**Form 3253 Application for Inpatient and**

**Outpatient Service Rate Change,**

**as Required under the**

**Certificate of Public Advantage (COPA)**

**Made for** ***Enter Hospital Name***

**According to Texas Health**

**and Safety Code §314A.102**

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### Overview

The Texas Health and Human Services Commission (HHSC) shall approve the proposed rate change if HHSC determines:

(1) the proposed rate change likely benefits the public by maintaining or improving the quality, efficiency, and accessibility of health care services offered to the public; and

(2) the proposed rate does not inappropriately exceed competitive rates for comparable services in the hospital’s market area.

This application must provide HHSC with sufficient information required to consider the requested rate change under the two criteria above.

A complete application including exhibits, schedules, documents, and other requested information should be loaded into an electronic portal, one for the complete version and one for the redacted public version. HHSC will provide access to the portal. Please contact the Provider Finance Department Hospitals team (pfd\_hospitals@hhsc.state.tx.us) for submission instructions.

The completed application must be submitted as described above at least 90 days before the intended effective date of the rate change.

 Application

#### Hospital Rate Change Request

* + 1. Enter percent rate change requested.      %
		2. Is the rate change applied across the board? [ ] Yes [ ] No
		3. If not, please provide schedules supporting the calculation of a weighted average change.

*Enter narrative response here and note any additional attachments associated with this data request.*

#### Explanation of the Benefits Provided by the Rate Change

Provide a narrative and supporting schedules, if required, to explain the financial basis of any rate change, including but not limited to labor cost, supply cost, capital funding needs, and expansion of services.

*Enter narrative response here and note any additional attachments associated with this data request.*

#### Historical Rate Changes

Provide the average rate change for the previous five years expressed as a percentage for each year.

Year 1      %

Year 2      %

Year 3      %

Year 4      %

Year 5      %

Source of Revenue

Appendix B - Tab 4 “Revenue Sources”:

Provide data for the past 12 months or 12 months of projected data consistent with the current year for all payors listed. If applicable, explain any changes in the past 12 months to the payor mix, terms of payment, or other factors related to payors impacted by a change in rates.

*Enter narrative response here and note any additional attachments associated with this data request.*

#### Financial Performance

Appendix B, Tab 5 “Financial Performance”:

Provide information from income statements and a schedule of unrestricted cash balances from the previous year’s audited financial statements (adjust categories as required) as indicated.

The net income and earnings before interest, taxes , depreciation and amortization (EBITDA) presented in the column labeled “Prior Year Based on Audited Financials” should agree with the amounts taken from the audited financial statements. If there is a variance, include a reconciliation. Amounts in the other columns should be reported consistent with the treatment of similar amounts under Generally Applied Accounting Principles (GAAP) in the audited financials.

Budgeted or Forecasted Results

* + 1. Key Assumptions

Provide a summary of key assumptions used in the development of the next year’s budget or forecasted income statements, including, but not limited to, key volume changes, payor rates, labor cost, supply, drug, and other expense increases.

*Enter narrative response here and note any additional attachments associated with this data request.*

* + 1. Additional Information

*Enter narrative response here and note any additional attachments associated with this data request.*

Provide an additional narrative to assist HHSC in evaluating benefits to the public from a rate change.

#### Test of Ratio of Costs to Charges (RCC) Reasonableness

Use Appendix B, Tab 7 “RCC Reasonableness” to provide the following information:

* Total charges for the merged hospital from Worksheet C, Part I, Column 8, Line 202;
* Allowable cost from Worksheet C, Part I, Column 3, Line 202; and
* Cost to charge ratio reported on Worksheet S-10 from the most recent Medicare cost report.

An example schedule of RCC Reasonableness is included in Appendix B.

#### Rate Comparison

Use Appendix B, Tab 8 “Rate Comparison” to provide the following information:

* Current Procedural Terminology (CPT) code,
* Rate Description,
* Merged Hospital Volume for the Respective Code,
* Merged Hospital Rate, and
* Rates of at least five comparable hospitals.

An example schedule of Rate Comparison is included in Appendix B.

#### Other Comparison

In addition to the required submission, the merged hospital may submit an alternative comparison of rates for comparable hospitals. An alternative rate comparison should explain the data source, methodology (including why the methodology is more appropriate), and calculations. Calculation explanations should include, but not be limited to, adjustments made for case mix and changes in expense load or payor mix. Any additional methodology should be noted below and submitted under a separate email.

Is an additional methodology being submitted under a separate cover?

[ ]  Yes [ ]  No

Supporting Documentation

HHSC requires that the following supporting information be included with the application at the time of submission:

[ ]  Most recent audited financial statements for the merged hospital

[ ]  Chargemaster for the merged hospital

[ ]  Separate chargemasters prior to the merger for each hospital included in the merger (1st-year applicants only)

[ ]  List of third party contractors reimbursed based on charges

[ ]  List of discounts provided to uninsured or underinsured patients

#### Required Certification

I attest as follows:

I have the authority to submit this inpatient and outpatient hospital services rate change application on behalf of  *Enter Applicant Hospital Name* .

All information provided in this application and the attached documents is an accurate and complete representation of the facts and circumstances.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

Printed Name

### Appendix A - Definitions

| Term | Acronym | Definition |
| --- | --- | --- |
| Active Supervision |  | To properly immunize the applicant from anti-trust challenges, HHSC must actively supervise the parties to a COPA. In addition to periodic reporting requirements, the applicant can expect a variety of questions and requests for additional information from HHSC as it seeks to understand performance relative to obligations under the COPA. |
| Audited Financial Statement |  | A report required of each hospital operating under a Certificate of Public Advantage, including both information specified in the Statute at Section 314A.103 and reporting requirements included in the Terms and Conditions. |
| Applicant |  | For purposes of the COPA, the hospital, including any parent organization or other entity overseeing the hospital, making application for a Certificate of Public Advantage or applying for a rate change under the Certificate of Public Advantage. |
| Benefits |  | Benefits are used in the statute with different meanings and should be carefully considered in the context of the application. Specifically, benefits may refer to things funded through merger savings or other means, giving rise to benefits that exceed the various anti-trust consequences. These are benefits that did not exist at all or in the same magnitude before the merger. This term may also refer to the benefits of a rate increase, specifically how a proposed rate increase benefits the public and may include a variety of issues around funding ongoing hospital operations but do not include the funding of merger-specific benefits. |
| Certificate of Public Advantage | COPA | A legal means for states to permit mergers between hospitals that would otherwise reduce or eliminate competition within the market, in exchange for the active supervision and oversight by the State, and more specifically, by the designated agency, Health and Human Services Commission (HHSC). The Certificate of Public Advantage is the written approval by HHSC that governs a cooperative agreement. |
| Chargemaster | CDM | *Chargemaster (Charge Description Master or CDM)* means the list of all individual items and services maintained by a hospital for which the hospital has established a charge. |
| Commitments |  | Specific commitments outlined in the Application and additional commitments the Applicant and HHSC may agree to under Terms or Conditions. Adherence to these commitments ensures that the benefits of the COPA exceed any anticompetitive effects of joining the hospitals together. |
| Comparable Hospitals |  | Hospitals in the market area proposed by the Merged Hospital outlined in the initial COPA application as approved by HHSC.  |
| Corresponding Net Revenue |  | Net Revenue that corresponds to the specific comparable hospital's financial source. |
| Current Procedural Terminology | CPT | A medical code set reports medical, surgical, and diagnostic procedures and services to healthcare entities. |
| Earnings Before Interest, Taxes, Depreciation, and Amortization | EBITDA | A term commonly used to measure cash from operations before consideration of debt. It includes earnings or income before interest, taxes (income-based taxes only), depreciation, and amortization. |
| EBITDA Margin |  | Earnings (net income) before interest, taxes (income-based taxes only), depreciation, and amortization (EBITDA) divided by Net Revenue. |
| Financial Assistance Program | FAP | Financial assistance to an applicant or participant to accomplish a public purpose of support  |
| Generally Accepted Accounting Principals | GAAP | A common set of accounting principles, standards, and procedures issued by the Financial Accounting Standards Board. |
| Gross Charges |  | The hospital industry more commonly uses this term to mean the same thing as Rates. A hospital or other provider makes the standard charge before discounts or contractual adjustments based on an agreed or regulated payment amount for the service. Also commonly referred to as billed charges. |
| Healthcare Common Procedure Coding System | HCPCS | The Healthcare Common Procedure Coding System is a set of health care procedure codes based on the American Medical Association’s Current Procedural Terminology. HCPCS codes primarily correspond to services, procedures, and equipment not covered by CPT® codes. |
| Health and Human Service Commission | HHSC | The agency designated by the Governor to administer COPA legislation. |
| Hospital |  | For purposes of this application, a nonpublic general hospital licensed under Texas Health and Safety Code Chapter 241 and not maintained or operated by a political subdivision of this state. |
| Long Term Debt to Total Capitalization |  | Long-term debt of all types, divided by the sum of long-term debt and equity (also referred to as fund balances and net assets). |
| Market Area |  | The combination of the Primary Service Area and Secondary Service Area, as defined by the Applicant in the Application. |
| Medicare Cost Report |  | CMS 2552-10 report containing provider information such as facility characteristics, utilization, cost, and charges by cost center. |
| Merged Hospital |  | The hospitals party to the merger agreement and all operations licensed under the consolidated provider numbers or one of the two hospitals, if the provider number is not consolidated. The definition can expand as more entities are brought under a hospital license. |
| Net Income |  | For the purpose of the Initial Application and all Rate Change Applications, net income is net revenue less expenses, including interest expense and depreciation but before investment income. |
| Net Revenue |  | The amount expected to be collected from all sources, patient revenues after discounts, contractual adjustments, and bad debts, as well as other revenue, including but not limited to rent, cafeteria sales, and parking fees. |
| Payor |  | Person or organization responsible for settling a claim or financial obligation related to healthcare services. |
| Payor Mix |  | Percentage of hospital revenue that comes from insurance companies, private pay, or government insurance programs like Medicare and Medicaid. |
| Primary Service Area | PSA | The immediate area of service for the hospitals included in a COPA application, most often the county in which the hospitals are located but may include parts of bordering counties. Definitions for each application are to be provided by the Applicant. |
| Ratio of Costs to Charges | RCC | The total amount of hospital costs related to patient care divided by the sum of hospital charges. |
| Rates |  | The standard charge made by a hospital or other provider before discounts or contractual adjustments based on an agreed or regulated payment amount for the service. Also commonly referred to as billed charges or gross charges. |
| Secondary Service Area | SSA | The area of service for the hospitals included in a COPA application surrounding the PSA and from which the hospitals draw most patients outside the PSA. The shape and size of the SSA is often dependent on road systems, historical employment, retail pattern, and long-standing physician referral patterns. Definitions for each application are to be provided by the Applicant. |
| Shoppable Services |  | The 70 or so services required by CMS plus an additional 230 common services for a total of 300 to be publicly available for consumers to compare prices. For the purpose of rate comparison, HHSC adds Emergency Room Visits at all levels and a variety of daily charges for room or other services. |
| State Agency |  | A department, commission, board, office, or other agency in the executive branch of state government created by the constitution or a statute of this state. |
| Terms and Conditions |  | Any actions or measures that HHSC may require as a condition for issuing a COPA or allowing continued operation under a COPA. |
| Third Party Payor |  | An entity that pays medical claims on behalf of the insured. |
| Underinsured |  | A patient with limited insurance coverage that does not cover the full range of expenses. |
| Uninsured |  | A patient with no insurance coverage. |
| Unrestricted Cash Balance |  | Cash that is readily available to be used at the company’s discretion. |

### Appendix B – Rate Change Application Supplemental Information

File Name – COPA Rate Change Application Supplemental Information (Available on Texas HHSC Website)