



Medicare Geographic Classification Review Board Rules

The Medicare Geographic Classification Review Board's rules, which are effective July 21, 2016, are attached. These rules apply to all approved geographic redesignations and any new applications filed on or after July 21, 2016. These rules supersede all previous Board instructions that were issued on an annual basis. The Board may revise these rules to reflect changes in the law, regulations, or the Board's policy and procedures.

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Overview

The Medicare Geographic Classification Review Board ("MGCRB" or "Board") was established by the Omnibus Budget Reconciliation Act of 1989 to review and make determinations on geographic reclassification requests of hospitals who are receiving payment under the inpatient prospective payment system ("IPPS") but wish to reclassify to a higher wage area for purposes of receiving a higher payment rate. These rules govern proceedings before the MGCRB and contain instructions for completing the application(s) that providers will need in applying for geographic redesignation. These rules are consistent with 42 U.S.C. § 1395ww(d)(10) and 42 C.F.R. § 412.230ff.

The Board has discretion to take action if a provider fails to comply with these rules or fails to comply with a Board order. While these rules cite regulatory cross-references as a guide, the omission of a cross-reference does not excuse the provider from meeting all controlling statutory and regulatory requirements.

Providers may obtain the average hourly wage data necessary to prepare applications to the MGCRB from Federal Register documents. The IPPS proposed rule is typically published by the end of April each year and the IPPS final rule is published by mid-August. Both the proposed and final rules are on display approximately 1 week prior to the official publication date. See <https://www.federalregister.gov/>.

The Centers for Medicare & Medicaid Services ("CMS") also posts copies of the proposed and final rules along with all tables, additional data and analysis files, and the impact file at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>. Applicants are encouraged to review the federal register publications prior to filing an application as the Board will utilize the relevant information in the IPPS final rule in making decisions on applications for geographic redesignation.

The term "provider" and "hospital" are used interchangeably in MGCRB rules. Notwithstanding references to the term "provider" or "hospital" in the singular, all MGCRB rules apply to individual, group, and statewide applications unless the rule indicates otherwise.

Rule 1 – Correspondence Requirements

1.1 MGCRB Contact Information

All documents must be addressed as follows:

Medicare Geographic Classification Review Board
2520 Lord Baltimore Drive, Suite L
Baltimore, MD 21244-2670

Board Rules and application forms are available on the MGCRB website at <https://www.cms.gov/Regulations-and-Guidance/Review-Boards/MGCRB/index.html>.

1.2 Delivery of Materials to the Board

All submissions must be made in hard copy format to the Board’s mailing address. Documents must be delivered to the Board in any one of the following ways:

- by regular mail (the United States Postal Service (USPS));
- by express or overnight mail by a nationally-recognized next-day courier (such as USPS Express Mail, Federal Express, UPS, etc.); or
- by hand or courier.

You must allow sufficient time for documents to be received in a timely manner.

The normal business hours for the mail room are 8:00 a.m. to 4:00 p.m. (EDT/EST), Monday through Friday. Hand deliveries must be made to the mail room only during normal business hours. The Board suggests that you call ahead [(410) 786-1174] to inform a staff member of the delivery to ensure that someone will be available to accept the delivery. The Board does not currently accept applications or other correspondence submitted by e-mail, fax, or other electronic means.

1.3 Simultaneous Service to CMS

A provider must simultaneously submit a copy of its geographic redesignation application(s) and other correspondence to CMS’ Center for Medicare, Hospital & Ambulatory Policy Group. Effective immediately, providers must e-mail a copy of the applications and correspondence to CMS at wageindex@cms.hhs.gov. Delivery to CMS does not constitute delivery to the MGCRB.

1.4 Case Identification on All Submissions

All filings and correspondence must contain the case number (except for the initial application), along with the provider name and provider number and/or the group name as applicable.

1.5 Contact with the Board

Administrative or procedural inquiries should be directed to the Board staff at (410) 786-1174. Do not call or e-mail Board members directly.

1.6 Ex Parte Communication

The members of the MGCRB and its staff may not consult or be consulted by an individual representing the interests of an applicant provider or by any other individual on any matter at issue before the MGCRB without notice to the provider or CMS. If such communication occurs, the MGCRB will disclose it to the provider or CMS, as appropriate, and make it part of the record after the provider or CMS has had an opportunity to comment. MGCRB members and staff must not consider any information outside of the record about matters concerning a provider's application for reclassification.

The provisions in this section do not apply to:

- communications among MGCRB members and its staff;
- communications concerning the MGCRB's administrative functions or procedures;
- requests from the MGCRB to a party or CMS for a document;
- material that the MGCRB includes in the record after notice and an opportunity to comment.

Rule 2 – Provider Case Representative

2.1 Persons

A party may be represented by legal counsel or by any other person appointed to act as its representative at any proceeding before the MGCRB or the Administrator. All actions by the representative are considered to be those of the provider and notice of any action or decision sent to the representative has the same effect as if it had been sent to the provider itself.

The designated case representative is the individual with whom the Board maintains contact. There may be only one case representative per application.

The case representative may be an external party (e.g., attorney or consultant) or an internal party (e.g., employee or officer of the provider or its parent organization). If no case representative is designated, the Board will consider the officer who filed the application as the case representative. The Board will not accept an application or other correspondence from any external organization that is not designated as the official case representative.

2.2 Responsibilities

The case representative is responsible for ensuring his or her contact information is current with the Board and for timely responding to correspondence or requests from the Board. Failure of a representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines.

2.3 Communication with Representative

The Board will address all correspondence to the provider's official case representative. If other members of the representative's organization contact the Board, the Board will assume the contact is authorized by the representative and may communicate with these individuals about an application.

2.4 Letter of Representation

The letter designating the case representative must be on the provider's letterhead and be signed by an officer of the provider (e.g., Administrator, Vice President of Finance) or by a corporate officer of the provider's parent corporation. A letter of representation is required whether designating an external or internal representative.

The letter of representation must include the following information:

- the provider name and provider number,
- the reclassification period,
- full contact information for the representative (name, title organization, mailing address, e-mail address, and telephone number), and
- full contact information of the authorizing official.

The letter of representation does not need to be notarized.

2.5 Withdrawal or Change of Representation

A designated representative may withdraw an appearance by filing a notice of withdrawal signed by both the representative and the provider's authorizing official. Such notice should also include a concurrent submission of a new letter of representation by the provider. If a provider's written consent is not obtained, the representative must file a withdrawal notice listing the provider's last known contact information and document that a copy of the withdrawal notice was sent to the provider.

A provider may change its designated representative at any time by submitting a new letter of representation. Withdrawal of a case representative or the recent appointment of a new representative will not be considered cause for delay of any deadlines or proceedings.

Rule 3 – Filing an Application – General

3.1 The Geographic Redesignation Application

A provider may apply for geographic redesignation through (1) an individual application; (2) a group application by all IPPS hospitals in a county, and/or (3) a statewide wage index area application by all IPPS hospitals in a state. Federal regulations at 42 C.F.R. §§ 412.230 through 412.280 provide guiding regulatory criteria and conditions for such applications.

Providers requesting geographic redesignation must complete and submit an original and two copies of the application and all available supporting documentation to the Board by the regulatory deadline (see Board Rule 3.2).

3.2 Deadline for a Timely Application

A complete application must be received no later than the first day of the 13-month period preceding the federal fiscal year for which geographic redesignation is requested (September 1). The filing date of an application is the date the application is received by the MGCRB. 42 C.F.R. § 412.256(a).

If the specified deadline is a Saturday, a Sunday, a Federal legal holiday (as enumerated in Rule 6(a) of the Federal Rules of Civil Procedure), or a day on which the MGCRB is unable to conduct business in the usual manner due to extraordinary circumstances beyond its control (such as natural or other catastrophe, weather conditions, fire, or furlough), the deadline becomes the next day that is not one of the aforementioned days.

3.3 Complete Application

An application is complete if the application includes the following information: (1) the federal fiscal year for which the provider or group of providers is applying for redesignation; (2) which criteria constitute the basis of the request for reclassification; (3) an explanation of how the application meets the relevant criteria in 42 C.F.R. §§ 412.230 through 412.236, including any necessary data to support the application; and, (4) a letter of representation per Board Rule 2.4.

3.4 Dismissal for Late Filing

The Board will dismiss a provider's request for geographic redesignation if it does not receive the provider's application by the filing deadline.

3.5 Alternative Requests

A provider may simultaneously apply for geographic redesignation through an individual application, a group application, and a statewide application. The Board will rule on a statewide request first and then a group reclassification request before it reviews any individual reclassification request. If the Board approves a

statewide or group application, it will dismiss any individual reclassification applications filed by participating providers.

Providers may also apply for redesignation to more than one geographic area within their individual or group application. In such cases, the provider must submit a separate request within the application for each of the geographic areas to which it is requesting redesignation. The provider must also specify its preferred priority for the Board's consideration by clearly marking the respective requests as primary, secondary, tertiary, etc.

3.6 Rounding Not Permitted

Rounding of numbers is not permitted to meet the mileage or qualifying wage comparison percentage standards. 42 C.F.R. §§ 412.230(a)(4), 412.232(c), and 412.234(b).

Rule 4 – Filing an Individual Application

4.1 General Information for an Individual Application

A provider may seek geographic redesignation from a rural area to an urban area, from a rural area to another rural area, or from an urban area to another urban area for the purposes of using the other area's wage index value. An urban provider may seek redesignation to a rural area through 42 C.F.R. § 412.103, not through the MGCRB.

4.2 Criteria for an Individual Application

Federal regulations at 42 C.F.R. § 412.230 contain the criteria for individual providers seeking redesignation.

(A) A provider must demonstrate a close proximity to the area to which it seeks redesignation or qualify for special access by meeting one of the following conditions:

(1) *Proximity – Distance.* The distance from the provider to the requested area must be no more than 15 miles for an urban provider and no more than 35 miles for a rural provider. To demonstrate proximity, the provider must, at a minimum, submit map evidence using a nationally recognized electronic mapping service (e.g., Google Maps, Bing Maps, MapQuest). The map must show the route over improved roads from the provider's front entrance to the county line of the requested area and the distance of that route.

An improved road is any road that is maintained by a local, state, or federal government entity and available for use by the general public. An improved road includes the paved surface up to the provider's front entrance. For further information, see 66 Fed. Reg. 39874-75 (Aug. 1, 2001) which

discusses the definition of mileage for purposes of meeting the proximity requirements.

(2) *Proximity – Employee Commuting Pattern.* At least 50 percent of the provider's employees must reside in the requested area. For employee address data, the provider must submit current payroll records that include information that establishes the home addresses by zip code of its employees.

(3) *Special Access – Distance or Driving Time.* A provider that is a rural referral center, a sole community hospital, or both as of the date of the MGCRB's review need not demonstrate a close proximity to the area to which it seeks redesignation per the criteria above. Instead, the provider may request redesignation to the closest area. If the provider qualifies for urban redesignation, it may be redesignated to the urban area that is closest to the provider. If a rural provider is closer to another rural area than to any urban area, it may seek redesignation to either the closest rural or the closest urban area.

To demonstrate the closest area, the provider must, at a minimum, submit map evidence using a nationally recognized electronic mapping service (e.g., Google Maps, Bing Maps, MapQuest). The map must show the shortest route over improved roads from the provider's front entrance to the requested area and the distance or driving time of that route. The provider must also submit the same evidence to the next closest area.

(B) A provider must demonstrate that a comparison of the provider's average hourly wage ("AHW") to other provider wage costs in its own area and the requested area meet the thresholds as noted below.

(1) *Provider located in a rural area.* The provider's AHW must be at least:

- 106 percent of the AHW of all other hospitals in the area in which the provider is located; and
- 82 percent of the AHW of hospitals in the area to which it seeks redesignation;

(2) *Provider located in an urban area.* The provider's AHW must be at least:

- 108 percent of the AHW of all other hospitals in the area in which the provider is located; and
- 84 percent of the AHW of hospitals in the area to which it seeks redesignation.

(3) *Exceptions.* See 42 C.F.R. §§ 412.230(d)(3)-(5) for exceptions to the wage comparisons for rural referral centers, special dominating hospitals, and a single hospital in an MSA.

(4) *Appropriate wage data.* The provider must submit a weighted 3-year average of its hospital-specific data, plus a weighted 3-year average of the AHW in both the area in which the provider is located and the area to which the provider seeks reclassification. The wage data are taken from the CMS hospital wage survey used to construct the wage index in effect for IPPS payment purposes.

The Board will use the final official data in evaluating if a provider meets the redesignation criteria. Providers may obtain this wage data information via the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files.html>, and then accessing the "Three Year MGCRB Reclassification Data" file for the federal fiscal year for which the provider is applying. Any inquiries concerning the CMS wage and hour data should be directed to wageindex@cms.hhs.gov.

4.3 Requirements for an Individual Application

The individual application consists of a series of questions and attachments required to be filed, along with supplemental forms addressing the specific reclassification method. The provider must identify the criteria that constitute the basis of the request and supply all necessary supporting documentation to demonstrate that the provider meets the relevant criteria. Failure to provide adequate support may result in denial of the application.

4.4 Limitations on Redesignation

The following limitations apply to redesignation:

(A) An individual provider may not be redesignated to another area for purposes of the wage index if the pre-reclassified average hourly wage for that area is lower than the pre-reclassified average hourly wage for the area in which the hospital is located.

(B) A provider may not be redesignated to more than one area, except for an urban hospital that has been granted redesignation as rural under 42 C.F.R. § 412.103 and receives an additional reclassification by the MGCRB.

(C) If a provider is already reclassified to a given geographic area for wage index purposes for a 3-year period, and submits an application for reclassification to the same area for either the second or third year of the 3-year period, that application will not be approved. The Board can, however, approve a hospital's request to a different geographic area than the area to which it is currently redesignated.

Rule 5 – Filing a Group Application

5.1 General Information for a Group Application

All IPPS hospitals in a county may file a group application for geographic redesignation with the Board. A provider that is the only IPPS hospital in its county may also apply as a group. The Board can redesignate a hospital group only for the purpose of using the requested area's wage index and may reclassify a rural group only to an urban area or an urban group to another urban area.

5.2 Criteria for a Group Application

Federal regulations at 42 C.F.R. § 412.232 contain the criteria for hospitals in a rural county seeking redesignation. 42 C.F.R. § 412.234 sets forth the criteria for all hospitals in an urban county seeking redesignation to another urban area. The following conditions must be met:

(A) The county in which the hospitals are located must be adjacent to the MSA to which they seek redesignation. In order to demonstrate that the group meets this requirement, the group must include a map on which the group highlights the county in which the hospital group is located and the requested area (e.g., see Census Bureau maps at <http://census.gov/geo/maps-data/maps/statecbsa.html>).

(B) All hospitals in a county must jointly apply for redesignation as a group.

(C) For rural county groups only, the county in which the providers are located must meet the criteria for metropolitan character. Specifically, the group must demonstrate that the rural county in which they are located meets the standards for redesignation to a Metropolitan Statistical Area ("MSA") as an "outlying county." The providers may submit data, estimates, or projections, made by the Census Bureau concerning population density or growth, or changes in designation of urban areas. The MGCRB only considers the most recently issued data developed by the Bureau of the Census.

(D) Urban hospitals located in counties that are in the same Combined Statistical Area ("CSA") or Core-Based Statistical Area ("CBSA") as the urban area to which they seek redesignation qualify as meeting the proximity requirements for reclassification. To demonstrate, the group must attach the applicable page(s) of the CSA or CBSA listing based on the most recent updates to statistical areas announced by the Office of Management and Budget ("OMB"). See OMB Bulletin 15-01 (July 15, 2015), which may be accessed at: <https://www.whitehouse.gov/sites/default/files/omb/bulletins/2015/15-01.pdf>.

(E) The aggregate average hourly wage for all hospitals in the group must be equal to at least 85 percent of the average hourly wage in the adjacent urban area. The hospitals must submit appropriate wage data computations demonstrating the group meets this threshold. The computations must include wages and hours for the three years used to calculate the wage index for each hospital in the group and the 3-year average hourly wage for the requested area. The wage data are to be

taken from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes.

The Board will use the final official data in evaluating if a group meets the redesignation criteria. Providers may obtain this wage data information via the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files.html>, under the "Three Year MGCRB Reclassification Data" file for the federal fiscal year for which the group is applying. Any inquiries concerning the CMS wage and hour data should be directed to wageindex@cms.hhs.gov.

(F) The pre-reclassified average hourly wage for the area to which the providers seek redesignation is higher than the pre-reclassified average hourly wage for the area in which they are currently located.

5.3 Requirements for a Group Application

The group application consists of a series of questions and supporting documentation, including a letter of representation from each provider in the group and aggregate hourly wage computations. The Board will dismiss an application that does not include all IPPS hospitals in the referenced county or that fails to submit a fully executed letter of representation from each provider indicating its participation in the group by the application due date.

Rule 6 – Filing a Statewide Application

6.1 General Information for a Statewide Application

An appropriate statewide entity can apply to have all of the geographic areas in the state treated as a single geographic area for purposes of computing and applying the area's wage index for redesignations.

6.2 Criteria for a Statewide Application

Federal regulations at 42 C.F.R. § 412.235 contain criteria for hospitals in a state seeking a wage index redesignation. The following conditions must be met:

(A) All IPPS hospitals in the state must apply as a group for reclassification to a statewide wage index through a signed single application.

(B) All IPPS hospitals in the state must agree to the reclassification to a statewide wage index through a signed affidavit on the application.

(C) All IPPS hospitals in the state must agree, through an affidavit, to withdrawal of an application or to termination of an approved statewide wage index reclassification.

(D) All IPPS hospitals in the state must waive their rights to any wage index classification that they would otherwise receive absent the statewide wage index classification, including a wage index that any of the hospitals might have received through individual geographic reclassification.

(E) New hospitals that open within the state prior to the deadline for submitting an application for a statewide wage index reclassification, regardless of whether a group application has already been filed, must agree to the use of the statewide wage index as part of the group application. New hospitals that open within the state after the deadline for submitting a statewide wage index reclassification application or during the approved reclassification period will be considered a party to the statewide wage index application and reclassification.

6.3 Requirements for a Statewide Application

The statewide wage index application consists of a series of questions and supporting documentation, including an affidavit and letter of representation from each hospital in the statewide group. Each affidavit must be fully executed and notarized and submitted in original form (copies are not permitted). The Board will dismiss a statewide application that does not include all IPPS hospitals in the referenced state or that fails to include a proper affidavit and letter of representation from each provider by the application due date.

Rule 7 – Acknowledgement of an Application

7.1 Board’s Notice

The Board will send an acknowledgement notice indicating that the application for geographic redesignation has been received, identifying the case number assigned, and stating whether the application is either complete or incomplete. If the application contains all the necessary elements, the Board notifies the case representative in writing (with a copy to CMS) that the application is complete and that the case may proceed.

If the Board determines that an application is incomplete, the notice will identify the additional documentation required and the deadline for submission. Upon completion of the application, the Board will issue a supplemental notice to the parties. Failure to timely submit the requested information will result in the dismissal of the application.

7.2 Parties’ Responsive Comments

CMS has 30 days from the date of receipt of notice of a complete application to submit written comments and recommendations (with a copy to the provider) for consideration by the MGCRB. The provider has 15 days from the date of receipt of CMS' comments to submit written comments to the MGCRB (with a copy to CMS) for the purpose of responding to CMS' comments. 42 C.F.R. § 412.258.

7.3 Additional Documentation

Upon substantive review of a filed application that was previously identified as technically complete in accordance with 42 C.F.R. § 412.256(b), the Board may determine that further information is needed to process the application. In such cases, the Board will issue a supplemental request for additional supporting documentation. Failure to timely submit the requested information may result in the denial of the geographic redesignation application.

Rule 8 – Board Hearings and Decisions

8.1 On the Record Hearing

The MGCRB will ordinarily issue an on-the-record decision without conducting an oral hearing. The decision will be based upon all documents, data, and other written evidence and comments submitted timely to the MGCRB by the parties. 42 C.F.R. § 412.254(a).

8.2 Oral Hearing

The MGCRB may hold an oral hearing on its own motion or if a party demonstrates to the MGCRB's satisfaction that an oral hearing is necessary. 42 C.F.R. § 412.254(b). The provider must advise the Board in writing if it is requesting an oral hearing and attach the rationale for the oral hearing to its application.

8.3 Quorum

A quorum consisting of at least a majority of the members of the MGCRB, one of whom is representative of rural hospitals, is required for making MGCRB decisions. 42 C.F.R. § 412.248.

8.4 Recusals

An MGCRB member may not participate in any decision in which he or she may be prejudiced or partial with respect to a party or has any other interest in the case. In such a case, the MGCRB member will withdraw (recuse) themselves from that decision. 42 C.F.R. § 412.262.

8.5 Timing, Term, and Finality of MGCRB Decisions

The Board will issue all decisions within 180 days after the deadline for filing geographic redesignation applications. 42 C.F.R. § 412.276.

A decision by the MGCRB on a geographic redesignation application will be effective for 3 years beginning with discharges occurring on the first day (October 1) of the second federal fiscal year following the federal fiscal year in which the providers filed a complete application. 42 C.F.R. § 412.274.

A decision of the MGCRB is final and binding upon the parties unless it is reviewed by the Administrator and the decision is changed by the Administrator in accordance with 42 C.F.R. § 412.278.

Providers may withdraw or terminate an approved 3-year reclassification in accordance with 42 C.F.R. § 412.273. See Board Rule 10.

Rule 9 – Administrator’s Review

9.1 Provider’s Request for Review

In accordance with 42 C.F.R. § 412.278, a hospital or group of hospitals dissatisfied with an MGCRB’s geographic redesignation decision may request that the CMS Administrator review the MGCRB decision. Providers may also request that the Administrator review the MGCRB’s dismissal of an application as untimely filed or incomplete.

Providers must submit such requests in writing to the CMS Administrator, in care of the Office of the Attorney Advisor, at the following address.

Centers for Medicare & Medicaid Services
Office of the Attorney Advisor
Room C3-01-20
7500 Security Boulevard
Baltimore, MD 21244-1850

The request must be received by the Administrator within 15 days after the date the MGCRB issues its decision. A request for Administrator review filed by facsimile or other electronic means will not be accepted.

Providers must also e-mail a copy of its request to CMS’ Center for Medicare, Hospital & Ambulatory Policy Group at wageindex@cms.hhs.gov.

9.2 Administrator Discretionary Review

The CMS Administrator may, at his or her own discretion, review any final decision of the MGCRB. The provider will be notified if the Administrator decides to review a MGCRB decision and the provider may submit a response to the Administrator within 15 days of receipt of the Administrator’s notice of review. 42 C.F.R. § 412.278(c).

9.3 Administrator Decision

The Administrator may not receive or consider any new evidence and must issue a decision based only upon the record as it appeared before the MGCRB and any comments submitted under 42 C.F.R. § 412.278(b)-(c). The Administrator will issue a decision to the provider no later than 90 days following receipt of the

provider's request for review or no later than 105 days following the issuance of the MGCRB decision in the case of discretionary review. The Administrator's decision is the final Departmental decision and is not subject to judicial review.

Rule 10 – Withdrawals and Terminations

10.1 Withdrawals and Terminations – General

Providers are encouraged to review the provisions contained in 42 C.F.R. § 412.273 regarding withdrawals and terminations. Additional information can also be found in the IPPS final rules for federal fiscal years 2002, 2003, 2008, 2009 and 2011 (see 66 Fed. Reg. 39887-39777 (Aug. 1, 2001), 67 Fed. Reg. 50065-50066 (Aug. 1, 2002), 72 Fed. Reg. 47332-47334 (Aug. 22, 2007), 73 Fed. Reg. 48586 (Aug. 9, 2008) and 75 Fed. Reg. 50172-50173 (August 16, 2010).

10.2 Withdrawal of an Application Prior to Board Decision

Providers may withdraw their request for geographic redesignation at any time before the Board issues a decision on the application. 42 C.F.R. § 412.273(c)(1)(i).

10.3 Withdrawal of an Approved Geographic Redesignation

Withdrawal refers to the withdrawal of a 3-year MGCRB reclassification that has been approved by the Board but has not yet gone into effect. Withdrawal requests approved by the Board will be effective for the full 3-year reclassification period.

Hospital groups and statewide wage index groups may also withdraw an approved geographic redesignation, but the request to withdraw must be made by all hospitals that are a party to the approved redesignation.

A request to withdraw an approved geographic redesignation must be received by the Board within 45 days from the date of publication of CMS' annual notice of proposed rulemaking concerning the changes to the hospital IPPS and proposed payment rates for the fiscal year for which the application has been filed.

10.4 Termination of an Approved Geographic Redesignation

Termination refers to the termination of an already existing 3-year MGCRB reclassification where such reclassification has already been in effect for 1 or 2 years, and there are 1 or 2 years remaining on the 3-year reclassification. A termination is effective only for the full fiscal year(s) remaining in the 3-year period at the time the request is received. Requests for terminations for part of a fiscal year are not considered.

Hospital groups and statewide wage index groups may terminate an approved geographic redesignation in its entirety or any individual provider within the group

may individually request to terminate participation in the second and/or third year(s) of a 3-year geographic redesignation.

A request to terminate an approved geographic redesignation must be received by the Board within 45 days from the date of publication of CMS' annual notice of proposed rulemaking concerning the changes to the hospital IPPS and proposed payment rates for the fiscal year for which the application has been filed.

10.5 Cancellations of Withdrawals and Terminations

A hospital or group of hospitals may cancel a withdrawal or termination in a subsequent year and request that the MGCRB reinstate the wage index reclassification for the remaining fiscal year(s) of the 3-year period. Withdrawals may be cancelled only in cases where the MGCRB issued a decision on the geographic reclassification request.

Cancellation requests must be received in writing by the MGCRB no later than the deadline for submitting reclassification applications for the following fiscal year, as specified in 42 C.F.R. § 412.256(a)(2).

10.6 Reapplications

A provider may apply for reclassification to a different area (that is, an area different from the one to which it was originally reclassified for the 3-year period). If the application is approved, the reclassification will be effective for 3 years. The provider's existing 3-year reclassification will be terminated when a second 3-year wage index reclassification goes into effect for payments for discharges on or after the following October 1. Once the new reclassification becomes effective, a provider may no longer cancel a withdrawal or termination of a prior 3-year reclassification.

Appendix A – Geographic Terms and Concepts

Statistical Areas

Core Based Statistical Areas ("CBSAs") consist of the county or counties or equivalent entities associated with at least one core area with a population of at least 10,000 (urbanized area or urban cluster), plus adjacent counties having a high degree of social and economic integration with the core area as measured through commuting ties with the counties associated with the core area. The term "core based statistical area" became effective in 2003 and refers collectively to metropolitan statistical areas and micropolitan statistical areas. The U.S. Office of Management and Budget ("OMB") defines CBSAs to provide a nationally consistent set of geographic entities for the United States and Puerto Rico for use in tabulating and presenting statistical data and updates the CBSAs based on U.S. Census Bureau data.

Combined Statistical Areas ("CSAs") consist of two or more adjacent CBSAs that have substantial employment interchange. The CBSAs that combine to create a CSA retain separate identities within the larger CSA.

Metropolitan Divisions are smaller groupings of counties or equivalent entities defined within a metropolitan statistical area containing a single core area with a population of at least 2.5 million. Not all metropolitan statistical areas with urbanized areas of this size will contain metropolitan divisions. A metropolitan division consists of one or more main/secondary counties that represent an employment center or centers, plus adjacent counties associated with the main/secondary county or counties through commuting ties.

Metropolitan Statistical Areas ("MSAs") are CBSAs associated with at least one urbanized area that has a population of at least 50,000. The metropolitan statistical area comprises the central county or counties or equivalent entities containing the core area, plus adjacent outlying counties having a high degree of social and economic integration with the central county or counties as measured through commuting.

Micropolitan Statistical Areas are CBSAs associated with at least one urban cluster that has a population of at least 10,000 but less than 50,000. The micropolitan statistical area comprises the central county or counties or equivalent entities containing the core area, plus adjacent outlying counties having a high degree of social and economic integration with the central county or counties as measured through commuting.

New England City and Town Areas ("NECTAs") are an alternative set of geographic entities, similar in concept to the county-based CBSAs defined nationwide, that OMB defines in New England based on county subdivisions—usually cities and towns. NECTAs are defined using the same criteria as county-based CBSAs, and, similar to CBSAs, NECTAs are categorized as metropolitan or micropolitan.

New England City and Town Area Divisions are smaller groupings of cities and towns defined within a NECTA containing a single core area with a population of at least 2.5 million. A NECTA division consists of a main city or town that represents an employment center, plus adjacent cities and towns associated with the main city or town through commuting ties. Each NECTA division must contain a total population of 100,000 or more.

Urban and Rural Areas

Hospitals in MSAs and Metropolitan Divisions are classified as “urban hospitals” for application purposes. These areas are identified using a five-digit numeric code that is assigned alphabetically based on title and is unique within the nation. All applications must use the urban identification codes and names as identified in OMB Bulletin No. 15-01 (July 15, 2015). This bulletin may be accessed at: <https://www.whitehouse.gov/sites/default/files/omb/bulletins/2015/15-01.pdf>

All other areas (including Micropolitan Statistical Areas) are classified as “rural hospitals” for application purposes. The rural areas are identified using a two-digit numeric code that is unique to each state. The state codes are included within this appendix.

42 U.S.C. § 1395ww(d)(8), through paragraphs (B) and (E), sets forth provisions for certain hospitals located in rural counties to be redesignated as urban (commonly referred to as “Lugar hospitals”) or for hospitals located in urban areas to apply to be treated as being located in a rural area (commonly referred to as “Section 401 hospitals”). See also 42 C.F.R. §§ 412.64(b)(3) and 412.103. These provisions are separate and distinct from the MGCRB application process.

State Codes for Rural Areas

State Code	StateName
01	Alabama
02	Alaska
03	Arizona
04	Arkansas
05	California
06	Colorado
07	Connecticut
08	Delaware
10	Florida
11	Georgia
12	Hawaii
13	Idaho
14	Illinois
15	Indiana
16	Iowa
17	Kansas
18	Kentucky
19	Louisiana
20	Maine
21	Maryland
22	Massachusetts
23	Michigan
24	Minnesota
25	Mississippi
26	Missouri

State Code	StateName
27	Montana
28	Nebraska
29	Nevada
30	New Hampshire
31	New Jersey
32	New Mexico
33	New York
34	North Carolina
35	North Dakota
36	Ohio
37	Oklahoma
38	Oregon
39	Pennsylvania
41	Rhode Island
42	South Carolina
43	South Dakota
44	Tennessee
45	Texas
46	Utah
47	Vermont
49	Virginia
50	Washington
51	West Virginia
52	Wisconsin
53	Wyoming

Appendix B – Summary of Application Forms

The following application and supporting forms are available on the MGCRB website at <https://www.cms.gov/Regulations-and-Guidance/Review-Boards/MGCRB/index.html>:

- (1) Individual Application
Individual Reclassification Request Forms (by method):
 - Proximity – Distance
 - Proximity – Employee Commuting Pattern
 - Special Access – Distance
 - Special Access – Driving Time

- (2) Group Application

- (3) Statewide Application
Statewide Affidavit