

2002-2003

**NATIONAL HEALTH LAW
MOOT COURT COMPETITION**

Transcript of Record
Docket No. 02-972

SUPREME COURT OF THE UNITED STATES

October Term, 2002

OLYMPIAN BEHAVIORAL HEALTH CENTER, INC.,

Petitioner and Cross Respondent,

v.

ARNOLD M. POTTER,

Respondent and Cross Petitioner.

SPONSORS:

Southern Illinois University School of Law

*Southern Illinois University School of Medicine,
Department of Medical Humanities*

American College of Legal Medicine

1396(a)(10). States may also opt to provide services to medically needy individuals such as certain children under age 18 and pregnant women. *Id.* A state's Medicaid plan must offer certain statutorily-enumerated services to eligible individuals and may also provide certain additional services. *Id.* Participation in Medicaid is voluntary. However, once a state agrees to participate and accepts federal funds, the state must comply with the requirements of the Medicaid Act. 42 U.S.C. ' 1396a-v; see *Evergreen Presbyterian Ministries*, 235 F.3d at 909.

A significant development in Medicaid has been the growth in managed care as an alternative to the traditional fee-for-service system. Managed care allows a state to better control its Medicaid costs while, in theory, maintaining or enhancing quality. Under a managed care system, health maintenance organizations, prepaid health plans, or similar entities agree to provide specific services to Medicaid enrollees in return for fixed periodic payments per enrollee. Prior to the passage of the Balanced Budget Act of 1997, 42 U.S.C. ' 1396u-2 ("BBA"), a state could obtain a "freedom-of-choice" waiver pursuant to section 1915(b) of the Social Security Act, 42 U.S.C. ' 1396n(b). Under such section 1915 (b) waivers, states are permitted to restrict a client's choice of providers to those providers participating in a managed care program. Following passage of the BBA, states may now require recipients to enroll in mandatory managed care programs without first getting a waiver of the Medicaid requirements.

The State of Rome currently provides health care coverage through the Rome Medical Services Program ("MSP") for over 175,000 individuals per month at an annual cost of approximately \$900 million through a state plan approved by the Centers for Medicare and Medicaid Services ("CMS"), formerly the Health Care Financing Administration ("HCFA"). Defendant Potter is the Secretary of the Rome Department of Human Services, the state agency designated to administer the MSP pursuant to Title XIX of the Social Security Act ("Medicaid Act"), 42 U.S.C. ' 1396a - 1396v.

Because of the increasing cost of health care, and a substantial shortage of state funding to pay for Medicaid, the State of Rome passed legislation in 1997 that directed the Department to develop a Medicaid managed care program ("RomeCare"). The RomeCare program was designed to contain costs by paying a network of participating providers a lower rate in return for a guaranteed stream of patients. The program was also designed to improve appropriate utilization of services by Medicaid beneficiaries. RomeCare includes (1) a basic benefits component (i.e., medical/surgical services), and (2) a mental health benefits component. Enrollment in the managed care mental health benefits component is mandatory for state Medicaid clients requiring such mental health services.

The managed care mental health component of RomeCare was implemented on a statewide basis on August 1, 1998. For the delivery of these benefits, the Department chose to utilize a single prepaid health plan and contracted with a Rome corporation doing business as PHP, Inc. ("PHP"). PHP is a managed care company, licensed as a

health maintenance organization in the State of Rome that arranges for and manages mental health services to enrolled Medicaid clients under a contract with the Department. PHP is compensated by the State through “capitation” payments paid on a per enrollee basis.

Generally under a capitation arrangement, the prepaid health plan receives from the State a flat payment per enrollee per month. For this fixed monthly fee (“capitated” fee), the prepaid health plan agrees to provide all of the specified covered medical services to the enrollees. The number of enrollees controls the prepaid health plan's incoming revenues. The level of utilization controls the prepaid health plan's expenditures. The prepaid health plan bears the financial risk that the need for services will exceed the revenues received per enrollee. Thus, if the amount required to reimburse PHP network providers for medically necessary services provided to RomeCare enrollees exceeds the amount of payments received from the State, PHP bears the additional liability for such payments. If the amount of medically necessary services provided to enrollees is less than the capitated payment, PHP retains 70% of the net savings and 30% is returned to the State.

The Department established a capitation rate that was expected to be less than the cost of providing the same services on a fee-for-service basis. The total amount paid to PHP by the Department cannot exceed the upper payment limit of what it would have cost the Department to provide the same services under a fee-for-service system to an equivalent population based on eligibility category, gender, age and type of services. Capitation rates are fixed for three years.

PHP is required under its contract with the Department to develop a network of providers through which it provides mental health services paid for under RomeCare. One such provider under contract with PHP is the Plaintiff, Olympian Behavioral Health Center, Inc. Plaintiff is a not-for-profit corporation organized under the laws of the State of Olympia, which borders Rome to the north along the Tiber River. Plaintiff is comprised of a 100-bed inpatient and outpatient behavioral health facility and three outpatient counseling clinics (including an adolescent clinic and an alcohol and substance abuse clinic). All of Plaintiff's facilities are located in Olympia, in and around the City of Athens, a city of some 250,000 people. Athens is located directly across the Tiber River from Rome. For people living in northern Rome, a rural area, the nearest mental health facilities, other than Plaintiff-s, are located 150 miles away in Imperial, the Rome state capital. As a result, Plaintiff is the largest provider of mental health services for RomeCare enrollees in all of northern Rome.

PHP network providers are reimbursed according to a fee-schedule established by the Department. The fee schedule has been developed using a complex formula that takes into account a statewide average of the cost of providing such services. Under the fee schedule, an in-state provider is paid the established fee schedule amount. An out-of-state provider's reimbursement, however, is capped at the amount

that the out-of-state provider's home state would pay for the same service under its Medicaid program. In other words, the out-of-state provider receives the lesser of Rome's fixed schedule or that of the provider's home state. In all other respects, in-state and out-of-state providers are treated the same under the plan. PHP is responsible for paying all claims for medically necessary services in accordance with this fee schedule.

Plaintiff filed a complaint in this court seeking a declaratory judgment and injunction under 42 U.S.C. § 1983 alleging that the Department's managed care arrangement for mental health benefits violates 42 U.S.C. § 1396(a)(30)(A) of the Medicaid Act ("section 30(A)"). In support, Plaintiff alleges that PHP has established, without oversight from the Department, a system of utilization review that systematically denies services provided by network providers on the basis of lack of medical necessity at such a high volume that it jeopardizes the quality of care provided to Medicaid enrollees. Plaintiff's complaint alleges that PHP denies payment for claims that are medically necessary as a method of cost containment to increase its profit margin, thus resulting in a severe shortage of mental health providers willing to participate in the Medicaid program. Plaintiff alleges that the number of providers of mental health services to the state's Medicaid population has declined by over 40% since implementation of the prepaid health plan model. Plaintiff claims that this results in Medicaid enrollees being denied critical mental health services required by the Plan.¹

Plaintiff also alleges that the method of reimbursement discriminates against out-of-state providers in violation of the Commerce Clause of the United States Constitution.² Plaintiff argues that limiting out-of-state providers to the amount that its home state would pay if such amount is less than the RomeCare fee schedule adversely affects the commercial health of out-of-state providers. Plaintiff claims that the difference in fee schedule payments between the two states resulted in 17% less total reimbursement to the Plaintiff than it would have received had it been located in the state of Rome. Plaintiff asserts that if the inadequate and discriminatory reimbursement method continues, there is a substantial likelihood it will choose not to renew its contract to participate in the Plan when it expires in January, 2004, leaving the residents of northern Rome without convenient access to critical mental health services.

Defendant filed a Motion to Dismiss or, in the alternative, for Summary Judgment, on the basis that Plaintiff may not bring a § 1983 action to enforce section

¹ The claims raised by the Plaintiff are based solely on rights it alleges to have under section 30(A), and not on any claims Medicaid recipients might have regarding services or reimbursement under RomeCare.

² Plaintiff initially also alleged that the reimbursement schedule violated Plaintiff's rights to equal protection under the law in violation of the Fourteenth Amendment to the Constitution, but subsequently indicated that it withdrew that claim. The defendant's motion would, therefore, resolve all pending claims if granted.

30(A) of the Medicaid Act. Defendant also seeks summary judgment on the Commerce Clause claim on the basis that Defendant is a market participant and its conduct is therefore exempt from the reach of the Commerce Clause. Defendant also asserts that even if this court disagrees that Defendant is immune from Commerce Clause scrutiny under the market participant exception, the Defendant's program nevertheless does not violate the Commerce Clause. Defendant insists that its treatment of out-of-state providers does not unlawfully discriminate against them. It argues that most state Medicaid reimbursement schemes factor in some measure of the cost of providing the service. The cost average for the State of Rome has been factored in the RomeCare fee schedule formula. Applying the payment rate of the foreign state when such amount is less than Rome's fee schedule is designed to factor in the difference in cost that occurs when the provider is in a foreign state, based on the cost average that state has identified. The Department insists that its reimbursement method is the only way of taking into account each state's cost mix to avoid overpaying for Medicaid services. If the amount RomeCare would otherwise pay is less than the amount set by the foreign state's fee schedule, the capitation method of the managed care model then compels Rome to cap the payment at its fee schedule amount, to which all providers are subject.

II. ANALYSIS

A. Enforcing Section 30(A) through 42 U.S.C. § 1983

Plaintiff asserts that the Department's actions in establishing a managed care model that encourages decreased payments to providers and its failure to oversee the operations of the RomeCare program violate section 30(A) of the Medicaid Act. Section 30(A) provides that a state plan for medical assistance must:

provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

42 U.S.C. ' 1396(a)(30(A)). Plaintiff's argument is that RomeCare's managed care delivery system for mental health benefits fails to meet the requirements of section 30(A) in that the medical necessity review procedures utilized by PHP have resulted in drastically reduced payments to providers, such that providers like the Plaintiff are unwilling to provide Medicaid covered mental health services. This is compounded, Plaintiff argues, by the Department's discriminatory payment scheme for out of state providers. Thus, the Plaintiff asserts, the Department's plan fails to ensure that RomeCare "enlist[s] enough providers so that care and services are available under the

plan at least to the extent that such services are available to the general population" as required by section 30(A).

Plaintiff seeks to redress such alleged violations of section 30(A) through this action brought under 42 U.S.C. § 1983 against the state official responsible for administering RomeCare. The issue before this court is whether Plaintiff, as a provider of medical services in the RomeCare program, is a proper plaintiff in a § 1983 action based on an alleged violation of section 30(A). *Wilder v. Virginia Hospital Ass'n*, 496 U.S. 498, 508 (1990). Section 1983 provides that any person who, under the color of state law, deprives a person "of any rights, privileges, or immunities secured by the Constitution and laws" of the U.S. Constitution is subject to a suit for relief. *Id.* Plaintiff may use this civil rights vehicle to remedy violations of federal rights contained in statutes, in addition to violations of rights contained in the Constitution. *Id.*

To establish that a violation of a federal statute is at issue, the Supreme Court has directed us to make the following inquiry:

First, Congress must have intended that the provision in question benefit the plaintiff. Second, the plaintiff must demonstrate that the right assertedly protected by the statute is not so "vague and amorphous" that its enforcement would strain judicial competence. Third, the statute must unambiguously impose a binding obligation on the States. In other words, the provision giving rise to the asserted right must be couched in mandatory, rather than precatory, terms.

Blessing v. Freestone, 520 U.S. 329, 340-41 (1997). This court does not need to address the second and third prongs of this inquiry as we are not persuaded that Congress intended to confer a benefit on Plaintiff when it enacted section 30(A).

Plaintiff relies on cases holding that Congress intended section 30(A) to benefit health care providers. See, e.g. *Arkansas Medical Society, Inc. v. Reynolds*, 6 F.3d 519 (8th Cir. 1993). Courts reaching such result have done so through a comparison of section 30(A) to its predecessor statute, the Boren Amendment, and have relied on the Supreme Court's decision in *Wilder* that the Boren Amendment was intended to benefit providers. *Wilder*, 496 U.S. at 518.

This court believes that such courts have overlooked, or improperly dismissed, important differences between the language of the two statutes. Unlike the Boren Amendment, section 30(A) focuses squarely on recipients of services, rather than on the providers receiving payment for such services. *Evergreen Presbyterian Ministries v. Hood*, 235 F.3d 908, 927 (5th Cir. 2000). This conclusion is bolstered by Plaintiff's fundamental allegation in this case that *recipients* are being denied essential mental health services by the lack of mental health care providers. Any discussion of payment for services in section 30(A) serves as a conduit to the accomplishment of the intended

benefit of the statute, which is to ensure quality services are available to Medicaid recipients.

Although Plaintiff may incidentally benefit from section 30(A), the appropriate inquiry is whether Congress intended to benefit Plaintiff when it drafted such statute. This court finds that Plaintiff is not an intended beneficiary of this provision, and may not assert a section 30(A) claim under 42 U.S.C. ' 1983. Defendant's motion for summary judgment on this count is granted.

B. Commerce Clause

Plaintiff also alleges that the Department's reimbursement mechanism violates the so-called Dormant Commerce Clause, U.S. Const., art. I, ' 8, cl. 3. The Plaintiff asserts that the reimbursement mechanism regulates interstate commerce and impermissibly discriminates against out-of-state providers. The Department argues that it is entitled to judgment as a matter of law on this claim.

The Commerce Clause "is by its text an affirmative grant of power to Congress to regulate interstate and foreign commerce." *South-Central Timber Development, Inc. v. Wunnicke*, 467 U.S. 82, 87 (1984). However, "the Clause has long been recognized as a self-executing limitation on the power of the States to enact laws imposing substantial burdens on such commerce." *Id.* This implicit limitation on states is not absolute, and "the States retain authority under their general police powers to regulate matters of legitimate local concern, even though interstate commerce may be affected." *Pharmaceutical Research and Manufacturers of America v. Concannon*, 249 F.3d 66, 79 (1st Cir. 2001) (quoting *Maine v. Taylor*, 477 U.S. 131, 138 (1989)).

The Department argues that the reimbursement method used by the State of Rome in conjunction with the managed care program is removed from the reach of the dormant Commerce Clause because the State is acting as a market participant rather than a market regulator. *Pharmaceutical Research*, 249 F.3d at 80. "If a State is acting as a market participant, rather than as a market regulator, the dormant Commerce Clause places no limitation on its activities." *South-Central Timber*, 467 U.S. at 93.

This court is persuaded by Defendant's argument that its activities here are proprietary and not regulatory in nature. Faced with a deficit of state funds to pay for the rising costs of health care for its Medicaid population, Rome entered into the commerce of health care through RomeCare, its Medicaid managed care program. Acting through its agent, PHP, Rome purchases health care services from providers who voluntarily choose to participate in the managed care program. In times of such shortage, the state can enter into the market in order to favor in-state interests because the state is acting as a guardian of its people. *Reeves*, 447 U.S. at 439-41.

This court finds that the Department was acting as a market participant through the RomeCare program. Because the Department's actions fall under the market participant exception, this court need not address whether the reimbursement method would survive scrutiny under the Commerce Clause. The Defendant is entitled to dismissal of this claim as a matter of law.

III. CONCLUSION

Defendants' Motion to Dismiss pursuant to Federal Rule 12(b)(6), or alternatively Motion for Summary Judgment, which is treated by the court as a Motion for Summary Judgment under Federal Rule 56, is GRANTED. The Clerk of the Court is directed to enter judgment for Defendant.

SO ORDERED

Date: January 7, 2002

/s/ Kelly Clarke
DISTRICT JUDGE

**IN THE UNITED STATES COURT OF APPEALS
FOR THE TWELFTH CIRCUIT**

No. 01-0204

**OLYMPIAN BEHAVIORAL HEALTH
CENTER, INC., a not for profit corporation,**

Plaintiff - Appellant

v.

**ARNOLD M. POTTER, in his
official capacity as Secretary of
the State of Rome Department
of Human Services,**

Defendant - Appellee

Appeal from the United States District Court
for the Northern District of Rome
Civil No. 01-CV-1883 - Olympia Clarke, District Judge

Argued February 20, 2002 - Filed April 25, 2002

Before BLECHA, Chief Judge, DITTRICK and SULLIVAN, Circuit Judges.

BLECHA, Chief Judge. This action comes before the court on the Plaintiff's appeal of the district court's grant of summary judgment. The district court's judgment is affirmed in part, and reversed in part for the reasons stated herein.

Facts

Judge Clarke in her opinion below fully sets forth the facts of this case. In 2001 the Plaintiff, Olympian Behavioral Health Center, filed suit in federal court seeking a declaratory judgment and injunction under 42 U.S.C. § 1983 against Defendant Arnold Potter in his official capacity as Secretary of the State of Rome Department of Human Services, alleging ongoing deprivation of federal rights found at § 1396(a)(30)(A) of the Medicaid Act ("section 30(A)"). Specifically, Plaintiff alleges that RomeCare, the Medicaid managed care program established under Rome's state plan, enables and encourages a system of utilization review that denies payment for medically necessary services. Under the capitation method of reimbursement between the State and the prepaid health plan carrying out the mental health benefits component of RomeCare, the prepaid health plan has incentive to reduce the cost of services provided to Medicaid beneficiaries in order to increase its profits. Plaintiff alleges that the prepaid health plan denies services that are otherwise medically necessary in order to retain a greater percentage

of the capitation paid to the prepaid health plan by the State. The increased denial rates following the implementation of the prepaid health plan, Plaintiff argues, has resulted in substantially decreased numbers of providers willing to provide mental health benefits to Medicaid enrollees.

Plaintiff also claims that the Department's fee schedule favoring in-state providers violates the dormant Commerce Clause of the U.S. Constitution. Plaintiff argues that the reimbursement scheme protects Rome's citizens while unconstitutionally burdening interstate commerce.

The Defendant filed a motion to dismiss, or alternatively, a motion for summary judgment, which the district court treated as a motion for summary judgment. The motion asserted that Plaintiff could not enforce section 30(A) through a cause of action under 42 U.S.C. § 1983. The motion also sought summary judgment on the Commerce Clause claim on the grounds that the State's conduct fits within the market participant exception and is therefore exempt from the Commerce Clause's prohibitions. The Defendant also insists that even if the market participant doctrine is inapplicable, the State's program does not violate the Commerce Clause. The district court agreed with the Defendant on the § 1983 claim, and also found the State was a market participant. It did not reach the question of whether the State can justify the reimbursement program under the Commerce Clause if the market participant exception does not apply. The Plaintiff now appeals the district court's rulings.

Analysis

A. Section 1983 Claim.

We agree with the district court that section 30(A) was not intended to benefit Plaintiff as a provider of medical services under the RomeCare program. That section "manifests concern solely for the well-being of recipients." *Pennsylvania Pharmacists Ass'n. v. Houstoun*, 283 F.3d 531, 536 (3d Cir. 2002). While the statute does address payment, "the adequacy of payments is measured in relation to the health needs of recipients." *Id.* We agree with the district court and the Third Circuit that key differences in the precise statutory language between Section 30(A) and the Boren amendment, which was considered by the Supreme Court in *Wilder v. Virginia Hospital Association*, 496 U.S. 498 (1990), necessitate a different outcome than in *Wilder*. We affirm the district court's grant of summary judgment in favor of Defendant.

B. Commerce Clause.

In contrast to the preceding issue, however, we find ourselves in disagreement with the district court's conclusion regarding the nature of the Department's activities in paying for health care services for its residents. We note at the outset, as did the Supreme Court in *Reeves, Inc. v. Stake*, 447 U.S. 429 (1980), "the competing considerations in cases involving state proprietary action often will be subtle, complex, politically charged, and difficult to assess under traditional Commerce Clause analysis." *Id.* at 439. This case presents such a challenge.

We are not persuaded that the State's activities fall under the market participant exception

to the dormant Commerce Clause. We do not believe that the state conduct at issue here truly constitutes participation in an open private market. The reimbursement to providers for the costs of providing treatment to state Medicaid residents is merely the State acting in its traditional role of carrying out its responsibilities as the regulator of the state Medicaid program. The State of Rome is not a purchaser, trader, seller or otherwise of services here sufficient to invoke the protections of the exception. *Cf. Reeves*, 447 U.S. at 440 (finding South Dakota a market participant entitled to limit sale of cement from state-owned cement plant to state residents only).

Finding that the Defendant may not avail himself of the market participant exception, we now turn to the issue left unresolved by the district court; that is, whether the Department's reimbursement scheme violates the dormant Commerce Clause. Based on the record before us, we find that it does. The United States Supreme Court has adopted a two-tiered approach to Commerce Clause analysis:

When a state statute directly regulates or discriminates against interstate commerce, or when its effect is to favor in-state economic interests over out-of-state interests, [the Court has] generally struck down the statute without further inquiry. When, however, a statute has only indirect effects on interstate commerce and regulates evenhandedly, [the Court has] examined whether the State's interest is legitimate and whether the burden on interstate commerce clearly exceeds local benefits.

Brown-Forman Distillers Corp. v. New York State Liquor Authority, 476 U.S. 573, 578-79 (1986) (internal citations omitted).

While the Court in *Brown-Forman* also recognized that there is no clear line separating one tier from the other, *see id.* at 579, in this case, the regulation falls squarely into the first tier of analysis. The reimbursement program clearly favors in-state economic interests, because only out-of-state providers are subject to lower reimbursement for the same services. The effect of the reimbursement method is to set a "scale of prices for use in other states," which the Court has prohibited in other cases. *See Healy v. The Beer Institute*, 491 U.S. 324, 336 (1989) (quoting *Baldwin v. G.A.F. Seelig, Inc.*, 294 U.S. 511, 528 (1935)). The Defendant argues that Rome's reimbursement method is not based on economic protectionism of in-state commerce, but rather legitimate factors related to the proper cost-mix for Medicaid services. *Cf. Maine v. Taylor*, 477 U.S. 131, 138 (1986). We are not persuaded by that argument. The reimbursement method on its face regulates out-of-state transactions, and is the sort of "simple economic protectionism" the Court has found *per se* invalid. *See Brown-Forman*, 476 U.S. at 579-80.

Conclusion

We affirm summary judgment of Plaintiff's § 1983 claim on the grounds that Plaintiff may not state a cause of action under 42 U.S.C. § 1983 for violations of section 30(A). We reverse that part of the summary judgment finding the Defendant's conduct met the market participant exception to the dormant Commerce Clause. We further find that the RomeCare program violates the dormant Commerce Clause.

No. 02-972

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM 2002

OLYMPIAN BEHAVIORAL HEALTH CENTER,

PETITIONER AND CROSS RESPONDENT

v.

ARNOLD M. POTTER

RESPONDENT AND CROSS PETITIONER

ORDER GRANTING CERTIORARI

Upon consideration of the Cross Petitions for Certiorari, the Court hereby GRANTS the petitions as to the following issues:

1. Whether Petitioner may assert a claim under 42 U.S.C. ' 1983 for alleged violations of 42 U.S.C. ' 1396a(30)(A).
2. Whether the RomeCare program violates the dormant Commerce Clause.

IT IS SO ORDERED.

Date: June 27, 2002

DOCS/505316.2