

MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD

2520 Lord Baltimore Drive, Suite L, Baltimore, MD 21244-2670

**2015 JOINT APPLICATION FOR HOSPITAL GROUPS
FOR GEOGRAPHIC RECLASSIFICATION
EFFECTIVE FEDERAL FISCAL YEARS 2017 THROUGH 2019**

PLEASE READ INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION

THIS APPLICATION MUST BE COMPLETED AND RECEIVED BY THE MGCRB
BY **5:00 P.M. EDT, SEPTEMBER 1, 2015.**

FAILURE TO COMPLY WILL RESULT IN DISMISSAL.

PRINT IN INK OR TYPE WHEN COMPLETING THIS APPLICATION

I. GROUP INFORMATION

1. NAME OF THE COUNTY IN WHICH THE HOSPITALS ARE LOCATED:

2. IDENTIFICATION CODE FOR THE AREA INDICATED IN NUMBER 1 (REFER TO GROUP INSTRUCTIONS):

3. CONTACT FOR ALL COMMUNICATIONS REGARDING THIS APPLICATION:

NAME: _____

ORGANIZATION: _____

ADDRESS: _____

E-MAIL ADDRESS: _____

TELEPHONE NUMBER: _____

4. A. THE GROUP SHOULD PROVIDE, USING THE FOLLOWING FORMAT, A LISTING OF ALL IPPS HOSPITALS IN THE COUNTY AT **ATTACHMENT A**. COLUMNS A THROUGH C ARE SELF-EXPLANATORY. FOR COLUMN D, PROVIDE AN ASTERISK IF THE HOSPITAL IS ALSO FILING AN INDIVIDUAL APPLICATION WITH THE MGRB. IN COLUMN E, THE GROUP MUST IDENTIFY ALL HOSPITALS WHICH ARE ALREADY RECLASSIFIED FOR THE WAGE INDEX IN FFY 2017 AS PART OF A 3-YEAR RECLASSIFICATION. COMPLETE COLUMN E BY INDICATING THE AREA IDENTIFICATION CODE TO WHICH THE HOSPITAL IS RECLASSIFIED IN FFY 2017. **NOTE:** THE BOARD WILL RULE ON A GROUP RECLASSIFICATION REQUEST BEFORE IT RULES ON A HOSPITAL'S INDIVIDUAL REQUEST. IF THE BOARD RECLASSIFIES A GROUP, IT WILL DISMISS ANY INDIVIDUAL RECLASSIFICATION APPLICATION FILED BY HOSPITALS IN THE GROUP.

<u>COL. A</u> HOSPITAL NAME	<u>COL. B</u> HOSPITAL ADDRESS	<u>COL. C</u> MEDICARE PROV. NUMBER	<u>COL. D</u> INDIVIDUAL APPLICATION	<u>COL. E</u> FFY 2017 RECLASS. AREA
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- B. IN SUPPORT OF 4.A. IMMEDIATELY ABOVE, INCLUDE, AS **ATTACHMENT B**, A CURRENT LETTER FROM THE APPROPRIATE CMS REGIONAL OFFICE WHICH LISTS ALL OF THE CURRENTLY LICENSED IPPS HOSPITALS IN THE COUNTY NAMED IN I.1. ABOVE.

II. RECLASSIFICATION REQUEST

NOTE: PLEASE READ THE ACCOMPANYING HOSPITAL GROUP INSTRUCTIONS (PAGES 2 AND 3) FOR THE BOARD'S TREATMENT OF URBAN AND RURAL AREAS.

5. NAME OF THE AREA (RURAL/URBAN AREA) TO WHICH THE GROUP IS REQUESTING RECLASSIFICATION (THE GROUP MAY BE RECLASSIFIED TO ONLY ONE AREA):
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6. IDENTIFICATION CODE FOR THE AREA SHOWN IN NO. 5 (REFER TO GROUP INSTRUCTIONS)
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7. THE GROUP SHOULD CIRCLE THE RECLASSIFICATION CRITERIA UNDER WHICH IT IS APPLYING AND COMPLETE THE SECTIONS INDICATED:
- A. ALL HOSPITALS IN A RURAL COUNTY SEEKING REDESIGNATION TO AN URBAN AREA (42 C.F.R. § 412.232). COMPLETE SECTIONS III, IV, V, THE WAGE INDEX COMPARISON AND THE AFFIDAVIT(S).
- B. ALL HOSPITALS IN AN URBAN COUNTY SEEKING REDESIGNATION TO ANOTHER URBAN AREA (42 C.F.R. § 412.234). COMPLETE SECTIONS III, IV, VI, THE WAGE INDEX COMPARISON AND THE AFFIDAVIT(S).

III. GENERAL INFORMATION

8. ARE ALL IPPS HOSPITALS IN THE COUNTY LISTED IN NO. 4 MEMBERS OF THE GROUP?

YES _____ NO _____

9. HAVE THE HOSPITALS IN THE GROUP ALSO REQUESTED RECLASSIFICATION AS A PART OF A STATEWIDE WAGE INDEX APPLICATION FOR FFY 2017?

YES _____ NO _____

10. IF THE GROUP APPLYING FOR RECLASSIFICATION IS AN URBAN GROUP:

A. IS ANY IPPS HOSPITAL IN THE COUNTY CURRENTLY CLASSIFIED BY THE CMS REGIONAL OFFICE UNDER 42 C.F.R. § 412.103 AS BEING IN A RURAL AREA?

YES _____ NO _____

B. DOES ANY IPPS HOSPITAL IN THE COUNTY HAVE A PENDING APPLICATION WITH THE CMS REGIONAL OFFICE TO BE TREATED AS BEING IN A RURAL AREA UNDER 42 C.F.R. § 412.103?

YES _____ NO _____

C. IF THE ANSWER TO 10.A. IS "YES," HAS THE HOSPITAL(S) OBTAINED WRITTEN NOTICE FROM THE CMS REGIONAL OFFICE DEMONSTRATING THAT ITS RURAL REDESIGNATION WILL CANCEL PRIOR TO OCTOBER 1, 2016?

YES _____ NO _____

IF "YES" TO EITHER 10.A., 10.B., OR 10.C., PROVIDE A LIST OF THE HOSPITALS AT **ATTACHMENT C**. ALSO PROVIDE A COPY OF THE APPLICABLE CMS REGIONAL OFFICE APPROVAL LETTER FOR ANY HOSPITAL LISTED IN **ATTACHMENT C** UNDER 10.A. AND 10.C. (**ATTACHMENT C-1 AND C-3 RESPECTIVELY**) AND THE HOSPITAL'S OWN LETTER REQUESTING CMS REGIONAL OFFICE APPROVAL UNDER 10.B. (**ATTACHMENT C-2**). REFER TO THE INSTRUCTIONS FOR FURTHER DETAIL.

11. IS THE GROUP REQUESTING AN ORAL HEARING?

YES _____ NO _____

IF "YES" ATTACH RATIONALE UNDER **ATTACHMENT D**.

12. PRIOR YEAR GROUP CASE NUMBER(S):

14G _____ 15G _____ 16G _____

IV. ADJACENCY (ALL GROUPS)

13. IS THE COUNTY IN WHICH THE HOSPITALS ARE LOCATED ADJACENT (CONTIGUOUS) TO THE AREA TO WHICH THE GROUP SEEKS REDESIGNATION?

YES _____ NO _____

(ATTACH MAP UNDER ATTACHMENT E.)

V. METROPOLITAN CHARACTER (RURAL GROUP ONLY)

14. DOES THE COUNTY IN WHICH THE HOSPITALS ARE LOCATED MEET THE STANDARDS FOR REDESIGNATION TO AN URBAN AREA AS AN "OUTLYING COUNTY"?

YES _____ NO _____

(ATTACH THE SUPPORTING 2010 U.S. CENSUS BUREAU DATA UNDER ATTACHMENT F.)

VI. CSA/CBSA CRITERIA (URBAN GROUP ONLY)

15. IS THE COUNTY IN WHICH THE HOSPITALS ARE LOCATED A PART OF THE COMBINED STATISTICAL AREA (CSA) OR CORE-BASED STATISTICAL AREA (CBSA) THAT INCLUDES THE URBAN AREA TO WHICH THE GROUP SEEKS REDESIGNATION?

YES _____ NO _____

(ATTACH OFFICIAL U.S. CENSUS BUREAU CSA OR CBSA LISTING UNDER ATTACHMENT G.)

WAGE CRITERIA – 85 PERCENT COMPARISON (RURAL AND URBAN GROUPS)

ATTACH THE GROUP'S AGGREGATE HOURLY WAGE COMPUTATIONS USING 3-YEAR AVERAGES OF WAGES AND HOURS FOR THE 85 PERCENT COMPARISON AS ATTACHMENT H. TAB 1 OF THE GROUP APPLICATION INSTRUCTIONS PROVIDES AN EXAMPLE OF THIS COMPARISON.

AFFIDAVIT

COUNTY OR PARISH OF _____

STATE OF _____

I, _____ (TYPE OR PRINT NAME),
BEING DULY SWORN, DEPOSE AND SAY AS FOLLOWS:

- (1) I CERTIFY THAT I HAVE EXAMINED THE ACCOMPANYING APPLICATION FOR GEOGRAPHIC RECLASSIFICATION AND ALL OF THE SUPPORTING INFORMATION AND DATA INCLUDED IN THE SUBMITTAL BY _____

(HOSPITAL NAME AND MEDICARE PROVIDER NUMBER) THAT IS DUE TO THE MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD NO LATER THAN SEPTEMBER 1, 2015. I HEREBY DECLARE UNDER PENALTY OF PERJURY (28 U.S.C. SECTION 1746) THAT THE FOREGOING IS TRUE AND CORRECT.
- (2) I UNDERSTAND THAT AN OMISSION, MISSTATEMENT, MISREPRESENTATION, OR ERROR MADE IN A HOSPITAL'S APPLICATION AND SUPPORTING INFORMATION AND DATA FOR GEOGRAPHIC RECLASSIFICATION MAY BE GROUNDS FOR DENIAL OF THE HOSPITAL'S APPLICATION.
- (3) I UNDERSTAND THAT AN OMISSION, MISSTATEMENT, MISREPRESENTATION, OR ERROR MADE IN A HOSPITAL'S APPLICATION AND SUPPORTING INFORMATION AND DATA FOR GEOGRAPHIC RECLASSIFICATION MAY BE CAUSE FOR LEGAL ACTION AGAINST THE APPLICANT HOSPITAL AND ITS OFFICIALS.
- (4) I CERTIFY THAT I AM AN OFFICER OF THE HOSPITAL NAMED IN (1) ABOVE OR A CORPORATE OFFICER OF THE HOSPITAL'S PARENT CORPORATION WITH AUTHORITY TO SIGN THE APPLICATION FOR GEOGRAPHIC RECLASSIFICATION ON BEHALF OF THE HOSPITAL.

SIGNATURE: _____

TITLE: _____

PHONE NUMBER: _____

E-MAIL ADDRESS: _____

SUBSCRIBED AND SWORN BEFORE ME
THIS _____ DAY OF _____ 2015
(DAY) (MONTH)

(SIGNATURE OF NOTARY)

NOTARY PUBLIC
MY COMMISSION EXPIRES: _____