Government of the District of Columbia
Office of the Chief Financial Officer

Natwar M. Gandhi
Chief Financial Officer

MEMORANDUM

TO:	**The Honorable Mary M. Cheh** **Acting Chair, Council of the District of Columbia**
FROM:	**Natwar M. Gandhi** **Chief Financial Officer**
DATE:	**June 12, 2012**
SUBJECT:	**Fiscal Impact Statement – "Provider Screening, Enrollment, and Termination State Plan Amendment Approval Resolution of 2012"**
REFERENCE:	**Draft resolution, shared with the Office of Revenue Analysis on May 23, 2012**

Conclusion

Funds are sufficient in the FY 2012 budget and the FY 2013 through FY 2016 budget and financial plan to implement the proposed resolution.

Background

The proposed resolution would approve an amendment to the District of Columbia State Plan for Medical Assistance ("State Plan") that implements sections 6401 and 6501 of the Patient Protection and Affordable Care Act of 2010 ("ACA").[1] Section 6401 of the ACA outlines enhanced procedures for states' screening of Medicaid providers and suppliers. In particular, at the time a provider requests enrollment or re-enrollment in the District's Medicaid program, the Department of Healthcare Finance (DHCF) must complete background checks on those providers that are deemed high-risk and conduct site visits to all providers that are deemed medium- or high-risk and are located within thirty miles of the District. Section 6501 directs states to terminate provider agreements when another program (Medicaid or Medicare) terminates a provider. This State Plan Amendment is necessary to bring the District Medicaid program into compliance with Federal law.

[1] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 6401, 6501, 124 Stat. 119, 747-753, 776 (March 23, 2010).

Financial Plan Impact

Funds are sufficient in the FY 2012 budget and the FY 2013 through FY 2016 budget and financial plan to implement the proposed resolution. Implementation of the State Plan Amendment will raise some revenue, and the costs, which begin to outstrip revenues in FY 2014, will be absorbed in DHCF's budget.

As part of the regulations behind this State Plan Amendment, the federal Centers for Medicare and Medicaid Services (CMS) allows states to charge an application fee to any provider seeking enrollment or re-enrollment. CMS set the fee at $523 per provider for 2012 and will announce an increase to the fee annually based on the percent change in the Consumer Price Index.[2] Fee revenues may be used only to implement these federal regulations.

The costs of implementation come from conducting the background checks and site visits, which together will require an additional two FTEs at Grade 12 and some minor administrative costs. The estimated revenue and costs are detailed in the following table, with the fiscal impact netting to zero.

Estimated Fiscal Impact of Provider Screening, Enrollment, and Termination State Plan Amendment Approval Resolution of 2012 -- FY 2012-FY 2016						
	FY 2012	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**5 Year Total**
Local Cost	$19,562	$97,049	$102,945	$102,541	$105,492	**$427,589**
Less: O-Type revenue offset	($19,562)	($97,049)	($48,243)	($53,296)	($56,181)	**($274,332)**
Net Local Cost	**$0**	**$0**	**$54,702**	**$49,244**	**$49,310**	**$153,257**
Funds absorbed in DHCF budget	$0	$0	$54,702	$49,244	$49,310	**$153,257**
Net Fiscal Impact	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

[2] This analysis assumes an increase of 2.7 percent per year, which is the inflation rate CMS is currently using for the nursing services market basket.