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

REPLY BRIEF FOR PETITIONER

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TABLE OF CONTENTS

	Page
REPLY BRIEF FOR PETITIONER	1
ARGUMENT	2
I. The Circuits Are Split Regarding States' Reimbursement Obligations For Services Provided By FQHCs To Medicaid Beneficiaries	2
II. The Fifth Circuit's Decision Grossly Distorts Congress's Scheme For Funding FQHCs	7
III. The Question Presented Has Nationwide Importance And Is Cleanly Presented For This Court's Review	9
CONCLUSION	14

TABLE OF AUTHORITIES

Page

CASES

Armstrong v. *Exceptional Child Center, Inc.*, 135 S. Ct. 1378 (2015) 13

Blessing v. *Freestone*, 520 U.S. 329 (1997) 13

Cal. Ass'n of Rural Health Clinics v. *Douglas*, 738 F.3d 1007 (9th Cir. 2013) 4

Cmty. Health Care Ass'n of N.Y. v. *Shah*, 770 F.3d 129 (2d Cir. 2014) 3, 6, 8

Gonzaga Univ. v. *Doe*, 536 U.S. 273 (2002) 13, 14

N.J. Primary Care Ass'n v. *N.J. Dep't of Human Servs.*, 722 F.3d 527 (3d Cir. 2013) 4, 6

Rio Grande Cmty. Health Ctr., Inc. v. *Rullan*, 397 F.3d 56 (1st Cir. 2005) 4

Three Lower Ctys. Cmty. Health Servs., Inc. v. *Maryland*, 498 F.3d 294 (4th Cir. 2007) 3, 6

STATUTES

31 U.S.C. §§ 6101 *et seq.* (Federal Funding Accountability and Transparency Act) 12

31 U.S.C. §§ 7501 *et seq.* (Single Audit Act) 12

41 U.S.C. § 2313 (Federal Awardee Performance and Integrity Information System) 12

42 U.S.C. § 254b 8, 11, 12

42 U.S.C. § 1396a ..... *passim*

42 U.S.C. § 1396b 5, 7, 8

42 U.S.C. § 1396u 7

TABLE OF AUTHORITIES—Continued

Page

REGULATIONS

42 C.F.R. § 51c.303 11

42 C.F.R. § 438.50 8

OTHER AUTHORITIES

H.R. Rep. No. 101-247 (1989) 9

REPLY BRIEF FOR PETITIONER

Before the Fifth Circuit's decision in this case, every Circuit to consider 42 U.S.C. § 1396a(bb)'s mandate that every "State plan shall provide for payment for [FQHC] services" to Medicaid beneficiaries at "100 percent of the[ir] average costs" held, based on that provision's plain terms, that States' full-reimbursement obligation operates independently of the particulars of a State's Medicaid managed-care system. These Circuits recognized that Congress enacted Section 1396a(bb) to prevent States from diverting funds appropriated for the Section 330 program, which provides federal funds to pay for medical services to the uninsured, to subsidize Medicaid, a joint State/Federal insurance program for low-income populations.

In stark contrast, the Fifth Circuit held, based not on statutory text but on what it thought "makes paramount sense," that payment requirements under Section 1396a(bb) do not extend to out-of-network services provided to Medicaid beneficiaries in managed-care States. The Fifth Circuit remarkably declared that Section 330 funds *should* pay the cost of those services—an outcome Congress expressly prohibited.

Respondent's arguments against this Court's review mischaracterize the holding below, the relevant statutory provisions, and the decisions of other Circuits that have authoritatively construed the meaning and scope of Section 1396a(bb)'s full-reimbursement obligation. But no amount of obfuscation can hide the

need for this Court's review. The decision below creates an irreconcilable conflict with other Circuits on an important issue of federal law and threatens immediate harm to federal programs vital to the provision of health services to those in greatest need. The petition for a writ of certiorari should be granted.

ARGUMENT

I. The Circuits Are Split Regarding States' Reimbursement Obligations For Services Provided By FQHCs To Medicaid Beneficiaries.

As petitioner explained (at 18-29), the First, Second, Third, and Fourth Circuits all have rejected States' claims that managed care modifies their reimbursement obligations under 42 U.S.C. § 1396a(bb). The Fifth Circuit, in direct conflict with these Circuits, held instead that the Act's general managed-care provisions modify Section 1396a(bb)'s specific full-reimbursement obligation and allow a State like Texas to shift the cost of so-called out-of-network services to the federal Section 330 grant—a result even respondent concedes Congress intended to foreclose. BIO 4. Immediate review by this Court is warranted to resolve that conflict and restore Congress's carefully reticulated funding system for FQHCs.

1. Respondent denies the split created by the Fifth Circuit's decision. He narrowly characterizes the facts of each case, ignores the decisions' essential

reasoning and legal holdings, and pretends that this case presents a novel legal issue concerning the meaning of "emergency services" in the managed-care provisions of the Act and not Section 1396a(bb)'s full-reimbursement obligation. BIO 15-19. Not so. The Fifth Circuit has adopted a construction of Section 1396a(bb)'s full-reimbursement obligation that directly conflicts with other Circuits' construction of that provision.

The Second Circuit in *Community Health Care Ass'n of N.Y.* v. *Shah*, for example, held that all FQHC services to Medicaid beneficiaries must be reimbursed, even if they are provided out-of-network. 770 F.3d 129, 156-57 (2d Cir. 2014). Contrary to respondent's suggestions, *Shah*'s holding did not turn on the particulars of the State's managed-care system. Nor did it turn on the general managed-care provisions of the Act. Rather, the Second Circuit expressly held that the source of the State's duty to reimburse out-of-network FQHC services was Section 1396a(bb)'s specific full-reimbursement obligation, and not the general managed-care provisions of the Act. *Shah*, 770 F.3d at 157-58. Thus, the court held that if any "contractual arrangement" related to the State's managed-care system "stops short of ensuring full repayment" for FQHC services to Medicaid patients, "then [the State's managed-care system] does not comport with the statute." *Id.* at 157; see also *Three Lower Ctys. Cmty. Health Servs., Inc.* v. *Maryland*, 498 F.3d 294, 303-04 (4th Cir. 2007) (rejecting similar arrangement).

Respondent seeks (at 16-17) to dismiss any conflict with the Second Circuit's construction of Section 1396a(bb)'s full-reimbursement obligation by twisting the Circuit's decision into a narrow ruling on emergency services. This is wrong. The Second Circuit authoritatively construed Section 1396a(bb) to independently mandate full reimbursement of out-of-network FQHC services, regardless of the State's managed-care system. Thus, in the Second Circuit, the plain terms of Section 1396a(bb) require full reimbursement for all FQHC services to Medicaid patients. Not so in the Fifth.

Similarly, the Third Circuit in *N.J. Primary Care Ass'n* v. *N.J. Department of Human Services* struck down a State's attempt to use its managed-care system to avoid reimbursement—this time by using an MCO's refusal to pay a claim as an excuse not to issue its supplemental payment. 722 F.3d 527, 539 (3d Cir. 2013); see also *Rio Grande Cmty. Health Ctr., Inc.* v. *Rullan*, 397 F.3d 56, 62, 76 (1st Cir. 2005) (FQHCs must receive PPS rate whether or not they operate in managed-care States). These cases ensure that FQHCs are reimbursed *the same* whether a State uses managed care or not. See Pet. 20-21. In fact, the Ninth Circuit saw the statutory provisions clearly and simply: "the statute imposes a mandatory obligation [that] the state plan 'shall provide for payment for services.'" *Cal. Ass'n of Rural Health Clinics* v. *Douglas*, 738 F.3d 1007, 1013 (9th Cir. 2013) (citation omitted). CMS agrees, explaining in its Statement of Interest in this case that FQHCs must "continue to receive their full PPS reimbursement rate regardless of the Medicaid delivery

system" and "regardless of whether the covered services" are provided "in-network or out-of-network." App. 132-33.

In conflict with these decisions and CMS, the Fifth Circuit held that Section 1396a(bb)'s full-reimbursement obligation is limited by inapposite provisions of the Act, which dictate general payment requirements that a State must impose on MCOs when their members go out of network to *any* healthcare provider—provisions that have nothing to do with the specific FQHC payment methodologies. *Cf.* 42 U.S.C. §§ 1396a(bb), 1396b(m)(2)(a)(vii); App. 33-34.

Thus, in Texas, with the Fifth Circuit's blessing, FQHCs are denied full reimbursement for services provided to Medicaid beneficiaries. This result would be unlawful in the Second Circuit and others—a clear conflict that warrants this Court's review.

2. Respondent and the Fifth Circuit champion an inappropriate policy of using non-reimbursement for out-of-network services as a punishment designed to compel FQHCs to remain in managed care. BIO 13, 22-23; see App. 33-34. That policy makes no sense. Petitioner did not elect to leave Texas's managed-care network; it was forced out in response to the State's requirement that MCOs must pay full PPS rates for in-network FQHC services, thereby improperly shifting the State's statutory duty onto MCOs and incentivizing them to push FQHCs out of network.

But putting aside its illogic, the Fifth Circuit's invented policy only heightens the conflict with the

Second, Third, and Fourth Circuits, each of which recognize that the Act's express policy of reimbursing *all* Medicaid-eligible encounters is "paramount notwithstanding the risk of loss to the state." *N.J. Primary Care*, 722 F.3d at 541. Thus, those Circuits reject the policy arguments the Fifth Circuit used to justify nonpayment for FQHCs' out-of-network services. *Shah*, 770 F.3d at 157 (rejecting argument that managed-care depends on being "able to direct patients to certain providers"); *Three Lower Ctys.*, 498 F.3d at 303 ("induc[ing] compliance" with managed-care cannot justify nonpayment for FQHC "services outside the patient's network").

Unlike the Fifth Circuit, those Circuits recognize that Congress in Section 1396a(bb) has decided that reimbursing FQHCs for out-of-network services is essential to ensuring that Section 330 grants are used for uninsured patients, *not* Medicaid patients. As the Second Circuit put it, failing to fully reimburse out-of-network FQHC services to Medicaid beneficiaries would impermissibly compel Section 330 funds to "subsidize Medicaid programs." *Shah*, 770 F.3d at 150.

Respondent never denies that such a subsidy has, in fact, taken place here. He never denies petitioner has served Medicaid patients or that it has been denied reimbursement for those services. He merely argues that denying reimbursement furthers his illogical and inappropriate policy of punishing FQHCs for doing precisely what Congress intended them to do. This Court's review is necessary to prevent the shifting of

appropriated funds based on a policy invented by the Fifth Circuit that has no foundation in the statute.[1]

II. The Fifth Circuit's Decision Grossly Distorts Congress's Scheme For Funding FQHCs.

Respondent persuaded the Fifth Circuit that two Medicaid managed-care provisions, 42 U.S.C. §§ 1396b(m)(2)(A)(vii) (requiring States to include in managed-care contracts payment for out-of-network emergency services) and 1396u-2(a)(1)(A) (allowing States to require Medicaid beneficiaries "to enroll with a managed-care entity as a condition of receiving [medical] assistance"), "qualify," or impliedly repeal, States' specific obligation to reimburse FQHCs for all Medicaid beneficiary services. BIO 2-4, 16-18, 21-23. Respondent's arguments are meritless and flatly inconsistent with the other Circuit decisions discussed above.

The fact that Congress permits States to use "managed-care networks" generally, BIO 21, does not alter the specific provision requiring States—regardless of how they structure their Medicaid system—to

[1] As petitioner explained (at 4-5, 38-39), what Texas has done in requiring MCOs to fully reimburse FQHCs and refusing to reimburse out-of-network FQHCs are inextricably intertwined. Respondent's argument (at 30-35) that the Question Presented does not relate to Texas's policy regarding MCO-reimbursement is wrong. The Question Presented rightly focuses on whether Section 1396a(bb)'s full-reimbursement obligation applies regardless of the particulars of a State's managed-care system or whether an FQHC is in or out of network. That question encompasses all aspects of Texas's unlawful reimbursement scheme.

fully reimburse all FQHC services to Medicaid beneficiaries. See *Shah*, 770 F.3d at 157. Rather, when Congress "expanded states' authority to require enrollment in managed care as a condition of coverage for most beneficiaries," its "commitment to ensuring that Medicaid supports [FQHCs] remained steadfast." Brief of Public Health Scholars as *Amici Curiae* in Support of Petitioner ("Scholars Br.") at 18. In amending the MCO-provisions, lawmakers preserved States' "basic obligation to pay FQHCs for the cost of covered services." *Id.* at 18-22. The general "context" of managed care (BIO 21) does not *sub silentio* limit States' FQHC-reimbursement duty.

That conclusion is further confirmed by the fact that—regardless of a State's managed-care system—FQHCs remain obligated under federal law to provide services to all patients, including Medicaid beneficiaries. 42 U.S.C. §§ 254b(k)(3)(E)(i), (G)(iii); Scholars Br. 13-16. Thus, States may be able to require "beneficiaries to receive their benefits through" MCOs in other circumstances, BIO 21 (quoting 42 C.F.R. § 438.50(c)(3)), but States may *not* require FQHCs to treat only in-network patients. In all events, out-of-network Medicaid beneficiaries *will* receive medical services from FQHCs they visit. The only question is whether those services will be paid by FQHCs' Section 330 grants or States' Medicaid budgets.

Under respondent's construction, Section 1396a(bb)(1) would be superfluous in managed-care States, since Section 1396a(bb)(5)(A) requires *in-network* reimbursement and Section 1396b(m)(2)(A)(vii), respondent

claims, provides reimbursement for only the *out-of-network* services that need reimbursing. Pet. 26.

Congress did not intend this absurd result. Instead, it made clear that Section 330 funds should be reserved for "the primary care needs of those without any public or private coverage"—the uninsured—and Medicaid funds should cover Medicaid beneficiaries. H.R. Rep. No. 101-247, at 392-93 (1989), reprinted in 1989 U.S.C.C.A.N. 1906, 2119; Scholars Br. 16-17, 22.

The Fifth Circuit effectively re-appropriated Section 330 funds to cover a State's Medicaid obligations in a manner prohibited by Congress. Only review by this Court can restore the proper balance of Section 330 and Medicaid funding for FQHCs under Congress's preferred reimbursement scheme.

III. The Question Presented Has Nationwide Importance And Is Cleanly Presented For This Court's Review.

1. As petitioner explained (at 32-37) and *Amici* support, the services provided by FQHCs are uniquely important to the Nation's health safety net. Scholars Br. 9-20; Brief of Community Health Choice as *Amicus Curiae* in Support of Petitioner ("Cmty. Health Br.") at 3, 9-10. FQHCs "are the *sole* health-care providers in many" medically underserved areas, and "they are the *only* providers with a mandate to provide primary care without regard to ability to pay." Cmty. Health Br. 6. This role makes FQHCs the "single most important source of comprehensive primary health care for the

nation's poorest urban and rural communities," many of whom are uninsured. Scholars Br. 3.

But the Fifth Circuit's decision will lead to "significant financial strain" on FQHCs, "thereby limiting the services they are able to offer [uninsured] patients." *Id.* at 5. Ignoring this reality, respondent claims (at 13) that the Fifth Circuit's decision "will not affect [Section 330] funding" because "[p]etitioner is still receiving its [PHSA] grant funds." But if FQHCs are forced to use Section 330 funds to serve Medicaid beneficiaries, they will have less funds available for services to the uninsured and services to these individuals will "plummet." Scholars Br. 22.

Respondent's suggestion (at 25-26) that the opinion below will not affect other FQHCs in the same way as petitioner is belied by *Amicus* Community Health Choice, an MCO operating in Texas, which explained that respondent's new full-PPS-reimbursement requirement for MCOs will disincentivize them from dealing with FQHCs. Cmty. Health Br. 7. This action disincentivizing MCOs from contracting with FQHCs makes respondent's refusal to reimburse out-of-network claims even more harmful because more FQHC services will be provided out-of-network, and thus more Medicaid costs will "free ride" on Section 330 funds. Pet. 38-39; Scholars Br. 20. These impacts threaten to disrupt healthcare funding across the Nation. Scholars Br. 24-27; see Pet. 30-31 (discussing State Medicaid Director Letters and other CMS guidance making clear that States, and not MCOs, are

obligated to fully reimburse both in-network and out-of-network FQHC services).

In short, the decision below will have immediate impact on every FQHC (including those in MCO-networks) that is visited by out-of-network Medicaid beneficiaries—a frequent occurrence, Scholars Br. 25 & n.33.[2]

2. Respondent makes the absurd argument that what happened to petitioner is anomalous and is petitioner's fault. BIO 6, 25-26. Petitioner's actions to serve the unmet needs of its patients have no bearing on a statutory analysis in all events. However, even if they were relevant, respondent's claims are unfounded.

Petitioner has certainly grown to provide needed services to a needy community. For example, it expanded mental health services and related care to underserved communities. R.3209-10. But this growth in services was not "aggressive" and was consistent with the objectives of Section 330 grants. Nor did petitioner's costs "skyrocket" as a result of providing

[2] Respondent's additional claim (at 27) that Section 330 funds need not subsidize Medicaid services because FQHCs may inform patients of other healthcare options and bill patients under "the sliding fee discount schedule" is doubly risible. First, FQHCs *must* treat all patients. Second, that "discount schedule" requires FQHCs to provide services *for free* to all patients at or below the federal poverty line (over 70 percent of FQHC-patients), and reduced-price to patients whose income is not greater than two-times the poverty line (another 20 percent of FQHC-patients). 42 U.S.C. §§ 254b(k)(3)(G)(i)-(iii); 42 C.F.R. § 51c.303(f); Scholars Br. 10-11.

those additional services. BIO 25-26. Petitioner's costs-per-visit, or its PPS rate, actually remained stable between 2012 and 2014. R.3371. Instead, total costs increased because petitioner's Medicaid encounters increased. App. 6-7. But if those services to Medicaid beneficiaries were not provided by petitioner, they would have been provided elsewhere (or nowhere). In which case, the State managed-care system would still have to bear the cost of those services—or worse, bear the future costs of untreated patients. See Scholars Br. 12.

Moreover, the services petitioner provides and the locations where it provides them are approved every year by the U.S. Department of Health and Human Services as part of the Section 330 grant administration process. 42 U.S.C. § 254b(k). In addition, petitioner's costs are audited every year under the Single Audit Act, 31 U.S.C. §§ 7501 *et seq*., in addition to numerous other federal oversight measures applicable to Section 330 grantees, see, e.g., the Federal Awardee Performance and Integrity Information System, 41 U.S.C. § 2313, and the Federal Funding Accountability and Transparency Act, 31 U.S.C. §§ 6101 *et seq*. Petitioner's PPS rate is based on these audited costs, which respondent has never challenged.

3. In a last-ditch effort to avoid this Court's review, respondent argues (at 28-30) that whether petitioner has a private right of action presents "a threshold issue that makes this case a poor vehicle" for the question presented. Not so.

While this Court has not considered the specific question "whether 42 U.S.C. § 1396a(bb)(1)-(5) confers on [FQHCs] a private right of action," BIO 28, respondent hides the fact that all five Circuits to have addressed the issue unanimously have held the answer is yes. App. 22 & n.13 (Fifth Circuit citing cases from First, Third, Fourth, and Ninth Circuits). Respondent also misleadingly implies (at 28) that the Fifth Circuit panel did not apply the framework under *Gonzaga University* v. *Doe*, 536 U.S. 273 (2002), but it specifically applied that case and *Blessing* v. *Freestone*, 520 U.S. 329 (1997), on which *Gonzaga* relied. App. 21-23 & n.12. Under that framework, Section 1396a(bb) unambiguously confers a right because it (1) states "FQHCs are its intended beneficiaries," (2) "provides for judicially administrable standards," and (3) "imposes 'a binding obligation on the States.'" App. 23-25 (citation omitted).

The private right of action created under Section 1396a(bb) is clear and distinguishable from the provision discussed in *Armstrong* v. *Exceptional Child Center, Inc.*, 135 S. Ct. 1378, 1385 (2015) (plurality)—requiring "efficien[t]" and "econom[ic]" payments—which is neither as specific about what healthcare providers must be reimbursed nor as judicially administrable as Section 1396a(bb). *Ibid.* A clear entitlement to easily calculable PPS reimbursement, on the other hand, grants an easily administrable right to FQHCs.

Accordingly, five Circuits are unanimous that Section 1396a(bb) provides a private right of action to

FQHCs, and they all held as much after the *Gonzaga* decision. This issue presents no barrier to this Court's review.

CONCLUSION

The petition for certiorari should be granted.

August 21, 2018 Respectfully submitted,

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