NO.

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

WASHINGTON STATE HEALTH CARE AUTHORITY and SWINOMISH INDIAN TRIBAL COMMUNITY, Petitioners, v. CENTERS FOR MEDICARE AND MEDICAID SERVICES, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, Respondent.	PETITION FOR REVIEW OF SECRETARY'S FINAL DECISION

The Washington State Health Care Authority ("State") and the Swinomish Indian Tribal Community ("Tribe") jointly petition this Court for review of the final determination made by the Secretary of the United States Department of Health and Human Services, acting through the Administrator of the Centers for Medicare and Medicaid Services, to disapprove the State's proposed Medicaid State Plan Amendment 17-0027 (Attachment 1). The Secretary's final determination is dated January 19, 2021.

The State and the Tribe file this Petition for Review under the authority of 42 U.S.C. § 1316(a)(3), 42 C.F.R. §§ 430.38(a) and 430.102(c), and Federal Rule of Appellate Procedure 15(a). The Petition has been filed within the 60-day deadline required by 42 U.S.C. § 1316(a)(3) and 42 C.F.R. § 430.38(b)(1).

RESPECTFULLY SUBMITTED this __ day of February, 2021.

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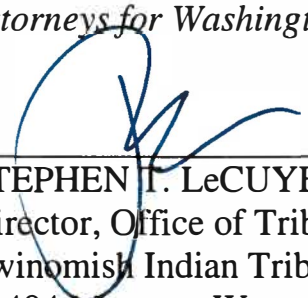

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PROOF OF SERVICE

I hereby certify that I caused to be electronically filed, the foregoing/attached document(s) on the below date with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit using the Appellate Electronic Filing system.

I further certify that I caused to be served, the foregoing/attached document(s) via email to all registered case participants on this date because it is a sealed filing or is submitted as an original petition or other original proceeding and therefore cannot be served via the Appellate Electronic Filing system.

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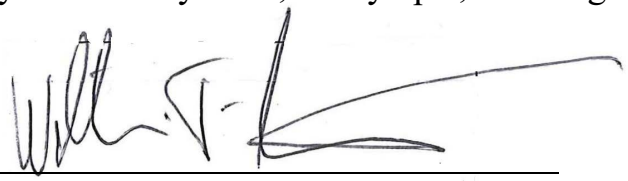
I certify under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

DATED this 16th day of February 2021, at Olympia, Washington.



William T. Stephens, Assistant Attorney General

ATTACHMENT 1

CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the matter of:	
The Disapproval of the	
Washington State Plan Amendment 17-0027	Hearing Docket No. 2018-01

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for the final agency review pursuant to 42 C.F.R. §430.102. The CMS Presiding Officer presented his recommended findings and proposed decision to the Administrator. CMS' submitted exceptions to the Presiding Officer's recommended decision. All exceptions to the CMS Presiding Officer's recommended decision have made part of the administrative record and reviewed.

Proposed State Plan Amendment 17-0027

The issue is whether the proposed State of Washington State Plan Amendment (SPA) 17–0027 is inconsistent with the requirements of section 1902(a)(23) of the Social Security Act because it would restrict access to services provided by Dental Health Aide Therapists (DHATs) to a limited group of beneficiaries, and it would also prevent beneficiaries from receiving DHAT services from similarly qualified dental services providers that provide services outside the boundaries of a tribal reservation or that are not Indian health programs.[1]

Background

On August 22, 2017, the Washington State Health Care Authority (also referred to as HCA or the State), submitted proposed SPA 17-0027, to authorize reimbursement for Dental Health Aide Therapists or "DHATs" in accordance with Senate Bill 5079, signed into law on February 22, 2017.

The SPA 17–0027 proposed the coverage and reimbursement of services provided by DHATs only when furnished in a practice setting within the boundaries of a tribal reservation and only when provided to Medicaid beneficiaries that are members of a federally recognized tribe or otherwise eligible for services under Indian Health Service (IHS) criteria. Therefore, the proposed SPA will not permit Medicaid beneficiaries to receive Medicaid coverage for DHAT services if they are not members of a federally recognized tribe or otherwise eligible for services under IHS criteria.

[1] CMS also disapproved the proposed SPA based on section 1902(a)(10)(A) of the Act. The record indicates that this issue was resolved by a stipulation between CMS and the State while pending before the Presiding Officer. To resolve the issue, the State agreed to substitute certain pages in the SPA in order to satisfy the language in the proposed SPA that had been found to be insufficient.

By lettered dated August 22, 2017, Washington submitted Medicaid State Plan Amendment (SPA) 17-0027 "in order to authorize reimbursement for Dental Health Aide Therapists (DHATs) in accordance with Senate Bill 5079, signed into law on February 22, 2017." [2]The attachment with the SPA revisions included certified registered dental health aide therapists, as included as all other practitioners covered by the Medicaid program. [3]CMS sent questions and HCA responded regarding issues relating to DHATs' scope of practice, licensure and supervision questions.

On August 28, 2017, CMS asked whether DHATs were license, and if unlicensed, that the State clarify issues about their supervision. On September 6, 2017, HCA sent CMS answers explaining, among other things, that DHATs are "not licensed under state law." HCA also submitted revised SPA pages that referred to provisions of the Revised Code of Washington. The proposed SPA described all other practitioners covered by the Medicaid agency to include "dental health aide therapists (in accordance with the requirements in chapter 70.350 RCW and the exemptions in RCW 18.29.180, 18.32.030, 18.260.110, and 18.350)." [4]

The State explained that all services are performed: 1) in a practice setting with the exterior boundaries of tribal reservation and operated by an Indian health program; in accordance with the standards adopted by the certifying body in (a) of this subsection, including scope of practice, training, supervision, and continuing education; 2) pursuant to any applicable written standing orders by a supervising dentist; and 3) on persons who are members of a federally recognized tribe or otherwise eligible for services under Indian Health Service criteria, pursuant to the Indian Health Care Improvement Act. [5]

On September 7, 2017, CMS sent a second set of questions. CMS requested that the State "Please remove the addition of '(in accordance with the requirements in chapter 70.350 RCW and the exemptions in RCW 18.29.180, 18.32.030, 18.260.110, and 18.350.060)' from the state plan amendment (SPA) language since state regulation citations are not appropriate for inclusion in the state plan language." [6] CMS also stated that HCA had not added the requested language about supervision to the SPA and asking HCA to include the title of the licensed supervising practitioner who could supervise DHATs within their scope of practice.

On September 11, 2017, HCA responded to CMS' second set of questions and submitted a revised proposed SPA. The revised Attachment 3.1-A stated that DHATs would provide services under the supervision of a dentist within their scope of practice as defined under state law. The supervising licensed practitioner assumes professional responsibility for the services provided by the unlicensed practitioner and the licensed practitioner bills for services furnished by unlicensed practitioners. The State also removed the reference to the State law and regulations describing the DHATs.

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[2] CMS Administrative Record (A.R.) 131.
[3] CMS A.R. 133.
[4] CMS A.R. 123.
[5] Washington State Response, dated September 6, 2017, CMS A.R. 122.
[6] CMS A.R. 119.

On October 12, 2017, HCA sent a revised SPA, which incorporated changes it received from the Swinomish Indian Tribal Community therapists. Finally, on October 25, 2017, during a technical assistance call with CMS, Washington asserted that DHATs do not require supervision to furnish services because DHAT certification is equivalent to licensure in the State.

On November 16, 2017, CMS issued a formal request for additional information (RAI), citing the freedom of choice of provider provision at section 1902(a)(23) of the Act and the regulation at 42 C.F.R. § 431.51. CMS stated that:

> [N]on-tribal beneficiaries in the state are unable to receive the services from a qualified DHAT. These limitations are unrelated to the ability of the provider to perform the medical service. Lastly, it appears that the state has established qualifications of the DHAT to include criteria unrelated to the ability of the provider to perform the medical service.
>
> I. Please add an assurance in the state plan that all Medicaid beneficiaries may choose to receive services from a qualified DHAT and that any willing and qualified provider may become a provider of this service even if they are not providing services on tribal lands.

After consultation with the tribe and further communications with CMS, on February 14, 2018, the HCA filed its response to CMS' information request, incorporating comments from the tribal consultation requesting that CMS reconsider how it apparently proposed to apply the free choice of provider rule to SPA 17-0027.[7] The State did not incorporate the changes requested by CMS, which CMS stated were required to conform to section 1902(a)(23) of the Act and the regulation at 42 C.F.R. § 431.51. The State requested that CMS approve SPA 17-0027 and further request technical assistance to effect the direction of SSB 5079 for Medicaid reimbursement of DHATs. By letter dated February 22, 2017, the Chairman of the Swinomish Indian Tribal Community wrote in support of the State's response to CMS RAI. [8]

On May 14, 2018. CMS denied the proposed SPA. CMS stated:

> [U]nder the state plan, states are not authorized to limit beneficiaries' free choice of willing and qualified providers, which means that states must ensure that all willing and qualified providers are able to furnish state plans services to beneficiaries who opt to receive those services from them. On its face, proposed WA SPA 17-0027 is inconsistent with section l 902(a)(23) because it would restrict DHAT access to a limited group of beneficiaries, and it would also prevent beneficiaries from receiving DHAT services from similarly qualified dental services providers that provide services outside the boundaries of a tribal reservation or that are not Indian health programs. We find Washington's arguments in its response to the RAI that SPA 17-0027 is nonetheless consistent with section 1902(a)(23) to be unpersuasive, and to be inconsistent with binding,

[7] CMS A.R.23.
[8] CMS A.R.18.

federal legal precedent from the U.S. Court of Appeals for the Ninth Circuit interpreting the plain language of section l 902(a)(23).[9]

After explaining the reconsideration process, CMS also offered technical assistance regarding Medicaid coverage for dental mid-level practitioners, including DHATs.

HCA requested reconsideration of CMS' disapproval on June 8, 2018. Pursuant to a letter dated July 6, 2018[10] (published in the *Federal Register* at 83 Fed. Reg. 32300-01 (July 12, 2018)), the CMS Administrator scheduled the subject hearing in response to HCA's request for reconsideration and appointed the CMS Presiding Officer.

On July 19, 2018, pursuant to 42 C.F.R. § 430.76(b)(2), the Swinomish Indian Tribal Community (Swinomish Tribe) filed an unopposed petition to participate as a party. The Presiding Officer granted the petition on July 30, 2018. In addition, the Presiding Officer received three petitions for participation as amicus curiae. Amicus curiae status was granted, pursuant to 42 C.F.R. § 430.76(c)(l), to the Washington State Dental Association jointly with the American Dental Association (WSDA/ADA), the Northwest Portland Area Indian Health Board (NPAIHB) and the Lummi Tribe of the Lummi Indian Reservation ('Lummi Nation) A hearing was held on December 18, 2018.

CMS Presiding Officer Recommended Decision

The CMS Presiding Officer found that the proposed Washington State Plan Amendment 17-0027 complies with section 1902(a)(23) of the Social Security Act. The Presiding Officer held that the SPA would, in effect, provide beneficiaries in Washington the affirmative right to utilize DHATs, which is dependent upon a factor beyond the DHAT's medical qualification to provide the services. The Presiding Officer found that this fact did not constitute a section 1902(a)(23) violation. The Presiding Officer claimed that the "statutory provision itself establishes no requirement that a State either consider or ensure that beneficiary sub-groups have a congruent universe of qualified and willing providers from which to choose." The Presiding Officer claimed CMS' analysis "conflates" a "lack of eligibility or entitlement" to obtain treatment from a qualified provider based upon beneficiary-specific parameters, with a statewide disqualification of a health care provider to serve the Medicaid population as a whole. The Presiding Officer also distinguished this case from the Ninth Circuit Court of Appeals case involving section 1902(a)(23) of the Act, which CMS had found was controlling and required the disapproval.

[9] CMS A.R. 23.
[10] CMS A.R. 1.

Discussion

The Medicaid Program, enacted in 1965 as Title XIX of the Act, is jointly financed by the Federal and State governments and is administered by the States. Section 1901 of the Social Security Act and the promulgating regulation at 42 C.F.R. § 430.0 provide that within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures.[11] Under section 1902 (a), to receive Federal funding, a participating State must develop a "plan for medical assistance" and submit it to the Secretary for approval. Congress granted the Secretary authority to administer the Medicaid program at the Federal level, which includes reviewing state plans and any state plan amendment (SPA) for compliance with Federal law under section 1902(b). The Act provides that "[t]he Secretary shall approve any plan, which fulfills" the statutory requirements. The Secretary has delegated the responsibility and authority to approve State plans and SPAs to the CMS Administrator and, in turn, the CMS delegated officials.

Pursuant to section 1905(a)(6) of the Social Security Act, the Medicaid Act provides for the payment of physician services and dental services, and the Act authorizes payment of the services of "other licensed practitioners" as "medical assistance." The regulation at 42 C.F.R. § 440.60(a) further provides that "[m]edical care or any other type [of] remedial care provided by licensed practitioners means any medical or remedial care or services, other than physicians· services provided by licensed practitioners within the scope of practice as defined under State law" and may be provided by unlicensed providers if they are provided under the supervision of a licensed practitioner as defined under State law.

The statute also provides for the freedom of choice provision at section 1902(a) of the Act by requiring that:

> A State plan for medical assistance must-
>
> * * * *
>
> (23) provide that:
>
> (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides

[11] The Secretary has authority to issue regulations under the program. The regulations at 42 C.F.R. Part 430 implement the statute and set forth the State plan requirements, standards, procedures and conditions for obtaining Federal financial participation (FFP). States that choose to participate in the Medicaid program must submit to the Secretary a State plan to provide medical assistance. The Secretary has delegated responsibility for approving State plans and state plan amendments to CMS. 42 C.F.R. § 430.12. State plans must contain all information necessary for CMS to determine whether the plan can be approved. 42 C.F.R. § 430.10.

> such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services…[12]

The statute is implemented in the regulations at 42 C.F.R. §431.51, which also reflects the exceptions to this requirement as set forth in the statute and is based on sections 1902(a)(23), 1902(e)(2), and 1915(a) and (b) and 1932(a)(3) of the Act. 42 C.F.R. §431.51(a)(1) states that:

> (1) Section 1902(a)(23) of the Act provides that beneficiaries may obtain services from any qualified Medicaid provider that undertakes to provide the services to them.
> …
> (b) State plan requirements. A State plan, except the plan for Puerto Rico, the Virgin Islands, or Guam, must provide as follows:
> (1) Except as provided under paragraph (c) of this section and part 438 of this chapter, a beneficiary may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is -
> (i) Qualified to furnish the services; and
> (ii) Willing to furnish them to that particular beneficiary.
> This includes an organization that furnishes, or arranges for the furnishing of, Medicaid services on a prepayment basis.
> ….
> (c) Exceptions. Paragraph (b) of this section does not prohibit the agency from -
> (1) Establishing the fees it will pay providers for Medicaid services;
> (2) Setting reasonable standards relating to the qualifications of providers; or
> (3) Subject to paragraph (b)(2) of this section, restricting beneficiaries' free choice of providers in accordance with one or more of the exceptions set forth in § 431.54, or under a waiver as provided in § 431.55; or

[12] Under section 1115 of the Act, CMS may approve any experimental, pilot, or demonstration project that, in the judgment of CMS, is likely to assist in promoting the objectives of certain Act programs including Medicaid. Congress enacted section1115 of the Act to ensure that federal requirements did not "stand in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients." As relevant here, section 1115(a)(1) of the Act allows CMS to waive compliance with the Medicaid program requirements of section 1902 of the Act, to the extent and for the period CMS finds necessary to carry out the demonstration project. In addition, section 1115(a)(2) of the Act allows CMS to provide federal financial participation for demonstration cost that would not otherwise be considered as federally matched expenditures under section 1903 of the Act, to the extent and for the period prescribed by CMS. ("Sec. 1115 (a) In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of title I, X, XIV, XVI, or XIX, or part A or D of title IV, in a State or States— (1) the Secretary may waive compliance with any of the requirements of section 2, 402, 454, 1002, 1402, 1602, or 1902, as the case may be, to the extent and for the period he finds necessary to enable such State or States to carry out such project…")

> (4) Limiting the providers who are available to furnish targeted case management services defined in § 440.169 of this chapter to target groups that consist solely of individuals with developmental disabilities or with chronic mental illness. This limitation may only be permitted so that the providers of case management services for eligible individuals with developmental disabilities or with chronic mental illness are capable of ensuring that those individuals receive needed services.[13]

In addition, section 1911(c) of the Social Security Act provides that: "The Secretary is authorized to enter into agreements with the State agency for the purpose of reimbursing such agency for health care and services provided in Indian Health Service facilities to Indians who are eligible for medical assistance under the State plan."

Indian Health Service Community Health Aide Program (CHAP)

Relevant to the State's arguments in this case, in the 1960s the Indian Health Service (IHS) created the Community Health Aide Program (CHAP) to address shortages of medical professionals in Alaska.[14] In 1968, the CHAP received formal recognition and congressional funding.[15] Dental health aide therapists or DHATs are a class of dental health professional, created by the IHS to provide services under the CHAP. As set forth in 25 U.S.C. §1616l, Congress subsequently provided statutory authority for Community Health Aides in the Indian Health Care Improvement Act (IHCIA). By statute, IHS approves community health aide practitioners who have successfully completed training through a Federal certification board. 25 U.S.C. §1616l(b)(3). In the early 2000s, the Alaska CHAP added DHATs to the types of providers trained and certified by the Alaska Certification Board. Consequently, during this period, community health aide practitioners were only authorized under the IHS for the Alaskan tribal community.

In 2010, Congress authorized the IHS to expand the CHAP beyond Alaska as set forth at 25 U.S.C. §1616l, stating that: "[T]he Secretary, acting through the [Indian Health] Service, may establish a national [CHAP] program." The IHS is taking steps to nationalize this program and recently issued the Indian Health Service Circular No. 20-06 for Community Health Aide Program (dated 06-12-2020)[16] which states:

1. PURPOSE. To implement, outline, and define a National Community Health Aide Program (CHAP) policy for the contiguous 48 states. The policy encompasses community-based provider selection, culturally tailored care and curriculum, and competency-based education. The policy is also inclusive of health aides as part of a team of healthcare providers focused on providing effective, efficient, and patient-centered care, consistent with the structure of the Alaska CHAP.

[13] 56 FR 8847, Mar. 1, 1991, as amended at 67 FR 41094, June 14, 2002; 72 FR 68091, Dec. 4, 2007.
[14] See http://www.akchap.org/html/about-chap.html.
[15] https://www.ihs.gov/ehr/chap/resources.
[16] https://www.ihs.gov/ihm/circulars/2020/community-health-aide-program/

2. SCOPE. This policy implements the statutory requirements of the Indian Health Care Improvement Act (IHCIA) that apply to CHAPs operated by the Indian Health Service (IHS) and Indian Self-Determination and Education Assistance Act (ISDEAA) contractors outside of Alaska. It is not applicable to the Alaska CHAP. In this policy, CHAP refers to the CHAPs operated by the IHS or ISDEAA contractors in the contiguous 48 states. This policy is not applicable to Urban Indian Organizations (UIOs) because UIOs are not authorized by law to implement CHAPs.

Further, per paragraph 4, the Circular explains that:

> E. To date, Congress has not appropriated specific funding for the expansion of the CHAP. At the time of the effective date of this policy, the IHS Director has not determined how much, if any, of IHS' lump-sum appropriation will be used to carry out the CHAP in the contiguous 48 states. Tribes and Tribal Organizations may propose to redesign or re-budget a PSFA in their ISDEAA agreement subject to any other applicable requirements to include this program."

The expanded CHAP program, under 25 U.S.C. §1616l(d)(3)(A),[17] authorizes the services of DHATs in a State other than Alaska, if a State is one "in which the use of dental health aid therapist services or midlevel dental health provider is authorized under State law to supply such services in accordance with State law"'. At some point in the future, the services are to be paid through appropriations to the IHIS. The use and purposed use of DHATs has resulted in lobbying and litigation on this issue in Alaska and in opposition to the expansion beyond Alaska by certain dental groups.[18]

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[17] 25 U.S.C. 1616(ld) Nationalization of program
(1) In general
Except as provided in paragraph (2), the Secretary, acting through the Service, may establish a national Community Health Aide Program in accordance with the program under this section, as the Secretary determines to be appropriate.
(2) Requirement; exclusion
Subject to paragraphs (3) and (4), in establishing a national program under paragraph (1), the Secretary-
(A) shall not reduce the amounts provided for the Community Health Aide Program described in subsections (a) and (b); and
(B) shall exclude dental health aide therapist services from services covered under the program.
(3) Election of Indian tribe or tribal organization
(A) In general. Subparagraph (B) of paragraph (2) shall not apply in the case of an election made by an Indian tribe or tribal organization located in a State (other than Alaska) in which the use of dental health aide therapist services or midlevel dental health provider services is authorized under State law to supply such services in accordance with State law.
(B) Action by Secretary. On an election by an Indian tribe or tribal organization under subparagraph (A), the Secretary, acting through the Service, shall facilitate implementation of the services elected.

[18] See, e.g., IHCIA Coalition Letter to The Honorable Byron Dorgan, Chairman, Senate Committee on Indian Affairs, supporting limitation of DHATs to Alaska dated December 3,

Washington State Law

On July 23, 2017, the Washington Legislature formally authorized DHAT services in tribal settings under State law in Substitute Senate Bill ("SSB") 5079, §§ 1-3. [19]

> SSB 5079 § I [20]states:
> NEW SECTION. Sec. I. (I) The legislature finds that American Indians and Alaska Natives have very limited access to health care services and are disproportionately affected by oral health disparities. These disparities are directly attributed to the lack of dental health professionals in Indian communities. This has caused a serious access issue and backlog of dental treatment among American Indians and Alaska Natives. The legislature also finds that tribal leaders face a significant challenge in recruiting dental health professionals to work in Indian communities that results in further challenges in ensuring oral health care for tribal members.
> (2) The legislature finds further that there is a strong history of government-to-government efforts with tribes in Washington to improve oral health among tribal members and to reduce the disproportionate number of American Indians and Alaska Natives affected by oral disease. One of the goals in the 2010-2013 American Indian health care delivery plan developed jointly by the department of health and the American Indian health commission is to improve the oral health of tribal members and the ability of tribes to provide comprehensive dental services in their communities. A critical objective to achieving that goal is ·to explore options for the use of trained/certified expanded function personnel in order to increase oral health care services in tribal communities …
> (3) The legislature finds further that sovereign tribal governments are in the best position to determine which strategies can effectively extend the ability of dental health professionals to provide care for children and others at risk of oral disease and increase access to oral health care for tribal members. The legislature does not intend to prescribe the general practice of dental health aide therapists in the state.

2009, http://www.ada.org/~/media/ADA/Advocacy/Files/hcr_IHCIA_letter_091202.pdf; A Statement for the Record submitted by the American Dental Association February 29, 2012; Committee on Health, Education, Labor and Pensions Subcommittee on to Expand Access." http://www.ada.org/~/media/ADA/Publications/ADA%20News/Files/statement_120227_expandaccess.pdf

Jakush, J., Alaska lawsuit filed, ADA news, 37(3), Chicago, IL, American Dental Association. Posted January 31, 2006. http://www.ada.org/prof/resources/pubs/adanews/adanewsarticle.asp?articleid=1771

Alaska Dental Soc. v. Alaska Native Tribal Hlt. Consortium, No. 3:06-cv-00039 JWS, [Re: Motions at Docket Nos. 14 and 20] (D. Alaska Jun. 28, 2006)

[19] Chapters 70.350.0 I 0, 70.350.020 of the Revised Code of Washington ("RCW").

[20] (HCA Prehearing Brief: Exhibit CC at 2-4)

SSB 5079 § 2 authorized DHAT services as follows:
NEW SECTION. Sec. 2. (I) Dental health aide therapist services are authorized by this chapter under the following conditions:
(a) The person providing services is certified as a dental health aide therapist by:
(i) A federal community health aide program certification board; or
(ii) A federally recognized Indian tribe that has adopted certification standards that meet or exceed the requirements of a federal community health aide program certification board;
(b) All services are performed:
(i) In a practice setting within the exterior boundaries of a tribal reservation and operated by an Indian health program;
(ii) In accordance with the standards adopted by the certifying body in (a) of this subsection, including scope of practice, training. supervision, and continuing education;
(iii) Pursuant to any applicable written standing orders by a supervising dentist; and
(iv) On persons who are members of a federally recognized tribe or otherwise eligible for services under Indian health service criteria, pursuant to the Indian health care improvement act, 25 U.S.C. Sec. 1601 et seq.
(2) The performance of dental health aide therapist services is authorized for a person when working within the scope, supervision. and direction of a dental health aide therapy
training program that is certified by an entity described in subsection (I) of this section.
(3) All services performed within the scope of subsection (I) or (2) of this section, including the employment or supervision of such services, are exempt from licensing requirements under chapters 18.29, 18.32, 18.260, and 18.350 RCW.
SSB 5079 § 3 provides the following definitions:
NEW SECTION. Sec. 3. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.
(I) "Dental health aide therapist" means a person who has met the training and education requirements, and satisfies other conditions, to be certified as a dental health aide therapist by a federal community health aide program certification board or by a federally recognized Indian tribe that has adopted certification standards that meet or exceed the requirements of a federal community health aide program certification board.
(2) "Federal community health aide program" means a program operated by the Indian health service under the applicable provisions of the Indian health care improvement act, 25 U.S.C. Sec. 16161.

> (3) "Indian health program" has the same meaning as the definition provided in the Indian health care improvement act, 25 U.S.C. Sec. 1603, as that definition existed on the effective date of this section.[21]

State Arguments

The State (HCA) argued that the requirements in chapter 70.350 RCW reasonably related to the health and welfare of Washington State in terms of balancing respect for tribal sovereignty and deferral of DHAT authorization, the oral health crisis for American Indians and Alaska Natives in Washington State, and access to culturally appropriate care. Additionally, the State analyzed the relevancy of Planned Parenthood Arizona, Inc. v Betlach, 727 F.3d 960, 975 (9th Cir. 2013); Planned Parenthood of Indiana, Inc. v. Commissioner of the Indiana State Department of Health, 699 F.3d 962 (7th Cir. 2012) and Planned Parenthood of Gulf Coast, Inc. v. Gee, 862 F.3d 445 (5th Cir. 2017) arguing that it is inapposite to chapter 70.350 RCW and SPA 17-0027. The SPA17-0027, the State claimed, is distinguished from the Ninth Circuit case as it is expanding the types of providers and services that are available to tribal members. In consultation with the tribes, the Legislature determined that DHATs are qualified and willing to provide care to tribal members.

Regarding the issue of equal access between Medicaid beneficiaries and others, the State maintained that the requirements of chapter 70.350 RCW do not differ depending on whether the patient seeking services is covered by Medicaid or some other payer. Therefore, Medicaid beneficiaries have the same opportunities to choose among DHATs as are normally offered to the general population. To put it another way, there is a free choice of DHAT providers available in accordance with the statutory chapter. In addition, the requirements of chapter 70.350 RCW do not restrict coverage of dental services among Medicaid beneficiaries. The services that tribal members can now access through DHATs are also available to non-tribal

[21] Based on witness testimony, CMS pointed out that the passage of this legislation appeared to be the result of mixed support amongst various Dental groups, which resulted in the establishment of the DHAT services limited to tribal lands and members. See, CMS Post-Hearing Brief, at 2, Transcript (Tr.) at 141-142; see also, e.g., Gawel, R., "Washington State Passes Dental Therapy Bill for Tribal Lands" March 1, 2017 Todays Dental News https://www.dentistrytoday.com/news/todays-dental-news/item/1728-washington-state-passes-dental-therapy-bill-for-tribal-lands ("The ADA formally opposes the licensing of dental therapists, noting that there is no available data demonstrating that new practice models have increased access to care at a lower cost. In addition, the ADA reports that the current number of dentists will continue to grow through 2035 and outpace population growth, while 27% of dentists can add more patients. Instead of new professionals, the ADA believes efforts should focus on better connecting patients with care. The dental lobby is currently opposing a separate effort in the state's House of Representatives, House Bill 1364, that would permit dental therapists to practice statewide. But while the Washington State Dental Association is part of those efforts and had joined the ADA in previously opposing work to introduce dental therapists to tribal lands, it chose not to work against Senate Bill 5079.")

Medicaid clients from dentists and other providers located throughout the state; DHATs do not provide any services that are not available from other dental professionals.

The State argued that the services of DHATs are imperative to address the unique crisis of oral health in tribal country and claimed that CMS has not historically found any conflict between Medicaid's free choice of provider requirement and the fact that not all providers are eligible to become IHS or Tribal providers. The IHS and tribal programs operating under the Indian Self-Determination and Education Assistance Act are specifically authorized to bill and be reimbursed by State Medicaid programs through Section 1911 of the Social Security Act, In addition, under 25 U.S.C. § 1647a, a Medicaid program must accept an IHS or tribal health program as a provider eligible to receive payment on the same basis as any other qualified provider if the IHS or tribal health program meets generally applicable state or other requirements for participation in Medicaid. Furthermore, under 45 C.F.R. §80.3(d), the eligibility requirements for IHS and tribally-operated health programs do not constitute discrimination. The State claimed that the DHAT program and SPA 17-0027 further the policies embodied in these provisions.

Amici and other party

In addition to the legal arguments made corresponding to the ones offered by the State, the Swinomish Tribe, (which occupies the Swinomish Indian Reservation in Northwest Washington and operates health care programs in accordance with a self-governance compact and a funding agreement with the IHS), explained that, as IHS funding is generally insufficient, the Tribe supplements funding by utilizing its own funds and payments received from third parties, including insurers and the Medicaid program. The Tribe indicates that funding shortages have resulted in severe shortages of dentists and health disparities for tribal communities. After studying Alaska's DHAT program, the Swinomish Tribe's governing body (the Swinomish Indian Senate) decided to address the Tribe's long-standing oral health-related challenges by establishing its own DHAT program in which DHATs served under the supervision of a dentist. The use of DHATs intended to provide dentists the opportunity to focus on the more complex treatment needs, and to make the fullest use of each trained professional's skillset in the most efficient manner. Swinomish Washington State Medicaid Director testified that a dentist could perform all the services of a DHAT. The Tribe, through its Senate, enacted a dental licensing code that established a Dental Health Provider. The Licensing Board formed in December 2015 and all dental providers were licensed in January 2016. Additionally, in January 2016, the Swinomish Tribe hired a DHAT who previously trained and worked in Alaska to serve on the professional Swinomish dental team.

At this time, the Swinomish Tribe stated that other tribes within Washington State are sponsoring tribal members to be DHATs. The Confederated Tribes of the Colville Reservation, located on 1.4 million acres with 10,000 tribal members who use multiple clinics, is sponsoring a tribal member to be a DHAT. The Lummi Tribe of the Lummi Indian Reservation ('Lummi Nation), an amicus participant, has employees of its Tribal Health Center currently completing DHAT training. The Lummi Nation anticipates that the addition of DHATs would reduce costs; decrease appointment wait times thereby increasing access to emergent, preventative and restorative care; augment educational outreach and awareness.

NPAIHB joined fully in the legal analysis provided by the Swinomish Indian Tribal Community and the State and further discussed the impact on tribal health. The brief discussed at length the development and demonstrated success of the use of DHATs to improve tribal health and stated that DHATs are a proven tool in helping tribes address the pervasive and critical dental health disparities that plague their communities.

The Lummi Nation requested that the Presiding Hearing Officer reverse the CMS denial of State Plan Amendment 17-0027. The Lummi Nation faces significant oral healthcare challenges around access to care and the availability of providers on the Reservation. Permitting DHATs to treat patients would increase treatment rates by an estimated 50 percent. The addition of DHATs would enable an expansion of current on-site clinics at local schools and daycares, and the opening of a new on-site clinic at a senior living facility, bringing effective oral health treatment directly to patients and improving educational outcomes for children in the Lummi school system by reducing absenteeism. Due to the increased availability of care, dental clinics would commensurately be able to increase preventative and restorative care, as well as education outreach. The Lummi Nation anticipated that the approval of the State Plan Amendment would enable the Tribal Health Center to meet that goal with only a small budget increase. Without DHATs, meeting that goal will not be possible because the tribe cannot afford to hire the number of dentists required given budgeting constraints.

The Washington State Dental Association (WSDA) and the American Dental Association (ADA), serving as amici curiae, submitted the brief amicus curiae in support of Washington Medicaid SPA 17- 0027. The Amici strongly support CMS's approval of SPA 17-0027 for the reasons outlined.

Findings

The Administrator finds that Washington SPA 17-0027, as proposed, is contrary to section 1902(a)(23) of the Act. Absent a waiver or exception as provided by law, the Administrator finds that the Medicaid statute and regulations require that, under a State plan, beneficiaries must be able to obtain covered services from any willing and qualified provider/practitioner. However, in this case, the Administrator finds that Washington SPA 17-0027 restricts access to DHAT services for some Medicaid beneficiaries for reasons unrelated to whether DHATs are "qualified" to provide services to those beneficiaries. The plain language of section 1902(a)(23) sets forth a requirement that "any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services." The plain language of section 1902(a)(23) does not sets forth a requirement that a "discrete subset of individuals eligible" for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services.

Contrary to the State's arguments, section 1902(a)(23) is not satisfied if a Medicaid beneficiary, who is not a Tribal member, may receive the same dental procedures from a dentist that a DHAT could provide to a Tribal member.[22] As CMS pointed out, the issue is not one of comparability of services. The State's prohibition of access to "any individual eligible" for medical assistance from any DHAT (provider/practitioner type) qualified and willing to perform the service, warrants disapproval here. Section 1902(a)(23) of the Act guarantees each beneficiary a right to access the provider/practitioner (not the services) of their choice. Federal courts have consistently rejected the argument that States may use the availability of other providers/practitioners of the same services as a reason to deny access to a qualified and willing provider/practitioner. Thus, while the proposed Washington SPA 17-0027 does not limit access to dental services, it does limit access to the services performed by DHATs, such that the services are available only to some Medicaid beneficiaries, and not all Medicaid beneficiaries, contrary to section 1902(a)(23) of the Act.

The Presiding Officer's proposed decision mistakenly concludes that a State plan is in conformity with section 1902(a)(23) of the Act, if a subset of the eligible beneficiaries can receive covered services from a provider or practitioner type. Absent a waiver, the only basis that the statute provides to deny "any individual" his or her free choice of a willing provider is if the provider/practitioner is "unqualified." The record shows that the DHATs are qualified to provide mid-level dental services. The State's limitation of the Medicaid payment of DHAT services only when operated by an Indian health program Medicaid beneficiaries who are IHS eligible members/tribal members are not criteria that involves the fitness of the provider/practitioner to perform the service(s).

Generally, if an IHS clinic or other IHS provider/practitioner, such as a clinic, doctor or dentist, is unwilling to treat a non-HIS/tribal beneficiary, the beneficiary can receive services from a non-IHS clinic, doctor or dentist of the same provider/practitioner type. However, pursuant to this proposed SPA, the State has authorized DHAT services to be covered under the Medicaid OLP benefit for the entire provider/practitioner type that will be completely unavailable to Medicaid beneficiaries that are non-IHS eligibles/tribal members. While the State argues that CMS has not applied such a strict reading of the free-choice-of-provider requirement when applied in the Tribal health care context, neither the State, nor the other parties, have pointed to any other specific provider/practitioner type whose services are a covered benefit under Medicaid that is available only to IHS eligible member. The State has not cited any case law or statutory exception to the free choice of provider requirement to support that CMS must approve Medicaid coverage for a provider/practitioner type that is available only to IHS-eligible members in contradiction of section 1092(a)(23) of the Act.

CMS has not claimed that an IHS clinic that declines to provide services to Medicaid beneficiaries who are not IHS-eligible/tribal members is violating the free-choice-of-provider requirement. In that case, such a provider is unwilling to treat the beneficiary, with the term "willing" a necessary element of the requirement. Section 1902(a)(23)of the Act requires only that beneficiaries have the freedom to see any qualified and "willing" (i.e., one "who undertakes to provide him such services") provider/practitioner. CMS also did not based its disapproval on any challenge to the prerogative of Tribes to limit services provided on their

[22] CMS Pre-hearing Brief at 13.

lands. Rather, CMS disapproved the proposed SPA, because the State (not the tribe) will treat as "qualified" only those DHATs practitioners that provide services to persons who are members of a federally recognized tribe or otherwise eligible for services under IHS criteria. Because CMS agrees that Tribes may choose to not treat persons who are not "members of a federally recognized tribe" or are "otherwise eligible for services under Indian health service criteria," CMS' implementation of the plain language of the statute would not tax the resources of Tribal dental programs and undermine the reason for the program as suggested by the State.

The Washington State SPA would prevent any Medicaid beneficiaries from seeking DHAT services who are not Tribal members. The statute allows States to restrict Medicaid beneficiaries from using "unqualified" providers. It would defeat the purpose of the free choice of provider requirement and be contrary to its express language to allow States to create a provider type restricted to only a subgroup within the Medicaid population, where no "qualification" impediment exists for providing services to other beneficiaries.

The parties also argued that there are many Medicaid laws, regulations and policies that treat Indian Health Services providers differently from other providers in the Medicaid program and none of them requires States to treat non-Indian health care providers similarly in order to meet free choice of provider requirements. The special treatment of Indian Health Service providers has not resulted in an exception to the free choice of provider provision, but rather the prompt implementation of the section 1911 of the Act by CMS has been, in part at least, because of section 1902(a)(23) of the Act.[23] The issue is that the State seeks to exclude an entire provider/practitioner category and thereby the related proposed benefit, from non-IHS /tribal beneficiaries. Any special treatment of HIS facilities does not demonstrate that CMS can create an exception where there is none in the law, nor ambiguity in the language, to avoid application of a mandated Medicaid State plan statutory requirements. Congress specified how and when it required CMS to treat those beneficiaries differently, just as it specified when section 1902(a)(23) of the Act could be exempted or waived. Nowhere in the Medicaid statute

[23] As an example of the special treatment of Indian Health Service providers, CMS (formerly HCFA) at 42 Fed. Reg. 64345 (Dec. 23, 1977) provided that in accordance with section 1911(b) of the Social Security Act that:

> The Department finds that there is good cause to dispense with the Notice of Proposed Rulemaking since the law is already in effect and the intent of Congress is that Native Americans receive the benefits of the Medicaid program as soon as possible from qualified Indian Health Service facilities. This is evident from the law (Pub. L. 94-437), Section 1911(b) which allows participation in the program by those facility which, while not yet meeting all the conditions and requirements for compliance with the State plan, nevertheless have submitted an acceptable plan for achieving compliance. The prompt and complete implementation of the law would be further delayed in some States, therefore, by the time period required for the Notice of Proposed Rulemaking.

has Congress excused States from complying with section 1902(a)(23) in order to benefit the members of federally-recognized Tribes as the SPA proposes to do,// here.

Furthermore, the State asserted, citing to 25 U.S.C. §5392(a)(3), that Congress has instructed that HHS "shall interpret all Federal laws, Executive orders, and regulations in a manner that will facilitate ... the achievement of tribal health goals and objectives." Therefore, the State claims that CMS is violating this requirement by denying Federal Medicaid funding for DHAT services. However, CMS disapproval action is not contrary to any requirement that HHS interpret Federal laws for the foregoing ends. That cited provision is expressly qualified by the phrase "except as otherwise provided by law" As noted, while Congress specifically recognizes the foregoing intend of the IHCA, Congress also unambiguously set forth specific requirements and exceptions to the free choice of providers provision of the Medicaid law that does not encompass what the State requests be done here.[24] For the reasons explained above, section 1902(a)(23) does not permit the State to restrict who may receive services from DHATs based on criteria unrelated to whether they are "qualified" within meaning of the Act to provide those services. CMS stated that it "strongly supports DHATs and improving dental services for tribes", however, CMS must disapprove any SPA if it is contrary to the Medicaid statute and regulations. Because the proposed SPA does not comport with statutory and regulatory requirements, the proposed SPA is disapproved. CMS has stated that it remains willing to work with the State in the future to cover the issues that resulted in disapproval of this SPA, in an effort to reach a solution that meets Medicaid program requirements.

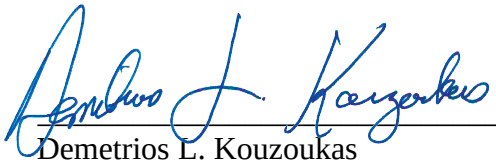
[24] As noted, the Medicaid statute with respect to the free choice of provider language and its exceptions has no such ambiguity in this respect to allow the interpretation advocated in this case.

DECISION

The CMS Presiding Officer's recommended decision is not adopted as the Decision of the Administrator in this case. The proposed WA SPA-17-0027 is disapproved.

THIS CONSTITUTES THE FINAL ADMINISTRATIVIE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: January 19, 2021



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