No. 18–40

IN THE

Supreme Court of the United States

LEGACY COMMUNITY HEALTH SERVICES, INCORPORATED,

Petitioner,

v.

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

Respondent.

ON PETITION FOR WRIT OF CERTIORARI FROM THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF OF AMICI CURIAE PUBLIC HEALTH SCHOLARS IN SUPPORT OF PETITIONER

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INTEREST OF *AMICI CURIAE*[1]

Amici are the Dean and members of the faculty at the Milken Institute School of Public Health at the George Washington University. One of the preeminent schools of public health in the United States, the School is committed to excellence in scholarship to advance local, national, and global community health.

The School is home to the Geiger Gibson Program in Community Health Policy. Established in 2004, the Geiger Gibson Program is named after Drs. H. Jack Geiger and Count Gibson, founders of the nation's community health center movement and pioneers in public health and human rights. The Geiger Gibson Program focuses on the history, contributions, and impact on health and health care of the nation's community health centers and the well–being of the patients and medically underserved urban and rural communities they serve. The Program manages a rich research agenda through the Geiger Gibson/RCHN Community Health Foundation Research Collaborative, which focuses on national health policy in the context of medically underserved populations and communities.

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[1] In accordance with Supreme Court Rule 37.2(a), parties' counsel of record consented to the filing of this *amicus* brief after receiving timely notice on July 26, 2018. Pursuant to Supreme Court Rule 37.6, counsel for *amici* state that this brief was not authored, in whole or in part, by counsel to a party, and no monetary contribution to the preparation or submission of this brief was made by any person or entity other than *amici* or their counsel.

Participating scholars write as experts in public health law and policy and do not express the formal views of the University. Together, they have a shared interest in the legal and policy issues affecting community health centers and bring a national perspective to the issues at the core of this case. They are uniquely positioned to speak to the history and origin of community health centers, the central role community health centers play in serving low–income and medically underserved communities, and the potential effects of a major shift in health care financing policy on health centers' stability and community–wide access to care.

The *amici* joining this brief are:

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SUMMARY OF ARGUMENT

This appeal is about whether community health centers will be able to continue to care for residents of medically underserved communities to the full extent envisioned by Congress. Community health centers represent the single most important source of comprehensive primary health care for the nation's poorest urban and rural communities, serving all without regard to insurance status or ability to pay.

Recognizing the unique mission of community health centers under Section 330 of the Public Health Service Act ("PHSA") and the modest size of their federal grants, Congress amended Medicaid in 1989 to establish certain requirements regarding coverage of "federally qualified health center services" and payment rules for "federally qualified health centers" ("FQHCs").[2] These coverage and payment provisions were designed to prevent state Medicaid programs from shifting the cost of care for Medicaid enrollees onto limited grants covering the cost of care for the uninsured.

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[2] The term "federally qualified health center" encompasses community health centers that receive operating federal grants under Section 330, as well as entities that meet all Section 330 requirements but are supported through alternative means, such as state and local grants. 42 U.S.C. § 254b(a)(1); 42 U.S.C. § 1396d(l)(2)(B).

In 1997, Congress sought to encourage states to make greater use of managed care as a primary means for organizing care delivery and payment to Medicaid beneficiaries. The importance of community health centers to managed care's success has increased, because of their central role anchoring primary health care—the lynchpin of successful managed care—in poor communities. Today community health centers serve 1 in 6 Medicaid beneficiaries nationally, most of whom are enrolled in managed care.[3]

In encouraging the growth of managed care, Congress struck a balance between market solutions to problems of cost and quality and maintaining the comprehensive, high quality primary care for which health centers are known. The 1997 managed care amendments thus preserved the FQHC coverage and payment rules even as it expanded the use of managed care.

Today, federal law allows managed care organizations ("MCOs") doing business with states to pay community health centers operating in their networks the same discounted rates applicable to other network providers. However, states must make up any difference between MCOs' discounted rate and payment due under the FQHC prospective payment system ("PPS").

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[3] Sara Rosenbaum et al., *Community Health Centers: Growing Importance in a Changing Health Care System* (2018), at 4, http://files.kff.org/attachment/Issue-Brief-Community-Health-Centers-Growing-Importance-in-a-Changing-Health-Care-System.

The law also preserves states' obligations to pay FQHCs, at the PPS rate, for the Medicaid–covered services they furnish to beneficiaries, regardless of whether care is rendered in– or out–of–network. Together, these payment rules promote state flexibility to use managed care, encourage MCOs to include health centers in their provider networks, while at the same time guaranteeing that health centers are paid at the PPS rate for the health care they furnish to Medicaid beneficiaries. This approach ensures that Medicaid managed care does not shift costs flowing from discounted MCO payments onto federal grant funding. This promotes financial stability for community health centers, even in a competitive market environment, so they can continue to comply with their Section 330 mission—to open their doors to the entire community.

The State of Texas upended this balance. It did so by refusing to pay Legacy Community Health Services ("Legacy") in accordance with FQHC payment rules for the out–of–network care it provided in thousands of separate visits by Medicaid managed care enrollees for medically necessary, but non–emergency care. Unless this Court grants review, the decision of the Fifth Circuit Court of Appeals to uphold Texas's policy will place significant financial strain on community health centers like Legacy, thereby limiting the services they are able to offer vulnerable patients with few other primary care options.

Other courts of appeal have correctly hewed to the careful balance struck by Congress between market–

based strategies for health care and the need to preserve stable access to primary care. In contrast, the Fifth Circuit has upset Congress's careful planning. This Court should grant review to ensure that other states do not follow Texas' practice, thereby impairing access to basic health care for medically underserved populations throughout the country.

STATEMENT OF THE CASE

Legacy is a community health center that receives operating grants under Section 330 of the PHSA. For purpose of Medicaid coverage and payment, Legacy is also a FQHC and therefore qualifies for Medicaid payment at the FQHC rate.

Federal law requires the State of Texas to reimburse FQHCs like Legacy for services provided to Medicaid beneficiaries at an amount determined by the Medicaid statute's PPS. 42 U.S.C. § 1396a(bb); 42 U.S.C. § 1396d(a)(2)(C). The Texas Health and Human Services Commission (the "Commission") manages the Texas Medicaid program. The Commission has elected to contract with MCOs, including the Texas Children's Health Insurance Plan ("TCHP"), to serve some of its Medicaid beneficiaries.

In 2009, TCHP contracted with Legacy to include Legacy as part of its provider network. Pursuant to the contract, Legacy and TCHP agreed to a negotiated payment rate, by which TCHP agreed to pay Legacy an amount equal to about 25% of its Medicaid PPS guaranteed by federal statute. *See* Petition for Writ of Certiorari ("Pet.") at 10, Appendix ("App.") at 5–6.

This meant that under Medicaid rules applicable to FQHCs that are part of Medicaid managed care networks, the State would be responsible for paying Legacy the difference between the discounted rate paid by the MCO to Legacy as a network provider and Legacy's PPS rate. 42 U.S.C. § 1396a(bb)(5)(A). In addition, under Medicaid's general FQHC payment rule, the State was obligated to pay Legacy for all covered services in accordance with the PPS rate. This general obligation, 42 U.S.C. § 1396a(bb)(1), is separate from the rule for in–network care furnished by FQHCs.

In 2011, the Commission amended its contract with TCHP and other MCOs to require that MCOs pay Legacy and other community health centers the full PPS rate instead of the negotiated rate. App. 6. The Commission effectively left TCHP with two choices: (1) pay Legacy at the full FQHC PPS rate, which is four times greater than the discounted rate it had agreed to previously, or (2) exclude Legacy as a network provider. Not surprisingly, TCHP chose to terminate its contract with Legacy and removed Legacy from its provider network effective February 2015. App. 7, Pet. 11.

TCHP's termination of Legacy's contract, however, has not stopped TCHP's beneficiaries from continuing to go to Legacy for their health care services. As a Section 330 grant recipient, Legacy cannot turn these patients away—Legacy is required to care for *all* patients regardless of coverage, including TCHP beneficiaries, even though it is no longer a part of TCHP's provider network. 42 U.S.C. § 254b(k)(3). Legacy has continued to serve TCHP patients and

submit claims to TCHP for reimbursement, but TCHP has denied nearly 3,000 claims submitted for out–of–network non–emergency services.[4] App. 7. The Commission has also refused to pay these claims.

Legacy brought suit against the Commission in January 2015, challenging Texas' policy of requiring MCOs to pay community health centers at the PPS rate, and its refusal to pay for out–of–network care. Although Legacy was successful at the District Court, the Fifth Circuit Court of Appeals reversed. As to the first claim, the Fifth Circuit held that the statute says nothing about a state's ability to impose conditions on MCOs that contract with FQHCs for in–network services: "[I]t is fully consistent with § 1396a(bb)(5)(A) for the state to require the contract to reimburse the [community health center] fully." App. 28.

Turning to the State of Texas' refusal to pay for out–of–network care furnished by Legacy to TCHP beneficiaries, the Fifth Circuit interpreted the PPS payment requirement as applicable only to in–network services and emergency out–of–network care. The panel found that it would be "inconsistent" for Congress to guarantee equal reimbursement for in–network and out–of–network services for FQHCs. Instead, the panel asserted, FQHCs "*should* have to

[4] TCHP did pay approximately 3,000 other claims submitted by Legacy, which TCHP determined were emergency services. App. 7. Medicaid MCOs are required to pay emergency out-of-network services to all providers, regardless of whether they qualify for FQHC payments, under a separate section of the Medicaid statute. *See* 42 U.S.C. § 1396b(m)(2)(A)(vii).

contract with … MCOs" in order to be reimbursed for covered Medicaid services. App. 34 (emphasis added).

ARGUMENT

I. MEDICAID'S FEDERALLY QUALIFIED HEALTH CENTER PAYMENT RULES RAISE ISSUES OF NATIONAL IMPORTANCE AFFECTING ACCESS TO HEALTH CARE IN MEDICALLY UNDERSERVED COMMUNITIES.

Medicaid's federally qualified health center payment rules are part of a coordinated national policy spanning the Social Security Act, which establishes Medicaid, and the PHSA, which establishes and authorizes funding for community health centers. Medicaid is a public health insurance program designed to "reimburse [the] costs of medical treatment for needy persons." *Harris v. McRae,* 448 U.S. 297, 301 (1980). Community health centers are publicly supported clinics that care for medically underserved communities and populations. 42 U.S.C. § 254b(e)(1)(A). Congress has recognized for decades that Medicaid and community health centers are inextricably linked.

A. Community Health Centers Play a Critical Role in Delivering Care to Underserved Populations.

Community health centers play a key role in America's health care safety net. Established as a federal pilot program in 1965 by the Office of Economic Opportunity ("OEO"), community health centers provide high–quality, comprehensive primary care in communities designated as "medically underserved." 42 U.S.C. § 254b(a)(1). These communities lack access to medical care either because no primary care physicians are available or because community physicians do not participate in Medicaid.[5] By law, community health centers must serve all residents of medically underserved communities regardless of ability to pay. 42 U.S.C. § 254b(b)(3)(B)(ii).

Community health centers thus care for vulnerable populations. Their patients tend to be poorer, more ethnically and racially diverse and to live in more rural areas than the average private practice patients.[6] Over 90% of community health

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[5] Health Resources & Services Administration, *Medically Underserved Areas and Populations (MUA/Ps)* (October 2016), https://bhw.hrsa.gov/shortage-designation/muap.

[6] Martell Hesketh and Kathleen Dwiel, *Background Note on Federally Qualified Health Centers (FQHC)*, Harvard Medical School Center for Primary Care (March 2017), https://primarycare.hms.harvard.edu/wp-content/uploads/2017/06/FQHC-Note.pdf?submissionGuid=a50c31f1-072d-4a36-9a28-7ca8b3581f16.

center patients have incomes at or below 200% of the federal poverty level ("FPL"), and over 70% have incomes at or below 100% of the FPL.[7] Nationally, nearly one quarter of community health center patients are uninsured. Of those patients who do have insurance, the overwhelming majority receive coverage from Medicaid or other public health programs.[8] Nearly 50% of all community health center patients are enrolled in Medicaid.[9]

These marginalized populations often have elevated health risks. For instance, as compared to the average low–income American, community health center patients have higher rates of diabetes, asthma, and hypertension.[10] Community health center

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[7] National Association of Community Health Centers, *Community Health Center Chart Book* (hereafter, "Chart Book") (June 2018), http://www.nachc.org/wp-content/uploads/2018/06/Chartbook_FINAL_6.20.18.pdf.

[8] Chart Book, *supra* n. 7.

[9] Bureau of Primary Health Care, *2016 National Health Center Data: National Data.*, Table 4, https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2016&state.

[10] Peter Shin et al., *A profile of community health center patients: implications for policy*, Kaiser Commission on Medicaid and the Uninsured (2013), available at http://kff.org/medicaid/issue-brief/a-profile-of-community-health-center-patients-implications-for-policy/. *See also* Hooker E. Hing et al., *Primary health care in community health centers and comparison with office-based practice*, 36 J. OF COMMUNITY HEALTH 406-413 (2013); Lerun L. Shi et al., *Characteristics of Ambulatory Care Patients and Services: A Comparison of*

patients are also more likely to be obese, smokers, or to have one or more chronic health conditions.[11] These increased health risks make access to primary care vitally important.

Despite the difficulties inherent in caring for underserved and poor populations, the community health center model has proven immensely successful.[12] Uninsured people living near a community health center are less likely than other uninsured individuals to have an unmet medical need, visit the emergency room, or experience a hospital stay, and are more likely to have had a general medical visit.[13] By reducing hospital stays and emergency room visits, community health centers improve overall community health while generating significant system–wide savings.[14] Currently, community health centers provide quality, cost–effective health care to approximately 27 million Americans.[15]

Community Health Centers and Physicians' Offices, 21 J. of Health Care for the Poor and Underserved 1169-83 (2010).

[11] Chart Book, supra n. 7.

[12] Michelle Proser, *Deserving the Spotlight: Health Centers Provide High-Quality and Cost-Effective Care*, 28 J. OF AMBULATORY CARE MANAGEMENT 321, 330 (2005).

[13] James Hennessy, *FQHCs and Health Reform: Up to the Task*, 9 Nw. J. L. & Soc. Pol'y 122, 124 (2013).

[14] *Id.*

[15] Chart Book, *supra* n. 7.

B. Community Health Centers Must Meet Stringent Federal Guidelines, Including Provision of Free or Discounted Health Care to Patients.

Congress designed the community health center model to be open to all community residents regardless of ability to pay. To qualify for federal operating grants, community health centers must meet a stringent set of requirements found in Section 330 of the PHSA. 42 U.S.C. § 254b. Under Section 330, community health centers are required to provide patients with a full array of primary care services, and must offer substantial discounts or free care for patients near or below the federal poverty level. 42 U.S.C. §§ 254b(k)(3)(E) & (G)(i)–(iii); 42 C.F.R. § 51c.303(f).

Section 330 also requires community health centers to offer services that assist patients in overcoming common barriers to health care access, such as transportation, patient outreach, interpretation services, insurance enrollment, and home visitation.[16] 42 U.S.C. § 254(a)–(b). These "enabling services" are not found in traditional private practice, but help patients isolated by poverty, disability, or other factors obtain needed care. By combining high quality clinical care with enabling services, community health centers have improved

[16] National Association of Community Health Centers, *Enabling Services* (2016), http://www.nachc.org/wp-content/uploads/2015/06/Enabling_Services_May_2016.pdf.

the health of patients, and the communities in which they serve.[17]

Congress funds community health centers through a combination of strategies. Although grants appropriated pursuant to Section 330 cover some operational costs, community health centers receive the majority of their financing through provision of care to Medicare and Medicaid patients—Medicaid, in particular.

Medicaid alone accounts for almost half (43%) of community health centers' annual operating funds.[18] In 2016, community health centers received $10.3 billion in Medicaid payments—$2.5 billion from payments made under large MCO contracts, $3.6 billion from a more modest form of Medicaid managed care known as primary care case management,[19] and $4.2 billion from services paid for by the traditional Medicaid program. In comparison, Section 330 operating grants accounted for only 19% of community health centers' 2016 operating revenue.[20]

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[17] Hennessy, *supra* n. 13.

[18] Rosenbaum et al, *supra* n. 3, at 1.

[19] Bureau of Primary Health Care, *2016 National Health Center Data: National Data*, Table 9D, https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2016&state=.

[20] The remaining 38% of revenue is a combination of Medicare, private insurance, self-pay, other grants and contracts, and miscellaneous revenue sources. *See* Rosenbaum et al., *supra* n. 3, at 1.

Thus, Medicaid today is the pivotal source of community health center financing.

C. Congress Carefully Calibrated the Relationship between Community Health Centers and Medicaid to Balance Market Solutions and Access to Care.

Since community health centers were first established, policymakers were clear that Medicaid would be the primary funder. In 1967, the OEO, which oversaw the first health center pilots, entered into an agreement with the Department of Health, Education, and Welfare ("HEW") under which OEO would establish 1,000 additional health centers by 1973. For its part, HEW, which administered Medicare and Medicaid, would ensure that Medicaid covered 80% of health centers' annual operating costs.[21]

To foster this relationship, Congress established the community health center program in 1975 as an authority under Section 330 of the PHSA. Section 330 made Medicaid participation a condition of Section 330 funding, in order to prevent community health centers from refusing treatment to Medicaid beneficiaries. 42 U.S.C. § 254b(k)(3)(E)(i)(I).

In 1989, Congress amended Medicaid to create the FQHC coverage and payment rules to align Medicaid policy with the expansion of community health

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[21] Peter Shin et al., *Community Health Centers and Medicaid at 50: An Enduring Relationship Essential for Health System Transformation*, 34 HEALTH AFF. 1096–1104 (2015).

centers and the use of Section 330 grant funds to care for those without insurance.[22] Under the FQHC structure, states must cover FQHC services. 42 U.S.C. § 1396d(a)(2)(C). In addition, states must pay FQHCs for the Medicaid–covered services they furnish in accordance with a formula linked to the reasonable cost of care. 42 U.S.C. § 1396a(bb)(1) and (2). In this way, Medicaid pays for the cost of treating Medicaid beneficiaries, thereby freeing Section 330 grants for costs associated with providing uninsured care.

The 1989 amendments set the payment rate at "100 percent" of the reasonable cost of serving Medicaid enrollees.[23] Congress was explicit that their purpose was to "ensure that [Section 330] grant funds are not used to subsidize health center or program services to Medicaid beneficiaries."[24] Congress remarked:

> The role of the programs funded under Section [] … 330 … is to deliver comprehensive primary care services to underserved populations or areas without regard to ability to pay. To the extent that the Medicaid program is not

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[22] *See generally* Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, (codified at 42 U.S.C. § 1396(a)(13)(C) (repealed by the Benefits Improvement and Protection Act of 2000), codified at 42 U.S.C. § 1396a(bb)(1)).

[23] H.R. Rep. No. 101–247, at 392 (1989), *as reprinted in* 1989 U.S.C.C.A.N. 1906, 2118.

[24] *Id.*

> covering the cost of treating its own beneficiaries, it is compromising the ability of the centers to meet the primary care needs of those without any public or private coverage whatsoever.[25]

The 1989 FQHC amendments thus were the culmination of a quarter century of carefully developed federal policies linking Medicaid and the PHSA in common purpose—care for the most vulnerable—and aimed at creating a sustainable source of primary care in poor communities. The FQHC provisions are stated in absolute terms: "the State plan shall provide for payment for services described in 1396d(a)(2)(C) [federally qualified health center services] furnished by a Federally qualified health center." 42 U.S.C. § 1396a(bb)(1). In other words, States must reimburse federally qualified health centers for services furnished to Medicaid beneficiaries, in accordance with the payment methodology specified in statute.

The FQHC amendments worked. Prior to 1989, state Medicaid programs covered less than 70% of total costs incurred by community health centers for treating Medicaid patients.[26] Today, that number stands at 82%.[27]

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[25] *Id.*

[26] *Id.*

[27] National Association of Community Health Centers, *The Facts About Medicaid's FQHC Prospective Payment System* (2016), http://www.nachc.org/wp-content/uploads/2016/02/PPS-One-Pager-noask-Final.pdf.

Congress' commitment to ensuring that Medicaid supports community health center program goals remained steadfast even when lawmakers expanded states' authority to require enrollment in managed care as a condition of coverage for most beneficiaries. The Balanced Budget Act ("BBA") of 1997 expands state managed care options. *See* Pub. L. No. 105–33 § 4701, 111 Stat. 251, 489–92 (Aug. 5, 1997), codified at 42 U.S.C. 1396u–2. But as part of the amendments, Congress also took steps to explicitly preserve FQHC coverage and payment rules.

First, the BBA amendments spell out MCO contract payment rules with FQHCs, requiring MCOs to pay FQHCs at least as much as would be paid to other providers for similar services. *See* Pub. L. No. 105–33 § 4712, 111 Stat. 509 (Aug. 6, 1997).

Second, the amendments require states to supplement these market–based MCO payments, up to the required FQHC payment rate, that is, to pay the difference if any between what the MCO pays and what the state owes the FQHC under federal payment rules. *Id.* This preserves the FQHC rate for services covered by MCO contracts, even though the MCO itself need pay only its standard market rate. The state remains responsible for making up the difference.

Third, Congress retained the basic 1989 rule that Medicaid programs pay FQHCs for all covered Medicaid services at the required rate. In 2000 Congress revised the original FQHC payment methodology to move to a formula known as the

PPS.[28] But in doing so, lawmakers left untouched the basic relationship between Medicaid managed care and what FQHCs ultimately are owed, as established by the BBA of 1997. States remain obligated to pay FQHCs for the cost of the Medicaid services they furnish. 42 U.S.C. § 1396a(bb)(1). States also remain obligated to make payment supplements to FQHCs under Section 1396a(bb)(5)(a) for the difference, if any, between the MCO payment and the FQHC rate. A state's basic obligation to pay FQHCs for the cost of covered services remains untouched.

The Fifth Circuit's decision misreads the statute and ignores the relationship between Section 330 and the Medicaid program. The panel stated that paying FQHCs for out of network non–emergency services would decrease community health centers "incentive" to participate in managed care arrangements because they would face no "penalty" for failing to do so. App. 33. This reading ignores both the express terms of the statute and Congress' underlying policy intent.

First, as described above, the law states explicitly that states must pay FQHCs for covered services, without qualification. 42 U.S.C. § 1396a(bb)(1).

Second, the incentive for FQHC participation in Medicaid managed care is obvious on the face of the statute. Indeed, the statute explicitly avoids penalizing FQHCs for managed care participation by

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[28] Benefits Improvement and Protection Act of 2000 ("BIPA"), Pub. L. No. 106–554 § 702(a), 114 Stat. 2763, 2763A-572–574 (Dec. 21, 2000), now codified at 42 U.S.C. § 1396a(bb).

preserving FQHC payment rules while at the same time dividing payment responsibility for in–network care between the MCO, which gets to pay competitive rates, and the state, which makes up the difference. This bifurcation avoids disincentivizing MCOs from contracting with FQHCs.

It was Texas itself that disincentivized the integration of FQHCs into managed care, by requiring contracting MCOs to assume full FQHC payment obligations, which in turn led TCHP to exclude Legacy from its network. Texas' actions quadrupled TCHP's payment obligation to Legacy, which in turn caused TCHP to push Legacy out of network. Legacy continued to furnish care pursuant to its own obligations as a Section 330–funded community health center, and Texas then refused to pay for out–of–network care other than emergency care. In essence, Texas created the conditions that led to Legacy's exclusion and then became a free rider on Legacy's Section 330 grant—precisely the result Congress intended to avoid.

II. THE CIRCUIT SPLIT IDENTIFIED IN THE PETITION REFLECTS THE FIFTH CIRCUIT'S DEPARTURE FROM THE BALANCE CONGRESS STRUCK BETWEEN MARKET–DRIVEN CARE AND THE UNIQUE CIRCUMSTANCES OF MEDICALLY UNDERSERVED COMMUNITIES.

The petition compares the decision of the Fifth Circuit with the decisions of other federal courts of appeal and identifies conflicting authority governing

whether § 1396a(bb) requires States to reimburse FQHCs for *all* Medicaid services. Pet. 18–29. These conflicting approaches leave states in the Fifth Circuit with different Medicaid FQHC payment obligations compared to other states across the country. The circuit split also illustrates the Fifth Circuit's fundamental misunderstanding of the relationship between the Medicaid program and Section 330 community health centers on one hand and Medicaid FQHC payment rules and Medicaid managed care on the other.

The Fifth Circuit views Medicaid's general FQHC coverage and payment rules as irreconcilable with Medicaid managed care. Specifically, the panel finds it "inconsistent" that Congress require states to pay health centers for both in–network and out–of–network care and inserts its own policy judgment regarding how to align PHSA with Medicaid payment policy, stating that FQHCs "*should* have to contract with … MCOs" in order to be reimbursed for Medicaid services. App. 34 (emphasis added).

The law contains no such inconsistency. Payment of FQHCs for covered care at the FQHC rate remains bedrock Medicaid policy. Where FQHCs are part of managed care networks, states are expected to follow a bifurcated payment approach, with the MCO paying at its normal discounted rate and the state making up the difference. This compromise—which has worked for decades–ensures primary care stability while allowing managed care companies to contract with FQHCs, not only a high–quality source of primary care, but in many communities, the only such source of care. This approach may modify a fully–market–

driven model. But it accommodates market–oriented solutions through a strategy that keeps a safety feature under primary care financing. The compromise makes sense given the modest size of community health centers' operating grants under Section 330 and their legal obligation under the PHSA to treat all patients regardless of ability to pay. *See* 42 U.S.C. § 254b(k)(3)(G)(iii). Without FHQC payment for Medicaid services furnished to Medicaid beneficiaries, the cost would shift to grants, and the number of patients who could be treated would plummet.

Other courts of appeal have correctly recognized that Congress struck a careful balance between promoting market–based managed care while ensuring that underserved communities have the primary–care infrastructure in place for managed care to succeed. For example, the Fourth Circuit has found that when community health centers are "required to use Section 330 grant funds to subsidize care of its Medicaid patients" it "undermines" the statutory purpose. *Three Lower Counties Cmty. Health Services v. Md. Dep't of Health & Mental Hygiene*, 498 F.3d 294, 303 (4th Cir. 2007). Similarly, the Second Circuit properly understood that the Medicaid program and Section 330 grants together create a "dual funding mechanism" for community health centers that "allows FQHCs to allocate most of its direct grant dollars toward treating those who lack … Medicaid coverage." *Cmty. Health Care Ass'n of N.Y. v. Shah*, 770 F.3d 129, 137 (2nd Cir. 2014). These courts have found that reliance upon a managed care plan does not relieve states of these obligations. *Three Lower Counties*, 498 F.3d at 299; *see also Cmty.*

Health Care Ass'n of N.Y., 770 F. 3d at 148 ("To the extent that out–of–network services constitute a part of the services provided by FQHCs, there *must* be some arrangement by which FQHCs are reimbursed for them") (emphasis added); *N.J. Primary Care Ass'n v. State Dep't of Human Servs.,* 772 F.3d 527, 540 (3rd Cir. 2013) (stating Section § 1396a(bb) "established the primacy of making FQHCs whole").

The Fifth Circuit's misunderstanding of the relationship between Medicaid managed care and Medicaid's FQHC provisions leads to a result that threatens the basic ability of Section 330 grantees to carry out their responsibilities. As the Petition explains in more detail, whereas the Fifth Circuit has declared Section 1396a(bb)(1) payment rules to be inconsistent with Medicaid managed care, other reviewing courts have correctly recognized Congressional intent to align two policies. Pet. 18–22. This tension between the Fifth Circuit and other circuits creates different FQHC payment rules in different circuits and leaves community health centers receiving Section 330 grants exposed to massive uncovered Medicaid costs. This Court should grant certiorari to clarify the single national policy clearly expressed by Congress.

III. THE FIFTH CIRCUIT'S OPINION WILL SIGNIFICANTLY DISRUPT FEDERAL HEALTHCARE RESOURCES IN CONFLICT WITH CONGRESSIONAL INTENT.

Absent review by this court, the Fifth Circuit's decision will limit access to care for patients in medically underserved communities. Although it is difficult to project the exact impact, if Texas' non–payment for out–of–network care policy were adopted nationwide, *amici* project that such a shift would result in reduced care for well over a million patients. Community health centers will struggle to maintain services as they begin to experience significant losses for uncompensated out–of–network care.[29] These losses could grow exponentially as more states and managed care contractors recognize that they can free ride off the statutory obligation of health centers to treat all patients regardless of their ability to pay. *See* 42 U.S.C. § 254b(k)(3)(G)(iii).

The effects on community health centers' financial stability would be profound. As discussed in Part I, Congress intended Medicaid to be the primary funding source for clinics established under Section 330. Today, Medicaid (including Medicaid MCO) reimbursement represents almost half of overall

[29] As discussed above, the decisions of other federal courts of appeal prevent a number of states from adopting a policy similar to the Texas policy in this case. The projection of a nationwide impact is intended to illustrate the conflict between the Fifth Circuit's ruling and Congressional intent.

community health center funding.[30] In 2016, 58% of all health centers reported Medicaid managed care participation,[31] reporting nearly 93.4 million managed care member months that year.[32]

Even in a managed care environment, patients may turn to a community health center that is not in their provider network for many reasons, including access barriers in their own plans, reliance on their local community health center for special needs or because it is open evenings and weekends, or inability to grasp complex network rules.[33] Community health centers are obligated to serve these patients, as they would others.

Under the financial incentives created by the Texas policy, community health centers could experience a surge in non–emergency out–of–network care if they are pushed out of network, as Legacy was. This means increasing cost shift onto Section 330

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[30] *Id.*

[31] Based on health centers who reported any Medicaid managed care member months.

[32] Bureau of Primary Health Care, *2016 National Health Center Data: National Data*, Table 4 https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2016&state

[33] Leighton Ku et al., *Legacy Community Health Services v. Smith: What are the Implications for Community Health Centers and Their Communities?* (2018), https://publichealth.gwu.edu/sites/default/files/downloads/GGRCHN/Legacy%20Community%20Health%20Services%20v%20Smith.pdf.

grants. Because these grants are limited, subject to the whims of the annual federal appropriations process, and intended for care for the uninsured, a major cost–shift would lead to widespread reduction in services, staffing, and patient care capacity.[34]

To evaluate the potential impact of this policy nationally, *amici* looked to the record in *Legacy* as an example. Legacy Community Health is a particularly notable provider of children's mental health care, a service, which compared to primary health care generally, can be relatively costly because of its time and intensity. TCHP paid only 3,000 of the 6,000 claims that Legacy submitted for the various types of out–of–network care it furnished, labeling the paid claims as emergency care. Pet. 11. The State of Texas then refused to pay for the remainder of the claims as required under Section 1396a(bb).

Amici project that community health centers could lose about 50% of their managed care revenue if states moved to adopt the Texas model, thereby encouraging MCOs to exclude health centers from provider networks altogether.

The *amici* created a loss estimate range between one–sixth at the low end and one–third at the high–end.[35] If community health centers lose one–third of

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[34] *See e.g.,* Health Resources and Services Administration (HRSA), Policy Information Notice 2009-05, at 6 (March 23, 2009) ("[A]ll change in scope requests must be fully accomplished with no additional Federal section 330 grant support").

[35] Ku et al., *supra* n. 33.

their managed care revenue, this could amount to $2.0 billion lost. A revenue cut of that magnitude translates into access losses for 2.2 million patients, including 700,000 children and 1.5 million adults. Losses would span all patients, including those insured through Medicare, Medicaid, or private insurance. Large numbers of very low income patients would also see diminished service availability; visits would likely drop by 8.9 million, and staffing losses would amount to about 18,000 full–time equivalent positions.

A more conservative estimate setting the loss to health centers at one–sixth of their Medicaid managed care revenue would translate into a revenue loss of $1.0 billion nationally, with a commensurate reduction of 1.1 million patients nationwide and staffing reductions of about 8,900 FTE positions.

These are precisely the results Congress designed Medicaid to avoid.

CONCLUSION

For the foregoing reasons, *amici* urge this Court to grant the Petition for Writ of Certiorari.

Respectfully submitted,

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