UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

PAUL BURKE, *Pro Se* Plaintiff, vs. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Defendant.	Case: 1:16-cv-00825 (CRC)

PLAINTIFF'S MOTION FOR AWARD OF COSTS

Plaintiff Paul Burke respectfully petitions the Court for an award of costs as provided by the Freedom of Information Act ("FOIA"), 5 U.S.C. § 552(a)(4)(E). Plaintiff only seeks payment of the $400 filing fee.

Plaintiff filed a Notice of Voluntary Dismissal on June 30, 2016 after receiving the documents requested. Plaintiff has substantially prevailed and received the documents by "a voluntary or unilateral change in position by the agency" (5 U.S.C. § 552(a)(4)(E)(ii)). He has provided public benefit, putting the important information online, without commercial benefit to him. Defendant HHS acted unreasonably in withholding for years information which it had provided to other members of the public, and in authorizing the original deciding official to make decisions on the administrative appeal.

Plaintiff is filing this motion to keep the case moving, in case settlement negotiations fail to resolve the remaining issue of cost. Pursuant to Local Civil Rule 7(m) Plaintiff has discussed with HHS counsel, and the agency takes no position at this time.

ELIGIBILITY FOR AWARD OF COSTS

5 U.S.C. § 552(a)(4)(E) says,

> "(i) The court may assess against the United States… litigation costs reasonably incurred in any case under this section in which the complainant has substantially prevailed.

> "(ii) For purposes of this subparagraph, a complainant has substantially prevailed if the complainant has obtained relief through… a voluntary or unilateral change in position by the agency, if the complainant's claim is not insubstantial."

For almost three years HHS improperly refused to release the documents. They keep the documents on a password-protected web portal for instant release to Accountable Care Organizations, which serve Medicare patients (Exhibit 6 and paragraph 7 in Plaintiff's Declaration filed with this Motion). HHS could have accessed the documents and given them to Plaintiff instantly. Instead, HHS released the documents 1,059 days after it received the FOIA request, 440 days after it received the administrative appeal, but only 35 days after the court case was filed, one day after HHS FOIA staff told Plaintiff they were aware of the court case, and on the same day the HHS Answer to the Complaint was originally due.

HHS only provided the documents when they were facing the deadline to respond to the lawsuit. The timing of this "unilateral change in position by the agency" was too far from the dates of the request and the administrative appeal, and too close to the court filing, to be coincidental. Dates are documented in the Plaintiff's Declaration.

Requests for costs in FOIA cases survive dismissal of the underlying case (Carter v. VA, 780 F.2d 1479, 1481 (9th Cir. 1986); Anderson v. HHS, 3 F.3d 1383, 1385 (10th Cir. 1993)).

ENTITLEMENT FOR AWARD OF COSTS

Four aspects entitle the plaintiff to award of his costs (Davy v. CIA, 550 F.3d 1155, 1159 (D.C. Cir. 2008)):

(1) Public benefit derived from the case - CMS has 430 Accountable Care Organizations participating in the "Shared Savings Program" in 49 states and DC, serving 7.7 million patients (Exhibit 12 in Plaintiff's Declaration, "Medicare Makes Enhancements to the Shared Savings Program ..." Press release June 6, 2016 from Centers for Medicare and Medicaid Services, "CMS"). With 7.7 million patients, this is a large effort by CMS to give financial

rewards to doctors and hospitals participating in Accountable Care Organizations, when they reduce unnecessary spending on their Medicare patients (42 CFR 425.604(d) and 425.606(d)). Documents obtained by this case govern the wording which these organizations must use to tell patients about the program and its incentives (42 CFR 425.20 and 425.310(c)). Because of this case, anyone can now see this wording, which covers important topics such as reducing the cost of Medicare and coordinating care.

Plaintiff has already posted the documents received in this case online for anyone to see, and he is preparing an analysis for publication (paragraph 1 in Plaintiff's Declaration).

(2) Lack of commercial benefit to the plaintiff - Plaintiff derives no income from the information, nor from his website, which does not take advertisements and is maintained as a contribution to the public interest.

(3) Nature of the plaintiff's interest in the records - Plaintiff needed the records to report fully on how Medicare patients are informed about Accountable Care Organizations. He can now report on what CMS allows and requires these organizations to tell patients.

(4) Reasonableness of the agency's withholding of the requested documents - HHS was unreasonable in three ways: the records were not exempt, processing time was excessive, and the administrative appeal process was not independent of the original decision.

(4A) RECORDS WERE NOT EXEMPT

Plaintiff's request asked for "signs," "standardized written notices," "templates," and "model language," which CMS gives to medical providers in Accountable Care Organizations. The request is Exhibit 1 in Plaintiff's Declaration. The following wording identifies the material. CMS used this wording when it published its Final Rule (76 *Federal Register* 67946-67947, 11/2/11):

- "CMS will develop appropriate language" for signs, which medical providers must display to patients.

- Medical providers must "make available standardized written notices developed by CMS to the Medicare FFS beneficiaries whom they serve." [FFS-Fee For Service]
- CMS may supply "templates or model language for ACOs to use in marketing materials".

Similar wording is codified at 42 CFR 425.310(c)(1) and 425.312(a). The wording indicated that providers must offer some of the material to patients, and may offer them the rest.

The CMS denial letter, signed by Mr. Hugh Gilmore, withheld "the materials in their entirety, under Exemption 5 of the FOIA (5 U.S.C. § 552(b)(5))." The denial letter is Exhibit 2 in Plaintiff's Declaration.

The letter made conclusory mention of civil discovery privileges, attorney-client privilege and deliberative process privilege. It did not explain how any of these privileges applies to information already released to the public, i.e. doctors participating in Accountable Care Organizations, pursuant to a Final Rule. Accountable care Organizations are independent legal entities, separate from the government (42 CFR 425.104).

The documents are not pre-decisional, since Medicare has approved them for release to doctors in Accountable Care Organizations and to Medicare patients. The documents cannot contain recommendations on legal or policy matters, nor personal medical information, since their purpose is to tell patients factual information about the Accountable Care Organizations.

The two *Federal Register* pages cited above and referenced in the FOIA request have numerous statements confirming the public nature of the documents, as shown in Exhibit 5, page 12, of Plaintiff's Declaration.

There was no basis for withholding, since a claim of privilege cannot apply to information which doctors "make available" to the public.

(4B) EXCESSIVE PROCESSING TIME

A first-in first-out principle of processing FOIA requests was endorsed by Open America v. Watergate Special Prosecution Force, 547 F.2d 605 at 616 (D.C. Cir. 1976).

CMS had 3,383 FOIA requests pending September 30, 2013. One of them was Plaintiff's. They received another 26,361 during the next 12 months, and processed 25,027, which could have covered the entire 3,383 backlog (Exhibit 9, page 16, in Plaintiff's Declaration, taken from Table V. A. of *HHS Fiscal Year 2014 Freedom of Information Annual Report*). However Plaintiff's request was still pending at the end of the 12 months, and languished until 2/25/2015.

Plaintiff's request was one of the simplest, since the material sits on a CMS web portal, readily accessible to Accountable Care Organizations and to CMS (Exhibit 6). 16,341 other "simple requests" were indeed processed in 20 days or less during FY 2014 (Exhibit 10). All these were received after, and processed before, Plaintiff's request.

The median time to process a simple FOIA request at CMS was 11 days in 2013, 14 days in 2014, and 10 days in 2015; even complex requests had median response times of 2, 3 and 22 days (Exhibit 11). It was unreasonable that CMS took hundreds of days for this request, and it was contrary to the first-in first-out principle.

(4C) NOT AN INDEPENDENT APPEAL PROCESS

HHS gave authority to resolve or delay the administrative appeal to Mr. Gilmore, the CMS FOIA Officer who originally denied the request, while bypassing the independent HHS offices who are responsible for administrative appeals under the law and regulations.

FOIA establishes for requesters, "the right of such person to appeal to the head of the agency any adverse determination" (5 U.S.C. §552(a)(6)(A)(i)). HHS Rules say that HHS names a "review official identified in the denial letter" (45 CFR 5.34(a)). The denial letter identifies "The Deputy Administrator and Chief Operating Officer, CMS" (Exhibit 2). HHS Rules require,

> "... the designated review official will consult with the General Counsel to ensure that the rights and interests of all parties affected by the request are protected. Also, the concurrence of the Assistant Secretary for Public Affairs is required in all appeal decisions, including those on fees. When the review official responds to an appeal, that constitutes the Department's final action on the request..." (45 CFR 5.34(c))

CMS has its own Rules at 42 CFR 401.148, which allow the Administrator to delegate review. CMS is unreasonable if the Administrator delegates to the original deciding official. Such delegation defeats the purpose of having an appeal.

The staff who contacted Plaintiff about resolving the appeal, and who did resolve it, were the original deciding official, Mr. Gilmore, and his staff, not an independent reviewing official.

On January 4, 2016, while the appeal was pending, Mr. Derrick McNeal, who works for Mr. Gilmore, called Plaintiff and said HHS policy is that only Accountable Care Organizations have access to the written documents, so Plaintiff was not allowed to have them (Plaintiff's Declaration paragraph 7).

As detailed in Plaintiff's Declaration paragraphs 9-10, on June 7, 2016 Mr. Gilmore and two of his staff, Mr. McNeal and Mr. Paul Levitan, telephoned the Plaintiff with authority to negotiate resolution of the appeal. Mr. Gilmore said he was "calling about [the] appeal" and that he was "aware of the litigation." They said the agency could take weeks or years to release the documents, but offered to release them in three days if Plaintiff withdrew his appeal. Plaintiff did not do so, but they released the documents anyway the next day, with no mention of decisions by the agency head, Deputy Administrator, General Counsel, or Assistant Secretary for Public Affairs, who are the officials specified by law and regulation.

Plaintiff accepts the release, but believes the involvement of Mr. Gilmore and his staff in the appeal was unreasonable, and an independent review process could have released the documents far sooner and without need for court action.

CONCLUSION

Plaintiff should not have had to pay $400 and bring this into court, in order to get 17 pages which were clearly not privileged, were not exempt from disclosure, and are important in revealing how CMS governs information for patients about its Shared Savings Program.

Plaintiff has attached a proposed order, as required by Local Civil Rule 7(c).

July 11, 2016

Respectfully submitted,

Paul Burke, *Pro Se*
29 Dance Lane
Harpers Ferry, WV 25425
304-876-2227
PaulBurke@Globe1234.info

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

PAUL BURKE, *Pro Se* Plaintiff, vs. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Defendant.	Case: 1:16-cv-00825 (CRC)

DECLARATION OF PAUL BURKE

I, Paul Burke, declare as follows:

1. I write and manage web pages at aco.Globe1234.com, with information on Accountable Care Organizations ("ACOs") which serve Medicare patients. The web pages summarize rules, data, comments by others, the difficulties for patients in learning about ACOs, and implications for better patient care and for achieving cost savings in the Medicare program. I pay the site's costs; it does not take advertisements. The documents obtained by this FOIA request are posted at Globe1234.info/medicare/informing. I will also post an analysis when it is ready.

2. On July 15, 2013, I submitted a FOIA request to the Centers for Medicare and Medicaid Services ("CMS"), which is part of the US Department of Health and Human Services ("HHS"). My request asked for explanatory material which CMS wrote and distributed to ACOs. Those offices, in turn, provide the material to Medicare patients. My request is Exhibit 1.

3. On February 25, 2015, after 590 days and numerous phone calls between the parties, Mr. Hugh Gilmore of CMS denied the request. His denial is Exhibit 2.

4. On March 26, 2015, HHS received my administrative appeal, as shown by the Postal Service receipt, Exhibit 3.

5. On June 4, 2015, I contacted the Office of Government Information Services ("OGIS"), since one of its functions is to "offer mediation services to resolve disputes" under the FOIA (5 U.S.C § 552(h)(3)).

6. On August 5, 2015 OGIS sent me an email, Exhibit 4. The email said that CMS had satisfied the OGIS Deputy Director and an OGIS staff member, that in administrative appeals, "... the agency provides a de novo review of its initial action on a request." The email also said they understood that "... Mr. Gilmore's office is responsible for logging CMS FOIA appeals in the agency's tracking system ..."

7. On January 4, 2016 Mr. Derrick McNeal called me and said HHS policy is that only Accountable Care Organizations have access to the written documents, so I was not allowed to have them. He asked me to re-state what I was requesting. My re-statement is Exhibit 5. Mr. McNeal wrote back saying the documents are on a web portal accessible to ACOs and not to the public (Exhibit 6). I was told later that Mr. McNeal is Mr. Gilmore's subordinate (see paragraph 9 below).

8. On May 3, 2016, I filed a court appeal, since I had received no written decision. I paid a $400 filing fee as shown by Exhibit 7 and the Clerk's entry for item 1 of the case docket.

9. On June 7, 2016, Mr. Gilmore (who issued the original denial) telephoned me about the administrative appeal. Two other staff identified themselves on the call: Mr. Paul Levitan said that he is the boss of Mr. McNeal, also on the call, and that his own boss is Mr. Gilmore. Mr. Gilmore explicitly said he was "calling about [the] appeal" and that he was "aware of the litigation." He said he was not seeking withdrawal of the litigation, which could continue. He said that if I sent an email withdrawing the administrative appeal, HHS would send the requested documents within three days. He also said that if I did not withdraw the administrative

appeal and waited for a decision, HHS would take 5-6 weeks to send the same information. Mr. Levitan said "5-6 weeks is optimistic. We've seen this go on for years." Mr. Gilmore offered to send a "document saying the court case survives" in the absence of the administrative appeal. I was not clear how that would work, and I was not willing to drop the administrative appeal before seeing the documents, and with no agreement in writing. Exhibit 8 shows the email where I documented the conversation.

10. On June 8, 2016, Mr. McNeal emailed me the documents, even though I had not dropped the appeal, and without any other action on my part.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct, that Exhibits 1 through 8 attached hereto are true and correct copies except for redactions of private identifiers such as email and US mail addresses, and that Exhibits 9 through 12 contain true screen images from the CMS website as of July 8 or July 10, 2016, with red lines added.

Executed on: July 11, 2016

Paul Burke

Exhibits
1 - FOIA Request from Paul Burke Submitted to HHS Online July 15, 2013
2 - Denial Letter from HHS to Paul Burke, February 25, 2015
3 - Postal Service Receipt for Administrative Appeal, March 26, 2015
4 - Email from OGIS to Burke Describing de Novo Appeals, August 5, 2015
5 - Email from Burke to Derrick McNeal Restating Request, CMS, January 4, 2016
6 - Email from Derrick McNeal, CMS, to Burke Saying Documents on Portal Not Available to Burke, January 5, 2016
7 - Receipt for Filing Fee, May 3, 2016
8 - Email June 8, 2016 from Burke to Hugh Gilmore, CMS, Documenting Previous Day's Conversation
9 - Flow of FOIA Requests at HHS in FY 2014
10 - Response Times for Simple FOIA Requests at HHS in FY 2014
11 - Median FOIA Response Times at HHS in FY 2013-2015
12 - Extract of HHS Press Release, June 6, 2016

EXHIBIT 1 - FOIA REQUEST FROM BURKE SUBMITTED TO HHS ONLINE JULY 15, 2013, CONTROL # 071620137079

I request copies of language provided by Medicare to Accountable Care Organizations for signs and informing beneficiaries about the Shared Savings Program, as identified on pp.67946-67947 of the Federal Register 11/2/11 (ACO Final Rule)

P.67946 said Medicare would provide language for signs and notices:

"Nor should posting signs be inappropriately burdensome, since CMS will develop appropriate language"

"make available standardized written notices developed by CMS"

P.67947 said Medicare may provide language for marketing materials:

"To the extent that CMS supplies templates or model language for ACOs to use in marketing materials, we will ensure it complies with the Plain Writing Act of 2010."

The signs and notices tell patients that the facility is part of an ACO, that the patient may go elsewhere if desired, how to opt out of data sharing, and other issues.

I requested signs and written notices from aco@cms.gov, and they answered, " We provide the standardized written notices to ACOs upon acceptance to the program. They are not available on our website." (see below)

So Medicare was able to identify what I need, and it is readily available.

I am an individual seeking information for personal use and not for a commercial use.

I am willing to pay fees for this request up to a maximum of $100. If you estimate that the fees will exceed this limit, please inform me first.

I request that the information I seek be provided in electronic format, by email.

If you have any questions about handling this request, you may call me at 304-876-2227.

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from: Globe1234.com Researcher
to: aco@cms.hhs.gov
sent: Wed, Jul 10, 2013 at 3:46 PM
subject: standardized written notices developed by CMS

Dear Ms Weiss:

The 11/2/11 final rules for ACOs say participants will provide the public:

"standardized written notices developed by CMS" to tell patients that the facility is part of an ACO, and the patient may go elsewhere if desired. (Federal Register 11/2/11 p.67946)

I do not find these "standardized written notices" on your websites. Could you point me to a link, or send them to me?

I am interested in handouts and signs if you have standard versions.

Thank you,

Paul Burke

304-876-2227

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from: CMS ACO - CMSACO@cms.hhs.gov
to: Globe1234.com Researcher
date: Thu, Jul 11, 2013 at 5:32 AM
subject RE: standardized written notices developed by CMS

Dear Mr. Burke,

Thank you for your interest in the Medicare Shared Savings Program. We provide the standardized written notices to ACOs upon acceptance to the program. They are not available on our website.

Sincerely,

Medicare Shared Savings Program Staff
7500 Security Blvd. Baltimore, MD 21244
ACO@cms.hhs.gov

EXHIBIT 2 - DENIAL LETTER FROM HHS TO BURKE, FEBRUARY 25, 2015

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop N2-20-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Office of Strategic Operations and Regulatory Affairs /Openness, Transparency and Accountability Group

Refer to: Control Number 071620137079 and PIN **[Private identifiers redacted]**

Paul Burke

FEB 2 5 2015

Dear Mr. Burke:

This is in response to your July 15, 2013, Freedom of Information Act (FOIA) (5 U.S.C. § 552) request submitted to the Center for Medicare & Medicaid Services (CMS) or one of this agency's Medicare contractors via letter, facsimile transmission or e-mail seeking copies of language provided by Medicare to Accountable Care Organization for signs and informing beneficiaries about the Shared Savings Program. Documents responsive to your request, consisting of 17 pages, were forwarded to this agency because of my responsibility for administering the FOIA.

After a careful review of the 17 pages forwarded to this office for review and release determination, I have determined to withhold the materials in their entirety, under Exemption 5 of the FOIA (5 U.S.C. § 552(b)(5)).

Exemption 5 of the FOIA permits an agency to withhold "inter-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency." Documents that are privileged in the context of civil discovery are thus exempt from release under Exemption 5. Among the civil discovery privileges incorporated into Exemption 5 are attorney-client privilege and the deliberative process privilege.

Exemption 5's Deliberative Process Privilege is being invoked in order to prevent injury to the quality of agency decisions by preserving the ability of agency employees to engage in free and candid discussions on matters of policy. The Deliberative Privilege applies to inter-agency or intra-agency communications that are (1) pre-decisional, i.e. antecedent to the adoption of an agency policy and (2) deliberative, i.e. a direct of the part of the deliberative process in that it makes recommendations on legal or policy matters.

You have the right to appeal this decision. To do so, you must put your appeal in writing and send it within 30 days to: The Deputy Administrator and Chief Operating Officer, CMS, Room C5-16-03, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. Please mark the envelope containing your letter of appeal, "Freedom of Information Act Appeal" and enclose a copy of this letter with your appeal.

Sincerely,

Hugh Gilmore
Director
Division of Freedom of Information

Enclosure

EXHIBIT 3 - POSTAL SERVICE RECEIPT FOR ADMINISTRATIVE APPEAL, MARCH 26, 2015

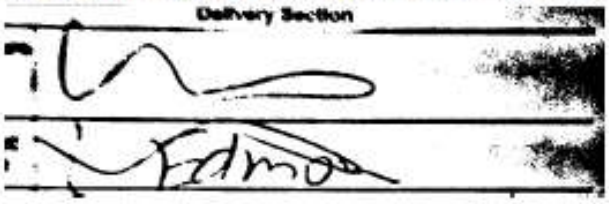
UNITED STATES POSTAL SERVICE

Date: March 26, 2015

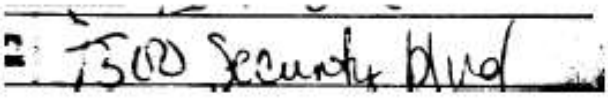
Paul Burke:

The following is in response to your March 26, 2015 request for delivery information on your Priority Mail Express® item number EK353944455US. The delivery record shows that this item was delivered on March 26, 2015 at 11:07 am in WINDSOR MILL, MD 21244 to L EDMON. The scanned image of the recipient information is provided below.

Signature of Recipient :



Address of Recipient :



Thank you for selecting the Postal Service for your mailing needs.

If you require additional assistance, please contact your local Post Office or postal representative.

Sincerely,
United States Postal Service

EXHIBIT 4 - EMAIL FROM OGIS TO BURKE DESCRIBING DE NOVO APPEALS, AUGUST 5, 2015

Subject: Re: Office of Government Information Services (OGIS) Case No. 201500798
From: Christa Lemelin **[Private identifiers redacted]** Wed, Aug 5, 2015 at 4:31 PM
To: "Globe1234.com Researcher"
Dear Mr. Burke:

This email is in reference to Office of Government Information Services (OGIS) case No. 201500798. I am sorry for my delay in following up with you.

When we discussed your dispute on June 17, 2015, you expressed your concern that the Centers for Medicare & Medicaid Services (CMS) assigned your pending Freedom of Information Act (FOIA) appeal to the same employee who signed the letter responding to your initial request (Hugh Gilmore, CMS's FOIA Officer). OGIS Deputy Director Nikki Gramian and I contacted CMS to discuss the agency's appeals process. CMS FOIA staff explained the agency's appeal process and directed us to the relevant FOIA regulations.

The Department of Health and Human Services' (HHS) FOIA regulations explain the role of CMS's Freedom of Information Officer (Mr. Gilmore) in determining the response to a request. HHS's FOIA regulations are available online at http://www.gpo.gov/fdsys/pkg/CFR-2002-title45-vol1/pdf/CFR-2002-title45-vol1-part5.pdf. CMS's FOIA regulations are available online at http://www.gpo.gov/fdsys/pkg/CFR-1999-title42-vol2/pdf/CFR-1999-title42-vol2-part401.pdf.

42 CFR 401.148 of CMS's regulations describes the agency's appeal process. While Mr. Gilmore's office is responsible for logging CMS FOIA appeals in the agency's tracking system, CMS sends all records and information concerning the appealed request to the Deputy Administrator and Chief Operating Officer for review of the initial decision and the findings upon which CMS based the decision. In their review, the Deputy Administrator and Chief Operating Officer consider any written argument and evidence provided in the appeal. The final decision on the appeal is made in consultation with the agency's General Counsel, the Assistant Secretary for Public Affairs and the appropriate program official. This multi-level review provides checks and balances to help ensure that the agency provides a de novo review of its initial action on a request.

I hope you find this information useful. Please contact me if you have any questions.
Best,
Christa Lemelin

EXHIBIT 5 - EMAIL FROM BURKE TO DERRICK MCNEAL, CMS, RESTATING REQUEST, JANUARY 4, 2016

Subject: Burke FOIA appeal 071620137079
From: Paul Burke **[Private identifiers redacted]** Mon, Jan 4, 2016 at 4:06 PM
To: Derrick McNeal

Thanks for your phone call this afternoon.

I tried to be as clear as possible in the attached pdf.

Please call if you have any questions.

Paul Burke

304-876-2227

[CONTENTS OF ATTACHED PDF:]

Email to Derrick McNeal

A. On 7/15/13 I submitted FOIA 071620137079, which used the language in the box below to identify the documents requested (emphasis added):

I request copies of **language provided by Medicare** to Accountable Care Organizations **for signs and informing beneficiaries** about the Shared Savings Program, as identified on pp.67946-67947 of the Federal Register 11/2/11 (ACO Final Rule)

P.67946 said Medicare **would** provide language for **signs** and **notices**:

- "Nor should posting **signs** be inappropriately burdensome, since **CMS will develop appropriate language**"
- "make available standardized written **notices developed by CMS**"

P.67947 said Medicare **may** provide language for **marketing materials:**

- "To the extent that CMS supplies **templates or model language** for ACOs to use in **marketing materials**, we will ensure it complies with the Plain Writing Act of 2010."

The signs and notices tell patients that the facility is part of an ACO, that the patient may go elsewhere if desired, how to opt out of data sharing, and other issues.

B. My appeal still seeks these same items:

- "signs" which CMS has provided to ACOs
- "standardized written notices" which CMS has provided to ACOs for informing beneficiaries about the SSP

- "templates or model language for... marketing materials" which CMS has provided to ACOs

The FOIA referenced two Federal Register pages, which further discuss the public nature of the materials needed.

p. 67946

- we retain a notification policy in this final rule...
- our proposal to inform beneficiaries at the point of care...
- posting signs will serve the purpose of calling the attention of beneficiaries to the existence of the ACO and the choice of the ACO participant and its ACO providers/suppliers to participate in it, ultimately resulting in increased transparency...
- The presence of signs and written materials will provide a useful initial notification for every beneficiary...
- **Nor should posting signs be inappropriately burdensome, since CMS will develop appropriate language.**..
- we believe that it is appropriate to finalize the requirement that the ACO agree to post signs in the facilities of ACO participants indicating the ACO provider's/supplier's participation in the Shared Savings Program and make available standardized written notices to Medicare FFS beneficiaries whom they serve...
- *Final Decision:* We are finalizing our proposal to require ACO participants to post signs in their facilities indicating their associated ACO provider's/supplier's participation in the Shared Savings Program and to **make available standardized written notices developed by CMS** to Medicare FFS beneficiaries whom they serve...

p. 67947

- we will make template language available for certain marketing materials and require that such template language be used when available...
- **To the extent that CMS supplies templates or model language for ACOs to use in marketing materials, we will ensure it complies with the Plain Writing Act of 2010...**

C. Mr. Gilmore's 2/25/15 denial letter said 17 pages of responsive documents were identified. Can you list them so we can discuss them further? How many are signs? How many notices? How many templates?

Thank you,
Paul Burke

EXHIBIT 6 - EMAIL FROM DERRICK MCNEAL, CMS, TO BURKE SAYING DOCUMENTS ON PORTAL NOT AVAILABLE TO BURKE, JANUARY 5, 2016

Subject: RE: Burke FOIA appeal 071620137079
From: McNeal, Derrick E. (CMS/OSORA) **[Private identifiers redacted]**
Tue, Jan 5, 2016 at 2:42 PM
To: Paul Burke

Medicare approved ACOs have access to the templates and other materials through the CMS Enterprise Portal which is accessible to the ACO by logging into the portal with their CMS users ID. The templates and guidance documents are not available on the CMS public website.

> From: Paul Burke
> Sent: Tuesday, January 05, 2016 2:40 PM
> To: McNeal, Derrick E. (CMS/OSORA)
> Subject: Re: Burke FOIA appeal 071620137079
>
> again
>
> On Mon, Jan 4, 2016 at 1:06 PM, Paul Burke wrote:
>
> Thanks for your phone call this afternoon.
>
> I tried to be as clear as possible in the attached pdf.
>
> Please call if you have any questions.
>
> Paul Burke

EXHIBIT 7 - RECEIPT FOR FILING FEE, MAY 3, 2016

Court Name: District of Columbia
Division: 1
Receipt Number: 4616077366
Cashier ID: CLesley
Transaction Date: 05/03/2016
Payer Name: PAUL BURKE

CIVIL FILING FEE
For: PAUL BURKE
Amount: $400.00

CREDIT CARD
Amt Tendered: $400.00

Total Due: $400.00
Total Tendered: $400.00
Change Amt: $0.00

16-825

Only when the bank clears the check, money order, or verifies credit of funds, is the fee or debt officially paid or discharged. A $53 fee will be charged for a returned check.

EXHIBIT 8 - EMAIL JUNE 8, 2016 FROM BURKE TO HUGH GILMORE, CMS, DOCUMENTING PREVIOUS DAY'S CONVERSATION

Subject: June 7 call, on Burke FOIA appeal 071620137079
From: Paul Burke **[Private identifiers redacted]** Wed, Jun 8, 2016 at 11:18 AM
To: Hugh Gilmore
Re: FOIA appeal 071620137079

Dear Mr. Gilmore,

Thanks for your phone call Tuesday morning June 7. I understand you offered to drop the assertion of exemptions, and to provide the documents I requested, if I first drop the administrative appeal.

I also appreciate your offer that you weren't asking me to drop the court case, and that after I dropped the administrative appeal, you could give me a "document saying the court case survives" in the absence of the administrative appeal, though I am not sure how that would work. Can you point me to any information on this?

I understand your estimate that you have some way to release the documents by Friday if I drop the appeal, but that if I don't drop it, you will need to "go through proper channels, which takes 5-6 weeks," though your staffer Mr. Levitan said he'd seen it take years.

While I am not willing to drop the rights I have under the administrative appeal before seeing the documents, and in the absence of any written agreement to make everything clear, if you send the documents, and they are what I asked for in the FOIA request, then I can look at dropping further legal action.

If I have misunderstood, please let me know. As I said at the end of our phone call, if there's another approach which doesn't involve me dropping the administrative appeal before seeing the documents, let's talk again.

Paul Burke

EXHIBIT 9 - FLOW OF FOIA REQUESTS AT HHS IN FY 2014

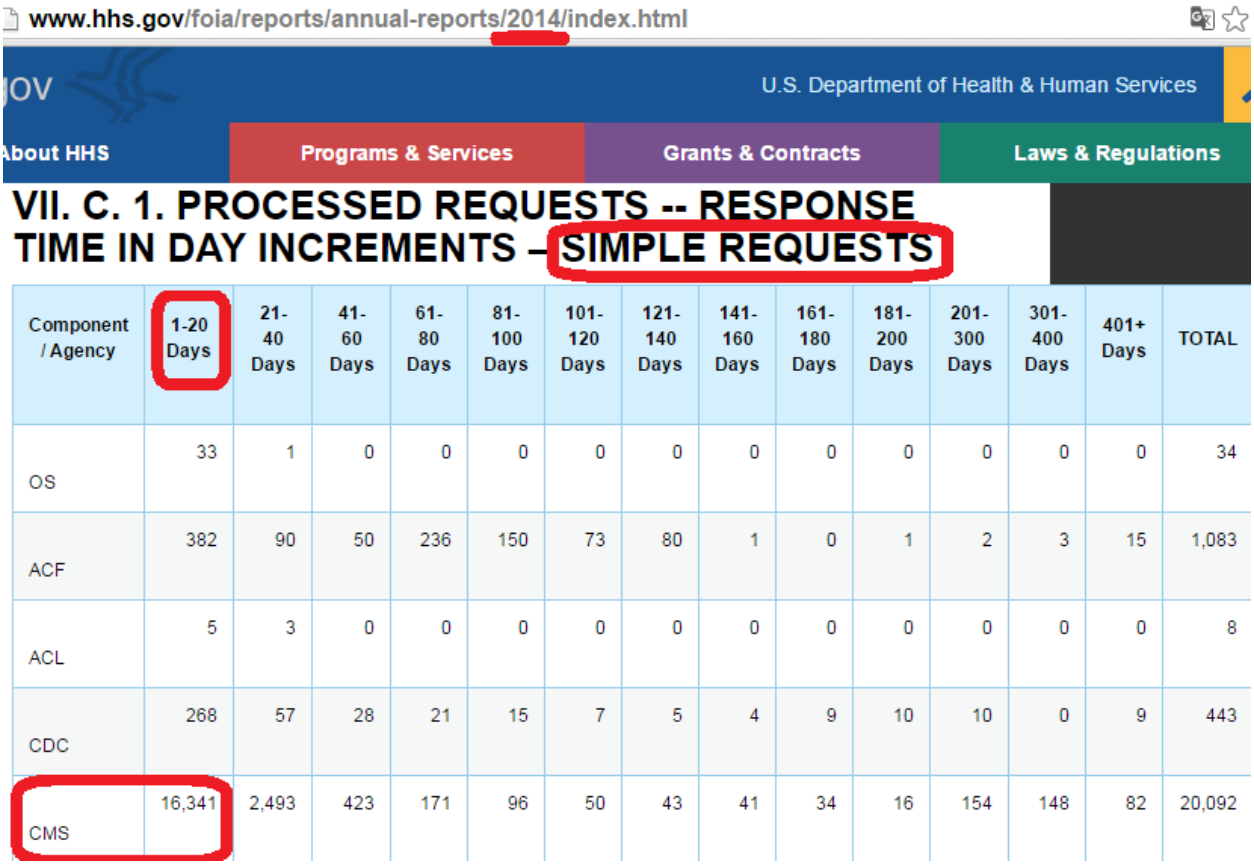
Source: HHS Fiscal Year 2014 Freedom of Information Annual Report
www.hhs.gov/foia/reports/annual-reports/2014

V. A. FOIA REQUESTS -- RECEIVED, PROCESSED AND PENDING FOIA REQUESTS

Component / Agency	Number of Requests Pending as of Start of Fiscal Year	Number of Requests Received in Fiscal Year	Number of Requests Processed in Fiscal Year	Number of Requests Pending as of End of Fiscal Year
OS	388	1,531	1,605	314
ACF	154	1,864	1,255	763
ACL	0	13	11	2
CDC	578	1,141	1,028	691
CMS	3,383	26,361	25,027	4,717

EXHIBIT 10 - RESPONSE TIMES FOR SIMPLE FOIA REQUESTS AT HHS IN FY 2014

Source: HHS Fiscal Year 2014 Freedom of Information Annual Report
www.hhs.gov/foia/reports/annual-reports/2014



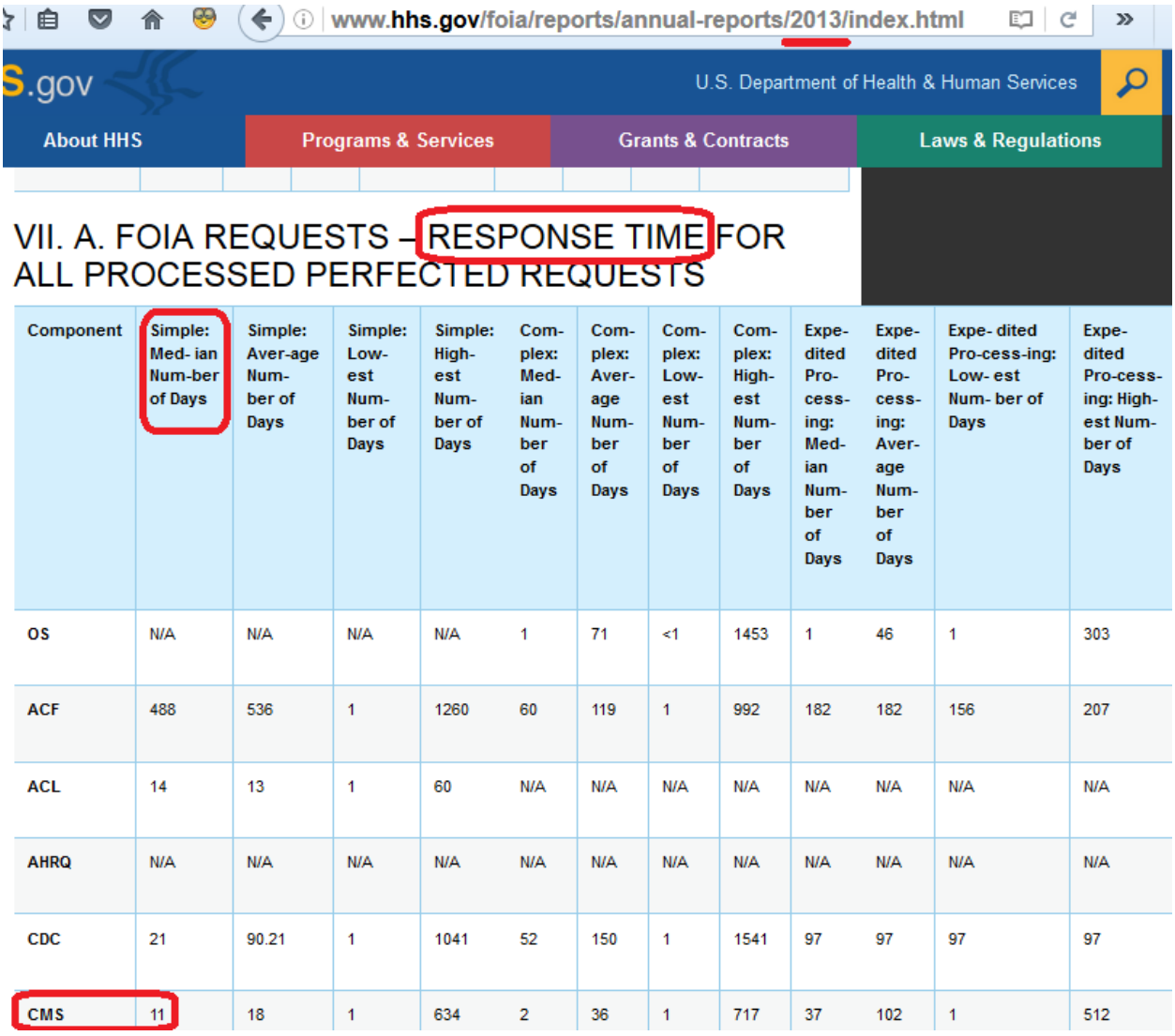
VII. C. 1. PROCESSED REQUESTS -- RESPONSE TIME IN DAY INCREMENTS – SIMPLE REQUESTS

Component / Agency	1-20 Days	21-40 Days	41-60 Days	61-80 Days	81-100 Days	101-120 Days	121-140 Days	141-160 Days	161-180 Days	181-200 Days	201-300 Days	301-400 Days	401+ Days	TOTAL
OS	33	1	0	0	0	0	0	0	0	0	0	0	0	34
ACF	382	90	50	236	150	73	80	1	0	1	2	3	15	1,083
ACL	5	3	0	0	0	0	0	0	0	0	0	0	0	8
CDC	268	57	28	21	15	7	5	4	9	10	10	0	9	443
CMS	16,341	2,493	423	171	96	50	43	41	34	16	154	148	82	20,092

EXHIBIT 11 - MEDIAN FOIA RESPONSE TIMES AT HHS IN FY 2013-2015

www.hhs.gov/foia/reports/annual-reports

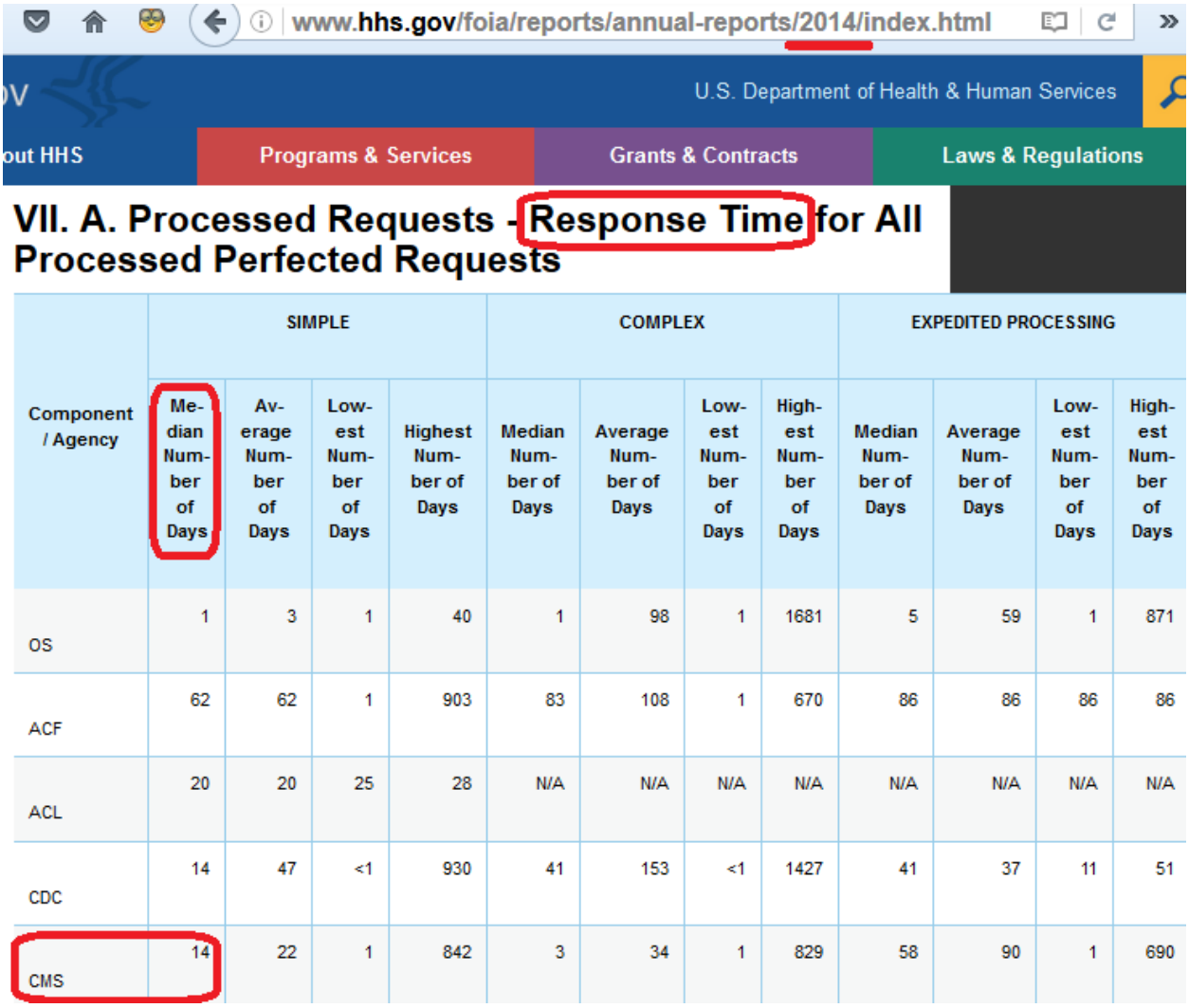
Source: HHS Fiscal Year 2013 Freedom of Information Annual Report



VII. A. FOIA REQUESTS – RESPONSE TIME FOR ALL PROCESSED PERFECTED REQUESTS

Component	Simple: Median Number of Days	Simple: Average Number of Days	Simple: Lowest Number of Days	Simple: Highest Number of Days	Complex: Median Number of Days	Complex: Average Number of Days	Complex: Lowest Number of Days	Complex: Highest Number of Days	Expedited Processing: Median Number of Days	Expedited Processing: Average Number of Days	Expedited Processing: Lowest Number of Days	Expedited Processing: Highest Number of Days
OS	N/A	N/A	N/A	N/A	1	71	<1	1453	1	46	1	303
ACF	488	536	1	1260	60	119	1	992	182	182	156	207
ACL	14	13	1	60	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
AHRQ	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
CDC	21	90.21	1	1041	52	150	1	1541	97	97	97	97
CMS	11	18	1	634	2	36	1	717	37	102	1	512

Source: HHS Fiscal Year 2014 Freedom of Information Annual Report



VII. A. Processed Requests - Response Time for All Processed Perfected Requests

Component / Agency	SIMPLE				COMPLEX				EXPEDITED PROCESSING			
	Median Number of Days	Average Number of Days	Lowest Number of Days	Highest Number of Days	Median Number of Days	Average Number of Days	Lowest Number of Days	Highest Number of Days	Median Number of Days	Average Number of Days	Lowest Number of Days	Highest Number of Days
OS	1	3	1	40	1	98	1	1681	5	59	1	871
ACF	62	62	1	903	83	108	1	670	86	86	86	86
ACL	20	20	25	28	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
CDC	14	47	<1	930	41	153	<1	1427	41	37	11	51
CMS	14	22	1	842	3	34	1	829	58	90	1	690

Source: HHS Fiscal Year 2015 Freedom of Information Annual Report

VII. A. Processed Requests - Response Time for All Processed Perfected Requests

Agency / Component	SIMPLE				COMPLEX				EX
	Median Number of Days	Average Number of Days	Lowest Number of Days	Highest Number of Days	Median Number of Days	Average Number of Days	Lowest Number of Days	Highest Number of Days	Median Number of Days
OS	<1	3.3	<1	37	133	211.68	22	1395	70.5
ACF	27	78	1	791	63	143	1	765	10
ACL	23	33	13	90	N/A	N/A	N/A	N/A	N/A
CDC	33	101.39	<1	1225	22	159.52	<1	1334	59.5
CMS	10	10	1	191	22	73	1	1109	161

EXHIBIT 12 - EXTRACT OF HHS PRESS RELEASE, JUNE 6, 2016

cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-06-06.html

cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-06-06.html

Medicare Makes Enhancements to the Shared Savings Program to Strengthen Incentives for Quality Care

Date	2016-06-06
Title	Medicare Makes Enhancements to the Shared Savings Program to Strengthen Incentives for Quality Care
Contact	press@cms.hhs.gov

Medicare Makes Enhancements to the Shared Savings Program to Strengthen Incentives for Quality Care

The Centers for Medicare & Medicaid Services (CMS) today released a final rule improving how Medicare pays Accountable Care Organizations in the Medicare Shared Savings Program for delivering better patient care. Medicare is moving away from paying for each service a physician provides towards a system that rewards physicians for coordinating with each other. Accountable Care Organizations are a major part of that transition, rewarding providers that deliver high-quality, efficient, and coordinated care for patients.

Medicare bases Accountable Care Organizations' payments on a variety of factors, including whether the Accountable Care Organization can deliver high-quality care at a reasonable cost. The final rule should help more Accountable Care Organizations successfully participate in the Medicare Shared Savings Program by improving the shared savings payment methodology and providing a new participation option for certain Accountable Care Organizations to move to the more advanced tracks of the program.

"Today's changes will encourage more physicians to improve patient care by joining Accountable Care Organizations, while also refining how the program measures success, so that current participants are better rewarded for quality," said CMS Acting Administrator Andy Slavitt. "These new flexibilities are based on significant input from participants and will help physicians prepare for the new Quality Payment Program, part of bipartisan legislation Congress passed last year repealing the failed Sustainable Growth Rate."

Already, the Medicare Shared Savings Program includes over 430 Accountable Care Organizations in 49 states and the District of Columbia serving over 7.7 million Medicare beneficiaries. This final rule changes how Medicare pays

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

PAUL BURKE, *Pro Se* Plaintiff, vs. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Defendant.	Case: 1:16-cv-00825 (CRC)

[PROPOSED] ORDER

Upon consideration of Plaintiff's Motion for Award of Costs, as well as any opposition and reply thereto, it is hereby

ORDERED that Plaintiff's Motion is GRANTED, and it is further

ORDERED that Defendant pay Plaintiff's costs in this matter in the amount of $400 within thirty (30) days of the date of this order.

So ordered on this _____ day of _____, 2016

_____
CHRISTOPHER R. COOPER
UNITED STATES DISTRICT JUDGE