STATE OF WASHINGTON
HEALTH CARE AUTHORITY
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July 29, 2013

Barbara Coulter Edwards, Director
Disabled and Elderly Health Programs Group
Department of Health and Human Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, MD 21244-1850

Dear Ms. Edwards:

I am following up on the letter we received from you on July 5, 2013 regarding the state's arrangements with its Regional Support Networks (RSN) to provide behavioral health services to Medicaid beneficiaries. We have not yet completed our full analysis of this issue, and we have several areas where greater clarity would be helpful.

We understand the rules related to procurement under 45 CFR 92.36(a) require a state to follow the same procurement policies and procedures that it uses for non-federal funds. Under Washington law, both client service contracts and intergovernmental agreements are exempt from competitive procurement. In addition, our mental health statute defines RSN as a "county authority" and mandates the Department of Social and Health Services Secretary to recognize them in contract. Does this approach create any issues relative to OMB Circular A-87?

While Washington pays prospectively for RSN services, the amount for administration built into the rates is based on costs reported by the RSNs using standardized Revenue and Expenditure reports. No profit margin is specifically built into the actuarially sound rates. We believe that our prospective rate setting methodology provides assurance that our rates do not include increments above costs under OMB Circular A-87.

Similar issues to those raised in the recent letter were raised by the Center for Medicare and Medicaid Services (CMS) in 2003-04. The State was under CMS scrutiny for questions regarding accountability for expenditure of Medicaid funds for Medicaid clients and Medicaid covered services in the mental health system. Pursuant to that inquiry, the state developed a response that satisfied CMS, ensuring that Medicaid funds were appropriately being used only for Medicaid clients and Medicaid covered services. That basic infrastructure continues today.

Our initial analysis has confirmed that these questions are complex and will require further dialogue with CMS to reach a common understanding. Because of the additional time necessarily

involved, the State is requesting an extension of the ninety-day clock for the required corrective action plan.

We look forward to your response, and to a continued, constructive dialogue.

Sincerely,

MaryAnne Lindeblad
Medicaid Director
Health Care Authority

Jane Beyer
Assistant Secretary
Department of Social and Health Services