DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
Kansas City, Missouri 64106

Division of Medicaid and Children's Health Operations

January 27, 2017

Jonathan Shorman
Reporter
Topeka Capital-Journal
616 SE Jefferson
Topeka, KS 66607

Dear Mr. Shorman:

This letter is in response to your Freedom of Information Act (FOIA) request dated January 6, 2017, asking for "any and all correspondence and documentation provided to the State of Kansas since December 1, 2016, that document or include the findings of an audit, examination, inquiry, or investigation of KanCare".

Our office has enclosed copies of the correspondence provided to the State of Kansas since December 1, 2016 containing review findings of the KanCare program.

Additionally, you requested "any and all correspondence and documentation in the possession of CMS or provided to the State of Kansas pertaining to focus groups, roundtable discussions or other stakeholder input gathering regarding KanCare conducted since August 1, 2016".

Please be advised that correspondence and documentation regarding focus groups, roundtable discussions, or other stakeholder input are not within the Region's authority to release. These documents contain personally identifying information and per FOIA exemption number six, the Kansas City Regional Office believes that these documents may not be releasable. Therefore, we have forwarded those records and a copy of your request to the official listed below for review and potential release.

Hugh Gilmore
Director
Division of Freedom of Information
Room N2-20-16
7500 Security Blvd
Baltimore, MD 21244
(410) 786 – 5353

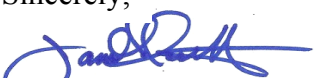
If you consider this response to be an adverse determination, you may appeal. Your appeal should be mailed, within 30 days of the date of this letter, to:

The Deputy Administrator and Chief Operating Officer
Centers for Medicare and Medicaid Services
Room C5-16-03
7500 Security Boulevard
Baltimore, Maryland 21244

If you have any further questions regarding this manner, please contact Karen Hatcher at (816) 426-5925.

1/27/2017

Sincerely,



James G. Scott
Associate Regional Administrator
for Medicaid and Children's Health Operations

Sign

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
Kansas City, Missouri 64106

Division of Medicaid and Children's Health Operations

January 20, 2017

Susan Mosier, M.D., Secretary
Kansas Department of Health and Environment
Division of Health Care Finance
Landon State Office Building
900 SW Jackson Street, Room 900N
Topeka, KS 66612

Dear Dr. Mosier:

The U.S. Department of Health and Human Services (HHS), Centers for Medicaid & Medicare Services (CMS) is committed to working with States to ensure that States employ processes and procedures to correctly and timely determine Medicaid and Children's Health Insurance Program (CHIP) eligibility. In September 2016, CMS performed a review of Kansas' eligibility and enrollment policies and procedures, including the State's eligibility and enrollment system. This letter summarizes the review's findings.

Background

In late 2015 and early 2016, the CMS Kansas City Regional Office received reports from stakeholders regarding inaccurate and delayed processing of Medicaid applications. In February 2016, in response to questions posed during routine oversight discussions, the Kansas Department of Health and Environment (KDHE) notified CMS that a backlog existed of approximately 7,000 applications that had not been processed within required timeframes.

In response to these concerns, CMS sent a letter to Kansas on February 17, 2016, requesting biweekly reports on the backlog of pending applications and redeterminations. CMS also requested an action plan to eliminate the State's backlog. On March 8, 2016, Kansas provided CMS a response that both identified factors causing the backlog, and provided a detailed plan for resolving it. Kansas identified the following factors as causes of the backlog: the implementation of its new eligibility and enrollment system, the Kansas Eligibility Enforcement System (KEES) in July 2015; a change in the State agency responsible for processing applications based on age and disability; and an increase in the number of cases received from the Federal Marketplace during 2015-2016 Open Enrollment.

Kansas' plan for resolving the backlog included actions such as hiring additional staff, authorizing overtime, and redesigning business processes to reduce processing times. These actions helped reduce the number of unprocessed applications, as indicated by the decreasing numbers in Kansas' biweekly reports between March and June 2016. CMS acknowledges progress that the State has made to address the application backlog. However, in June 2016, Kansas explained that errors in

reporting had significantly underestimated the severity of the State's backlog, and at the time, nearly 11,000 applications had been pending over 45 days.

As part of a comprehensive review of Kansas' oversight of the Medicaid and CHIP programs and in response to continued feedback from the public, CMS conducted an onsite review of eligibility and enrollment processes in September of 2016. The CMS onsite review included a discussion of the underlying factors contributing to this backlog as well as an assessment of KEES policies and procedures post phase II implementation. The review also assessed KDHE's oversight of the Clearinghouse, the State's centralized processing center. The primary purpose of the Clearinghouse is to determine eligibility for State and Federally funded medical assistance programs. The Clearinghouse is operated by Maximus Inc. through a contract with the State.

Objectives, Methods, Scope

This onsite review included detailed discussions of Medicaid and CHIP eligibility and enrollment policies and procedures with KDHE leadership and contractor representatives as well as system demonstrations.

Prior to going on site, CMS requested documentation, including call center scripts and employee training materials; copies of applications, renewal notices, notice of action forms; required reports; information on fair hearings conducted; the results of recent quality assurance reviews; and a list of all calls to the clearinghouse between January 1 and July 31, 2016. A review of that documentation was completed in late August/early September. A request for follow-up documentation was sent in late September, including information on the backlog mitigation plan; KEES reports; eligibility and enrollment policies and processes; case review materials; fair hearing reports; and KDHE's consumer assistance plan. The requested documents were provided on October 13, 2016.

The review was conducted to assess compliance with Federal regulations at, 42 CFR § 431, 42 CFR § 433, 42 CFR § 435 and 42 CFR § 457. It included the following objectives:

- reviewing KDHE compliance with Federal eligibility and enrollment regulations;
- determining whether KEES meets CMS functional system standards and is an adequate reflection of the system identified in the original Implementation Advance Planning Document (IAPD);

Through the onsite review, CMS identified a number of deficiencies related to the eligibility and enrollment processes which violate Federal Medicaid and CHIP requirements. The review findings and requested follow-up steps are outlined in detail in Table 1 below. For the items listed in Section 1, this letter is a formal request for a corrective action plan describing in detail a reasonable timeline for each of the findings identified as well as milestones and dates specifying when the plan will be fully implemented. As described in more detail below, CMS is also requesting additional information on the ability for individuals to apply for, and renew, Medicaid and CHIP coverage in person, with assistance.

The State has 60 days from the date of this letter to provide the corrective action plan described above. Failure to respond will result in the initiation of a formal compliance process. During the 60 days, CMS is available to provide technical assistance, as needed.

We thank you and your staff for all the assistance provided to CMS during our review and for providing all the requested documentation and information on a timely basis. If you have any questions regarding this letter, please contact Michala Walker at (816) 426-5925.

Sincerely, 1/20/2017

James G. Scott
Associate Regional Administrator
for Medicaid and Children's Health Operations

Signed by: James G. Scott -A

Enclosure

Table 1.

Requirement	Regulation(s)	Finding	Follow-Up Requested
1. Issues Requiring Corrective Action			
Timely determination of eligibility (Elimination of Application Backlog)	42 CFR § 435.912 and 42 CFR § 457.340(d) require the State agency to determine eligibility for Medicaid and CHIP within 45 days for individuals applying for coverage on a basis other than disability.	According to the reports provided to CMS, KDHE reduced the number of unprocessed applications pending over 45 days from nearly 11,000 in June 2016 to under 2,000 as of November 2016. This reduction was due, in part, to the implementation of the staff augmentation and process improvement plans outlined in the State's March 2016 corrective action plan. At the time of the onsite review, KDHE staff estimated that the backlog would be eliminated by the end of September 2016. However, the State continues to report a backlog of pending applications. As of January 1, 2017, KDHE reports 1,409 applications pending over 45 days. Bi-weekly data provided by the State also show that the number of pending applications over 45 days has steadily increased over the past several months, from under 1,500 in October 2016.	Please provide an updated plan and timeline for eliminating the State's remaining Medicaid and CHIP application backlog.
Issuance of denials, with fair hearing rights, for beneficiaries determined ineligible for Medicaid on the basis of a disability	42 CFR § 435.912 requires the State agency to determine eligibility for Medicaid within 90 days for applicants who apply for Medicaid on the basis of disability. 42 CFR § 435.541(c) requires that the State agency make a determination of disability.	When Kansas completes an eligibility determination on the basis of disability, applicants who are not determined to be disabled by the State are not issued appropriate denials of eligibility. Instead, the State pends these applications while applicants pursue a disability determination with the Social Security Administration (SSA). This policy makes it appear that disability-related applications are pending for more than 90 days, and contributes to the backlog of applications. The State's practice of pending disability-related applications also does not comply with Federal rules requiring States to issue denials of eligibility and notices of fair hearing rights, since denials and notices of fair hearing rights are not issued for applicants whom the State does not determine to be disabled.	During a follow-up call on November 15, 2016, KDHE representatives acknowledged that the State has not been issuing denials with notices of fair hearing rights for applicants whom the State determines ineligible for Medicaid based on a disability. The State noted that it would work to revise its policy and procedures. Please provide a detailed description and timeline of how the State plans to revise its current policy and issue appropriate denials, with notices of fair hearing rights, for individuals whose applications were inappropriately pended after the State determined them ineligible based on a disability. Please include any system modifications that may be necessary.

Redetermination of eligibility every 12 months	42 CFR § 435.916(a) and 42 CFR § 457.343 require the eligibility of Medicaid and CHIP beneficiaries whose financial eligibility is determined using MAGI-based income be renewed once every 12 months, and no more frequently than once every 12 months.	In November 2015, in an effort to focus State resources on the application backlog, Kansas stopped processing annual renewals for Medicaid and CHIP beneficiaries. As a result, KDHE did not complete required annual redeterminations for Medicaid and CHIP beneficiaries due for renewal between November 2015 and October 2016. During CMS' onsite review and in follow-up discussions, Kansas provided a plan and timeline to complete processing of delayed renewals scheduled for November 2015 through October 2016 by October 31, 2017, and resume the regular processing of renewals in accordance with 42 CFR 435.916.	Please review the State's plan for processing backlogged renewals, which was shared with CMS in October 2016. Please incorporate any changes to the plan, as necessary, and include the updated version as part of the response to this letter.
Reporting functionality	42 CFR § 433.112(b)(15) establish necessary reporting functionality for eligibility determination systems funded with enhanced Federal funding	When Kansas was approved for system funding, it committed to meeting the following conditions: (1) the system must provide more efficient, economical and effective administration of the State Plan; (2) The system must support accurate and timely processing and adjudications/eligibility determinations and effective communications with providers, beneficiaries, and the public; and (3) the system must produce transaction data, reports, and performance information that would contribute to program evaluation and continuous improvement in business operations. KDHE was not able to obtain key application processing reports needed to ensure monitoring and compliance with application processing requirements. Additionally, given the limited reporting functionality in KEES, the State has not reported required Performance Indicator data to CMS on application processing timeframes on ongoing basis. State staff explained that reports were being built in KEES at the time of our onsite review that would produce application processing time, and that they hoping to be able to generate reports on processing time from KEES by the end of 2016. However, at the time of this report KEES was still not able to produce application processing time reports.	Please provide a detailed plan to improve processes to enable KEES reporting functionality, which will allow the State to produce monthly performance indicator data and application processing timeframe reports. CMS expects the State to report progress on implementation of the plan via the combined bi-weekly State Operations and Technical Assistance (SOTA) and Enrollment and Eligibility (EE) meetings.

		In accordance with the aforementioned Federal conditions, CMS will continue to monitor the progress of the State's eligibility and enrollment modernization project using the Enterprise Life Cycle (ELC) model. This approach supports the high degree of interaction that will be required between Medicaid and the Health Insurance Marketplace, and the use of a shared eligibility service among the programs. Based on the State's project management plan, CMS will be working with the State to schedule the next Medicaid IT review. As part of the ELC model, the State should submit to CMS monthly status reports and quarterly Independent Verification and Validation reports, as well as participate in regular monitoring calls. Monthly status reports should include, at a minimum, the status of the project as well as risks, issues, and planned mitigations. Providing such reports is a condition of receiving Federal Financial Participation (FFP). Requirements for receiving FFP and for claims processing and information retrieval systems in general are available in State Medicaid Director Letters 16-004, 16-009, and 16-010.	
KEES Functionality	42 CFR § 433.112 establish conditions which eligibility determination systems must meet if funded with enhanced Federal funding.	When Kansas was approved for system funding, it committed to meeting the following conditions: (1) the system must provide more efficient, economical and effective administration of the State Plan; (2) the system must support accurate and timely processing and adjudications/eligibility determinations and effective communications with providers, beneficiaries, and the public; and (3) the system must produce transaction data, reports, and performance information that would contribute to program evaluation and continuous improvement in business operations. The CMS review team found limited evidence of KEES compliance with the approved Concept of Operations document and with these required conditions. State staff reported that KEES has not provided all intended functionality and that workarounds to address system defects continue to be in place. For example, the system does not identify duplicates as	Please provide a detailed plan for bringing KEES into compliance with the conditions required by 42 CFR § 433.112.

		it was designed to, meaning that staff must review each application to determine whether a record for the applicant(s) already exists. KEES also does not create notices correctly, causing manual creation of notices to be necessary. The State also confirmed that KEES has not been able to process any applications following the intended "no-touch" design which was included in the scope for the system approved by CMS. Additionally, a significant proportion of manual interventions and redundant processes were still in place at the time of the onsite review—14 months after system implementation. Some of the manual processes identified by the review team that could have been completed automatically by the system include: (1) registration of application (i.e., creating a record for an application in the system); (2) manual verification of whether the application or a case for the applicant already exists in KEES; and (3) manual triggering of electronic verification of data elements by case worker (e.g., verification of Social Security numbers). The review team also noted that a preliminary assessment of eligibility must be completed by contractor staff, which is confirmed or denied by KDHE staff. While this is a necessary step as State staff must make the final eligibility determination pursuant to 42 CFR § 431.10, the review team observed opportunities to streamline eligibility determination and redetermination processes.	
2. Issues Requiring Additional Information			
Opportunity to apply or renew coverage in person with sufficient assistance	42 CFR § 435.906 requires the Medicaid agency afford an individual wishing to do so the opportunity to apply for Medicaid without delay. 42 CFR § 435.907(a) requires that the agency accept	Based on information provided during the site visit and during subsequent conversions with the State, CMS was not able to determine whether Kansas' centralized clearinghouse model provides adequate opportunity for applicants wishing to apply for and renew Medicaid and CHIP coverage in person with sufficient assistance.	Please provide additional information to CMS on the ability for individuals to apply for and renew their Medicaid and CHIP eligibility in person, with in-person assistance provided by the State. Please include details on the availability of assistance for both MAGI and non-MAGI-based beneficiaries. CMS will assess the adequacy of this assistance in accordance with Federal regulations and will request a plan and timeline for addressing any concerns if it

	applications online, by phone, by mail, and in person. 42 CFR § 435.908(a) requires the Medicaid agency to provide assistance to any individual seeking help with the application or renewal process in person, over the telephone, and online, and in a manner that is accessible to individuals with disabilities and those who are limited English proficient. 42 CFR § 457.340(a) requires that the terms of 42 CFR § 435.906, 42 CFR § 435.907, 42 CFR § 435.908 apply equally in States administering a separate CHIP.		determines that the State's practices are not in compliance with applicable regulations.
3. Issues Requiring No Action			
Requests for fair hearings	42 CFR § 431.221(b) requires that the Medicaid agency not limit or interfere with the applicant's or beneficiary's freedom to make a request for a hearing.	The Kansas City Regional Office received reports from KanCare stakeholders who reported that KDHE Clearinghouse customer service representatives were discouraging callers from filing grievances and/or appeals. The CMS Federal Review Team listened to recordings of a random sample of calls related to appeals and grievances placed to the Clearinghouse in the first six months of calendar year 2016. Forty percent of the sampled calls were coded incorrectly, and were not actually related to grievances or appeals. Of the remaining calls sampled, CMS found no evidence of callers being discouraged from filing appeals and grievances.	None required as CMS did not find evidence of non-compliance in this area.

		CMS also reviewed the State's appeals policies and procedures as part of the September onsite review. The State verified that individuals are notified of their right to appeal and that Clearinghouse call center representatives receive appropriate training regarding requests for fair hearings.	

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

State Demonstrations Group

JAN 17 2017

Michael Randol
Director, Division of Healthcare Finance
Kansas Medicaid Director
Landing State Office Building
9800 SW Jackson, Suite 900N
Topeka, KS 66612-1220

Dear Mr. Randol:

This letter is in response to your December 8, 2016 request to extend the Kansas KanCare section 1115 Medicaid demonstration (Project No. 11-W-00283/7) for one additional year beyond the scheduled expiration date of December 31, 2017, until December 31, 2018. For the reasons outlined below the Centers for Medicare & Medicaid Services (CMS) cannot grant the state's request at this time.

As you indicate in your correspondence, Kansas submitted the December 8th letter in response to Special Terms and Condition (STC) #8(a) that requires the state to submit a request to extend the demonstration by no later than 12 months prior to the expiration date of the demonstration. However, STC #8(b) outlines the requirements that the state's extension submission must meet prior to submission to CMS. Specifically, Kansas must comply with federal transparency requirements for application procedures listed at 42 C.F.R §431.412(c), which includes completion of a state public notice process that meets the minimum standards listed at 42 C.F.R §431.408 and an annual post-award public forum as outlined in 42 C.F.R §431.420(c). Kansas' December 8th correspondence was not submitted in accordance with these requirements. As we discussed with the state on December 16, 2016, CMS cannot formally consider the state's request for a one-year extension until the state conforms to all requirements in STC #8. Following on our discussion on December 16th, we have considered whether this extension request meets the limited exception outlined in the transparency regulation, whereby CMS would consider a temporary extension of a demonstration that has a pending application under review for renewal, and we have determined that this limited exception is not applicable. There is no successor demonstration under review, because Kansas has not submitted an application for an extension of the demonstration.

Further, CMS has substantive concerns about the implementation of the KanCare demonstration. As communicated to Dr. Susan Mosier, Secretary, Kansas Department of Health and Environment, in a January 13, 2017 correspondence from Mr. James G. Scott, Kansas City Associate Regional Administrator for Medicaid and Children's Health Operations, CMS received a significant number of complaints and concerns from beneficiaries, providers, and advocates regarding the

operation of the KanCare demonstration that were substantiated during a CMS onsite review in October 2016. In light of these concerns, we request that Kansas' post-award forum, which as noted is part of CMS' section 1115 extension transparency requirements, include an opportunity for public input on the implementation of corrective actions to address concerns described in the January 13 correspondence.

CMS is happy to work with the state to provide flexibility on the application submission timeframe to develop an extension application that addresses our concerns and a corrective action plan, as well as to complete the state public notice and input process.

We look forward to continuing to work with you and your staff, and are available to provide technical assistance as you prepare to submit an extension application. If you have additional questions or concerns, please contact your project officer, Linda Macdonald at (410) 786-3872, or by e-mail at Linda.Macdonald@cms.hhs.gov.

Sincerely,

Eliot Fishman
Director

cc:
James G. Scott, Associate Regional Administrator, CMS Kansas City Region

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
Kansas City, Missouri 64106

Division of Medicaid and Children's Health Operations

January 13, 2017

Susan Mosier, M.D.
Secretary and State Health Officer
Kansas Department of Health and Environment
Curtis State Office Building
1000 SW Jackson Street, Suite 340
Topeka, KS 66612

Dear Dr. Mosier:

This letter addresses the Kansas Department of Health and Environment's (KDHE) noncompliance with the requirements of the KanCare program, authorized under Section 1115 of the Social Security Act (the Act), provisions of Kansas' Home and Community-Based Services (HCBS) waivers, and Federal Medicaid statute and regulations. This noncompliance, which is detailed in the enclosed KanCare Findings and Recommendations Report, places the health, welfare, and safety of KanCare beneficiaries at risk and requires immediate action.

The KanCare program establishes a managed care delivery system through a combination 1115/1915(c) waiver for nearly all of the 425,564 Medicaid and Children's Health Insurance Program (CHIP) beneficiaries in Kansas. KanCare's average annual costs total $3.4 billion.[1] The combined nature of the program means that some of the State's most vulnerable and medically complex individuals are enrolled in managed care, such as those living in nursing facilities or enrolled in HCBS waivers.

Throughout 2016, CMS received a significant number of complaints and concerns regarding the KanCare program from beneficiaries, providers, and advocates. In response, CMS reviewed information concerning the reported issues, discussed systemic concerns with State staff, and engaged State representatives to remediate individual cases as appropriate. Ultimately, CMS conducted an on-site visit from October 24, 2016 to October 27, 2016. The on-site review consisted of interviews with State agencies responsible for the KanCare program; interviews with staff of Amerigroup Kansas, Inc., Sunflower Health Plan, and UnitedHealthcare Community Plan of Kansas, the three KanCare managed care organizations (MCOs); and three stakeholder listening sessions with KanCare beneficiaries and families, providers, and advocacy groups. Additionally, CMS requested documentation both prior to and after the onsite. Our review of the provided documentation substantiated concerns

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[1] *Kansas Department of Health and Environment. State Fiscal Year 2016. Kansas Medical Assistance Report (MAR). Retrieved from:* http://www.kancare.ks.gov/policies-and-reports/medical-assistance-report

regarding administrative oversight of the program. In addition, the on-site discussions and documentation review revealed a number of concerns regarding the operation of KanCare.

The results of our on-site review confirm that Kansas is substantively out of compliance with Federal statutes and regulations, as well as its Medicaid State Plan. Kansas has failed to administer the KanCare program as required by section 1902(a)(4) of the Act and 42 C.F.R. § 431.15. The results of CMS' onsite review outlined in this letter and the accompanying report are particularly concerning given the large role KanCare plays in delivering care to Medicaid beneficiaries in Kansas. We have detailed some of the key findings of the review below, but want to underscore the serious nature of these concerns and the risks it poses to beneficiaries. These concerns affect beneficiaries' receipt of services necessary to stay in the community, beneficiaries' ability to access needed care, and the State's ability to ensure the health and welfare of beneficiaries.

Administrative Authority: 42 C.F.R § 431.10(b); 42 C.F.R. § 441.745

CMS regulations require States to establish a Single State Medicaid Agency with ultimate administrative authority over the Medicaid program. The Single State Medicaid Agency is responsible for the administration and supervision of the Medicaid State Plan, as well as any State operating agencies and/or contractors that perform functions on the State Medicaid Agency's behalf.

- The State has failed to establish clear roles and responsibilities for State employees who administer and operate the KanCare program. The State relied on a memorandum of understanding between KDHE and the Kansas Department of Aging and Disability Services (KDADS) that was last updated in 2010, prior to the implementation of KanCare. The memorandum references State departments that no longer exist and lacks criteria for KDHE to evaluate performance of KDADS.
- Limited coordination between KDHE and KDADS poses a risk to the health and safety of Managed Long Term Services and Supports (MLTSS) participants, who may experience difficulty managing their benefits. Review of MCO oversight and performance reports is divided between KDHE and KDADS and the lack of communication and collaboration creates a knowledge gap between the agency that operates the HCBS waivers (KDADS) and the agency responsible for managed care contract implementation (KDHE). This lack of communication also reduces the State's ability to identify problems, determine whether identified problems are improving in any systemic way, and initiate necessary changes at the MCO level.
- Kansas did not engage in sufficient oversight of the activities of the MCOs. While the State receives many reports from the MCOs, there is no evidence of significant analysis or subsequent program changes based on those reports. For example, recent MCO reports indicate that a low percentage of required health screenings were completed, but there is no evidence that the State provided feedback to the MCOs regarding completion of health screenings. The MCOs reported receiving little feedback on submitted reports, and the feedback that is provided is verbal rather than written. Further, reporting is inconsistent among the MCOs, which limits the State's ability to track issues and identify trends

across the program. For example, the levels used by each of the three MCOs to categorize critical incidents vary, resulting in inconsistent reporting to the State.

- The State's oversight of the MCOs has diminished over the four years of KanCare operation, as evidenced by its annual onsite reviews of the MCOs and subsequent reports. The 2013 annual report was a comprehensive document, and corrective action plans were issued to the MCOs regarding identified issues. The 2014 and 2015 annual reports were each two pages long, with little content of substance.
- Public feedback consistently describes a lack of engagement and adversarial communication from the State. Comments from KanCare stakeholders at multiple stakeholder sessions overwhelmingly reflect an inability to obtain clear and consistent information from the State and MCOs, making it difficult for KanCare enrollees to navigate their benefits.
- Stakeholders further noted that the State often does not respond to public comments or include changes in final policy documents to address public comments. The State maintains the KanCare Advisory Committee, and the MCOs each maintain an advisory board, but these committees do not meet all applicable requirements. Furthermore, committee members indicated that the committee meetings did not provide opportunities for meaningful public input.

Person-Centered Planning Process: 42 C.F.R § 441.301(c); 42 C.F.R § 441.725(b)

CMS requires that service plans for each participant in Medicaid HCBS programs be developed through a person-centered planning process that reflects the beneficiary's individual preferences and goals. The rules require that the person-centered planning process is directed by the participant, and may include other individuals as chosen by the participant. This planning process, and the resulting person-centered service plan, assist the participant in achieving personal outcomes in the most integrated community setting, ensure delivery of services that reflect personal preferences and choices, and help assure the participant's health and welfare.

- CMS uncovered significant compliance deficiencies with the person-centered planning process, which included: MCOs requesting participants sign incomplete forms without the number of hours or types of services they would receive; MCOs revising person-centered plans without the participant's input; and MCOs failing to ensure provider signatures on person-centered plans as required.
- One MCO indicated that while a service plan is developed for each waiver participant within 14 days of entering the waiver, the required person-centered plan is not developed until 3 to 6 months after services are authorized. The delayed completion of the person-centered plans compromises safeguards meant to ensure that waiver services and supports reflect participants' individual preferences and goals.
- None of the MCOs have processes in place that ensure all final service plans are signed and agreed to by the participant or that the participant receives a copy of the final plan. All three MCOs described processes that required participants to sign "interim" or "proposed" plans that were then reviewed and possibly revised by a utilization review committee within the MCO. If changes were made, MCOs attempted to obtain participant signatures on the final plans; but MCO staff stated they are not always successful in obtaining those signatures.

- None of the three MCOs currently require the signature of providers responsible for plan implementation, as required by 42 C.F.R. § 441.725(b)(9). The lack of member and provider signatures jeopardizes waiver participants' understanding of the services they should be receiving, and delivery of those services by providers.

Provider Access and Network Adequacy: 42 C.F.R § 441.730; 42 C.F.R. § 438.206
CMS requires States to ensure that each MCO maintains a network of providers that is sufficient to provide adequate and timely access to Medicaid services covered under the contract between the State and the MCO.

- The State's approach to tracking, monitoring, and overseeing provider network adequacy and access to care for KanCare consumers is limited. Given that KanCare serves nearly all Medicaid and CHIP beneficiaries, many of whom live in rural and frontier areas known to be underserved, CMS would expect a more robust oversight process including proactive monitoring of the number of providers enrolled in each MCO's network in regions with known access issues.
- MCOs must submit multiple reports to the State regarding access to care. However, there seemed to be little analysis or trending based on these reports at the State level. CMS staff have asked KDHE staff multiple times in late 2016 for the State's analysis of network adequacy. Although KDHE provided MCO provider network reports in response to these requests, CMS has never received any evidence of the State's analysis of network adequacy.
- The provider network data produced by the MCOs for much of 2015 contained incorrect and inconsistent information on provider specialties related to HCBS, making the data not useful for analyzing trends in HCBS provider network adequacy. The MCOs report that the data now being reported is correct, after a data clean-up effort in 2015.
- This lack of oversight and reliable data makes it difficult to determine whether sufficient providers are in the networks to serve enrolled beneficiaries, and to effectively track the impact of policy changes on provider networks.

Participant Protections: 42 C.F.R. § 438.100; 42 C.F.R. § 441.301(c)(2)(xiii); 42 C.F.R. § 441.302; 42 C.F.R. § 438.440
States are required to ensure that managed care enrollees are free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. To obtain HCBS waivers, States must assure CMS that necessary safeguards are in place to protect the health and welfare of beneficiaries and that any modification to an individual's freedoms meets specific requirements and is fully documented in the person-centered service plan. Finally, CMS requires that States and MCOs provide information to enrollees regarding grievance, appeal, and fair hearing procedures and timeframes, using a State-developed or State-approved description.

- Staff of one MCO mistakenly believed that use of restrictive interventions were not permitted in any of Kansas' HCBS waivers. However, two waivers allow for restraints, restrictions, and/or seclusion in certain circumstances. Because this MCO did not correctly understand the rules around restrictive interventions, they did not document rights restrictions in the person-centered plans as required.

Therefore, safeguards to protect beneficiaries' health and welfare with regard to restrictive interventions could not be carried out.

- The State does not have a comprehensive system for reporting, tracking, and trending critical incidents. MCO staff indicated that there was no formal, systematic process for them to report critical incidents, or resolution of critical incidents, for their members to the State; rather, they would call or email State staff to report such incidents. Recent HCBS reports provided no data to demonstrate that unexpected deaths were investigated within required timeframes; that reviews of critical incidents were initiated and reviewed within required timeframes; that the use of restraints, seclusion, or other restrictive interventions followed procedures as specified in the approved waivers; or that the unauthorized use of restrictive interventions was detected. The lack of oversight of critical incidents increases the risk that waiver recipients' rights, health, and safety could be in jeopardy.
- During the implementation of KanCare, the State permitted the MCOs to develop their own provider appeal processes. However, according to Federal rules, those processes should have been developed or approved by the State. The State recognized that difficulties resulted from the differing provider appeal processes, and asked the MCOs to develop one standardized process in late 2015. Until the new process is implemented, the MCOs continue to use differing provider appeal processes, creating administrative burden for providers who must navigate three different appeal processes.

Due to the severe and pervasive nature of the on-site review findings and the resulting impacts this has on the beneficiaries and providers, CMS is requiring Kansas to develop a Corrective Action Plan (CAP) describing the actions it will take to correct the identified noncompliance. KDHE must submit the CAP to CMS as soon as possible, and no later than February 17, 2017. The CAP must include a detailed plan addressing each of the findings identified in the attached report. The CAP must also include the milestones and dates specifying when the actions will be fully implemented; their impact on the health, welfare, and safety of waiver participants; and a strategy for ongoing review and monitoring of the KanCare program. CMS expects the State agencies responsible for the KanCare program to implement the CAP in an expeditious and transparent manner which includes engaging stakeholders on changes and planned changes. Implementation of the CAP, once approved, will be monitored by CMS.

Federal regulations at 42 C.F.R. § 430.35 allow CMS to withhold Federal Financial Participation payments from a State after a finding that the State's plan fails to comply, or to substantially comply, with the provisions of section 1902 of the Act. In the event that Kansas fails to: 1) submit the required CAP in the indicated timeframe, 2) submit a CAP that is sufficient to mitigate the issues, or 3) implement and monitor the CAP as approved by CMS, we plan to initiate formal compliance action as described in 42 C.F.R. § 430.35, including financial sanctions of State administrative funds. Kansas' execution of the CAP and measured performance improvement will ultimately inform the extension of Kansas' 1115 demonstration program , as well as future managed care contracts and 1915(c) waiver actions. KDHE is entitled to appeal the findings of noncompliance pursuant to the procedures set forth at 42 C.F.R. Part 430, Subpart D.

If you have any questions regarding this matter, please contact me at (816) 426-5925 or via email at James.Scott1@cms.hhs.gov.

Sincerely,

James G. Scott
Associate Regional Administrator
for Medicaid and Children's Health Operations

cc:
Vikki Wachino
Mike Nardone
Eliot Fishman
Mike Randol
Christiane Swartz
Tim Keck
Codi Thurness
Brandt Haehn
Brad Ridley
Susan Fout

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
Kansas City, Missouri 64106

Division of Medicaid and Children's Health Operations

December 14, 2016

Mike Randol, Division Director and Medicaid Director
Kansas Department of Health and Environment
Division of Health Care Finance
Landon State Office Building
900 SW Jackson Street, Room 900N
Topeka, KS 66612

Dear Mr. Randol:

The purpose of this letter is to inform you that the State of Kansas is required to develop a Corrective Action Plan (CAP) by January 31, 2017, to address the following:

- Failure to meet statutory requirements under §1915(c) of the Social Security Act
- Failure to demonstrate that the state is implementing its waiver program as identified in the approved waivers in the Waiver Management System (WMS) per 42 CFR §441.302
- Failure to comply with 1115(a) Waiver Demonstration 11-W-00283/7 Special Terms and Conditions (STC) #38, STC #46, and STC #78.

The issues outlined in the enclosed document affect the following HCBS Waivers:

- Autism #0476
- Frail Elderly #0303
- Intellectual/Developmental Disability #0224
- Physical Disability #0304
- Serious Emotional Disturbance #0320
- Technology Assisted #4165
- Traumatic Brain Injury #4164

The Centers for Medicare & Medicaid Services (CMS) will provide technical assistance to your staff regarding the required components of a CAP. We would like to set up an initial conference call by December 30, 2016, to discuss the issues described above and determine our next steps. Deborah Read from the CMS Kansas City Regional Office will contact you to schedule this initial call.

If you have any questions, please feel free to contact me or Deborah Read at Deborah.Read@cms.hhs.gov. We look forward to assisting your efforts to develop and implement your CAP. We believe that this endeavor will benefit the waiver participants enrolled in these home- and community-based waiver programs.

12/14/2016

Sincerely,

James G. Scott
Associate Regional Administrator
for Medicaid and Children's Health Operations

Signed by: James G. Scott -A

Enclosure

cc:
Fran Seymour-Hunter - KDHE
Tim Keck - KDADS
Kim Tjelmeland - KDHE
Brandt Haehn - KDADS
Brad Ridley - KDADS
Codi Thurness - KDADS
Christiane Swartz - KDHE

Kansas HCBS
372 Quality Reporting
CORRECTIVE ACTION PLAN

SECTION 1: Completed by CMS	
State	Kansas
Precipitating Cause or Event	Monitoring of KS CMS 372 Quality Reporting
Waivers covered by CAP	➢ Autism #0476 ➢ Services for the Frail Elderly #0303 ➢ I/DD #0224 ➢ Physical Disability #0304 ➢ Serious Emotional Disturbance #0320 ➢ Technology Assisted #4165 ➢ Traumatic Brain Injury #4164
CAP to Address	The CAP shall include: ➢ A description of the assurances and sub-assurances that were/are approved in the waiver. ➢ A description of how the state will improve its processes to come into compliance with these assurances and sub-assurances. ➢ Development of reporting practices to produce data demonstrating compliance with these assurances and sub-assurances. o The CAP should also include: ▪ Milestones/action steps (e.g., staff training completed, beta test conducted, protocols issued, etc.) ▪ Deliverables ▪ Target date for completion of each action step ▪ Responsible entity ▪ Status updates ▪ Date action was completed ▪ How progress of the CAP will be overseen by the Single State Agency
Assurance(s)	(Please see the attached chart for specific data on the performance measures identified in the statements below.) ➢ Administrative Authority – Data indicates that the Single State Agency (KDHE) is not overseeing the Operating Agency (KDADS) in the manner identified in the approved waivers; of the 4 performance measures, one reports only 25% compliance across all 7 waivers and another ranges as low as 45% compliance. The current Memorandum of Understanding (MOU) between

Kansas HCBS
372 Quality Reporting
CORRECTIVE ACTION PLAN

	KDHE and KDADS was last updated in 2010 and references state departments no longer in existence. The MOU does not specify the criteria upon which the delegated agency will be evaluated as part of the Single State Medicaid Agency's oversight responsibility, define periodic reporting requirements, or consequences for non-compliance. ➢ Level of care – Data reported for the 7 waivers, identified participants in 4 waivers receiving waiver services without a current LOC on file. Data for 6 of 7 waivers identified participants with LOCs not completed by qualified staff; and data for 4 of 7 waivers identified participants with LOCs not completed on the appropriate tool. ➢ Plan of Care – Data for 5 of the 7 waivers show multiple measures related to the appropriateness of POCs below 86 percent. For example, there are 3 POC performance measures for which the data falls below 86% across all 5 of these waivers and there are an additional 3 POC performance measures for which the data falls below 86% on 4 of the 5 waivers. ➢ Qualified Providers – The state provided almost no data for this assurance. For all 7 waivers, the state indicates using the MCOs' credentialing standards as a proxy for the performance measures. Additionally, for the data which was provided, the state has not provided any validation of MCO credentialing standards as a proxy measure. Furthermore, when asked how they are overseeing the MCOs to ensure that providers are qualified, the State responds that oversight of the MCO credentialing standards **will be** accomplished through a review of a sample of files, suggesting that no oversight of provider qualifications is currently being performed by the State. ➢ Health & Welfare – No data was provided for 6 of 10 performance measures related to this assurance for 5 of the 7 waivers. Additionally, the data provided for 2 additional performance measures were below 86% across 5 of the 7 waivers. CMS understands that the state lacks a centralized system to receive information regarding reported and/or investigated incidents. To ensure effective oversight of Health & Welfare, the state should have an operationalized data system that supports the identification of trends and patterns in the occurrence of critical incidents or events. Such system would allow the state to identify opportunities for improvement and thus support the development of strategies to reduce the occurrence of incidents in the future.
Date of CMS request	11/23/2016
Regulation/statute/policy	Failure to meet statutory requirements under §1915(c)(2)(E) of the Social Security Act Failure to demonstrate that the state is implementing its waiver program as identified in the approved waivers in the Waiver Management System per 42 CFR § 441.302

Kansas HCBS
372 Quality Reporting
CORRECTIVE ACTION PLAN

Other	
SECTION 2: Completed by CMS – subsequent to kick off meeting	
Goal Statement	(Specify goal of CAP (compare "what is" with "what should be") i.e., develop and implement waiver program monitoring processes across multiple waivers, develop, implement and manage a system to track remediation actions across all waivers, develop and implement a process to ensure Freedom of Choice is offered to all Aged waiver participants) The goals of this CAP include the following: ➢ Assure that KDHE is overseeing the operation of their waiver programs by KDADS by reviewing performance measure data quarterly, attending KDADS quality meetings as specified in the approved waivers, and implementing effective remediation actions when compliance is below 86%. ➢ Review the performance measures to ensure that appropriate data is collected to demonstrate to CMS State oversight of all the waiver assurances. ➢ Institute reporting to CMS on a quarterly basis the results of the KDHE and KDAD's monitoring to demonstrate the continuous quality improvement cycle, i.e., remediating those areas where problems have been identified and implementing systems changes where necessary. ➢ The state needs to demonstrate that waivers are operated in accordance with the approved CMS assurances by improving systems and processes.
CAP Conclusion Statement	(Specify circumstance to describe when CAP will be deemed complete) Through the CAP, CMS requires KS to submit the final CAP document describing related activities to demonstrate that the state has designed and implemented an effective system for reviewing the activities delegated to the Operating Agency and MCOs. The CAP will be complete when the State has submitted 2 years of complete data on all performance measures for all waivers with either (1) all measures above the 86% threshold or (2) effective remediation actions for all measures below the 86% threshold. All data and remediation must demonstrate sufficient KDHE oversight of the HCBS program.
SECTION 3: Completed by State and Approved by CMS	
Objective #1: Establish Measurable Tasks	(i.e., develop process to generate LOC performance reports, develop possible remediation actions, develop/modify Freedom of Choice Form)

Kansas HCBS
372 Quality Reporting
CORRECTIVE ACTION PLAN

Action Steps	Milestones	Deliverables	Target Date	Responsible Entity	Status Updates	Date Completed	CMS Only	CMS Acceptance
List each step	*List milestones associated with action step*	*If any*		*Waiver Manager?*	*In process*	*Enter date action completed*	*CMS updates/ notes related to monitoring*	*CMS updates/date of CMS' final acceptance of the Action Step*

Attachment: State Acronyms/Abbreviations	(state identifies terms and abbreviations used in the CAP)

SECTION 4: State Signatures		
Initial CAP Submission	Name, Title	Date
Final CAP Submission	Name, Title	Date

SECTION 5: CMS Review – Completed by CMS	
Date submitted by state	
CMS action	Approved/Returned for Revision
Date of CMS action	
Summary of revisions requested by CMS	Completed by CMS if returned to the State for revisions
Date re-submitted by State	
CMS action	Approved/Returned for Revision
Date of CMS action	Completed by CMS if returned to the State for revisions
Summary of revisions requested by CMS	Completed by CMS if returned to the State for revisions

Kansas HCBS
372 Quality Reporting
CORRECTIVE ACTION PLAN

Date re-submitted by State	
Summary of revisions made by state	
RO Analyst signature	
Date CMS Approved CAP	

	Performance Measure - 2014	TA Waiver (4165)	I/DD Waiver (0224)	Autism Waiver (0476)	PD Waiver (0304)	FE Waiver (0303)	SED Waiver (0320)	TBI Waiver (4164)	Average for Each Performance Measure Across all 7 waivers
Administrative Authority	# and % of Quality Review reports generated by KDADS that were submitted to KDHE	25%	25%	25%	25%	25%	25%	25%	**25%**
	# and % of waiver amendments and renewals reviewed and approved by KDHE prior to submission to CMS by KDHE	100%	N/A	100%	100%	100%	100%	100%	**100%**
	# and % of waiver policy changes that were submitted to KDHE prior to implementation by KDADS	N/A	100%	N/A	N/A	N/A	N/A	N/A	**100%**
	# and % of LTC meetings that were represented by the program managers through in-person attendance or written reports	64%	91%	91%	45%	82%	100%	100%	**82%**
Level of Care	# and % of waiver participants who were determined to meet LOC requirements prior to receiving HCBS services	89%	94%	No data provided	83%	91%	89%	89%	**89%**
	# and % of waiver participants who receive their annual LOC evaluation within 12 months of the previous LOC determination	90%	74%	No data provided	52%	70%	88%	88%	**77%**
	# and % of waiver participants whose LOC determinations used the state's approved screening tool	98%	95%	No data provided	84%	91%	79%	79%	**88%**
	# and % of initial LOC determinations made by a qualified assessor	100%	85%	No data provided	68%	86%	71%	71%	**80%**

	# and % of initial LOC determinations made where the LOC criteria was accurately applied	98%	95%	No data provided	83%	90%	88%	88%	**90%**
Qualified Providers	# and % of new licensed waiver provider applicants that initially met licensure requirements and other waiver standards prior to furnishing waiver services	No data provided	100%	No data provided	No data provided	No data provided	No new applicants	No new applicants	**100%**
	# and % of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements and other waiver standards	No data provided	100%	No data provided	No data provided	No data provided	100%	100%	**100%**
	# and % of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services	No data provided	No data provided	No data provided	No data provided	No data provided	N/A	N/A	**No data provided**
	# and % of enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements	No data provided	No data provided	No data provided	No data provided	No data provided	N/A	N/A	**No data provided**
	# and % of active providers that meet training requirements	No data provided	No data provided	No data provided	No data provided	No data provided	91%	91%	**91%**
	# and % of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment	96%	78%	68%	87%	86%	90%	90%	**85%**
	# and % of waiver participants whose service plans address participant's goals	61%	49%	69%	50%	50%	90%	90%	**66%**

Plan of Care	# and % of waiver participants whose service plans address health and safety risk factors	96%	93%	74%	91%	93%	88%	88%	**89%**
	# and % of waiver participants whose service plans were developed according to the processes in the approved waiver	91%	No data provided	65%	86%	86%	90%	90%	**85%**
	# and % of waiver participants (or their representatives) who were present and involved in the development of their service plan	91%	84%	69%	87%	85%	90%	90%	**85%**
	# and % of service plans reviewed before the waiver participant's annual redetermination date	89%	82%	59%	82%	85%	87%	87%	**82%**
	# and % of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change	42%	23%	11%	39%	38%	86%	86%	**46%**
	# and % of waiver participants who received services in the type, scope, amount, duration and frequency specified in the service plan	98%	92%	86%	95%	92%	93%	93%	**93%**
	# and % of waiver participants whose record contains documentation indicating a choice of waiver service providers	86%	64%	63%	65%	74%	89%	89%	**76%**
	# and % of waiver participants whose record contains documentation indicating a choice of waiver services	91%	64%	72%	72%	80%	89%	89%	**80%**

	# and % of waiver participants whose record contains documentation indicating a choice of community-based services vs. institutional alternative	92%	66%	72%	76%	80%	90%	90%	**81%**
	Number of survey respondents who reported receiving all services as specified in their service plan	87%	94%	71%	94%	84%	Not a PM in this waiver	Not a PM in this waiver	**86%**
	Number of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care	90%	53%	50%	71%	75%	Not a PM in this waiver	Not a PM in this waiver	**68%**
	# and % of unexpected deaths for which review/investigation resulted in the identification of non-preventable causes	No data provided	No data provided	No data provided	No data provided	No data provided	No data provided	No data provided	**No data provided**
	# and % of unexpected deaths for which review/investigation followed the appropriate policies and procedures	No data provided	No data provided	No data provided	No data provided	No data provided	No data provided	No data provided	**No data provided**
	# and % of unexpected deaths for which the appropriate follow-up measures were taken	No data provided	No data provided	No data provided	No data provided	No data provided	No data provided	No data provided	**No data provided**
	# and % of participants' reported critical incidents that were initiated and reviewed within required timeframes	No data provided	No data provided	No data provided	No data provided	No data provided	No data provided	No data provided	**No data provided**
Health and	# of waiver participants who received information on how to report suspected abuse, neglect, or exploitation	82%	75%	50%	64%	78%	89%	89%	**75%**

Welfare	# and % of reported critical incidents requiring review/investigation where the state adhered to its follow-up measures	100%	100%	100%	100%	100%	100%	100%	**100%**
	# and % of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver	No data provided	No data provided	No data provided	No data provided	No data provided	N/A	N/A	**No data provided**
	# and % of unauthorized uses of restrictive interventions that were appropriately reported	No data provided	No data provided	No data provided	No data provided	No data provided	N/A	N/A	**No data provided**
	# and % of waiver participants who received physical exams in accordance with state policies	100%	97%	98%	73%	95%	52%	52%	**81%**
	# of waiver participants who have a disaster red flag designation with a related back-up plan	83%	64%	64%	67%	70%	Not a PM in this waiver	Not a PM in this waiver	**70%**
Financial Accountability	# and % of provider claims that are coded and paid in accordance with the state's approved reimbursement methodology	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**N/A**
	# of clean claims that are paid by the MCO within the timeframes specified in the contract	90%	90%	90%	90%	90%	90%	90%	**90%**
	# and % of payment rates that were certified to be actuarially sound by the state's actuary and approved by CMS	100%	100%	100%	100%	100%	100%	100%	**100%**
									83%

From: Shorman, Jonathan
To: CMS FOIA Request
Subject: Re: FOIA for Kansas City region
Date: Monday, January 9, 2017 5:38:42 PM

My apologies. Please see below.

January 6, 2017

CMS FOIA Officer
Centers for Medicare & Medicaid Services

Dear FOIA Officer:

Under the Freedom of Information Act, 5 USC subsection 552, I am requesting access to:

>> any and all correspondence and documentation provided to the State of Kansas since December 1, 2016, that document or include the findings of an audit, examination, inquiry, or investigation of KanCare

>> any and all correspondence and documentation in the possession of CMS or provided to the State of Kansas pertaining to focus groups, roundtable discussions or other stakeholder input gathering regarding KanCare conducted since August 1, 2016

I am willing to pay fees up to the amount of $100. If the estimate for fulfilling the request exceeds this amount, please inform me first.

I also request a waiver of all fees for the request because disclosure of the information is in the public interest because it will shed light on the current situation at a publicly-funded institution.

If part of my request can be fulfilled immediately or more quickly than another part, I request that you immediately provide the available documents.

Feel free to contact me at any time. I request that, if possible, records be sent to me electronically at this address: jonathan.shorman@cjonline.com

My mailing address is 616 SE Jefferson, Topeka, Kansas, 66607.

Sincerely,

Jonathan Shorman

Reporter
The Topeka Capital-Journal
785.312.1854

From: CMS FOIA Request <FOIA_Request@cms.hhs.gov>
Sent: Monday, January 9, 2017 4:12:41 PM
To: Shorman, Jonathan
Subject: RE: FOIA for Kansas City region

Good Afternoon,

The request below does not include a mailing address. Please, resubmit with your full mailing address to be considered for processing.

Thank You, and Have a Great Evening!

From: Shorman, Jonathan [mailto:jonathan.shorman@cjonline.com]
Sent: Friday, January 6, 2017 2:38 PM
To: CMS FOIA Request <FOIA_Request@cms.hhs.gov>
Subject: FOIA for Kansas City region

January 6, 2017

CMS FOIA Officer
Centers for Medicare & Medicaid Services

Dear FOIA Officer:

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Feel free to contact me at any time. I request that, if possible, records be sent to me electronically at this address: jonathan.shorman@cjonline.com

Sincerely,

Jonathan Shorman
Reporter
The Topeka Capital-Journal
785.312.1854