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8-22-62

REVISED REGULATIONS RE. RATES AND CHARGES AT PHILADELPHIA GENERAL HOSPITAL

Above regulations have been on file in the Department of Records since July 23, 1962.

The above regulations were advertised in the local newspapers on July 24 and 25, 1962.

Since no requests for a hearing were received as a result of this advertising, the regulations, having been on file for the required thirty days, are now in effect.

GAB:cad

cc: Henry W. Kolbe, Executive Director, PGH
I. Kranzel, Assistant City Solicitor

(Proposed - Incorporating Changes Recommended 6/19/62
by Committee on Rates and Charges)

REGULATION OF THE BOARD OF TRUSTEES GOVERNING RATES
AND CHARGES AT THE PHILADELPHIA GENERAL HOSPITAL

Approved - Board of Trustees
June 27, 1962

Approved - Law Department
July 17, 1962

SECTION I Rates for In-Patients and Out-Patients

- A. The rates set forth in these regulations apply to the Philadelphia General Hospital.
- B. The per diem in-patient rate will be fixed by the Board of Trustees at an amount at least equal to the average operating cost per in-patient day. The Board of Trustees will review the operating cost at least once yearly, and fix the per diem in-patient rate as provided in Section II A below. The per diem in-patient rate shall include bed and board, medical care, drugs, radiologic and laboratory services, and such other services as may from time to time be approved by the Board of Trustees for inclusion in this rate.
- C. The per visit out-patient rate will be fixed by the Board of Trustees at a standard amount for each visit to each clinic in the out-patient department of the hospital, as provided in Section II B below. This per visit out-patient rate shall include medical care, drugs, radiologic and laboratory services, and such other services as may from time to time be approved by the Board of Trustees for inclusion in this rate.
- D. Subject to the provisions of Section III of these regulations, the per diem in-patient rate fixed by the Board of Trustees shall be the charge to be made for hospitalization, and the per visit out-patient rate fixed by the Board of Trustees shall be the charge to be made for out-patient care.
- E. Persons treated in the Receiving Ward or Accident Ward of the hospital and discharged therefrom without being admitted to the hospital as in-patients shall be considered out-patients and shall be charged the per visit out-patient rate.

SECTION II Method of Computing Rates

- A. The per diem in-patient rate shall be determined in the following manner:
 1. The Executive Director shall calculate the cost per in-patient day according to the following formula and report the result to the Board of Trustees:

Cost per in-patient day =
$$\frac{\text{total annual operating cost of the hospital for the previous year}}{\text{total number of in-patient days plus one-fifth of the total number of out-patient department visits of the hospital for the previous year.}}$$

2. The Board of Trustees may consider factors which may reasonably be expected to increase or decrease the operating cost and may adjust the per diem in-patient rate accordingly. This per diem in-patient rate shall be further adjusted to the nearest multiple of \$.25. Any change in the per diem in-patient rate made by the Board of Trustees at a regular or special meeting shall become effective at a time fixed by the Board not later than three months after the determination of the change.

- B. The per visit out-patient rate shall be fixed at one-fifth the per diem in-patient rate adjusted to the nearest multiple of \$.25. This ratio between the per diem in-patient rate and the per visit out-patient rate shall remain constant, and any adjustment in the in-patient rate shall result in a corresponding adjustment in the out-patient rate.

SECTION III Exceptions to Established Rates

- A. Rates for maternity cases and for care of the newborn.

1. The per diem rate of \$27.75 per in-patient day shall be the rate for maternity in-patient care.
2. Maternity patients who deliver and the newborn hospitalized shall have a combined daily rate of:
 - a. \$17.25 per diem for maternity patient
 - b. \$10.50 per diem for newborn patient
3. In the event the mother or the newborn is no longer hospitalized, the rate shall automatically be adjusted to an in-patient per diem rate of \$27.75 for the remaining in-patient.

- B. Patients whose cost of medical care and treatment is payable by a third party payor.

Any patient whose cost of medical care and treatment is paid by a third party payor shall be excluded from the categories of patients eligible for discounts listed in Paragraph C of this section, for the period during which payment is made by the third party payor. Neither shall such patient be considered "totally indigent," "medically indigent," "part pay," as defined in this regulation for the period during which payment is made by the third

party payor. Any patient whose cost of medical care and treatment is paid by a third party payor shall be charged the established per diem in-patient rate or the per visit out-patient rate during the period when payment is made by the third party payor. If the third party payor benefits have terminated, the patient may be re-rated, taking into consideration his financial circumstances from the date of termination of third party payor benefits.

C. Discounts for special categories of patients.

The following categories of patients shall receive a discount in the amount equal to the established rate for hospitalization.

1. Patients admitted for medical treatment or hospitalization of active tuberculosis subject to quarantine or isolation controls of the Department of Public Health of Philadelphia.
2. Patients whose hospitalization is required and specifically requested by the Commissioner of Health or his designee in the enforcement of the quarantine laws for the control of communicable disease.
3. Persons in training capacity in the hospital, including the following:
 - a. Student Nurses;
 - b. Practical Nurse Trainees;
 - c. Dietetic Interns;
 - d. Student X-ray and Laboratory Technicians;
 - e. Medical and Dental Interns and their wives and dependent children; and
 - f. Resident Physicians and Dentists and their wives and dependent children; and
 - g. Such other trainees as may be determined from time to time by the Board of Trustees.
4. Persons who receive financial assistance from the Pennsylvania Department of Public Assistance.
5. Employees of the City of Philadelphia who require hospital care for treatment of compensable injuries or disease. A compensable injury or disease shall, for the purposes of this regulation, have the same meaning as provided under the Pennsylvania Workmen's Compensation Act and the Pennsylvania Occupational Disease Act, both as amended.
6. Inmates of City Institutions.
7. Wards of the City.
8. Those patients approved for Medical Assistance to the Aged Benefits for the period of time during which the benefits are in effect.

D. Discounts for totally indigent, medically indigent and part pay patients.

1. Definitions

- a. The totally indigent are those persons whose financial resources are inadequate to meet the cost of basic necessities of food, clothing and shelter and who are unable to meet any of the costs of personal health services.
- b. The medically indigent are those persons who are able to provide themselves with the basic necessities of food, clothing and shelter, but who are unable to meet the costs of personal health services.
- c. Part pay patients are those who are able to provide themselves with the basic necessities of food, clothing and shelter and who are able to meet the costs of personal health services only to a limited extent.

2. Patients who are medically indigent or totally indigent shall be granted a discount in an amount equal to the established rate for hospitalization. Patients shall be considered totally or medically indigent if they meet the following two requirements:

a. Income

A	single person	with an annual income of less than	\$2000
A	family of 2	" " " " " "	\$2600
A	" " 3	" " " " " "	\$3200
A	" " 4	" " " " " "	\$3800
A	" " 5	" " " " " "	\$4400
A	" " 6 or more	" " " " " "	\$5000

This scale was developed using as a guide the study entitled "Medical Indigence" prepared by the Research Department of the Health and Welfare Council, Inc., of Philadelphia, Montgomery and Delaware Counties, in 1961. It shall be adjusted from time to time as evidence is submitted which indicates that a change is warranted.

b. Property

The net value of any property other than home, household furnishings and car cannot exceed \$1500 for a family unit of one and \$2400 for a family unit of two or more.

3. Patients with income and/or property in excess of the limits set forth in Paragraph 2 -

a. Income

(1) Patients whose individual or family income is

over the level set forth in Paragraph 2 a., but is not in excess of income level set forth in Paragraph 3 a. (2) - below - shall be considered part pay. Their responsibility for meeting medical care and treatment costs shall be determined by multiplying a x b x c (below):

- (a) Difference between the annual individual or family income and the level of Paragraph 2 a
- (b) Six and one-half per cent
- (c) Number of members of the family unit .

(2) Maximum Income Limits of Part Pay Patients -

A single person with an annual income of up to	\$3000
" family of 2 " " " " " "	\$3600
" " " 3 " " " " " "	\$4200
" " " 4 " " " " " "	\$4800
" " " 5 " " " " " "	\$5400
" " " 6 or more " " " " "	\$6000

b. Property

After income has been considered, the net value of any property in excess of \$1500 for a family unit of one and \$2400 for a family unit of two or more other than home, household furnishings and car shall be added to the patient's liability to the Hospital up to the full established rate of hospitalization, subject, however, to any exceptions for patients approved for Medical Assistance to the Aged Benefits.

- 4. Full pay patients are those who are able to provide themselves with the basic necessities of food, clothing and shelter and who are able to pay for personal health services. Such patients are liable for the full amount of hospitalization costs to the extent that income and property exceed the above levels (3-a-(2)-) in addition to the formula which covers that part of income in the part pay range.
- 5. In cases where the Department of Collections find that financial circumstances of the patient or his account guarantor are not properly reflected in the amount which he is rated liable to pay, it may recommend to the Hospital a different amount of liability. Likewise, if the estate of a deceased patient or deceased account guarantor indicates that the amount which he was rated liable to pay does not properly reflect the financial circumstances, the Department of Collections may recommend to the Hospital a different amount of liability. However, with respect to persons subject to such evaluation at the time of admission, nothing herein contained shall prohibit the City from participating in the estate of such persons and/or their legally liable relatives but not in excess of the total charges before the application of such discounts.

- a. If the patient or his account guarantor feels that the amount for which he has been rated to pay does not reflect the peculiarities of his circumstances (examples of such peculiarities are unusual liabilities, unusual family responsibility, limited opportunities for employment, unanticipated decreases in income, etc.), he may take the matter to the Department of Collections. The Department of Collections shall be authorized to review the circumstances and may recommend to the hospital a different amount of liability for the patient.
- b. The amount which the patient is rated to pay shall be an annual cost of personal health services. If valid receipts for medical, hospital, or drug costs, paid for by the patient or his account guarantor during the last twelve months are presented to the Department of Collections, the total of the valid receipts may be deducted from the amount for which the patient has been rated as liable to pay.

SECTION IV Liability for Charges

A patient shall be personally liable for the charges made for medical care under this regulation and such liability shall extend to his legally responsible relatives in accordance with the provisions of the Support Law, Act of June 24, 1937, P. L. 2045, as amended, 62 P.S. 1971 et seq.

SECTION V Responsibility for Granting Discounts

- A. The Executive Director shall be responsible for granting discounts to patients in accordance with the standards and procedures established by these regulations. Applications for discounts, on forms prepared by the Executive Director, shall be submitted to the Executive Director by a patient, together with an affidavit and schedule of his property, real, personal and mixed.
- B. The Executive Director shall submit a monthly report to the Board of Trustees of all charges made and discounts granted to patients during the preceding month, together with any other information desired by the Board.
- C. The Executive Director, subject to the approval of the Board of Trustees, may, at the request of the Revenue Commissioner, review and increase the discount granted a patient on the basis of the written findings and recommendation of the Revenue Commissioner with respect to the patient's financial ability to pay.