ENROLLMENT(S)

(5)

COUNCIL OF THE DISTRICT OF COLUMBIA

NOTICE

D.C. LAW 9-188

"Health Care Provider Assessment Temporary Act of 1992".

Pursuant to Section 412 of the District of Columbia Self-Government and Governmental Reorganization Act, P. L. 93-198, "the Act", the Council of the District of Columbia adopted Bill No. 9-574 on first and second readings, July 7, 1992, and October 6, 1992, respectively. Following the signature of the Mayor on November 2, 1992, this legislation was assigned Act No. 9-308, published in the November 13, 1992, edition of the D.C. Register, (Vol. 39 page 8230) and transmitted to Congress on January 6, 1993 for a 30-day review, in accordance with Section 602(c)(1) of the Act.

The Council of the District of Columbia hereby gives notice that the 30-day Congressional Review Period has expired, and therefore, cites this enactment as D.C. Law 9-188, effective March 16, 1993.

JOHN A. WILSON
Chairman of the Council

Dates Counted During the 30-day Congressional Review Period:

January 6,20,21,22,25,26,27

February 2,3,4,16,17,18,19,22,23,24,25,26

March 1,2,3,4,5,8,9,10,11,12,15

Enrolled Original

Codification
District of Columbia Code
(1993 Supplement)

AN ACT

D.C. ACT 9-308

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

NOVEMBER 2, 1992

To provide, on a temporary basis, for the funding of health care services, in a manner designed to generate federal Medicaid matching funds, by certain health care providers granted the privilege of operating or practicing in the District of Columbia.

BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this act may be cited as the "Health Care Provider Assessment Temporary Act of 1992". Note, Section 47-1207

Sec. 2. Definitions.

For the purposes of this act, the term:

(1) "Fiscal year" means the 12-month accounting period of the District of Columbia beginning on October 1 and ending on September 30 of each year.

(2) "Gross patient services revenue" means the sum of inpatient service charges, ambulatory service charges, ancillary services charges, and other charges related to the provision of services to patients. Gross patient services revenue does not include any nonpatient services revenue.

(3) "Health care provider" means an individual, corporation, partnership, or other entity subject to an assessment under this act.

(4) "Hospital" means a health care facility as defined in section 2(a)(1) of the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Code § 32-1301(a)(1)), but does not include a health care facility operated by the federal government.

(5) "Intermediate care facility for the mentally retarded" shall have the same meaning as under section 1905(d) of the Social Security Act, approved July 30, 1965 (79 Stat. 351; 42 U.S.C. § 1396d(d)), but does not include a facility operated by the federal government.

(6) "Net Medicaid revenue" means payments received or to be received by a health care provider from a medical assistance program pursuant to title XIX of the Social Security Act, approved July 30, 1965 (79 Stat. 343; 42 U.S.C. § 1396 *et seq.*), for medical and other health care services provided by the health care provider to eligible individuals during a 12-month accounting period of the health care provider.

(7) "Net patient services revenue" means gross patient services revenue, as defined in paragraph (2) of this section, less total

deductions from gross patient services revenue, as defined in paragraph (10) of this section.

(8) "Nursing home" means a health care facility as defined in section 2(a)(3) of the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Code § 32-1301(a)(3)), but does not include a health care facility operated by the federal government or operated as part of a continuing care retirement community, as described in the District of Columbia Health Plan, issued December 1989, at pages VII-A-8 and VII-A-9.

(9) "Patient day" means a day in which a patient occupies a bed for purposes of receiving inpatient services, including intermediate care services for persons who are mentally retarded, but shall not include the day of the patient's discharge from a facility. A patient shall be considered to occupy a bed on a day when he is physically absent from a facility, provided that the facility is eligible to receive payment for the day from a medical assistance program or any other payer.

(10) "Total deductions from gross patient services revenue" means deductions from gross patient services revenue resulting from a health care provider's inability to collect full payment of its established charges to patients. Such deductions include:

(A) Bad debts;

(B) Contractual adjustments, including the difference between the amount that would be realized at the health care provider's established charges and amounts actually received pursuant to contractual agreements entered into in order to receive Medicare payments, Medicaid payments, Blue Cross/Blue Shield plan payments, or other 3rd-party payments;

(C) Uncompensated or charity care;

(D) Administrative, courtesy, and policy discounts and adjustments; and

(E) Other similar deductions.

Sec. 3. Assessment on hospitals.

(a) Each hospital operating in the District of Columbia shall pay an assessment equal to 1.5% of the hospital's annual net patient services revenue, excluding net Medicaid revenue.

(b) The assessment shall be paid annually each fiscal year in 2 equal installments. The 1st installment shall be due on May 1, and the 2nd installment shall be due on September 30 of each fiscal year. The assessment shall be based on the hospital's most recently completed 12-month accounting period ending on or before the date the 1st payment in a given fiscal year is due. In the case of a hospital having an accounting period of other than a 12-month period, the Mayor shall determine the accounting period upon which the assessment shall be based.

(c) Each hospital shall report net patient services revenue for the period upon which the assessment is imposed by submitting an audited financial statement and other information, as may be prescribed by the Mayor in the rules issued pursuant to section 13. The report shall be submitted on May 1 of each fiscal year, together with the hospital's 1st installment payment.

(d) If, for reasonable cause shown, an audited financial statement is not available to a hospital at the time it is required to make its 1st payment, the hospital shall report net patient services revenue using an unaudited financial statement and shall base its payment on that statement. The hospital shall submit its audited financial statement with the payment due on September 30 of each fiscal year and shall adjust that payment to reflect the information in its audited financial statement.

Sec. 4. Assessment on nursing homes.

(a) Each nursing home operating in the District of Columbia shall pay an assessment equal to $11.88 per patient day.

(b) The assessment shall be paid twice each fiscal year. The 1st payment shall be due on May 1 of each fiscal year, and shall be based on the nursing home's total patient days during the immediately preceding 6-month period beginning on October 1 and ending on March 31 of each fiscal year. The 2nd payment shall be due on September 30 of each fiscal year, and shall be based on the nursing home's total patient days during the immediately preceding 6-month period beginning on April 1 and ending on September 30 of each fiscal year.

(c) Each nursing home shall report its total patient days for the period upon which the assessment is imposed on the form and in the manner prescribed by the Mayor in the rules issued pursuant to section 13. The report shall be submitted with each payment by the nursing home.

(d) If, for reasonable cause shown, a nursing home is not able to determine its actual number of patient days by the date a payment is due, it shall submit a report estimating the number of patient days and providing the basis for its estimate. The nursing home shall report the actual number of patient days no later than 30 days after the date the payment is due and adjust its next scheduled payment to reflect that information. Within 30 days following the date the final payment under this section is due, the nursing home shall report the actual number of patient days for the relevant period and reconcile its final payment, either by tendering the remaining amount due or by claiming a refund.

(e) Pursuant to section 1903(w)(3)(E)(i) of the Social Security Act, approved July 30, 1965 (79 Stat. 349; 42 U.S.C. § 1396b(w)(3)(E)(i)), the Mayor shall submit to the Secretary of the Department of Health and Human Services an application for a waiver of the assessment imposed by this section for nursing homes that provide uncompensated charity care in an amount that exceeds the total amount that the nursing home would be required to pay under this section.

Sec. 5. Assessment on intermediate care facilities for the mentally retarded.

(a) Each intermediate care facility for the mentally retarded ("intermediate care facility") operating in the District of Columbia shall pay an assessment equal to $15.29 per patient day.

(b) The assessment shall be paid twice each fiscal year. The 1st payment shall be due on May 1 of each fiscal year, and shall be based on the intermediate care facility's total patient days during the immediately preceding 6-month period beginning on October 1 and ending on March 31 of each fiscal year. The 2nd payment shall be due on September 30 of each fiscal year, and shall be based on the intermediate

care facility's total patient days during the immediately preceding 6-month period beginning on April 1 and ending on September 30 of each fiscal year.

(c) Each intermediate care facility shall report its total patient days for the period upon which the assessment is imposed on the form and in the manner prescribed by the Mayor in the rules issued pursuant to section 13. The report shall be submitted with each payment by the intermediate care facility.

(d) If, for reasonable cause shown, an intermediate care facility is not able to determine its actual number of patient days by the date a payment is due, it shall submit a report estimating the number of its patient days and providing the basis for its estimate. The intermediate care facility shall report the actual number of patient days no later than 30 days after the date the payment is due and adjust its next scheduled payment to reflect that information. Within 30 days following the date the final payment under this section is due, the intermediate care facility shall report the actual number of patient days for the relevant period and reconcile its final payment, either by tendering the remaining amount due or by claiming a refund.

Sec. 6. Interest and penalties.

(a) When a health care provider fails to pay an assessment in the amount or on the date required by this act, interest at the rate of 1.5% per month, or any fraction of a month, shall be added to the unpaid amount of the assessment from the date prescribed for its payment until the date it is paid.

(1) If a health care provider fails to pay all or part of an assessment within 60 days of the date that payment is due, the Mayor may deduct the unpaid balance of the assessment from medical assistance payments otherwise due to the health care provider by the District of Columbia. Any such deduction shall be made only after written notice has been received by the health care provider and shall be taken in reasonable amounts over a reasonable period of time, taking into account the financial condition of the health care provider.

(2) If the Mayor is satisfied that the failure to pay all or part of an assessment was due to reasonable cause, the Mayor may waive all or part of the interest provided for in this subsection. For purposes of this paragraph, a health care provider's good faith inability to obtain an audited financial statement, as described in section 3(d), or to determine its actual number of patient days, as described in section 4(d) or 5(d), by the date a payment is due, shall constitute reasonable cause.

(b) When a health care provider fails to file a report required under this act, there shall be added to the assessment otherwise due under this act an amount equal to 5% of the assessment for each month or any fraction of a month that the failure to file continues, not to exceed 25% of the assessment in the aggregate. If the Mayor is satisfied that the failure to file the report was due to reasonable cause, the Mayor may waive all or part of the penalty provided for in this subsection.

(c) In addition to any other penalty prescribed pursuant to this act, a health care provider who fails to pay all or part of an assessment due under this act with an intent to defraud the District of Columbia shall be subject to a penalty in an amount equal to:

(1) 75% of the difference between the amount of the assessment due and the amount of the assessment paid; and

(2) 50% of the interest payable under subsection (a) of this section.

(d) In addition to any other penalty prescribed pursuant to this act or by law, a health care provider who knowingly provides false information in a report required to be filed under this act shall be subject to a penalty in an amount not to exceed $1,000. For purposes of this subsection, submitting a report that contains unaudited financial information or estimated patient days shall not constitute a knowing filing of false information, provided that the health care provider states that the report contains unaudited or estimated information and reports its audited financial data or actual patient days as provided in sections 3(d), 4(d) or 5(d), whichever applies.

(e) In the case of a health care provider to whom no medical assistance payments are due, or for whom the amount of any assessment, interest or penalties owed under this act exceeds the amount of the medical assistance payments due to the health care provider, the District of Columbia shall have a lien upon the real and personal property located in the District of Columbia of the health care provider for any assessments, interest, or penalties that are due under this act. The District of Columbia shall have the priority of a secured creditor.

(f) Any action under this section shall be brought in the Superior Court of the District of Columbia by the Corporation Counsel of the District of Columbia in the name of the District of Columbia.

Sec. 7. Payment.

(a) An assessment imposed under this act shall be collected by the Mayor.

(b) The funds generated by the health care provider assessments imposed by this act shall be deposited into an account in the General Fund designated for the support of health care services in the District of Columbia.

(c) The Mayor and the Council of the District of Columbia shall request that an amount equal to the revenues deposited in the account established by subsection (b) of this section shall be appropriated for the support of health care services.

Sec. 8. Confidentiality; audit; determination or redetermination of assessment.

(a) Unless otherwise provided by law, information submitted by a health care provider under this act is confidential and shall not be disclosed by the Mayor, or by a person designated by the Mayor to ascertain the correctness of the information, in a form which reveals the identity of an individual health care provider.

(b) The Mayor, or a person designated by the Mayor to ascertain the correctness of the information reported, may audit the information required to be reported by a health care provider under this act and, based on that audit, may determine or redetermine the amount of the assessment due under this act.

(1) The Mayor may summon any person to appear before the Mayor to give testimony or answer interrogatories or to produce books, records or other pertinent information relating to matters subject to

audit. The summons may be served by a member of the Metropolitan Police Department or by registered mail or certified mail addressed to the person at the person's last dwelling place or principal place of business. A verified return by the person serving the summons, or, in the case of service by registered or certified mail, the return post office receipt signed by the person served, shall be proof of service.

(2) The Mayor may report a person who, having been served pursuant to paragraph (1) of this subsection, neglects or refuses to obey the summons, to the Superior Court of the District of Columbia. The Superior Court may compel obedience to the summons to the same extent as witnesses may be compelled to obey the subpoenas of the Superior Court.

(c) If the Mayor determines, as a result of an audit conducted pursuant to subsection (b) of this section, that a health care provider owes additional funds under this act, the health care provider shall be notified of the amount determined to be owed by registered mail or by certified mail. Payment shall not be due until 30 days after the provider receives written notice, as determined by the date of the return post office receipt, of the amount determined to be owed. Any interest and penalties applicable to the payment pursuant to this section shall not accrue until after the 30-day period has expired.

Sec. 9. Periods of limitation on audit and collection.

No audit of information required to be reported under sections (3)(c), (4)(c), or (5)(c) shall be commenced more than 3 years following the date the information is reported, except in the case of false or fraudulent information reported with intent to evade assessment or in the case of a failure to report required information. In such case, an audit may be commenced at any time.

Sec. 10. Appeals.

(a) A health care provider contesting the amount of an assessment imposed under this act may within 60 days after the date the assessment is due or the date it receives notice of a determination or redetermination of the amount of the assessment due pursuant to section 8, request a hearing to contest the assessment, determination or redetermination by filing a notice of appeal with the District of Columbia Board of Appeals and Review. The hearing shall be subject to the provisions of the District of Columbia Administrative Procedure Act, approved October 21, 1968 (82 Stat. 1204; D.C. Code § 1-1501 *et seq.*), governing adjudication of contested cases and shall be conducted pursuant to the rules of the Board of Appeals and Review in chapter 5 of title 1 of the District of Columbia Municipal Regulations (1 DCMR 500 *et seq.*).

(b) Before filing an appeal pursuant to subsection (a) of this section, the health care provider shall first pay the assessment together with any penalties and interest due on the assessment to the Mayor.

Sec. 11. Certain suits forbidden.

No suit shall be filed to enjoin the assessment and collection by the Mayor of any assessment, interest, or penalty imposed by this act.

Sec. 12. Federal determinations.

(a) In the event that the federal government determines that an assessment imposed on a class of health care providers pursuant to this act does not satisfy the requirements for federal financial participation set forth in section 1903(w) of the Social Security Act, approved July 30, 1965 (79 Stat. 349; 42 U.S.C. § 1396b(w)), or that a payment by the District of Columbia to an individual health care provider for a cost directly resulting from an assessment imposed by this act is not eligible for federal financial participation, the moneys collected pursuant to the assessment shall be refunded to the class of health care providers who paid the assessment and the assessment shall not be enforced with respect to future payments.

(b) An adverse determination with respect to an assessment imposed on a class of health care providers pursuant to this act shall not affect the validity, amount, applicable rate, or any other terms of any other assessment on a class of health care providers imposed by this act. An adverse determination with respect to all the assessments imposed by this act shall render this act null and void.

(c) Notwithstanding any other provision of this act, in the event that the federal government determines that any exclusions from a class of health care providers specified under this act would prevent an assessment upon that class from qualifying as a broad-based health care related tax, as that term is defined in section 1903(w)(3)(B) of the Social Security Act, approved July 30, 1965 (79 Stat. 349; 42 U.S.C. § 1396b(w)(3)(B)), then the exclusions shall not be made.

Sec. 13. Rules.

The Mayor may, pursuant to title 1 of the District of Columbia Administrative Procedure Act, approved October 21, 1968 (82 Stat. 1204; D.C. Code § 1-1501 *et seq.*), issue rules to implement the provisions of this act. If the Mayor determines that circumstances require the immediate adoption of rules, the Mayor may issue emergency rules without prior Council approval, which shall be effective for not more than 90 days.

Sec. 14. Applicability.

The assessments imposed by this act shall be in effect during the 2-year period beginning October 1, 1992, and ending on September 30, 1994.

Sec. 15. Effective date.

(a) This act shall take effect after a 30-day period of Congressional review following approval by the Mayor (or in the event of veto by the Mayor, action by the Council of the District of Columbia to override the veto) as provided in section 602(c)(1) of the District of Columbia Self-Government and Governmental Reorganization Act, approved December 24, 1973 (87 Stat. 813; D.C. Code § 1-233(c)(1)), and publication in either the District of Columbia Register, the District of Columbia Statutes-at-Large, or the District of Columbia Municipal Regulations.

(b) This act shall expire on the 225th day of its having taken effect.

Chairman
Council of the District of Columbia

Mayor
District of Columbia

APPROVED: November 2, 1992

COUNCIL OF THE DISTRICT OF COLUMBIA

Council Period Nine

RECORD OF OFFICIAL COUNCIL VOTE

DOCKET NO: Bill 9-574

☐ Item on Consent Calendar

☒ ACTION & DATE: Adopted First Reading, 7-7-92

☒ VOICE VOTE: Approved

Recorded vote on request

Absent: all present

☐ ROLL CALL VOTE: — RESULT _____ (__/__/__/__)

COUNCIL MEMBER	AYE	NAY	N.V.	A.B.	COUNCIL MEMBER	AYE	NAY	N.V.	A.B.	COUNCIL MEMBER	AYE	NAY	N.V.	A.B.
CHMN. WILSON					JARVIS					ROLARK				
BRAZIL					LIGHTFOOT					SMITH, JR.				
CRAWFORD					MASON					THOMAS, SR.				
CROPP					NATHANSON									
EVANS					RAY									

X — Indicates Vote A.B. — Absent N.V. — Present, not voting

CERTIFICATION RECORD

Secretary to the Council

October 20, 1992
Date

☒ Item on Consent Calendar

☒ ACTION & DATE: Adopted Final Reading, 10-6-92

☒ VOICE VOTE: Approved

Recorded vote on request

Absent: all present

☐ ROLL CALL VOTE: — RESULT _____ (__/__/__/__)

COUNCIL MEMBER	AYE	NAY	N.V.	A.B.	COUNCIL MEMBER	AYE	NAY	N.V.	A.B.	COUNCIL MEMBER	AYE	NAY	N.V.	A.B.
CHMN. WILSON					JARVIS					ROLARK				
BRAZIL					LIGHTFOOT					SMITH, JR.				
CRAWFORD					MASON					THOMAS, SR.				
CROPP					NATHANSON									
EVANS					RAY									

X — Indicates Vote A.B. — Absent N.V. — Present, not voting

CERTIFICATION RECORD

Secretary to the Council

October 20, 1992
Date

☐ Item on Consent Calendar

☐ ACTION & DATE: _____

☐ VOICE VOTE: _____

Recorded vote on request

Absent: _____

☐ ROLL CALL VOTE: — RESULT _____ (__/__/__/__)

COUNCIL MEMBER	AYE	NAY	N.V.	A.B.	COUNCIL MEMBER	AYE	NAY	N.V.	A.B.	COUNCIL MEMBER	AYE	NAY	N.V.	A.B.
CHMN. WILSON					JARVIS					ROLARK				
BRAZIL					LIGHTFOOT					SMITH, JR.				
CRAWFORD					MASON					THOMAS, SR.				
CROPP					NATHANSON									
EVANS					RAY									

X — Indicates Vote A.B. — Absent N.V. — Present, not voting

CERTIFICATION RECORD

Secretary to the Council

Date