

STATE OF WISCONSIN
SUPREME COURT

APPEAL NO. 2009AP000728

WISCONSIN MEDICAL SOCIETY, INC.,
AND DAVID M. HOFFMANN, M.D.,

Plaintiffs-Appellants,

vs.

MICHAEL L. MORGAN,

Defendant-Respondent.

Appeal From The December 19, 2008 Decision And Order From The
Circuit Court For Dane County
The Honorable Michael N. Nowakowski, Presiding

**NOTICE OF MOTION AND MOTION OF WISCONSIN
MEDICAL SOCIETY, INC. AND DAVID M. HOFFMANN, M.D.
FOR RECONSIDERATION OF THE ORDER GRANTING
ADVOCATES FOR MEDICAID PATIENTS LEAVE TO FILE A
NON-PARTY BRIEF, OR, IN THE ALTERNATIVE, FOR LEAVE
TO RESPOND TO NON-PARTY BRIEF**

To: Disability Rights Wisconsin
ABC for Health (Advocacy and Benefits Counseling for Health Inc.)
Community Advocates Public Policy Institute
c/o Lester A. Pines
Cullen Weston Pines & Bach LLP
122 W. Washington Ave., Ste. 900
Madison, WI 53703

Michael L. Morgan
c/o Christopher J. Blythe and
Charlotte Gibson
Wisconsin Department of Justice
17 W. Main St.
Madison, WI 53707

PLEASE TAKE NOTICE that, pursuant to Wis. Stat. § 809.14(2), the Wisconsin Medical Society, Inc. and David M. Hoffmann, M.D. (collectively referred to as “WMS”) hereby move for reconsideration of the Court’s March 19, 2010 Order (“Order”) granting the Motion for Leave to File a Non-Party Brief (“Motion”) of Disability Rights Wisconsin, Advocacy and Benefits Counseling for Health, Inc. and Community Advocates Public Policy Institute (“Proposed Amici”). In the alternative, WMS requests the opportunity to respond to Proposed Amici’s brief. The grounds for this motion follow.

The Proposed Amici claim that their participation is necessary to protect the interests of poor and disabled State of Wisconsin (“State”) citizens receiving Medicaid benefits. (Motion, pp. 1-3.) According to the Proposed Amici, if the \$200 million raided from the injured patients and families compensation fund (the “Fund”) is ordered to be returned, access to health care for Medicaid recipients will be negatively impacted. (Motion, pp. 4-5.) The Proposed Amici’s basis for participation is legally erroneous.

“Medicaid is a cooperative federal-state program through which the Federal Government provides financial assistance to States so that they may furnish medical care to needy individuals.” *Wilder v. Virginia Hosp. Ass’n*, 496 U.S. 498, 502 (1990) (citing 42 U.S.C. § 1396) superceded by statute in part on other grounds, as stated in *Alaska Dep’t of Health and Social Servs. v. Ctrs. for Medicare and Medical Servs.*, 424 F.3d 931 (9th Cir. 2005). The states that choose to participate in Medicaid must comply with the requirements imposed by the federal Medicaid statute and attendant regulations. *Id.* To participate in the Medicaid program, a state must submit a “state plan” to the federal Department of Health and Human Services Secretary. *Wilder*, 496 U.S. at 502. Among the requirements, a state plan must:

[P]rovide 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. § 1396a(a)(30)(A) (hereinafter “Section 30(A)”). Thus, a state plan must establish health care provider reimbursement rates that are, among other things, consistent with high-quality medical care (quality of care) and sufficient to enlist enough providers to ensure that medical services are generally available to Medicaid recipients (access to care). *Indep. Living Ctr. of S. Cal. v. Shewry*, 543 F.3d 1050, 1053 (9th Cir. 2008), cert. denied, *Maxwell Jolly v. Indep. Living Ctr. of S. Cal.*, 129 S.Ct. 2828 (U.S. June 22, 2009).

States participating in Medicaid *must* furnish medical assistance to the “categorically needy,” a group that includes financially-needy blind, aged, and disabled individuals, pregnant women, and children. *See, e.g., Lankford v. Sherman*, 451 F.3d 496, 504 (8th Cir. 2006) (citing 42 U.S.C. § 1396a(a)(10)(A)). The federal Medicaid law mandates that a state plan include seven enumerated services: 1) inpatient hospital; 2) outpatient hospital; 3) laboratory and x-ray; 4) nursing facility; 5) physician; 6) nurse-midwife; and 7) nurse practitioner. *Id.* (citing 42 U.S.C. §§ 1396a(a)(10), 1396d(a)(1)-(5), (17), (21)). Pursuant to Section 30(A), states must also ensure that their Medicaid program reimbursement rates are consistent with high-quality medical care and are sufficient to ensure adequate access to such care.

According to the Proposed Amici, restoration of the Fund will impact the State’s next budget such that access to health care for Medicaid recipients will be impacted, an argument which has no factual support in the appellate record. As a matter of law, however, the State may not reduce quality or access to the Medicaid program based on alleged budget constraints. In a very recent case, the Court of Appeals for the Ninth Circuit reiterated that, “state Medicaid rate reductions may not be based

solely on state budgetary concerns.” *Indep. Living Ctr. of S. Cal. v. Maxwell-Jolly*, 572 F.3d 644, 655 (9th Cir. 2009). The Court of Appeals for the Seventh Circuit has ruled similarly, concluding that states cannot develop their state Medicaid plans solely on the basis of budgetary appropriations and that budgetary constraints would not excuse a failure to conform to the federal reasonable and adequate standard. *Wis. Hosp. Ass’n v. Reivitz*, 733 F.2d 1226, 1235 (7th Cir. 1984).

Contrary to the Proposed Amici’s assertion, therefore, the State may not reduce Medicaid rates to the point where it would adversely impact the quality of and access to care that is required by Section 30(A). *Indep. Living Ctr.*, 572 F.3d at 657 (finding that the ten percent rate reduction might conflict with the quality of care and access provisions of § 30(A) as the cuts have apparently forced at least some providers to stop treating Medic-Cal beneficiaries); *Methodist Hosps., Inc. v. Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996) (finding that even if a state reduces what it is willing to pay Medicaid providers, under Section 30(A) a state must raise the price until there is an adequate supply of providers in the market). Moreover, the State is prohibited from eliminating the seven enumerated services provided to categorically needy individuals without completely forfeiting its participation in the Medicaid program. *See* 42 U.S.C. § 1396a(a)(10).

Quality of care and access to health care are two significant reasons advanced by WMS for protection of the Fund. However, the Proposed Amici’s basis for participation as amicus curiae is legally erroneous and, therefore, the Court should deny their Motion.¹ If the Court does not reconsider the Order and deny the Proposed Amici’s Motion, WMS respectfully requests leave to file a response to the Proposed Amici’s brief so that it may refute the assertion that access to quality health care by Medicaid recipients will be impacted if the \$200 million raided from the Fund is ordered to be returned.

¹ Pursuant to Wis. Stat. § 809.19(7)(c), motions for leave to file non-party briefs “*shall not* be filed later than 14 days after respondent’s brief is filed.” (Emphasis added.) Respondent’s brief was filed on March 2, 2010, making all motions for leave to file non-party briefs due on or before March 16, 2010. The Proposed Amici’s Motion was filed on March 17, 2010, after the statutory deadline, and the Motion contains no explanation for the untimely nature of the Motion. In addition to the reasons set forth in the text above, because the Motion was untimely, the Court should also reconsider and deny the Motion.

Dated this 24th day of March, 2010.

WHYTE HIRSCHBOECK DUDEK S.C.

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