FOIA REQUEST PROTOTYPING:

INCORPORATING USER RESEARCH AND UX INTO FOIA AT MEDICARE

Centers for and Medicaid Services

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PROBLEM

At present, FOIA requests are the only way Medicare beneficiaries can get their claim records from CMS.

28,045* new requests each year

28,405* requests processed yearly

3,000* requests unprocessed at year-end

20* days to review simplest requests

55%* fully rejected or not found

15%* partially rejected

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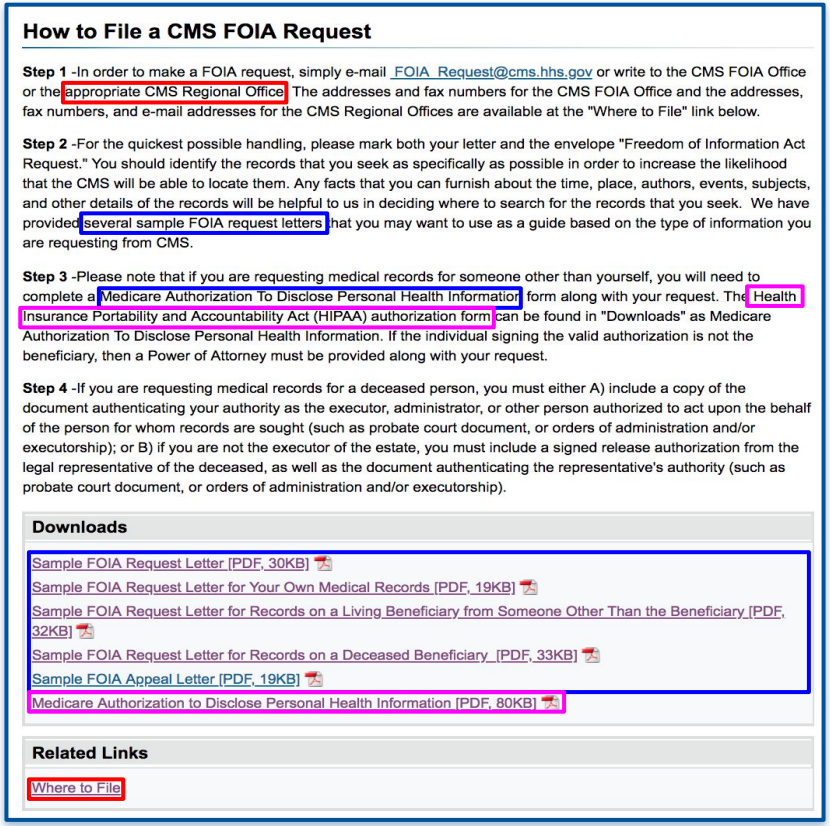
*5-Year Averages. Source: HHS Fiscal Year Freedom of Information Annual Reports, 2013-2017

CURRENT STATE: INSTRUCTIONS



How to File a CMS FOIA Request

Step 1 -In order to make a FOIA request, simply e-mail FOIA_Request@cms.hhs.gov or write to the CMS FOIA Office or the appropriate CMS Regional Office. The addresses and fax numbers for the CMS FOIA Office and the addresses, fax numbers, and e-mail addresses for the CMS Regional Offices are available at the "Where to File" link below.

Step 2 -For the quickest possible handling, please mark both your letter and the envelope "Freedom of Information Act Request." You should identify the records that you seek as specifically as possible in order to increase the likelihood that the CMS will be able to locate them. Any facts that you can furnish about the time, place, authors, events, subjects, and other details of the records will be helpful to us in deciding where to search for the records that you seek. We have provided several sample FOIA request letters that you may want to use as a guide based on the type of information you are requesting from CMS.

Step 3 -Please note that if you are requesting medical records for someone other than yourself, you will need to complete a Medicare Authorization To Disclose Personal Health Information form along with your request. The Health Insurance Portability and Accountability Act (HIPAA) authorization form can be found in "Downloads" as Medicare Authorization To Disclose Personal Health Information. If the individual signing the valid authorization is not the beneficiary, then a Power of Attorney must be provided along with your request.

Step 4 -If you are requesting medical records for a deceased person, you must either A) include a copy of the document authenticating your authority as the executor, administrator, or other person authorized to act upon the behalf of the person for whom records are sought (such as probate court document, or orders of administration and/or executorship); or B) if you are not the executor of the estate, you must include a signed release authorization from the legal representative of the deceased, as well as the document authenticating the representative's authority (such as probate court document, or orders of administration and/or executorship).

Downloads

Sample FOIA Request Letter [PDF, 30KB]

Sample FOIA Request Letter for Your Own Medical Records [PDF, 19KB]

Sample FOIA Request Letter for Records on a Living Beneficiary from Someone Other Than the Beneficiary [PDF, 32KB]

Sample FOIA Request Letter for Records on a Deceased Beneficiary [PDF, 33KB]

Sample FOIA Appeal Letter [PDF, 19KB]

Medicare Authorization to Disclose Personal Health Information [PDF, 80KB]

Related Links

Where to File

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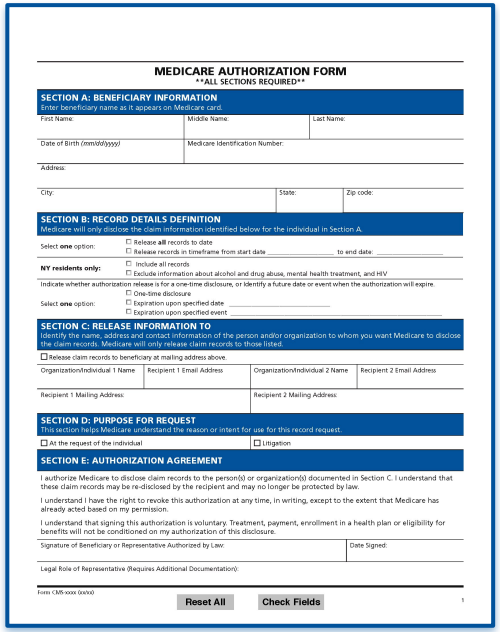
TASK: CLARIFY AND ERROR-PROOF

- Low-fidelity: PDF
  - Suggested changes to fields and instructions for clarity on a one-page PDF version of the authorization form developed by CISP team and contractors
  - Added JavaScript form field error checking, including contradiction testing
- Medium fidelity: Web form
  - Incorporated real-time form field error checking
  - Clarified instructions for each step and when
  - Utilized JavaScript and JQuery to call attention to semi-required fields
  - Consolidated redundant steps (i.e., information requested in both required cover letter and required authorization form)

RESULT - TWO PROTOTYPES



MEDICARE AUTHORIZATION FORM

ALL SECTIONS REQUIRED

SECTION A: BENEFICIARY INFORMATION
Enter beneficiary name as it appears on Medicare card.

First Name: | Middle Name: | Last Name:

Date of Birth (mm/dd/yyyy) | Medicare Identification Number:

Address:

City: | State: | Zip code:

SECTION B: RECORD DETAILS DEFINITION
Medicare will only disclose the claim information identified below for the individual in Section A.

Select **one** option:
- ☐ Release **all** records to date
- ☐ Release records in timeframe from start date _____ to end date: _____

NY residents only:
- ☐ Include all records
- ☐ Exclude information about alcohol and drug abuse, mental health treatment, and HIV

Indicate whether authorization release is for a one-time disclosure, or identify a future date or event when the authorization will expire.

Select **one** option:
- ☐ One-time disclosure
- ☐ Expiration upon specified date _____
- ☐ Expiration upon specified event _____

SECTION C: RELEASE INFORMATION TO
Identify the name, address and contact information of the person and/or organization to whom you want Medicare to disclose the claim records. Medicare will only release claim records to those listed.

☐ Release claim records to beneficiary at mailing address above.

Organization/Individual 1 Name | Recipient 1 Email Address | Organization/Individual 2 Name | Recipient 2 Email Address

Recipient 1 Mailing Address: | Recipient 2 Mailing Address:

SECTION D: PURPOSE FOR REQUEST
This section helps Medicare understand the reason or intent for use for this record request.

☐ At the request of the individual | ☐ Litigation

SECTION E: AUTHORIZATION AGREEMENT

I authorize Medicare to disclose claim records to the person(s) or organization(s) documented in Section C. I understand that these claim records may be re-disclosed by the recipient and may no longer be protected by law.

I understand I have the right to revoke this authorization at any time, in writing, except to the extent that Medicare has already acted based on my permission.

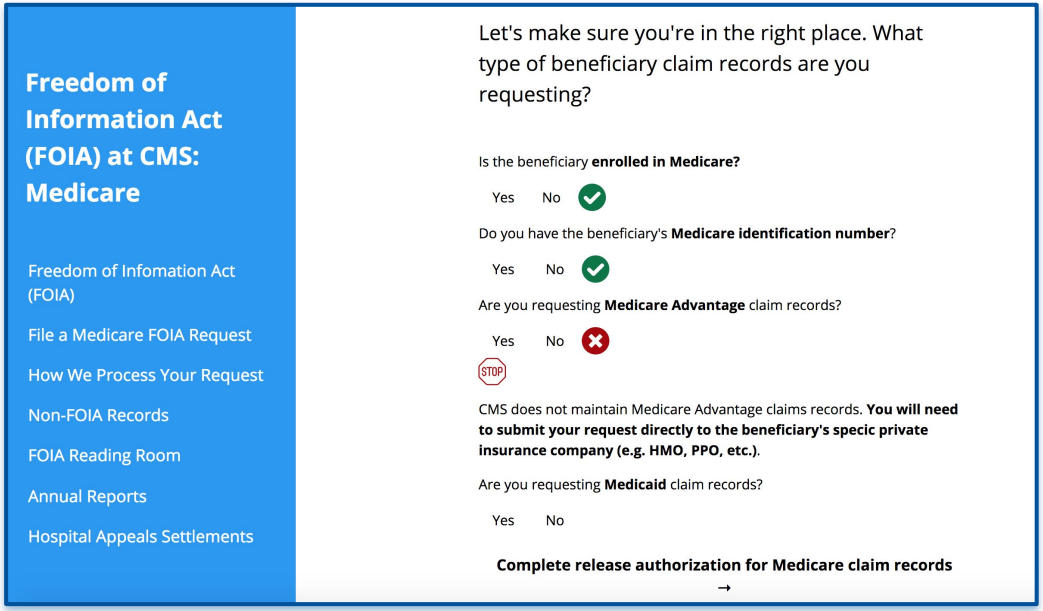
I understand that signing this authorization is voluntary. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on my authorization of this disclosure.

Signature of Beneficiary or Representative Authorized by Law: | Date Signed:

Legal Role of Representative (Requires Additional Documentation):

Form CMS-xxxx (xx/xx) 1

Reset All | Check Fields



Freedom of Information Act (FOIA) at CMS: Medicare

- Freedom of Infomation Act (FOIA)
- File a Medicare FOIA Request
- How We Process Your Request
- Non-FOIA Records
- FOIA Reading Room
- Annual Reports
- Hospital Appeals Settlements

Let's make sure you're in the right place. What type of beneficiary claim records are you requesting?

Is the beneficiary **enrolled in Medicare?**

Yes No ✓

Do you have the beneficiary's **Medicare identification number**?

Yes No ✓

Are you requesting **Medicare Advantage** claim records?

Yes No ✗

STOP

CMS does not maintain Medicare Advantage claims records. **You will need to submit your request directly to the beneficiary's specic private insurance company (e.g. HMO, PPO, etc.).**

Are you requesting **Medicaid** claim records?

Yes No

Complete release authorization for Medicare claim records

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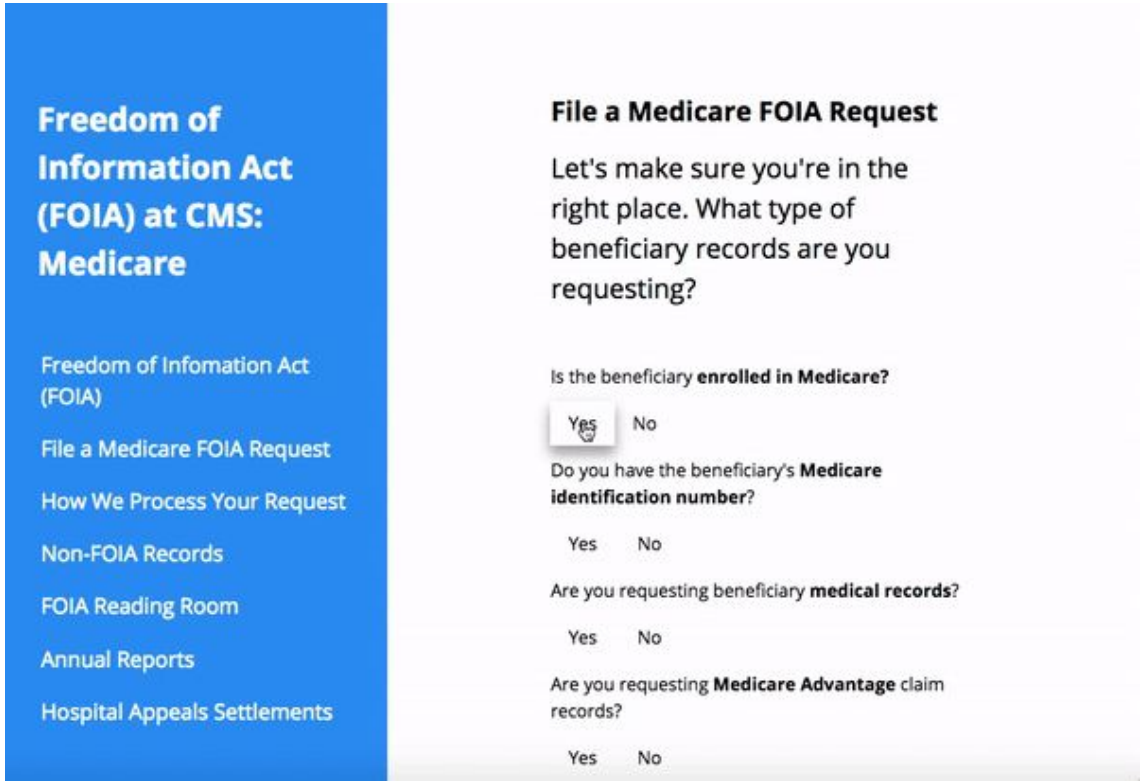

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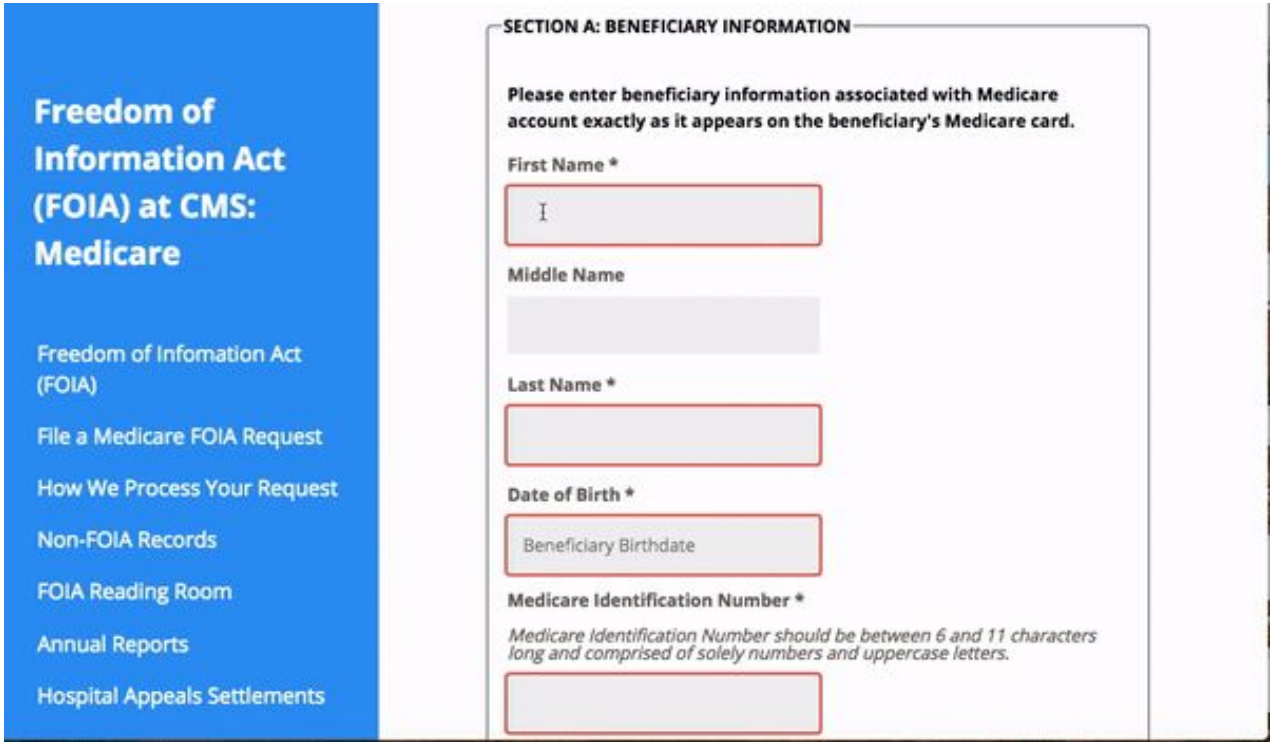

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IMPACT

- Brings error checking earlier in FOIA request process with automatic error checking on the customer side
- Reduces error checking steps after submission, saving time and resources
- Reduces backlog of CMS FOIA requests
- Medicare customers get their requested information more quickly, and with less effort!

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SPECIAL THANKS TO:

- **Kevin Larsen,** Director - CMS Continuous Improvement and Strategic Planning (CISP)
- **Stephanie Magill,** Field Spread Operations Lead for Lean - CMS CISP
- **Maria Elena Stopher,** President - ULTIMATE LEAN & CISP Contractor
- **Walter Mitton & Rush Gross,** CMS CISP Staff
- **Yadira Sanchez,** Senior Technical Advisor - CMS OEDA
- **Kevin McTigue,** Director - HHS IDEA Lab
- **Kate Appel,** Program Analyst, HHS Office of the Chief Technology Officer
- **Aspen Kissell,** Special Assistant to the HHS Chief Technology Officer
- **Ed Simcox,** HHS Chief Technology Officer
- **Maia Laing,** Business consultant - HHS Office of the CTO
- **and many more!!**

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