No. 18-40

In the Supreme Court of the United States

LEGACY COMMUNITY HEALTH SERVICES, INC.,
PETITIONER

v.

CHARLES SMITH, EXECUTIVE COMMISSIONER, TEXAS HEALTH AND HUMAN SERVICES COMMISSION

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

BRIEF IN OPPOSITION

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QUESTION PRESENTED

Whether federally-qualified health centers can collect Medicaid reimbursement funds for treating patients wholly outside a State's Medicaid managed-care network system, and without regard to the Medicaid Act's limited requirement that States ensure payment for out-of-network services of an *emergency* nature.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page

Cases

Constitutional Provisions, Statutes, & Rules

Other Authorities

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STATEMENT

1. Medicaid is a joint federal–state program that provides for medical assistance to low-means individuals. Enacted under Congress's Spending Clause power, Medicaid requires a State that accepts its federal funds to submit, for approval by the federal government, a state plan for medical assistance that meets federal requirements. 42 U.S.C. § 1396-1.

a. "Medical assistance" is a term of art under the Medicaid Act. It includes "payment of part or all of the cost" of specified medical care or services. *Id.* § 1396d(a). So "medical assistance" includes not just care or service, but also the State's payment of money to "the person or

institution providing such care or service." *Id.* § 1396a(a)(32).

Section 1396a thus defines various payment obligations that a state plan must include. For instance, the state plan must provide for "payment for primary care services" within certain categories. *Id.* § 1396a(a)(13)(C). Similarly, the state plan must provide for "payment for hospice care in amounts no lower than" specified rates. *Id.* § 1396a(a)(13)(B).

As relevant here, the state plan likewise must "provide for payment for services described in [a clause addressing federally-qualified health centers] in accordance with subsection (bb)." *Id.* § 1396a(a)(15). A federally-qualified health center ("FQHC") is a healthcare provider that receives federal grant funds under Section 330 of the Public Health Service Act for providing services in medically underserved areas. *Id.* § 254b(a), (e); *id.* § 1396d(*l*)(2)(B) (defining term). The cross-referenced subsection (bb) defines the health-center services that a state plan must pay for. *Id.* § 1396a(bb)(1). It then defines the amount of payment owed for those services for different periods of time. *Id.* § 1396a(bb)(2)-(4). That payment amount is known as the Prospective Payment System (PPS) rate. *See* H.R. REP. NO. 106-1033, at 861-63 (2000) (Conf. Rep.); 42 U.S.C. § 1396a(bb)(3)-(4).

Importantly for this case, after requiring those payment obligations as part of a state plan for medical assistance, the Act separately allows States to condition that "medical assistance" in a given instance on an individual's participation in a managed care network. 42 U.S.C. § 1396u-2(a)(1)(A) (allowing States to "require an individual who is eligible for medical assistance under the

State plan . . . to enroll with a managed care entity as a condition of receiving such assistance"). Thus, although the Act requires a state plan to provide for paying for certain types of medical services—such as health-center services—the Act separately lets States condition that medical assistance in any given instance on a beneficiary obtaining medical services through a managed care network. *Id.*; *see* 42 C.F.R. § 438.50(c)(3) (discussing the State's option to require beneficiaries to use managed-care entities).

Under that managed-care system, Medicaid beneficiaries are enrolled with "managed care organization[s]." 42 U.S.C. § 1396u-2(a)(1)(B). Those MCOs, in turn, enter into contracts to establish networks of specific medical providers adequate to care for their enrollees. 42 C.F.R. § 438.206. MCOs receive from the State a periodic, per-enrollee "capitation" payment at a specified rate. *Id.* §§ 438.2, .6. An MCO is then responsible for paying the providers in its network for delivering medical care to its enrollees. *See id.* § 438.206(b)(1).

b. The Medicaid Act expressly contemplates that federally-qualified health centers may be among the providers in an MCO's network. Pet. App. 34 & n.28 (collecting citations). Health centers can therefore have multiple sources of funding, including (1) Public Health Service Act grants, based on the area served; and (2) payments under a Medicaid state plan, based on services provided to a specific individual.

To obtain Medicaid funds where available, health centers that receive Public Health Service Act grants must seek Medicaid reimbursement when treating a patient

"entitled to . . . medical assistance" under a state Medicaid plan. 42 U.S.C. § 254b(k)(3)(F). Conversely, health centers need not pursue Medicaid payment if a patient is not entitled to medical assistance under Medicaid, such as where a patient is not "receiv[ing] their benefits through managed care entities" when a State has so required, 42 C.F.R. § 438.50(c)(3), and is not otherwise eligible for medical assistance, *e.g.*, 42 U.S.C. § 1396b(m)(2)(A)(vii) (requiring MCOs or the State to cover certain emergency, out-of-network expenses); *see also* 1 Tex. Admin. Code § 353.4(b)(2) (authorizing out-of-network expenses if prior authorization obtained from MCO).

This framework was designed to ensure that health centers need not use grant funds to cover the costs of providing services that Medicaid will cover. *See Three Lower Ctys. Cmty. Health Servs., Inc. v. Maryland*, 498 F.3d 294, 297 (4th Cir. 2007).

c. The Medicaid Act also regulates how health centers are paid when treating patients who are enrolled with an MCO. The Act directs that a State must require MCOs to pay in-network health centers "not less than" the market rate for a covered service. *Id.* § 1396b(m)(2)(A)(ix).

Of course, if the market rate is all that an MCO pays, and if that market rate is less than the full PPS rate to which the health center is entitled under the Medicaid Act, the health center would be left short. In that event, the Act requires the State to make up any difference by a supplemental payment:

> the State plan shall provide for payment to the [health center] 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 [with the MCO].

Id. § 1396a(bb)(5)(A). The Act thus provides for a supplemental payment only "if any" difference exists between the PPS amount and the MCO payment. *Id.* Nothing in the Act addresses a State's discretion to require MCOs to pay the full PPS rate in the first instance.

2. In Texas, Medicaid is administered by the Texas Health and Human Services Commission (the Commission). Tex. Gov't Code § 531.021(a). Texas has adopted a managed-care model for Medicaid, and Texas thus contracts with MCOs to enroll Medicaid beneficiaries and create a healthcare network of providers. *Id.* § 533.002.

Before 2011, Texas allowed MCOs to negotiate with health centers to set the rates that MCOs would themselves pay. Pet. App. 43-45. Those rates were generally lower than the PPS rate required by the Act, so health centers would request supplemental payments from the Commission, which the Commission made on a quarterly basis. Pet. App. 45-46 (describing the state plan that took effect in 2010, labeled State Plan Amendment 10-61).

In 2011, to streamline reimbursement to federally-qualified health centers, the Commission amended its MCO contracts to require MCOs to pay the full PPS rate to their in-network health centers. Pet. App. 46-47. Funds for MCOs to make those payments were then included in the capitation payment from the State to MCOs. Pet. App. 46. The Commission thus ceased mak-

ing supplemental payments, as health centers were receiving the full PPS rate from MCOs. Pet. App. 46. The Commission subsequently submitted to the federal government an amended state plan that eliminated supplemental payments, which the federal government approved. Pet. App. 50 (discussing State Plan Amendment 16-02).

3. Petitioner is a federally-qualified health center in Texas. Pet. App. 1. From 2009 through 2015, petitioner contracted with an MCO—the Texas Children's Health Plan—to provide services to the MCO's enrollees. Pet. App. 48-49. In 2011, when the Commission required MCOs to pay health centers the full PPS rate, the Texas Children's MCO modified its contract with petitioner accordingly. Pet. App. 49. Petitioner agreed to the change. Pet. App. 49 n.10.

In the ensuing four years, petitioner's costs of providing services to the Texas Children's MCO's enrollees skyrocketed—thus, so did its PPS reimbursement amount. Pet. App. 6. At the same time, petitioner pursued an aggressive expansion. Pet. App. 6, 49. Those developments unique to petitioner made petitioner prohibitively expensive to the Texas Children's MCO, so the Texas Children's MCO terminated petitioner's provider contract in 2015. Pet. App. 6-7, 49. The Texas Children's MCO retained all of its contracts with other federally-qualified health centers—a total of seventeen. Pet. App. 30 n.23; R.1849.[1]

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[1] Citations to "R.*p#*" refer to pages of the Fifth Circuit electronic record on appeal.

After its contract termination, petitioner began filing with the Texas Children's MCO claims for out-of-network reimbursement for services that it provided to Medicaid recipients enrolled with the Texas Children's MCO. Pet. App. 7. The Texas Children's MCO paid those out-of-network claims if they involved emergency services or if the Texas Children's MCO had provided prior authorization for the services. Pet. App. 7. But the Texas Children's MCO (and the Commission on appeal) denied those out-of-network claims when they involved non-emergency, non-preauthorized, services. Pet. App. 7.

4. Petitioner brought this 42 U.S.C. § 1983 action against the Commission seeking injunctive relief "on two separate theories." Pet. App. 39. The district court separately issued summary judgment for petitioner on each "independent claim for relief." Pet. App. 40.

a. First, petitioner argued that the State's policy of requiring MCOs to pay the full PPS rate to in-network health centers violates the Medicaid Act. Pet. App. 38-80. That is petitioner's "in-network" claim, Pet. App. 26, which is not encompassed within the question presented before this Court, *see infra* Part V.

The district court acknowledged that the Act, in section 1396b(m)(2)(A)(ix), requires only that MCOs pay health centers "not less than" the market rate, stating a mere "floor" on MCO payments. Pet. App. 65. The district court also acknowledged that "the Medicaid Act is silent or ambiguous" as to a State's discretion to require that MCOs pay health centers more than this floor. Pet. App. 66 (quotation marks omitted).

But the district court held that the "only reasonable interpretation" of the statutory floor and the State's duty

to make up "any" shortfall is that "the State cannot raise MCOs' payment obligation above the statutory floor." Pet. App. 66, 67. The court thus incorrectly deemed the statutory *floor* as also defining a *ceiling* on MCOs' payment obligation. Pet. App. 67. On that view, the district court held that the state plan could not dispense with supplemental payments to health centers. Pet. App. 59-64.

The district court acknowledged that it "is the first to consider" this precise issue. Pet. App. 59. And the court acknowledged that "[n]owhere in . . . the Medicaid Act[] is there language that explicitly prohibits a state from demanding that MCOs pay [health centers] 100 percent of the PPS amount." Pet. App. 65. The court did not grapple with the clear-notice requirement under the Spending Clause that, "when Congress attaches conditions to a State's acceptance of federal funds, the conditions must be set out unambiguously." *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006) (quotation marks omitted). Instead, the district court relied on selected legislative history and the court's view of "Congress's aim." Pet. App. 75.

After the district court's ruling, the federal government filed a statement of interest. Pet. App. 124-41. The government explained that a "state *could* properly achieve this result"—avoiding supplemental payments—by an "alternative payment methodology" under which the State ensures complete payment by MCOs in the first instance. Pet. App. 134; *accord* Pet. App. 138 ("a state could contractually require an MCO to provide for payment [to a health center for covered services] at the PPS rate"). For this reason, the government noted, it had

approved Texas's State Plan Amendment 16-02, which contains the disputed policy. Pet. App. 135.

b. Petitioner's second claim is that, even after being dropped from the Texas Children's MCO's provider network in 2015, petitioner was still entitled to Medicaid reimbursement for *all* of the out-of-network services that it provided to patients enrolled in that MCO—even non-emergency, non-prior-authorized services. That is petitioner's "out-of-network" claim. Pet. App. 32.

At first, petitioner characterized all of its services as falling within the statutory duty to reimburse providers for out-of-network services that were "immediately required due to an unforeseen illness, injury, or condition" and "medically necessary." 42 U.S.C. § 1396b(m)(2)(A)(vii). Petitioner's theory was that all illness is unforeseen, thus bringing all medical services within this out-of-network mandate. *See* R.3626-30 (petitioner's motion for summary judgment).

The federal government subsequently filed its statement of interest, noting undeveloped factual issues on this out-of-network claim—about whether the disputed services were "immediately required" and "medically necessary." Pet. App. 139. The federal government expressly described those issues as determining whether the services were "Medicaid-covered services." Pet. App. 139. And those issues, the federal government argued, were "better addressed in the context of a concrete dispute, involving a particular claim for payment for particular disputed services." Pet. App. 139-40.

In its response to the federal government's statement, petitioner advanced a new, alternative argument.

It argued that *all* federally-qualified-health-center services are Medicaid compensable, whether or not the patient is enrolled in an MCO that includes the health center in its network. R.5007. Petitioner's argument turns on reading in isolation the requirement in 42 U.S.C. § 1396a(bb) that a "State plan shall provide for payment for" health-center services—ignoring the qualification in section 1396u-2(a) that "medical assistance under the State plan" may be conditioned on participation in managed-care networks.

The district court rejected petitioner's initial primary argument that its unpaid out-of-network claims all fell within the emergency-services mandate. Pet. App. 93-94. But the district court adopted petitioner's alternative argument, analyzing the issue without even citing section 1396u-2. Pet. App. 95-98. The district court thus enjoined the Commission's policy for reimbursing out-of-network claims by health centers. Pet. App. 99.

5. The Fifth Circuit reversed and remanded. Pet. App. 35.

a. The court of appeals first addressed petitioner's in-network claim—the challenge to how health centers are paid the PPS amount for in-network services. The court addressed two aspects of that claim, rejecting one on the merits and one for lack of standing.

i. First, the court rejected on the merits petitioner's challenge to the Commission's policy requiring MCOs to fully reimburse in-network health centers. Pet. App. 26-31. The court found standing for petitioner to pursue that challenge as it allegedly led to petitioner's termination, Pet. App. 11-16—a conclusion on which Judge Jones dissented, Pet. App. 36-37. The court also held that section

1396a(bb) states a right of payment, as opposed to a mere funding condition, allowing petitioner a private action under 42 U.S.C. § 1983 for asserted violations of the statute. Pet. App. 21-26.

But, turning to the merits, the court of appeals held that the statute requiring the State to make supplemental payments of "any" shortfall after the MCO pays does not "prevent[] the state from attempting to eliminate such shortfalls" by requiring the MCO to pay fully at the outset. Pet. App. 28. Similarly, the court held that the statutory floor on MCO payments to health centers does not somehow also set "an implied ceiling" on those payments. Pet. App. 29.

The court next rejected petitioner's "bare policy arguments" as speculative and, in any event, without expression in the statutory text. Pet. App. 30 & n.23. And the Fifth Circuit observed that no other court disagrees with its view: "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's contract with a health center. Pet. App. 29 n.21 (citing *Three Lower Ctys.*, 498 F.3d at 304-05).

ii. As to the second half of the in-network claim, the court held that petitioner lacked standing to challenge Texas's failure to provide in State Plan Amendment 16-02 for supplemental payments to a health center if an MCO fails to make full payment for in-network claims. Pet. App. 17-20. The court explained that this policy could not have caused the injury of petitioner's termination from the Texas Children's MCO's provider network, because the state plan amendment was not in effect then. Pet. App. 19.

b. Finally, the court of appeals turned to petitioner's out-of-network claim: that Medicaid patients never need to go through an MCO managed-care provider network to obtain a health center's services in order for those services to be Medicaid reimbursable, since section 1396a(bb) says that a "State plan shall provide for payment" for health-center services. Pet. App. 31-35.

The court explained that "the entire structure of the Medicaid Act contemplates states' using MCOs as intermediaries," including to reimburse federally-qualified health centers for treating Medicaid beneficiaries. Pet. App. 34 & n.28 (citing 42 U.S.C. § 1396u-2(a)(1) and other provisions). The court noted that it would be "wholly inconsistent with that structure to eliminate the distinction between in-network and out-of-network care for [health centers], thereby effectively removing MCOs from the equation and obviating the need for . . . contracts" between MCOs and health centers. Pet. App. 34.

The court observed that the Act further reflects the baseline requirement for health centers to obtain Medicaid reimbursement through an MCO provider network (if a State elects that model), because the Act specifically requires Medicaid to pay out-of-network health centers for only a limited class of emergency services. Pet. App. 33 (discussing section 1396b(m)(2)(A)). Confirming that point, the court noted that the federal government has expressly equated this limited class of emergency out-of-network services and the "covered out-of-network services" for which health centers receive Medicaid funds. Pet. App. 34 n.29.

ARGUMENT

Petitioner is still receiving its grant funds under the Public Health Service Act as a federally-qualified health center. The issues here will not affect that funding. Instead, petitioner disputes whether it can additionally collect Medicaid funds for treating patients *wholly outside* the State's managed-care medical provider network system authorized by Congress for Medicaid—and *without reference* to the limited statutory requirement for Medicaid to pay for out-of-network services of an emergency nature. This Court's review is unwarranted.

No circuit has accepted that novel argument. Only two other cases have addressed out-of-network Medicaid reimbursement in the context of federally-qualified health centers, and those cases addressed only reimbursement of *emergency* services—which the Act specifically directs and which the Texas Children's MCO here paid for. The Fifth Circuit was the first to address petitioner's argument. Accordingly, no circuit split exists. *Cf.* Sup. Ct. R. 10(a). At most, further percolation in the lower courts is warranted.

And the Fifth Circuit correctly rejected petitioner's sweeping theory. As the Fifth Circuit recognized, petitioner is attempting an end-run around the managed-care network structure specifically authorized by Congress. Indeed, the district court's analysis of petitioner's claim did not even cite the Act's provision allowing States to condition medical assistance on use of managed-care networks. Petitioner's theory would enable health centers to opt out of a State's managed-care system entirely and still obtain Medicaid reimbursement. Petitioner cites no decision of this Court countenancing that result,

or with which the decision below conflicts. *Cf.* Sup. Ct. R. 10(c).

Nor does this case present any issue of national importance. *Cf.* Sup. Ct. R. 10(c). Petitioner fails to establish any legal or factual basis for its suggestion that the decision below will result in federal grant funds under the Public Health Service Act, 42 U.S.C. § 254b, being misappropriated throughout Texas, much less the Nation. This case arises from petitioner's particular business strategy of expansion, and the resulting decision of one MCO to cancel petitioner's in-network contract. Petitioner asks the Court to bless its subsequent, novel theory for circumventing the managed-care system by billing Medicaid for non-emergency, out-of-network services.

This case also would be a poor vehicle for reviewing whether petitioner is entitled to Medicaid reimbursement for non-emergency out-of-network claims, because as the Commission argued below, that issue requires first resolving the predicate question whether petitioner has a private right of action under 42 U.S.C. § 1983.

Finally, to the extent that the petition presents argument on petitioner's separate in-network claim (about how health centers are paid the full PPS rate for in-network services under Texas's system), *see* Pet. 31, that issue: (a) is outside the question presented; (b) is not adequately briefed; (c) is not the subject of any circuit split; (d) was correctly decided by the Fifth Circuit below; and (e) has its own vehicle problems.

The petition should be denied.

I. The Decision Below Does Not Create Any Circuit Split.

A. No other circuit has addressed whether States with managed-care Medicaid networks must compensate out-of-network services by health centers, apart from the Medicaid Act's limited mandate for emergency services.

The decision below does not create or implicate any circuit split. Petitioner asserts a circuit split on whether States with managed-care Medicaid networks must reimburse health centers for *all*—and not just *emergency*—services rendered by out-of-network medical providers. Pet. 19-22. But no circuit, other than the Fifth Circuit below, has addressed that issue. As the Fifth Circuit observed, the cases upon which the district court and petitioner rely are "inapposite"—"although they held that states are required to reimburse [health centers] for all covered services, those courts did not have occasion to decide what 'covered' services are." Pet. App. 32 n.27.

1. Only two other cases have addressed out-of-network Medicaid reimbursement in the context of health centers, and those cases addressed only reimbursement for *emergency* out-of-network services. *See Three Lower Ctys.*, 498 F.3d 294; *Comm. Health Care Ass'n of N.Y. v. Shah*, 770 F.3d 129 (2d Cir. 2014). Contrary to petitioner's depiction, those cases did not find "an unambiguous command covering *all* FQHC services to Medicaid enrollees as defined by the *FQHC* (not MCO) provisions of the Medicaid statute." Pet. 23.

Rather, the problem in the Fourth Circuit case was that, "when [a health center] has provided *emergency*

services to out-of-network Medicaid patients, it has not received the per-visit payment to which it is entitled under § 1396a(bb)(5)." *Three Lower Ctys.*, 498 F.3d at 304 (emphasis added). The Fourth Circuit held:

> Section 1396b(m)(2)(A)(vii) requires either the State or the managed care organization to compensate a health center *for emergency services* provided to Medicaid patients, even if the health center is out-of-network. And when the health center is an FQHC, . . . § 1396a(bb)(5) requires that the health center's compensation be equal to the statutory per-visit rate.

Id. (emphasis added). But that is undisputed here. Petitioner selectively quotes that opinion, however, omitting its focus on the *emergency* services covered by section 1396b(m)(2)(A)(vii). Pet. 28.

Rather than relying on the Fourth Circuit's holding, petitioner instead contends that a health center need not go through section 1396b(m)(2)(A)(vii) to be paid for out-of-network care. But *Three Lower Counties* neither "take[s] as a given" that out-of-network services by a health center must always be fully reimbursed, Pet. 21, nor stands for a "policy view" that Medicaid should pay for all out-of-network care provided by a health center, Pet. 28.

Likewise, petitioner's cited Second Circuit case addressed reimbursement to health centers for *emergency* out-of-network services to Medicaid beneficiaries. *Shah*, 770 F.3d at 157. New York had in place no system for reimbursing health centers for out-of-network emergency services if the patient's MCO denied payment. *Id.* at 156. New York offered in justification that, since most

clinics do not have emergency rooms, these uses would be so rare that there was no need to have a reimbursement mechanism for them. *Id.* at 157. The court rejected that argument as minimizing but not resolving the problem. *Id.* The Court held:

> 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 may be reimbursed for them. If that contractual arrangement is between the state and the MCO in the first instance, *under Section 1396b(m)(vii),* that is permissible. But if this arrangement stops short of ensuring full repayment for *these* services because there is no method for appealing an MCO's refusal to pay, then it does not comport with the statute."

Id. (emphases added). Again, petitioner selectively quotes this language. Pet. 20. As the Second Circuit's full discussion shows, the need for "some arrangement" by which health centers could be reimbursed for out-of-network services extends only to subsection (vii) *emergency* services. *See* 42 U.S.C. § 1396b(m)(2)(A)(vii) (requiring coverage for services "immediately required due to an unforeseen illness, injury, or condition"). The Second Circuit merely held that a State violates the Medicaid Act if its state plan does not provide for full reimbursement of "these" emergency services at issue there. 770 F.3d at 157. That holding, like the Fourth Circuit's in *Three Lower Counties*, is fully consistent with the Fifth Circuit's holding here.

2. Petitioner's other cited cases do not even address reimbursement for out-of-network services by a federally-qualified health center.

In *New Jersey Primary Care Association Inc. v. New Jersey Department of Human Services*, the Third Circuit addressed a State's argument that "it is not responsible for reimbursement at the PPS rate if the MCO has failed to make prior payment." 722 F.3d 527, 539 (3d Cir. 2013). The concern was that "valid" *in-network* claims would go unreimbursed, elaborating that "MCOs often deny payments for reasons unrelated to Medicaid . . . , 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." *Id.* at 542.

Here, in contrast, the Commission's denial of payment was not "for reasons unrelated to Medicaid"—it was because the out-of-network claims did not comply with the Medicaid Act. Rather, payment was denied because the services were neither obtained through an in-network provider (creating an entitlement to payment under section 1396u-2(a)(1)(A)) nor for emergency services (creating an entitlement to payment under section 1396b(m)(2)(A)(vii) even if obtained outside managed-care networks).

Because the unpaid out-of-network claims here were not "Medicaid-eligible," there is no conflict with the Third Circuit's holding that a State is responsible "for reimbursement of the entire PPS rate for *all* Medicaid-eligible encounters." *Id.* at 539. Nor is there conflict with

the Third Circuit's statement that health centers are entitled to their PPS rate "even in managed-care states." *Id.* at 540. That statement again concerns the *amount* of reimbursement, rather than expanding *what* out-of-network services are eligible for Medicaid reimbursement.

The First Circuit dealt with similar issues in *Rio Grande Community Health Center, Inc. v. Rullan*, 397 F.3d 56 (1st Cir. 2005). Although petitioner calls it part of a circuit split, petitioner only includes *Rullan* in one string cite for the proposition that courts "have taken as a given that out-of-network FQHC services must be fully reimbursed." Pet. 21. *Rullan* does not support that categorical statement. Like the Third Circuit in *New Jersey Primary Care*, the First Circuit in *Rullan* was concerned only with ensuring payment for valid in-network claims, and did not discuss out-of-network claims at all.

Finally, the petition relies on a Ninth Circuit case, *California Association of Rural Health Clinics v. Douglas*, 738 F.3d 1007 (9th Cir. 2013), that does not address managed care at all. Pet. 24. There, the Ninth Circuit reviewed a California law that eliminated coverage of certain *types* of services, including adult dental, podiatry, optometry, and chiropractic services. 738 F.3d at 1010. The court found it impermissible for California to narrow the types of services for which health centers could be reimbursed, since the relevant statutory definition of "Federally-qualified health services" (in 42 U.S.C. § 1396d(*l*)(2), which in turn references 42 U.S.C. § 1395x(aa)(1)) includes those types of services. 738 F.3d at 1016. Nothing in those definitional sections—which describe the types of services that are considered feder-

ally-qualified-health-center services—converts a patient's care outside of managed care into care obtained through managed care, as to allow Medicaid reimbursement.

B. The circuits are not split on the "policy" behind the Medicaid Act's limited mandate for reimbursing only emergency out-of-network services.

Unable to point to any conflict between the holdings of the circuits on this issue, petitioner tries to manufacture a conflict in "policy" in their decisions. Pet. 27. But that does not exist either. Because no other circuit has addressed whether non-emergency services provided by health centers outside a managed-care network are eligible for Medicaid reimbursement, no other circuit has had occasion to address the "policy behind States' duty to reimburse FQHCs" for these non-emergency, out-of-network services. Pet. 27-29.

The petition points to general statements by other circuits to the effect that Public Health Service Act funds should not subsidize a State's obligation to reimburse Medicaid-eligible services. Pet. 27-29. But the Fifth Circuit *reaffirmed* that policy—even citing the same cases. Pet. App. 34-35. Applying that policy to a specific context requires determining whether a specific service is, in fact, eligible for Medicaid reimbursement. The Fifth Circuit made that determination as to non-emergency, out-of-network care of a Medicaid recipient by a federally-qualified health center—a context no other circuit has addressed. The Fifth Circuit thus can hardly be said to have created a conflict in "policy."

II. The Fifth Circuit Correctly Rejected Petitioner's Sweeping Argument About Medicaid Reimbursement Of Out-Of-Network Claims.

A. The Fifth Circuit correctly interpreted the Medicaid Act.

The Fifth Circuit correctly read the Medicaid Act in its entirety, rather than isolating and blindly focusing only on 42 U.S.C. § 1396a(bb). Pet. App. 34 n.28 (citing this Court's directions to consider statutory context). As the Fifth Circuit noted, the all-important context here is that the Medicaid Act specifically contemplates States using MCO managed-care networks as intermediaries to deliver medical-assistance payments to healthcare providers. Pet. App. 34 & n.29 (citing numerous provisions). Thus, "the distinction between in-network and out-of-network care" is part of the structure of the Act. Pet. App. 34.

The central provision authorizing that managed-care system is section 1396u-2(a)(1)(A), which permits a State to withhold "medical assistance under the State plan" if a Medicaid beneficiary does not enroll with an MCO network. *See* 42 C.F.R. § 438.50(c)(3) (noting, under that statutory provision, "the State's option to limit freedom of choice by requiring beneficiaries to receive their benefits through managed care entities").

Petitioner ignores that a State need not deliver "medical assistance under the State plan" if a given individual does not obtain services through a managed-care network. 42 U.S.C. § 1396u-2(a)(1)(A). Hence, a State's Medicaid program need not reimburse a health center (or any other healthcare provider) for serving a Medicaid

beneficiary unless the beneficiary obtains the care through a managed-care network, or unless a separate payment obligation exists (as for emergency services).

The Fifth Circuit thus accurately concluded that 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." Pet. App. 34. If petitioner's novel interpretation were correct, health centers "would have little or no incentive to contract with MCOs," as they could provide all of their services to Medicaid beneficiaries and receive full reimbursement from the State. Pet. App. 33.

But that would contravene Congress's specific authorization of a managed-care condition for medical assistance under a state plan. That regime also would not make sense of the Medicaid Act's express contemplation that managed-care networks will include federally-qualified health centers. *See, e.g.*, 42 U.S.C. §§ 1396a(bb)(5); 1396b(m)(2)(A)(ix).

Petitioner's unusual mode of interpretation—focusing only on provisions creating an obligation while ignoring provisions qualifying the obligation—would produce other absurd results. For example, 42 U.S.C. § 1396a(a)(13)(B) directs that a state plan must "provide . . . for payment for hospice care in amounts no lower than" specified amounts. That provision thus parallels subsection (bb)'s requirement that a state plan must provide for payment to health centers in specified amounts. Both of those provisions, however, are addressing *what types* of medical assistance must be included in a state

plan. They do not erase other Medicaid Act provisions qualifying *whether* a patient is entitled to that medical assistance in a managed-care context. Under petitioner's interpretative methodology, however, because the Act's obligation to provide for hospice care does not itself reference the separate managed-care condition, the State must always pay a hospice for serving even a Medicaid beneficiary that never enrolled in managed care. That would flout the Act's "entire structure." Pet. App. 34.

As described above, Congress did separately obligate Medicaid to reimburse healthcare providers—including health centers—for providing care of an emergency nature outside of a managed-care network. 42 U.S.C § 1396b(m)(2)(A)(vii) (making either the State or a beneficiary's MCO responsible for that reimbursement). This ensures that when Medicaid beneficiaries need to find the nearest provider for immediate care, the provider is paid regardless of whether it is in the beneficiary's managed-care network. Petitioner initially sought to use that provision for the disputed claims. But the district court rejected that attempt, and petitioner has not renewed that effort either before the Fifth Circuit or in the petition—thus waiving any such arguments.

Instead, petitioner now argues that Medicaid must reimburse health centers for out-of-network claims without regard to whether they are for emergency services. The district court's injunction adopting that theory invited every health center in Texas to end its contractual relationship with MCOs and evade the State's managed-care system. As the Fifth Circuit concluded, "Congress did not order that absurd result." Pet. App. 34.

B. The Fifth Circuit correctly rejected petitioner's misplaced reliance on the federal government's statements.

The Fifth Circuit's holding does not conflict with any statement by the federal government, either in the federal government's statement of interest in district court or in prior guidance letters.

Petitioner notes the federal government's statement reaffirming a State's responsibility to pay health centers the full PPS rate for "covered" out-of-network services. Pet. 30. But the government then expressly specified that the duty to pay for "covered" out-of-network services is, as relevant here, the duty to reimburse for "medically necessary services which were provided . . . because the services were immediately required due to unforeseen illness, injury, or condition"—that is, *emergency* services. Pet. App. 139 (quoting subsection 1396b(m)(2)(A)(vii)). Petitioner likewise notes statements made by the federal oversight agency in an April 2016 letter, but again the quoted statements reflect only that federally-qualified health centers are entitled to payment for "*covered* services to Medicaid-eligible individuals." Pet. 30 (emphasis added).

The Fifth Circuit recognized just this. Pet. App. 34 n.29. It rightly dismissed petitioner's mistaken appeal to the federal government's statement of interest.

III. This Case Has No Nationwide Importance.

A. This case is about one cancelled contract, and managed-care Medicaid networks continue to include federally-qualified health centers.

Petitioner grandiosely conflates the cancellation of one of its provider contracts with a broken healthcare system nationwide. Petitioner's complaints stem from the business decision of one MCO to drop petitioner from its network—after petitioner pursued a course of aggressively expanding the number of clinics under its ambit, while failing to contain its costs of treatment, thus preventing the Texas Children's MCO from earning profits under the risk-based managed care model.

The managed-care system in Texas does not suffer from systemic failures when it comes to the availability of health centers. The only alleged "failure" identified is that petitioner, specifically, was dropped by the Texas Children's MCO here. That is no "failure" at all: The Texas Children's MCO continues to contract with seventeen other federally-qualified health centers in the area. Pet. App. 30 n.23.

Petitioner's argument seems to be that the State's only option is to take whatever measures are necessary to ensure that petitioner, specifically, is not dropped by any MCO (and therefore remains in-network with any and all MCOs of its choosing)—or else the State must pay petitioner its full PPS rate anyway for providing any and all out-of-network services to any MCO's enrollees. But the overall success or failure of the managed-care and health-center systems in Texas are not measured in terms of petitioner's specific business.

The Texas Children's MCO terminated its contract with petitioner due to facts unique to this case. From 2011 through 2014, petitioner's PPS rate was approximately $270. Pet. App. 49. In comparison, the average PPS rate for other federally-qualified health centers in the Texas Children's MCO's network was approximately $195. R.1849. After petitioner's aggressive expansion, the Texas Children's MCO "accused [petitioner] of effectively gaming the Medicaid system." Pet. App. 6; *see also* R.1232 (stating that the Texas Children's MCO "terminated Legacy because Legacy's practice of acquiring existing practices arbitrarily and artificially inflated the average cost of services provided"). It was petitioner's business practices, not a general disincentive problem with Texas's Medicaid reimbursement system, that led to the termination of petitioner's contract.

B. Petitioner's policy arguments about misappropriation of federal grant funds are legally untenable and factually unsubstantiated.

Petitioner broadly claims that "[b]y forcing the [Public Health Service Act's] Section 330 [grant] program to pay for covered Medicaid services, the decision re-appropriates federal funds in a blatant end-run around Congress's express funding scheme." Pet. 4; *see also* Pet. 32. That characterization is neither logically or factually sound.

If petitioner's patients are not entitled to Medicaid assistance for petitioner's care—because the care was not obtained through a managed-care network—then there is no misuse when grant funds instead pay for the care. To the contrary, that is the intended use of those

funds. The Public Health Service Act envisions a health center pursuing Medicaid funds only for a patient "entitled to . . . medical assistance" under a state Medicaid plan. 42 U.S.C. § 254b(k)(3)(F). Thus, when a health center treats a patient not entitled to Medicaid assistance for the care, "that requirement [to treat the patient] is part of the responsibilities that attach to Section 330 grants." Pet. App. 34-35. There is no nefarious "re-appropriat[ion]" of grant funds. Pet. 4.

In any event, petitioner is also factually mistaken in asserting that its inability to receive Medicaid funds for out-of-network, non-emergency services "disrupts the flow of essential healthcare resources to FQHCs and their patients." Pet. 4. The record shows that when a patient would come to petitioner on an out-of-network basis for a non-emergency service, the usual process would be for petitioner to inform and educate the patient regarding the option to receive care from a different, in-network provider; and if the patient chose to remain, it would bill the individual patient consistent with the sliding fee discount schedule. R.3646-47. Petitioner has provided no evidence that essential healthcare was not provided.

Finally, for the first time in this litigation, the petition claims a constitutional problem with the Commission's out-of-network policy. Pet. 33 (citing Appropriations Clause, U.S. Const. art. 1, § 9, cl. 7). That meritless argument is waived: it was not presented or passed on below. This case is, and always has been, about statutory interpretation.

IV. This Is a Poor Vehicle Because the Question Presented Requires Consideration Of A Threshold Private-Right-Of-Action Issue.

Unlike a hypothetical dispute between the federal government and a State over the sufficiency of a state plan, this private action presents a threshold issue that makes this case a poor vehicle for deciding the question presented.

This Court has not previously considered whether 42 U.S.C. § 1396a(bb)(1)-(5) confers on health centers like petitioner a private right of action to challenge a State's Medicaid reimbursement procedures. Under *Gonzaga University v. Doe*, 536 U.S. 273 (2002), and *Armstrong v. Exceptional Child Center, Inc.*, 135 S. Ct. 1378 (2015), the answer is no. This predicate question is an alternative basis to affirm the judgment below, making this case a poor vehicle to confront the underlying statutory question presented.

Gonzaga held that the right asserted must be "unambiguously conferred" on the particular individual asserting it. 536 U.S. at 283. This holding contained an implied repudiation of *Wilder v. Virginia Hospital Association*, which had reflected a more permissive approach to private rights of action. 496 U.S. 498, 512 (1990). The *Gonzaga* dissent recognized this, complaining that the majority "*sub silentio* overrules cases such as . . . *Wilder*," because the statutes in those cases did not "'clear[ly] and unambiguous[ly]' . . . intend *enforceability under § 1983*." *Gonzaga*, 536 U.S. at 300 n.8 (Stevens, J., dissenting) (alterations in original).

Armstrong made this repudiation explicit. Writing for the majority, Justice Scalia explained that "our later opinions plainly repudiate the ready implication of a § 1983 action that *Wilder* exemplified." 135 S. Ct. at 1386 n.*; *see also Does v. Gillespie*, 867 F.3d 1034, 1040 (8th Cir. 2017) (finding this "repudiation" of *Wilder* to be the functional equivalent of "overruling" it). And in a separate section of the opinion that garnered only a plurality, Justice Scalia cast even further doubt on whether providers are ever intended to be conferred private rights of action under the Medicaid Act: "We doubt, to begin with, that providers are intended beneficiaries (as opposed to mere incidental beneficiaries) of the [federal-state] Medicaid agreement, which was concluded for the benefit of the infirm whom the providers were to serve, rather than for the benefit of the providers themselves." *Armstrong*, 135 S. Ct. at 1387 (Scalia, J., plurality opinion).

While the Fifth Circuit concluded that it was bound by *Wilder* and this Court's earlier cases, Pet. App. 25, this Court is in a position to confirm *Wilder*'s repudiation. Furthermore, because *Wilder* concerned a law (the Boren Amendment, 496 U.S. at 501-02) that has since been repealed, and private right of action cases are determined on a provision-by-provision basis, *see Gonzaga*, 536 U.S. at 283, the Court need not formally overrule *Wilder*.

The statute here is analogous to the provision reviewed in *Armstrong*. The Fifth Circuit distinguished the two on the basis that 42 U.S.C. § 1369a(a)(30)(A) (at issue in *Armstrong*) dealt with procedures to make efficient payments, rather than issuing a command of full reimbursement to a provider. Pet. App. 24-25. But both

provisions address the sufficiency of payment—and the methods of payment—to providers. That the provisions at issue in this case concern a narrower swath of providers (federally-qualified health centers) does not meaningfully change the analysis. Because they provide a general payment calculation methodology, and noncompliance with these provisions by the State is tied to withholding of Medicaid funding, *see* 42 U.S.C. § 1396c, section 1396a(bb) is analogous to the provision in *Armstrong*.

While the Fifth Circuit found a private right of action based on its analysis of *Blessing v. Freestone*, 520 U.S. 329, 340-41 (1997), it acknowledged that "admittedly, this is not as clear as the 'rights-creating language' that *Gonzaga* specifically referenced." *Legacy Cmty. Health Servs., Inc. v. Smith*, 881 F.3d 358, 372 (5th Cir. 2018).[2] In light of the shift that *Gonzaga* signaled in this Court's jurisprudence, any ambiguity in whether Congress intended to confer a right of action on the plaintiff in question is dispositive.

V. Petitioner's Separate In-Network Claim Is Not Encompassed Within the Question Presented And Review of That Claim Would, In Any Event, Be Unwarranted.

The impetus for this case is the termination of a provider-network contract between petitioner and an MCO.

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[2] Citation here is to the published opinion, rather than the petition appendix, due to a misprint in that appendix. *See* Pet. App. 23 (containing an erroneous reproduction of part of the opinion's footnote 12 in the body of the opinion, appearing in the middle of the sentence quoted).

In the district court and Fifth Circuit, petitioner blamed the termination of this contract on the Commission's requirements for who paid petitioner—specifically, the requirement that MCOs make full reimbursement for in-network services provided by health centers.

The petition contains only brief argument that the State may not require MCOs to make full payment, as to avoid the need for supplemental payment by the State. Pet. 31. To the extent that this scant argument even seeks review on this "in-network claim," certiorari is unwarranted because this issue: (a) is not included within the question presented; (b) is not adequately briefed; (c) is not the subject of any circuit split; (d) was correctly decided by the Fifth Circuit below; and (e) has its own vehicle problems.

A. The "in-network claim" is not fairly included in petitioner's question presented. Pet. i. This Court considers only "questions set out in the petition, or fairly included therein." Sup. Ct. R. 14.1(a). Scant discussion of an issue in the body of the petition does not place the issue before the Court. *See Izumi Seimitsu Kogyo Kabushiki Kaisha v. U.S. Philips Corp.*, 510 U.S. 27, 31 n.5 (1993) (per curiam).

Petitioner's sole question presented is: "Whether 42 U.S.C. § 1396a(bb)(1)-(5) impose an independent duty on States to fully reimburse FQHCs for all services they provide to Medicaid beneficiaries regardless of how a State structures its managed-care network or whether the FQHCs are in or out of that network." Pet. i. Petitioner's corresponding restatement of what the "case involves" likewise identifies only petitioner's claim with respect to out-of-network services: "This case involves the

[Commission's] refusal to reimburse FQHCs for services provided to Medicaid beneficiaries, if those services are not provided through a contract with a[n MCO]." Pet. 2-3.

The out-of-network claim presented for review is different from the in-network claim that the petition's argument grazes only briefly. The district court recognized the two claims as distinct and treated them accordingly. Pet. App. 39-40. So did the Fifth Circuit. Pet. App. 26-34.

And neither issue is fairly included within the other. Namely, the question presented—*whether* the disputed *out-of-network* services are eligible for Medicaid compensation—has no bearing on *who* must deliver the payment for compensable *in-network* claims. A question that is merely "*complementary*" or "*related*" to the question presented is not "fairly included therein." *Yee v. City of Escondido, Cal.*, 503 U.S. 519, 537 (1992).

B. At minimum, the in-network issue has not been presented with sufficient clarity. Under this Court's Rule 14.4, the "failure of a petitioner to present with . . . clarity whatever is essential to ready and adequate understanding of the points requiring consideration is sufficient reason for the Court to deny a petition."

To the extent it is discussed at all, the petition primarily attempts to leverage the in-network claim as support for the importance of its out-of-network claim. *See, e.g.*, Pet. 4, 38-39. Indeed, only two sentences in the petition argue the merits of the Fifth Circuit's analysis of the in-network claim. Pet. 38-39. The petition's only substantive contention is that the Fifth Circuit's ruling on the in-network claim conflicts with federal agency guidance to which the State had somehow allegedly bound itself. Pet.

31. But even that meritless argument was waived through failure to brief it before either of the courts below.

C. Even if the in-network claim were properly presented, it would be unworthy of certiorari review.

There is no circuit split on that issue, and petitioner does not assert one. The only other court that addressed the issue found, as did the Fifth Circuit, that § 1396b(m)(2)(A)(ix) did not impose a ceiling on the amount that States may require MCOs to pay under their contracts with federally-qualified health centers. *See Three Lower Ctys.*, 498 F.3d at 304-05.

Petitioner makes no suggestion that the Fifth Circuit's ruling on the in-network claim is of surpassing national importance or contrary to any decision of this Court. *Cf.* Sup. Ct. R. 10(c).

D. In any event, the Fifth Circuit's ruling on the in-network claim is correct. The court of appeals looked to the plain text of the contested provisions, correctly recognizing that nothing in them prohibit a State from requiring MCOs to fully reimburse health centers in the first instance. Pursuant to the cooperative state-federal model embodied in the Medicaid Act, States receiving Medicaid funds are permitted flexibility to develop their programs, so long as these programs do not violate any unambiguous condition of that funding. *See Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006) (providing that conditions of federal funding "must be set out 'unambiguously'").

As to a State's duty to make a supplemental payment under section 1396a(bb)(5)(A), the Fifth Circuit correctly noted the statute's "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"—and that nothing in that provision "prohibits states from requiring MCOs to pay the full PPS rate, thereby obviating the need for supplemental payments in the first place." Pet. App. 27. The term "if any" confirms that interpretation by expressly contemplating that a shortfall may not exist.

Lastly, as to section 1396b(m)(2)(A)(ix), the Fifth Circuit correctly held that this provision plainly "only sets a floor—the market rate—for MCO-FQHC contracts." Pet. App. 29. The court of appeals soundly declined petitioner's invitation to go beyond the text of the statute and read that statutory floor as a statutory ceiling. Pet. App. 29-30.

E. The in-network claim also presents its own vehicle problems, in addition to the lack of a private right of action, *see supra* Part IV.

First, petitioner lacks standing for the in-network claim. This conclusion forms the basis of Judge Jones's dissent. Pet. App. 35-37. As Judge Jones correctly observed, "Legacy admits it was never denied a dime of reimbursement under its contract with [the Texas Children's MCO]," the termination of which was the sole basis for Legacy's claim to standing. Pet. App. 36. Furthermore, as Judge Jones explained, petitioner cannot rely on *Clinton v. City of N.Y.*, 524 U.S. 417 (1998), because it "failed to present any evidence, or even argue[], that it has been injured because it 'undoubtedly will have future dealings with MCOs.'" Pet. App. 35-36.

Second, the Commission would prevail on the in-network claim on other grounds that were not reached by

the Fifth Circuit. The court did not reach the Commission's alternative argument that its in-network reimbursement system was a permissible "alternative payment methodology" under 42 U.S.C. § 1396a(bb)(6), to which petitioner had consented. The merits of this alternative argument are further complicated by the intervening approval of State Plan Amendment 16-02, which the federal CMS later stated was approved as an alternative payment methodology.[3] Pet. App. 26 n.20. Because of the Fifth Circuit's correct conclusion that "the Medicaid Act does not bar Texas from requiring MCOs fully to reimburse FQHCs in the first place," Pet. App. 31 n.25, it did not have occasion to address Texas's alternative argument. These alternative bases for affirmance further confirm that certiorari review is unwarranted.

[3] The Fifth Circuit found that Legacy had not established standing to challenge State Plan Amendment 16-02's lack of a requirement that Texas provide supplemental payments because State Plan Amendment 16-02 was enacted after it had already lost its contract with the Texas Children's MCO and could not have contributed to its injury. Pet. App. 17-20.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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