Legacy Community Health Services v. Smith: What are the National Implications for Community Health Centers and Their Communities?

Geiger Gibson / RCHN Community Health Foundation Research Collaborative

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About the Geiger Gibson / RCHN Community Health Foundation Research Collaborative

The Geiger Gibson Program in Community Health Policy, established in 2003 and named after human rights and health center pioneers Drs. H. Jack Geiger and Count Gibson, is part of the Milken Institute School of Public Health at the George Washington University. It focuses on the history and contributions of health centers and the major policy issues that affect health centers, their communities, and the patients that they serve.

The RCHN Community Health Foundation is a not-for-profit foundation established to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the U.S. dedicated solely to community health centers, RCHN CHF builds on a long-standing commitment to providing accessible, high-quality, community-based healthcare services for underserved and medically vulnerable populations. The Foundation's gift to the Geiger Gibson program supports health center research and scholarship.

Additional information about the Research Collaborative can be found online at https://publichealth.gwu.edu/projects/geiger-gibson-program-community-health-policy or at www.rchnfoundation.org.

Executive Summary

In a recent decision, the United States Court of Appeals for the Fifth Circuit in *Legacy Community Health Services v. Smith* held that state Medicaid programs may refuse to pay community health centers for the non-emergency, out-of-network care they furnish to Medicaid managed care enrollees. This issue brief discusses the national implications of this ruling and estimates the economic impact on community health centers, their staff, and their patients nationally if the decision stands. Our estimate of potential losses suggest that community health centers nationwide could lose between $1.0 and $2.0 billion in revenue annually, an amount that translates into between 4.3 percent and 8.6 percent of total community health center revenue. Losses of this magnitude translate into the loss of as many as 8,900 to 17,800 community health center jobs and would reduce the number of patients served by as many as 1.1 million to 2.2 million per year.

Introduction

In *Legacy Community Health Services v. Smith*, 881 F.3d 358 (5th Cir., 2018), the United States Court of Appeals for the Fifth Circuit ruled that despite Medicaid's federally qualified health center (FQHC) payment rules, a state Medicaid program may refuse to pay community health centers for the non-emergency, out-of-network care they furnish to enrollees of managed care plans. The ruling applies to all entities treated as federally qualified health centers under Medicaid, both those that receive federal health center grant funding under § 330 of the Public Health Service Act and "look-alike" FQHCs that meet § 330 requirements but may be funded for the indigent care they furnish through state and local funding rather than federal grants.

The *Legacy* decision carries important implications for the financial stability of community health centers in states that rely extensively on managed care, because the decision effectively penalizes community health centers for fulfilling their most fundamental § 330 obligation – to serve all community residents regardless of their insurance status or status as Medicaid managed care enrollees. Furthermore, the *Legacy* decision creates a major incentive for states and managed care plans to refuse to extend in-network status to community health centers, thereby pushing onto federal grant funds (or funds provided by state and local governments) potentially millions of dollars in care costs attributable to Medicaid, essentially making Medicaid a "free-rider" on grant funds intended for indigent health care.

Furthermore, the decision not only creates large financial risks for community health centers and the uninsured patients they serve, but also upends the careful relationship – spelled out in the Medicaid statute itself – that Congress created in order to balance health centers' obligations to serve the entire community under § 330 on the one hand, and state flexibility to adopt market-based solutions for delivering and paying for health care on the other. The ruling violates Medicaid's FQHC coverage and payment rules – rules Congress preserved and maintained as part of its 1997 state flexibility amendments under the Balanced Budget Act (BBA). Indeed, the decision runs counter to other key rulings by other federal courts of appeal. The decision also runs counter to federal policy positions taken by the Centers for Medicare and Medicaid Services (CMS) regarding the obligation of state Medicaid programs to pay for all medically necessary health care furnished by FQHCs and covered under states' Medicaid plans, regardless of whether such care is furnished in-network or on an out-of-network basis.

For these reasons, lawyers representing Legacy Community Health Services have petitioned the United States Supreme Court to review the 5th Circuit ruling,[1] and faculty of the Geiger Gibson Program in Community Health Policy at the George Washington University's Milken Institute School of Public Health have filed an amicus brief in support of this request for Supreme Court review.[2] The amicus brief explains the legal issues in more depth; this policy brief provides an overview of the background and describes the potential impact.

In this policy brief, the Geiger Gibson/RCHN Community Health Foundation Research Collaborative presents the results of an analysis, designed to accompany the amicus brief, regarding the potential impact of *Legacy* on community health centers across the nation. If the decision is permitted to stand, community health centers, patients, and medically underserved communities could feel the repercussions, which could be particularly severe for those health centers operating in states with high managed care penetration rates.

It is difficult to predict the nationwide impact of a policy such as this with precision, because it depends on variables such as any particular state's participation in Medicaid managed care, how managed care plans interact with particular community health centers in terms of the contracts they offer, the relative accessibility of in-network care for enrollees and the sufficiency of plans' provider networks, the degree to which health centers have many longstanding patients who will continue to seek care from them regardless of their network status, and the possibility of not only total exclusion but of exclusion for all but selected services. Since community health centers cannot turn away the patients in their service areas and must accept them all into care regardless of their ability to pay or their managed care plan enrollment status, we assume that the impact of the Texas policy, if extended to other states, will be a constant issue and is one that may be likely to grow as states and plans realize that free-riding is possible simply by refusing to make a community health center in the plan's service area in-network.

Background

In 2016, 1,367 community health centers furnished care to nearly 25.9 million patients in approximately 10,400 urban and rural community locations.[3] Community health centers are active participants in Medicaid managed care; in 2016, 58 percent of all community health centers reported Medicaid managed care participation,[4] reporting nearly 93.4 million managed care member months that year.[5]

Although they participate in all federal insurance programs, community health centers must abide by special Public Health Service Act requirements aimed at ensuring universal access to care, regardless of ability to pay. By law, community health centers must serve all patients regardless of insurance status; this means that they may not deny care to those who are enrolled in a Medicaid plan whose provider network they may not be part of.

In any given year, community health centers operating in states that rely on managed care plans using provider networks can be expected to serve many out-of-network patients. In states that use managed care, community health centers are active participants. However, they do not all necessarily participate in all managed care plans, with the net result that they may be out-of-network for some plans. But even if a Medicaid managed care plan limits the providers available to its members, those members may still seek care from community health centers in their communities – without regard to whether they are in a network — for many reasons. They may experience access barriers within the networks contracted by their own

[1] The petition for writ of certiorari can be accessed at https://publichealth.gwu.edu/sites/default/files/downloads/GGRCHN/Legacy%20Petition%20AS%20FILED.pdf

[2] The amicus brief can be accessed at https://publichealth.gwu.edu/sites/default/files/downloads/GGRCHN/Legacy%20Community%20Health%20Services%20v%20Smith%20Amicus%20Brief.pdf

[3] Bureau of Primary Health Care. (2017). 2016 National Health Center Data: National Data. Health Resources and Services Administration. https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2016&state=; 2016 Uniform Data System (UDS) data

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

[5] Bureau of Primary Health Care. (2017). 2016 National Health Center Data: National Data. (Table 4). Health Resources and Services Administration. https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2016&state

managed care plans; they have come to rely on the community health center for special needs in managing chronic illness; the local health center may maintain hours that work for them or may be close to where they live; or they are perhaps new to Medicaid managed care and unfamiliar with the distinction between in-network and out-of-network care.

Recognizing that the growth of managed care could affect community health centers obligated to provide care to all and increasingly exposed to the possibility of non-payment for out-of-network care, Congress sought to balance two imperatives when it expanded states' managed care options in 1997.[6] Under the 1997 law, states have the flexibility to establish mandatory Medicaid managed care systems for most beneficiaries; the law also incentivizes community health center participation by ensuring that plans pay them no less than competitive rates when they become network providers.

But in order to avoid results that would leave health centers unpaid for the Medicaid-covered services they furnish – a guarantee established under federal law in 1989 – Congress also required that states pay community health centers for all covered services furnished to Medicaid beneficiaries, in accordance with the FQHC payment rate. This requirement was preserved in 1997, when Congress expanded state flexibility to adopt Medicaid managed care as a state option. While the FQHC payment methodology underwent modification in 2000, the basic principle – that states must pay for covered services furnished by entities designated as community health centers at the FQHC payment rate – remains enshrined in law, and the statute's FQHC coverage and payment rules draw no distinction between in-network or out-of-network care.

For decades this compromise has worked. In communities in which Medicaid managed care is a key feature of the Medicaid program, community health centers participate extensively. Indeed, community health centers' participation is crucial to managed care success because of the degree of reliance states and plans place on community health centers as a leading source of primary health care for Medicaid beneficiaries. At the same time, regardless of whether their Medicaid patients are in- or out-of-network, community health centers continue to be paid for the covered services they furnish, thereby preserving grant funds for care of the uninsured. This carefully-wrought policy compromise ensures that community health centers can preserve their relatively modest grants (including federal grants under Section 330 of the Public Health Service Act) for care furnished to uninsured populations as well as for key primary health services that many state Medicaid plans may not cover for working age adults or the elderly, such as dental, substance abuse, vision, and enabling services for working-age adults.

The *Legacy* case upends this special set of relationships among state Medicaid agencies, community health centers, and managed care organizations. Although the decision focuses on the financial relationship between one FQHC and one Medicaid managed care organization, if applied more broadly, *Legacy* could create a powerful incentive for free-riding – that is, excluding of community health centers as contracted network providers and rejecting claims for all but emergency care furnished out of network. States in turn, as Texas has done, could then refuse to pay for non-emergency out-of-network care – not only the special payment supplement required under the FQHC payment methodology but also the basic payment as well. As non-emergency out-of-network care volume grows, community health center uncompensated care volume would increase, thereby shifting costs to grants intended for care of the uninsured. Because these grants, while vital, also are limited (accounting for less than 20 percent of total community health center revenue in 2016),[7] this cost shift ultimately would be expected to lead to widespread reductions in services, staffing, and ultimately, patient care capacity.

[6] Balanced Budget Act of 1997, Pub. L. 105–33, 111 Stat. 251 (105th Cong. 1st sess.)

[7] Rosenbaum, S., Tolbert, J., Sharac, J., Shin, P., Gunsalus, R. & Zur, J. (2018). Community Health Centers: Growing Importance in a Changing Health Care System. Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/community-health-centers-growing-importance-in-a-changing-health-care-system/

Potential National Impact of the Texas Policies

In *Legacy*, the Texas Children's Health Plan (TCHP) excluded the community health center from its provider network. Legacy Community Health Services is a particularly notable provider of children's mental health care, a service very difficult to secure for Medicaid children, and one that, compared to primary health care generally, can be relatively costly because of its time and intensity. The plan paid only 3,000 of the 6,000 claims that Legacy submitted for the various types of out-of-network care it furnished, labeling the paid claims as "emergency" care.[8] The plan rejected the remaining 3,000 claims as being both out-of-network and non-emergency. The state of Texas then refused to pay these denied claims – both the plan's share and its supplemental share under the FQHC Medicaid payment methodology. (Subsequently, TCHP agreed to restore Legacy's network status for children's behavioral services, but not for the other primary care services Legacy furnishes).

It is difficult to predict the impact of the exclusion of payment to community health centers for out-of-network non-emergency care. As noted, these effects could be expected to vary from state to state and from health center to health center. Some Medicaid programs use managed care systems extensively, while others use little managed care. The eventual impact would also depend on subsequent interpretations and policy decisions made by CMS, states, and Medicaid managed care plans, such as what constitutes an "emergency" for FQHC payment purposes. However, there should be no doubt that the policy would create a strong financial incentive for managed care plans to exclude some or all community health centers from their provider networks and to reject out-of-network claims. This radical shift in policy away from what was intended under the 1997 amendments would also create an incentive for states and plans to deny payment for care; the plan would have made a determination that the visit was an unnecessary emergency care claim and would deny it, thereby eliminating the state's obligation to pay either the basic claim or the supplement owed. In other words, although community health centers participate extensively in managed care plans and bring great value to managed care systems, both plans and states would have a financial incentive to push care costs onto community health centers and their grant funding.

In Exhibit 1, we use 2016 data (the most recent year available) from the Uniform Data System,[9] the federal reporting system for community health centers administered by the Health Resources and Services Administration, to estimate the range of potential impacts of the broad application of such a policy at the national level. The top portion of the panel shows actual 2016 total community health center revenue for the nation, including Medicaid revenue and revenue from Medicaid managed care.

The lower portion of the exhibit illustrates the range of potential impacts, recognizing the inherent uncertainty of any prediction. If all Medicaid managed care organizations and states behaved in a fashion similar to Legacy, TCHP, and the state of Texas, community health centers would lose about 50 percent of all Medicaid managed care revenue. To be more conservative, Exhibit 1 illustrates the potential impacts if losses ranged from one-third (at the higher level) to one-sixth (at a lower level) of 2016 Medicaid managed care revenue. Under either scenario, we assume that community health centers would still be included in some managed care networks and some states would continue to provide supplemental payments, but that Medicaid revenue would decline overall because there would be a strong incentive for some managed care plans or states to reduce payments to community health centers.

If community health centers lose one-third of all Medicaid managed care revenue, this would equate to $2.0 billion in lost revenue, or 8.6 percent of total community health center revenue nationally in 2016. Under this scenario, 2.2 million patients would lose care nationally, including almost 700,000 children and 1.5 million adults. As seen in the

[8] Since community health centers provide primary care services and not emergency-department-level care, the plan may have identified certain services as meeting a level of urgency for which it was willing to pay. In a strict definition of emergency care, such as that used under the Emergency Medical Treatment and Labor Act, a health center would rarely, if ever, be paid for emergency care.

[9] The Uniform Data System data are available at https://bphc.hrsa.gov/uds/datacenter.aspx.

Exhibit 1. Potential Revenue Losses and Other Effects if the Texas Policy Applies Nationally

Actual Revenue in 2016	National
Total Community Health Center Revenue	$23,753,000,000
Total Medicaid Revenue	$10,289,000,000
Total Medicaid Managed Care Revenue (Payment Plus Supplementals)	$6,108,000,000

Potential Losses If Policy Is Applied Nationally	Assumed Medicaid Managed Care Revenue Lost	
	33% Lost	17% Lost
Revenue Lost	$2,034,000,000	$1,017,000,000
% of Medicaid Revenue Lost	19.8%	9.9%
% of Total Revenue Lost	8.6%	4.3%
Potential Numbers of Patients Who Could Not Be Served		
Total Patients	2,214,000	1,107,000
Children, 0-17	686,000	343,000
Adults, 18 or Older	1,529,000	764,500
Medicaid Patients	1,089,000	544,500
Medicare Patients	204,000	102,000
Uninsured Patients	519,000	259,500
Patients Below Poverty Line	1,120,000	560,000
African American Patients	431,000	215,500
Hispanic Patients	570,000	285,000
Other Race/Ethnicity Patients	1,213,000	606,500
Potential Reduction in Patient Visits	8,916,000	4,458,000
Potential Reduction in Staffing		
Total Community Health Center Staff	17,780	8,890
Medical Staff	6,200	3,100
Mental Health/Substance Abuse Staff	890	440
Dental Staff	1,380	690

Source: Health Resources and Services Administration, Uniform Data System for 2016. Sums may not total due to rounding.

exhibit, we estimate that such revenue losses would harm care not only for Medicaid patients, but for those on Medicare and the uninsured as well. Large numbers of patients with incomes below the poverty line and African American and Hispanic patients would be disenfranchised. In total, the volume of care provided by community health centers would be reduced by 8.9 million visits. The revenue losses would also result in about 18,000 full-time equivalent (FTE) community health center staff members nationally losing their jobs. Personnel losses would include medical providers as well as dental, mental health, substance abuse, and enabling services staff.

Under the more conservative scenario in which only one-sixth of Medicaid managed care revenue is lost, community health centers would lose $1.0 billion nationally. As a result, 1.1 million patients nationwide could lose care at community health centers and about 8,900 FTE staff members nationwide would lose their jobs.

In light of the uncertainty, we offer this wide range of estimates of potential effects. But even the lower impact estimate signals serious repercussions for vulnerable Medicaid enrollees, including those living in areas where there is an undersupply of health care providers, as well as for other vulnerable patients.

Conclusion

If Texas's policy is permitted to stand and to apply nationally, it could have grave consequences. The broader application of this policy would give states and Medicaid managed care plans a substantial incentive to push community health centers out of network, or to deny them in-network participation status to begin with, thereby excluding community health centers as in-network providers. Coupled with states' refusal to provide supplemental payments, this would put enormous strain on total community health center revenue and lead to staffing losses and major reductions in care capacity, decreasing the total number of people who would receive care. This result is exactly what Congress intended to avoid by combining greater flexibility for states on Medicaid managed care with rules regarding payment for medically appropriate Medicaid-covered services furnished by community health centers as participating FQHCs, regardless of the managed care enrollment status of their patients.

A substantial body of research points to the importance and cost-effectiveness of the comprehensive primary care that community health centers furnish. The research shows that patients cared for at community health centers receive high quality primary care, which results in the reduction of net medical and Medicaid expenditures.[10] The provision of timely primary care can reduce the need for, and cost of, expensive specialty, emergency, or inpatient care and can lower medication expenses.

Thus, paradoxically, the net result of the loss of care at community health centers could be reduced access to the very care that helps control state and federal health care costs. It is this serious consequence that caused Congress to design a far more careful approach to Medicaid managed care, one that permits states great flexibility in moving to market-based strategies for coverage and care delivery while leaving undisturbed the primary care providers on which thousands of communities depend.

[10] For example, see: Bruen, B. & Ku, L. (2017) Community health centers reduce the costs of children's health care. Geiger Gibson / RCHN Community Health Foundation Research Collaborative Policy Research Brief # 48. Duggar, B., Keel, K., Balicki, B., & Simpson, E. (1994). Utilization and costs to Medicaid of AFDC recipients in New York served and not served by community health centers. Rockville, MD: Health Resources and Services Administration, Bureau of Primary Health Care, Center for Health Policy Studies. Epstein, A. (2001). The role of public clinics in preventable hospitalizations among vulnerable populations. Health Services Research, 36(2), 405-420. Falik, M., Needleman, J., Wells, B. L., & Korb, J. (2001). Ambulatory care sensitive hospitalizations and emergency visits: Experiences of Medicaid patients using federally qualified health centers. Medical Care, 39(6), 551-561. Mundt, C., & Yuan, S. (2014). An evaluation of the cost efficiency of Federally Qualified Health Centers (FQHCs) and FQHC lookalikes operating in Michigan. Lansing, MI: The Institute for Health Policy at Michigan State University. Nocon R., et al. (2016). Health care use and spending for Medicaid enrollees in federally qualified health centers versus other primary care settings. American Journal of Public Health, 106(11): 1981-89. Probst, J. C., Laditka, J. N., & Laditka, S. (2009). Association between community health center and rural health clinic presence and county-level hospitalization rates for ambulatory care sensitive conditions: An analysis across eight US states. BMC Health Services Research, 9(134). doi: 10.1186/1472-6963-9-134. Richard, P., Ku, L., Dor, A., Tan, E., Shin, P., & Rosenbaum, S. (2012). Cost savings associated with the use of community health centers. Journal of Ambulatory Care Management, 35(1), 50-59. Rothkopf, J., Bookler, K., Wadhaw, S., & Sajowetz, M. (2011). Medicaid patients seen at federally qualified health centers use hospital services less than those seen by private providers. Health Affairs, 30(7), 551-561. Streeter, S., Braithwaite, S., Ipakchi, N., & Johnsrud, M. (2009). The effect of community health centers on healthcare spending & utilization. Washington, DC: Avalere Health.