DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

Disabled and Elderly Health Programs Group

JUL 05 2013

Dorothy Frost Teeter, Director
MaryAnne Lindeblad, State Medicaid Director
Washington State Health Care Authority
PO Box 45502
Olympia, WA 98504-5050

Dear Ms. Teeter and Ms. Lindeblad:

I am following up on your conversation with CMS staff. During that call, you requested specific information in writing regarding CMS' concerns about the state's arrangements with its Regional Support Networks (RSNs) to provide behavioral health services to Medicaid beneficiaries.

A Memorandum of Understanding (MOU) between the Department of Social and Health Services (DSHS) and the single State Medicaid Agency, the Health Care Authority, allows DSHS to execute contracts with the RSNs. All of these entities, including the RSNs, are governmental entities and none of these agreements are entered into through competitive processes or open procurements. CMS has identified that these arrangements, including the contracts between DSHS and the RSNs appear to be intergovernmental agreements, or subgrants, whose costs need to be determined based on the provisions of OMB Circular A-87[1].

Department of Health & Human Services (HHS) regulations at 45 C.F.R. § 92.22[2] limit the use of Medicaid grant funds to "allowable costs," which are determined in accordance with OMB Circular A-87 (A-87). For grants and subgrants with state and local governments, allowable costs under A-87 do not include profit or other increments above cost. This includes the amounts by which capitation payments paid to a governmental entity under an intergovernmental agreement or subgrant exceed costs incurred under that agreement or subgrant.

For purposes of analyzing the behavioral health contracts between the state and the RSNs, there are two critical issues:

1. Whether the RSNs which have capitated payment arrangements with DSHS, are considered local governments; and
2. Whether the arrangements are in the nature of intergovernmental agreements or subgrants to which A-87 cost principles apply.

[1] OMB Circular A-87, http://www.whitehouse.gov/omb/circulars_a087_2004
[2] http://www.gpo.gov/fdsys/pkg/CFR-2011-title45-vol1/pdf/CFR-2011-title45-vol1-sec92-23.pdf

State or Local Government Status

For purposes of A-87, local government is defined in Attachment A, paragraph B.16 as "a county, municipality, city, town, township, local public authority, school district, special district, intrastate district, council of governments (whether or not incorporated as a non-profit corporation under state law), any other regional or interstate government entity, or any agency or instrumentality of a local government." RSNs are defined in state statute as a county authority or group of county authorities or other entity recognized by the secretary in contract in a defined region. County authorities are thus, under state law, instrumentalities of counties, and local public authorities, and fall under the definition of local government in A-87.

Application of A-87 Principles

The second point of analysis – whether A-87 cost principles apply to these arrangements with RSNs – turns on the nature of the arrangements. If the arrangements have the characteristics of a subgrant or an intergovernmental agreement, then A-87 cost principles apply. If the arrangements have the characteristics of validly procured contractual agreements, then they do not. In order for an arrangement between the state and a public entity to be considered a validly procured contract, the following elements must be in place:

- The services must be openly procured;
- All bidders must be provided the same terms for performance; and
- Rates must be set through an arms-length negotiation without any conflict of interest among the negotiators.

If these elements of a contract are not met, then an arrangement would not be considered a validly procured contract for the purpose of determining allowable costs and would be subject to the cost principles of A-87 for that purpose.

The CMS has determined, based on the information currently available, that the arrangements between DSHS and all but one of the eleven RSNs have not historically been openly procured, because the RSNs are given the right of first refusal to provide behavioral health services which means that there is no open procurement to the extent that the RSN makes that election. Therefore, when the RSN has made the election, the arrangements cannot be considered validly procured contracts. Instead, these arrangements are more in the nature of subgrants or intergovernmental agreements, and the cost principles of A-87 apply. If you do not agree with this analysis, please let me know.

The CMS has identified two options for the state in this circumstance:

1. Make these arrangements into validly procured contracts by openly procuring behavioral health services and making the RSNs compete on the same basis as any other commercial entity (including using the same basis for determining the capitation payment whether the winning bidder is the RSN or a commercial entity); or
2. Comply with A-87 principles by changing the payment methodology for these arrangements and reimburse the counties only for the costs of services actually rendered (plus administrative costs consistent with an approved cost-allocation plan) under a non-risk contract.

We recognize that changing a long-standing delivery system will take time, and potentially, state legislation. Assuming you agree with the analysis provided here, CMS is seeking the state's agreement to develop and implement a corrective action plan (CAP). While we will not specify a date certain by which the corrective action plan must be completed, we expect prompt attention to this matter, and request that the CAP be developed and submitted to CMS no later than 90 days following the date of this letter.

Once the CAP is submitted and agreed upon by CMS and the state, CMS will be able to approve the following pending actions:

- actuarial certification of a new rate range for CY 2013; and
- 11 contract amendments which extend the terms of the contracts until December 31, 2013 and which implement new rates.

To the degree that state legislation is required to implement the required changes, the request from the Health Care Authority to the legislature must be made in sufficient time to be considered in the 2014 legislative session, with the expectation that actions required to implement the system redesign will be taken immediately upon either the Authority's request being approved or the closure of the legislative session, whichever occurs first.

Please note that after CMS and the state have mutually agreed to the timeframes in your corrective action plan, failure to adhere to it could result in future deferrals or disallowances of FFP related to these contracts.

We would like to reach a mutually agreeable resolution of this issue, and look forward to working with the state to that end. Please contact Carol Peverly, Associate Regional Administrator for the Division of Medicaid and Children's Health Operations in our Seattle regional office to begin those conversations. Ms. Peverly can be reached at (206) 615-2515 or carol.peverly@cms.hhs.gov.

Sincerely,

Nancy Kelmon
for

Barbara Coulter Edwards
Director

cc: Kevin Quigley, Secretary, Department of Social and Health Services
Jane Beyer, Assistant Secretary, DSHS, Behavioral Health and Service Integration Administration
Carol Peverly, ARA, CMS Seattle Regional Office
Camille Dobson, Senior Policy Advisor for Managed Care, CMS Central Office