REVISED February 1, 2018

IN THE UNITED STATES COURT OF APPEALS

FOR THE FIFTH CIRCUIT

No. 16-20691

LEGACY COMMUNITY HEALTH SERVICES, INCORPORATED,

Plaintiff–Appellee,

versus

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

Defendant–Appellant.

Appeal from the United States District Court for the Southern District of Texas

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(Filed Jan. 31, 2018)

Before JONES, SMITH, and PRADO, Circuit Judges.

JERRY E. SMITH, Circuit Judge:

Legacy Community Health Services ("Legacy")—a Federally Qualified Health Center ("FQHC")—sued the Texas Health and Human Services Commission (the "Commission"), through its Executive Commissioner, alleging that Texas's reimbursement scheme

violated the Medicaid Act (1) by requiring Managed Care Organizations ("MCOs") fully to reimburse FQHCs, (2) by failing to ensure that Texas itself would reimburse an FQHC if an MCO does not reimburse the FQHC in the first place, and (3) by withholding payments for certain non-emergency services that Legacy has been providing to the enrollees of an MCO with which Legacy has no contract. The district court granted Legacy summary judgment on all of its claims. We reverse and remand, concluding that (1) the Commission's requirement that MCOs fully reimburse FQHCs does not violate the Medicaid Act; (2) Legacy lacks standing to challenge the Commission's lack of a policy that the state directly reimburse an FQHC if it is not fully reimbursed by the MCO; and (3) Legacy is not entitled to reimbursement for the non-emergency, out-of-network services about which it complains.

I.

A.

FQHCs are designed to provide care to medically underserved populations. 42 U.S.C. § 254b(a), (e), (k). FQHCs have two sources of compensation: federal grants under § 330 of the Public Health Service Act ("PHSA"), 42 U.S.C. § 254b, for medically underserved communities and state reimbursements for Medicaid services, *id.* § 1396a(bb). MCOs are private organizations that arrange for the delivery of healthcare services to individuals who enroll with them. *See id.* §§ 1396u-2(a)(1)(A), 1396b(m). As relevant here, they

act as intermediaries between the state and FQHCs. The state disburses funds to an MCO, which then contracts with FQHCs and reimburses them for the services they provide to the MCO's enrollees. *See id.* § 1396b(m)(2)(A)(ix); 42 C.F.R. § 438.2. The Medicaid Act is managed by the Centers for Medicare and Medicaid Services ("CMS").

States are required to reimburse FQHCs for their covered Medicaid services. 42 U.S.C. § 1396a(bb). They may either reimburse the FQHCs directly or use MCOs to reimburse the FQHCs. *Id.* § 1396u-2(a). Before 1997, the law allowed either the state or the MCO fully to assume this reimbursement requirement. The Balanced Budget Act of 1997, however, changed that and provided the statutory provisions relevant here: 42 U.S.C. §§ 1396a(bb) and 1396b(m).

Section 1396a(bb) provides that the state is obligated to ensure that FQHCs are reimbursed for covered Medicaid services. It generally requires that "the State plan shall provide for payment for services described in section 1396d(a)(2)(C) * * * furnished by [FQHCs]." § 1396a(bb)(1). That section also sets forth the framework for assessing reimbursement amounts: the Prospective Payment System ("PPS"). § 1396a(bb)(1)–(4).

Section 1396b(m) contains the requirements for contracts between states and MCOs. If the state elects to use MCOs to pay the FQHCs, then the Medicaid Act mostly leaves the MCOs free to negotiate and contract with FQHCs. But § 1396b(m) requires the MCO to

"provide payment that is not less than the level and amount of payment which the [FQHC] would make" if it were not an FQHC—*i.e.*, the MCO must pay the FQHC at least competitive market rates. § 1396b(m)(2)(A)(ix).[1]

This can lead to shortfalls for the FQHC, which may be entitled under § 1396a(bb) to a PPS amount greater than what the MCO pays. In that event, § 1396a(bb) requires the state to "provide for payment to the [FQHC] by the State of a supplemental payment equal to the amount (if any)" of the difference between the MCO's payment and the required PPS amount. § 1396a(bb)(5)(A). These are sometimes called "wraparound" payments. The parties dispute, however, whether a state can require the MCO to pay the full PPS amount in the first instance, thereby obviating the need for such supplemental "wraparound" payments.

Furthermore, § 1396a(bb) provides for "[a]lternative payment methodologies" ("APM"). *Id.* § 1396a(bb)(6). Under these APMs, a state may "provide for payment" under any kind of mechanism that is both "agreed to by the State and [FQHC and] * * *

[1] When the Balanced Budget Act was passed, CMS issued a State Medicaid Director Letter ("SMDL") that took the position that states cannot impose any requirements other than those within § 1396b(m)—*i.e.*, CMS claimed that states cannot require an MCO to pay *more* than a competitive market rate. For reasons we will explain, we reject that position.

results in payment to the [FQHC] of an amount" at least equal to the PPS. *Id.*

Finally, § 1396b(m) addresses situations in which a patient, enrolled with a certain MCO, goes to an FQHC that has not contracted with that MCO. These "out-of-network" claims are treated slightly differently from "in-network" claims (*i.e.*, where the MCO has a contract with the FQHC). Generally, the MCO has no reimbursement obligations to the FQHC for out-of-network claims. But § 1396b(m)(2)(A)(vii) requires that all state-MCO contracts address out-of-network services that "were immediately required due to an unforeseen illness, injury, or condition." The state-MCO contract must designate whether the state or the MCO will reimburse the FQHC for such out-of-network emergency services. *Id.* The parties also dispute whether the state must independently reimburse the FQHC for other, non-emergency out-of-network services, not covered by § 1396b(m)(2)(A)(vii). *See also id.* § 1396a(bb).

B.

The Commission manages Texas's Medicaid program ("the program"), TEX. GOV'T CODE § 531.021(a), and has elected to contract with MCOs to provide Medicaid services, *id.* § 533.002. One such MCO is the Texas Children's Health Plan ("TCHP"). Legacy—designated an FQHC for purposes of Medicaid reimbursement and Section 330 grants—formed a contract with TCHP in 2009 that specified that Legacy would

provide medical care to TCHP's members and that TCHP would pay Legacy $67 per-patient visit, below Legacy's PPS rate.

In 2011, the Commission amended its contract with TCHP, requiring TCHP to pay FQHCs their full PPS rate instead of the rates that TCHP had negotiated with its FQHCs. Legacy and TCHP amended their contract to mirror that change: TCHP would pay Legacy its full PPS rate of about $270 per visit. Furthermore, the Commission gave FQHCs the option to keep the traditional PPS or calculate its rates using an alternative PPS ("APPS"); Legacy elected to use the APPS. At that time, Texas still provided that it would make supplemental payments if the MCO's payment was less than the required PPS amount. *Cf.* § 1396a(bb).

From 2011 to 2014, Legacy's Medicaid encounters and costs skyrocketed. For instance, its Medicaid encounters increased by 246%, and its claims expenses per month increased by 283%. For the 2014 fiscal year, TCHP paid about $20 million to all FQHCs with which it had contracted. Of that amount, it paid Legacy over $12 million, even though only 2.7% of TCHP's office visits occurred at Legacy, and less than 2% of TCHP's Medicaid enrollees selected Legacy as their primary care provider. Though TCHP maintained contracts with numerous other FQHCs and accused Legacy of effectively gaming the Medicaid system, TCHP indicated to Legacy that it wanted the state to reinitiate supplemental "wraparound" payments to allow TCHP to give lower initial reimbursements. But because Legacy's

utilization trend exceeded the Medicaid premium trend and other FQHC trends, TCHP ultimately terminated its contract with Legacy effective February 2015.

Since Legacy's contract was terminated with TCHP, Legacy has continued to provide services to patients who have TCHP as their provider. Accordingly, Legacy submitted approximately 6,000 "out-of-network" claims to TCHP between February and August 2015. TCHP denied nearly half of those claims as (1) lacking prior authorization and (2) not relating to emergency services. Legacy appealed those denials to the Commission, but Texas has similarly refused to reimburse Legacy for those claims, contending that the Medicaid Act does not entitle Legacy to receive payment for such out-of-network services.

After Legacy filed this suit, Texas changed its Medicaid policies. In January 2016, the Commission submitted to the CMS a state plan amendment ("SPA 16-02") that eliminates the requirement that Texas make supplemental "wraparound" payments to FQHCs in the event that the MCOs fail fully to reimburse the FQHCs at their PPS rate. Furthermore, SPA 16-02 specified that MCOs would fully reimburse FQHCs. CMS approved the amendment.

C.

In January 2015, Legacy sued the Commission under 42 U.S.C. § 1983, alleging that it had violated its rights under 42 U.S.C. § 1396a(bb). Legacy offered two theories.

First, Legacy contended that the Commission had unlawfully delegated its FQHC reimbursement obligations to MCOs by requiring them to reimburse FQHCs fully. Legacy's underlying theory is that the purpose of §§ 1396a(bb) and 1396b(m)(2)(A) is to allow FQHCs to negotiate freely with MCOs for above-market, but below-PPS, rates and thereby encourage FQHC-MCO contracts. The Commission countered that nothing in the text of either § 1396a(bb) or § 1396b(m)(2)(A) prevented the state from requiring MCOs to reimburse FQHCs fully.

Second, Legacy asserted that the Commission had failed to ensure payment for certain out-of-network services, in violation of 42 U.S.C. § 1396b(m)(2)(A)(vii). Texas replied that the Commission had ensured reimbursement for the kind of emergency out-of-network services contemplated by § 1396b(m)-(2)(A)(vii) and that the Medicaid Act did not require reimbursement for any other out-of-network services.

Texas moved to dismiss, averring that Legacy lacked standing and a cause of action under § 1983. The district court denied the motion. Legacy and Texas then cross-moved for summary judgment. After those motions were filed, SPA 16-02 was enacted and approved. The court ordered supplemental briefing on the effect of CMS's approval of SPA 16-02 on the pending litigation; Legacy's brief and Texas's reply were framed in terms of whether *Chevron* deference should be accorded to that approval.

The district court then issued two opinions on the cross-motions for summary judgment. In the first, the court held that the Commission's policy violated § 1396a(bb) (1) by eliminating its requirement to make supplemental "wraparound" payments, thereby failing to ensure reimbursement of FQHCs and (2) by requiring MCOs to fully reimburse FQHCs.

CMS then issued a "statement of interest," clarifying its position on § 1396a(bb) as follows: (1) States may not "simply do away with their obligation to make supplemental payments"; (2) the state may eliminate the need for supplemental payments through an APM under § 1396a(bb)(6); (3) CMS approved SPA 16-02 as an APM but had not determined whether the FQHCs had given the requisite consent to make SPA 16-02 a valid APM, so SPA 16-02 would be valid only if there were proper FQHC consent; and (4) the state is similarly obligated to ensure that FQHCs are fully reimbursed for out-of-network emergency services.

Reviewing that statement, the district court issued its second opinion, holding that the Commission's out-of-network policy violated § 1396a(bb) because it failed to reimburse Legacy for non-emergency out-of-network services. The court then enjoined the Commission.

II.

We first decide whether the district court had Article III jurisdiction. Federal courts have jurisdiction only over a "case" or "controversy." *See* U.S. CONST.

ART. III, § 2, cl. 1. To establish a "case or controversy," a plaintiff must establish that it has standing. *Lujan* v. *Defs. of Wildlife*, 504 U.S. 555, 560–61 (1992). Accordingly, Legacy must demonstrate that (1) it has suffered an "injury in fact," which is "an invasion of a legally protected interest" that is "concrete and particularized" and "actual and imminent" rather than "conjectural or hypothetical," (2) there is a "causal connection between the injury and the conduct complained of" such that the injury is "fairly traceable to the challenged action of the defendant, and not the result of the independent action of some third party not before the court," and (3) the injury will likely "be redressed by a favorable decision." *Id.* (internal quotations, brackets, ellipses, and citations omitted).

If, as here, a plaintiff seeks injunctive relief, it must also show that "there is a real and immediate threat of repeated injury." *City of Los Angeles* v. *Lyons*, 461 U.S. 95, 102 (1983) (citation omitted).[2] Past injury alone is insufficient; the plaintiff must show a "real or immediate threat that the plaintiff will be wronged again." *Id.* at 111. Moreover, "each element of Article III standing 'must be supported in the same way as any other matter on which the plaintiff bears the burden of proof,' " with the same evidentiary requirements of that stage of litigation. *Bennett* v. *Spear*, 520 U.S.

[2] Neither party briefed the requirements of injunctive relief or discussed the issue of Legacy's standing to challenge SPA 16-02, discussed *infra*. But standing is jurisdictional and should be addressed "when there exists a significant question about it." *K.P.* v. *LeBlanc*, 627 F.3d 115, 122 (5th Cir. 2010) (addressing standing sua sponte).

154, 167–68 (1997) (quoting *Lujan*, 504 U.S. at 561). Thus, at the summary judgment stage, Legacy must "'set forth' by affidavit or other evidence 'specific facts' to survive a motion for summary judgment." *Id.* at 168 (quoting Fed. R. Civ. P. 56(c)).

"[S]tanding is not dispensed in gross"; a party must have standing to challenge each "particular inadequacy in government administration." *Lewis* v. *Casey*, 518 U.S. 343, 357–58 & n.6 (1996). Thus, Legacy must show standing to challenge each alleged deficiency in Texas's remedial scheme. As we explain below, Legacy has established standing to challenge both Texas's requirement that MCOs fully reimburse FQHCs and the state's refusal to reimburse Legacy for non-emergency out-of-network services. But Legacy has not established standing to challenge SPA 16-02's lack of a requirement that Texas provide supplemental "wraparound" payments.

A.

Legacy has standing to challenge the Commission's in-network policy of requiring MCOs fully to reimburse FQHCs. It has shown injury in fact, causation, and redressability (as well as a threat of future injury).

1.

Legacy's first and primary alleged injury is the loss of its contract with TCHP, which Legacy traces to

the Commission's policy of requiring MCOs fully to reimburse FQHCs. As Legacy notes, its contract with TCHP yielded about $14 million for Legacy, and the termination of that contract has resulted in some lost revenue and patients. Second, Legacy maintains that the Commission's policy remains a barrier to any future contractual relationship between Legacy and TCHP (or other MCOs, which are all subject to the same policy).

Texas disputes that this injury can establish standing, maintaining that Legacy has not shown a true "injury in fact" because it has been paid its full PPS rate and has no right to a contract with TCHP. This overstates what is required for an injury in fact. Legacy has suffered a "'direct pecuniary injury' that generally is sufficient to establish injury-in-fact." *K.P* v. *LeBlanc*, 627 F.3d 115, 122 (5th Cir. 2010). Moreover, the fact that Legacy did not have a *right* to contract with TCHP is immaterial; there can be injury-in-fact where a governmental entity erects barriers to private contracting or deprives a party of its rightful bargaining position.[3]

Legacy's alleged injury is analogous to that in *Clinton*, 524 U.S. at 432–33. There, the Court held that plaintiffs who sought to acquire processing plants had

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[3] *See, e.g.*, *Clinton* v. *City of N.Y.*, 524 U.S. 417, 432–33 (1998) (finding standing where the President had canceled a tax benefit to facilitate the acquisition of processing plants); *Vill. of Arlington Heights* v. *Metro. Hous. Dev. Corp.*, 429 U.S. 252, 261–63 (1977) (finding standing where a zoning board had refused to rezone so that a developer could build houses).

standing to challenge the cancellation of a tax benefit for acquiring such plants. *Id.* The reason was that the tax benefit was "the equivalent of a statutory 'bargaining chip' * * * [to] purchase * * * such assets," and the loss of that bargaining chip "inflicted a sufficient likelihood of economic injury." *Id.* at 432. Legacy stands in a materially similar situation to the circumstance[s] [of] those plaintiffs. According to Legacy, the Medicaid Act confers on it a right freely to negotiate with MCOs for contracts (at least with a market-rate floor) in a way that is meant to incentivize MCO-FQHC contracts.[4] Thus, even if incorrect, Legacy is suing to recover this "bargaining chip" in its negotiations with the MCOs.[5] Therefore, Legacy has alleged a proper injury in fact as to this MCO reimbursement policy.

2.

Legacy's injury is traceable to the Commission's policy. Texas maintains that the loss of Legacy's contract with TCHP was a result of Legacy's misconduct and thus was not caused by the policy. Admittedly, Legacy would not have standing if it were purely speculative as to whether the policy made TCHP more likely to terminate the TCHP-Legacy contract. *See*

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[4] *See* 42 U.S.C. §§ 1396a(bb)(5), 1396b(m)(2)(A)(ix); *cf. Cmty. Health Care Ass'n of N.Y.* v. *Shah*, 770 F.3d 129, 150 (2d Cir. 2014) (stating that the purpose of the provision is to incentivize "MCOs to contract with FQHCs").

[5] *See Grant ex rel. Family Eldercare* v. *Gilbert*, 324 F.3d 383, 387 (5th Cir. 2003) (stating that standing should be considered separately from the merits).

Simon v. *E. Ky. Welfare Rights Org.*, 426 U.S. 26, 43–46 (1976). But that is not the situation. Legacy has provided e-mails from TCHP indicating that TCHP wanted Texas to re-initiate wraparound payments. Thus, although TCHP ultimately terminated because of Legacy's high PPS rates, it is far from speculative to say that the Commission's policy impacted that decision.[6] Indeed, TCHP objected to Legacy's rates only after the Commission had changed its policy to require TCHP to cover Legacy's full PPS amount.

Additionally, Legacy's loss of its proper bargaining position is obviously the result of the Commission's policies. According to Legacy's theory of the merits, the Commission's policies directly undermine Legacy's ability to negotiate freely with MCOs and therefore deprive Legacy of its rightful "bargaining chip."[7] That injury is directly traceable to the Commission insofar as the injury and policy are merely different sides of the same coin. *See Clinton*, 524 U.S. at 432–33.

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[6] *See K.P.*, 627 F.3d at 123 (explaining that government actions that pose barriers to negotiation and "significantly contributed to the" plaintiff's injuries are considered causes of those injuries); *see also Bennett*, 520 U.S. at 168–71 (finding that an opinion by the Fish and Wildlife Service that would have a "powerful coercive effect" on an agency's action to harm the plaintiffs fairly caused their injury).

[7] *Cf. Clinton*, 524 U.S. at 432–33 (reasoning that a tax benefit can be "the equivalent of a statutory 'bargaining chip' * * * [to] purchase * * * such assets").

3.

Legacy has shown redressability and a threat of future injury, but not as to its contract with TCHP. Legacy rightly notes that in certain situations the removal of a substantial barrier to forming a contract will satisfy redressability. *See, e.g.*, *Bennett*, 520 U.S. at 169–71; *Vill. of Arlington Heights*, 429 U.S. at 261–62. But Legacy must also show that, if the barrier is removed, the injury is likely to be redressed—in this case, that the contract is likely to be restored. This Legacy has not done. There is nothing in the record to indicate ongoing contractual negotiations between Legacy and TCHP or anything to establish that Legacy is likely to regain its contract with TCHP.

But there is Legacy's second alleged injury: the loss of its statutory "bargaining chip" with TCHP and the many other MCOs with whom Legacy has or may one day have contracts. *See Clinton*, 524 U.S. at 432–33. As to that injury, Legacy has certainly established redressability. A favorable court ruling would return to it that "bargaining chip" and would redress that injury. Moreover, because Legacy has already traced one lost contract to the Commission's policy, the loss of this "bargaining chip" has "inflicted a sufficient likelihood of economic injury." *Id.* at 432. And because this injury is ongoing and will relate to Legacy's future contractual dealings, it has shown the kind of "real and immediate threat of repeated injury" for injunctive relief.

Lyons, 461 U.S. at 102 (citation omitted).[8] Accordingly, Legacy has standing to bring its "in-network" challenge to the policy of requiring MCOs to reimburse FQHCs fully.

B.

Legacy has established standing as to the Commission's out-of-network policy of reimbursing FQHCs only for emergency services covered by § 1396b(m)(2)(A)(vii) instead of for a wider range of services. Legacy easily meets the injury-in-fact requirement: If its theory is correct, then it has not received payment to which it is entitled. Texas's response to this injury—that Legacy has not identified any claims to which it is entitled and for which it was not reimbursed—conflates the merits of the case with standing.[9]

Furthermore, there is plainly causation and redressability. The lack of payment stems from Texas's refusal to issue these reimbursements. And if we grant Legacy the injunctive relief it seeks, Texas will be required to issue those payments. Finally, the injury is ongoing; Legacy seems to be providing these services

[8] Indeed, Legacy maintains that the Commission's policy will stand as a barrier to any future contractual relationship with other MCOs. And the record indicates that Legacy has been expanding and hopes to continue expansion in the future. As an FQHC, Legacy thus undoubtedly will have future dealings with MCOs.

[9] *See Grant ex rel. Family Eldercare*, 324 F.3d at 387 (stating that standing should be considered separately from the merits).

currently without reimbursement. Accordingly, there is a clear threat of future injury warranting injunctive relief should Legacy prevail on the merits. Therefore, it has standing to challenge the Commission's out-of-network policy of reimbursing FQHCs only for emergency Medicaid services.

C.

Consequently, Legacy has established standing to challenge the Commission's out-of-network policy and its requirement that MCOs fully reimburse FQHCs. Yet we must independently examine whether Legacy has standing to challenge the Commission's refusal to reimburse FQHCs with supplemental "wraparound" payments if an MCO fails to reimburse the FQHC fully. This policy, which was enacted as part of SPA 16-02, was gratuitously enjoined by the district court even though SPA 16-02 was enacted after Legacy initiated this litigation. Although Legacy had standing to bring its initial challenges to the requirement that MCOs fully reimburse FQHCs and to the lack of reimbursement for non-emergency out-of-network services, Legacy lacks standing to challenge this portion of SPA 16-02.

A plaintiff that has "demonstrated harm from one particular inadequacy in government administration" does not automatically have the right to challenge the entirety of the government's administrative scheme. *Casey*, 518 U.S. at 357–58 & n.6. Put another way, "a plaintiff who has been subject to injurious conduct of

one kind [does not] possess by virtue of that injury the necessary stake in litigating conduct of another kind, although similar, to which he has not been subject." *Blum* v. *Yaretsky*, 457 U.S. 991, 999 (1982).[10]

Accordingly, in *Yaretsky* the Court found that the plaintiffs had standing to challenge the procedural adequacy of their nursing homes' discharges or transfers to *lower* levels of care—but *lacked* standing to challenge those procedures with respect to discharges or transfers to *higher* levels of care. *Id.* at 1000–01. "[T]he threat of transfers to *higher* levels of care" lacked "sufficient immediacy and reality" because "[n]othing in the record * * * suggest[ed] that any of the individual [plaintiffs] have been either transferred to more intensive care or threatened with such transfers." *Id.* at 1001. Although it was "not inconceivable that [plaintiffs would] one day confront this eventuality," "assessing the possibility now would 'tak[e] us into

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[10] *See also Davis* v. *Fed. Election Comm'n*, 554 U.S. 724, 733–34 (2008) (explaining that "[t]he fact that [plaintiff] has standing to challenge § 319(b) does not necessarily mean that he also has standing to challenge the scheme of contribution limitations that applies when § 319(a) comes into play"); *DaimlerChrysler Corp.* v. *Cuno*, 547 U.S. 332, 350–53 (2006) (rejecting an attempt to challenge state taxes on the basis of taxpayer standing); *Friends of the Earth, Inc.* v. *Laidlaw Envtl. Servs. (TOC), Inc.*, 528 U.S. 167, 185 (2000) (noting that "a plaintiff must demonstrate standing separately for each form of relief sought"); *Nat'l Fed'n of the Blind of Tex., Inc.* v. *Abbott*, 647 F.3d 202, 209 (5th Cir. 2011) (holding that plaintiffs had standing to challenge a flat-fee provision but lacked standing to contest a materially identical percentage provision).

the area of speculation and conjecture.'" *Id.* (citation omitted).

Legacy's position is similar to that of the *Yaretsky* plaintiffs. The harm that Legacy suffers from the policy of requiring MCOs to reimburse FQHCs fully is quite distinct from any harm it might suffer from the Commission's declining to require supplemental payment. As explained above, Legacy can establish standing to challenge the former policy because it has lost a statutory "bargaining chip," *i.e.*, the ability to negotiate freely with MCOs for below-PPS but above-market rates. And Legacy has shown that this "bargaining chip" may affect it because it already lost one contract—the TCHP contract—partially because of the policy of limited reimbursement.

But that injury is wholly unrelated to any requirement (or lack thereof) that Texas reimburse FQHCs if the MCO fails to do so. This latter policy does not affect Legacy's bargaining position with TCHP or any other MCO; nor could it relate in any way to TCHP's decision to terminate Legacy's contract, given that SPA 16-02 was enacted after the contract was terminated. Finally, the policies are "sufficiently different" such that standing for each must be independently established. *Id.* One policy deals with how MCOs are to reimburse FQHCs in the first instance; the other addresses Texas's supplemental-reimbursement obligations. It is obvious that any injuries flowing from one policy would be different from those arising from the other.

Thus, Legacy must independently demonstrate standing to challenge Texas's lack of a supplemental reimbursement policy. This it cannot do. The only possible injury Legacy could assert would be that it now is at risk of not receiving full reimbursement. Yet "[a]bstract injury," such as risk alone, is insufficient to confer standing. *Lyons*, 461 U.S. at 101. Instead, Legacy must show that it "has sustained or is immediately in danger of sustaining some direct injury." *Id.* at 102. But as Texas points out repeatedly, Legacy has failed to identify a single instance in which it was not reimbursed at its full PPS rate from TCHP.[11] As in *Yaretsky*, it is "not inconceivable that [Legacy] will one day confront [the] eventuality" of failing to receive full reimbursement, but "assessing [that] possibility now would 'tak[e] us into the area of speculation and conjecture.'" *Yaretsky*, 457 U.S. at 1001 (citation omitted).

Therefore, Legacy is without standing to challenge the Commission's lack of a requirement that Texas reimburse FQHCs with supplemental "wraparound" payments if the MCO fails to reimburse the FQHC at the full PPS rate. The district court should not have enjoined Texas as to this policy.

III.

On the merits, we agree with the district court that Legacy may sue under 42 U.S.C. § 1983, which

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[11] *Cf. Yaretsky*, 457 U.S. at 1001 (explaining that a mere possibility that lacks "sufficient immediacy and reality" is insufficient where "[n]othing in the record" shows a concrete threat).

confers a private right of action on those who suffer deprivations of "any rights, privileges, or immunities secured by" federal law. Not every federal law is actionable under § 1983, however. A plaintiff must "assert the violation of a federal *right*, not merely a violation of federal *law*." *Gonzaga Univ.* v. *Doe*, 536 U.S. 273, 282 (2002) (citation omitted). Thus, the particular statute must provide "an unambiguously conferred right" with an "*unmistakable* focus on the benefitted class." *Id.* at 283–84. To determine whether a particular statute gives rise to a federal right, the Court has enunciated three factors: (1) "Congress must have intended that the provision in question benefit the plaintiff"; (2) "the plaintiff must demonstrate that the right assertedly protected by the statute is not so 'vague and amorphous' that its enforcement would strain judicial competence"; and (3) "the statute must unambiguously impose a binding obligation on the States."[12]

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[12] *Blessings* v. *Freestone*, 520 U.S. 329, 340–41 (1997) (citations omitted). There is a second step to this inquiry. Once the plaintiff establishes "that a statute confers an individual right, the right is presumptively enforceable by § 1983." *Gonzaga*, 536 U.S. at 284. Defendants "may rebut this presumption by showing that Congress 'specifically foreclosed a remedy under § 1983,'" such as by providing for "a comprehensive enforcement scheme that is incompatible with individual enforcement under § 1983." *Id.* at 284 n.4 (citations omitted). But Texas has offered nothing to rebut this presumption, nor do we find anything in § 1396 to constitute such a comprehensive remedial scheme. Rather, the only case Texas cites, *Armstrong* v. *Exceptional Child Ctr., Inc.*, 135 S. Ct. 1378, 1385 (2015), involved an implied right of action—a situation lacking the presumption that § 1983 itself provides the

Whether § 1396a(bb) meets these requirements is a question of first impression in this court, although at least five other circuits have found that § 1396a(bb) is enforceable via § 1983.[13] Moreover, our circuit has held that a similar provision in the Medicaid Act creates rights enforceable under § 1983.[14] Although these cases are not binding here, they inform our analysis.

A first glance at § 1396a(bb) shows the potential "rights-creating language" that *Gonzaga* calls for. For instance, look to § 1396a(bb)(5)(A): "[T]he State plan shall provide for payment to the center or clinic by the State of a supplemental payment * * * * *" Similarly, § 1396a(bb)(1) states that "the State plan shall provide for payment for services * * * furnished by a [FQHC] * * * in accordance with the provisions of this subsection." As other circuits have noted, this language

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private right of action. Accordingly, our analysis hinges on whether there is a federal right to enforce in § 1396a(bb).

[13] *See Cal. Ass'n of Rural Health Clinics* v. *Douglas*, 738 F.3d 1007, 1013 (9th Cir. 2013); *N.J. Primary Care Ass'n* v. *N.J. Dep't of Human Servs.*, 722 F.3d 527, 539 (3d Cir. 2013); *Concilio de Salud Integral de Loiza, Inc.* v. *Pérez–Perdomo*, 551 F.3d 10, 17–18 (1st Cir. 2008); *Pee Dee Health Care, P.A.* v. *Sanford*, 509 F.3d 204, 212 (4th Cir. 2007); *Rio Grande Cmty. Health Ctr., Inc.* v. *Rullan*, 397 F.3d 56, 74 (1st Cir. 2005). Furthermore, other circuits have permitted suits to enforce § 1396a(bb) under § 1983 but did not discuss the issue. *See also*, *e.g.*, *Cmty. Health Care Ass'n of N.Y.* v. *Shah*, 770 F.3d 129, 157 (2d Cir. 2014).

[14] *See Romano* v. *Greenstein*, 721 F.3d 373, 377–79 (5th Cir. 2013) (finding 42 U.S.C. § 1396a(a)(8) enforceable under § 1983). Section 1396a(a)(8) requires state plans to "provide that all individuals wishing to make application for medical assistance under the plan shall have [the] opportunity to do so, and that such assistance shall be furnished with reasonable promptness."

seems to be "rights-creating * * * because it is mandatory and has a clear focus on the benefitted FQHCs." *E.g.*, *Rio Grande*, 397 F.3d at 74. But admittedly, this is not as clear as the "rights-creating language" that Defendants "may rebut this presumption by showing that Congress 'specifically foreclosed a remedy under § 1983,'" such as by providing for "a comprehensive enforcement scheme that is incompatible with individual enforcement under § 1983." *Id.* at 284 n.4 (citations omitted). But Texas has offered nothing to rebut this presumption, nor do we find anything in § 1396 to constitute such a comprehensive remedial scheme. Rather, the only case Texas cites, *Armstrong* v. *Exceptional Child Ctr., Inc.*, 135 S. Ct. 1378, 1385 (2015), involved an implied right of action—a situation lacking the presumption that § 1983 itself provides the private right of action. Accordingly, our analysis hinges on whether there is a federal right to enforce in § 1396a(bb). *Gonzaga* specifically referenced.[15] Hence we turn to the *Blessings* factors.

The three *Blessings* factors show that § 1396a(bb) provides enforceable rights. First, by requiring states to ensure that FQHCs are fully paid, the subsection

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[15] For example, *Gonzaga*, 536 U.S. at 287, referenced Titles VI and IX, which state that "[n]o person * * * shall * * * be subjected to discrimination." Although that language may be the paradigm of "rights-creating," the paradigm of non-rights-creating language would be the statute at issue in *Gonzaga*: "'[N]o funds shall be made available' to any 'educational agency or institution' which has a prohibited 'policy or practice.'" *Id.* (citing FERPA, 20 U.S.C. § 1232g(b)(1)). The language at issue here is somewhere in between Title IX and FERPA.

indicates that FQHCs are its intended beneficiaries. *See Rio Grande*, 397 F.3d at 74. Second, the subsection provides for judicially administrable standards. Specific requirements that states reimburse FQHCs for certain services, at definite amounts, are far from overly vague or amorphous. *See Pee Dee Health Care*, 509 F.3d at 212. Third, the statute imposes "a binding obligation on the States." *Blessings*, 520 U.S. at 341. The language "the State plan shall provide" is precisely the same language that this court has said is binding.[16] Thus, the *Blessings* factors establish that § 1396a(bb) confers a private right enforceable through § 1983.[17]

Texas offers two counterarguments, but they are unavailing. First, the state posits that we should consider the plurality opinion in *Armstrong*, 135 S. Ct. at 1387 (Scalia J., plurality opinion). Specifically, Texas points to the plurality's statement that the Medicaid Act may have been intended to benefit the infirm rather than health care providers such as FQHCs. But in the first place, this language is distinguishable. As

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[16] *See S.D. ex rel. Dickson* v. *Hood*, 391 F.3d 581, 603 (5th Cir. 2004) (holding that 42 U.S.C. § 1396a(a)(10)(A)(i) was enforceable under § 1983 in part because of the language "[a] State Plan must provide").

[17] Texas notes that the district court only analyzed § 1396a(bb)(5) and that the other provisions only set forth a payment methodology. Fair enough; this suit involves § 1396a(bb)(1) as well. But our analysis applies equally to § 1396a(bb)(1): "[T]he State shall provide for payment for services * * * furnished by a [FQHC] * * * in accordance with the provisions of this subsection."

stated above, § 1396a(bb) issues a command to benefit FQHCs by ensuring that they are fully reimbursed. Conversely, the provision at issue in *Armstrong* had no such focus on beneficiaries, as that provision dealt with procedures to make efficient payments. *See Armstrong*, 135 S. Ct. at 1382, 1385.[18] In the second place, the plurality's statement, if taken to the conclusion urged by Texas, would likely overrule cases such as *Wilder* v. *Virginia Hospital Association*, 496 U.S. 498, 512 (1990), in which the Court found other provisions of the Medicaid Act to be enforceable by health care providers through § 1983—thus Texas's contention goes too far.

Second, Texas contends that § 1396a(bb) could only confer the right to be paid at its full PPS rate, as distinguished from the right to be paid in a particular way. Yet Texas again conflates Legacy's winning on the merits with its having a cause of action. Texas may be correct that § 1396a(bb) does not give Legacy a right to be paid in full by the state rather than by MCOs. But Legacy can have a right to sue under § 1983 and still

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[18] In *Armstrong*, 135 S. Ct. at 1382, the Court considered 42 U.S.C. § 1369a(a)(30)(A), which requires state plans to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan * * * as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

lose on the merits.[19] Accordingly, Legacy has a private right of action, under § 1983, to enforce § 1396a(bb).

IV.

Given that Legacy has standing to bring two of its claims and has a cause of action under § 1983, we turn to the merits of those claims. We conclude that summary judgment should have been granted to Texas, not Legacy.

A.

Regarding Legacy's "in-network" claim that the Commission may not require MCOs fully to reimburse FQHCs in the first instance, the district court reasoned that the text and purposes behind § 1396a(bb)(5) require imposing an implied limit on Texas's disbursement of Medicaid funds.[20] We disagree.

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[19] *See, e.g.*, *Cal. Ass'n of Rural Health Clinics* v. *Douglas*, 738 F.3d 1007, 1011–17 (9th Cir. 2013) (taking this approach); *Three Lower Ctys. Cmty. Health Servs., Inc.* v. *Maryland*, 498 F.3d 294, 305 (4th Cir. 2007) (rejecting a challenge under § 1396a(bb)(5) for improper delegations to MCOs instead of dismissing for want of a cause of action).

[20] The district court accorded *Chevron* deference to CMS's approval of SPA 16-02. On appeal, Texas maintains that the approval should receive *Chevron* deference, reading the approval as buttressing the idea that Texas's plan is permissible (and, although Legacy lacks standing to challenge SPA 16-02 as such, that approval could still be relevant inasmuch as SPA 16-02 codified Texas's practice of requiring MCOs fully to reimburse FQHCs). To the contrary, CMS's approval of SPA 16-02 has no bearing on this case.

For "all issues of statutory interpretation, the appropriate place to begin * * * is with the text itself." *Hamilton* v. *United Healthcare of La., Inc.*, 310 F.3d 385, 391 (5th Cir. 2002) (citation omitted). The main provision, § 1396a(bb)(5)(A), says that "the State plan shall provide for payment to the center or clinic by the State of a supplemental payment equal to the amount (if any) by which the amount determined under * * * this subsection exceeds the amount of the payments provided under the contract." The plain meaning is that the state must provide for supplemental payments only if there is a shortfall between the PPS rate and the MCO reimbursement rate. Nothing in this subsection prohibits states from requiring MCOs to pay the full PPS rate, thereby obviating the need for supplemental payments in the first place.

This reading is buttressed by the inclusion of "if any," which demonstrates that there may not be a shortfall between the PPS rate and MCO reimbursements. Legacy responds that the words "if any" have meaning only in the event that an MCO *in its discretion* just happens to contract with an FQHC to

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As CMS explained in its statement of interest to the district court, it did so only as an APM under § 1396a(bb)(6)—not under § 1396a(bb)(5). Given that the initial approval did not specify under which subsection CMS approved SPA 16-02, we see no reason not to credit this explanation of the approval. *Cf. Auer* v. *Robbins*, 519 U.S. 452, 460–63 (1997). Accordingly, the approval has no bearing on whether Texas's policy is permissible under § 1396a(bb)(5). Because, as explained below, we do not reach the question of whether Texas's policy would be a valid APM, we have nothing about which to give *Chevron* deference to CMS.

reimburse it at the full PPS rate. But nothing in the text supports such a conclusion. The statute merely says there must be supplemental payments if there is "any" shortfall—nothing prevents the state from attempting to eliminate such shortfalls or requires the amount of the shortfall to be determined entirely by the MCO.

The district court also examined the reference to "the contract" at the end of § 1396a(bb)(5)(A)—*i.e.*, the statement that the shortfall amount is determined by the PPS amount less the amount provided under "the contract." The court reasoned that "the contract" must refer to the MCO-FQHC contract. We agree. Section 1396a(bb)(5)(A) would make little sense otherwise.

But the district court then erred in deducing that this reference to the MCO-FQHC contract compels reading § 1396a(bb)(5)(A) to require unfettered discretion in MCO-FQHC contracts. The reference says nothing about whether the state may impose conditions on the MCO-FQHC contract. Instead, the subsection merely points to what the terms of the contract are, without regard to how those terms came into being. Thus, it is fully consistent with § 1396a(bb)(5)(A) for the state to require the contract to reimburse the FQHCs fully. In that situation, there just would not be "any" supplemental payment to be made, because the PPS rate would not exceed the amount "provided under the [MCO-FQHC] contract." 42 U.S.C. § 1396a(bb)(5)(A).

Without any aid from the text of § 1396a(bb)(5), Legacy turns to § 1396b(m)(2)(A)(ix). Section 1396b(m)(2)(A) imposes certain obligations on the states that must be established in the state-MCO contracts. As relevant here, § 1396b(m)(2)(A)(ix) requires that all state-MCO contracts "provide[], in the case of an [FQHC-MCO contract] * * * that the [MCO] shall provide payment that is not less than the level and amount of payment which the [MCO] would make for the services if the services were furnished by a provider which is not [an FQHC]." Essentially, MCOs must contract with FQHCs at a rate "not less than" the going market rate for services.

The plain meaning of this text only sets a floor—the market rate—for MCO-FQHC contracts. Legacy contends, however, that the statute also prohibits states from imposing any other floors on MCO-FQHC contracts. That is, Legacy declares that § 1396b(m)(2)(A)(ix)'s floor is the only floor allowed and sets an implied ceiling for what is required of MCO-FQHC contracts.[21]

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[21] The only other court squarely to address this issue found that § 1396b(m)(2)(A)(ix) did not impose any ceiling on what states may require in an MCO-FQHC contract. *See Three Lower Ctys.*, 498 F.3d at 304–305. Although the district court relied on cases from other circuits, those decisions are not on point insofar as they merely state that MCOs have to reimburse FQHCs at a minimum market rate and that states have to make supplemental wraparound payments if needed. *See, e.g.*, *N.J. Primary Care*, 722 F.3d at 539–40; *Cmty. Health Care*, 770 F.3d at 153–58; *Rio Grande*, 397 F.3d at 75–76.

We are loath to read such implied limits into statutes. "We have stated time and again that courts must presume that a legislature says in a statute what it means and means in a statute what is says there." *Barnhart v. Sigmon Coal Co.*, 534 U.S. 438, 461–62 (2002).[22] If the statute is unambiguous, then the "judicial inquiry is complete." *Id.* at 462. Our reading of the text reflects no ambiguity, and Legacy offers nothing to the contrary.

The provisions, in combination, provide that MCOs must contract with FQHCs at a rate "not less than" the market rate.[23] If, and only if, the MCO-FQHC

[22] It is for this reason that we do not adhere to CMS's position, articulated in its guidance letters (such as its 1998 SMDL letter), that states are not permitted to impose any requirements on MCO-FQHC contracts other than those in § 1396b(m)(2)(A)(ix). Though CMS undoubtedly has carefully considered this position, its letter is not entitled to *Chevron* deference insofar as it was not "promulgated in the exercise" of CMS's law-making powers. *United States* v. *Mead Corp.*, 533 U.S. 218, 226–27 (2001); *see also Christensen* v. *Harris Cty.*, 529 U.S. 576, 587 (2000) (finding that "an interpretation contained in an opinion letter" does not warrant *Chevron* deference). Accordingly, we look to the agency's views in this regard only "for guidance" or persuasion. *Skidmore* v. *Swift & Co.*, 323 U.S. 134, 140 (1944); *see also Greathouse* v. *JHS Sec. Inc.*, 784 F.3d 105, 114 (2d Cir. 2015).

[23] Instead of pointing to any statutory ambiguity, Legacy makes bare policy arguments about § 1396a(bb)(5). But it is not our job to decide what policies Congress *should* have enacted. *Sigmon Coal Co.*, 534 U.S. at 462. Even addressing Legacy's policy arguments, it is far from certain that the parade of horribles it posits will ever come to pass. Although Legacy insists that MCOs will never contract with FQHCs under Texas's policy, the record shows that TCHP still has contracts with approximately seventeen FQHCs. And although Legacy is correct that the

contract is less than the PPS rate, then the state must make supplemental wraparound payments. Because the plain text of §§ 1396b(m)(2)(A)(ix) and 1396a(bb)(5) is unambiguous and does not forbid states from requiring MCOs to reimburse FQHCs fully, we will not read such a prohibition into what Congress wrote.[24] Therefore, Texas may require MCOs to reimburse FQHCs fully in the first instance.[25]

B.

Legacy claims that the Commission violated § 1396a(bb)(1)–(2) by failing to reimburse it for

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Medicaid Act itself, before * * * 1997, required MCOs to reimburse FQHCs fully, that does not mean that states are now barred from requiring MCOs to reimburse FQHCs fully. Given that Congress did not impose such a prohibition on the states, we cannot infer one where Congress may well have wanted to leave that decision up to each respective state. *Cf. Three Lower Ctys.*, 498 F.3d at 305.

[24] At oral argument, Legacy suggested that even if the Medicaid Act does not prohibit Texas from requiring MCOs fully to reimburse FQHCs, Texas somehow consented to CMS's 1998 SMDLs in a way that bound itself to CMS's position articulated above. Yet we see no authority for the idea that a state may somehow legally bind itself to an agency's guidance documents. Indeed, the notion that a state might consent to an agency's interpretation and thereafter be forever bound to it is wholly inconsistent with the fact that agencies are permitted to change their own interpretation of statutes. *See Nat'l Cable & Telecomm. Ass'n* v. *Brand X Internet Servs.*, 545 U.S. 967, 981–82 (2005).

[25] Because the Medicaid Act does not bar Texas from requiring MCOs fully to reimburse FQHCs in the first place, we need not address Texas's alternative argument that its MCO reimbursement requirement is permissible as an APM under § 1396a(bb)(6).

services that it has been providing to TCHP's Medicaid enrollees. As explained above, Legacy has continued to provide all of the Medicaid services to TCHP's Medicaid patients even after the contract was terminated. The Commission requires MCOs to reimburse FQHCs for emergency "out-of-network" services such as these but not for non-emergency out-of-network services unless the FQHC received prior authorization for the service. Because Legacy did not receive prior authorization for many of these non-emergency services, its claims were denied by TCHP and the Commission. Legacy insists that the Commission is required by § 1396a(bb) to reimburse it for non-emergency out-of-network services.[26] The district court agreed with Legacy.[27] We reverse.

The starting point is the plain text of § 1396a(bb)(1), which requires states to "provide for payment for services described in section 1396d(a)(2)(C)

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[26] In the district court, Legacy claimed that the Commission also was failing to reimburse it for certain emergency out-of-network services. The court rejected that contention, and Legacy does not raise it on appeal.

[27] The district court again cited *New Jersey Primary Care*, 722 F.3d at 539–40, and *Community Health Care*, 770 F.3d at 153–158, to support its decision. Those cases are inapposite; although they held that states are required to reimburse FQHCs for all covered services, those courts did not have occasion to decide what "covered" services are. Instead, they turned on the fact that the defendant-states had made reimbursements contingent on prior MCO payment. *See N.J. Primary Care*, 722 F.3d at 540; *Cmty. Health Care*, 770 F.3d at 156–57. Thus, the courts were concerned with FQHCs' performing covered services and not being reimbursed by the state merely because the MCO denied payment.

of this title furnished by a [FQHC] * * * in accordance with the provisions of this subsection," *i.e.*, the PPS rate. In turn, § 1396d(a)(2)(C) refers to "care and services * * * for individuals [within an enumerated list] * * * whose income and resources are insufficient to meet all of such cost * * * [of FQHC] services." Yet § 1396d(a)(2)(C) does not explain what the relevant FQHC services are.

Texas points to § 1396b(m)(2)(A), which provides definitions and requirements for MCOs. Specifically, § 1396b(m)(2)(A)(vii) requires state-MCO contracts to specify whether the state or MCO will reimburse healthcare providers for emergency out-of-network services. Thus, Texas reasons, § 1396b(m)(2)(A)(vii) specifies which out-of-network services the state is responsible for.

We agree. If states had to reimburse FQHCs for *all* out-of-network services to Medicaid enrollees, then FQHCs would have little or no incentive to contract with MCOs. Indeed, this case is exemplary—if the district court were affirmed, Legacy would have lost its contract with TCHP with almost no penalty, continuing to provide services to TCHP's enrollees while receiving full reimbursement from the state.

It follows that using § 1396b(m)(2)(A)(vii) as the limit for what out-of-network services the FQHC may provide makes paramount sense. The statute requires reimbursement only for emergency services, for which patients need to find the nearest clinic and get quick care, without concern for whether the clinic is in or out

of their network. For non-emergency services, though, FQHCs should have to contract with those MCOs to provide services when the state uses MCOs to manage its Medicaid services. And finally, the entire structure of the Medicaid Act contemplates states' using MCOs as intermediaries and MCO-FQHC contracts.[28] It would be wholly inconsistent with that structure to eliminate the distinction between in-network and out-of-network care for FQHCs, thereby effectively removing MCOs from the equation and obviating the need for MCO-FQHC contracts. Congress did not order that absurd result.[29]

The closest Legacy comes to an opposing consideration is its claim that, as an FQHC, it is required to assure that patients are treated despite inability to pay. *See* 42 U.S.C. § 254b(k)(3)(G)(iii). But that requirement is part of the responsibilities that attach to Section 330 grants. As Legacy acknowledges, one of

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[28] *See, e.g.*, §§ 1396a(a)(23), 1396a(bb), 1396b(k), 1396b(m), 1396u-2(a)(1); *see generally Yates* v. *United States*, 135 S. Ct. 1074 (2015) (using context to ascertain the meaning of a statutory provision).

[29] CMS's statement of interest fully accords with our reading. Although Legacy purports to rely on CMS's statement that FQHCs must be paid "the full PPS amount for any covered out-of-network services," context indicates that statement is consistent with our conclusion. The critical question is what "covered" serv[ic]es are. And while citing § 1396b(m)(2)(A)(vii), CMS expressly framed the requirement as "out-of-network health centers [must] be reimbursed for 'medically necessary services which were provided * * * because the services were immediately required due to unforeseen illness, injury, or condition," *i.e.*, emergency services.

the main points of the relevant Medicaid Act provisions is to ensure that Section 330 funds are not used to subsidize Medicaid services. *See Cmty. Health Care*, 770 F.3d at 150; *Three Lower Ctys.*, 498 F.3d at 297–98. It thus makes little sense to create a situation in which Medicaid funds would be used to fulfill a Section 330 obligation. Accordingly, Texas is not required to reimburse Legacy for the non-emergency out-of-network services about which it complains.

For the reasons explained, the judgment is REVERSED and REMANDED with instruction that Legacy's claim as to SPA 16-02's lack of a requirement to make supplemental "wraparound" payments be DISMISSED for want of standing and that judgment be entered for the Commission as to the remaining claims.

EDITH H. JONES, Circuit Judge, dissenting in part:

With respect, I would dismiss Legacy's complaint regarding the Commission's rule that MCOs must fully reimburse FQHCs because Legacy has failed to establish standing to raise this issue. "The party invoking federal jurisdiction bears the burden" of establishing standing. *Lujan* v. *Defs. of Wildlife*, 504 U.S. 555, 561, 112 S. Ct. 2130, 2136 (1992). At the summary judgment stage, the party invoking federal jurisdiction "can no longer rest on * * * 'mere allegations,' but must 'set forth' by affidavit or other evidence 'specific facts.'" *Id.* at 561, 112 S. Ct. at 2137. Legacy has failed to

present any evidence, or even argued, that it has been injured because it "undoubtedly will have future dealings with MCOs." And *Clinton* cannot save Legacy from its failure to do so. *Clinton* v. *City of N.Y.*, 524 U.S. 417, 118 S. Ct. 2091 (1998). In *Clinton*, the farmer's cooperative plaintiff presented evidence that it was "actively searching for other processing facilities for possible future purchase if the President's cancellation [were] reversed; and there [were] ample processing facilities in the State that [the cooperative might have been] able to purchase." *Clinton*, 524 U.S. at 432, 118 S. Ct. at 2100.[1]

Here, in contrast, Legacy has contended from the outset that it has standing simply because of its terminated contract with TCHP. Legacy improperly relied on *Planned Parenthood* v. *Gee*, a case that was altered on rehearing due to Supreme Court case law.[2] Legacy admits it was never denied a dime of reimbursement under its contract with TCHP. Regardless whether I agree with the opinion's resolution of the merits, we do not have jurisdiction to decide this claim because Legacy does not have standing to pursue this claim. I

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[1] The majority relies on the "bargaining chip" language in *Clinton*, which has never been referenced in the Supreme Court in nearly twenty years since it was decided.

[2] *Compare Planned Parenthood of the Gulf Coast, Inc.* v. *Gee*, 837 F.3d 477, 487 & n.14 (5th Cir. 2016), *with Planned Parenthood of the Gulf Coast, Inc.* v. *Gee*, 862 F.3d 445, 455 & n.14 (5th Cir. 2017) (quoting *Spokeo, Inc.* v. *Robins*, 136 S. Ct. 1540, 1549 (2016)).

respectfully dissent from this piece of an otherwise excellent opinion.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

LEGACY COMMUNITY HEALTH SERVICES, INC.,	§	
Plaintiff,	§	**CIVIL ACTION NO.**
VS.	§	**4:15-CV-25**
DR. KYLE L. JANEK, *et al*,	§	
Defendants.	§	

MEMORANDUM & ORDER

(Filed May 3, 2016)

I. INTRODUCTION

This case concerns a challenge to certain aspects of how Texas administers its responsibilities under the federal Medicaid Act, 42 U.S.C. § 1396a *et seq.* ("the Medicaid Act" or "the statute"). Plaintiff Legacy Community Health Services ("Plaintiff"), a community health center serving low-income patients in the Houston area, filed this lawsuit to assert its rights under the Medicaid Act. Defendant Dr. Kyle L. Janek[1] is sued in his official capacity as Executive Commissioner of Texas's Health and Human Services Commission ("HHSC" or "the State"). Legacy claims that HHSC

[1] Although Dr. Janek was Commissioner at the time the complaint was filed, Chris Traylor was appointed as his successor effective July 1, 2015. As Dr. Janek's successor, Mr. Traylor is "automatically substituted as a party." FED. R. CIV. PRO. 25(d).

has violated the Medicaid Act with respect to how it reimburses Legacy for services Legacy provides to Medicaid patients. In the Court's Memorandum & Order of July 2, 2015 (Doc. No. 66), the Court held that Plaintiff had stated a claim for relief on two separate theories: first, that the State's process for providing reimbursement for services rendered to out-of-network patients allegedly violates the Medicaid Act, 42 U.S.C. § 1396b(m)(2)(A)(vii), and, second, that the State's delegation of its reimbursement responsibility to third-party Managed Care Organizations allegedly violates the Act, *id.* § 1396a(bb)(5)(A). Plaintiff seeks injunctive relief under 42 U.S.C. § 1983 to remedy the alleged shortcomings in Texas's method for providing payments to Legacy for its Medicaid services.[2]

The parties cross-moved for summary judgment pursuant to Federal Rule of Civil Procedure 56. On April 18, 2016, the Court held a hearing on the cross-motions for summary judgment and took the motions under advisement. The Court now issues its decision as to the claim that the State has unlawfully allocated

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[2] In the July 2015 Memorandum & Order, the Court held that 42 U.S.C. § 1396a(bb)(5)(A) gives rise to a private cause of action under § 1983 for Federally Qualified Health Centers ("FQHCs"), such as Legacy, to enforce their right to receive the reimbursement payments required under § 1396a(bb)(5)(A). *See* Mem. & Order, July 2, 2015, at 10-13. In Defendant's Motion for Summary Judgment, Defendant continues to make the argument that no such right of action exists. Nothing in the parties' briefing or the summary judgment record changes the Court's ruling that a private action can be brought by an FQHC under § 1983 to enforce § 1396a(bb)(5)(A).

its payment obligation to Managed Care Organizations. The Court does not here decide Plaintiff's claim with respect to out-of-network services, but finds that there is no just reason to delay the summary judgment decision as to the other, independent claim for relief. After considering the parties' arguments, the applicable law, and the record in this case, the Court finds that Plaintiff's Motion for Summary Judgment (Doc. No. 84) should be granted as to the claim that the State has unlawfully delegated its payment obligation. Likewise, the Court finds that Defendant's cross-Motion for Summary Judgment (Doc. No. 89) should be denied as to this claim.

II. BACKGROUND

A. Federal Statutory Framework

The Medicaid Act is a cooperative federal-state program through which the federal government provides financial assistance to states so that they can furnish medical care to low-income individuals. *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990), *superseded on other grounds by statute*. Medicaid is jointly financed by federal and state governments and is administered by the states. States are not required to participate in Medicaid but, "once a state chooses to join, it must follow the requirements set forth in the Medicaid Act and its implementing regulations." *S.D. v. Hood*, 391 F.3d 581, 586 (5th Cir. 2004) (quoting *Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F.3d 908, 915 (5th Cir. 2000)). The Centers for Medicare and Medicaid

Services ("CMS"), a subsidiary of the Department of Health and Human Services, is the federal agency responsible for overseeing state compliance with federal Medicaid requirements. *Perry Cty. Nursing Ctr. v. U.S. Dep't of Health & Human Servs.*, 603 F. App'x 265, 267 (5th Cir. 2015). States electing to participate in Medicaid must submit to CMS a "state plan" detailing how the state will expend its funds.[3] *See* 42 U.S.C. §§ 1396, 1396a (2000). Each state plan must be approved by CMS. *Id.*; 42 C.F.R. § 430.0. Defendant HHSC is the Texas state agency responsible for establishing and complying with the Texas State Plan and must submit any state plan amendments ("SPAs") to CMS for review and approval. 42 U.S.C. § 1396a(a)(5); 42 C.F.R. §§ 430.10, 430.12, 430.14, 431.10.

Among the Medicaid Act's many requirements is that states must provide payment for Medicaid-covered services rendered by Federally Qualified Health Centers ("FQHCs"), health centers that provide medical care to an under-served population. 42 U.S.C. § 1396d(a)(2)(B)-(C); *id.* § 1396a(bb)(1). Plaintiff is designated as an FQHC. In addition to receiving Medicaid funding from the state, FQHCs are also eligible to receive federal grants under Section 330 of the

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[3] "A 'state plan' is a comprehensive description of the nature and scope of the state's intended Medicaid program, and this document provides CMS with assurances that the state will administer the Medicaid program in conformity with CMS regulations and federal law. Filing of the state plan is a pre-requisite to receiving federal funding." *Women's Hosp. Found. v. Townsend*, No. CIV A 07-711-JJB-DLD, 2008 WL 2743284, at *1 (M.D. La. July 10, 2008).

Public Health Services Act. 42 U.S.C. § 254b. "The constituencies served by Medicaid funding and by Section 330 grants are not identical, however." *Cmty. Health Care Ass'n of New York v. Shah*, 770 F.3d 129, 136 (2d Cir. 2014). The dual sources of FQHC funding—direct federal grants and indirect federal Medicaid dollars filtered through the states—"allows the FQHC to allocate most of its direct grant dollars towards treating those who lack even Medicare or Medicaid coverage." *Cmty. Health Ctr. v. Wilson-Coker*, 311 F.3d 132, 134 n.2 (2d Cir. 2002). To ensure that Section 330 grants are not used to cover the cost of treating Medicaid patients, the Medicaid Act requires that states reimburse FQHCs for services provided to Medicaid beneficiaries. 42 U.S.C. § 254b(k)(3)(F).

The Medicaid Act, specifically § 1396a(bb), also governs precisely *how* a state must reimburse FQHCs for Medicaid services. Since 2001, reimbursement payments are assessed through what is known as the Prospective Payment System ("PPS"). *Id.* § 1396a(bb)(1)-(3). Stated simply, an FQHC's reimbursement from the state is calculated by multiplying the number of Medicaid patient encounters by the average reasonable costs of serving Medicaid patients in 1999 and 2000, adjusted yearly for inflation. *Id. See generally New Jersey Primary Care Ass'n Inc. v. New Jersey Dep't of Human Servs.*, 722 F.3d 527, 529 (3d Cir. 2013). The total amount owed by the state to reimburse an FQHC

for a Medicaid patient encounter is referred to as the "PPS rate" or the "PPS amount."[4]

The "system of states reimbursing FQHCs for their Medicaid costs is complicated considerably by the fact that many states * * * use a managed care approach to running their Medicaid system." *Rio Grande Cmty. Health Ctr., Inc. v. Rullan*, 397 F.3d 56, 62 (1st Cir. 2005). Under a managed care approach, the state administers its Medicaid program by contracting with private-sector managed care organizations ("MCOs"), analogous to private-sector HMOs, that arrange for the delivery of healthcare services to individuals who enroll with them. 42 U.S.C. § 1396u-2(a)(1). In exchange for its services, an MCO receives from the state a prospective per-patient, per-month payment, called a "capitation" payment, based on the number of patients enrolled in the MCO.[5] The MCO, in turn, contracts with healthcare providers, including FQHCs, to provide services to its enrollees. Under the MCO model, the state does not directly reimburse FQHCs for their services to Medicaid recipients; rather, the MCOs reimburse FQHCs out of their capitation funds. *See*

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[4] Instead of reimbursing FQHCs on a per-service basis, the statute requires the state to reimburse FQHCs for each visit or "encounter" that they have with a Medicaid patient.

[5] *See* 42 C.F.R. § 438.2 (2014) ("Capitation payment means a payment the State agency makes periodically to a contractor on behalf of each beneficiary enrolled under a contract for the provision of medical services under the State plan. The State agency makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment.").

Shah, 770 F.3d at 137; *New Jersey Primary Care Ass'n*, 722 F.3d at 530. If an MCO's costs are less than the capitation payments received from the state, the MCO makes a profit; if costs exceed capitation payments, the MCO incurs a loss.

The tripartite relationship between the state, MCOs, and FQHCs—and the provisions of the Medicaid Act that govern this relationship—forms the crux of this case. As this Court has previously recognized, "[b]ecause federal law requires states to pay FQHCs a designated amount per visit, the FQHC system sits uneasily with the MCO model, which requires MCOs to have the flexibility to negotiate with health care providers." Mem. & Order, July 2, 2015, at 3. To resolve this tension, Congress enacted a pair of statutory provisions—42 U.S.C. § 1396a(bb)(5)(A) and § 1396b(m)(2)(A)(ix) (hereinafter, "the payment provisions")—that together achieve a careful balance between two competing objectives. The payment provisions ensure that FQHCs will be paid the PPS rate to cover the costs of providing Medicaid services while also ensuring that MCOs are able to negotiate with FQHCs just as they would with any other healthcare provider. The precise framework established by the payment provisions is as follows: Section 1396b(m)(2)(A)(ix) provides that MCOs are required to pay FQHCs "not less than" they would pay non-FQHC providers for the same services.[6] Section

[6] *See* 42 U.S.C. § 1396b(m)(2)(A)(ix) ("such contract [between the state and the MCO] provides, in the case of an [MCO] that has entered into a contract for the provision of services with a

1396a(bb)(5)(A) then requires states to pay FQHCs a supplemental payment to bring the FQHC's total compensation to the PPS rate, referred to as a "wraparound payment." Specifically, § 1396a(bb)(5)(A) places on the states the following reimbursement obligation: "In the case of services furnished by a[n] [FQHC] * * * pursuant to a contract between the [FQHC] * * * and a[n] [MCO] * * * the State plan shall provide for payment to the center or clinic by the State of a supplemental payment equal to the amount (if any) by which the [PPS] amount * * * exceeds the amount of the payments provided under the contract." 42 U.S.C. § 1396a(bb)(5)(A). Plaintiff's suit contends that Texas's system for reimbursing FQHCs violates this provision of the Medicaid Act.

B. Texas's Medicaid Reimbursement Regime

Texas has chosen to implement Medicaid through a managed care system. Tex. Gov. Code § 533.002. Beginning in October 2010, when State Plan Amendment ("SPA") 10-61 went into effect, the Texas State Plan mandated that the State make wraparound payments to FQHCs, as contemplated under § 1396a(bb)(5)(A). Specifically, SPA 10-61 provided that "[i]n the event that the total amount paid to an FQHC by a managed care organization is less than the amount the FQHC

Federally-qualified health center or a rural health clinic, that the [MCO] shall provide payment that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a provider which is not a Federally-qualified health center or a rural health clinic.").

would receive under PPS * * * , the state will reimburse the difference on a state quarterly basis." *See* Pl.'s Mot. Summ. J. Ex. E at 10 (hereinafter, "SPA 10-61"); *see also* Def.'s Reply 4 n.5 (Doc. No. 96) (explaining that SPA 10-61 tracked the language of § 1396a(bb)(5)(A)). In 2011, however, Texas changed its method of reimbursing FQHCs for Medicaid services. The State began requiring—and today continues to require—that MCOs reimburse FQHCs at the full PPS rate, thereby obviating the need for the State to make a wraparound payment.[7] *See* Def.'s Mot. Summ. J. 28 ("[T]here is no need for wraparound payment because the contracted MCO is required to pay the full PPS to the provider."). Despite the language of SPA 10-61, which provided for state wraparound payments, HHSC's contracts with MCOs have, since 2011, stated that:

> *The MCO must pay full encounter [i.e., PPS] rates to FQHCs* * * * for Medically Necessary Covered Services provided to Medicaid and CHIP Members using the prospective payment methodology described in Sections 1902(bb) and 2107(e)(1) of the Social Security

[7] In 2011 the National Association of Community Health Centers reported that five other states used a similar system. (*See* National Association of Community Health Centers, *Update on the Status of the FQHC Medicaid Prospective Payment System in the States, State Policy Report #40*, November 2011, *available at* http://www.nachc.com/client/2O11%2OPPS%2OReport%2OSPR%2040.pdf, at p. 5) ("5 states (CO, CT, MA, MS, DE) actually pay the managed care organizations the wrap-around who in turn pay the health centers. Texas just made this change, which is effective September 1st. NJ, NC, and TN are considering this change.").

> Act. *Because the MCO is responsible for the full payment amount in effect on the date of service, HHSC cost settlements (or "wrap payments") will not apply*.[8]

Pl.'s Mot. Summ. J. Ex. H at H-16 [hereinafter HHSC/MCO Contract] (emphasis added); *see also* Def.'s Mot. Summ. J. at 44-45 ("Section 8.1.22 of the [HHSC/MCO contract] * * * expressly indicates that there is no need for a wraparound payment because the contracted MCO is required to pay the full PPS to the provider."); *id.* Ex. A, Affidavit of Gary Jessee ¶ 2 [hereinafter Jessee Aff.] (discussing HHSC's Uniform Managed Care Contract). HHSC's contractual requirement that MCOs pay FQHCs the full PPS amount was also authorized by the Texas legislature. *See* House Bill No. 1 (General Appropriations Bill) ("[t]o the extent allowable by law, in developing the premium rates for Medicaid and CHIP Managed Care Organizations * * * , the Health and Human Services Commission shall include provisions for payment of the FQHC Prospective Payment System (PPS) rate and establish contractual requirements that require MCOs to reimburse FQHCs at the PPS rate.").

As the Court has previously observed, by requiring MCOs to pay 100 percent of the PPS amount, "Texas's

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[8] This is the language that HHSC currently uses in its contracts with MCOs. The predecessor version of the contract used nearly identical language: "MCOs are required to pay full encounter rates (as determined by HHSC) directly to FQHCs and RHCs for Medically Necessary Covered Services. HHSC cost settlements (or 'wrap payments') no longer apply." Def.'s Mot. Summ. J. Ex. A, Affidavit of Gary Jessee ¶ 18 n.2.

method of reimbursing FQHCs * * * for services provided to Medicaid patients differ[s] from what is contemplated in federal law." Mem. & Order, July 2, 2015, at 4. Instead of allowing MCOs to pay an FQHC a rate that the MCO has negotiated with that individual FQHC, and then making up the difference directly from state funds, HHSC has attempted to incorporate the FQHC's PPS rate into the monthly capitation payments it makes to MCOs. Jessee Aff. Ex. A, attachment 3 at pp. 2, 8, 14; *see also* Def.'s Mot. Summ. J. 50. The State then requires MCOs to pay FQHCs at the full PPS rate rather than at the lower negotiated rate. Def.'s Mot. Summ. J. Ex. B, Affidavit of Christopher Born ¶ 17 [hereinafter Born Aff].

C. Legacy, HHSC, and the Texas Children's Health Plan

Plaintiff Legacy Community Health Services is a 501(c)(3) nonprofit corporation that operates eight school-based clinics, two education or outreach locations, and twelve outpatient clinics, all of which provide care to medically under-served populations. Legacy is designated as an FQHC for purposes of Medicaid reimbursement and is also a recipient of Section 330 grants.

One of the MCOs that contracts with HHSC to provide care to Texas Medicaid recipients is the Texas

Children's Health Plan ("TCHP").[9] Legacy contracted with TCHP from 2009 to 2015 to provide medical care to Medicaid patients enrolled in TCHP. TCHP implemented the State's 2011 requirement that it pay Legacy the PPS rate rather than the negotiated rate.[10] During that same period, Legacy significantly expanded the number of its clinic locations and the services it offered. Born Aff. ¶ 32-34. As Legacy expanded, Medicaid patients' use of Legacy services increased faster than the capitation payments TCHP received from the State, causing TCHP eventually to determine that Legacy's PPS rate had made Legacy prohibitively expensive for TCHP. Born Aff. ¶ 45. TCHP's required payment to Legacy had increased by over 350%, from a rate of $59 per visit to a PPS rate of approximately $270 per visit. *Id.*; Pl.'s Reply 2 (Doc. No. 94). In February 2014, TCHP complained to Legacy about the cost of its services and also asked HHSC to modify its PPS payment requirement, but HHSC refused to modify its policy. *See* Pl.'s Mot. Summ. J. Ex. X at X-3. HHSC rejected TCHP's proposal that HHSC "transition the payment of the full FQHC encounter rate back to the State, so that it is no longer the Managed Care Organization's responsibility." *Id*. This proposal, the State concluded, "was not a feasible option." *Id.* On November 1, 2014, TCHP notified Legacy that

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[9] TCHP was originally named as a defendant in this action. Plaintiff's Second Amended Complaint dropped TCHP as a defendant and stated claims only against HHSC.

[10] HHSC's contract with TCHP contains the provision from the standard HHSC/MCO Contract, quoted above, requiring the MCO to pay the FQHC the full PPS rate.

it would be terminating its contract with Legacy effective February 1, 2015. *Id.* Ex. I at I-1.

D. Recent Developments

Each state plan must include, among its numerous details, a provision for payment to FQHCs. 42 U.S.C. § 1396a(bb) (2000). At the time the parties filed their cross motions for summary judgment, Texas's reimbursement scheme—in which MCOs are required to pay FQHCs the full PPS rate and the State's wraparound payments therefore "will not apply"—was imposed only as a term of the State's contract with MCOs. It was not codified in the Texas State Plan. In fact, the contractual language stating that wraparound payments "will not apply" stood in clear tension with the State Plan, specifically SPA 10-61, which ensured FQHCs that the State would make wraparound payments. *See* HHSC/MCO Contract at H-16.

In January 2016, however, the State submitted a new SPA to CMS for review and approval. SPA 16-02, which supersedes SPA 10-61, amends the State Plan in two significant ways as relevant here. First, SPA 16-02 incorporates into the State Plan the requirement that MCOs pay the full PPS amount. *See* Def.'s Advisory Ex. A, at 7 [hereinafter SPA 16-02] (Doc. No. 97-1). Specifically, the SPA states that FQHCs must be "paid their full per-visit [i.e., PPS] rate by state-contracted managed care organizations when the service is rendered." *Id.* Second, SPA 16-02 does away with the guarantee that "the state will reimburse [FQHCs

for] the difference," if any, between the MCO payment and the PPS amount. *Compare id.*, *with* SPA 10-61.

On February 25, 2016, CMS approved of SPA 16-02 for incorporation into the Texas State Plan, with a retroactive effective date of January 1, 2016. *See* Def.'s Advisory Ex. A, at 2 [hereinafter CMS Approval Letter]. The Court ordered the parties to brief the effect of CMS's approval on the pending motions for summary judgment and to address the level of deference, if any, that the Court owes to CMS's approval of the SPA.

III. DISCUSSION

A motion for summary judgment under Federal Rule of Civil Procedure 56 requires the court to determine whether the moving party is entitled to judgment as a matter of law based on the evidence thus far presented. FED. R. CIV. P. 56(a). Summary judgment is proper if "there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." *Id.* The movant has the burden of establishing that there is no genuine issue of material fact. *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-23 (1986). Once the movant has met its burden, the burden shifts to the nonmovant to show that summary judgment is not appropriate. *Id.* at 325. The nonmovant "must go beyond the pleadings and designate specific facts showing that there is a genuine issue for trial." *Little v. Liquid Air Corp.*, 37 F.3d 1069, 1071 (5th Cir. 1994) (en banc) (citing *Celotex*, 477 U.S. at 325). "This burden will not be satisfied by some

metaphysical doubt as to the material facts, by conclusory allegations, by unsubstantiated assertions, or by only a scintilla of evidence." *Boudreaux v. Swift Transp. Co., Inc.*, 402 F.3d 536, 540 (5th Cir. 2005) (internal quotation omitted). In deciding a summary judgment motion, the court draws all reasonable inferences in the light most favorable to the nonmoving party. *Connors v. Graves*, 538 F.3d 373, 376 (5th Cir. 2008).

The parties agree, and the Court finds, that there are no genuine issues of material fact in dispute. *See* Pl.'s Reply 1 ("The material facts are few and undisputed."); Def.'s Mot. Summ. J. 27 ("Because there is no genuine triable issue as to any material fact before this Court concerning CMS's approval of HHSC's State Plan and MCO contracts, HHSC is entitled to judgment as a matter of law."). Plaintiff's challenge to the State's reimbursement scheme presents only legal issues for resolution by the Court and should be resolved on the parties' cross motions for summary judgment.

A. *Chevron* Deference

Legacy claims that the payment provisions of the Medicaid Act do not permit a state to dispense with the obligation to reimburse FQHCs at the PPS rate by requiring that MCOs pay the full PPS amount, as Texas has done in SPA 16-02. As discussed above, CMS has approved of SPA 16-02 and the change that it effects "for the reimbursement methodology for Federally Qualified Health Centers." *See* CMS Approval Letter.

Because the Court is reviewing an agency's interpretation of a statute that it administers, the Court's analysis is governed by *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), which sets forth a two-step test.[11] A reviewing court must first ask "whether Congress has directly spoken to the precise question at issue." *Id.* at 842. "If Congress has done so, the inquiry is at an end; the court 'must give effect to the unambiguously expressed intent of Congress.'" *Food & Drug Admin. v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 132 (U.S. 2000) (quoting *Chevron*, 467 U.S. at 843). "But if Congress has not specifically addressed the question, a reviewing court must respect the agency's construction of the statute so long as it is permissible." *Id.* In other words, the Court is required to abide by the agency's implementation of a statute it administers if (1) Congress has not "directly spoken to the precise question at issue," and (2) the agency's decision is "permissible" under the statute. *Chevron*, 467 U.S. at 842-43.

Defendant suggests, citing *State of Texas v. U.S. Dep't of Health & Human Services*, that CMS decisions approving or denying SPAs are necessarily entitled to *Chevron* deference. *See* Def.'s Mot. Summ. J. 46-47. In *State of Texas*, the state appealed the denial of an SPA

[11] When CMS approves an SPA, CMS "implicitly approve[s] [the state's] interpretation of the Medicaid Act," and, as such, a court reviewing CMS's approval of an SPA must apply the *Chevron* doctrine. *California Ass'n of Rural Health Clinics v. Douglas*, 738 F.3d 1007, 1014 (9th Cir. 2013); *see also State of Texas v. U.S. Dep't of Health & Human Services.*, 61 F.3d 438, 440 (5th Cir. 1995); *Shah*, 770 F.3d at 144-48.

by the Health Care Financing Administration (the predecessor agency to CMS), and the Fifth Circuit accorded the agency's denial *Chevron* deference. 61 F.3d 438, 442 (5th Cir. 1995). The portion of the Medicaid Act at issue there was 42 U.S.C. § 1396d(a)(13), "which provides federal matching funds for the provision of rehabilitative services." *Id.* at 440. Other circuit courts, considering other provisions of the Medicaid Act, have also granted *Chevron* deference to CMS approvals of SPAs. *See Managed Pharmacy Care v. Sebelius*, 716 F.3d 1235, 1240 (9th Cir. 2013); *Christ the King Manor, Inc. v. Sec'y of U.S. Dep't of Health and Human Servs.*, 730 F.3d 291, 307 (3rd Cir. 2013); *Harris v. Olszewski*, 442 F.3d 456, 467 (6th Cir. 2006); *Pharm. Research and Mfrs. of America v. Thompson*, 362 F.3d 817, 822 (D.C. Cir. 2004). *State of Texas* and the other cases cited here do not, however, establish a rule that CMS approvals of SPAs are categorically entitled to *Chevron* deference. The decision whether to apply *Chevron* deference requires an inquiry that is focused not on the agency's decision, but on Congress's intent as expressed in the relevant statute. Hence the threshold determination in *Chevron* analysis is "whether Congress has directly spoken to the precise question at issue." *Chevron*, 467 U.S. at 842; *see also State of Texas*, 61 F.3d at 440 (asking whether a "certain portion of the Medicaid statute unambiguously indicates that Congress intended the statute to be interpreted" in a particular way). Whether an agency's decision should be accorded *Chevron* deference is a question that depends on the particular statutory provision at issue and the "precise question at issue." As a result, it is entirely possible

that a CMS approval of an SPA should be accorded *Chevron* deference in the context of a challenge to one aspect of a state's Medicaid scheme but not in the context of a challenge to an entirely different aspect of the scheme. The Ninth Circuit, for example, has recently found that *Chevron* deference should be applied to CMS's approval of an SPA where one provision of the Medicaid Act was at issue, but found that *Chevron* deference did not apply when considering a different provision of the Act. *Compare Managed Pharmacy Care*, 716 F.3d at 1240 ("[T]he Secretary's approval of California's requested reimbursement rates * * * is entitled to deference under *Chevron*."), *with California Ass'n of Rural Health Clinics v. Douglas*, 738 F.3d 1007, 1014 (9th Cir. 2013) ("[T]he statutory text provides a clear answer, and, thus, we do not defer to CMS's approval of the SPA.").[12] Similarly, the Fifth Circuit's decision to apply *Chevron* deference in *State of Texas*, where Texas challenged the agency's implementation of § 1396d(a)(13), has no bearing on the Court's decision whether to apply *Chevron* deference in the instant case, as there are entirely different statutory provisions and questions at issue. *See Thompson v. Goetzmann*, 337 F.3d 489, 501-02 (5th Cir. 2003) ("We reject this effort by the government to clothe itself in the deference given to agencies' reasonable interpretations of ambiguous statutory provisions.").

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[12] *See also Douglas*, 738 F.3d at 1014 (explaining why the decision to accord *Chevron* deference in *Managed Pharmacy Care* does not dictate the same result in *Douglas* because the statutory language in question is clear and unambiguous).

Because step one of the *Chevron* analysis requires the Court to "ascertain whether the statute is silent or ambiguous in addressing the precise question at issue," *Texas Savings & Cmty. Bankers Ass'n v. Fed. Hous. Fin. Bd.*, 201 F.3d 551, 554 (5th Cir. 2000), the Court must begin by identifying the "precise question at issue." *Chevron*, 467 U.S. at 842; *see also Douglas*, 738 F.3d at 1014. Here, Legacy's claim that the Medicaid Act prohibits the state from passing onto MCOs the duty to make PPS payments actually involves two distinct questions. One question is whether a state may require that MCOs pay the full PPS rate rather than a negotiated rate. A separate issue is, even assuming that a state is allowed to require that MCOs pay the full PPS rate, whether a state is allowed to remove its guarantee that the state will pay FQHCs at the PPS rate in the event that an MCO fails to do so.[13] The Court will perform the *Chevron* analysis separately for each question, beginning with the latter, as it is the easier to resolve.

B. Must a state guarantee that FQHCs receive the full PPS rate?

The Court cannot defer to CMS on any issue about which "Congress has directly spoken," such that "the

[13] Defendant also recognizes that Plaintiff's claim implicates these two discrete questions. *See* Def.'s Reply 4 ("Legacy contends [1] that the law requires HHSC to guarantee Legacy receives 100 percent of its PPS and [2] that at least some portion of that 100 percent must come in the form of a payment from the state, even where—as here—Legacy otherwise received 100 percent of its PPS for services rendered.").

intent of Congress is clear." *Chevron*, 467 U.S. at 842. Here, the question is whether Congress has "directly spoken" to the issue of whether a state may do away with its guarantee of making wraparound payments to FQHCs when such payment is necessary to reimburse the FQHC at the PPS rate. As was discussed above, the Texas State Plan formerly provided, pursuant to SPA 10-61, that "[i]n the event that the total amount paid to an FQHC by a managed care organization is less than the amount the FQHC would receive under PPS * * * , the state will reimburse the difference on a state quarterly basis." The new SPA approved by CMS eliminates this backstop provision, makes no mention of any obligation on the part of the State to make supplemental payments, and instead simply states: "FQHCs are paid their full per-visit [i.e., PPS] rate by state-contracted managed care organizations when the service is rendered." SPA 16-02. The State's contract with MCOs expressly provides that "[b]ecause the MCO is responsible for the full [PPS] payment * * * , HHSC cost settlements (or 'wrap payments') will not apply." HHSC/MCO Contract. HHSC concedes that its policy is that "no Wrap Payments will ever be owed by HHSC to Legacy." Jessee Aff. ¶ 16.

While the payment provisions of the Medicaid Act are perhaps not quite as straightforward as one would wish, the Act does speak clearly and unambiguously to the question at hand: whether a state may do away with a mechanism by which it will provide wraparound payments where necessary to reimburse FQHCs at the

PPS rate. For the reasons set out below,[14] the statute clearly prohibits a state from refusing *ex ante* to make wraparound payments, and, thus, as to this issue, the Court will not defer to CMS's approval of the SPA. As the Third Circuit has concluded, in declining to apply *Chevron* deference, "the meaning of the sections of the Medicaid Act at issue here [§ 1396a(bb)(5)] are clear" with respect to "a State's obligations under the federal Medicaid program when paying [FQHCs] for services they render to Medicaid patients." *Three Lower Counties Cmty. Health Servs., Inc. v. Maryland*, 498 F.3d 294, 296, 302 n.2. (4th Cir. 2007). *See also Genesis Health Care, Inc. v. Soura*, No. 3:14-CV-03449-CMC, 2015 WL 10550133, at *9 (D.S.C. Dec. 9, 2015) (holding that CMS's approval of the challenged SPA cannot be afforded *Chevron* deference because § 1396a(bb) is clear and unambiguous).

Because the Court does not defer to CMS's approval of the State's decision not to guarantee payment at the PPS rate, the Court must determine for itself whether this aspect of the State's reimbursement scheme conflicts with the Medicaid Act. *Chevron*, 467 U.S. at 843. The provision of the Medicaid Act relevant here, § 1396a(bb)(5)(A), states as follows:

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[14] Because the Court must "use traditional tools of statutory construction to determine whether Congress has spoken to the precise point at issue," *Nat'l Pork Producers Council v. E.P.A.*, 635 F.3d 738, 749 (5th Cir. 2011), the below discussion of the correct construction of the statute also provides the analysis to support the conclusion that the statute is clear and unambiguous as to the question at issue.

> In the case of services furnished by a[n] [FQHC] * * * pursuant to a contract between the [FQHC] * * * and a[n] [MCO] * * * the State plan shall provide for payment to the center or clinic by the State of a supplemental payment equal to the amount (if any) by which the [PPS] amount * * * exceeds the amount of the payments provided under the [MCO-FQHC] contract.

42 U.S.C. § 1396a(bb)(5)(A). This Court is the first to consider whether § 1396a(bb)(5)(A) permits a state to stop making the wraparound payments and to instead delegate to MCOs the responsibility, in its entirety, of paying FQHCs at the PPS rate. However, a number of courts have interpreted this provision of the Medicaid Act in cases challenging a state's *method* of providing wraparound payments. The courts in these cases have been unanimous in concluding that, "[u]nder the Medicaid statute, the State is, indeed, responsible for reimbursement of the *entire* PPS rate for *all* Medicaid-eligible encounters." *New Jersey Primary Care*, 722 F.3d at 539 (emphasis added). As the Second Circuit has stated, the Medicaid Act "imposes an absolute burden on the state to reimburse FQHCs for the entirety of their reasonable costs." *Shah*, 770 F.3d at 154. *See also id.* at 153 ("[T]he State has a clear responsibility to make a supplemental payment in the case of services furnished by a[n] FQHC."); *Douglas*, 738 F.3d at 1013 ("[T]he statute plainly requires state plans to pay for services furnished by FQHCs* * * * [T]he statute imposes a mandatory obligation, stating that the state plan "*shall* provide for payment for services."); *Three*

Lower Counties, 498 F.3d at 303 ("By opting into a managed care system, the State cannot avoid its responsibility to reimburse FQHCs at the full PPS amount."); *Health Ctr., Inc. v. Rullan*, 397 F.3d 56, 62 (1st Cir. 2005) ("[S]tates must pay FQHCs a supplemental or wraparound payment to make up the difference between what the MCO is paying the FQHC and what the FQHC is entitled to via the detailed PPS methodology.").

The Court agrees with the conclusion reached by these courts. While § 1396a(bb)(5)(A) allows a state to require that MCOs offset the cost of reimbursing FQHCs at the PPS rate, the statutory provision states in no uncertain terms that "the State plan *shall* provide for payment to the center or clinic *by the State*." 42 U.S.C. § 1396a(bb)(5)(A) (emphasis added). The statute thus makes clear that the obligation to ensure that FQHCs are paid the PPS rate ultimately rests with the state and the state alone. "Whether or not the MCO makes a payment, the State is responsible for the supplemental payment (which may in fact be the entire PPS rate, if the MCO fails to make a payment)." *Cmty. Healthcare Assoc. of New York v. New York State Dep't of Health*, 921 F. Supp. 2d 130, 145 (S.D.N.Y. 2013), *aff'd in part, vacated in part on other grounds, remanded sub nom. Shah*, 770 F.3d at 129.

Two of the cases cited above are particularly illuminating on the question of whether a state may refuse to ensure that it will make a payment in the event that the MCO payment falls short of the PPS rate. *Shah* and *New Jersey Primary Care* both considered whether

§ 1396a(bb)(5)(A) permits a state reimbursement system in which the state would make wraparound payments only on Medicaid claims "for which an MCO has paid an FQHC." *Shah*, 770 F.3d at 153; *see also New Jersey Primary Care*, 722 F.3d at 539-542 (discussing "[New Jersey's] refusal to make wraparound payments on claims for which the MCO has not paid a FQHC"). In neither case did the state go so far as to shift the PPS payment obligation entirely onto the MCOs, as Texas has done. But the states' policies did reduce the states' reimbursement responsibility, namely by making the MCO "the final arbiter of whether a claim is Medicaid eligible" and thus of whether a wraparound payment is necessary. *Id.* at 155. Both the Second and Third Circuits held that such a delegation of the state's PPS payment obligation violates § 1396a(bb)(5)(A). *Shah*, 770 F.3d at 156; *New Jersey Primary Care*, 722 F.3d at 542-43. These reimbursement policies ran afoul of the Medicaid Act because "[t]he state * * * cannot simply shift its reimbursement obligations to MCOs." *New Jersey Primary Care*, 722 F.3d at 540-41; *see also Shah*, 770 F.3d at 156. The same principle applies here, but with even more force. The state plans at issue in *Shah* and *New Jersey Primary Care* at least maintained the general wraparound framework established in § 1396a(bb)(5)(A). Texas, by contrast, has abandoned the state's wraparound obligation altogether.

Even assuming that a state may require MCOs to reimburse FQHCs at a rate higher than the individual negotiated rate, the state plan must, at a minimum,

maintain a mechanism by which the state will pay an FQHC the PPS amount in the event that an MCO fails to pay, or pays below, the PPS rate. In replacing SPA 10-61 with SPA 16-02, Texas eliminated from its state plan precisely this mechanism. The "fact that there is no mechanism by which FQHCs are reimbursed for services actually furnished under MCO contract and not paid by the MCO is * * * in clear contravention of the plain language of [§] 1396a(bb)(5)." *Cmty. Healthcare Assoc. of New York*, 921 F. Supp. 2d at 145; *see also Shah*, 770 F.3d at 129 (finding that New York's reimbursement policy violates § 1396a(bb)(5)(A) "because the risk of non-payment by an MCO now has no remedy"). The fact that MCOs are "the primary avenue for payment * * * cannot relieve the state of its specific burden to ensure payment to FQHCs" at the PPS rate. *Shah*, 770 F.3d at 157.

The State contends that the fact that Legacy "received 100 percent of its PPS rate from TCHP while Legacy contracted with TCHP" supports the conclusion that the State "did not unlawfully delegate its obligations under the Medicaid Act." Def.'s Reply 4; *see also* Def.'s Mot. Summ. J. 38-41 ("Section 1396a(bb) does not require states to create policies or programs leading to supplemental payments where no deficiency or discrepancy [in PPS payment] exists."). But the fact that a particular FQHC received full PPS payments from a certain MCO during a particular period is irrelevant to the question of whether the State's

reimbursement policy violates § 1396a(bb).[15] This is because the statute specifically requires state plans to provide for the potential situation in which an FQHC does *not* receive a full PPS payment from an MCO. A state plan that even "raise[s] the *possibility* that FQHCs will 'be left holding the bag,' [is] a clearly impermissible result given that * * * the State has a clear responsibility to make a supplemental payment in the case of services furnished by an FQHC." *Shah*, 770 F.3d at 153 (quoting *New Jersey Primary Care*, 722 F.3d at 541) (emphasis added). It is the "*risk* that FQHCs will bear the cost of non-payment by MCOs" that is "impermissible" under the statute. *Id.* (emphasis added); *see also id.* at 155 (finding that § 1396a(bb)(5)(A) prohibits a state plan that creates "the potential for FQHCs to be reimbursed neither by MCOs, nor New York for services they provide."); *New Jersey Primary Care*, 722 F.3d at 542 ("MCOs often deny payments for reasons unrelated to Medicaid * * *

[15] While not relevant to the merits question of § 1396a(bb) liability, the issue of whether Legacy received full PPS payments certainly might be relevant to the question of remedies as well as to the question of standing, specifically, whether Plaintiff has suffered an injury-in-fact. On the issue of standing, the Court ruled in its July Memorandum & Order that Legacy had suffered an injury-in-fact sufficient for standing not based on underpayment for particular claims, but rather based on TCHP's termination of its contract with Legacy, which, the Court found, bore a sufficient causal nexus to the State's requirement that TCHP pay the full PPS amount. Mem. & Order, July 2, 2015, at 6-8. Although Defendant reasserts arguments on the issue of standing in its Motion for Summary Judgment, nothing in the parties' briefing or the summary judgment record changes the Court's ruling that Plaintiff does have standing.

e.g., MCO delays, multiple visits in different locations in the same day, and visits with non-primary care physicians" such that MCOs "inevitably exclude valid, Medicaid-eligible encounters and result in underpayment."). Under § 1396a(bb)(5)(A), the state plan must provide for an administrative process by which FQHCs can recover payment of the PPS rate *from the state* for any valid Medicaid claim for which an MCO has failed to pay or for which the MCO's payment is less than the PPS rate. A state plan lacking such a process cannot "be squared with the clear intent of Congress to ensure that Section 330 [grants] do not end up subsidizing state Medicaid programs." *Shah*, 770 F.3d at 155. Accordingly, to the extent that Defendant's reimbursement policy lacks such a process, it must be enjoined. *See Shah*, 770 F.3d at 157 (affirming district court injunction ordering the state to create "the necessary procedural mechanism to ensure that FQHCs would have the opportunity to seek redress in the event of non-payment.").

C. May a state require that MCOs pay the full PPS rate rather than a negotiated rate?

Distinct from the question of whether a state must guarantee reimbursement at the PPS rate is the question of whether a state may in the first instance require that MCOs pay FQHCs the full PPS amount. Thus the Court must return to the first step of the *Chevron* analysis. The Court finds that, as to this

second question, the text of the Medicaid Act is "silent or ambiguous." *Chevron*, 467 U.S. at 843.

The question of whether a state may mandate full PPS payment by MCOs implicates both § 1396a(bb)(5)(A) and its companion provision, § 1396b(m)(2)(A)(ix), which states:

> such contract [between the state and the MCO] provides, in the case of an [MCO] that has entered into a contract for the provision of services with a Federally-qualified health center or a rural health clinic, that the [MCO] shall provide payment that is not less than the level and amount of payment which the [MCO] would make for the services if the services were furnished by a provider which is not a Federally-qualified health center or a rural health clinic.

42 U.S.C. § 1396b(m)(2)(A)(ix). Nowhere in this provision, nor elsewhere in the Medicaid Act, is there language that explicitly prohibits a state from demanding that MCOs pay FQHCs 100 percent of the PPS amount. Section 1396b(m)(2)(A)(ix) provides that a state must require MCOs to pay FQHCs "not less than" what the MCO would pay a non-FQHC for the same services. It is clear that this language "imposes a floor" on the rates that MCOs must pay FQHCs and that this floor is pegged at the market rate. *Three Lower Counties*, 498 F.3d at 305. It is also clear that the Medicaid Act contemplates the possibility that MCOs might reimburse FQHCs at a rate above this minimum requirement. The statute provides that the state's

wraparound payment shall equal "the amount *(if any)* by which the [PPS rate] exceeds" the MCO's payment to the FQHC, 42 U.S.C. § 1396a(bb)(5)(A) (emphasis added), thereby recognizing that an MCO's payment might, in some instances, equal the PPS amount. What the Medicaid Act does not expressly address, however, is *who* may raise the MCOs' payment above the statutory market-rate floor: may the states do so or only the MCOs themselves? Defendant contends that the states are permitted to require that MCOs pay an amount above the market rate. Plaintiff, in contrast, contends that "[a]n MCO may, in its own discretion pay more, but it cannot be forced by the state to do so." Pl.'s Supp. Br. 4. The statute simply does not say.

Because the Medicaid Act is "silent or ambiguous with respect to [this] specific issue," the Court must defer to the agency's decision so long as it is "based on a permissible construction of the statute." *Chevron*, 467 U.S. at 843. Under this deferential standard, "a court reviewing an agency action may not substitute its own judgment for that of the agency." *Louisiana Environmental Action Network v. E.P.A.*, 382 F.3d 575, 581-82 (5th Cir. 2004). Rather, the court's inquiry is limited to determining "whether the agency action 'bears a rational relationship to the statutory purposes' and [whether there is] 'substantial evidence in the record to support it.'" *Id.* (quoting *Texas Oil & Gas Ass'n v. E.P.A.*, 161 F.3d 923, 934 (5th Cir. 1998)). "Consistent with § 706 of the Administrative Procedure Act ("APA"), [the court will] reverse only where the agency's construction of the statute is 'arbitrary,

capricious, an abuse of discretion, or otherwise not in accordance with law.'" *Id.* (quoting 5 U.S.C. § 706(2)(A)). Here, in approving SPA 16-02, CMS implicitly adopted the view that the payment provisions of the Medicaid Act allow states to mandate, as Texas has, that MCOs pay FQHCs 100 percent of the PPS amount. For the reasons set forth below, the Court finds that this is not a permissible interpretation of the Medicaid Act. The only reasonable interpretation of the statute, when reading the payment provisions as a whole and in light of the legislative history,[16] is as follows: the *only* FQHC reimbursement obligation that a state may impose on MCOs is the requirement that MCOs pay "not less than" the market rate; the state must then pay FQHCs whatever wraparound payment is necessary to equal the PPS rate. Because the State cannot raise MCOs' payment obligation above the statutory floor, the State cannot require that MCOs pay the full PPS rate if the PPS rate would be more than the market rate.

As with all issues of statutory interpretation, the appropriate place to begin is with the text itself.

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[16] It is a "fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme." *Davis v. Michigan Dept. of Treasury*, 489 U.S. 803, 809 (1989). "A court must therefore interpret the statute 'as a symmetrical and coherent regulatory scheme,' and 'fit, if possible, all parts into an harmonious whole.'" *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000) (quoting *Gustafson v. Alloyd Co.*, 513 U.S. 561, 569 (1995) and *FTC v. Mandel Brothers, Inc.*, 359 U.S. 385, 389 (1959)).

Hamilton v. United Healthcare of Louisiana, Inc., 310 F.3d 385, 391 (5th Cir. 2002). Defendant argues that the words "if any" in § 1396a(bb)(5)(A) must authorize states to require full PPS payment by an MCO, "[o]therwise, the '*if any*' language would be superfluous because there would *always* be a supplemental payment." Def.'s Reply 5; *see also* Def.'s Mot. Summ. J. at 39. This interpretation is erroneous. To be sure, the purpose of the words "if any" is to account for the possibility that an MCO's payment to an FQHC might equal the PPS rate. Contrary to Defendant's interpretation, however, what the statute contemplates as giving rise to a situation where the MCO payment equals the PPS rate is not that the state would mandate such an equivalence, but rather that the rate negotiated between the MCO and the FQHC might equal the PPS rate. As the Second Circuit has explained: "if an FQHC contracts with an MCO, and *under this contractual arrangement an MCO pays the FQHC for services at a rate that is less than the PPS rate*, the FQHC must still be made whole by the state." *Shah*, 770 F.3d at 137. Every reading of § 1396a(bb)(5)(A) in the caselaw confirms that the purpose of the phrase "if any" is not to allow states to require that MCOs pay the full PPS amount, but rather simply to make clear that states are relieved of the duty to make wraparound payments in the event that an MCO, in its discretion, agrees to pay an amount equal to the PPS rate. *See, e.g.*, *Rullan*, 397 F.3d at 62 ("A problem arises when the MCO contract with the FQHC gives the FQHC less than the amount of compensation it is supposed to get according to the detailed per visit PPS reimbursement method

outlined above. Congress has dealt with this problem by providing that states must pay FQHCs a supplemental or wraparound payment to make up the difference between what the MCO is paying the FQHC and what the FQHC is entitled to via the detailed PPS methodology."); *New Jersey Primary Care*, 722 F.3d at 530 ("A frequent problem * * * occurs in a managed care system: the contracted-for payment from the MCO to the FQHC for a Medicaid-covered patient encounter is often less than the amount the FQHC is entitled to receive under the PPS. In this situation, the Medicaid statute requires the state to make a supplemental payment—the wraparound payment—at least once every four months, to make up the difference between the PPS rate and the MCO payment.").

The meaning of the last word of § 1396a(bb)(5)(A)—"contract"—makes plain why Defendant's proposed construction of the words "if any" is untenable. The payment provisions of the Medicaid Act govern two distinct contractual relationships: the contract between the state and MCOs and the contract that MCOs in turn enter into with FQHCs. If the State's interpretation of the statute were correct, the "contract" in § 1396a(bb)(5)(A) would, logically, have to refer to the contract between the state and MCOs: the words "if any" would, then, absolve the state of its duty to make wraparound payments in the event that the PPS rate equals the amount that the MCO is obligated, by the terms of its contract with the state, to pay FQHCs. But it is indisputable that the contract to which § 1396a(bb)(5)(A) refers is that between the

MCO *and the FQHC*. *See* 42 U.S.C. § 1396a(bb)(5)(A) ("a contract between the center or clinic and a managed care entity"); *see also Cmty. Health Care Assocs.*, 921 F. Supp. 2d at 145 (holding that "the phrase 'payments provided under the contract' permits" a state to deduct from its payment obligation only the amounts "actually paid by the MCO" pursuant to its contract with the FQHC) (emphasis removed); *Concilio de Salud Integral de Loiza, Inc. v. Perez-Perdomo*, 551 F.3d 10, 14 (1st Cir. 2008). Because the contract referred to is that between the MCO and the FQHC, it is clear that the only purpose of "if any" is to release states of the obligation to make wraparound payments in the unlikely event (hence the parentheses around "if any") that the MCO and FQHC decide to contract at a price equal to the PPS rate.

Congress's use of the precise words "payment * * * *by the State*" in § 1396a(bb)(5)(A) further demonstrates that the payment provisions prohibit a state from requiring that MCOs pay the full PPS amount. The State contends that the payment provisions only entitle FQHCs to receive reimbursement at the PPS rate, but do not entitle FQHCs to receive reimbursement from two different entities, MCOs and the state. However, the statutory language makes quite clear that this is exactly what the statute requires. In several provisions of § 1396a(bb), the statute states that "the State plan shall provide for payment" to FQHCs at the PPS rate. *See, e.g.*, 42 U.S.C. § 1396a(bb)(1); § 1396a(bb)(2). This language arguably does not require the state itself to make any payments to FQHCs,

but rather permits a state to arrange, in its state plan, for a third party to make PPS payments on its behalf. But in § 1396a(bb)(5)(A), Congress was clear: "the State plan shall provide for payment to the [FQHC] *by the State* of a supplemental payment." *Id.* § 1396a(bb)(5)(A) (emphasis added). As the First Circuit, interpreting § 1396a(bb)(5)(A), has held, "[s]ince [the state] uses a managed care system, FQHCs will get Medicaid payments *from two sources*: first, the MCO, and second, a wraparound payment from the Commonwealth." *Rullan*, 397 F.3d at 62 (affirming preliminary injunction requiring the state to make wraparound payments to FQHCs where the state had failed to set up a PPS and make wraparound payments) (emphasis added); *see also New Jersey Primary Care*, 722 F.3d at 540 (3d Cir. 2013) (interpreting "supplemental payment" to mean that the state must make a payment that is "'in addition to' the MCO contractual payment").

This is not a case where the Court must speculate as to whether Congress even considered the issue of whether a state may require that MCOs reimburse FQHCs at the PPS rate.[17] Congress was well aware that one possible framework for the reimbursement structure would be to give states the option to delegate the payment responsibility to MCOs, for this is

[17] *Cf. Tafflin v. Levitt*, 493 U.S. 455, 462 (1990) ("[E]ven if we could reliably discern what Congress' intent might have been had it considered the question, we are not at liberty to so speculate; the fact that Congress did not even consider the issue readily disposes of any argument [as to] Congress[']s unmistakabl[e] inten[t].").

precisely the option that Congress gave the states in § 1396b(m)(2)(A)(vii), just two paragraphs above the ambiguous provision in question, § 1396b(m)(2)(A)(ix). Section 1396b(m)(2)(A)(vii) governs how states must reimburse health care providers for certain services rendered to out-of-network patients—i.e., Medicaid patients enrolled in an MCO with which the provider does not have a contract. The provision requires that providers be reimbursed for out-of-network services when such services are "immediately required due to an unforeseen illness, injury or condition." 42 U.S.C. § 1396b(m)(2)(A)(vii). The provision further specifies that states are permitted to designate "*either the [MCO] or the State* [to] provide[] for reimbursement with respect to those services." *Id.* (emphasis added). As the Second Circuit put it, "Section 1396b(m)(2)(A)(vii) allows the state to contractually allocate to the MCO the obligation to pay for services provided by out-of-network FQHCs." *Shah*, 770 F.3d at 143; *see also Three Lower Counties*, 498 F.3d at 304 ("In plain language, this section requires States to include in their contracts with managed care organizations a provision that requires either the managed care organization or the State to reimburse out-of-network health centers* * * *"). A critical distinction between § 1396b(m)(2)(A)(vii) and §§ 1396b(m)(2)(A)(ix) and 1396a(bb)(5)(A) is that the former applies to all Medicaid providers whereas the latter two provisions impose special requirements that pertain only to

FQHCs.[18] Because Congress expressly authorized states to require that MCOs make full reimbursement payments in a provision governing all providers, and did not use any such language in the provisions governing payment to FQHCs, "[t]he proper inference * * * is that Congress considered the issue of" granting states the authority to pass the reimbursement obligation onto MCOs, "and, in the end, limited [the grant of such authority] to the one[] set forth" in § 1396b(m)(2)(A)(vii). *United States v. Johnson*, 529 U.S. 53, 58 (2000). *See also NLRB v. Bildisco & Bildisco*, 465 U.S. 513, 522-23 (1984) ("Obviously, Congress knew how to draft an exclusion for collective-bargaining agreements when it wanted to; its failure to do so in this instance indicates that Congress intended that § 365(a) apply to all collective-bargaining agreements covered by the NLRA."); *In re Mirant Corp.*, 378 F.3d 511, 522 (5th Cir. 2004). Had Congress wanted to allow states the ability to shift the PPS payment entirely onto the MCOs, Congress would have said so, just as it did in § 1396b(m)(2)(A)(vii).

The Court's conclusion is bolstered by the legislative history of the payment provisions, which reveals a clear congressional intent to constrain states' ability to require that MCOs make payments higher than the market rate. Prior to 1997, when § 1396a(bb)(5) and § 1396b(m)(2)(A)(ix) were added, MCOs were required by the Medicaid Act to reimburse FQHCs "the full

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[18] In addition to FQHCs, §§ 1396b(m)(2)(A)(ix) and 1396a(bb)(5)(A) also apply to Rural Health Clinics (RHCs), but RHCs are of no relevance here.

amount of the 100 percent reasonable cost" of providing services. *See generally New Jersey Primary Care*, 722 F.3d at 540-41; *Shah*, 770 F.3d 129 at 137. With the passage of the 1997 Balanced Budget Amendment ("BBA"),[19] Congress eliminated the requirement that MCOs pay FQHCs at the full, cost-based rate, and instead created the wraparound payment system in which MCOs need only pay FQHCs "not less than" they would pay to non-FQHCs, 42 U.S.C. § 1396b(m)(2)(A)(ix), while the state must make up the difference, *id.* § 1396a(bb)(5). By mandating that MCOs pay the full PPS amount, Texas has, in effect, attempted to return to the very system that Congress decided to repeal when it passed the BBA. Congress's intent in replacing the former system with the wraparound regime was to ensure that FQHCs would not be disadvantaged, relative to non-FQHCs, in their ability to secure contracts with MCOs. *See Shah*, 770 F.3d 129, 137 ("[The BBA] was designed to encourage MCOs to contract with FQHCs for provision of Medicaid services to MCO enrollees."). CMS's own guidance on the implementation of the payment provisions, in its October 1998 State Medicaid Director Letter ("SMDL"), instructed that the purpose of the wraparound requirement was "to assure that MCOs do not perceive or incur any undue burdens when contracting with FQHCs/RHCs versus other providers of care thus creating unintended barriers or disincentives to contract." Health Care Financing Administration, State

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[19] Pub. L. No. 105-33, 111 Stat. 251, formerly codified at 42 U.S.C. § 1396a(13)(c) (1999).

Medicaid Director Letter (October 23, 1998), *available at* https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD102398.pdf [hereinafter October 1998 SMDL]. *See also* Health Care Financing Administration, State Medicaid Director Letter (April 20, 1998), *available at* http://www.medicaid.gov/Federal-Policy-guidance/federal-policy-guidance.html ("Congress intended to encourage contracting between FQHCs/RHCs and MCOs and to remove financial barriers to this contracting.") [hereinafter April 1998 SMDL].[20]

Because Congress's aim was to level the playing field between FQHCs and non-FQ[HC]s in the competition for MCO contracts, the key innovation of the wraparound requirement is that it "allows MCOs to negotiate their own rate for FQHC care of MCO enrollees," just so long as that rate is "not less than" the amount offered to a non-FQHC. *Shah*, 770 F.3d at 150; *see also New Jersey Primary Care*, 722 F.3d at 540

[20] The agency's SMDLs—"like interpretations contained in policy statements, agency manuals, and enforcement guidelines, all of which lack the force of law—do not warrant *Chevron*-style deference." *Christensen v. Harris County*, 529 U.S. 576, 587 (2000). However, such interpretations are "entitled to respect" under *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944), "to the extent that those interpretations have the power to persuade." *Christensen*, 529 U.S. at 587 (internal quotation marks and citation omitted). The courts that have interpreted § 1396a(bb)(5) and enforced its wraparound provision against a state have found persuasive the 1998 SMDLs and have construed § 1396a(bb)(5) to conform with the guidance offered in those SMDLs. *See New Jersey Primary Care*, 722 F.3d at 541; *Shah*, 770 F.3d 129; *id.* at 151-52. This Court agrees with that conclusion. *See* Mem. & Order, July 2, 2015, at 19 ("Ultimately, the Court finds CMS's guidance persuasive, and consistent with the statutory purpose.").

("[T]he BBA removed the responsibility of MCOs to reimburse FQHCs at their cost-based rates as required under the predecessor statute. Rather, MCOs could agree on a contractual reimbursement rate as long as that rate was no less than the amount offered to a non-FQHC."). By departing from the wraparound system and requiring that MCOs pay the full PPS rate, Texas has instituted a system that encourages MCOs to drop FQHCs from their provider networks—as TCHP did of Legacy—thus undermining Congress's intent to safeguard the role of FQHCs providing Medicaid services in managed care systems. *See Rullan*, 397 F.3d at 61 ("The special provisions on FQHC reimbursement reflect the important public health role that these centers play.").

Beyond these many reasons why CMS's approval of SPA 16-02 rests on an impermissible construction of the Medicaid Act, the approval itself bears the traits of an agency decision that is arbitrary and capricious, which further supports the Court's decision not to defer to the agency's approval. *Louisiana Environmental Action Network*, 382 F.3d at 582. The CMS approval contains no explanation or statement of reasons in support of its decision. The failure to explain its decision is of particular concern because the CMS approval contradicts the agency's consistently-stated policy on the question of whether a state may do away with wraparound payments and instead mandate that MCOs reimburse FQHCs at the PPS rate. *See Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 56 (1983) ("While the agency is entitled to

change its views on the acceptability of [a prior policy], it is obligated to explain its reasons for doing so."). CMS's position, as far back as April 1998, has been that the wraparound payment "requirement cannot and should not be delegated to an MCO, and that each State must determine any differences in payment and make up these amounts." *See* April 1998 SMDL. In the agency's October 1998 SMDL, CMS expressly rejected the exact sort of reimbursement scheme that Texas has adopted. CMS wrote that a reimbursement approach in which the state pays MCOs "a capitation payment that includes the State's best estimate of 100 percent of the FQHCs['] reasonable costs" and, "[i]n turn, the MCOs are required to make payments to FQHCs * * * equal to their reasonable costs" is "not consistent with" and "contradictory to" the payment provisions of the Medicaid Act. *See* October 1998 SMDL. In its approval of SPA 16-02, CMS does not even acknowledge, much less explain, its departure from its longstanding position that a state may not shift its wraparound payment obligation onto the MCOs. The Court "cannot uphold [an agency's] decision * * * if it represents an unexplained reversal of past [agency] policy." *Texas Office of Pub. Util. Counsel v. F.C.C.*, 265 F.3d 313, 322 (5th Cir. 2001).

Perhaps the most revealing indication that CMS's approval of the Texas State Plan constitutes an arbitrary and capricious agency decision is that the approval of SPA 16-02 is not only inconsistent with CMS's prior position on the issue of MCO delegation, but is also inconsistent with the position that the

agency has articulated *subsequent* to its approval of SPA 16-02. Just two months after CMS approved the SPA, CMS issued another guidance letter that expressly affirms the validity of the 1998 SMDLs and instructs that states may not "requir[e] that managed care contracts provide FQHCs and RHCs the full PPS reimbursement rate" in the manner that Texas has adopted. *See* Centers for Medicare and Medicaid Services, State Health Official Letter 1-2 (April 26, 2016), *available at* https://www.medicaid.gov/federal-policy-guidance/downloads/smd16006.pdf [hereinafter April 2016 SHO Letter]. Rather, the letter states, a requirement that MCOs pay the full PPS amount is valid only if the state seeking "[t]o accomplish this goal" has satisfied certain "conditions." *Id.* at 2. First, the requirement "that managed care contracts provide FQHCs and RHCs the full PPS reimbursement rate" must be incorporated into the state plan as an "alternative payment methodology (APM)," meaning that it must be "an *optional* alternative to the PPS requirements, including the supplemental payment requirement[]." *Id.* (emphasis added); *see also* 42 U.S.C. § 1396a(bb)(6) (defining "alternative payment methodologies"). Second, the state must "demonstrate that each affected FQHC and RHC has agreed to the APM." *Id.* at 3. And third, the state must "remain responsible for ensuring that FQHCs and RHCs receive at least the full PPS reimbursement rate" and must maintain "reconciliation and oversight processes to ensure that the managed care payments comply with the statutory requirements of the APM." *Id.*

Texas's delegation of the PPS payment responsibility to MCOs does not comply with these conditions for instituting such a delegation. The State's requirement that MCOs reimburse FQHCs at the full PPS rate was not implemented as an "alternative payment methodology" in which FQHCs may elect to participate; rather, it was, and continues to be, mandatory for all FQHCs. Because the requirement was implemented as a rule applicable to all FQHCs, individual FQHCs never had the opportunity to consent to the requirement. And, as was discussed at length above, Texas has eliminated its guarantee that it will make supplemental payments where necessary, and has thereby failed to "remain responsible for ensuring that FQHCs and RHCs receive at least the full PPS reimbursement rate." *Id.*

The Court cannot explain why CMS would have approved of a state plan that CMS had declared inconsistent with the Medicaid Act in its 1998 guidance letters, and that CMS would again declare impermissible just two months after rendering its approval. But it is precisely because CMS's decision lacks rational explanation that the Court cannot defer to it. *See Diaz-Resendez v. I.N.S.*, 960 F.2d 493, 495 (5th Cir. 1992) ("[T]he [agency's] decision may be reversed as an abuse of discretion when it is made without rational explanation, or inexplicably departs from established policies."); *Navarro-Aispura v. I.N.S.*, 53 F.3d 233, 235 (9th Cir. 1995) ("[W]hatever deference is owed to the agency is overcome by the lack of a rational explanation for the agency's decision."). Because the Court does not

defer to CMS's approval of the State's requirement that MCOs pay the full PPS amount, and because the Court further finds that such a requirement violates § 1396a(bb)(5)(A) and § 1396b(m)(2)(A)(ix), this aspect of the State's reimbursement policy must be enjoined.

IV. CONCLUSION

For the reasons set forth above, the Court finds that Plaintiff's Motion for Summary Judgment (Doc. No. 84) should be, and hereby is, **GRANTED IN PART**. Likewise, Defendant's cross-Motion for Summary Judgment (Doc. No. 89) is **DENIED IN PART**. The State's reimbursement policy is hereby enjoined until modified in a manner consistent with this Opinion. The parties are asked to resolve consensually their remaining disputes.

IT IS SO ORDERED.

SIGNED at Houston, Texas on this the 3rd day of May, 2016.

/s/ Keith P. Ellison
HON. KEITH P. ELLISON
U.S. DISTRICT JUDGE

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

LEGACY COMMUNITY HEALTH SERVICES, INC.,	§	
Plaintiff,	§	**CIVIL ACTION NO. 4:15-CV-25**
VS.	§	
DR. KYLE L. JANEK,	§	
Defendant.	§	

MEMORANDUM & ORDER

(Filed Sep. 2, 2016)

I. INTRODUCTION

This case concerns a challenge to certain aspects of the State's administration of its responsibilities under the federal Medicaid Act, 42 U.S.C. § 1396a *et seq*. ("the Medicaid Act" or "the statute"). Plaintiff Legacy Community Health Services ("Plaintiff"), a community health center serving low-income patients in the Houston area, filed this lawsuit to assert its rights under the Medicaid Act. Defendant Dr. Kyle L. Janek[1] is sued in his official capacity as Executive Commissioner of Texas's Health and Human Services Commission

[1] Although Dr. Janek was Executive Commissioner at the time the complaint was filed, Mr. Charles Smith was appointed to the position effective June 1, 2016. As Dr. Janek's successor, Mr. Smith is "automatically substituted as a party." FED. R. CIV. PRO. 25(d).

("HHSC" or "the State"). Legacy claims that HHSC has violated the Medicaid Act with respect to the reimbursement of Legacy for services it provides to Medicaid patients.

In its Memorandum & Order of July 2, 2015 (Doc. No. 66), the Court determined that Plaintiff had stated a claim for relief on two separate theories. First, the Court held that Plaintiff had stated a claim that the State's delegation of its reimbursement responsibility for in-network services to third-party managed care organizations ("MCOs") violates the Medicaid Act. Second, the Court held Plaintiff had stated a claim that the State's process for providing reimbursement for out-of-network services violates the Act. Plaintiff has sought injunctive relief under 42 U.S.C. § 1983 to remedy the alleged shortcomings in Texas's method for providing payments to Legacy for its Medicaid services.

The parties cross-moved for summary judgment pursuant to Federal Rule of Civil Procedure 56. On May 3, 2016, the Court granted summary judgment for Legacy on the issue of whether the State had unlawfully delegated its in-network reimbursement obligation to MCOs, but reserved judgment on Legacy's claim regarding reimbursement for out-of-network services. Mem. & Order, May 3, 2016 [hereinafter May 2016 Opinion] (Doc. No. 119). On May 13, 2016, the Court issued a Notice inviting the Centers for Medicare and Medicaid Services ("CMS") to file a statement of interest on the latter issue. The United States, on behalf of CMS, filed its Statement of Interest (Doc. No. 128) on

July 25, 2016 and both parties have filed briefs in response.[2]

The Court now turns to Legacy's claim that the State's policies for providing reimbursement for out-of-network services violate the Medicaid Act. After considering the Statement by CMS, the parties' arguments, and the applicable law, the Court finds that Plaintiff's Motion for Summary Judgment (Doc. No. 84) should be granted as to the claim that the State has failed to provide reimbursement for services rendered to out-of-network patients in conformity with the Medicaid Act. Likewise, the Court finds that Defendant's cross-Motion for Summary Judgment (Doc. No. 89) should be denied as to this claim.

II. BACKGROUND

A. Federal Statutory Framework

Among the many requirements set forth in the Medicaid Act is one which mandates that states provide payment for Medicaid-covered services rendered by Federally Qualified Health Centers ("FQHCs"), health centers that provide medical care to an underserved population. 42 U.S.C. § 1396d(a)(2)(B)-(C); *id.* § 1396a(bb)(1). Plaintiff is an FQHC. In addition to the Medicaid funds that FQHCs receive from the state, FQHCs are also eligible to receive federal grants under

[2] In HHSC's response to CMS's Statement of Interest, HHSC asks the Court to reconsider the issues ruled on in the May 2016 Opinion. Def.'s Resp. Stmt. Intrst. 1 n.2 (Doc. No. 130). This request is **DENIED**.

Section 330 of the Public Health Services Act. 42 U.S.C. § 254b. The dual sources of FQHC funding—direct federal grants and indirect federal Medicaid dollars filtered through the states—"allows the FQHC to allocate most of its direct grant dollars towards treating those who lack even Medicare or Medicaid coverage." *Cmty. Health Ctr. v. Wilson-Coker*, 311 F.3d 132, 134 n.2 (2d Cir. 2002). To ensure that Section 330 grants are not used to cover the cost of treating Medicaid patients, the Medicaid Act requires that FQHCs collect reimbursement from the state for services provided to Medicaid beneficiaries. 42 U.S.C. § 254b(k)(3)(F).

The Medicaid Act, specifically § 1396a(bb), also governs precisely *how* a state must reimburse FQHCs for Medicaid services. Since 2001, reimbursement payments have been assessed through what is known as the Prospective Payment System ("PPS"). *Id.* § 1396a(bb)(1)-(3). Stated simply, an FQHC's reimbursement from the state is calculated by multiplying the number of Medicaid patient encounters by the average reasonable costs of serving Medicaid patients in 1999 and 2000, adjusted yearly for inflation. *Id.*; *see generally New Jersey Primary Care Ass'n Inc.* v. *New Jersey Dep't of Human Servs.*, 722 F.3d 527, 529 (3d Cir. 2013). The total amount owed by the state to reimburse

an FQHC for a Medicaid patient encounter is referred to as the "PPS rate" or "PPS amount."[3]

Texas, like many states, has chosen to implement Medicaid through a managed care system. Tex. Gov. Code § 533.002. Under a managed care approach, the state administers its Medicaid program by contracting with private-sector managed care organizations ("MCOs") that arrange for the delivery of healthcare services to individuals who enroll with them. 42 U.S.C. § 1396u-2(a)(1). In exchange for its services, an MCO receives from the state a prospective per-patient, per-month payment, called a "capitation" payment, based on the number of patients enrolled in the MCO. The MCO, in turn, contracts with healthcare providers, including FQHCs, to provide services to its enrollees. A provider that has a contract with a certain MCO is an "in-network" provider for that MCO, and services it renders to that MCO's enrollees are known as "in-network services." Inversely, when a provider renders services to a patient enrolled in an MCO with which the provider does not have a contract, such services are "out-of-network."

The reimbursement process differs significantly depending on whether the provider's reimbursement claim is for an in-network or out-of-network service. When an FQHC submits a claim for in-network services, the state does not reimburse the FQHC directly;

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[3] Instead of reimbursing FQHCs on a per-service basis, the statute requires the state to reimburse FQHCs for each visit or "encounter" that they have with a Medicaid patient.

rather, the MCO reimburses the in-network FQHC out of its capitation funds. The Court's May 2016 Opinion focused on the Medicaid Act requirements that govern the in-network FQHC-MCO reimbursement process. As discussed in detail there, the MCO is free to negotiate a rate with the FQHC, so long as the MCO pays the FQHC no less than it would pay to a non-FQHC provider for the same services. If the negotiated rate is lower than the PPS rate, the state must cover the difference by making a supplemental (or "wraparound") payment. *See* 42 U.S.C. § 1396a(bb)(5)(A) (describing the state's reimbursement obligation for services provided "pursuant to a contract between" an FQHC and an MCO).

For out-of-network services, in contrast, the absence of any contract between the MCO and the provider means that, as a general matter, the MCO has no reimbursement obligation to the provider. Although the MCO will have no obligation stemming from a contract with the provider, the MCO may have an obligation to out-of-network providers stemming from the MCO's contract with the state. In fact, under § 1396b(m)(2)(A)(vii) of the Medicaid Act, the state-MCO contract *must* address reimbursement for a certain type of out-of-network services: those that "were immediately required due to an unforeseen illness, injury, or condition" (hereinafter, "clause vii services"). 42 U.S.C. § 1396b(m)(2)(A)(vii).[4] This provision

[4] § 1396b(m)(2)(A)(vii) provides as follows:

> [N]o payment shall be made under this subchapter to a State with respect to expenditures incurred by it for

requires states to designate, in their contracts with MCOs, that either the MCO or the state will pay the out-of-network provider for clause vii services. *Id.* When the out-of-network provider is an FQHC, § 1396a(bb) requires that the FQHC be reimbursed at the PPS rate. *Id.* § 1396a(bb)(1); *Three Lower Counties Cmty. Health Servs., Inc.* v. *Maryland*, 498 F.3d 294, 304 (4th Cir. 2007).

B. Texas's Regime for Out-of-Network Reimbursement

Texas requires that MCOs reimburse providers for certain out-of-network services. This requirement is set forth in HHSC's contracts with MCOs and in various provisions of the Texas Administrative Code. Pursuant to these contractual and regulatory provisions, MCOs are required to reimburse out-of-network providers for "*emergency services*." *See* 1 Tex. Admin. Code § 353.4(c)(1) ("An MCO may not refuse to reimburse an out-of-network provider for emergency services."); *id.*

> payment for services provided by [an MCO] which is responsible for the provision (directly or through arrangements with providers of services) * * * unless * * * such contract provides that, in the case of medically necessary services which were provided (I) to an individual enrolled with the entity under the contract and entitled to benefits with respect to such services under the State's plan and (II) other than through the organization because the services were immediately required due to an unforeseen illness, injury, or condition, either the entity or the State provides for reimbursement with respect to those services.

§ 353.4(c)(2)(B); HHSC-MCO Contract,[5] Section 8.1.3 (Def.'s Appx. 207-08) ("The MCO must provide coverage for Emergency Services to Members 24 hours a day and seven (7) days a week, without regard to prior authorization or the Emergency Service provider's contractual relationship with the MCO."). The term "emergency services" is defined as those services "that are needed to evaluate or [to] stabilize an Emergency Medical Condition." *Id.* at 7 (Def.'s Appx. 32). An "Emergency Medical Condition" is, in turn, defined as:

> [A condition] manifesting itself by acute symptoms and recent onset and sufficient severity * * * such that a prudent layperson * * * could reasonably expect the absence of immediate medical care could result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part; (4) serious disfigurement; or (5) in the case of a pregnant woman, serious jeopardy to the health of the woman or her unborn child.

Id. If a provider seeing an out-of-network patient has provided a service that does not conform with the above definition of "emergency service," then the MCO is only required to provide reimbursement if the MCO has provided "prior authorization" for its enrollee to seek treatment at the out-of-network provider. *Id.* at Sections 8.1.3 & 8.2.2.1; *see also* Pl.'s Mot. Summ. J.

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[5] *See* Def.'s Mot. Summ. J., Attach. 1 to Ex. A (Doc. No. 90-1).

Ex. V. Declaration of Christopher Born[6] ¶ 62 [hereinafter Born Decl.] (Doc. No. 84-23).

C. Factual Background[7]

Legacy is designated as an FQHC for purposes of Medicaid reimbursement and is also a recipient of Section 330 grants. One of the MCOs that contracts with HHSC to provide care to Texas Medicaid recipients is the Texas Children's Health Plan ("TCHP"). Legacy contracted with TCHP from 2009 to 2015 to provide medical care to Medicaid patients enrolled in TCHP. On February 1, 2015, the effective date of termination of TCHP's contract with Legacy, Legacy became an out-of-network provider for TCHP. Born Decl. ¶ 52. Despite the termination of Legacy's contract with TCHP, patients enrolled in TCHP continued to receive Medicaid-covered services from Legacy, and Legacy continued to submit claims to TCHP for these out-of-network services. *Id.* ¶ 63. Between February 1 and August 9, 2015, TCHP denied approximately 6,000 of Legacy's claims for out-of-network services. Def.'s Mot. Summ. J. Ex. H, Rule 30(b)(6) Deposition of Melisa Garcia,[8] 22:13-22 (Doc. No. 89-9). Approximately 2,700 claims were denied "due to a lack of prior authorization for the out-of-network services," Born Decl. ¶ 66, which, in short, means that TCHP denied the claim because it

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[6] Christopher Born is the President of the Texas Children's Health Plan ("TCHP"), an MCO with which Legacy contracted.

[7] The facts stated here are undisputed.

[8] Melisa Garcia is the Vice President of Clinical Business Services at Legacy.

determined that the claim did not fall within the category of "emergency services" and thus reimbursement was not required.

III. LEGAL STANDARD

A motion for summary judgment under Federal Rule of Civil Procedure 56 requires the court to determine whether the moving party is entitled to judgment as a matter of law based on the evidence thus far presented. FED. R. CIV. P. 56(a). Summary judgment is proper if "there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." *Id.* The movant has the burden of establishing that there is no genuine issue of material fact. *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-23 (1986). Once the movant has met its burden, the burden shifts to the nonmovant to show that summary judgment is not appropriate. *Id.* at 325.

The nonmovant "must go beyond the pleadings and designate specific facts showing that there is a genuine issue for trial." *Little* v. *Liquid Air Corp.*, 37 F.3d 1069, 1071 (5th Cir. 1994) (en banc) (citing *Celotex*, 477 U.S. at 325). "This burden will not be satisfied by some metaphysical doubt as to the material facts, by conclusory allegations, by unsubstantiated assertions, or by only a scintilla of evidence." *Boudreaux* v. *Swift Transp. Co., Inc.*, 402 F.3d 536, 540 (5th Cir. 2005) (internal quotation omitted). In deciding a summary judgment motion, the court draws all reasonable inferences in the light most favorable to the

nonmoving party. *Connors* v. *Graves*, 538 F.3d 373, 376 (5th Cir. 2008).

IV. DISCUSSION

The issue of FQHC reimbursement for out-of-network services implicates two different provisions of the Medicaid Act. Section 1396b(m)(2)(A)(vii) governs reimbursement for Medicaid-covered out-of-network services rendered by any provider, whether FQHC or non-FQHC, while § 1396a(bb)(1)-(2) governs reimbursement for any Medicaid-covered service rendered by an FQHC, whether in-network or out-of-network. The Court will address, first, the arguments pertaining to § 1396b(m)(2)(A)(vii) and, second, those pertaining to § 1396a(bb)(1)-(2).

A. § 1396b(m)(2)(A)(vii)

Plaintiff claims that the language Texas has used to implement § 1396b(m)(2)(A)(vii)'s requirement that out-of-network providers be reimbursed for services "immediately required due to an unforeseen illness, injury, or condition" is inadequate under the plain text of that provision. Plaintiff argues that, by defining the category of out-of-network services for which an MCO must provide reimbursement as "emergency services," the State requires MCO reimbursement for a narrower category than is mandated under § 1396b(m)(2)(A)(vii). This argument rests on the premise that the State's category of "emergency services" captures a smaller universe of claims than does § 1396b(m)(2)(A)(vii)'s

category of "immediately required" services. Legacy has offered conclusory assertions that this is so, *see* Pl.'s Mot. Summ. J. 29-30, but no evidence or caselaw to support the alleged discrepancy. Nor has Plaintiff provided any authority for the proposition that compliance with § 1396b(m)(2)(A)(vii) requires that states reproduce verbatim the text of § 1396b(m)(2)(A)(vii) in the state-MCO contract.

Plaintiff's conclusory argument is not sufficient to prove a violation of § 1396b(m)(2)(A)(vii) because it is not obvious, on the face of the statute, that "immediately required due to an unforeseen illness, injury, or condition" represents a category any wider than "emergency services." The few cases interpreting § 1396b(m)(2)(A)(vii) have referred to clause vii services as "emergency services" and "emergency care." *See Three Lower Counties Cmty. Health Servs., Inc.* v. *Maryland*, 498 F.3d 294, 304 (4th Cir. 2007); *Cmty. Health Care Ass'n of New York* v. *Shah*, 770 F.3d 129, 157 (2d Cir. 2014); *Three Lower Counties Cmty. Health Servs., Inc.* v. *Maryland*, No. CIV.A. WMN-10-2488, 2011 WL 31444, at * 19 (D. Md. Jan. 5, 2011), *aff'd*, 490 F. App'x 601 (4th Cir. 2012). Furthermore, both legal and medical dictionaries define "emergency" in terms very similar to those used in § 1396b(m)(2)(A)(vii). *See* BLACK'S LAW DICTIONARY (10th ed. 2014) ("an unforeseen change in circumstances that calls for immediate action to avert, control, or remedy harm"); STEDMAN'S MEDICAL DICTIONARY 582 (27th ed. 2000) ("[a] patient's condition requiring immediate treatment); MERRIAM-WEBSTER'S MEDICAL DESK DICTIONARY 207–08 (1986)

("an unforeseen combination of circumstances or the resulting state that calls for immediate action"). This suggests that the discrepancy between the language Congress used in § 1396b(m)(2)(A)(vii) and the language the State has used to implement the provision may be a distinction without a difference. *See* Pl.'s Mot. Summ. J. Ex. Q, Deposition of Gary Jessee[9] 113:5-10 (Doc. No. 84-18) (stating that the distinction between "immediately required due to unforeseen illness" and "emergency condition" is "semantic[]"). The burden is on Plaintiff to prove otherwise.

To show that the State's policies do not comport with § 1396b(m)(2)(A)(vii), Plaintiff needed to present some evidence that the State's implementation of § 1396b(m)(2)(A)(vii) has caused MCOs to deny payment for out-of-network claims that are properly reimbursable under § 1396b(m)(2)(A)(vii). Plaintiff did provide the Court with three out-of-network claims that TCHP denied for failing to qualify as "emergency services." Pl.'s Mot. Summ. J. Ex. Y (Doc. No. 84-26). These claims sought reimbursement for treating patients with "abdominal pain," *id.* at 4, "acut[e] bronchiolitis," *id.* at 7, and "streptococcal sore throat," *id.* at 10. However, Plaintiff has presented no evidence to show that treatment of these conditions qualifies under § 1396b(m)(2)(A)(vii) as services "immediately required due to an unforeseen illness, injury, or condition."

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[9] Gary Jessee is the Deputy Director of the Medicaid/CHIP Division at HHSC.

There are any number of ways in which Legacy could have demonstrated that, if Texas had used the language of § 1396b(m)(2)(A)(vii) as opposed to its "emergency services" definition, the MCO would have paid Legacy's out-of-network claims. Plaintiff could have presented fact testimony from a claims administrator at TCHP, or expert testimony from an expert in out-of-network claims administration. Or, Plaintiff could have presented evidence that the type of out-of-network claims that were denied by TCHP are granted by MCOs in one of the states that has implemented § 1396b(m)(2)(A)(vii) using the exact wording of the statute. *See, e.g.*, MD. CODE REGS. 10.09.65.20(C)(1) ("[A]n MCO shall reimburse an out-of-network federally qualified health center (FQHC) for services provided to an enrollee that are immediately required due to an unforseen [sic] illness, injury, or condition[.]"). Without any showing of this sort, the Court is not convinced that the State's provisions for out-of-network reimbursement run afoul of § 1396b(m)(2)(A)(vii).

B. § 1396a(bb)(1)-(2)

The fact that Legacy has not demonstrated a violation of § 1396b(m)(2)(A)(vii) does not end the inquiry into whether Texas has satisfied its reimbursement obligations under the Medicaid Act. Because Legacy is an FQHC, the dispositive provision of the Medicaid Act for the issue of out-of-network reimbursement is not

§ 1396b(m)(2)(A)(vii), but rather § 1396a(bb)(1)-(2).[10] Under § 1396a(bb), "the [s]tate is * * * responsible for reimbursement of the entire PPS rate for *all* Medicaid-eligible encounters."[11] *New Jersey Primary Care Ass'n Inc. v. New Jersey Dep't of Human Servs.*, 722 F.3d 527, 539 (3d Cir. 2013); *see also* May 2016 Opinion 16-17 (collecting other cases so holding). Because the state's reimbursement obligation under § 1396a(bb) extends to "*all* Medicaid-eligible encounters," the state bears the responsibility of ensuring that FQHCs receive PPS reimbursement for both in-network and out-of-network Medicaid-covered services. *See* CMS Stmt. Interest 8, 11. As this Court has previously explained, the state has an "obligation [which] flows directly from 42 U.S.C. § 1396a(bb)" to "ensure that FQHCs are actually reimbursed for [out-of-network] services they provide." Mem. & Order, July 2, 2015, at 14.

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[10] In ruling, at the motion to dismiss stage, that Plaintiff had stated a claim to enjoin the State's out-of-network reimbursement policies, the Court made clear that this claim arises under § 1396a(bb), *not* § 1396b(m)(2)(A)(vii). Mem. & Order, July 2, 2015, at 13, 15.

[11] 42 U.S.C. § 1396a(bb) sets forth the state's obligations with respect to "[p]ayment for services provided by Federally-qualified health centers." *See* 42 U.S.C. § 1396a(bb)(1) ("the State plan shall provide for payment for [Medicaid services] furnished by a Federally-qualified health center * * * in accordance with [the PPS methodology]."); *id.* § 1396a(bb)(2) ("[T]he State plan shall provide for payment for * * * 100 percent * * * of the costs * * * which are reasonable and related to the cost of furnishing services."). The provisions of § 1396a(bb) make no distinction between services that an FQHC provides in-network or out-of-network.

When a state delegates to MCOs the task of reimbursing FQHCs for clause vii services—as § 1396b(m)(2)(A)(vii) allows and as Texas has done—the state retains the ultimate responsibility of ensuring that FQHCs receive full PPS reimbursement for all Medicaid-covered services. This responsibility creates two distinct payment obligations for the state as relates to out-of-network services provided by FQHCs. First, in the event that an MCO declines to pay or underpays an FQHC for a valid clause vii claim, the state must make payment to the FQHC at the PPS rate for the clause vii service.[12] *Three Lower Counties*, 498 F.3d at 303-304; *Shah*, 770 F.3d at 157; CMS Stmt. Interest 11-12 ("If an FQHC provides covered services that fall within the scope of [§1396b(m)(2)(A)(vii)], and payment is appropriate thereunder, then the FQHC would be entitled to receive payment for such services at the full PPS amount * * * * [, and], as in the case of in-network services, the State cannot divest itself of [the] responsibility for ensuring that the FQHC receives full payment for this amount."). Second, in the event that an FQHC seeks reimbursement for an out-of-network Medicaid-covered service *that does not fall within the scope of §1396b(m)(2)(A)(vii)*, the state must still

[12] The state could then "bring suit against a non-compliant MCO for breach of contract, unjust enrichment and any other claims as it may see fit." *Cmty. Healthcare Assoc. of New York* v. *New York State Dep't of Health*, 921 F. Supp. 2d 130, 145 (S.D.N.Y. 2013), *aff'd in part, vacated in part on other grounds sub nom. Cmty. Health Care Ass'n of New York* v. *Shah*, 770 F.3d 129 (2d Cir. 2014).

provide the FQHC with the PPS payment. As CMS has explained:

> Consistent with [§ 1396b(m)(2)(A)(vii)], a state could contractually require an MCO to provide for payment of [clause vii] services at the PPS rate. Even if a state were to do so, however, that delegation would not 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 it provides.

CMS Stmt. Interest 12 (emphasis added). *See also Shah*, 770 F.3d at 157 ("The fact that MCOs are the primary avenue for payment for out-of-network emergency care under [the state's] standard contractual arrangements cannot relieve the state of its specific burden to ensure payment to FQHCs under Section 1396a(bb)(2)."); Mem. & Order, July 2, 2015, at 13 n.4 ("[Section] 1396a(bb) * * * create[s] an enforceable right" that "guarantee[s] that FQHCs will be paid at the PPS rate for services provided to Medicaid patients * * * * § 1396b(m) simply addresses whether Legacy should turn first to the MCO or to the state for payment."). In short, "[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." *Shah*, 770 F.3d at 157.

Under these principles, it is clear that HHSC has not satisfied its obligations under § 1396a(bb). It is

undisputed that: (1) Legacy has provided Medicaid-covered services to out-of-network individuals, (2) TCHP has denied payment on claims for such out-of-network services, and (3) Legacy has been left with no payment from the State for the out-of-network services it has provided.[13] Without intervention from the Court, the State will continue to refuse to reimburse Legacy for such services. For the reasons stated above, this is impermissible under § 1396a(bb) and must be enjoined. *See Shah*, 770 F.3d at 153 ("[T]he possibility that FQHCs will 'be left holding the bag,' [is] a clearly impermissible result[.]" (quoting *New Jersey Primary Care*, 722 F.3d at 541)).

The State contends that its approach to out-of-network reimbursement satisfies the Medicaid Act because the State maintains an administrative process by which a provider can challenge an MCO's denial of (or underpayment on) an out-of-network claim. *See* 1 Tex. Admin. Code § 353.4(h). But this administrative review process covers, at most, only the subset of out-of-network services that fall within § 1396b(m)(2)(A)(vii). There remains no procedure by which the State can reimburse FQHCs for Medicaid-covered out-of-network services that do not meet the requirements of § 1396b(m)(2)(A)(vii). The State's failure to provide

[13] The State disputes whether the out-of-network claims for which Legacy seeks reimbursement qualify as clause vii claims, *see* Def.'s Mot. Summ. J. 25, but the State does not dispute that Legacy has out-of-network claims for covered services that have gone unpaid.

PPS payment for this segment of out-of-network services must be enjoined.

V. CONCLUSION

For the reasons set forth above, the Court finds that Plaintiff's Motion for Summary Judgment (Doc. No. 84) should be, and hereby is, **GRANTED IN PART**. Defendant's cross-Motion for Summary Judgment (Doc. No. 89) is **DENIED**. The State's reimbursement policy for out-of-network claims by FQHCs is hereby enjoined until modified in a manner consistent with this Opinion.

IT IS SO ORDERED.

SIGNED at Houston, Texas on this the 2nd day of September, 2016.

/s/ Keith P. Ellison
HON. KEITH P. ELLISON
UNITED STATES
DISTRICT JUDGE

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 16-20691

LEGACY COMMUNITY HEALTH SERVICES, INCORPORATED,

Plaintiff-Appellee

v.

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

Defendant-Appellant

Appeal from the United States District Court
for the Southern District of Texas

ON PETITION FOR REHEARING
AND REHEARING EN BANC

(Filed Mar. 5, 2018)

(Opinion 1/31/18, 5 Cir., ___, ___ F.3d ___)

Before JONES, SMITH, and PRADO, Circuit Judges.

PER CURIAM:

(✓) The Petition for Rehearing is DENIED and no member of this panel nor judge in regular active service on the court having requested that the court be polled on Rehearing En Banc, (FED R. APP.

P. and 5TH CIR. R. 35) the Petition for Rehearing En Banc is also DENIED.

( ) The Petition for Rehearing is DENIED and the court having been polled at the request of one of the members of the court and a majority of the judges who are in regular active service and not disqualified not having voted in favor, (FED R. APP. P. and 5TH CIR. R. 35) the Petition for Rehearing En Banc is also DENIED.

( ) A member of the court in active service having requested a poll on the reconsideration of this cause en banc, and a majority of the judges in active service and not disqualified not having voted in favor, Rehearing En Banc is DENIED.

ENTERED FOR THE COURT:

/s/ Jerry Smith
UNITED STATES CIRCUIT JUDGE

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 16-20691

D.C. Docket No. 4:15-CV-25

LEGACY COMMUNITY HEALTH SERVICES, INCORPORATED,

Plaintiff-Appellee

v.

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

Defendant-Appellant

Appeal from the United States District Court
for the Southern District of Texas

Before JONES, SMITH, and PRADO, Circuit Judges.

JUDGMENT

(Filed Jan. 31, 2018)

This cause was considered on the record on appeal and was argued by counsel.

It is ordered and adjudged that the judgment of the District Court is reversed, and the cause is remanded to the District Court with instruction that Legacy's claim as to SPA 16-02's lack of a requirement to make supplemental "wraparound" payments be

dismissed for want of standing and that judgment be entered for the Commission as to the remaining claims.

IT IS FURTHER ORDERED that plaintiff-appellee pay to defendant-appellant the costs on appeal to be taxed by the Clerk of this Court.

[SEAL]

42 U.S.C.A. § 1396a

§ 1396a. State plans for medical assistance

* * *

(bb)Payment for services provided by Federally-qualified health centers and rural health clinics

(1)In general

Beginning with fiscal year 2001 with respect to services furnished on or after January 1, 2001, and each succeeding fiscal year, 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 and services described in section 1396d(a)(2)(B) of this title furnished by a rural health clinic in accordance with the provisions of this subsection.

(2)Fiscal year 2001

Subject to paragraph (4), for services furnished on and after January 1, 2001, during fiscal year 2001, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center or clinic of furnishing such services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1395*l*(a)(3) of this title, or, in the case of services to which such regulations do not apply, the same methodology used under section 1395*l*(a)(3) of this title, adjusted to take into account any increase or decrease in the scope of

such services furnished by the center or clinic during fiscal year 2001.

(3)Fiscal year 2002 and succeeding fiscal years

Subject to paragraph (4), for services furnished during fiscal year 2002 or a succeeding fiscal year, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to the amount calculated for such services under this subsection for the preceding fiscal year—

(A) increased by the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) applicable to primary care services (as defined in section 1395u(i)(4) of this title) for that fiscal year; and

(B) adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during that fiscal year.

(4)Establishment of initial year payment amount for new centers or clinics

In any case in which an entity first qualifies as a Federally-qualified health center or rural health clinic after fiscal year 2000, the State plan shall provide for payment for services described in section 1396d(a)(2)(C) of this title furnished by the center or services described in section 1396d(a)(2)(B) of this title furnished by the clinic in the first fiscal year in which the center or clinic so qualifies in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of

furnishing such services during such fiscal year based on the rates established under this subsection for the fiscal year for other such centers or clinics located in the same or adjacent area with a similar case load or, in the absence of such a center or clinic, in accordance with the regulations and methodology referred to in paragraph (2) or based on such other tests of reasonableness as the Secretary may specify. For each fiscal year following the fiscal year in which the entity first qualifies as a Federally-qualified health center or rural health clinic, the State plan shall provide for the payment amount to be calculated in accordance with paragraph (3).

(5)Administration in the case of managed care

(A)In general

In the case of services furnished by a Federally-qualified health center or rural health clinic pursuant to a contract between the center or clinic and a managed care entity (as defined in section 1396u-2(a)(1)(B) of this title), the State plan shall provide for payment to the center or clinic by the State of a supplemental payment equal to the amount (if any) by which the amount determined under paragraphs (2), (3), and (4) of this subsection exceeds the amount of the payments provided under the contract.

(B)Payment schedule

The supplemental payment required under subparagraph (A) shall be made pursuant to

a payment schedule agreed to by the State and the Federally-qualified health center or rural health clinic, but in no case less frequently than every 4 months.

(6)Alternative payment methodologies

Notwithstanding any other provision of this section, the State plan may provide for payment in any fiscal year to a Federally-qualified health center for services described in section 1396d(a)(2)(C) of this title or to a rural health clinic for services described in section 1396d(a)(2)(B) of this title in an amount which is determined under an alternative payment methodology that—

(A) is agreed to by the State and the center or clinic; and

(B) results in payment to the center or clinic of an amount which is at least equal to the amount otherwise required to be paid to the center or clinic under this section.

* * *

42 U.S.C.A. § 1396b

§ 1396b. Payment to States

Effective: December 13, 2016

* * *

(m) "Medicaid managed care organization" defined; duties and functions of Secretary; payments to States; reporting requirements; remedies

* * *

(2)(A) Except as provided in subparagraphs (B), (C), and (G), no payment shall be made under this subchapter to a State with respect to expenditures incurred by it for payment (determined under a prepaid capitation basis or under any other risk basis) for services provided by any entity (including a health insuring organization) which is responsible for the provision (directly or through arrangements with providers of services) of inpatient hospital services and any other service described in paragraph (2), (3), (4), (5), or (7) of section 1396d(a) of this title or for the provision of any three or more of the services described in such paragraphs unless—

(i) the Secretary has determined that the entity is a medicaid managed care organization as defined in paragraph (1);

(ii) Repealed. Pub.L. 105-33, Title IV, § 4703(a), Aug. 5, 1997, 111 Stat. 495

(iii) such services are provided for the benefit of individuals eligible for benefits under this subchapter in accordance with a contract between the State and the entity under which prepaid payments to the entity are made on an actuarially sound basis and under which the Secretary must provide prior approval for contracts providing for expenditures in excess of $1,000,000 for 1998 and, for a subsequent year, the amount established under this clause for the previous year increased by the percentage increase in the consumer price index for all urban consumers over the previous year;

(iv) such contract provides that the Secretary and the State (or any person or organization designated by either) shall have the right to audit and inspect any books and records of the entity (and of any subcontractor) that pertain (I) to the ability of the entity to bear the risk of potential financial losses, or (II) to services performed or determinations of amounts payable under the contract;

(v) such contract provides that in the entity's enrollment, reenrollment, or disenrollment of individuals who are eligible for benefits under this subchapter and eligible to enroll, reenroll, or disenroll with the entity pursuant to the contract, the entity will not discriminate among such individuals on the basis of their health status or requirements for health care services;

(vi) such contract (I) permits individuals who have elected under the plan to enroll with the entity for provision of such benefits to terminate

such enrollment in accordance with section 1396u-2(a)(4) of this title, and (II) provides for notification in accordance with such section of each such individual, at the time of the individual's enrollment, of such right to terminate such enrollment;

(vii) such contract provides that, in the case of medically necessary services which were provided (I) to an individual enrolled with the entity under the contract and entitled to benefits with respect to such services under the State's plan and (II) other than through the organization because the services were immediately required due to an unforeseen illness, injury, or condition, either the entity or the State provides for reimbursement with respect to those services,[7]

(viii) such contract provides for disclosure of information in accordance with section 1320a-3 of this title and paragraph (4) of this subsection;

(ix) such contract provides, in the case of an entity that has entered into a contract for the provision of services with a Federally-qualified health center or a rural health clinic, that the entity shall provide payment that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a provider which is not a Federally-qualified health center or a rural health clinic;

(x) any physician incentive plan that it operates meets the requirements described in section 1395mm(i)(8) of this title;

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[7] So in original. The comma probably should be a semicolon.

(xi) such contract provides for maintenance of sufficient patient encounter data to identify the physician who delivers services to patients and for the provision of such data to the State at a frequency and level of detail to be specified by the Secretary;

(xii) such contract, and the entity complies with the applicable requirements of section 1396u-2 of this title; and

(xiii) such contract provides that (I) covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the entity shall be subject to the same rebate required by the agreement entered into under section 1396r-8 of this title as the State is subject to and that the State shall collect such rebates from manufacturers, (II) capitation rates paid to the entity shall be based on actual cost experience related to rebates and subject to the Federal regulations requiring actuarially sound rates, and (III) the entity shall report to the State, on such timely and periodic basis as specified by the Secretary in order to include in the information submitted by the State to a manufacturer and the Secretary under section 1396r-8(b)(2)(A) of this title, information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to individuals eligible for medical assistance who are enrolled with the entity and for which the entity is responsible for coverage of such drug under this subsection (other than covered outpatient drugs that under subsection (j)(1) of section 1396r-8 of this title are not subject to the requirements of

that section) and such other data as the Secretary determines necessary to carry out this subsection.

* * *

42 U.S.C.A. § 1396d

§ 1396d. Definitions

Effective: December 13, 2016

* * *

(a) Medical assistance

The term "medical assistance" means payment of part or all of the cost of the following care and services or the care and services themselves, or both (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1) of this section, if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title) not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, who are—

* * *

(2) * * * **(C)** Federally-qualified health center services (as defined in subsection (*l*)(2) of this section) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan;

* * *

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* * *

(*l*) Rural health clinics

* * *

(2)(A) The term "Federally-qualified health center services" means services of the type described in subparagraphs (A) through (C) of section 1395x(aa)(1) of this title when furnished to an individual as an[2] patient of a Federally-qualified health center and, for this purpose, any reference to a rural health clinic or a physician described in section 1395x(aa)(2)(B) of this title is deemed a reference to a Federally-qualified health center or a physician at the center, respectively.

* * *

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[2] So in original. Probably should be "a".

42 U.S.C.A. § 1395x

§ 1395x. Definitions

Effective: February 9, 2018

* * *

(s) Medical and other health services

The term "medical and other health services" means any of the following items or services:

(1) physicians' services;

(2)(A) services and supplies (including drugs and biologicals which are not usually self-administered by the patient) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills (or would have been so included but for the application of section 1395w-3b of this title);

* * *

(10)(A) pneumococcal vaccine and its administration and, subject to section 4071(b) of the Omnibus Budget Reconciliation Act of 1987, influenza vaccine and its administration; and

(B) hepatitis B vaccine and its administration, furnished to an individual who is at high or intermediate risk of contracting hepatitis B (as determined by the Secretary under regulations);

* * *

(aa) Rural health clinic services and Federally qualified health center services

(1) The term "rural health clinic services" means—

(A) physicians' services and such services and supplies as are covered under subsection (s)(2)(A) of this section if furnished as an incident to a physician's professional service and items and services described in subsection (s)(10) of this section,

(B) such services furnished by a physician assistant or a nurse practitioner (as defined in paragraph (5)), by a clinical psychologist (as defined by the Secretary) or by a clinical social worker (as defined in subsection (hh)(1) of this section), and such services and supplies furnished as an incident to his service as would otherwise be covered if furnished by a physician or as an incident to a physician's service, and

(C) in the case of a rural health clinic located in an area in which there exists a shortage of home health agencies, part-time or intermittent nursing care and related medical supplies (other than drugs and biologicals) furnished by a registered professional nurse or licensed practical nurse to a homebound individual under a written plan of treatment (i) established and periodically reviewed by a physician described in paragraph (2)(B), or (ii) established by a nurse practitioner or physician assistant and periodically reviewed and approved by a physician described in paragraph (2)(B),

when furnished to an individual as an outpatient of a rural health clinic.

(2) The term "rural health clinic" means a facility which—

(A) is primarily engaged in furnishing to outpatients services described in subparagraphs (A) and (B) of paragraph (1);

(B) in the case of a facility which is not a physician-directed clinic, has an arrangement (consistent with the provisions of State and local law relative to the practice, performance, and delivery of health services) with one or more physicians (as defined in subsection (r)(1) of this section) under which provision is made for the periodic review by such physicians of covered services furnished by physician assistants and nurse practitioners, the supervision and guidance by such physicians of physician assistants and nurse practitioners, the preparation by such physicians of such medical orders for care and treatment of clinic patients as may be necessary, and the availability of such physicians for such referral of and consultation for patients as is necessary and for advice and assistance in the management of medical emergencies; and, in the case of a physician-directed clinic, has one or more of its staff physicians perform the activities accomplished through such an arrangement;

(C) maintains clinical records on all patients;

(D) has arrangements with one or more hospitals, having agreements in effect under section 1395cc of this title, for the referral and admission

of patients requiring inpatient services or such diagnostic or other specialized services as are not available at the clinic;

(E) has written policies, which are developed with the advice of (and with provision for review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more physician assistants or nurse practitioners, to govern those services described in paragraph (1) which it furnishes;

(F) has a physician, physician assistant, or nurse practitioner responsible for the execution of policies described in subparagraph (E) and relating to the provision of the clinic's services;

(G) directly provides routine diagnostic services, including clinical laboratory services, as prescribed in regulations by the Secretary, and has prompt access to additional diagnostic services from facilities meeting requirements under this subchapter;

(H) in compliance with State and Federal law, has available for administering to patients of the clinic at least such drugs and biologicals as are determined by the Secretary to be necessary for the treatment of emergency cases (as defined in regulations) and has appropriate procedures or arrangements for storing, administering, and dispensing any drugs and biologicals;

(I) has a quality assessment and performance improvement program, and appropriate procedures for review of utilization of clinic services, as the Secretary may specify;

(J) has a nurse practitioner, a physician assistant, or a certified nurse-midwife (as defined in subsection (gg) of this section) available to furnish patient care services not less than 50 percent of the time the clinic operates; and

(K) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are furnished services by the clinic.

For the purposes of this subchapter, such term includes only a facility which (i) is located in an area that is not an urbanized area (as defined by the Bureau of the Census) and in which there are insufficient numbers of needed health care practitioners (as determined by the Secretary), and that, within the previous 4-year period, has been designated by the chief executive officer of the State and certified by the Secretary as an area with a shortage of personal health services or designated by the Secretary either (I) as an area with a shortage of personal health services under section 330(b)(3) or 1302(7) of the Public Health Service Act, (II) as a health professional shortage area described in section 332(a)(1)(A) of that Act because of its shortage of primary medical care manpower, (III) as a high impact area described in section 329(a)(5) of that Act, or (IV) as an area which includes a population group which the Secretary determines has a health professional shortage under section 332(a)(1)(B) of that Act, (ii) has filed an agreement with the Secretary by which it agrees not to charge any individual or other person for items or services for which such individual is

entitled to have payment made under this subchapter, except for the amount of any deductible or coinsurance amount imposed with respect to such items or services (not in excess of the amount customarily charged for such items and services by such clinic), pursuant to subsections (a) and (b) of section 1395*l* of this title, (iii) employs a physician assistant or nurse practitioner, and (iv) is not a rehabilitation agency or a facility which is primarily for the care and treatment of mental diseases. A facility that is in operation and qualifies as a rural health clinic under this subchapter or subchapter XIX of this chapter and that subsequently fails to satisfy the requirement of clause (i) shall be considered, for purposes of this subchapter and subchapter XIX of this chapter, as still satisfying the requirement of such clause if it is determined, in accordance with criteria established by the Secretary in regulations, to be essential to the delivery of primary care services that would otherwise be unavailable in the geographic area served by the clinic. If a State agency has determined under section 1395aa(a) of this title that a facility is a rural health clinic and the facility has applied to the Secretary for approval as such a clinic, the Secretary shall notify the facility of the Secretary's approval or disapproval not later than 60 days after the date of the State agency determination or the application (whichever is later).

(3) The term "Federally qualified health center services" means—

> **(A)** services of the type described in subparagraphs (A) through (C) of paragraph (1) and

preventive services (as defined in section 1395x(ddd)(3) of this title); and

(B) preventive primary health services that a center is required to provide under section 330 of the Public Health Service Act,

when furnished to an individual as an outpatient of a Federally qualified health center by the center or by a health care professional under contract with the center and, for this purpose, any reference to a rural health clinic or a physician described in paragraph (2)(B) is deemed a reference to a Federally qualified health center or a physician at the center, respectively.

(4) The term "Federally qualified health center" means an entity which—

(A)(i) is receiving a grant under section 330 of the Public Health Service Act, or

(ii) (I) is receiving funding from such a grant under a contract with the recipient of such a grant, and (II) meets the requirements to receive a grant under section 330 of such Act;

(B) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant;

(C) was treated by the Secretary, for purposes of part B of this subchapter, as a comprehensive Federally funded health center as of January 1, 1990; or

(D) is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act.

(5)(A) The term "physician assistant" and the term "nurse practitioner" mean, for purposes of this subchapter, a physician assistant or nurse practitioner who performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law), and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.

(B) The term "clinical nurse specialist" means, for purposes of this subchapter, an individual who—

(i) is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed; and

(ii) holds a master's degree in a defined clinical area of nursing from an accredited educational institution.

(6) The term "collaboration" means a process in which a nurse practitioner works with a physician to deliver health care services within the scope of the practitioner's professional expertise, with medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as

defined by the law of the State in which the services are performed.

(7)(A) The Secretary shall waive for a 1-year period the requirements of paragraph (2) that a rural health clinic employ a physician assistant, nurse practitioner or certified nurse midwife or that such clinic require such providers to furnish services at least 50 percent of the time that the clinic operates for any facility that requests such waiver if the facility demonstrates that the facility has been unable, despite reasonable efforts, to hire a physician assistant, nurse practitioner, or certified nurse-midwife in the previous 90-day period.

(B) The Secretary may not grant such a waiver under subparagraph (A) to a facility if the request for the waiver is made less than 6 months after the date of the expiration of any previous such waiver for the facility, or if the facility has not yet been determined to meet the requirements (including subparagraph (J) of the first sentence of paragraph (2)) of a rural health clinic.

(C) A waiver which is requested under this paragraph shall be deemed granted unless such request is denied by the Secretary within 60 days after the date such request is received.

IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

LEGACY COMMUNITY HEALTH SERVICES, INC., Plaintiff, v. DR. KYLE L. JANEK, *et al.*, Defendant.	Civil Action No. 4:15-CV-25 (Filed Jul. 25, 2016)

STATEMENT OF INTEREST OF UNITED STATES

Plaintiff Legacy Community Health Services ("Plaintiff" or "Legacy"), a federally qualified health center ("FQHC"), challenges the state of Texas's policies governing payment to FQHCs that furnish healthcare services to Medicaid beneficiaries. This case does not implicate a dispute over a particular payment amount. This Court invited the Centers for Medicare & Medicaid Services ("CMS" or the "agency"), a component of the Department of Health and Human Services, to be heard on the remaining issue in the case: "[W]hether the Texas Health and Human Service Commission's [THHSC's] * * * policies for providing reimbursement to FQHCs for services rendered to out-of-network patients[1] are consistent with the statutory

[1] In this case, "out of network" patients are those patients who are enrolled in a provider network that does not include Plaintiff.

requirement that out-of-network health centers be reimbursed for 'medically necessary services which were provided * * * because the services were immediately required due to unforeseen illness, injury, or condition[.]' 42 U.S.C. § 1396b(m)(2)(A)(vii)."

The United States now submits this Statement of Interest on behalf of CMS. Although CMS takes no position at this time on the ultimate issue, as framed by the Court, because CMS does not know the specific policies or processes that either THHSC or its managed care organizations have used in evaluating Legacy's claims for payment, CMS does wish to clarify and confirm its position regarding the state's payment obligations to FQHCs that furnish Medicaid-covered services.

BACKGROUND

I. STATUTORY AND REGULATORY BACKGROUND

The Medicaid program is a joint federal-state program in which the federal government assists states in financing the provision of medical assistance to eligible persons. *See* 42 U.S.C. §§ 1396 et seq.; 42 C.F.R. §§ 430.0 et seq. (implementing regulations). The program requires participating states to reimburse healthcare providers that provide covered services to Medicaid enrollees.

FQHCs are community health centers that provide medical care to under-served populations,

regardless of a patient's ability to pay. 42 U.S.C. § 1396d(a)(2)(B)-(C); *id.* § 1396a(bb)(1). Because of the unique role of FQHCs in the provision of federally subsidized healthcare, the Medicaid statute includes special provisions governing the manner in and rate at which a state must pay FQHCs for Medicaid services. *See* 42 U.S.C. § 1396a(bb). From 1989 through 2000, the statute required FQHCs to be reimbursed for "100 percent * * * of [each FQHC's] costs which are reasonable." 42 U.S.C. § 1396a(a)(13)(C)(repealed 2000). In 2001, to relieve FQHCs of having to submit cost data each year, a new prospective payment system (PPS) was implemented, in which FQHCs are paid based on average historical costs plus an annual adjustment reflecting certain economic index data. *Id.* § 1396a(bb)(1)-(3). The amount owed to an FQHC for a particular Medicaid patient encounter is thus known as the "PPS rate" or the "PPS amount."

Many states, including Texas provide some or all of that state's healthcare coverage of Medicaid-eligible individuals by contracting with managed care organizations (MCOs). Under such an arrangement, private MCOs arrange for the delivery of healthcare services to Medicaid beneficiaries who enroll with them. *Id.* § 1396u-2(a)(1). In exchange for its services, a contracting MCO receives from the state a per-person, per-month payment, called a "capitation" payment per Medicaid-eligible enrollee. A state agency (in this case, THHSC) makes a capitation payment to the MCO periodically on behalf of each Medicaid-eligible individual enrolled, regardless of whether the particular

Medicaid-eligible enrollee receives services during the period covered by the capitation payment. *See* 42 C.F.R. § 438.2. The MCO in turn contracts with healthcare providers—including but not limited to FQHCs—to provide services to the MCO's Medicaid enrollees. The managed care model permits an MCO to negotiate more favorable payment rates for services furnished by healthcare providers pursuant to a contract with the MCO ("in-network services").

Because it allows negotiation of more favorable rates for in-network services, the managed care model often results in a negotiated rate with in-network providers (including in-network FQHCs) that is less than the PPS amount that the statute requires FQHCs to be paid for their services to Medicaid beneficiaries. Congress addressed this problem by requiring states to pay FQHCs a supplemental or "wrap-around" payment to cover the difference between what the MCO paid the FQHC and what the FQHC is entitled to be paid under the Medicaid statute (i.e., the PPS rate). Thus, for services provided "pursuant to a contract" between an FQHC and an MCO, § 1396a(bb)(5)(A) generally requires the state to pay the difference (if any) between the amount paid by the MCO and the PPS rate.

In the managed care context, Medicaid beneficiaries are typically required to obtain services from in-network providers, but under certain circumstances, the Medicaid statute also provides for payment to out-of-network providers for their services to Medicaid-eligible individuals. For example, 42 U.S.C.

§ 1396u-2(b)(2) describes covered emergency out-of-network services. The Medicaid statute also states that the contract between the state and the MCO must provide that "in the case of medically necessary services which were provided (I) to an individual enrolled with the entity under the contract and entitled to benefits with respect to such services under the State's plan and (II) other than through the organization [i.e., out-of-network] because the services were immediately required due to an unforeseen illness, injury, or condition, either the entity or the State provides for reimbursement with respect to those services." 42 U.S.C. § 1396b(m)(2)(A)(vii) * * *.

II. FACTUAL AND PROCEDURAL BACKGROUND

Plaintiff is an FQHC. Defendant is the executive commissioner of the Texas Health and Human Services Commission, the state agency charged with administering the Medicaid program in Texas (the "State" or "Defendant"). From 2009-2015, Plaintiff provided in-network services to Texas Medicaid beneficiaries pursuant to a contract with one of the MCOs that contracts with the State, the Texas Children's Health Plan. In 2015, that MCO terminated its contract with Plaintiff. Thereafter, Plaintiff continued to provide some services to the MCO's Medicaid-eligible enrollees, albeit on an out-of-network basis. As noted above, the Medicaid statute requires that either the state or the MCO provide payment for out-of-network services that are "immediately required due to an

unforeseen illness, injury, or condition." *See id.* § 1396b(m)(2)(A)(vii).

Plaintiff sued the State under 42 U.S.C. § 1983, claiming that the State, in administering its Medicaid managed care program, had not complied with statutory payment obligations to FQHCs. In July 2015, the court denied the State's motion to dismiss the latest version of the complaint, *See* 2d Am. Compl., rejecting various grounds for dismissal, including lack of standing, ripeness, lack of any cause of action under 42 U.S.C. § 1983, and failure to state a claim. *See Legacy Cmty. Health Servs., Inc.* v. *Janek*, No. 4:15-CV-25, 2015 WL 4064270 (S.D. Tex. July 2, 2015). The Court found that Plaintiff had stated a proper claim for relief on two theories. First, Plaintiff claimed that the State had improperly delegated to the MCO the State's responsibility to pay FQHCs the full PPS amount for in-network services (in this case, services the FQHC provided while it was a contract provider within the MCO's provider network). Second, Plaintiff claimed that the State's process for providing payment for out-of-network services violates the Medicaid statute. *See id.* at *7.

In May 2016, the court granted judgment in favor of Plaintiff on the in-network services claim, while reserving decision on the second claim regarding out-of-network services provided by a (non-contract) FQHC. *See Legacy Cmty. Health Servs., Inc.* v. *Janek*, ___ F. Supp. 3d ___, 2016 WL 1752748 (S.D. Tex. 2016) (attached at Tab C). As to the in-network services claim, the Court found that the State had improperly

delegated to the MCO the State's obligation to pay FQHCs the full PPS amount for services provided pursuant to the contract between Legacy and the MCO. *See id.* at *8. The Court also found that the State had improperly required the MCO to bear the full cost of the PPS rate, so that the State would not have to make wraparound payments under 42 U.S.C. § 1396a(bb)(5)(A). *See id.* at *10-14. In so finding, the Court rejected the State's argument that, because CMS had recently approved a 2016 state plan amendment, or "SPA 16-02," that contained the challenged policies, those polices should be afforded *Chevron* deference. *See id.* at *13-14. The court found that CMS's approval of SPA 16-02 was not entitled to deference because the SPA policies on in-network FQHC payment were contrary to the Medicaid statute, and contrary to CMS's own guidance letters. *Id.* at *14 ("The Court cannot explain why CMS would have approved of a state plan that CMS had declared inconsistent with the Medicaid Act in its 1998 guidance letters, and that CMS would again declare impermissible just two months after rendering its approval. But it is precisely because CMS's decision lacks rational explanation that the Court cannot defer to it.").

Thereafter, the court invited CMS to be heard on the remaining claim, which challenged the State's policies regarding payment/reimbursement for out-of-network services. The Court framed the issue as follows: "[W]hether the Texas Health and Human Service Commission's * * * policies for providing reimbursement to FQHCs for services rendered to out-of-network

patients are consistent with the statutory requirement that out-of-network health centers be reimbursed for 'medically necessary services which were provided * * * because the services were immediately required due to unforeseen illness, injury, or condition[.]' 42 U.S.C. § 1396b(m)(2)(A)(vii).".

DISCUSSION

The United States submits this statement of interest to confirm and clarify CMS's views regarding the State's obligations to pay for covered services furnished by FQHCs in the managed care context. Although CMS takes no position on the validity of Texas's policies because CMS does not know the specific policies and processes the State or its contracting MCOs have used in evaluating Legacy's claims for payment, CMS does wish to confirm its view that FQHCs that furnish Medicaid-covered services to Medicaid-eligible individuals enrolled in a managed care plan must be paid for such services, and such payment should be made in an amount that is at least equal to the full PPS rate in accordance with the provisions of 42 U.S.C. § 1396a(bb).[2] In that regard, CMS generally agrees with courts, including this Court, that have held that a state may not absolve itself of ultimate

[2] We note that CMS has issued no authoritative guidance addressing the question whether services covered under § 1396b(m)(2)(A)(vii) are the same as emergency out-of-network services, which we understand may be part of the dispute between the parties.

responsibility to ensure that FQHCs receive the full PPS amount for such services.

Indeed, CMS recently affirmed this position in a letter to state health officials, providing guidance on FQHC payment methodologies under Medicaid managed care delivery systems. *See* Centers for Medicare and Medicaid Services, State Health Official Letter 1-2 (April 26, 2016), *available at* https://www.medicaid.gov/federal-policy-guidance/downloads/smd16006.pdf ("April 2016 SHO Letter"). As CMS made clear, FQHCs "are entitled to receive payment for providing covered services to Medicaid-eligible individuals under a Prospective Payment System (PPS) methodology." *Id.* at 2 (citing 42 U.S.C. § 1396a(bb)). The "basic requirements" of this methodology are set forth in § 1396a(bb)(2) through (4). *Id.* At the same time, § 1396a(bb)(6) sets forth an option for a state and FQHC to agree to an "alternative payment methodology (APM)," so long as that methodology provides "for payment of at least the same amount as would otherwise be required under the PPS." *Id.* Finally, where FQHC services are furnished through Medicaid managed care programs," § 1396a(bb)(5) "requires that state plans provide for supplemental payments from states to FQHCs * * * equal to the amount or difference between the payment under the PPS methodology and the payment provided under the managed care contract." *Id.* The purpose of such supplemental payments—or "wraparound" payments—"is to ensure that FQHCs * * * continue to receive their full PPS reimbursement rate regardless of the Medicaid delivery

system, in light of the traditional flexibility for capitated managed care plans to set provider payment rates." *Id.*

Read as a whole, the provisions of § 1396a(bb) make clear Congress's intent that FQHCs receive payment of the full PPS amount for covered services provided to Medicaid-eligible individuals. The state may not divest itself of ultimate responsibility to ensure that such payments are made, nor may it force the FQHC to bear the costs of improper non-payment (or underpayment) by the MCO. States must administer the Medicaid program in accordance with federal law. *See*, *e.g.*, *Cmty. Health Care Ass'n of New York* v. *Shah*, 770 F.3d 129, 153-58 (2d Cir. 2014) (citing § 1396a(bb), and holding that states must retain ultimate responsibility for ensuring that FQHCs are paid at the PPS rate for covered out-of-network services). And as a result, a state therefore may not divest itself of responsibility to ensure that FQHCs are paid the full PPS amount for covered services. This would be true regardless of whether the covered services in question were furnished on an in-network or out-of-network basis.

I. IN-NETWORK SERVICES

As noted above, where FQHC services are furnished "pursuant to a contract" with an MCO, § 1396a(bb)(5) generally requires states to make "supplemental payments" to FQHCs to cover any difference between the negotiated, in-network rate and the full

PPS amount. 42 U.S.C. § 1396a(bb)(5); *see also* April 2016 SHO Letter, at 2. Alternatively, a state and an FQHC may agree to an "alternative payment methodology (APM)," so long as that methodology "results in payment" to the FQHC "of an amount which is at least equal" to the PPS amount. 42 U.S.C. § 1396a(bb)(5); April 2016 SHO Letter, at 2 (APM must provide "for payment of at least the same amount as would otherwise be required under the PPS"). An APM functions as an "optional alternative to the PPS requirements" of § 1396a(bb)(1) through (5), including the supplemental payment requirements. *Id.* Thus, a state, such as Texas, could eliminate the need for supplemental payments under § 1396a(bb)(5) through a properly implemented APM under § 1396a(bb)(6), so long as: (1) the state and FQHC agree to use the APM; and (2) the APM results in the FQHC receiving at least the full PPS amount that would be required under § 1396a(bb). *See id.* at 2-3. *See also* 42 U.S.C. § 1396a(bb)(6)(A) & (B).

As a general matter, CMS agrees with this Court, and with the cases cited the Court's opinion, that where § 1396a(bb)(5) applies, it does not permit states to simply do away with their obligation to make supplemental payments. *See Legacy* 2016 WL 1752748, at *8-9. However, as the SHO letter and text of § 1396a(bb)(6) make clear, the state *could* properly achieve this result by implementing an APM, so long as the state secures agreement from affected FQHCs, and ensures full payment by the MCO to the FQHCs within the MCO's network of at least the PPS amount.

April 2016 SHO Letter, at 2-3. *See also* 42 U.S.C. § 1396a(bb)(6)(A) & (B). A properly implemented APM would render inapplicable the mandatory supplemental payments under § 1396a(bb)(5), because § 1396a(bb)(6) explicitly authorizes such alternative methodologies "[n]otwithstanding any other provision of this section." A properly implemented APM would also permit the State to require the MCO to pay FQHCs the full PPS amount. *See Legacy*, 2016 WL 1752748, at *9-14. Indeed, such a requirement would be necessary if the APM were intended to eliminate the need for supplemental payments, because the statute requires that the APM result in a payment that is "at least equal to" the full PPS amount that would be required under the section. *See* 42 U.S.C. § 1396a(bb)(6)(B).

For this reason, and because CMS approved SPA 16-02 as an APM under § 1396a(bb)(6), CMS respectfully disagrees with this Court's finding that such approval was arbitrary and capricious, or contrary to the Medicaid statute and/or * * * to the agency's own guidance. Toward the end of its opinion, the Court alluded to the April 2016 SHO letter and to the possibility that an APM could require the MCO to make full payment of the PPS amount, but the Court found that SPA 16-02 did not satisfy the requirements for such an APM. *See Legacy*, 2016 WL 1752748, at *13 (citing April 2016 SHO Letter and 42 U.S.C. § 1396a(bb)(6)(B) and stating, *inter alia*, that affected FQHCs were not given the opportunity to consent to the delegation). CMS takes no position at this time regarding whether,

as a factual matter, the State's APM, as implemented with respect to Legacy, fully complies with § 1396a(bb)(6). However, CMS respectfully submits that any failure to comply—if there is one—would indicate that the State had not properly implemented the APM, not that CMS's approval of the SPA was contrary to the Medicaid statute and/or arbitrary and capricious. CMS approved the SPA that effectuates the APM, but the SPA itself would not typically reflect the consent and/or agreement of affected FQHCs. We understand that CMS received assurances from the State that affected FQHCs had agreed to the payment methodology.

Perhaps more importantly, while a properly implemented APM would allow the state and the FQHC to avoid the need for regular supplemental payments under § 1396a(bb)(5), this would not mean that the state is absolved of responsibility to ensure that FQHCs receive the full PPS amount for covered services. To the contrary, the statutory provision that authorizes an APM makes clear that the APM is valid only if it "results in payment" to the FQHC "which is at least equal" to the PPS amount that would otherwise be required under § 1396a(bb). *See id.* § 1396a(bb)(6)(B). The absence of a plan provision requiring wraparound payments does not absolve the State of its obligation under the Medicaid statute to ensure compliance with this requirement. Or as CMS explained in the April 2016 SHO Letter, "states would remain responsible for ensuring that FQHCs * * * receive at least the full PPS reimbursement rate." *Id.* To that end, CMS continued,

"[s]tates must continue their reconciliation and oversight processes to ensure that the managed care payments comply with the statutory requirements of the APM." *Id.* Thus, the state remains ultimately responsible for ensuring that FQHCs providing covered in-network services are paid the full PPS rate, even if supplemental payments are no longer required under § 1396a(bb)(5)(A). In the event the MCO fails to pay the full PPS amount, the State itself is responsible for ensuring that the FQHC is made whole.

II. OUT-OF-NETWORK SERVICES

The same basic conclusion would apply to covered out-of-network services (if any) furnished by FQHCs to Medicaid-eligible individuals enrolled in the MCO's plan. As this Court and others have recognized, § 1396b(m)(2)(A)(vii) requires the contract between a state and an MCO to provide for either the MCO or the State to pay out-of-network providers for services that are "medically necessary" and "immediately required due to unforeseen illness, injury, or condition." 42 U.S.C. § 1396b(m)(2)(A)(vii). If an FQHC provides covered services that fall within the scope of this provision, and payment is appropriate thereunder, then the FQHC would be entitled to receive payment for such services at the full PPS amount. *See* 42 U.S.C. § 1396a(bb). Moreover, as in the case of in-network services, the State cannot divest itself of responsibility for ensuring that the FQHC receives full payment for this amount.

Again, Congress made clear in § 1396a(bb) that FQHCs must receive the full PPS amount for covered services provided to Medicaid-eligible individuals, 42 U.S.C. § 1396a(bb), which would include properly claimed out-of-network services that fall within the scope of § 1396b(m)(2)(A)(vii). In this respect, CMS agrees with this Court that "[s]tates have a general obligation to ensure that FQHCs receive '100 percent * * * of the costs * * * which are reasonable and related to the cost of furnishing services,'" *Legacy*, 2015 WL 4064270, at *8 (citing 42 U.S.C. § 1396a(bb)(2)), which in recent years is the full PPS amount. And as noted above, even if the state were to implement an alternative payment methodology, it must ensure that this methodology "results in payment to the [FQHC] of an amount which is at least equal" to the PPS amount. 42 U.S.C. § 1396a(bb)(6)(B).

To be clear, the Medicaid statute provides that *either* the state *or* the MCO must provide for payment for out-of-network services that are "immediately required due to unforeseen illness, injury, or condition." Consistent with this provision, a state could contractually require an MCO to provide for payment of such out-of-network services at the PPS rate. Even if a state were to do so, however, that delegation would not 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 it provides. In this respect, CMS agrees with the reasoning of the Second Circuit, that if the existing arrangement "stops short of ensuring full repayment" to FQHCs for covered

out-of-network services, "then it does not comport with the statute." *Shah*, 770 F.3d at, 157. Thus, in the event the MCO fails to properly pay the FQHC the full PPS amount, under circumstances when it is required to do so, the State must ensure that the FQHC receives the PPS amount for Medicaid-covered services, even when those services are rendered out-of-network. *See, e.g.*, *id.* at 157-58 (citing § 1396a(bb)), and holding that states must retain ultimate responsibility for ensuring that FQHCs are paid at the PPS rate for out-of-network services); *Three Lower Ctys. Cmty. Health Servs.* v. *Maryland*, 498 F.3d 294, 303-04 (4th Cir. 2007) (same).[3]

Although CMS believes the State must ensure that FQHCs receive the full PPS payment for Medicaid-covered services, CMS takes no position at this time as to whether the State's existing policies fall short of that obligation. Specifically, CMS takes no position as to "whether the [State's] * * * policies for providing reimbursement to FQHCs for services rendered to out-of-network patients are consistent with the statutory requirement that out-of-network health centers be reimbursed for 'medically necessary services which were provided * * * because the services were immediately required due to unforeseen illness, injury, or condition[.]' 42 U.S.C. § 1396b(m)(2)(A)(vii)." That question, CMS believes, would likely turn on subsidiary issues, both factual and legal, which do not appear to be well-developed on the current record, and

[3] The State could presumably seek redress from the MCO.

which may be better addressed in the context of a concrete dispute, involving a particular claim for payment for particular disputed services.

CONCLUSION

Accordingly, the United States respectfully asks this Court to consider the views expressed in this Statement of Interest.

Dated: July 25, 2016 Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on July 25, 2016, I filed the foregoing electronically through the CM/ECF system, which caused all parties to be served by electronic means.

/s/ Peter Bryce
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