No. _____

In The Supreme Court of the United States

LEGACY COMMUNITY HEALTH SERVICES, INCORPORATED,

Petitioner,

v.

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

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Section 330 of the Public Health Service Act provides federal grants for federally-qualified health centers ("FQHCs") to provide primary medical care to Medicaid and other patients in medically underserved areas, regardless of a patient's ability to pay. 42 U.S.C. § 254b. So that States do not divert those federal grants to subsidize their own Medicaid obligations, Congress provided in 42 U.S.C. §§ 1396a(bb)(1)-(5) that States must fully reimburse FQHCs for all services they provide to Medicaid beneficiaries—whether the FQHCs are in or out of the State's Medicaid managed-care network.

The First, Second, Third, Fourth, and Ninth Circuits hold that States cannot avoid the duty to fully reimburse FQHCs under 42 U.S.C. §§ 1396a(bb)(1)-(5), regardless of how they structure their managed-care network or whether an FQHC is in or out of that network. In the decision below, the Fifth Circuit held the opposite: that a State can structure its managed-care network so as to avoid its duty to fully reimburse FQHCs. The question presented is:

Whether 42 U.S.C. §§ 1396a(bb)(1)-(5) impose an independent duty on States to fully reimburse FQHCs for all services they provide to Medicaid beneficiaries regardless of how a State structures its managed-care network or whether the FQHCs are in or out of that network.

PARTIES TO THE PROCEEDINGS AND CORPORATE DISCLOSURE STATEMENT

The parties to the proceedings include those listed on the cover.

Legacy Community Health Services, by and through its undersigned attorneys and pursuant to Rule 29.6, submits that it has no parent companies, subsidiaries, or affiliates, and no publicly held company owns any of its stock.

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OPINIONS AND ORDERS BELOW

The Fifth Circuit opinion (App. 1-37) is reported at 881 F.3d 358. The district court orders granting summary judgment for petitioner (App. 38-80, 81-99) are reported at 204 F. Supp. 3d 923 and 184 F. Supp. 3d 407.

STATEMENT OF JURISDICTION

The judgment of the Fifth Circuit was entered on January 31, 2018. App. 102-03. The petition for rehearing was denied on March 5, 2018. App. 100-01. Petitioner's application to extend the time to file a petition for a writ of certiorari to July 3, 2018 was granted on May 9, 2018. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The relevant statutory provisions of 42 U.S.C. § 1396a(bb), 42 U.S.C. §§ 1396b(m)(2)(A), 42 U.S.C. §§ 1396d(a)(2)(C), (*l*)(2)(A), and 42 U.S.C. § 1395x(aa)(1) are reproduced in the appendix to this petition. App. 104-23.

INTRODUCTION

Federally-qualified health centers or "FQHCs" "occupy a unique place in the health services ecology"

established by Congress. *Cmty. Health Care Ass'n of N.Y.* v. *Shah*, 770 F.3d 129, 157 (2d Cir. 2014). Unlike other providers of Medicaid services, FQHCs are assigned a special mandate by Congress to provide primary medical care to all patients, including Medicaid beneficiaries, in medically underserved areas. They must provide care regardless of the patient's ability to pay, and they must charge reduced fees to patients making up to twice the poverty level and waive fees entirely for those below the federal poverty line. 42 U.S.C. §§ 254b(k)(3)(E) & (G)(i)-(iii); 42 C.F.R. § 51c.303(f).

Consistent with this special federal mandate, since 1975, Congress has provided distinct federal grants to FQHCs under Section 330 of the Public Health Services Act, 42 U.S.C. § 254b, to fund their provision of medical services to underserved areas. Because FQHCs must treat Medicaid enrollees, Congress also created a scheme by which States that participate in Medicaid must fully reimburse FQHCs for all services they provide to Medicaid beneficiaries, so that the dedicated federal funds that Congress provides to FQHCs under Section 330 are not diverted to subsidize a State's Medicaid funding obligation. See 42 U.S.C. § 1396a(bb); S. REP. NO. 94-29, at 6-7 (1975), reprinted in 1975 U.S.C.C.A.N. 469, 473-74.

The Fifth Circuit's decision below guts the States' clear statutory duty to fully reimburse FQHCs for Medicaid-related services. This case involves the Texas Health and Human Services Commission's ("the Commission") refusal to reimburse FQHCs for services

provided to Medicaid beneficiaries, if those services are not provided through a contract with a managed-care organization ("MCO"). The Fifth Circuit upheld the Commission's refusal, reasoning that when States contract with MCOs to implement their managed-care programs, the States need not reimburse FQHCs for services provided to Medicaid beneficiaries in cases where the MCO has not contracted with the FQHC ("out-of-network services"). This Court should review the panel's decision for three primary reasons.

First, the Fifth Circuit opinion conflicts with decisions of the First, Second, Third, Fourth, and Ninth Circuits, all of which hold that a State's obligation to fully reimburse FQHCs under 42 U.S.C. § 1396a(bb) operates independent of the State's managed-care system, and that full reimbursement for all FQHC services is required whether the FQHC is in or out of the State's MCO network. The Second Circuit's decision in *Shah* demonstrates the conflict. There, the Second Circuit rejected a similar state effort to evade Section 1396a(bb)'s full reimbursement requirement and held that States must reimburse FQHCs for all Medicaid services they provide, whether in-network or out-of-network. *Shah*, 770 F.3d at 157. Other circuits similarly hold that a State's managed-care system cannot excuse a State's failure to fully compensate FQHCs for "*all* Medicaid-eligible encounters" under Section 1396a(bb). *N.J. Primary Care Ass'n* v. *N.J. Dep't of Human Servs.*, 722 F.3d 527, 539 (3d Cir. 2013); see also *Cal. Ass'n of Rural Health Clinics* v. *Douglas*, 738 F.3d 1007, 1013 (9th Cir. 2013); *Three Lower Ctys. Cmty.*

Health Servs., Inc. v. *Maryland*, 498 F.3d 294, 303 (4th Cir. 2007); *Rio Grande Cmty. Health Ctr., Inc.* v. *Rullan*, 397 F.3d 56, 62 (1st Cir. 2005). The Fifth Circuit's dismissal of this repayment obligation for out-of-network FQHCs violates the plain language of the statute and creates a clear circuit split on an important issue of federal law that warrants this Court's immediate review.

Second, the opinion below improperly re-apportions federal funds based on the court's misguided assessment of what "makes paramount sense" in this context. App. 33. The panel viewed the States' independent statutory duty to fully reimburse FQHCs as an obstacle to an efficient managed-care network, and instead sought to punish FQHCs that have been pushed out of the managed-care network. In doing so, it ignored the plain terms of the statute and clear guidance from the Centers for Medicare and Medicaid Services ("CMS"), including its Statement of Interest filed in this case. By forcing the Section 330 program to pay for covered Medicaid services, the decision re-appropriates federal funds in a blatant end-run around Congress's express funding scheme. And it disrupts the flow of essential healthcare resources to FQHCs and their patients.

Third, the costs imposed on FQHCs by the Fifth Circuit's decision will be felt immediately. Among other things, the decision will result in fewer FQHCs—like petitioner—in MCO networks. Because the Fifth Circuit permitted Texas to require MCOs to pay an in-network FQHC's full reimbursement rate (writing the

State's supplemental, wraparound payment obligation under Section 1396a(bb)(5)(A) out of federal law), the decision incentivizes MCOs to push FQHCs out of their networks. Thus, more FQHCs will be out-of-network, where, according to the Fifth Circuit, the State can refuse to reimburse them and shift the Medicaid costs onto their Section 330 grants, notwithstanding Section 1396a(bb)'s full reimbursement requirement. This result is intolerable and will undermine the Nation's health safety net.

Certiorari should be granted to resolve the circuit split, stop the disruption of Congress's carefully designed FQHC-funding scheme, and correct the panel's errant interpretation of the Medicaid statute.

STATEMENT

I. Federal Statutory Background

This case involves the intersection of two cornerstones of the Nation's health safety net, a carefully reticulated statutory scheme designed by Congress to best provide funding for healthcare services to low-income individuals.

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 health centers (called 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 their 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—including Petitioner Legacy Community Health Services. TEXAS DEP'T OF STATE HEALTH SERVS., TEXAS PRIMARY CARE OFFICE (TPCO)—FEDERALLY QUALIFIED HEALTH CENTERS.[1]

The second cornerstone is the Medicaid program, 42 U.S.C. §§ 1396a *et seq.*, which is jointly financed by state and federal funds and provides a broad range of medical assistance to eligible persons whose resources are insufficient to meet the costs of medical services. States that choose to participate in the program receive federal financial assistance and must reimburse healthcare providers who provide services to Medicaid enrollees as prescribed by federal law. See, *e.g.*, 42 U.S.C. § 1396a(bb).

A. FQHCs and the full reimbursement requirement

One such federal requirement is that States pay for services rendered by FQHCs to Medicaid enrollees. 42 U.S.C. § 1396a(bb)(1) ("the State plan shall provide for payment for services in section 1396d(a)(2)(C) of this title furnished by a[n] [FQHC]"); see § 1396d(a)(2)(C) (noting States must cover all FQHC services (as defined in Section 1396d(*l*)(2)(A)) and other ambulatory services offered by FQHCs). Section 1396d(*l*)(2)(A) points to Section 1395x(aa)(1) to define FQHC services

[1] Available at http://dshs.texas.gov/chpr/FQHCmain.shtm.

as all "physicians' services" and "services furnished by a physician assistant or a nurse practitioner * * * , by a clinical psychologist * * * or by a clinical social worker," so long as these services are "furnished to an individual as a[ ] patient of a[n] [FQHC]."

Congress specifically required States to reimburse FQHCs for all of the above services rendered to Medicaid enrollees to ensure purely federal Section 330 funds are not used by States to "subsidize [FQHC] services to Medicaid beneficiaries." H.R. REP. NO. 101-247, at 393 (1989), reprinted in 1989 U.S.C.C.A.N. 1906, 2119; see also S. Con. Res. 65, 109th Cong. (2005) (noting FQHCs should not be "forced to cross-subsidize Medicaid underpayments with Federal grant dollars"). Thus, in 1989, Congress required States to reimburse FQHCs for "100 percent" of their reasonable "costs" in serving Medicaid enrollees. See Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106 (codified at 42 U.S.C. § 1396(a)(13)(C) (repealed 2000)). In 2000, the reimbursement method was altered, but the States' duty to reimburse remains: "the State plan *shall* provide for payment for services * * * furnished by [FQHCs]." 42 U.S.C. § 1396a(bb)(1) (emphasis added).

Now, FQHCs must be reimbursed for all Medicaid services based on a prospective payment system ("PPS rate" or "full reimbursement rate"), which relies on average historical cost and still requires full reimbursement. 42 U.S.C. §§ 1396a(bb)(2)-(4) ("the State plan shall provide for payment * * * that is equal to 100 percent of the average of the costs of the center" during preceding years).

B. Medicaid managed-care systems

Many States, including Texas, have chosen to outsource their Medicaid obligations to MCOs, which are responsible for managing the provision of covered services to Medicaid beneficiaries. The States grant Medicaid funds to MCOs, which then use the marketplace to contract with the full range of healthcare providers to create a "network." See 42 U.S.C. §§ 1396u-2(a), 1396b(m). Generally speaking, Medicaid enrollees must see in-network providers for the provision of covered services, and MCOs are not obligated to pay for the services provided to a Medicaid beneficiary by an out-of-network provider. One exception is that States may require MCOs to reimburse providers for out-of-network services when they are "immediately required due to an unforeseen illness, injury, or condition." 42 U.S.C. § 1396b(m)(2)(A)(vii) (referred to herein as "emergency services").

In managed-care systems, Congress previously had required MCOs to reimburse FQHCs at their "cost-based rates." *N.J. Primary Care*, 722 F.3d at 540. But in the Balanced Budget Act of 1997 ("BBA"), Congress permitted MCOs to negotiate freely with FQHCs to set payment rates at or above the market rate they would pay non-FQHC healthcare providers. Pub. L. No. 105-33, 111 Stat. 251, § 4712 (now codified at 42 U.S.C. § 1396b(m)(2)(A)(ix)). Congress also required States to make supplemental payments to FQHCs that contracted with MCOs for less than their full PPS reimbursement rate. 42 U.S.C. § 1396a(bb)(5)(A) ("In the case of services furnished by a[n] [FQHC] pursuant to

a[n] [MCO] contract * * * , the State plan shall provide for payment to the [FQHC] by the State of a supplemental payment equal to the amount (if any) by which [the PPS rate] exceeds the amount of payments provided under the contract."). These payment rights ensure FQHCs are *fully* reimbursed the same as if there were no MCO contract.

C. CMS's longstanding guidance requiring full reimbursement of FQHCs regardless of how a State structures its managed-care system

Soon after Congress passed the BBA, CMS issued interpretive guidance reinforcing the absolute requirement for States to reimburse FQHCs—whether in- or out-of-network. In April 1998, CMS explained that under Section 1396a(bb)(5)(A), States are not permitted to "delegate[ ] to an MCO" their supplemental payment obligation. CMS April 1998 State Medicaid Directors Letter ("SMDL").[2] Under CMS's interpretation of the statute, States must allow MCOs to negotiate freely with FQHCs, and *States* (not MCOs) must ensure FQHCs receive their full PPS reimbursement rate. *Ibid.*; see also CMS October 1998 SMDL.[3] In 2016, CMS reaffirmed its position that States may not require MCOs to make full PPS payments to FQHCs;

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[2] Available at https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD042098.pdf.

[3] Available at https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD102398.pdf.

rather, States must do so themselves. See CMS April 2016 State Health Official Letter ("SHO Letter").[4]

CMS also has recognized that Section 1396a(bb)(1) requires States to reimburse FQHCs for their full PPS rate for all services to "Medicaid-eligible individuals * * * regardless of the Medicaid delivery system." *Ibid.* Whether services are provided in- or out-of-network, CMS guidance has made clear that Section 1396a(bb) requires that FQHCs must be reimbursed.

II. Factual Background

The Commission is the "single state agency" administering the Texas Medicaid program. 42 C.F.R. § 431.10. It does so, in part, by contracting with MCOs to provide Medicaid services. TEX. GOV. CODE § 533.002. One MCO that contracts with the State is the Texas Children's Health Plan ("TCHP"). App. 5. Petitioner formed a contract with TCHP in 2009 to provide healthcare services to TCHP's members at an agreed upon rate. That rate was approximately one-fourth of petitioner's Section 1396a(bb) full PPS rate. App. 5-6. Texas was required to make up the difference between what petitioner received from TCHP and petitioner's full reimbursement rate as an FQHC. 42 U.S.C. § 1396a(bb)(5)(A).

In 2011, the Commission altered its contracts with MCOs, including TCHP, requiring them to pay

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[4] Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd16006.pdf.

FQHCs their full reimbursement rates instead of their negotiated contract rates. This change caused TCHP's costs to quadruple, and TCHP terminated its contract with petitioner as a result, effective February 2015. App. 6-7. Because petitioner was required to treat all patients, including Medicaid enrollees, 42 U.S.C. § 254b(k)(3), it continued providing services to TCHP patients, even though those services were now "out-of-network." App. 7. Petitioner submitted around 6,000 out-of-network claims to TCHP as a result—nearly half of which were denied because they did not relate to emergency services. *Ibid.* Subsequently, the Commission also refused to reimburse petitioner for these claims. *Ibid.* Texas has "no procedure by which the State can reimburse FQHCs for Medicaid-covered out-of-network services" that are not for emergencies. App. 98.

III. Procedural Background

A. District Court proceedings

1. In January 2015, petitioner sued the Commission under 42 U.S.C. § 1983 in the U.S. District Court for the Southern District of Texas, arguing its reimbursement rights under 42 U.S.C. § 1396a(bb) were violated. First, petitioner claimed the Commission was not permitted to require MCOs to fully reimburse FQHCs—effectively removing the State's obligation to make supplemental, wraparound payments to in-network FQHCs. Second, petitioner argued the Commission's failure to ensure payment for its out-of-network

services violates the Medicaid statute, which imposes an independent obligation to fully reimburse FQHCs for Medicaid services.

Texas moved to dismiss, arguing petitioner lacked standing and a cause of action under 42 U.S.C. § 1983. After the district court denied that motion, the parties cross-moved for summary judgment. The district court issued two separate opinions, granting summary judgment to petitioner on both of its challenges to the Commission's policies.

2. The district court issued its first opinion on May 3, 2016. App. 38. The district court held the Commission's policy requiring MCOs to fully reimburse FQHCs violated 42 U.S.C. § 1396a(bb)(5)(A). App. 67. That section states that in the case of services rendered by an FQHC "pursuant to a contract" with an MCO (in-network services), "the State plan shall provide for payment to the center * * * by the State of a supplemental payment equal to the amount (if any) by which" the full PPS rate "exceeds the amount of payment provided under the contract." 42 U.S.C. § 1396a(bb)(5)(A).

The court first noted the provision requires a supplemental payment *by the State* and quoted language from other Circuits noting the mandatory nature of the State's payment. App. 68-71 (quoting *N.J. Primary Care*, 722 F.3d at 530; *Rullan*, 397 F.3d at 62). The court also noted Congress could have expressly authorized states to require MCOs to make full reimbursements (as it authorized payments in Section

1396b(m)(2)(A)(vii)), but it chose not to. App. 72-73. It then concluded the legislative history of Section 1396a(bb)—first requiring MCOs to pay FQHCs their full PPS rates but then amending the statute to allow free negotiations for any rate above market-rate—meant Congress intended free negotiations. App. 73-75. Because the Commission's requirement turned back the clock on this statutory history, the district court concluded States may not require MCOs to pay the full PPS rate. App. 75.

3. Before the district court turned to the issue of whether States may refuse to reimburse FQHCs for out-of-network services to Medicaid beneficiaries, the United States filed a Statement of Interest on behalf of CMS. App. 124. In that Statement, CMS reasserted its position that "a state may not absolve itself of ultimate responsibility to ensure that FQHCs receive the full PPS amount for" all "Medicaid-covered services." App. 131-32, 139. This is because "FQHCs that furnish Medicaid-covered services to Medicaid-eligible individuals enrolled in a managed care plan must be paid for such services" at "the full PPS rate [under] § 1396a(bb)." App. 131.

CMS explained that the "special provisions" in the Medicaid statute "governing the manner in and rate at which a state must pay FQHCs for Medicaid services" are a result "of the unique role of FQHCs in the provision of federally subsidized healthcare." App. 126. Thus, CMS read the Medicaid statute's clear requirement that FQHCs are paid their full reimbursement rate for Medicaid services as unequivocal. Under CMS's reading, a State "may not divest itself of

responsibility to ensure" full payment "regardless of whether the covered services in question were furnished on an in-network or out-of-network basis." App. 133.

4. After reviewing the parties' briefs and the CMS Statement of Interest, the district court issued its second opinion on September 2, 2016. App. 81. The district court agreed with CMS and petitioner—holding that Section 1396a(bb)(1) requires States to reimburse "*all* Medicaid-eligible encounters." App. 95 (citing CMS Stmt.). The court reasoned that States may not use the managed-care system to decline to reimburse FQHCs for out-of-network services provided to Medicaid beneficiaries. *Ibid.*

While the Commission requires MCOs to reimburse FQHCs for *emergency* out-of-network services, it has no mechanism for reimbursing other, non-emergency out-of-network services—claiming it need not given its utilization of a managed-care system. See App. 87-88, 98. But the district court held that the obligation created by Section 1396a(bb) to fully repay all FQHC services to Medicaid enrollees applies equally to both in-network and out-of-network claims. App. 94-99 (citing *Shah*, 770 F.3d at 153; *N.J. Primary Care*, 722 F.3d at 541). And a State's delegation of reimbursing FQHCs for certain emergency out-of-network services to MCOs cannot "absolve the state of ultimate responsibility to ensure that an FQHC is actually paid the full PPS amount for *any* covered out-of-network services." App. 97 (quoting CMS Stmt., App. 138). The

Commission thus violated the statute by refusing to reimburse petitioner for its out-of-network services. App. 98-99.

B. Court of Appeals' proceedings

The Commission appealed the district court's opinions to the Fifth Circuit. The panel began by holding petitioner had standing to challenge both the Commission's in-network policy of requiring MCOs to pay FQHCs their full PPS rate and the Commission's policy of refusing to reimburse non-emergency out-of-network claims by FQHCs. App. 11-20. Next, the panel agreed with at least five other Circuits in holding that FQHCs (including petitioner) have a private right of action under Section 1983 to enforce their rights to full reimbursement under Sections 1396a(bb)(1) and (5), which are both "mandatory" and "clear[ly] focus[ed] on the benefitted FQHCs." App. 22-24.

Turning to the merits, the Fifth Circuit reversed the district court on both claims. First, the panel considered petitioner's claim that States may not require MCOs to pay FQHCs their full PPS rate. It interpreted Section 1396a(bb)(5)(A)'s requirement that States make supplemental payments as applying only when there is a shortfall between the PPS rate and the MCO rate. App. 26-27. Thus, the panel decided it was "fully consistent with § 1396a(bb)(5)(A) for the state to require the contract to reimburse the FQHCs fully." App. 28. In such cases, there "just would not be 'any' supplemental payment" necessary. *Ibid.*

The Fifth Circuit rejected the argument that Section 1396b(m)(2)(A)(ix)—which requires MCOs to contract with FQHCs at a rate "not less than" the market rate for services—meant States could not require MCOs to contract for *more* than the market rate with FQHCs. App. 29. The panel explained that it was "loath to read such implied limits into statutes." App. 30. In coming to this conclusion, the court (in footnotes) dismissed out-of-Circuit cases which assumed a dual payment scheme involving both MCOs and States as "not on point," App. 29 n.21, and gave short shrift to the implications of legislative history and CMS interpretations shortly after the BBA was enacted demonstrating Congress intended to introduce more flexibility into MCO-FQHC contracting. App. 30 n.23; App. 31 n.24.

Second, the panel held the Commission did not violate Sections 1396a(bb)(1)-(2) by failing to reimburse petitioner for non-emergency out-of-network services it provided to Medicaid beneficiaries. App. 31-32. The panel began by noting Section 1396a(bb)(1) requires States to "provide for payment for services described in Section 1396d(a)(2)(C)" to FQHCs at the PPS rate. App. 32-33. The court then noted Section 1396d(a)(2)(C) refers to "care and services" for certain individuals "whose income and resources are insufficient to meet all of such cost" of FQHC services. App. 33. Claiming that Section 1396d(a)(2)(C) "does not explain what the relevant FQHC services are," *ibid.*, the panel looked to the general provision governing MCOs, § 1396b(m)(2)(A), which states in clause (vii) that

either States or MCOs must reimburse healthcare providers for emergency out-of-network services. App. 33-34.

Attempting to distinguish other Circuit cases that held States must reimburse FQHCs for all services (whether in- or out-of-network), the Fifth Circuit panel claimed "those courts did not have occasion to decide what" out-of-network services are "covered" by the requirement. App. 32 n.27. The panel then concluded emergency services are the *only* "covered" out-of-network services States must reimburse—relying on its conclusion that such a limit "makes paramount sense" because "FQHCs would have little or no incentive to contract with MCOs" if States were required "to reimburse FQHCs for *all* out-of-network services to Medicaid enrollees." App. 33. Reasoning that petitioner should suffer a "penalty" for losing its contract with TCHP, and "FQHCs should have to contract with [] MCOs to provide services when the" State uses a managed-care system, the panel concluded States need not reimburse non-emergency out-of-network claims. App. 33-35.

Judge Jones filed a brief dissent in part, noting she would hold petitioner does not have standing to argue that the Commission may not require MCOs to fully reimburse FQHCs. App. 35. The dissent did not object to petitioner's standing to challenge the Commission's refusal to reimburse out-of-network services.

Petitioner sought rehearing *en banc* and the Fifth Circuit denied the petition on March 5, 2018. App. 100-01.

REASONS FOR GRANTING CERTIORARI

I. The Circuits Are Split On Whether The Full-Reimbursement Requirement Of 42 U.S.C. §§ 1396a(bb)(1)-(5) Applies Independent Of How The State Structures Its Managed-Care Network.

The text of 42 U.S.C. § 1396a(bb) unequivocally states that "the State plan shall provide for payment for services described in Section 1396d(a)(2)(C) of this title furnished by a Federally-qualified health center." 42 U.S.C. § 1396a(bb)(1). Section 1396d(a)(2)(C) lists two types of services, FQHC services as defined by other statutory provisions to include any service furnished to a patient at an FQHC by a physician, physician assistant, nurse practitioner, clinical psychologist, or social worker, §§ 1396d(*l*)(2)(A), 1395x(aa)(1), and "other ambulatory services" offered by FQHCs and included in the State Plan. § 1396d(a)(2)(C). The statute draws no distinction between out-of-network services and those provided in-network. Nor does it limit the States' reimbursement obligation to emergency out-of-network services. And Section 1396a(bb)(2) makes clear that the required "payment" for all these services is calculated on a per-visit basis, and is set based on "100 percent of the average of the costs of the center" for certain previous years. §§ 1396a(bb)(2)-(4)

(explaining calculation of the PPS rate). The conclusion from the text is unmistakable: Congress intended to ensure FQHCs were reimbursed for *all* FQHC services and ambulatory services included in the State Plan which are provided to Medicaid beneficiaries.

Consistent with that plain language, at least five Circuits (the First, Second, Third, Fourth, and Ninth) hold that Sections 1396a(bb)(1)-(5) apply independent of the statute's managed-care provisions and require States to fully reimburse all services FQHCs provide to Medicaid beneficiaries, whether the FQHCs are in or out of the managed-care network.

But now in the Fifth Circuit, which encompasses some of the largest medically underserved areas in the country, that same provision has no independent force in managed-care States and does not require payment for out-of-network services. This Court's review is needed to resolve the conflict.

A. The Circuits are split on whether Section 1396a(bb) creates an independent requirement for States to reimburse FQHCs for *all* Medicaid services.

In concluding that the Commission need not reimburse FQHCs for non-emergency out-of-network services provided to Medicaid beneficiaries, the Fifth Circuit panel reasoned that a State's implementation of a managed-care system relieves the State of its FQHC-reimbursement duty under Section 1396a(bb)(1) with respect to out-of-network services.

App. 33-35. All other Circuits to address this issue (including the First, Second, Third, Fourth, and Ninth Circuits) sharply disagree.

The Second Circuit in *Shah*, for example, held that a State's use of MCOs to reimburse most FQHC claims "cannot relieve the state of its specific burden to ensure payment to FQHCs under Section 1396a(bb)(2)." 770 F.3d at 157. States in the Second Circuit thus may not allow FQHCs to "be left holding the bag" for services to Medicaid enrollees, whether provided in- or out-of-network. *Id.* at 153. Consistent with the plain meaning of the statute, the Second Circuit concluded that "[t]o the extent that out-of-network services constitute a part of the services provided by FQHCs, there must be some arrangement by which FQHCs may be reimbursed for them." *Id.* at 157. And in direct contrast to the Fifth Circuit's decision below, *Shah* rejected the argument that the general MCO provisions override States' specific statutory obligation to reimburse FQHCs for all Medicaid services. See *ibid.* (explaining that "the general provisions of Section 1396b(m), which deal with contractual agreements between states and MCOs on the whole * * * cannot relieve the state of its specific burden to ensure payment to FQHCs under Section 1396a(bb)(2)").

The Third Circuit similarly has held that States are "responsible" under Section 1396a(bb) "for reimbursement of the entire PPS rate for *all* Medicaid-eligible encounters." *N.J. Primary Care*, 722 F.3d at 539. This obligation is no different in managed-care States. In the Third Circuit, if a State's chosen method

of implementing its managed-care system "will result in failures to fully reimburse FQHCs at the PPS rate for valid Medicaid claims," that system "violates the federal Medicaid statute." *Id.* at 540. Thus, consistent with the plain language of Sections 1396a(bb)(1)-(5), the Second and Third Circuits hold that States have a freestanding obligation to reimburse FQHCs, and no managed-care provision allows them to shirk that responsibility.

In addition, the First, Third, and Fourth Circuits all have taken as a given that out-of-network FQHC services must be fully reimbursed. As such, they have read the MCO provisions requiring reimbursement for certain services as seeking to ensure that *in*-network FQHCs are fully reimbursed, as well. Indeed, States' supplemental payment requirements for in-network services "w[ere] implemented to ensure * * * that *even in managed-care states*, FQHCs *still* received the full reimbursement amount to which they were entitled." *Ibid.* (emphases added); see also *Three Lower Ctys.*, 498 F.3d at 299 (Fourth Circuit holding that "even when a State relies upon a managed care system * * * , FQHCs are protected and must receive the full [PPS] rate"); *Rullan*, 397 F.3d at 62 (First Circuit noting same).

And the Ninth Circuit, while not discussing the distinction between in- and out-of-network services specifically, also has held that "the statute plainly requires state plans to pay for services furnished by FQHCs" and imposes "a mandatory obligation, stating that the state plan '*shall* provide for payment for services.'" *Douglas*, 738 F.3d at 1013.

Thus, directly contrary to the Fifth Circuit below, the First, Second, Third, Fourth, and Ninth Circuits have all concluded that Sections 1396a(bb)(1)-(5) clearly mandate that *all* FQHCs must be reimbursed for Medicaid services, whether in-network or out-of-network.

B. The Fifth Circuit's attempt to distinguish other Circuits' precedent only exacerbates the conflict.

The Fifth Circuit below, in an attempt to distinguish *N.J. Primary Care* and *Shah*, asserted that even though the Second and Third Circuits held "that states are required to reimburse FQHCs for all covered services, * * * [they] did not have occasion to decide what 'covered' services are." App. 32 n.27. The Fifth Circuit thus claimed the two cases were "inapposite" for determining which FQHC services are covered by the reimbursement obligation. *Ibid.* The panel then concluded the general MCO provisions (Section 1396b(m)(2)(A)) should provide the definition of covered FQHC services in managed-care States. App. 33. Because that section requires MCOs or States to reimburse all healthcare providers for emergency out-of-network services, § 1396b(m)(2)(A)(vii), the panel determined States need not reimburse any other types of out-of-network claims by FQHCs. App. 33-35.

Far from avoiding a circuit split, however, this portion of the Fifth Circuit's decision highlights the conflict it created in two key respects. First, the Fifth

Circuit found a statutory gap regarding which services are covered, where other Circuits have found an unambiguous command covering *all* FQHC services to Medicaid enrollees as defined by the *FQHC* (not MCO) provisions of the Medicaid statute. Second, the panel assumed the general MCO provisions should implicitly repeal the specific FQHC reimbursement provision, where other Circuits have concluded the more specific FQHC reimbursement provision applies.

1. The Fifth Circuit noted Section 1396a(bb)(1) refers to Section 1396d(a)(2)(C) to define the FQHC services that States must reimburse. App. 32-33. The panel then claimed that Section 1396d(a)(2)(C) "does not explain what the relevant FQHC services are." App. 33. Thus reading a gap in the statute, the panel looked to the MCO section to conclude only emergency services are covered for out-of-network FQHC claims. *Ibid.*

But the other Circuits to address Section 1396a(bb)'s reimbursement requirement have found no statutory gap regarding which FQHC services are covered (because there is none). The Second Circuit held that Sections 1396a(bb)(1)-(2) require all "services provided by FQHCs" (including out-of-network services) to be reimbursed. *Shah*, 770 F.3d at 157; see also *N.J. Primary Care*, 722 F.3d at 539 (Third Circuit noting the section covers "*all* Medicaid-eligible encounters" at FQHCs). These cases left no room to conclude some Medicaid-eligible services provided by FQHCs are not covered.

This is because—unlike the Fifth Circuit's claim otherwise—the FQHC-related Medicaid statute *does* define what relevant FQHC services are. As the Ninth Circuit has recognized, Section 1396a(bb)(1) requires reimbursement of all services "described in section 1396d(a)(2)(C)," which refers to "Federally-qualified health center services * * * and any other ambulatory services offered by" FQHCs. *Douglas*, 738 F.3d at 1015. *Douglas* went on to note that Section 1396d(a)(2)(C) explains FQHC services are "defined in subsection (*l*)(2)." 738 F.3d at 1015 (quoting § 1396d(a)(2)(C)). Following the statutory text to Section 1396d(*l*)(2)—what the Fifth Circuit panel inexplicably refused to do—the Ninth Circuit noted "'Federally-qualified health center services' means services of the type described in" Section 1395x(aa)(1)(A)-(C). *Douglas*, 738 F.3d at 1016 (quoting § 1396d(*l*)(2)). Section 1395x(aa)(1)(A)-(C), in turn, refers to "physician services," "services furnished by a physician assistant or a nurse practitioner * * * , by a clinical psychologist * * * or by a clinical social worker," and all supplies "furnished as an incident to" the above services. The statute explicitly states that all such services "furnished to an individual as a[ ] patient of a[n] [FQHC]" are covered. § 1396d(*l*)(2)(A).[5]

In conflict with the Ninth Circuit's careful statutory analysis, the Fifth Circuit completely ignored

[5] Section 1396d(a)(2)(C) also makes clear that "other ambulatory services offered by a[n] [FQHC]," which are included in the State Plan are "covered," as well. The statute does not support the Fifth Circuit's narrow view of covered services.

Sections 1396d(*l*)(2) and 1395x(aa)(1). If it had looked to those sections—as the plain terms of the statute require—it would have realized that "the statutory text does not use vague and amorphous words" about what services are covered. *Douglas*, 738 F.3d at 1014. Nor does it permit limiting States' reimbursement obligations to FQHCs for out-of-network services to *emergency* services. Instead, the statutory text "outlines specifically the types of services provided by * * * FQHCs that a state plan must cover." *Ibid.* All physician, nurse practitioner, physician assistant, psychologist, and social worker services (and related supplies) furnished to FQHC patients must be reimbursed—no exceptions. *Id.* at 1016. This definition does *not* distinguish between emergency and non-emergency services and, importantly, does *not* distinguish between in-network and out-of-network services. Only the Fifth Circuit has read these exceptions into the statute and limited reimbursement for covered out-of-network services to emergency services under Section 1396b(m)(2)(A)(vii). App. 33-34.

2. The Fifth Circuit's reading of the general MCO provisions as creating an implicit exception to States' specific obligation to reimburse FQHCs, see App. 33-34, also creates a clear circuit split. The Second Circuit rejected a State's similar "reliance on" an MCO's obligation to reimburse emergency services under Section 1396b(m)(2)(A)(vii) to evade its FQHC reimbursement duty. *Shah*, 770 F.3d at 157. Pointing to the "basic principle of statutory construction that a specific statute * * * controls over a general provision,"

the Second Circuit held general MCO provisions cannot trump States' obligation to fully repay FQHCs for Medicaid services. *Ibid.* (citation omitted). Congress has carved out reimbursement provisions *specific* to FQHCs, and the general MCO provisions do nothing to change these "unmistakably clear statutory requirements." *Ibid.* (quoting *Three Lower Ctys.*, 498 F.3d at 304).

Yet the Fifth Circuit failed even to mention this Court's doctrine instructing that specific statutory provisions govern general ones. See *Long Island Care at Home, Ltd.* v. *Coke*, 551 U.S. 158, 170 (2007). Instead, the panel held that the MCO requirement to reimburse out-of-network healthcare providers for emergency services implicitly meant States need not reimburse FQHCs for any other out-of-network services. App. 33-34.

Not only does that holding conflict with other Circuits, but it also impliedly repeals the more specific reimbursement mandate for FQHCs. Since Section 1396a(bb)(5)(A) requires States to ensure full reimbursement to FQHCs for *in-network* services, Section 1396b(m)(2)(A)(vii) requires payments for *emergency* out-of-network services, and these are the only reimbursement obligations the Fifth Circuit held exist in managed-care States, under the Fifth Circuit's reading, Section 1396a(bb)(1) has no independent force whatsoever in managed-care States. But no other Circuit to address the reimbursement requirements in Section 1396a(bb)(1) has read the section to be superfluous if a State chooses managed care. To the

contrary, they have concluded these sections impose a mandatory reimbursement obligation for *all* FQHC services to Medicaid patients. See, *e.g.*, *Shah*, 770 F.3d at 157; *N.J. Primary Care*, 722 F.3d at 539; *Douglas*, 738 F.3d at 1013. These latter holdings are clearly on the correct side of the split given this Court's warnings (ignored by the Fifth Circuit) to avoid finding statutory language repealed by implication, *Randall* v. *Loftsgaarden*, 478 U.S. 647, 661 (1986), and to decline interpretations that render statutory language superfluous, *Hibbs* v. *Winn*, 542 U.S. 88, 101 (2004).

C. The Circuits are split on the policy behind States' duty to reimburse FQHCs in managed-care States.

The Fifth Circuit also created a circuit conflict by concluding that the supposed policy of requiring FQHCs to contract with MCOs to receive reimbursements trumps Congress's express policy of disallowing federal Section 330 funds to subsidize a State's obligation to cover Medicaid expenses.

The Fifth Circuit panel concluded that States need only reimburse out-of-network claims for emergency services because it felt there *should* be a "penalty" to FQHCs for failing to contract with MCOs in managed-care States. App. 33-34. The panel read this limitation into the reimbursement requirement because it thought it made "paramount sense" to force FQHCs "to contract with MCOs." *Ibid.*

But the absence of a "penalty" for out-of-network FQHCs is an essential element—not a defect—in Congress's carefully reticulated scheme. Congress ensured that FQHCs are fully reimbursed for Medicaid services in all contexts. Congress viewed full reimbursement for FQHCs, rather than their coercion into a managed-care network, as "paramount notwithstanding the risk of loss to the state." *N.J. Primary Care*, 722 F.3d at 541. Thus, the Fifth Circuit gets Congress's intended policy exactly backwards.

Its decision, moreover, directly conflicts with the Fourth Circuit's decision in *Three Lower Counties*, which rejected the same policy view expressed by the Fifth Circuit panel: that a State or MCO should be able to "induce compliance with the system of managed care * * * by refusing to pay claims" for out-of-network services. 498 F.3d at 303. The Fourth Circuit held that while refusing out-of-network reimbursements may be "a fundamental and necessary part of the system of managed care * * * in the private sector," refusing to reimburse *FQHCs* is not an option since "the federal Medicaid statute requires something different." *Ibid.* That statute requires that FQHCs *not* be made to "bear the[] costs [of out-of-network services] as part of the cost of doing business in a managed care system." *Ibid.*

As the Second and Fourth Circuits have held, Congress's policy is clear: Section 330 grants to FQHCs cannot be allowed "to cross-subsidize Medicaid programs." *Shah*, 770 F.3d at 150; see *Three Lower Ctys.*, 498 F.3d at 297 (Congress ensured FQHCs receiving funds under Section 330 "would not have to divert

Public Health Services Act funds to cover the cost of serving Medicaid patients"). The Third Circuit also has declared that "full FQHC reimbursement for Medicaid-eligible encounters [i]s paramount notwithstanding the risk of loss to the state." *N.J. Primary Care*, 722 F.3d at 541 (discussing CMS guidance).

These holdings are 180 degrees from the Fifth Circuit's conclusion that it "makes paramount sense" to "penal[ize]" FQHCs for providing services to out-of-network Medicaid enrollees. App. 33. Incorrectly concluding that Section 1396a(bb)(1)'s requirement that States reimburse all FQHC services to Medicaid beneficiaries would "create a situation in which Medicaid funds would be used to fulfill a Section 330 obligation," App. 35, the Fifth Circuit ignored the fact—not lost on the other Circuits to address this issue—that a State's failure to reimburse for all Medicaid services would require Section 330 funds to subsidize the State's Medicaid program. The Fifth Circuit's holding penalizes the federal government (and the uninsured patients it has designated funds to serve) as much as FQHCs.

The Fifth Circuit's policy conclusions directly conflict with other Circuits' clear explanations that Section 1396a(bb) forbids any subsidy from federal Section 330 funds to Medicaid services. This Court's review is needed to resolve the circuit conflict created by the Fifth Circuit's decision.

II. The Decision Below Conflicts With Clear CMS Guidance.

Not only is the panel's policy-based logic in direct conflict with the plain language of the statute and other circuits' decisions, it also conflicts with CMS's interpretive guidance and Statement of Interest in this case.

CMS has reaffirmed the clear requirement that States pay FQHCs for all Medicaid services—even when out-of-network. For example, in a 2016 letter to state health officials, CMS made clear that FQHCs "are entitled to receive payment for providing covered services to Medicaid-eligible individuals under a [PPS] methodology." April 2016 SHO Letter. CMS also declared that FQHCs must "continue to receive their full PPS reimbursement rate regardless of the Medicaid delivery system"—whether managed care or otherwise. *Ibid.*

In line with its prior guidance, CMS's Statement of Interest to the district court in this case further explained that Section 1396a(bb) indicates "Congress's intent that FQHCs receive payment of the full PPS amount for covered services provided to Medicaid-eligible individuals," and that States "may not divest [themselves] of ultimate responsibility to ensure that such payments are made." App. 133. CMS's Statement explicitly agreed with the reasoning in *Shah* and *Three Lower Counties* that States must fully repay FQHCs, even for "out-of-network services," in order to "comport with the statute." App. 138-39.

CMS's longstanding guidance also makes clear that the Commission's requirement that MCOs pay FQHCs 100 percent of their PPS rate—obviating the State's supplemental payment obligation under Section 1396a(bb)(5)(A)—violates the Medicaid statute. See April 1998 SMDL; October 1998 SMDL (explaining that States, and not MCOs, must have ultimate responsibility to reimburse FQHCs).

For decades, Texas has accepted Medicaid funds under the condition that it may not delegate its supplemental, wraparound payment obligation to MCOs. See April 1998 SMDL. And since 1989, it has accepted funds under the statutory condition that it reimburse all FQHC services to Medicaid enrollees, see *Douglas*, 738 F.3d at 1010—a condition which was reaffirmed by CMS in 2016 and in the course of this litigation. See April 2016 SHO Letter; App. 138-39. Given the ongoing and cooperative nature of the Medicaid grant program and Texas's ability to seek clarification of program requirements, CMS's guidance provides more evidence (along with the statutory text) that the Fifth Circuit's decision should be reversed. See *Barnes* v. *Gorman*, 536 U.S. 181, 186 (2002) (noting this Court has "repeatedly characterized * * * Spending Clause legislation as 'much in the nature of a contract: in return for federal funds, the [recipients] agree to comply with federally imposed conditions'" (citation omitted)).

III. The Opinion Below Threatens Major Disruption Of Federal Resources For Healthcare In Underserved Areas.

This Court's immediate review is warranted because the decision will undermine the ability of FQHCs to fulfill their statutory mandate to provide healthcare to the uninsured in medically underserved areas. The opinion will do so by shifting appropriated Section 330 federal funds away from the uninsured, and will spell dire consequences for FQHCs' main functions.

A. The opinion below allows the misappropriation of federal funds away from FQHCs' Section 330 services.

The Fifth Circuit's decision to allow States to refuse to reimburse FQHCs for some services they provide to Medicaid beneficiaries—despite the dual statutory commands for FQHCs to serve Medicaid enrollees, 42 U.S.C. § 254b(k)(3)(E), and for States to cover these services, § 1396a(bb)(1)—misappropriates federal funds to cover States' Medicaid obligations. As discussed above, *supra* Section I.B, the Commission effectively uses Section 330 funds which Congress has designated for services to uninsured patients to subsidize Medicaid patients instead. This appropriation of federal funds away from Congress's intended recipients warrants this Court's review now, to restore the proper allocation of funds under Congress's carefully reticulated health safety net for the uninsured.

The misappropriation of funds also violates the "fundamental and comprehensive purpose" of the Appropriations Clause, U.S. CONST. art. 1, § 9, cl. 7—"to assure that public funds will be spent according to the letter of the difficult judgments reached by Congress as to the common good and not according to * * * the individual pleas of litigants." *Office of Pers. Mgmt.* v. *Richmond*, 496 U.S. 414, 427-28 (1990). The Fifth Circuit's decision that it would be "absurd" to require States to reimburse FQHCs the same amount for both in-network and out-of-network services to Medicaid enrollees, App. 34, substituted the panel's views regarding the primacy of managed care for Congress's view of what is best for "the common good." *Richmond*, 496 U.S. at 428. Under "the letter of [Congress's] difficult judgment[]," *ibid.*, Section 330 grants are to be spent *only* on FQHC services for uninsured and *not* on Medicaid services. See *Three Lower Ctys.*, 498 F.3d at 297-98 (citing H.R. REP. NO. 101-247, at 393, explaining the FQHC reimbursement provision is meant to "ensure that Federal [Section 330] funds are not used to subsidize [FQHC] services to Medicaid beneficiaries").

This Court's review is necessary to correct the Fifth Circuit's effective re-appropriation of federal Section 330 funds to cover States' Medicaid obligations, based on its own policy views, in violation of the Appropriations Clause.

B. FQHC services to uninsured patients in underserved areas are uniquely important in the Nation's health safety net.

FQHCs are uniquely protected by federal law because Congress views them as so important in bringing healthcare services to uninsured patients in underserved areas. The lack of full reimbursements for FQHCs in the Fifth Circuit, then, will hinder efforts of FQHCs to pay their bills and effectively serve uninsured patients.

The House Report that accompanied Congress's enactment of the reimbursement requirement now codified at Section 1396a(bb)(1) puts the matter plainly. In Congress's view, "[t]he role of [FQHCs] is to deliver comprehensive primary care services to underserved populations or areas without regard to ability to pay." H.R. REP. NO. 101-247, at 392. As such, it is of utmost importance that federal funding to FQHCs be used for *these* services, and not others that are covered under other programs. "To the extent that the Medicaid program is not covering the cost of treating its own beneficiaries, it is compromising the ability of the centers to meet the primary care needs of those *without any public or private coverage whatsoever*." *Ibid.* (emphasis added). Congress viewed this result as intolerable.

Congress created Section 1396a(bb) to save scarce federal dollars for this part of FQHCs' mission because it saw services to the uninsured as unique and worthy of protection. Indeed, the "special provisions

on FQHC reimbursement reflect the important public health role that these centers play." *Rullan*, 397 F.3d at 61. FQHCs' important role in public health—or their "unique place in the health services ecology" of the Nation—is the reason Congress specifically required States to reimburse FQHCs for *all* services they provide to Medicaid beneficiaries. *Shah*, 770 F.3d at 157. In this very case, CMS—the agency which "manage[s]" the Medicaid Act, App. 3—also has noted that the statute's special reimbursement provisions for FQHCs are a result of "the unique role of FQHCs in the provision of federally subsidized healthcare." App. 126. Any non-reimbursement necessarily takes funds away from the uninsured.

FQHCs' unique role in the healthcare system has led Congress to protect FQHCs in other ways, as well. For example, when Congress added the requirement for States to reimburse FQHCs for Medicaid services, it also gave them a Section 1983 cause of action to sue to enforce the States' payment obligations. Prior to 1989, FQHCs had no right to sue to collect reimbursements, but now they "have a private right of action to bring a § 1983 claim to enforce" Section 1396a(bb). *Douglas*, 738 F.3d at 1013. For another example, FQHCs are one of very few entities that are eligible to participate in the Section 340B program under the Public Health Service Act—whereby they and other "safety-net providers" may obtain relief from high drug

costs. See OVERVIEW OF THE 340B DRUG PRICING PROGRAM, 340B HEALTH.[6]

And yet another way in which Congress has sought to save scarce federal dollars allotted to FQHCs for services to the uninsured is by treating health centers and their personnel as federal Public Health Service employees. That federal status affords them an absolute immunity from any lawsuit resulting from their performance of medical functions by making the exclusive remedy a claim against the United States under the Federal Tort Claims Act. See 42 U.S.C. § 233(g) (allowing immunity for employees of "nonprofit private entit[ies] receiving Federal funds under section 254b"). Congress enacted this coverage to relieve FQHCs from the necessity to spend Section 330 funds on often expensive malpractice insurance. See H.R. REP. NO. 104-398, at 6 (1995) (Conf. Rep.). FQHCs' funding is protected in multiple ways by Congressional enactments to ensure that Section 330 funds are used, as much as possible, exclusively for the important health services they provide.

The ultimate goal of the rules surrounding FQHCs is to provide care to uninsured and underserved populations. "[R]esearch has found that [FQHCs], among other outcomes, improve health, reduce costs, and provide access to health care populations that may otherwise not obtain health care." CONG. RESEARCH SERV., FEDERAL HEALTH CENTERS: AN OVERVIEW (May 19,

[6] Available at https://www.340bhealth.org/340b-resources/340b-program/overview.

2017).[7] But the Fifth Circuit has flipped Congress's carefully reticulated scheme on its head, and has allowed the impermissible diversion of federal funds that should serve these populations to cover Medicaid services instead.[8]

Until the Fifth Circuit's decision below, every time a State has attempted to use its managed-care system to evade its responsibility to reimburse FQHCs for Medicaid services, the Circuit courts have said no. See, *e.g.*, *Shah*, 770 F.3d at 150; *N.J. Primary Care*, 722 F.3d at 539-40; *Three Lower Ctys.*, 498 F.3d at 303. This Court's immediate review is needed to reverse the Fifth Circuit and enforce Congress's protection of FQHCs and Section 330 funds.

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[7] Available at https://fas.org/sgp/crs/misc/R43937.pdf.

[8] This is even more worrisome given the size of Medicaid programs dwarfs the funds allotted for Section 330 programs. Compare CENTERS FOR MEDICARE & MEDICAID SERVS., NHE FACT SHEET, CMS.GOV (last modified Apr. 17, 2018), https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html (over $565 billion for Medicaid in 2016), with FEDERAL HEALTH CENTERS: AN OVERVIEW, *supra*, at 8-10 ($5.1 billion for Section 330 in FY2016). The relative size of the programs is likely another reason Congress made sure to prevent subsidization of Medicaid by the much smaller Section 330, and why the Fifth Circuit's fretting over the supposed use of "Medicaid funds * * * to fulfill a Section 330 obligation" makes little sense. App. 35.

C. The dangers of underpayment to FQHCs are both significant and immediate.

The costs of the Fifth Circuit's holding allowing non-payment to out-of-network FQHCs will be immediately felt, since the opinion's other holding will result in fewer FQHCs in MCO networks. That is, the Fifth Circuit held the Commission could require MCOs to pay all FQHCs with which they contract their full PPS rate. Of course, that rule raises the cost to MCOs of doing business with FQHCs higher than Congress intended. See *N.J. Primary Care*, 722 F.3d at 540 (explaining the Balanced Budget Amendment of 1997 specifically removed "the responsibility of MCOs to reimburse FQHC[]s at their cost-based rates," in order to allow FQHCs and "MCOs [to] agree on a contractual reimbursement rate as long as that rate was no less than the" market rate). These higher costs to MCOs naturally lead them to enter into fewer contracts with FQHCs—especially since MCOs are paid a fixed "capitation" rate by the States, and significantly increased costs at an FQHC necessarily reduce available funds for other patients. See App. 43-45, 49; 42 C.F.R. § 438.2 ("Capitation payment"). This case is a prime example: TCHP cancelled its contract with petitioner after its costs skyrocketed from the agreed-upon contract rate to the full PPS rate. App. 6-7.

The Commission's dis-incentivizing MCOs from contracting with FQHCs both violates the law and demonstrates the stakes in this case. First, it allows States to ignore their specific obligation to make supplemental, wraparound payments to FQHCs under

Section 1396a(bb)(5)(A). It also removes FQHCs' ability to negotiate freely with MCOs for below-PPS rates, vitiating the very purpose for Section 1396b(m)(2)(A)(ix): "incentivizing MCOs to contract with FQHCs." *Shah*, 770 F.3d at 150; see also App. 73-76.

Second, this holding is particularly consequential because it causes more FQHCs to be out-of-network at the same time the Fifth Circuit has approved States' refusal to reimburse out-of-network FQHCs. The Fifth Circuit has thus blessed a scheme by which States can offload Medicaid costs by carving FQHCs out of MCO networks and then refusing to cover the services they provide to Medicaid enrollees. The result accomplished by these combined holdings is the underpayment of increasing numbers of FQHCs, contrary to States' specific duty to fully repay all FQHC services to Medicaid enrollees. States using their managed-care system to leave FQHCs holding the bag for such services will seriously undermine Congress's carefully designed health safety net.

CONCLUSION

The petition for certiorari should be granted.

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