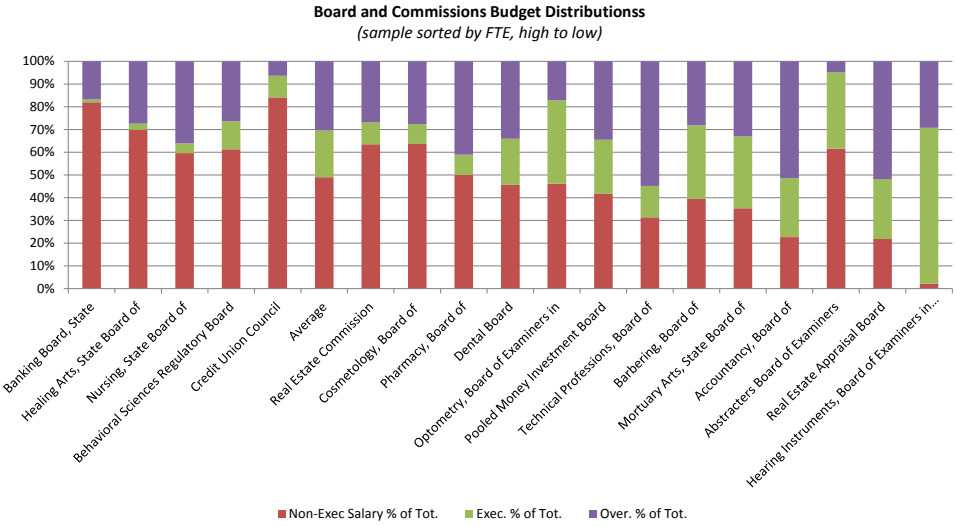
1 Office of the Governor. https://governor.ks.gov/serving-kansans/office-of-appointments

2 Sample boards and commissions: Abstracters Board of Examiners, Board of Accountancy, State Banking Board, Board of Barbering, Behavioral Sciences Regulatory Board, Board of Cosmetology, Credit Union Council, Dental Board, State Board of Healing Arts, Board of Examiners in Fitting and Dispensing of Hearing Instruments, State Board of Mortuary Arts, State Board of Nursing, Board of Examiners in Optometry, Board of Pharmacy, Pooled Money Investment Board, Real Estate Appraisal Board, Real Estate Commission, Board of Technical Professions

Recommendation

Establish separate general industry, public health and financial industry umbrella structures to leverage shared resources, labor capabilities and mission alignment.

The table below shows the sample group of boards and commissions, sorted by total FTE:



Financial Regulatory Boards: *State Banking Board, Credit Union Council, Pooled Money Investment Board;* ***Public Health Boards****: Behavioral Sciences Regulatory Board, Dental Board, State Board of Healing Arts, Board of Examiners in Fitting and Dispensing of Hearing Instruments, State Board of Nursing, Board of Pharmacy;* ***Technical Professions Boards:*** *Abstracters Board of Examiners, Board of Accountancy, Board of Barbering, Board of Cosmetology, State Board of Mortuary Arts, Real Estate Appraisal Board, Real Estate Commission, Board of Technical Professions*

These boards dedicate up to over 80% of their budgets on non-executive FTE salaries, yet share many thematic and strategic missions. This recommendation states that:

- Three separate committees should be established:
  - » Financial Services Regulation Committee
  - » Public Health Services Regulation Committee
  - » Technical Professions Regulation Committee
- The committees will serve as small task forces whose responsibilities include:
  - » Evaluate qualitatively the strategic missions of each disparate board and commission and determine where potential alignment may occur, if/how market forces and industry trends are taken into account and how shared resources may be leveraged
  - » Evaluate quantitatively how budgets and financial resources may be shared across thematically similar boards and commissions
  - » Issue recommendations to the Office of the Governor and Legislature on possible reform
- The task forces will be led by one representative chosen by the Governor and one representative chosen by the Legislature, from the pool of member boards and commissions
- They will be funded by a fixed percentage of each member boards' budget

Critical Steps to Implement

- Conduct an expanded, objective study of all 141 boards and commissions across the state to determine possible inclusion under the new committees
- Employ lean staffing strategy to ensure committee budgets are not overly burdensome with no/limited permanent FTE staffing

DOC.10 - Leverage Medicaid & Private Health Insurance for Parole & Community Corrections

ally, cooperation with the Kansas State Department of Administration will be required to clear hurdles for medical professionals seeking licensure to provide telemedicine services throughout KDOC facilities.

Background & Findings

- KDOC ranks 25th nationally on capitated health care spending, according to the 2014 Pew & MacArthur Report on State Prison Health Care Spending
- Kansas had 2,756 off-site medical care transports in 2014, compared to Iowa's 3,500 off-site medical care transports
- Despite KDOC's progress, the strain of low staffing and overtime remains a challenge and off-site medical visits impose an additional cost on the system
- Topeka Correctional Facility, the state's only women's prison, reported that the high number of off-site visits for mammograms was a significant cost driver and taxing on their staff
- The state should explore the business case behind either a mobile unit arrangement with an area hospital or purchase of a unit for the facility

Key Assumptions

- The department is seeking to reduce medical transports by an additional 120 transports in the next year and projects it could save as much as $120,000 as a result
- The staff expressed challenges with onboarding out-of-state providers to offer telemedicine services as a potential challenge
- Developing an inter-agency support team to help facilitate these agreements will help advance this effort

Critical Steps to Implement

- By February 2016, KDOC should conduct a thorough statewide impact assessment of off-site medical transports on overtime, staffing and resources in order to project savings
- By February 2016, KDOC should coordinate with the Department of Administration and present anticipated challenges to onboarding providers, as well as establish a plan for overcoming them in an efficient way moving forward

Recommendation #10 - Leverage Medicaid & Private Health Insurance for Parole & Community Corrections

Ensure that the state incentivizes Parole and Community Corrections contractors to become qualified to bill Medicaid and private health insurance, when possible, in order to maximize savings potential for health and behavioral health care. Create a task force to examine the feasibility of shifting the older, frailer inmate populations that are either Medicare or Medicaid eligible into a specialized, more secure nursing home setting on a form of any medical parole status.

Background & Findings

- Medicaid & Health Care Enrollment
  - » KDOC is a national leader at identifying Medicare and Medicaid eligible prisoners. While states are prohibited from accessing Medicaid for inmates receiving health care services within a prison facility, they may be reimbursed for off-site medical services. By developing an efficient process, KDOC has achieved significant savings on behalf of prisoners by identifying nearly 10% of the adult prison population (over 900 inmates) as eligible for Medicaid, and saving an average of $1.2 million annually. While this has been a great success, more savings opportunities present themselves.
  - » The benefits of Medicaid or any form of health care enrollment should not begin and end at the prison gate. However, there is little effort made to ensure that community-based providers serving Parole and Community Corrections programs obtain the necessary certifications to bill Medicaid, Medicare or even private health care plans. In fact, one official suggested that the process could begin as early as an offender's admission to local jails, where they can be screened for eligibility and enrolled soon

enough to begin accessing outpatient benefits that would then carry into a probation sentence.

- Exploration of Nursing Home Medical Parole Model
  - » With such a high number of Medicaid eligible inmates, as well as more than 1,000 inmates 55 and older, the costs imposed by a growing aged and long-term care population within KDOC are significant. In response to similar conditions, other states, have developed an innovative solution: they reclassify segments of their population to serve the remainder of their sentence in specialized nursing home care that is outside of prison walls and, therefore, reimbursable by Medicare and Medicaid.

Key Assumptions

- Medicaid & Healthcare Enrollment
  - » Sufficient data to conduct a thorough cost savings estimate does not exist. However, it is clear that investments in behavioral health services will reduce recidivism and ultimately reduce the impact on the state prison population. At least 900 state prison inmates are eligible for Medicaid and 97% of all inmates will be released back to Kansas communities. This evidence suggests that considerable costs may be shifted away from the state budget.
  - » Furthermore, with an estimated 25,000 inmates incarcerated in county jails and thousands more on probation, there is potential for even greater savings to be achieved for both health and behavioral health care services at the local level.
- Exploration of Nursing Home Medical Parole Model
  - » A detailed analysis must be conducted to determine the target population. However, it has been reported by KDOC that at least 14% of the prison population requires assistance with daily living, including more than 1,000 inmates aged 55 and older (a threshold provided by DOC)
  - » The challenge will be to determine the risk level to society and the level of security that inmates may require in a nursing home setting
  - » Furthermore, it is assumed that an analysis of the current law will have to be conducted to determine if legislation will be required to make this recommendation possible

Critical Steps to Implement

- By February 2016, KDOC should evaluate its aging and frail populations to determine how many inmates could be reasonably housed in a specialized nursing home setting. Based on the population profile, the department would need to craft legislation by March 2016 establishing the appropriate criteria for medical parole status for those inmates to be permanently housed in such a facility. Should the legislation pass, then an RFI would be issued to seek nursing home providers willing to establish specialized care facilities in Kansas dedicated to housing this population.
- By May 2016, KDOC should evaluate all of its community-based contractors and determine how many are certified to bill Medicaid or private health insurance for services. In addition, the department should require all Community Corrections contractors to do the same. Based on the findings, a plan should be established to require or incentivize more providers to become certified.

Recommendation #11 - Consolidate Shared Services

Review and rationalize shared service functions at each prison facility. Shared service functions can include, but are not limited to, Accounting (AP/AR), HR, and IT. If shared service FTE utilization is found to be greater than demand, or is a function which can be consolidated under the Central Office, then reduce or reallocate FTEs as needed. Security staffing was found to be adequate at each location examined and a reduction or reallocation of security related staff is not in scope for this recommended assessment.

Background & Findings

- At each prison facility there exist a number of resources that perform shared service functions such as HR, accounting or IT.
- Shared service related functions are also located

DOC.09 - Expand On-Site Medical Services and Telehealth agreements

ensure operational security and prove a replicable pilot to be implemented at other correctional facilities or state-owned buildings. Prison facilities are ideal candidates for supplemental renewable energy due to their consistent and predictable electricity needs.

Background & Findings

- After funds allocated for salaries, electricity utility costs are the number one cost driver across all correctional facilities—at Larned Juvenile Correctional Facility, electricity costs are even greater than Classified Regular salaries). El Dorado Correctional Facility is the number two user of electricity of all corrections facilities in Kansas and has the requisite amount of space needed for a solar array. El Dorado allocated more than $870,000 to electric utility costs in 2015. Fortunately, over the last four fiscal years, electricity costs as a percentage of total budget allocations have remained relatively stagnant at 2.5%-3%. This is due to a flat energy market that has resulted in depressed prices, which are unlikely to remain similarly low for the duration of a proposed PPA.
- Fortunately for the State of Kansas and the El Dorado Correctional Facility, by some measures Kansas has the seventh highest potential for solar energy generation in the country.(For citation: http://www.nrel.gov/docs/fy12osti/51946.pdf)
- Solar power purchase agreements are financial contracts enacted between a given facility (in this case, EDCF) and a vendor (or vendors). They allow the customer to lock-in a guaranteed savings over the course of many years—up to 20. On average, a solar PPA will net the customer a savings of $0.01 or $0.02 per kilowatt-hour of electricity used on site (in FY2015, EDCF used 4,172,110 KWH which would result in $41,000-$82,000 in savings annually). (For citation: http://www3.epa.gov/greenpower/buygp/solarpower.htm)
- There are a number of case studies nation-wide that have proven the model for solar arrays at correctional facilities, such as Santa Clara County, California or the (less sunny) Southern State Correctional Facility in Vermont. The details of the arrangement would require on-site due diligence and engineering (paid for and conducted by a vendor), but the crucial component of solar PPAs is that all risk is taken on by the PPA vendor, not the client (El Dorado Correctional Facility). EDCF would incur no upfront or ongoing capital investment, nor would the facility own or maintain any hardware. In return, EDCF would receive a savings on its utility spend allocations, stable baseline electricity generation ensuring safety standards during potential grid outages and a more sustainable energy portfolio statewide.[17]

Recommendation #8 - (dollars in 000's)				
FY17	FY18	FY19	FY20	FY21
$47	$50	$53	$56	$59

Key Assumptions

- Assumptions based on $0.012/KWH savings estimate derived from comparative valuations of solar PPA implementations at other state correctional facilities
- Electricity utility usage was linearly projected from 5 years of historic actuals
- Assumptions do not assume any rise in the price of energy in the future. If the price of energy returns to historic averages savings realized through the PPA would increase
- There are no significant legal hurdles given the grid-connected nature of the project

Critical Steps to Implement

- Initiate an RFP for solar PPA vendor to begin due diligence process

Phase 2 Recommendations - Long-Term Performance Improvement

Recommendation #9 - Expand On-Site Medical Services & Telemedicine Agreements

Strive to reduce off-site medical transports 10%-15% by strategically sourcing and consolidating affordable medical equipment prison medical units. Addition-

17 http://governor.vermont.gov/node/2581

ally, cooperation with the Kansas State Department of Administration will be required to clear hurdles for medical professionals seeking licensure to provide telemedicine services throughout KDOC facilities.

Background & Findings

- KDOC ranks 25th nationally on capitated health care spending, according to the 2014 Pew & MacArthur Report on State Prison Health Care Spending
- Kansas had 2,756 off-site medical care transports in 2014, compared to Iowa's 3,500 off-site medical care transports
- Despite KDOC's progress, the strain of low staffing and overtime remains a challenge and off-site medical visits impose an additional cost on the system
- Topeka Correctional Facility, the state's only women's prison, reported that the high number of off-site visits for mammograms was a significant cost driver and taxing on their staff
- The state should explore the business case behind either a mobile unit arrangement with an area hospital or purchase of a unit for the facility

Key Assumptions

- The department is seeking to reduce medical transports by an additional 120 transports in the next year and projects it could save as much as $120,000 as a result
- The staff expressed challenges with onboarding out-of-state providers to offer telemedicine services as a potential challenge
- Developing an inter-agency support team to help facilitate these agreements will help advance this effort

Critical Steps to Implement

- By February 2016, KDOC should conduct a thorough statewide impact assessment of off-site medical transports on overtime, staffing and resources in order to project savings
- By February 2016, KDOC should coordinate with the Department of Administration and present anticipated challenges to onboarding providers, as well as establish a plan for overcoming them in an efficient way moving forward

Recommendation #10 - Leverage Medicaid & Private Health Insurance for Parole & Community Corrections

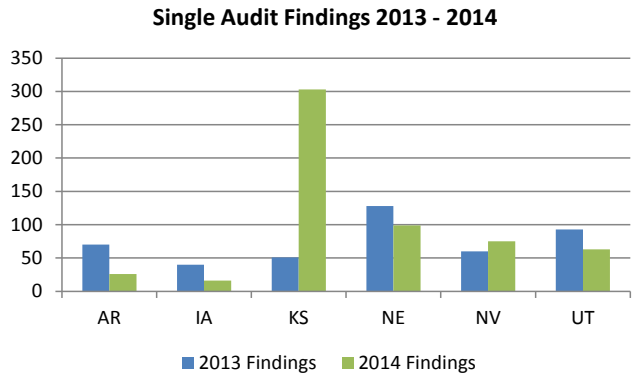
Ensure that the state incentivizes Parole and Community Corrections contractors to become qualified to bill Medicaid and private health insurance, when possible, in order to maximize savings potential for health and behavioral health care. Create a task force to examine the feasibility of shifting the older, frailer inmate populations that are either Medicare or Medicaid eligible into a specialized, more secure nursing home setting on a form of any medical parole status.

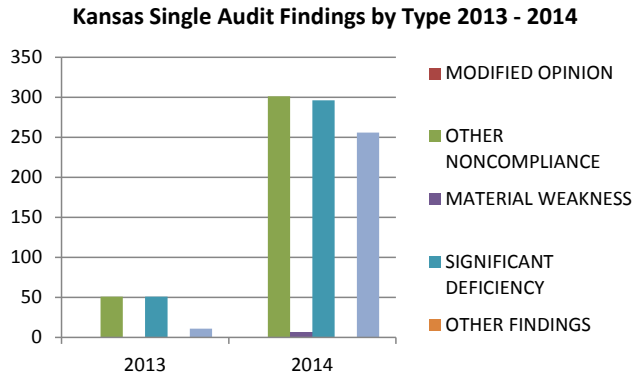
Background & Findings

- Medicaid & Health Care Enrollment
  - » KDOC is a national leader at identifying Medicare and Medicaid eligible prisoners. While states are prohibited from accessing Medicaid for inmates receiving health care services within a prison facility, they may be reimbursed for off-site medical services. By developing an efficient process, KDOC has achieved significant savings on behalf of prisoners by identifying nearly 10% of the adult prison population (over 900 inmates) as eligible for Medicaid, and saving an average of $1.2 million annually. While this has been a great success, more savings opportunities present themselves.
  - » The benefits of Medicaid or any form of health care enrollment should not begin and end at the prison gate. However, there is little effort made to ensure that community-based providers serving Parole and Community Corrections programs obtain the necessary certifications to bill Medicaid, Medicare or even private health care plans. In fact, one official suggested that the process could begin as early as an offender's admission to local jails, where they can be screened for eligibility and enrolled soon

GGO.01 - Create a new Governor's Grant Office focused on Statewide Federal Funding

tion that states with a high number of compliance and internal control findings are deemed to have shown poor financial management with regard to the execution of federally funded programs. As a result of these risked based discounts, the amount of funds Kansas receives in a competitive grant award process may be negatively impacted.





Source: Single Audit Database from harvester.census.gov

Recommendations

Recommendation #1 – Create a New Governor's Grants Office

A&M recommends that the state create a newly formed Governor's Grants Office (GGO) to enable a coordinated, prioritized, and compliance-driven approach to maximizing the amount and effective use of federal funds in the state's agency budgets and expenditures. Federal government assistance payments to Kansas state and local agencies decreased from $7.2 billion in 2013 to $6.6 billion in 2014[5]. The state would benefit from more coordinated approach in the prioritization, application, compliance, and reallocation of federal funds for use by state agencies, local entities, universities and foundations.

The GGO would provide support to the identification of grant opportunities, prioritizing the state's strategic goals, sharing best practices, and developing a compliance function to ensure proper execution of grant dollars received.

The GGO would coordinate with state agencies' point of contacts to track grant related activities. The GGO would also review reimbursements and cost allocation processes, assess compliance procedures and resolution plans, and monitor and track grant execution.

Background and Findings

- Currently, the State of Kansas does not have a centralized office to manage and coordinate the receipt of federal funds.

		Target Savings and Revenue Estimate (All values in 2015 dollars, in 000s)					
Rec #	Recommendation Name	FY17	FY18	FY19	FY20	FY21	Total
1	Create a new Governor's Grant Office focused on Statewide Federal Funding	$4,086	$5,032	$5,082	$5,131	$5,181	$24,513
2	Retitle the Governor's Grants Office into a Governor's Crime Prevention Office	$-	$-	$-	$-	$-	$-
		$4,086	**$5,032**	**$5,082**	**$5,131**	**$5,181**	**$24,513**

5 Single Audit Database from harvester.census.gov

- The state has a Governor's Grants Program office, which administers state and federal grant programs focused on the criminal justice system, public safety, crime victim services, and drug and violence prevention programs[6]. This office should be refocused around its actual mission as the Governor's Crime Prevention Office.
- Otherwise, stage agencies and local governments are responsible for grant management, including identifying new grant opportunities, fiscal and program management, and audit compliance.
- Audits and compliance efforts are conducted by the agencies, the Legislative Auditor, or outside private firms.
- A&M reviewed Maryland's Governor's Grants Office and Nevada's Office of Grant Procurement, Coordination and Management Budget. Both offices provide three key services for the state:
  - » Information Resource – both agencies maintain a website that provides consolidated information relating federal grants—including new grant opportunities listing, grant statistics, training and workshop schedules, and state agencies points of contacts for federal funds. In 2014, Maryland's Governor's Grant Office trained approximately 6,500 people[7].
  - » Special Point of Contact (SPOC) for state and local governments, as well as non-profit and non-governmental agencies and foundations. Each state agency appoints a point of contact (POC) that coordinates with the SPOC.
  - » Provide grants training and technical assistance.
  - » Publications – both agencies create reports on federal grant expenditures and produce grant manuals to promote fiscal and program requirement compliance. Maryland's grants office emailed their electronic newsletters to more than 6,000 subscribers[8].
- Over the decade since the formation of the Governor's Grant Office in the State of Maryland, the number of compliance related issues have been materially reduced both in number and in magnitude of compliance related findings. Correspondingly, Maryland's receipts of federal funds have increased overall as well as in relation to benchmark states.
- In 2013, the State of Maryland received $9.1 billion. In 2014, the state expended $9.8 billion[9]. This is a 7% increase in a year.
- Nevada's federal grant awards increased by 10% between 2013 and 2014 from $3.3 million to $3.6 million[10].

Recommendation #1 - (dollars in 000's)				
FY17	FY18	FY19	FY20	FY21
$4,086	$5,032	$5,082	$5,131	$5,181

Key Assumptions

Savings were identified using the following methodology:

- Five benchmark states were chosen based on region, size of the population and income. The five states are: Arkansas, Iowa, Nebraska, Nevada, and Utah.
- Potential new grants were identified by comparing the grants received by Kansas in 2014 versus grants received by the benchmark states.
- The top 50 grants that Kansas did not receive funding for in 2014, where the benchmark states were awarded funds were identified.
- A&M reviewed eligibility requirements and matching formulas for the 25 potentially eligible non-education and non-Medicaid grants.
- A conservative win rate of 10% was applied to the average amount received by the benchmark states, with a 1 percent increase in win rate per year until 2021.
- Seven of the potentially eligible grants had a matching requirement. Matching was calculated initially at $120,000 for 2017 and increasing as win rate increases by 1 percent each year. A total additional investment by the state is $659,000

6 http://www.grants.ks.gov/about-us/mission-values

7 http://grants.maryland.gov/Pages/AboutUs.aspx

8 Maryland GGO Annual Report 2015

9 Maryland GGO Annual Report 2015; Maryland GGO Annual Report 2014 Summary

10 Nevada Office of Grant Procurement, Coordination and Management 2015 BIENNIAL REPORT

over five years.

- Additionally, the analysis identified an average of $1.4 million in grant funding that was returned in 2012-2014. In 2015, $35 million in grant funding was returned.
- Savings associated with grant administration has not been factored into the savings model.
- Grant Management System implementation and website creation costs estimated at $300,000 to $500,000 and a 20% maintenance cost was factored into the savings. An investment in a Grant Management System will provide access to a comprehensive list of federal grants, allow tracking and pursuing new grant opportunities, increase efficiency through workflows, and assist in performance reporting.
- The new Governor's Grants Office will create five new positions for an additional annual investment of $376,000 for 5 FTEs.

Key responsibilities

The Federal Funds Office responsibilities include, but are not limited to:

- Be the single point of contact and subject matter expert on all things related to federal funds, including grant requirements and compliance questions.
- Provide technical assistance advice for all entities, including local, state, private and nonprofit.
- Provide agencies assistance in remediation of audit findings.
- Conduct training on topics such as researching grant opportunities, grant writing, grants management and budgeting.
- Maintain website to share information on federal funds coming into the state.
- Create annual report in tracking federal funds in the state.
- Monitor agency and grant performance through data-driven metrics.

Critical Steps to Implement

The critical steps necessary to complete the implementation of this recommendation include:

- Issuance of an executive order creating the Governor's Grants Office. An executive order may provide the best combination of structure and flexibility, whereas locking in the duties of a grants office via statute may make it harder to shift responsibilities and activities should the need arise[11].
- Create cost allocation plan to determine the overall cost of the program. A&M recommends the staffing of the GGO is five FTEs. Staffing requirements may increase if compliance issues are identified and compliance needs to become a priority for the GGO.
- Issuance of a Request for Proposal (RFP) for the creation of the GGO's website. A&M's recommendation is based on published rates in the OITS 2015 Service Catalog.
- All state and local agencies appoint a Point of Contact (POC) who will liaise with the GGO Director.

Recommendation #2 – Retitle the Governor's Grants Program Office into the Governor's Crime Prevention Office and assign additional pass-through responsibilities

A&M recommends that the state retitle the Office of the Governor Grants Program (KGGP) into a Governor's Crime Prevention Office. The existing Governor's Grants Program office currently administers state and federal grant programs focused on the criminal justice system, public safety, crime victim services, and drug and violence prevention programs[12]. KGGP also provides technical assistance and compliance oversight to sub grantees. As part of the retitling, the governor should look for opportunities to drive additional pass-through related crime prevention grants through the new Governor's Crime Prevention Office. The office is efficient at the process for accepting, distributing and monitoring grants to entities throughout the state and additional funds could be directed to that office for this type of higher administration funding.

11 FFIS Special Analysis 14-04, June 11, 2014 Establishing a Grants Office

12 http://www.grants.ks.gov/about-us

FLEET.01 - Fleet Reduction and Centralization

Currently, Kansas ranks with the 3rd highest proportion of vehicles to FTE wielding roughly 22 vehicles per every 100 employees. This calculation considers *all vehicles* throughout the state, inclusive of specialty or heavy vehicles, in order to appropriately compare across peer states. The peer states with fewer vehicles per FTE include Arkansas (11.1 vehicles per 100 FTE), Nebraska (9.8 vehicles per every 100 FTE) and Kentucky (3.75 vehicles per 100 FTE). Based on this analysis, significant precedent exists for fleet reduction within Kansas.

Recommendations

Fleet recommendations are quantified together due to their causal nature, i.e. a centralized and outsourced fleet management allows for a reduction in fleet.

		Target Savings and Revenue Estimate (All values in 2015 dollars, in 000s)						
Rec #	Recommendation Name	FY16	FY17	FY18	FY19	FY20	FY21	Total
1	Combined Fleet Recommendation	$1,333	$2,825	$995	$995	$995	$995	$8,138

Recommendation #1 - Centralized Fleet Management

Kansas should centralize passenger vehicle fleet resources under the Department of Administration and outsource fleet management to a fleet operations vendor. The consolidation of fleet operations under DOA will allow for the implementation of a centralized management solution and ensure resources are properly allocated to those employees who most require them.

- Recommendation
  - » Establish centralized ownership of all passenger vehicles – outside of the Universities and Highway Patrol – under the Department of Administration
  - » Issue an RFP for vendors to bid on the management and optimization of fleet resources, inclusive of the analysis necessary to determine fleet depot locations, on-going rental rates and the implementation of a network based reservation system
  - » Integrate fleet management improvements into management strategy to ensure the proper training of employees and reduction in use of third-party rental vehicles

Rationale and Assumptions

- Lack of interagency cooperation toward the efficient use of fleet management results in disparate systems, record keeping inconsistencies and a lack of transparency
- Current fleet strategy has resulted in not only the inefficient use of owned vehicles (in terms of FTE per vehicle) but also considerable use of rental cars
  - – On average, state employees rent roughly 750 vehicles monthly for an average cost of $35,000 a month
  - – These figures extrapolate to over $425,000 spent yearly on rental vehicles
  - – A modern, networked and more optimized fleet management system would reduce these ad-hoc rentals.
  - » More efficient use of passenger vehicles will allow for the concurrent reduction in fleet, and thus result in additional financial windfalls due to the sale of vehicles
  - » "Combined Fleet Recommendation" annual savings illustrated above are net of fleet management implementation costs ($300 annually per vehicle and upfront cost of roughly $7,000).

Critical Steps to Implement

- Foster buy-in with agency Secretaries and design a management strategy to train agency staff on use of the fleet management systems.
- Open a competitive bidding process for potential fleet operations vendors to perform due diligence and submit proposals to cover pricing, implementation and operations of centralized fleet management.

Recommendation #2 - Fleet Reduction

The State of Kansas should reduce the number of vehicles owned and operated by the state. A reduction in fleet owned will lower costs and reach usage efficiency levels achieved by its highest performing peer states.

- Recommendation
  - » The State should reduce the threshold by which passenger vehicles may be sold to 88,000 miles from the current rule of thumb of 130,000. This mileage target is derived from analyzing the 1,229 state owned passenger vehicles (exclusive of University and Highway Patrol vehicles) by their mileage quartiles, then reducing the oldest vehicles (by mileage) by 50%. The result is a smaller fleet with lower average mileage, thus ensuring the most productive vehicles remain.

Fleet Reduction - Full Year Results

Average Mileage of Vehicle Sold	Quantity Sold	% Sold	Total Opportunity
129,697	437	36%	$1,487,875

  - » Fleet reduction will be obligatory. Both during and after the initial fleet reduction in FY2016 and FY2017, state agencies will replace vehicles at the rate of attrition.
  - » Fleet reduction will result in roughly 650 fewer vehicles by the end of FY2017. This reduction will be made possible by the concurrent adoption of a modern, centralized fleet management system.
  - » Savings in FY2018, FY2019 and FY2020 represent the recurring costs avoided made possible by fleet reduction.
  - » The State will augment its current relationship with contracted auctioneers and others to dispose of the fleet in a timely and efficient manger.

Rationale and Assumptions

- The total eligible fleet for sale (and thus affected by this analysis) is defined as those vehicles located in denser metropolitan areas such as Topeka, Salina, Wichita and Kansas City, associated with all agencies except Universities and Highway Patrol.
- Passenger vehicles are defined as two-door sedans, four-door sedans, vans, pickup trucks and SUVs.
- Projected sale price of vehicles are derived from actual results garnered by DOA and KDOC. Projected price was calculated as:
  - » Projected Sale Price = Actual Realized Sale Price of Similar Vehicle by Type – (Mileage of Vehicle to be Sold * Dollar per Mile Value of Similar Vehicle by Type at Sale)
- Yearly maintenance, insurance, et al., costs are an estimated $1,518 per vehicle. This number was derived from costs realized by KDOC fleet management.
- The savings estimates include the 10% commission paid to the auctioneers.
- No new legislation necessary to implement fleet reductions.
- Savings do not take into account reduction of FTE made possible by fleet reduction and centralized management.
- Savings do not take into account lower wear and tear per-vehicle incurred due to reduced usage through centralized fleet management.

Critical Steps to Implement

- Assess the feasibility of vehicles to be sold with agency Secretaries and staff
- Comprehensively integrate projected vehicle reduction with DOA strategy and fleet management vendor to determine future usage patterns and inform management decisions
- Communicate intentions with auctioneers to prepare for increased sales volume