IN THE SUPREME COURT OF PENNSYLVANIA

No. 45 EAP 2014

JAMES EISEMAN, JR. and THE PUBLIC INTEREST LAW CENTER OF PHILADELPHIA,

Appellants,

v.

COMMONWEALTH OF PENNSYLVANIA, DEPARTMENT OF PUBLIC WELFARE,

Appellee.

REPLY BRIEF OF APPELLANTS

On Appeal from the Order of the Commonwealth Court in Case No. 1935 C.D. 2012, Affirming in Part and Reversing in Part the Final Determination of the Office of Open Records in No. AP 2011-1098
(*Eiseman I*)

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IN THE SUPREME COURT OF PENNSYLVANIA

No. 46 EAP 2014

JAMES EISEMAN, JR. and THE PUBLIC INTEREST LAW CENTER OF PHILADELPHIA,

Appellants,

v.

AETNA BETTER HEALTH, INC., HEALTH PARTNERS OF PHILADELPHIA, INC., and KEYSTONE MERCY HEALTH PLAN,

Appellees.

REPLY BRIEF OF APPELLANTS

On Appeal from the Order of the Commonwealth Court in Case No. 1949 C.D. 2012, Affirming in Part and Reversing in Part the Final Determination of the Office of Open Records in No. AP 2011-1098
(*Eiseman I*)

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IN THE SUPREME COURT OF PENNSYLVANIA

No. 47 EAP 2014

JAMES EISEMAN, JR. and THE PUBLIC INTEREST LAW CENTER OF PHILADELPHIA,

Appellants,

v.

UNITEDHEALTHCARE OF PENNSYLVANIA, INC. d/b/a UNITEDHEALTHCARE COMMUNITY PLAN, and HEALTHAMERICA PENNSYLVANIA INC. d/b/a COVENTRYCARES,

Appellees.

REPLY BRIEF OF APPELLANTS

On Appeal from the Order of the Commonwealth Court in Case No. 1950 C.D. 2012, Affirming in Part and Reversing in Part the Final Determination of the Office of Open Records in No. AP 2011-1098 (*Eiseman I*)

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I. SUMMARY OF ARGUMENT

Medicaid is a public program in which dental providers receive public funds to provide care to low-income children and other eligible enrollees. When the Commonwealth chooses to administer Medicaid via a fee-for-service system, the providers receive these public funds directly from the Department of Human Services (here referred to by its former acronym, DPW). When the Commonwealth chooses to administer Medicaid via a managed-care program, the public funds pass through one or two other hands before providers receive them. Under both approaches, the payments that providers receive are public funds, and the contracts that set forth the rates of payment along the chain are financial records subject to disclosure under the Right-to-Know Law (RTKL).

Unable to rebut the arguments in Requesters' opening brief that payments to providers are indeed payments of public funds, Appellees instead devote most of their efforts to trying to prove that the MCO Rates are trade secrets and confidential proprietary information. They are not, but that is beside the main point, which is that the RTKL mandates disclosure of the requested records even if they reveal trade secrets or confidential proprietary information.

Appellees and their amici attempt to demonstrate otherwise by depicting Medicaid as a purely commercial endeavor that the Commonwealth has contracted away to private companies, much as a Commonwealth agency might hire a private

janitorial firm to mop the floors in its offices. This is fundamentally mistaken, as Pennsylvania's Medicaid managed-care program must comply with comprehensive federal and state laws that, among other things, set standards for downstream payment rates. These standards protect beneficiaries from rates that are too low to provide for adequate access to care and quality of care. As a matter of law, DPW cannot delegate away its duty to ensure the adequacy of downstream payment rates.

Appellees' amici warn the Court that reversal of the decision below will cause the sky to fall. The sky hasn't fallen before when rates were released, and it won't fall this time.

Finally, DPW and some of the Appellees now contend that DPW does not possess the requested records. This brand-new argument is both untimely and incorrect.

II. ARGUMENT

A. Contracts Showing the Flow of Public Funds Through MCOs Are "Financial Records"

The contracts containing the MCO Rates are "financial records" as that term is defined in the RTKL; as such they are subject to disclosure under Section 708(c), 65 P.S. § 67.708(c), regardless of whether they reveal trade secrets or confidential proprietary information. Decisions of this Court and of the Commonwealth Court consistently recognized this principle under the old Right-

to-Know Act. *E.g.*, *Sapp Roofing Co. v. Sheet Metal Workers' Int'l Assoc., Local Union No. 12*, 713 A.2d 627 (Pa. 1998); *Lukes v. Dep't of Pub. Welfare*, 976 A.2d 609 (Pa. Commw. Ct.), *alloc. denied*, 987 A.2d 162 (Pa. 2009). Nothing in the new statute supports a different outcome.

The MCOs' arguments to the contrary would have the Court treat Medicaid as a purely commercial activity.[1] *E.g.*, Brief of Group A Appellees ("Group A Br."), at 15 ("Whether [medical and dental] services can be delivered at more or less cost to the MCO directly impacts the bottom-line of the MCO, not the finances of the Commonwealth."). On this basis, the MCOs contend that the billions of dollars expended by DPW for Medicaid become private as soon as they enter the MCOs' coffers, and so the records pertaining to downstream payment rates are not financial records of DPW.

This is incorrect as a matter of law under the RTKL, particularly in light of the extensive requirements federal and state law impose on downstream payment rates to assure and assess the provision of the intended services.[2] First, the funds that the MCOs pay to subcontractors (or directly to providers, in certain limited

[1] The five MCOs in this case are represented by two different attorneys, who have filed separate briefs. This brief will refer to Appellees Health Partners of Philadelphia and Keystone Mercy Health Plan as the "Group A Appellees," and to Appellees UnitedHealthcare of Pennsylvania, HealthAmerica Pennsylvania, and Aetna Better Health as the "Group B Appellees."

[2] Certain of the arguments in Appellees' *Eiseman I* briefs implicate both the MCO Rates at issue in this case and the Provider Rates at issue in *Eiseman II*. The two amici supporting Appellees filed identical briefs in this case and in *Eiseman II*, and most of the arguments they raise also apply to both cases. To spare the Court a repetitive *Eiseman II* reply brief, Requesters will respond in this brief alone to certain arguments that apply to both cases.

situations also at issue in this case), and the funds that subcontractors pay to providers, are funds ***of*** DPW that DPW disburses through the MCOs and subcontractors. Second, unlike in most situations in which governmental units engage subcontractors, the laws governing Medicaid managed-care programs obligate DPW to monitor downstream payment information to ensure that the rates ultimately paid to providers comply with the program's requirements. Third, the point at which the funds transition from public to private is when they are expended to fulfill their intended purpose, i.e., when they are paid to providers in exchange for treating Medicaid enrollees.

1. The Requested Records Deal With DPW's Funds

The RTKL defines "financial record" in relevant part as:

> (1) Any account, voucher or contract dealing with:
> (i) the receipt or disbursement of funds by an agency; or
> (ii) an agency's acquisition, use or disposal of services, supplies, materials, equipment or property.

65 P.S. § 67.102. The requested records are "financial records" under both (1)(i) and (1)(ii). A holding that they are financial records under either part of the definition compels reversal.

The Group A Appellees' brief ignores the statutory definition. The Group B Appellees propose, in essence, for the Court to take a red pen to the definition, rewriting it along these lines:

(1) Any account, voucher or contract ~~dealing with~~ showing:
(i) the receipt or disbursement of funds directly by an agency, but not the disbursement of agency funds for agency purposes by a contractor or subcontractor of the agency; or
(ii) an agency's direct acquisition, use or disposal of services, supplies, materials, equipment or property, but not such acquisition, use or disposal for agency purposes by a contractor or subcontractor of the agency.

See Brief of Group B Appellees ("Group B Br."), at 25. The proper forum to request this redrafting would be the General Assembly.

This Court rejected the MCOs' premise—that subcontracting ends the public nature of the governmental action—under the predecessor to the RTKL. *Sapp Roofing Co. v. Sheet Metal Workers' Int'l Ass'n, Local Union No. 12*, 713 A.2d 627, 629 (Pa. 1998) ("Thus, the [payroll] records submitted by Sapp Roofing[, a government contractor,] are, indeed, an essential component of the school district's decision regarding whether and what amount to pay to Sapp Roofing."). The outcome under the new RTKL should be the same.

2. Medicaid Managed Care Is Not a Typical Governmental Contracting Program, as Federal and State Laws Set Standards for the Downstream Payments of Program Funds

Medicaid is intended to benefit not MCOs, subcontractors, or providers, but low-income children, people with disabilities, and other vulnerable persons. *See, e.g.*, *Pa. Pharmacists Ass'n v. Houstoun*, 283 F.3d 531, 538 (3d Cir. 2002) (en banc) (Alito, J.) ("[T]he intended beneficiaries of [42 U.S.C. § 1396a(a)(30)(A)] are recipients, not providers."). The federal Medicaid Act requires DPW to balance

various interests, including ensuring that eligible recipients receive needed services while also protecting the public fisc. *See, e.g.*, *id.* at 537 (a state Medicaid plan "must assure that payments to providers produce four outcomes: (1) efficiency, (2) economy, (3) quality of care, and (4) adequate access to providers by Medicaid beneficiaries") (internal quotation marks omitted). Payments to providers must "be set at levels that are sufficient to meet recipients' needs." *Id.* at 538. An important indicator of compliance with this requirement is "the level of reimbursement to participating dentists in the market and the costs of providing such services." *Clark v. Richman*, 339 F. Supp. 2d 631, 644 (M.D. Pa. 2004); *see also Christ the King Manor, Inc. v. Sec'y U.S. Dep't of Health & Human Servs.*, 730 F.3d 291, 308 n.22 (3d Cir. 2013) ("Setting [Medicaid provider] payment levels to meet recipients' needs must therefore inevitably take into account provider costs.").

The Pennsylvania Coalition of Medical Assistance Managed Care Organizations ("PCMAMCO") concedes the importance of adequate rates. *See* Brief of Amicus Curiae PCMAMCO ("PCMAMCO's Br.") at 9 (stating that if Provider Rates go down, "some capable providers will refuse to accept the lower rates"); *id.* at 10 ("Worse yet, the low rates may drive some providers to reduce or withhold medically appropriate care.").

Opting to administer Medicaid via a managed-care program does not excuse DPW from responsibility for monitoring and ensuring the adequacy of downstream

payment rates. *See, e.g.*, *John B. v. Goetz*, 879 F. Supp. 2d 787, 860 (M.D. Tenn. 2010) (a state Medicaid agency "cannot delegate the administration of [the state Medicaid] program nor vest the [MCOs] with ultimate control over information necessary to determine compliance with federal law"); *see also id.* ("Federal regulations also require that the [state Medicaid] agency maintain or supervise the maintenance of the records necessary for the proper and efficient operation of the program . . . ."). Numerous federal courts have held that "states cannot contract away to managed care organizations . . . their responsibilities to Medicaid beneficiaries or the rights of Medicaid beneficiaries." *Salazar v. District of Columbia*, 596 F. Supp. 2d 67, 69-70 (D.D.C. 2009) (collecting cases); *see also Catanzano v. Dowling*, 60 F.3d 113, 119-20 (2d Cir. 1995) (holding that decisions made by a home health care agency, with which the state agency had contracted to provide Medicaid benefits, constituted action on behalf of the government); *Fla. Pediatric Soc'y/Fla. Chapter of Am. Acad. of Pediatrics v. Dudek*, No. 05-cv-23037, 2014 U.S. Dist. LEXIS 179434, at *215 (S.D. Fla. Dec. 29, 2014) (Florida's Medicaid agency "remains ultimately responsible as the designated agency that administers Florida's Medicaid program, regardless of whether it chooses to provide care for children on Medicaid through a fee-for-service arrangement or through a Medicaid HMO"); *Carr v. Wilson-Coker*, 203 F.R.D. 66, 75 (D. Conn. 2001) ("Although the state contracts with MCO's . . . its duties

relative to ensuring that the plaintiffs receive medical services with reasonable promptness are non-delegable.").

The MCOs and their amici misconceive the nature of the Medicaid program by characterizing the contracts setting forth the MCO Rates as black boxes containing matters of purely private interest. *See, e.g.*, Group B Br. at 12 (stating that examining how MCOs spend public funds to implement Pennsylvania's Medicaid program would be "meddling into the affairs of private contractors" (emphasis removed)). Public examination is not "meddling." Medicaid is a public program, and public scrutiny of the MCO Rates and Provider Rates is transparency of just the sort that motivated the General Assembly to enact the RTKL. *See, e.g.*, *Levy v. Senate of Pa.*, 65 A.3d 361, 381 (Pa. 2013) (noting "a legislative purpose of expanded government transparency through public access to documents").

The MCO Rates and Provider Rates are matters of significant public concern. At the most basic level, a large share of the Commonwealth's tax revenues pass through the MCOs and their subcontractors in order to provide care for Medicaid recipients. Pennsylvania taxpayers have a substantial, legitimate interest in examining this flow of revenue to ensure that Medicaid recipients are getting appropriate access to care. Examination of only the rates paid by DPW to the MCOs (the Capitation Rates) is not sufficient to answer that question. *See, e.g.*, *Pa. Pharmacists Ass'n*, 283 F.3d at 537-38; *Clark v. Richman*, 339 F. Supp. 2d at

644. The Capitation Rates, for example, lump together payments for medical and dental care, (*e.g.*, R. 270a, 372a), so only by examining the MCO Rates is it possible to calculate what share of Medicaid funds go specifically toward dental coverage. And only the Provider Rates reveal the rates paid to dentists to perform particular services, i.e., the total amount of public funds reaching Medicaid providers.[3]

As noted in Requesters' opening briefs in this case (pg. 26) and in *Eiseman II* (pp. 15-16, 26), there are numerous requirements for how Medicaid programs must provide healthcare, and it is impossible to gauge compliance with them solely by reference to the Capitation Rates.[4] To give a few examples:

- A state Medicaid plan must "provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals." 42 U.S.C. § 1396a(a)(8). "Setting reimbursement levels [i.e., Provider Rates] so low that private dentists cannot afford to treat Medicaid enrollees effectively frustrates the reasonable promptness provision by foreclosing the opportunity for enrollees to receive medical assistance at all, much less in a timely manner." *Health Care for All, Inc. v. Romney*, No. 00-cv-10833, 2005 U.S. Dist. LEXIS 14187, at *32-33 (D. Mass. July 14, 2005).

- A state Medicaid plan must "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist

[3] The sources listed in the appendix to the Group B Brief do not come close to answering these questions. Besides, the Court should reject any suggestion that by generating summaries of certain data, an agency can avoid providing basic data that it would otherwise have to release under the RTKL.

[4] The Medicaid requirements discussed here apply identically in fee-for-service and managed-care contexts. *See, e.g., Fla. Pediatric Soc'y*, 2014 U.S. Dist. LEXIS 179434, at *240-41.

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). This requirement "demands that payments be set at levels that are sufficient to meet recipients' needs." *Pa. Pharmacists Ass'n*, 283 F.3d at 538. Noncompliance with this requirement can be demonstrated "through a variety of indicators, such as: (1) the level of reimbursement to participating dentists in the market and the costs of providing such services; (2) the level of dentist participation in the MA program; (3) whether there are reports that recipients are having difficulty obtaining care; (4) whether the rate at which MA recipients utilize dental services is lower than the rates at which the generally insured population uses those services; and (5) whether DPW agents have admitted that reimbursement rates are inadequate." *Clark*, 339 F. Supp. 2d at 644. "If, for example, a state reduces its payments to significantly below the amount necessary for a nursing facility to treat its patients, some facilities might cut corners and provide inadequate care, whereas others might stop accepting Medicaid patients altogether and thus restrict access to providers." *Christ the King Manor*, 730 F.3d at 314 n.24.

- 62 P.S. § 201 assigns several duties to DPW that obligate it to collect and examine the MCO Rates and Provider Rates. Among these duties are: to "establish and enforce standards and to take such other measures as may be necessary to render the Commonwealth eligible for available Federal funds or other assistance," 62 P.S. § 201(2); "[t]o collect data on its programs and services, including efforts aimed at preventative health care, to provide the General Assembly with adequate information to determine the most cost-effective allocation of resources in the medical assistance program," *id.* § 201(5); and "[t]o submit on a biannual basis a report to the General Assembly regarding the medical assistance population, which shall include aggregate figures, delineated on a monthly basis, for the number of individuals to whom services were provided, the type and incidence of services provided by procedure and ***the cost per service*** as well as total expenditures by service," *id.* § 201(6) (emphasis added).

These laws require that downstream rates meet certain standards, but the amici supporting the MCOs ignore this special feature of Medicaid, treating it as

just another business activity that the government has contracted away. Quoting *McDonnell Douglas Corp. v. United States Department of the Air Force*, 375 F.3d 1182, 1193 (D.C. Cir. 2004), Amicus America's Health Insurance Plans ("AHIP") submits that "disclosure of MCO Rates and Provider Rates would not 'contribute significantly to public understanding of the operations or activities of the government.'" Brief of Amicus Curiae AHIP ("AHIP's Br.") at 12. *McDonnell Douglas* is inapt because the Air Force procurements involved there do not have the same panoply of provisions to assure that downstream subcontractors satisfy non-contracting beneficiaries.[5] Medicaid is designed to "furnish medical care to needy individuals," *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990). Medicaid beneficiaries are not contracting businesses, and provisions like those in the above bullet list are meant to ensure that state Medicaid programs are not administered so as to shortchange low-income children and other eligible recipients.

For similar reasons, the Court should reject the argument of PCMAMCO that "[t]he public can assess the program's effectiveness by examining the Capitation Rates (paid by DPW to the MCOs) in view of the resultant quality of care and access to care statistics provided by DPW." PCMAMCO's Br. at 8. The "effectiveness" of Pennsylvania's Medicaid managed-care program cannot be fully

[5] *McDonnell Douglas* is also inapt because it concerns the federal Freedom of Information Act, which lacks analogs to the key RTKL provisions at issue in this case. AHIP's analogies to Medicare Parts C and D fail for the same reason. *See* AHIP's Br. at 23-25.

assessed without examination of the downstream rates. *See, e.g.*, *Pa. Pharmacists Ass'n*, 283 F.3d at 538; *Clark*, 339 F. Supp. 2d at 644. PCMAMCO itself all but concedes this point, stating that "the amount ultimately paid to a dentist bears no resemblance to the amounts paid by DPW . . . ." PCMAMCO's Br. at 7. In keeping with this concession, disclosure of the Capitation Rates alone simply does not show whether the rates paid to dental providers are "adequate . . . to enlist a sufficient number of dentists to assure that dental care is available to MA recipients to the same extent and quality of care as dental care available to the general population in certain geographic areas," *Clark*, 339 F. Supp. 2d at 643.[6]

The records containing the MCO Rates and Provider Rates are therefore "financial records" under both of the definitions in 65 P.S. § 67.102. No complicated statutory construction is involved. The records are "contracts." They "deal with" the disbursement of funds by DPW via MCOs and subcontractors. And they "deal with" how DPW "acquires" (via MCOs) or "uses" the "services" of dentists to treat Medicaid enrollees.

[6] PCMAMCO goes so far as to admit that "the MCOs' rates . . . are still substantially lower than commercial payors' rates." PCMAMCO's Br. at 10. This mirrors a recent acknowledgment from DPW, quoted in Requesters' *Eiseman II* opening brief (pg. 15), that "Pennsylvania Medicaid provides payment rates for some services that are lower than Medicare or private market payers, causing some providers to forego [sic] participation in the program." These admissions strongly suggest Pennsylvania's Medicaid managed-care program is out of compliance with federal laws, highlighting the public significance, and the public nature, of the MCO Rates and Provider Rates.

3. The Funds Remain Public Until Received by Providers

The MCOs assert that treating the MCO Rates and Provider Rates as financial records of DPW must also mean that "[t]he providers' payment of their electric bill to run their dental drills so that they can perform dental work on Medicaid patients would be 'financial records' of the agency." Group A Br. at 20; *accord* Group B Br. at 27-28. No such absurd result follows. Instead, as discussed in Requesters' opening brief (pp. 25-26, 30 n.10), the funds transform from public to private when received by dental providers for treatment of Medicaid enrollees.

DPW pays billions of dollars per year so that Medicaid enrollees can receive medical and dental care. These public funds are not for the benefit of the MCOs, or the subcontractors, or the dentists: they are for the benefit of Medicaid enrollees. *See, e.g.*, *Pa. Pharmacists Ass'n*, 283 F.3d at 538.

How does DPW ensure that Medicaid enrollees get dental care? By making money available to pay to dentists. There is nothing mysterious about this setup. A wealthy individual without dental insurance makes out-of-pocket payments to her ***dentist***, not small separate payments to her dentist's electric utility, landlord, sealant supplier, and so forth. Medicaid works the same way. A Medicaid enrollee lacks the means to pay out-of-pocket, so DPW pays the dentist on his behalf. DPW may pay the dentist directly under a fee-for-service system, or may pay the dentist through MCOs and subcontractors under a managed-care system; in either event,

DPW provides for the enrollee to receive dental care by seeing to it that the ***dentist*** is paid, just as the wealthy patient does.

Before a dentist receives payment—i.e., while DPW funds are passing through the MCOs and subcontractors—the funds are subject to strict requirements set forth in the Standard Contract, as mandated by federal and state laws. But once the dentist has received payments, the funds convert from public to private. DPW does not control what utilities, vendors, or software the dentist chooses. Within the broad confines of maintaining a functioning practice, the dentist is free to make private business decisions about whether to spend Medicaid revenues to buy a new x-ray machine or to hire an additional hygienist. Those are private decisions about private expenditures of private funds, and they are beyond the reach of the RTKL.

B. Section 708(c) of the RTKL Requires the Disclosure of Financial Records Even if They Contain Trade Secrets or Confidential Proprietary Information, and PUTSA Does Not Dictate Otherwise

The MCOs devote substantial portions of their briefs to arguing that the MCO Rates are trade secrets or confidential proprietary information. *See also* AHIP's Br. at 16-17 (citing non-financial-record cases). But this Court is called upon to address whether financial records of DPW must be released ***regardless*** of whether this is so. The RTKL requires such disclosure, and the MCOs' arguments to the contrary cannot be sustained.

The first question presented in this case is whether Section 708(c) of the RTKL, ***which explicitly requires disclosure of financial records even if they contain trade secrets or confidential proprietary information***, is "nullified by the earlier-enacted Pennsylvania Uniform Trade Secrets Act." Biting the bullet, the Group A Appellees answer "yes."[7] Group A Br. at 22 n.4. Their argument is that Section 708(c)'s limitation on the "trade secret" exception of Section 708(b)(11) is a ***latent*** provision, meaningless now but perhaps meaningful someday. Group A Br. at 22 n.4 ("[G]iven the possibility that PUTSA may be amended or other legislation enacted that removes or modifies the protection afforded to trade secrets in general, or to MCO rates in particular, Sections 708(b)(11) and 708(c) clearly have vitality."). The theory goes that the General Assembly tucked the provision into the RTKL on the chance that a later legislature might soften PUTSA, at which point Section 708(c)'s previously nugatory limitation would bound into action. The Court should not accept this proposition.

The Court should instead hold that because the Section 708(c) carveout for trade secrets is more specific and more recent than PUTSA, PUTSA does not create a separate basis for withholding the records.

[7] The Group B Appellees' entire argument on this point consists of a short, conclusory footnote. Group B Br. at 34 n.14.

C. The Records Are Too Old and Too Widely Shared to Have Competitive Value

If the Court finds that the requested records are "financial records," and that PUTSA does not trump Section 708(c) of the RTKL, it can reverse without deciding whether the MCO Rates are stale or whether they have been maintained as secrets. But if the Court finds it necessary to reach those issues, it will find nothing in the MCOs' briefs that successfully rebuts Requesters' arguments.

The Group B Appellees suggest that if the Court holds in Requesters' favor on the staleness issue, "requestors would be incentivized to manipulate the process by engaging in protracted litigation in the hopes of 'running out the clock' on an exemption." Group B Br. at 34. This argument gets the incentives for requesters precisely wrong. Citizens request public records because the records are timely, not because the records are too old to be of interest. *See generally Commonwealth v. Donahue*, 98 A.3d 1223, 1240 (Pa. 2014) (discussing "the RTKL's purpose of facilitating the speedy resolution of record requests submitted to government bodies").[8]

[8] "Could an individual's psychiatric records become 'too old' to implicate privacy concerns?" Group B Br. at 34 n.16. No. A record is not exempt from disclosure on "confidential proprietary information" grounds unless its disclosure "would cause substantial harm to the competitive position of the person that submitted the information." 65 P.S. § 67.102. A balancing test is built into this definition. A similar balancing test is evident in the definition of "trade secret." *See id.* ("derives independent economic value, actual or potential, from not being generally known"). There is no balancing test under the RTKL for psychiatric records. *Id.* § 67.708(b)(5) (exempting from disclosure "[a] record of an individual's medical, psychiatric or psychological history or disability status"). This is consistent with the Mental Health Procedures Act, which strictly limits

AHIP attempts to prop up the argument that the rates never become stale by asserting that "the models used to generate rates from 2008 to 2012 may very well be the same or similar to those in contracts still in effect today." AHIP Br. at 15 n.15. AHIP's implication is that an MCO uses an essentially static algorithm to spit out new rates each year. *Id.* at 15. Thus, the argument goes, disclosing previous years' rates would make it trivial for competitors to "back out" the MCOs' pricing methodologies. But the MCOs themselves suggest the opposite. Group B Br. at 7 (renegotiations of the MCO Rates require "significant time and expense"); *id.* at 35 ("rates are the subject of an intense annual negotiating process"). The fact that annual renegotiations are so resource-intensive for the MCOs undercuts the suggestion that revealing old rates would be tantamount to revealing secrets of competitive value to next year's negotiations.

As for the four MCOs that use DentaQuest as their dental subcontractor, the record is bereft of any evidence of limitations on information-sharing by personnel ***within*** DentaQuest. The Group B Appellees seek to use argument to plug this evidentiary hole, but aside from the fact that their assertions are worded so noncommittally as to be meaningless, they are without any basis in the record. *See* Group B Br. at 36 ("Were DentaQuest to internally share the rates paid by each

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the dissemination of treatment records. 50 P.S. § 7111. Indeed, the confidentiality of psychiatric records "does not end with a person's death." *Hunt v. Pa. Dep't of Corr.*, 698 A.2d 147, 150 (Pa. Commw. Ct. 1997) (Right-to-Know Act case involving the mental health records of an executed inmate).

plan, such ***would appear to be*** a breach of contract." (emphasis added)); *id.* at 36 n.18 ("It is not hard to figure how DentaQuest might do so."). The Court should reject these arguments, and should also reject the attempt to pin the burden of proof on the Requesters, Group B Br. at 36 ("Appellants obviously have not established . . . ."); *id.* at 36 n.18 ("[T]here is no evidence to back up appellants' claim . . . ."). *See, e.g.*, *Allegheny Cnty. Dep't of Admin. Servs. v. Parsons*, 61 A.3d 336, 342 (Pa. Commw. Ct.) (en banc) ("Third-party contractors in possession of requested records are placed in the shoes of a local agency for purposes of the burden of proof . . . ."), *alloc. denied*, 72 A.3d 604 (Pa. 2013).

D. The Sky Won't Fall When the Rates Are Released

PCMAMCO vigorously asserts that releasing the records sought here and in *Eiseman II* would make MCO Rates and Provider Rates vary so precipitously, and generate such severe anticompetitive effects, that Medicaid managed care in Pennsylvania would effectively come to an end.[9] AHIP is similarly gloomy, predicting that the release of MCO Rates may prompt MCOs "to exit the Medicaid managed care market altogether." AHIP Br. at 22.

There is a gaping flaw in these amici's predictions of doom, referenced in Requesters' opening brief (pg. 12): similar records have ***already been released*** in

[9] PCMAMCO is confident that transparency will make the rates either soar or plunge, but it's unsure which. PCMAMCO's Br. at 9. This does not provide the Court a solid theoretical framework on which to base its decision.

Pennsylvania and elsewhere, and the sky hasn't fallen. Revealingly, amici do not devote a single word to these empirical disproofs of their theories.

First, as a result of the decision in *Lukes v. Department of Public Welfare*, 976 A.2d 609 (Pa. Commw. Ct.), *alloc. denied*, 987 A.2d 162 (Pa. 2009), West Penn Allegheny Health System (WPAHS), "which is a non-profit healthcare provider comprised of six hospitals located in western Pennsylvania," obtained "the production of Provider Agreements between the University of Pittsburgh Medical Center Health Plan, Inc.," which is an MCO, "and hospitals affiliated with the University of Pittsburgh Medical Center (UPMC) entered into for the purpose of administering a DPW Medicaid managed care program known as the HealthChoices Program." 976 A.2d at 612. According to the amici, this release of records should have allowed WPAHS to drive a harder bargain for high provider rates, netting out to higher overall costs to the Medicaid program. This is difficult to reconcile with the amici's proclamations that Medicaid managed care has generated ever-increasing savings for the Commonwealth. *See* AHIP's Br. at 18; PCMAMCO's Br. at 5-6.[10]

[10] This case is not about the merits of Medicaid managed care versus a fee-for-service system. Nevertheless, it must be noted that amici cite exactly two studies for the proposition that managed care has improved health and saved money: one was commissioned by DPW, the other commissioned by PCMAMCO. A less tendentious selection of sources would have revealed that "[i]t is hard to generalize with any certainty about the impact of Medicaid managed care on costs, access or quality." Michael Sparer, *Medicaid Managed Care: Costs, Access, and Quality of Care*, at 22 (Sept. 2012), *available at* http://www.rwjf.org/en/research-publications/find-rwjf-research/2012/09/medicaid-managed-care.html (last visited Jan. 31, 2015); *see also* Mark

Second, following a decision on behalf of a newspaper by the Court of Appeals of North Carolina, price lists in contracts between public hospitals and private (i.e., non-Medicaid) HMOs became available in that state as public records. *Wilmington Star-News v. New Hanover Reg'l Med. Ctr.*, 480 S.E.2d 53 (N.C. Ct. App. 1997). [11] At the very least, this outcome blunts AHIP's claim that "confidentiality in provider rates is the norm in market-based health systems." AHIP's Br. at 23.

Third, because of the Commonwealth Court's order in ***this*** case, in early May 2014 DPW released to all the parties in this action four years' worth of detailed information about historical capitation payments made by DPW to each of

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Duggan & Tamara Hayford, *Has the Shift to Managed Care Reduced Medicaid Expenditures? Evidence from State and Local-Level Mandates*, at 1 (July 2011), *available at* http://www.nber.org/papers/w17236 (last visited Jan. 31, 2015) ("Theoretically, it is ambiguous whether the shift from fee-for-service into managed care would lead to an increase or a reduction in Medicaid spending. This paper investigates this effect using a data set on state and local level MMC mandates and detailed data from CMS on state Medicaid expenditures. The findings suggest that shifting Medicaid recipients from fee-for-service into MMC did not reduce Medicaid spending in the typical state."); Bradley Herring & E. Kathleen Adams, *Using HMOs to Serve the Medicaid Population*, 20 Health Econ. 446, 458 (2011) ("Our results suggest that neither the increased use of commercial HMOs nor Medicaid-dominant HMOs over this time period resulted in significant decreases in health-care expenses or improvement in access to care for the Medicaid population, relative to what would have occurred under direct fee-for-service reimbursement from states.").

As for access to dental care specifically, according to the most recent data available from the United States Department of Health and Human Services, in fiscal year 2013 fewer than 40% of Pennsylvania children eligible for Medicaid received any dental services. *See* Centers for Medicare & Medicaid Services, *Annual EPSDT Participation Report: Form CMS-416* 115-16 (2013), *available at* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html (last accessed Feb. 2, 2015). This falls below the national average and raises serious questions about whether DPW is discharging its duty to provide access.

[11] The legal issues under the North Carolina Public Records Act were quite different from those here. Requesters cite this case not for its legal reasoning but for its outcome.

the Appellee MCOs. By amici's logic, "armed with the knowledge of the rates paid to their competitors," the MCOs should have "demand[ed] to be paid the highest rate being paid under Medicaid" by DPW, driving up the Commonwealth's costs. PCMAMCO's Br. at 9; *accord* AHIP's Br. at 18-19. Yet no such "parade of horribles," PCMAMCO's Br. at 12, has marched across Pennsylvania.[12]

PCMAMCO expands its argument beyond the healthcare context to warn that businesses "may be deterred from doing business with the Commonwealth" if they "are concerned that they will be required to disclose their sensitive and confidential proprietary information." PCMAMCO's Br. at 15. This echoes the MCOs' worry that reversal "could impair the willingness of private enterprise to do business with the Commonwealth." Group A Br. at 20. But this Court has already put that issue to bed: "While we have little doubt that the disclosure requirements pertaining to third-parties undertaking governmental functions may

[12] AHIP relies on the hearing testimony of United President Heather Cianfrocco as evidence that releasing the MCO Rates would harm her company. AHIP's Br. at 16-17 (quoting R. 382a). But in the quoted passage, Ms. Cianfrocco was discussing the alleged harmful effect of releasing the Capitation Rates paid by DPW to the MCOs.

Consistent with Ms. Cianfrocco's testimony, the MCOs' post-hearing briefs issued warnings about the effects of disclosing the Capitation Rates. The Group A Appellees stated that disclosure "could competitively disadvantage one or more of the HMOs in their negotiations with DPW" (R. 1078a-1079a), while the Group B Appellees wrote that "were a competitor to obtain an MCO's capitation rates, it could use that information to negotiate a better deal with DPW, causing a loss of market share to the MCO," (R. 1038a). But some nine months after the release of those Capitation Rates, at least the Group B Appellees have changed their stance, referring to the "palpable equity" of the Commonwealth Court's decision to order release of the Capitation Rates and announcing that the decision below has "preserv[ed] the health plans' abilities to compete in the marketplace." Group B Br. at 12. None of the MCOs, DPW, or amici have offered any argument that the release of the Capitation Rates has had any ill effects.

have bearing on their business decisions in dealing with agencies, this is within the range of considerations likely to have been taken into account in the General Assembly's open-records calculus." *SWB Yankees LLC v. Wintermantel*, 45 A.3d 1029, 1044 (Pa. 2012).

AHIP's analogy to the statute creating the Pennsylvania Health Care Cost Containment Council is inapposite. AHIP's Br. at 25-26. The Council does not collect data on dental care; rather, it "collects over 4.5 million inpatient hospital discharge and ambulatory/outpatient procedure records each year from hospitals and freestanding ambulatory surgery centers in Pennsylvania." Pennsylvania Health Care Cost Containment Council, *About the Council*, http://www.phc4.org/council/mission.htm (last visited Feb. 3, 2015). More generally, that statute "contemplated disclosure of health care cost data to the Council by private actors." AHIP's Br. at 25. Most of the data gathered by the Council concerns non-Medicaid-insured patients; unlike the records sought here, such data would otherwise never come into the possession of a public agency and would thus not be potentially accessible via the RTKL. The General Assembly accordingly enacted 35 P.S. § 449.10 to shield data coming from the ***private*** insurance market against RTKL disclosure by the Council. But neither the text nor the intent of 35 P.S. § 449.10 limits RTKL disclosure by DPW of such information pertaining to Pennsylvania's Medicaid program, let alone information about

payment for dental services under Medicaid. The MCO Rates and Provider Rates sought here are actually or constructively possessed by DPW in its capacity as the state agency running Medicaid, a ***public*** insurance program.

Finally, Appellees' amici imply that releasing the rates will promote antitrust violations. *See* AHIP's Br. at 20-21; PCMAMCO's Br. at 13-14. This is untrue. The United States Supreme Court has consistently held that "[t]he exchange of price data and other information among competitors does not invariably have anticompetitive effects; indeed such practices can in certain circumstances increase economic efficiency and render markets more, rather than less, competitive." *United States v. U.S. Gypsum Co.*, 438 U.S. 422, 443 n.16 (1978). That is particularly true in the context of ***non-current*** price information. *See id.* at 443 n.16 ("Exchanges of current price information, of course, have the greatest potential for generating anticompetitive effects . . . ."). In addition, the sharing of price information alone, without a collusive agreement among market participants, does not give rise to an antitrust violation. *E.g.*, *Burtch v. Milberg Factors, Inc.*, 662 F.3d 212, 223 (3d Cir. 2011).

E. DPW Possesses the Requested Records

Finally, DPW and the Group A Appellees have presented an argument about agency possession that no party ever previously raised in the 3½ years since the

original RTKL request.[13] Brief of DPW at 8 ("[T]he records in dispute are not in the possession of the Department but, rather, in the possession of the other appellees . . . ."); Group A Br. at 10 ("The documents in question . . . . are not in the possession of DPW . . . ."). *Contra* Group B Br. at 30 ("There is no . . . agency possession issue . . . in this *Eiseman I* case."). It is far too late for DPW and the Group A Appellees to mount such a defense. No party raised this argument before the Office of Open Records or the Commonwealth Court. The Commonwealth Court correctly stated that "there is no apparent dispute that DPW . . . has access to the MCO Rates." Opinion at 8. None of the Appellees petitioned for allowance of appeal from the Commonwealth Court's Order, and none asserted this defense in opposition to Requesters' Petition for Allowance of Appeal. It is not within the scope of the issues on appeal under this Court's Order granting allowance of appeal.

Even if this argument were somehow timely, it's wrong. Under the Standard Contract, the MCOs must submit to DPW, for advance written approval, all contracts containing the rates they pay to dental subcontractors or directly to providers. (R. 766a (stating that "[a]ny Subcontract between the PH-MCO and any individual, firm, corporation or any other entity to perform part or all of the selected PH-MCO's responsibilities under this Agreement" must be "submitted to

[13] In *Eiseman II*, by contrast, there has been a dispute all along about whether DPW possesses the requested records.

the Department for advance written approval," and that "[t]his provision includes . . . contracts for . . . dental services"); *see also* R. 706a (defining "Provider Agreement" as "[a]ny Department-approved written agreement between the PH-MCO and a Provider . . . ."); R. 798a ("The PH-MCO must obtain the Department's prior written approval of all Deliverables . . . . Deliverables include . . . Provider Agreements, Provider reimbursement methodology . . . . The Department may require the MCO to resubmit for Department approval previously approved Deliverables, as needed, to conform to the Agreement or applicable law.").) Accordingly, DPW has actual possession of the records showing the MCO Rates. Even if DPW lacked actual possession, the records would be public records of DPW under Section 506(d)(1) of the RTKL, 65 P.S. § 67.506(d)(1).

III. CONCLUSION

Requesters respectfully request that the Court reverse the Commonwealth Court's Order insofar as it reversed the Final Determination of the Office of Open Records.

Dated: February 3, 2015

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing brief complies with the 7,000 word limit established by Pa. R.A.P. 2135.

/s/ Benjamin D. Geffen
Benjamin D. Geffen

Dated: February 3, 2015

CERTIFICATE OF SERVICE

I hereby certify that on this day I am causing to be served this **Reply Brief of Appellants** by e-mail, per agreement of the parties under Pa. R.A.P. 121(c)(4), and by United States Postal Service First-Class Mail to:

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