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 TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR COMMUNITY HEALTH CHOICE, INC. AS AMICUS CURIAE IN SUPPORT OF PETITIONER

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CORPORATE DISCLOSURE STATEMENT

Community Health Choice, Inc., by and through its undersigned attorneys and pursuant to Rule 29.6, submits that it is a component unit and affiliate of the Harris County Hospital District (a public hospital system) d/b/a Harris Health System, and is an affiliate of Harris Health. No publicly held company owns more than 10% of its stock.

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INTEREST OF AMICUS CURIAE[1]

Community Health Choice, Inc. (Community) is a non-profit Health Maintenance Organization licensed by the Texas Department of Insurance and is an affiliate of Houston-based Harris County Hospital District, a public hospital system. Community operates as a Managed Care Organization (MCO) to insure over 280,000 people through several programs, including the Medicaid State of Texas Access Reform Program for low income children and pregnant women, the Children's Health Insurance Program for children of low-income parents, and multiple collaborative safety net projects. Community serves its members by providing access to the safety net providers with whom they are familiar, including all of the Federally Qualified Health Centers (FQHCs) in its service areas, Rural Health Centers, and public hospital systems.

Through these programs, Community's mission, which drives the organization, is to improve the health and well-being of underserved residents of Southeast Texas by providing access to coordinated, high-quality, affordable health care and health-related social services, often in Medically Underserved Areas as defined by the Health Resources and Services Administration.

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[1] No party authored this brief in whole or in part, and no one other than amicus, its members, and its counsel made a monetary contribution intended to fund the preparation or submission of this brief. Both parties were provided timely notice and consented to the filing of this Brief. A letter regarding the same is on file with the Clerk of the Court.

Community's members frequently utilize FQHCs due to their location in those underserved areas.

The Fifth Circuit opinion upholding the State's decision significantly impedes Community's ability to serve its members because it prevents Community from being able to fully recoup costs for care that its members receive at FQHCs. For that reason, Community, as an MCO, joins Petitioner, an FQHC, in urging the Court to grant certiorari to review the Fifth Circuit opinion.

SUMMARY OF ARGUMENT

Section 330 of the Public Health Service Act serves a critical function in the nation's health care safety net: it extends federal grants to FQHCs to provide primary medical care to Medicaid and other patients in Medically Underserved Areas, regardless of a patient's ability to pay. By law, FQHCs must treat any patient who walks through the door. Cognizant of that mandate and Medicaid's dual federal–state funding scheme, Congress has repeatedly taken steps to ensure that those grants are not diverted by States to subsidize their own Medicaid obligations.

Organizations like amicus Community occupy an important position within that regime: they support the congressionally mandated role of FQHCs by providing healthcare coverage in underserved communities through relationships with FQHCs. That mission is substantially undermined by the Fifth Circuit's decision affirming the State's refusal to reimburse FQHCs for out-of-network costs because it leaves MCOs like Community and the FQHCs with whom they contract with the burden of

providing care in underserved areas without the congressionally protected benefit of full reimbursement.

The Court should grant certiorari because the Fifth Circuit's decision has dire consequences for those communities. With fewer dollars to spread around, the quantity and quality of health care available to Americans who need it the most will be significantly harmed.

ARGUMENT

I. FEDERALLY-QUALIFIED HEALTH CENTERS SERVE A CRITICAL ROLE IN PROVIDING HEALTH CARE TO UNDERSERVED COMMUNITIES.

A. Texas Is Ground Zero for Medically Underserved Areas and Populations Who Lack Access to Health Insurance and Quality Health Care.

According to the Texas Medical Association, "more than 4.3 million Texans—including 623,000 children—lack health insurance" and Texas is the "uninsured capital of the United States." Texas Medical Association, *The Uninsured in Texas* (April 13, 2018).[2] The Code Red Task Force on Access to Health Care in Texas agrees: "Texas has the highest rate of uninsured in the United States." Code Red, *The Critical Condition of Health in Texas*, at 5 (2015).[3] The ramifications of that gap in care are stark. At least 11,000 deaths per year *in Texas alone* could be prevented if that gap were closed and

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[2] https://www.texmed.org/uninsured_in_texas/.

[3] https://www.utsystem.edu/sites/default/files/documents/Code%20Red%202015/2015-code-red-report.pdf.

Texans had access to quality care. University of Wisconsin Population Health Institute, *County Health Rankings Health Gaps Report 2015*, at 2 (2015).[4]

More broadly, the external burdens created by that gap are substantial. Costs are shifted onto taxpayers via increased use of hospitals and health facilities, and employers and small business owners also shoulder additional costs as insurance premiums increase. *Id.* According to The National Academies, "The costs of direct provision of health care services to uninsured individuals fall disproportionately on the local communities where they reside." The National Academies, *Hidden Costs, Values Lost: Uninsurance in America*, § 3 (2003).[5]

Texas is emblematic of the effects that care gaps have on a national level. Underserved populations have restricted access to insurance and quality care, and, in turn, the communities where they live, including local taxpayers and employers, bear the burden for that lack of coverage.

B. Amicus Community Health Choice, Inc. Works Closely with Federally-Qualified Health Centers to Close the Care Gaps in Texas.

Congress has long attempted to address the care gap through Medicaid and included Section 330 in the Public Health Services Act, 42 U.S.C. § 254b, to ensure that FQHCs received adequate federal funding for fulfilling their federal obligation to take

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[4] http://www.countyhealthrankings.org/sites/default/files/state/downloads/2015TexasHealthGapsReport_0.pdf.

[5] https://www.ncbi.nlm.nih.gov/books/NBK221659/.

anyone who walks through the door, regardless of whether they are "in network" or out. Pet. 2. Section 330 is representative of Medicaid's larger federalist arrangement—states administer Medicaid with oversight and coordination from federal agencies including the Centers for Medicaid and Medicare Services.

While states "are not required to participate in Medicaid," those that opt in "must comply with both the statutory requirements imposed by Medicaid and with regulations promulgated by the Secretary of Health and Human Services." *Cal. Ass'n of Rural Health Clinics v. Douglas*, 738 F.3d 1007, 1010 (9th Cir. 2013). In turn, laws like Section 330 ensure that the federal and state duties are well-defined, and that the States fulfill their part of the bargain in their administration of Medicaid.

Congress specifically created the FQHC designation so that FQHCs would bear the burden of providing health care in places where private services simply do not reach—Medically Underserved Areas—in exchange for funding in the form of *guaranteed* federal grants. Those grants ensure that FQHCs receive their full reimbursement for providing care by receiving a payment for their *actual* costs that were incurred to provide that care (referred to as the prospective payment system (PPS) rate), which is based on historical averages for actual care. 42 U.S.C. §§ 1396a(bb)(2)-(4); *see also* Pet. 7. For FQHCs who contract with MCOs like Community, Congress also required the States to provide supplemental payments to those FQHCs for the difference between their contracted rate with the

MCO and their full PPS rate. 42 U.S.C. § 1396a(bb)(5)(A); *see also* Pet. 8-9.

FQHCs, by law, must be located in Medically Underserved Areas and are the *sole* health-care providers in many of those areas; further, they are the *only* providers with a mandate to provide primary care without regard to ability to pay. Because of its lack of access to care, Texas has more than seventy health centers that receive federal funding under Section 330. Based in part on that longstanding and guaranteed source of funding for FQHCs, MCOs like Community contract directly with FQHCs to serve the MCO's members. Community specifically leverages its relationships with those FQHCs to ensure that its over 280,000 Medicaid members have access to health care, as a substantial portion of those members reside in Medically Underserved Areas. As a safety net health plan, Community's health plans focus on low-income populations below 200% of Federal Poverty Level.

In its role as an MCO, Community contracts with the Health and Human Services Commission to administer the State of Texas Access Reform Program and the Children's Health Insurance Program. The role of Community and similar organizations is especially critical in Texas because of the State's decision to outsource its obligations to MCOs that are responsible for arranging and managing the provision of covered Medicaid services for Medicaid beneficiaries. MCOs are responsible for contracting with the full range of health care providers (for example, primary and specialty care, hospitals, and the like), creating a network of

providers for the members to access for the provision of covered healthcare services.

II. IF *LEGACY* REMAINS IN PLACE, THE ABILITY OF COMMUNITY HEALTH CHOICE, INC. AND FQHCS TO SERVE UNDERSERVED AREAS WILL BE SUBSTANTIALLY DAMAGED.

A. The State's Decision to Defund Out-of-Network Providers Threatens Their Ability to Serve Those Populations That They Are Required to Serve.

The State of Texas has crippled FQHCs' ability to provide health care. The State delegated the payment obligations to MCOs like Community (who contract with, among others, FQHCs) and has now restricted reimbursement by those MCOs to only "in-network" providers. Then, the State's policy has the steerage effect of constructively terminating FQHCs as in-network providers by requiring MCOs to pay FQHCs their full reimbursement rates vis-à-vis the lower, contracted rates. This makes it economically unviable for MCOs to maintain their relationships with FQHCs. The net effect is that FQHCs are now "out-of-network," and the costs they incur for treating anyone who walks through their door—as required by federal law—are not reimbursable under Texas law. *See* Pet. 10-11.

Under the Texas MCO regime, all MCOs (like Community) contract with FQHCs to some extent. Many of the provider-based or safety net health plans have traditionally had significant relationships with those clinics for years, and, as a result, a substantial portion of MCO enrollees, including Community's enrollees, have chosen an

FQHC as their primary care provider. Under the State's requirements (upheld by the Fifth Circuit) that implement a cost-based Medicaid reimbursement methodology for FQHCs, the cost of a primary care provider visit for an enrollee empaneled to an FQHC is often significantly higher than the cost of a primary care provider visit for an enrollee empaneled to a private practice primary care provider.

Paradoxically, the cost for FQHC care can be as much as two or three times the average rate for a private practice primary care provider depending on the reimbursement level associated with each FQHC. Not only does that arrangement fly in the face of the plain statutory language and several circuit opinions, but it completely upends the congressional system of Medicaid federalism that laws like Section 330 were meant to protect. By law, FQHCs must be located in Medically Underserved Areas, which receive that designation precisely because *there is a lack of access to primary health care* in that area. *See* Health Resources & Services Administration, *Medically Underserved Areas & Populations (MUA/Ps)* (2018).[6] Thus, the State has made it impossible for MCOs like Community to utilize the *only* health care providers in areas where Congress has specifically created a designation for those providers and passed Section 330 to allocate (and protect) funding for providing health care in those areas.

A significant number of Community's members are provided services by FQHCs, often as their

[6] https://bhw.hrsa.gov/shortage-designation/muap.

primary care providers. Without the federally required reimbursement through the State, those FQHCs will not be made whole. In turn, neither FQHCs nor organizations like Community will be able to carry out their respective missions. The State's decisions cut the safety net and create the economic effect of significantly increasing the cost of Community's members who receive services from an FQHC vis-à-vis a private practice doctor. In turn, the State's rate adjustments disadvantage MCOs like Community who have a high utilization of FQHCs because those adjustments create the economic incentive for MCOs to terminate their contracts with FQHCs (or otherwise discourage their use because the expense is too high).

B. By Refusing to Disturb the State's Defunding of FQHCs, *Legacy* Will Substantially Harm the Ability to Treat Underserved Patients.

Fortunately, Congress and several circuit courts have been clear that the State's actions are impermissible: FQHCs must be reimbursed for the services they provide, regardless of whether those services are in- or out-of-network. *See* 42 U.S.C. § 1396a(bb); *see, e.g.*, *Cmty. Health Care Ass'n of N.Y. v. Shah*, 770 F.3d 129 (2d Cir. 2014); *N.J. Primary Care Ass'n v. N.J. Dep't of Human Servs.*, 722 F.3d 527 (3d Cir. 2013); *see also* Pet. 18-22. Unfortunately, in the decision below, the Fifth Circuit departed from the congressional mandate and from the other circuit courts by green-lighting the State's functional defunding of FQHCs. *Legacy Cmty. Health Svcs., Inc. v. Smith*, 881 F.3d 358 (5th Cir. 2018).

Not only is the Fifth Circuit's decision contrary to federal law and the decisions of its sister circuits, but it also inhibits the ability of organizations like Community and FQHCs to provide health care in the most-underserved State in the union. At its core, the decision spells disaster with regard to Texas' continued need to address its growing uninsured and underinsured population by limiting the spread of important and precious federal dollars.

Congress created Section 330 to ensure that communities like the ones that Community serves would receive consistent funding, even going so far as providing a Section 1983 private right for FQHCs to enforce their rights to be funded as to the States. 42 U.S.C. §§ 1396a(bb)(1), (5). The Fifth Circuit has departed from the statutory language and intent, and the communities that Community and its partner FQHCs serve are under serious threat of balkanization under this Medicaid system.

CONCLUSION

The petition for certiorari should be granted.

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Respectfully submitted,

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