MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD
2520 Lord Baltimore Drive, Suite L, Baltimore, MD 21244-2670

2015 INDIVIDUAL HOSPITAL APPLICATION 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. HOSPITAL INFORMATION

1. NAME OF HOSPITAL: _____

2. MEDICARE PROVIDER NUMBER: _____

3. STREET ADDRESS: _____

_____

_____

4. NAME OF THE COUNTY WITHIN
WHICH THE HOSPITAL IS LOCATED: _____

5. MAILING ADDRESS, E-MAIL ADDRESS AND CONTACT NAME AND TELEPHONE NUMBER FOR ALL COMMUNICATIONS REGARDING THE APPLICATION:

NAME: _____

ORGANIZATION: _____

ADDRESS: _____

_____

E-MAIL ADDRESS: _____

TELEPHONE NUMBER: _____

II. RECLASSIFICATION REQUEST

NOTE: PLEASE READ THE INDIVIDUAL HOSPITAL INSTRUCTIONS (PAGES 2 AND 3) REGARDING THE BOARD'S TREATMENT OF URBAN AND RURAL AREAS FOR APPLICATION PURPOSES.

6. CIRCLE THE RECLASSIFICATION AND CRITERIA CATEGORY USED FOR THE APPLICATION.

WAGE INDEX CATEGORY - (42 C.F.R. §§ 412.230(d)(l)(iii)(C) AND 412.230(d)(1)(iv)(E))

A. HOSPITALS LOCATED IN RURAL AREAS - 106 AND 82 PERCENT

B. HOSPITALS LOCATED IN URBAN AREAS - 108 AND 84 PERCENT

7. SEEKS RECLASSIFICATION **FROM**: _____

(SHOW THE NAME AND IDENTIFICATION CODE FOR THE STATE OR URBAN AREA.)

SEEKS RECLASSIFICATION **TO**: _____

(SHOW THE NAME AND IDENTIFICATION CODE FOR THE STATE OR URBAN AREA.)

III. GENERAL INFORMATION

8. **A.** IS THE HOSPITAL ALREADY RECLASSIFIED FOR FFY 2017 FOR THE WAGE INDEX UNDER A 3-YEAR WAGE INDEX RECLASSIFICATION?

YES _____ NO _____

B. IF "YES" TO 8.A., WHAT RURAL OR URBAN AREA IS THE HOSPITAL RECLASSIFIED TO FOR FFY 2017 UNDER ITS 3-YEAR WAGE INDEX RECLASSIFICATION?

_____

(SHOW THE NAME AND IDENTIFICATION CODE FOR THE STATE OR URBAN AREA.)

9. **A.** IF THE HOSPITAL WAS RECLASSIFIED FOR THE WAGE INDEX VALUE FOR FFY 2017 THROUGH A PRIOR 3-YEAR RECLASSIFICATION, DID THE HOSPITAL "WITHDRAW" OR "TERMINATE" SUCH RECLASSIFICATION?

YES _____ NO _____

B. IF "YES" TO 9.A, DID THE HOSPITAL APPLY TO CANCEL THE BOARD APPROVED "WITHDRAWAL" OR "TERMINATION" IN ORDER TO REINSTATE THE 3-YEAR RECLASSIFICATION IN 9.A. ABOVE, INCLUDING FFY 2017?

YES _____ NO _____

10. PRIOR YEAR CASE NUMBERS (ALL HOSPITALS MUST COMPLETE):

14C _____ 15C _____ 16C _____

11. **A.** IS THE HOSPITAL ALSO A MEMBER OF A GROUP RECLASSIFICATION REQUEST?

YES _____ NO _____

B. IF "YES" TO 11.A, ENTER THE NAME OF THE COUNTY IN WHICH THE GROUP IS LOCATED:

_____

C. IS THE HOSPITAL ALSO A MEMBER OF A STATEWIDE WAGE INDEX AREA REQUEST?

YES _____ NO _____

NOTE: THE BOARD WILL RULE ON ANY STATEWIDE WAGE INDEX APPLICATION FIRST AND THEN THE GROUP APPLICATION BEFORE IT REVIEWS THE INDIVIDUAL REQUEST.

12. IF THE HOSPITAL APPLYING FOR RECLASSIFICATION IS APPLYING AS AN URBAN HOSPITAL:

A. HAS THE HOSPITAL "EVER BEEN" CLASSIFIED BY THE CMS REGIONAL OFFICE UNDER 42 C.F.R. § 412.103 AS BEING IN A RURAL AREA?

YES _____ NO _____

B. IF "YES" TO 12.A., IS THE HOSPITAL "CURRENTLY" CLASSIFIED BY THE CMS REGIONAL OFFICE UNDER 42 C.F.R. § 412.103 AS BEING IN A RURAL AREA?

YES _____ NO _____ N/A _____

C. IF "YES" TO 12.B., HAS THE HOSPITAL OBTAINED WRITTEN NOTICE FROM THE CMS REGIONAL OFFICE DEMONSTRATING THAT ITS RURAL REDESIGNATION WILL CANCEL PRIOR TO OCTOBER 1, 2016?

YES _____ NO _____ N/A _____

D. DOES THE HOSPITAL 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 _____ N/A _____

SUPPORTING DOCUMENTATION REQUIRED FOR QUESTION 12:

- IF "YES" TO 12.B., PROVIDE A COPY OF THE CMS REGIONAL OFFICE APPROVAL LETTER AT **ATTACHMENT A-1**.
- IF "YES" TO 12.C., PROVIDE A COPY OF THE CMS REGIONAL OFFICE WRITTEN NOTICE AT **ATTACHMENT A-2**.
- IF "YES" TO 12.D., PROVIDE A COPY OF THE HOSPITAL'S LETTER TO THE CMS REGIONAL OFFICE REQUESTING RURAL RECLASSIFICATION AT **ATTACHMENT A-3**.

13. INDICATE WHETHER THE HOSPITAL IS CURRENTLY CLASSIFIED AS A:

A. SOLE COMMUNITY HOSPITAL (SCH) YES _____ NO _____

IF "YES," ATTACH WRITTEN VERIFICATION (E.G., A CURRENT LETTER, E-MAIL, ETC.) FROM THE CMS REGIONAL OFFICE OR THE HOSPITAL'S FISCAL INTERMEDIARY THAT CONFIRMS THE HOSPITAL'S CURRENT STATUS AS A SCH UNDER **ATTACHMENT B**.

B. HAS THE HOSPITAL LOST ITS DESIGNATION AS AN SCH DUE TO AN MGCRB RECLASSIFICATION IN A PREVIOUS YEAR?

YES _____ NO _____ N/A _____

IF "YES," IDENTIFY THE DATE STATUS WAS LOST: _____
ALSO, ATTACH THE FISCAL INTERMEDIARY OR CMS REGIONAL OFFICE LETTER INDICATING WHEN THE HOSPITAL'S SCH STATUS WAS LOST UNDER **ATTACHMENT C**.

14. INDICATE WHETHER THE HOSPITAL IS CURRENTLY CLASSIFIED AS A:

A. RURAL REFERRAL CENTER (RRC) YES _____ NO _____

IF "YES," ATTACH WRITTEN VERIFICATION (E.G., A CURRENT LETTER, E-MAIL, ETC.) FROM THE CMS REGIONAL OFFICE OR THE HOSPITAL'S FISCAL INTERMEDIARY THAT CONFIRMS THE HOSPITAL'S CURRENT STATUS AS A RRC UNDER **ATTACHMENT D-1**.

B. IF THE ANSWER TO 14.A. IS "NO," INDICATE WHETHER THE HOSPITAL "HAS EVER BEEN" CLASSIFIED AS AN RRC YES _____ NO _____

IF "YES," ATTACH WRITTEN VERIFICATION (E.G., A LETTER, E-MAIL, ETC.) FROM THE CMS REGIONAL OFFICE OR THE HOSPITAL'S FISCAL INTERMEDIARY THAT CONFIRMS THE HOSPITAL'S "HAS EVER BEEN" STATUS AS A RRC UNDER **ATTACHMENT D-1**.

ALSO ATTACH A COPY OF THE OFFICIAL LETTER FROM THE CMS REGIONAL OFFICE OR THE HOSPITAL'S FISCAL INTERMEDIARY THAT GRANTED RRC STATUS TO THE HOSPITAL UNDER **ATTACHMENT D-2.**

15. IF THE HOSPITAL IS LOCATED IN AN URBAN AREA (MSA), IS THE HOSPITAL THE SINGLE ACUTE CARE IPPS HOSPITAL IN THE HOSPITAL'S URBAN AREA?

YES _____ NO _____ N/A _____

IF "YES," ATTACH WRITTEN VERIFICATION (E.G., A CURRENT LETTER, E-MAIL, ETC.) FROM THE CMS REGIONAL OFFICE THAT CONFIRMS THAT THE HOSPITAL IS THE SINGLE ACUTE CARE IPPS HOSPITAL IN THE HOSPITAL'S MSA UNDER **ATTACHMENT E**.

16. INDICATE WHETHER THE HOSPITAL IS REQUESTING AN ORAL HEARING:

YES _____ NO _____ N/A _____

IF "YES," ATTACH RATIONALE FOR REQUEST UNDER **ATTACHMENT F**.

IV. RECLASSIFICATION REQUEST UNDER THE "SPECIAL ACCESS" RULES FOR SOLE COMMUNITY HOSPITALS AND RURAL REFERRAL CENTERS

17. IF THE HOSPITAL IS A SOLE COMMUNITY HOSPITAL OR A RURAL REFERRAL CENTER AND IS APPLYING UNDER THE "SPECIAL ACCESS" RULES, IS IT APPLYING TO THE CLOSEST URBAN AREA OR THE CLOSEST RURAL AREA (IF THE RURAL AREA IS CLOSER THAN THE CLOSEST URBAN AREA AND THE SCH/RRC ITSELF IS LOCATED IN A RURAL AREA)?

YES _____ NO _____

18. INDICATE WHETHER THE AREA REQUESTED IS CLOSEST IN DISTANCE (MILES) OR DRIVING TIME (OR BOTH) AS COMPARED TO THE NEXT CLOSEST URBAN OR RURAL AREA:

IF THE HOSPITAL IS REQUESTING RECLASSIFICATION BASED ON DISTANCE (CLOSEST IN MILES), IT MUST COMPLETE THE ROAD AND MILEAGE COLUMNS FOR BOTH THE REQUESTED AREA IN DISTANCE (18.A.) **AND** THE NEXT CLOSEST AREA IN DISTANCE (18.B.).

IF THE HOSPITAL IS REQUESTING RECLASSIFICATION BASED ON THE SHORTEST DRIVING TIME, IT MUST COMPLETE THE ROAD, MILEAGE, AND TIME COLUMNS FOR BOTH THE REQUESTED AREA IN DRIVING TIME (18.A.) AND THE NEXT CLOSEST AREA IN DRIVING TIME (18.B.). **ATTACH DISTANCE/TIME MEASUREMENTS USING A NATIONALLY RECOGNIZED ELECTRONIC MAPPING SERVICE (GOOGLE MAPS, BINGS MAPS, MAPQUEST, E.G.) UNDER ATTACHMENT G.**

NOTE: ALL ROADS MUST BE **IMPROVED*** ROADS AND ALL MEASUREMENTS MUST BEGIN AT THE FRONT ENTRANCE OF THE HOSPITAL.

A. REQUESTED AREA

ROAD	MILEAGE	TIME
TOTAL		

B. **NEXT CLOSEST AREA** – _____
(INDICATE NAME OF AREA)

ROAD	MILEAGE	TIME
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
TOTAL	_____	_____

***AN IMPROVED ROAD IS ANY ROAD THAT IS MAINTAINED BY A LOCAL, STATE, OR FEDERAL GOVERNMENT ENTITY AND IS AVAILABLE FOR USE BY THE GENERAL PUBLIC. AN IMPROVED ROAD INCLUDES THE PAVED SURFACE UP TO THE FRONT ENTRANCE OF THE HOSPITAL. (REFER TO THE APPLICATION INSTRUCTIONS FOR QUESTION 18.).**

V. RECLASSIFICATION REQUEST UNDER THE "PROXIMITY" RULES

19. IS THE HOSPITAL LOCATED WITHIN 35 MILES, IF A RURAL HOSPITAL, OR 15 MILES, IF URBAN, OF THE AREA TO WHICH IT SEEKS RECLASSIFICATION?

YES _____ NO _____

20. IF "YES" TO 19, SHOW THE NUMBER OF MILES OVER **IMPROVED*** ROADS FROM THE FRONT ENTRANCE OF THE HOSPITAL TO THE BORDER OF THE REQUESTED AREA. **ATTACH DISTANCE MEASUREMENTS USING A NATIONALLY RECOGNIZED ELECTRONIC MAPPING SERVICE (GOOGLE MAPS, BING MAPS, MAPQUEST, E.G.) UNDER ATTACHMENT G.**

ROAD	MILEAGE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
TOTAL	_____

***AN IMPROVED ROAD IS ANY ROAD THAT IS MAINTAINED BY A LOCAL, STATE, OR FEDERAL GOVERNMENT ENTITY AND IS AVAILABLE FOR USE BY THE GENERAL PUBLIC. AN IMPROVED ROAD INCLUDES THE PAVED SURFACE UP TO THE FRONT ENTRANCE OF THE HOSPITAL. (REFER TO THE APPLICATION INSTRUCTIONS FOR QUESTION 20 FOR FURTHER INFORMATION).**

21. IF THE URBAN HOSPITAL IS LOCATED MORE THAN 15 MILES FROM THE REQUESTED AREA OR THE RURAL HOSPITAL IS LOCATED MORE THAN 35 MILES FROM THE REQUESTED AREA, INDICATE, IF APPLICABLE, WHETHER AT LEAST 50 PERCENT OF ITS EMPLOYEES RESIDE IN THE AREA TO WHICH THE HOSPITAL REQUESTS RECLASSIFICATION:

YES _____ NO _____

IF "YES," ATTACH INFORMATION FROM THE HOSPITAL'S PAYROLL RECORDS THAT IDENTIFIES THE EMPLOYEES' HOME ADDRESSES BY ZIP CODE AND ATTACH A MAP THAT SHOWS THE RELATIONSHIP OF THE ZIP CODES TO THE COUNTIES AND/OR AREAS UNDER **ATTACHMENT H**.

ALSO, INDICATE THE PERCENTAGE OF HOSPITAL EMPLOYEES WHO RESIDE IN THE REQUESTED AREA:

_____%

WAGE COMPARISON

ATTACH THE HOSPITAL'S WAGE COMPUTATIONS USING 3-YEAR AVERAGE HOURLY WAGES (i.e., 106 AND 82 PERCENT COMPARISON FOR HOSPITALS LOCATED IN RURAL AREAS AND 108 AND 84 PERCENT COMPARISON FOR HOSPITALS LOCATED IN URBAN AREAS) UNDER **ATTACHMENT I**.

HOSPITALS THAT WERE EVER AN RRC ARE EXEMPT FROM THE 106/108 PERCENT THRESHOLDS AND WILL ONLY BE REQUIRED TO MEET THE 82 PERCENT THRESHOLD OF THE AREA TO WHICH IT IS APPLYING (NOT THE 84 PERCENT THRESHOLD), EVEN IF IT IS AN URBAN HOSPITAL. A HOSPITAL THAT IS THE SINGLE HOSPITAL IN ITS URBAN AREA (MSA) IS EXEMPT FROM HAVING TO MEET THE 108 PERCENT THRESHOLD.

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: _____