No. 18A-_____

IN THE
SUPREME COURT OF THE UNITED STATES

LEGACY COMMUNITY HEALTH SERVICES, INCORPORATED,

Applicant,

v.

CHARLES SMITH, in His Official Capacity as Executive Commissioner of Health and Human Services Commission,

Respondent.

APPLICATION FOR EXTENSION OF TIME TO FILE A PETITION FOR A WRIT OF CERTIORARI

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To Associate Justice Samuel A. Alito, Circuit Justice for the United States Court of Appeals for the Fifth Circuit:

1. Under this Court's Rules 13.5 and 22, Applicant Legacy Community Health Services, Inc.[1] respectfully requests an extension of thirty (30) days to file a petition for a writ of certiorari. The petition will challenge the decision of the Fifth Circuit in *Legacy Community Health Services, Inc.* v. *Smith*, 881 F.3d 358 (5th Cir. 2018), a copy of which is attached. The Court of Appeals issued its opinion on January 31, 2018, and denied the petition for rehearing and entered judgement in this case on March 5, 2018. Without an extension, the petition for a writ of certiorari would be due on June 3, 2018. With the requested extension, the petition would be due on July 3, 2018. This Court's jurisdiction will be based on 28 U.S.C. § 1254(1).

2. This case is a serious candidate for this Court's review. It involves the intersection of two cornerstones of the Nation's health care safety net, cornerstones that were designed by Congress to work in harmony, including carefully crafted provisions that ensure that appropriated funds are used for the purposes Congress intended. The Fifth Circuit's decision upsets this careful balancing, shifts appropriated funds contrary to law, and will have dire consequences across the Nation.

3. The first cornerstone is Section 330 of the Public Health Service Act, 42 U.S.C. § 254b, which provides federal grants mostly to private, non-profit community

[1] Pursuant to Rule 29.6 of the Rules of this Court, the parties to the proceedings include those listed on the cover. Legacy Community Health Services, Inc. does not have any stock-owning parent corporations. No publicly held company owns 10 percent or more interest in Legacy Community Health Services, Inc.

health centers (called "federally qualified health centers" or "FQHCs" for Medicaid and Medicare payment purposes). Section 330 supplies federal funding for FQHCs to provide primary and preventive care in medically underserved areas to any person who walks in the door, regardless of the ability to pay. 42 U.S.C. § 254b(k)(3)(G)(iii)(I). Texas has more than 70 FQHCs that receive federal grant funding under Section 330.

4. The second cornerstone is the Medicaid program, 42 U.S.C. §§ 1396 *et seq.*, which is jointly financed by state and federal funds and provides a broad range of medical assistance to eligible persons whose income and resources are insufficient to meet the costs of necessary medical services. Texas, like many states, has chosen to outsource its obligations under its Medicaid program to managed care organizations (MCOs) that are responsible for arranging and managing the provision of covered Medicaid services for Medicaid beneficiaries. MCOs use the marketplace to contract with the full range of health care providers to create a "network." Generally speaking, Medicaid beneficiaries must see in-network providers for the provision of covered services and neither a state nor an MCO is obligated to pay for the services provided to a Medicaid beneficiary by an out-of-network provider.

5. Unlike other Medicaid providers, FQHCs are required by federal law to treat all patients, even if the FQHC is out-of-network with respect to that patient. See 42 U.S.C. §§ 254b(a)(1), 254b(k)(3)(G). Failure to receive payment when FQHCs are out-of-network necessarily means that FQHCs must divert their Section 330 grant funds, generally the only other source available to pay for the services.

6. Congress has carefully coordinated respective payments to FQHCs from Section 330 and Medicaid to ensure that the purely federal funding provided to FQHCs to provide health care in underserved areas is not diverted by states to satisfy their Medicaid obligations, whether or not the FQHC is in the state's MCO network. Congress specifically provided that states must pay FQHCs their full cost-based rate (known as a prospective payment system or "PPS" rate) in the absence of a managed care contract. 42 U.S.C. § 1396a(bb)(1)–(4). And for in-network FQHCs (which have MCO contracts), Congress: (1) allowed MCOs to negotiate freely with FQHCs to set payment rates no differently than any other health care provider, 42 U.S.C. § 1396b(m); and (2) required States to make supplemental payments equal to the difference between the FQHC's PPS rate and the amount paid by the MCO. 42 U.S.C. § 1396a(bb)(5)(A). These payment rights (whether full or supplemental) ensure that FQHCs are paid roughly at their cost of providing services to Medicaid beneficiaries and, by doing so, prevent states from diverting Section 330 funds to satisfy their obligations under Medicaid.

7. The Fifth Circuit's decision below upends this scheme in two respects, both of which will have significant and negative effects not intended by Congress. First, by holding that states do not have to pay for out-of-network services provided by an FQHC, it forces the Section 330 program to pay for those Medicaid services, effectively rewriting federal appropriations law and shifting a Medicaid cost onto Section 330. Second, it allows states like Texas to write the supplemental payment provision out of federal law, 42 U.S.C. § 1396a(bb)(5)(A), by requiring MCOs to pay an FQHC's full PPS rate. This change turns the Congressional scheme of allowing

FQHCs to work seamlessly within Medicaid managed care on its head. Instead of allowing MCOs to negotiate rational payment rates with FQHCs (supplemented by the state), the decision incentivizes MCOs to push FQHCs out of their networks. As a consequence of federal law, FQHCs have different payment requirements than other in-network providers, and, under the Fifth Circuit's decision, both states and MCOs can avoid paying FQHCs' costs of providing covered services to Medicaid beneficiaries simply by excluding them from the states' MCO networks. Thus, under the Fifth Circuit's decision below, MCOs will, like any economic actor, turn away or terminate their contracts with FQHCs, as happened with Applicant in this matter.

8. The Fifth Circuit's decision permits Texas to push FQHCs out of the State's MCO network and then deny them Medicaid funds for treating Medicaid patients, whom they are required by federal law to treat. This is a blatant end run around Congress's reticulated scheme for funding FQHCs and ensuring that states cannot pass off their Medicaid expenses onto those vital, federally funded health care centers. Nationally, over two-thirds of all Medicaid beneficiaries were enrolled in comprehensive MCOs in 2016. The Fifth Circuit's disruption of the financial structure Congress mandated for Medicaid-managed care seriously undermines the viability of the Nation's health safety net.

9. The petition will present two questions: (1) whether the state is obligated to pay for nonemergency, out-of-network services provided by an FQHC, and (2) whether the state can require MCOs to pay the full PPS amount rather than making up the difference in the rates itself as required by Section 330. The Fifth Circuit's answers to those questions conflict with decisions by the Second Circuit in

Community Health Care Ass'n of New York v. *Shah*, 770 F.3d 129 (2d Cir. 2014), and the Ninth Circuit in *California Ass'n of Rural Health Clinics* v. *Douglas*, 738 F.3d 1007 (9th Cir. 2013). Both of those Circuits rejected similar state efforts to modify the clear payment requirements under 42 U.S.C. § 1396a(bb). Moreover, the Fifth Circuit disregarded long-standing interpretative guidance from 1998 and very recent guidance from 2016 issued by the Centers for Medicare and Medicaid Services ("CMS") that states cannot delegate their PPS obligation to MCOs except through a properly implemented alternative payment methodology that meets certain statutory requirements. That agency reiterated its guidance on the record in the District Court through a CMS Statement of Interest.

10. Applicant has recently added new counsel to assist in the preparation of a petition for a writ of certiorari in this important case. The extension is needed for the new members of Applicant's legal team to fully familiarize themselves with the record, decisions below, and relevant statutes and case law. As evident above, the health care statutory and regulatory framework is complex, and more time is needed to present the best advocacy to this Court. More time is needed, too, to allow potential *amici* to bring the important economic and health-related consequences of the Court of Appeals' decision to this Court's attention.

11. In light of the above, and the press of other matters on undersigned counsel, Applicant respectfully requests that the due date for its petition for writ of certiorari be extended to July 3, 2018.

Respectfully submitted,

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