STATE OF WASHINGTON
HEALTH CARE AUTHORITY
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February 14, 2018

David L. Meacham
Department of Health and Human Services
Centers for Medicare and Medicaid Services
Seattle Regional Office
701 Fifth Avenue, Suite 1600, MS/RX-200
Seattle, WA 98104

Dear Mr. Meacham:

SUBJECT: REQUEST FOR ADDITIONAL INFORMATION – SPA 17-0027

This letter is in response to your letter dated November 16, 2017, request for additional information (RAI) from the Health Care Authority (HCA), in relation to the submission of Medicaid State Plan Amendment (SPA) 17-0027. SPA 17-0027 pertains to the provision of services by dental health aide therapists (DHATs). Centers for Medicare and Medicaid Services' (CMS) letter addressed federal Medicaid standards regarding the "*free choice of provider*" requirement and the "*other licensed practitioner*" benefit.

Background Principles

In considering SPA 17-0027, HCA believes it is useful to keep in mind certain basic principles of tribal sovereignty and tribal rights to organize for their common welfare, especially as they relate to the unique circumstances surrounding the oral health crisis in tribal country.

The United States Supreme Court has explained that Tribes are "domestic dependent nations" that exercise "inherent sovereign authority." *Michigan v. Bay Mills Indian Community*, 134 S. Ct. 2024, 2030 (2014) (quotation marks and citations omitted). In their status as "domestic dependent nations," the Tribes "exercise sovereignty subject to the will of the Federal Government." *Bay Mills*, 134 S. Ct. at 2039.

Similarly, the Washington Supreme Court has explained that Tribes are "unique entities which do not fit into neat pigeonholes of the law" but nonetheless whose "*sovereign characteristics* are well recognized." *Anderson v. O'Brien*, 84 Wn.2d 64, 67, 524 P.2d 390 (1974) (emphasis added) (citing *State v. Bertrand*, 61 Wn.2d 333, 339, 378 P.2d 427 (1963)). The Court further explained that the "federal government recognizes the right of a tribe to organize for its *common welfare*." *Anderson*, 84 Wn.2d at 67 (emphasis added) (citing 25 U.S.C. § 476).

Under the federal law cited in *Anderson*, "[a]ny Indian tribe shall have the right to organize for its *common welfare*[.]" *See* 25 U.S.C. § 476(a) (emphasis added). The law further provides that "each Indian tribe shall retain *inherent sovereign power* to adopt governing documents under [any] procedures" it desires. *See* 25 U.S.C. § 476(h)(1) (emphasis added).

In addition, the federal government has long had a policy of attempting to improve the health of tribal members. As part of the Indian Health Care Improvement Act (IHCIA), Congress found the following:

> **(1)** Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's *historical and unique legal relationship* with, and resulting responsibility to, the American Indian people.
>
> **(2)** *A major national goal of the United States is to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States.*
>
> **(3)** *A major national goal of the United States is to provide the quantity and quality of health services, which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services.*
>
> **(4)** Federal health services to Indians have resulted in a reduction in the prevalence and incidence of preventable illnesses among, and unnecessary and premature deaths of, Indians.
>
> **(5)** Despite such services, *the unmet health needs of the American Indian people are severe and the health status of the Indians is far below that of the general population* of the United States.
>
> *See* 25 U.S.C. § 1601 (emphasis added).

IHCIA goes on to describe Congressional policy:

> Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians—
>
> **(1)** to *ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy*;
>
> **(2)** to raise the health status of Indians and urban Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives;

> **(3)** to *ensure maximum Indian participation in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities*;
>
> **(4)** to increase the proportion of all degrees in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each Service area is raised to at least the level of that of the general population;
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> **(5)** to require that all actions under this chapter shall be carried out with active and meaningful consultation with Indian tribes and tribal organizations, and conference with urban Indian organizations, to implement this chapter and the national policy of Indian self-determination;
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> **(6)** to ensure that the United States and Indian tribes work in a government-to-government relationship to ensure quality health care for all tribal members; and
>
> **(7)** to provide funding for programs and facilities operated by Indian tribes and tribal organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service.
>
> *See* 25 U.S.C. § 1602 (emphasis added).

In recognition of these overarching federal goals and policies, the Indian Health Service and CMS (then known as the Health Care Financing Administration) entered into a Memorandum of Agreement in 1996 pertaining to healthcare services for Tribal members (Memorandum). The Memorandum explains as follows:

> The United States Government has a historical and unique legal relationship with, and resulting responsibility to the AI/AN [American Indian and Alaska Native] people. A major national goal of the United States is to provide the quantity and quality of health services, which will permit the health status of Indians to be raised to the highest possible level and to encourage maximum participation of AI/ANs in the planning and management of those services.
>
> *See* Memorandum at II.

The language of the federal statutes and memorandum illustrate both the current and historical imperative for the federal and state governments to support the DHAT initiative. The statutes emphasize the importance of the federal government's obligation to tribal health and the desire for tribes themselves to participate in the delivery of the services. And this is precisely what is occurring with the DHAT program.

Free Choice of Provider

Medicaid's free choice of provider requirement stems from the following authorities (emphases added):

1. **Social Security Act (SSA) §1902(a)(23)(A)**: The State Plan must provide that any Medicaid client "may obtain [medical] assistance from any [provider] qualified to perform the service…who undertakes to provide" the service.
2. **42 C.F.R. §431.51(b)(1)**: The State Plan must provide that "…a beneficiary may obtain Medicaid services from any [provider] that is (i) qualified to furnish the services; and (ii) willing to furnish them to that particular beneficiary."
3. **CMS State Medicaid Manual §2100**: "The purpose of the free choice provision is to allow title XIX recipients the same opportunities to choose among available providers of covered health care and services as are normally offered to the general population. This means that Title XIX recipients are subject to the same reasonable limitations in exercising such choice as are nonrecipients." After reiterating SSA §1902(a) (23), the State Medicaid Manual states: "The agency is not prohibited from…imposing reasonable and objective qualification standards for provider eligibility…"
4. **State Medicaid Director (SMD) Letter #18-003** rescinded SMD Letter #16-005 and directed states to continue to look to SSA §1902(a)(23) and 42 C.F.R. §431.51 to determine their obligations regarding the free choice of provider requirement. SMD Letter #18-003 stated that CMS is "concerned that the 2016 Letter raises legal issues under the Administrative Procedure Act, and limited states' flexibility with regard to establishing reasonable Medicaid provider qualification standards."

CMS Request

In its November 16, 2017 letter, CMS requested the following:

> 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.

HCA Response

HCA respectfully requests that CMS reconsider how it apparently proposes to apply the free choice of provider rule to SPA 17-0027.

The regulation of health and safety is "primarily, and historically, a matter of [state and] local concern" (see *Hillsborough County v. Automated Medical Laboratories, Inc., 471 U.S. 707 (1985)*). Moreover, the structure and operation of the SSA "presume[s] and rel[ies] upon a

functioning medical profession regulated under the State's police powers" (see, e.g., *Gonzales v. Oregon, 546 U.S. 243 (2006)*).

After nearly ten years of deliberations, the Washington Legislature agreed in 2017 to authorize the provision of certain dental services by DHATs within the exterior boundaries of a tribal reservation and to individuals eligible for the Indian Health Service (IHS)[1] (see *Substitute Senate Bill 5079 (SSB 5079)*, codified at *chapter 70.350 RCW*). Ordinarily, this statute would not have been necessary for tribes to offer the services of DHATs to their members; as sovereign nations, tribal governments can – and do – enact their own regulatory regimes for dental providers. However, in March 2010, Congress permanently reauthorized the IHCIA with a new provision that only allowed IHS funding for DHATs if the state authorized DHATs (see 25 U.S.C. §1616*l*). In SSB 5079, the Legislature also directed HCA to pursue Medicaid reimbursement for DHAT services.

We understand that the question presented, with regard to the free choice requirement, is:

> **Whether the qualification requirements set forth in chapter 70.350 RCW are reasonable and objective and whether they allow Medicaid beneficiaries the same opportunities to choose among available providers of dental services as are normally offered to the general population.**

HCA believes the answer to this question is in the affirmative.

1. **Reasonable Requirements**. The requirements of chapter 70.350 RCW are reasonably related to the health and welfare of the state of Washington for the following reasons:

    a. ***Respect for Tribal Sovereignty***. With SSB 5079, the tribes and the Legislature sought to balance:

        (i) Respect for the sovereignty of tribes to regulate health care professionals serving their peoples on tribal lands or under tribal jurisdiction, and

        (ii) Deferral of authorization for DHATs for people under the jurisdiction of Washington state until some future date, if ever.

    b. ***Oral Health Crisis***. During the hearings of the Senate Health Care Committee on January 19, 2017 and the House Community Development, Housing, and Tribal Affairs Committee on January 25, 2017, tribal leaders presented IHS data on the oral health crisis for American Indians and Alaska Natives in Washington state.[2]

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[1] RCW 70.350.020(1)(a) provides that services will be provided to "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." Section 831 of the Indian Health Care Improvement Act authorizes services by IHS and tribal facilities not only to American Indians and Alaska Natives but also to their children and spouses and to other non-Indians under certain scenarios. 25 U.S.C. §1680c.

[2] See Indian Health Service Dental Portal at https://www.ihs.gov/DOH/.

According to testimony by the Swinomish Indian Tribal Community Chairman, his tribe's dentist had a patient panel of 3,000 – twice the typical patient panel of non-tribal dentists, and tribes have great difficulty recruiting dentists. The testimony illustrated in no uncertain terms the degree of the oral health crisis for tribal members, which exists to a degree not present for other Medicaid clients.

c. ***Access to Culturally Appropriate Care***. During the two hearings mentioned above, the Chairman and the Chief Dental Officer of the Swinomish Indian Tribal Community explained how Mr. Daniel Kennedy, DHAT, has been succeeding with tribal community members since January 2016 in providing trusted quality care and extending access to dental care. This level of service is unique and is simply not available to tribal members in any other location or in any other setting.

d. The Planned Parenthood family of cases is inapposite to chapter 70.350 RCW and SPA 17-0027. In short, in those situations, the states were clearly targeting one provider by terminating its contracts and attempting to unduly restrict the access of Medicaid clients to medically necessary services by a qualified and willing provider. In contrast, with SPA 17-0027, Washington 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.

(i) In *Planned Parenthood Arizona Inc. v. Betlach*, 727 F. 3d 960 (9th Cir. 2013) and in *Planned Parenthood of Indiana, Inc., v. Commissioner of the Indian State Department of Health*, 699 F.3d 962 (7th Cir. 2012), the state legislatures enacted laws that prohibited state agencies from contracting with any provider that performs abortions or maintains a facility where abortions are performed. The *Betlach* court noted "the pertinent professions which providers must be 'qualified' to practice are the various medical professions" (*Betlach*, at 969). Since the Arizona law's prohibition was unrelated to the provider's qualification to practice, the Arizona law violated the free choice requirement. Likewise, the *Planned Parenthood of Indiana* court found that Indiana's claim of plenary authority to exclude Medicaid providers for any reason conflicted with the free choice requirement.

- Unlike in Arizona or Indiana, the DHAT law in Washington is the state's law regarding DHATs as a profession. While the state chose not to authorize DHATs for non-tribal citizens at this time, the state chose to respect the sovereignty of tribal governments to regulate their health professions for their people and authorize DHATs for tribes. Furthermore, as explained during oral testimony before the Washington State House and Senate Committees, DHATs are able to provide more culturally appropriate care than dentists.

(ii) In *Planned Parenthood of Gulf Coast, Incorporated v. Gee*, 862 F.3d 445 (5th Cir. 2017), the Louisiana Department of Health and Hospitals terminated Planned Parenthood of Gulf Coast's (PPGC's) Medicaid provider agreements without relation to PPGC's "ability to continue providing adequate care to its non-Medicaid patients." The *Gee* court ruled that PPGC was substantially likely to succeed because Louisiana's "grounds for termination (1) do not relate to PPGC's 'qualifications', (2) are not authorized by §1396a(p), and (3), with one exception, are not even authorized by state law."

- Unlike Louisiana, the DHAT law in Washington is not an action on the Medicaid provider agreements with individual providers; the DHAT law is the state's law regarding DHATs as a profession. The DHAT law clearly is focused on ensuring that tribal members receive "adequate care." *Gee*, 862 F.3d at 484 n.3

2. **Objective Requirements**. The requirements of chapter 70.350 RCW are objective: DHAT services are authorized within the exterior boundaries of tribal reservations and for IHS-eligible individuals.

3. **Equal Access between Medicaid Beneficiaries and Others**. 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 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. But as described above, the services of DHATs are imperative to address the unique crisis of oral health in tribal country.

   Also, it is worth noting 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. 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, 42 U.S.C. § 1396j. Likewise, 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 DHAT program and SPA 17-0027 further the policies embodied in these provisions.

B. Other Licensed Practitioner Benefit

The services of "Other Licensed Practitioners" (OLP) are described in 42 C.F.R. §440.60 as:

- "Medical 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."

CMS Request

In its November 16 letter, CMS requested the following:

1. In accordance with the OLP benefit requirements, the assurances below are required in the state plan amendment. Please add the following assurances to the state plan amendment language:
    a. The licensed practitioner assumes professional responsibility for the services provided by the unlicensed practitioner.
    b. The licensed practitioner bills for the service.

HCA Response

HCA respectfully requests that CMS reconsider how it apparently proposes to apply the OLP requirements to SPA 17-0027.

1. RCW 70.350.020(1)(a) provides in full:

(1) 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 (1) of this section.

(3) All services performed within the scope of subsection (1) 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.

2. As authorized by chapter 70.350 RCW, DHATs meet the requirements of "Other Licensed Practitioners" set forth in 42 C.F.R. §440.60:

   a. State law recognizes DHATs as licensed practitioners.

      (i) RCW 70.350.020(1)(a) – DHATs must be certified by a federal Community Health Aide Program (CHAP) Certification Board or by an Indian tribe that has adopted certification standards that meet or exceed the requirements of a federal CHAP Certification Board.

   b. State law requires DHATs to perform their services within a defined scope of practice and under the supervision of a dentist.

      (i) RCW 70.350.020(1)(b)(ii) – DHATs must perform their services in accordance with the standards adopted by the CHAP Certification Board or by an Indian Tribe that has adopted certification standards that meet or exceed the requirements of a federal CHAP Certification Board.

      (ii) RCW 70.350.020(1)(b)(iii) – DHAT must perform their services pursuant to any applicable written standing orders by a supervising dentist.

In the alternative, if DHATs are not considered "Other Licensed Practitioners" within the meaning of 42 C.F.R. §440.60, RCW 70.350.020(1)(b)(iii) clearly authorizes dentists licensed under state law to supervise DHATs. To interpret the state statute otherwise would not "give effect, if possible, to every…word of a statute." *United States v. Menasche, 348 U.S. 528, 538-39 (1955)*, as quoted in *Betlach* at 969.

Other Medicaid Requirements

HCA further believes that other portions of federal Medicaid law support the approval of SPA 17-0027. Section 1902(a)(8) of the SSA requires HCA to furnish Medicaid services "with

reasonable promptness[.]" With the advent of DHAT services, HCA will be in a better position to ensure tribal members – especially in light of the testimony at legislative hearings described above – are able to receive dental care with reasonable promptness.

In addition, Section 1902(a)(19) of the SSA requires HCA to furnish Medicaid services in a manner that is in "the best interests of the recipients[.]" It clearly is in the best interests of tribal members, and the Medicaid program overall, to allow DHAT services and federal financial participation in those services.

Furthermore, under another federal statute, CMS is required to "take such steps as are necessary to facilitate cooperation with, and agreements between, States and the Indian Health Service, Indian Tribes, Tribal Organizations, or Urban Indian Organizations with respect to the provision of health care items and services to Indians under" the Medicaid program. *See* 42 U.S.C. § 1320b-9(b). Partnering with HCA and the tribes on the DHAT initiative, including approval of the SPA, would help CMS adhere to this statutory requirement.

Tribal Consultation

On February 2, 2018, HCA held a tribal consultation on this letter. In attendance were representatives of eleven (11) federally recognized tribes (including Swinomish Tribal Indian Community Chairman Brian Cladoosby), along with their legal counsel, the Executive Director and Chair of the American Indian Health Commission for Washington State, and the Policy Director and Oral Health Project Director of the Northwest Portland Area Indian Health Board. This letter incorporates their comments, along with comments from a twelfth tribe, and has their full support.

For the foregoing reasons, we request that CMS approve SPA 17-0027 and further request technical assistance to effect the direction of SSB 5079 for Medicaid reimbursement of DHATs.

Should you have further questions regarding the information provided, please feel free to contact me directly by telephone at 360-725-1863 or via email at maryanne.lindeblad@hca.wa.gov.

Sincerely,

MaryAnne Lindeblad, BSN, MPH
Medicaid Director

By email

cc: Brian Cladoosby, Chairman, Swinomish Indian Tribal Community
Jessie Dean, Tribal Affairs Administrator, EXO, HCA