Medicare Geographic Classification Review Board

Frequently Asked Questions for FY 2027 Application Period

Updated 07/17/2025[1]

1. Has anything changed in the MGCRB application for FY 2027?

    A. CMS adopted a revision to 42 CFR § 412.273(c)(1)(ii) and (c)(2) to provide that a withdrawal or termination request is due within 45 days of the date of filing for public inspection of the proposed rule at the website of the Office of the Federal Register, or within 7 calendar days of receiving a decision of the Administrator in accordance with § 412.278 of this part, whichever is later. To adopt this provision, providers using the 7-day extension must file an "Other" Case Action to upload its (1) OAA decision; (2) proof of receipt of its OAA decision; and (3) its request for a withdrawal or termination. MGCRB Rule 11 was updated.

2. Are there any provisions from the Proposed Rule to be aware of?

    A. Applications for FFY 2027 reclassifications are due to the MGCRB by September 2, 2025. This is also the current deadline for cancelling a previous withdrawal or termination.

    CMS released the Fiscal Year 2026 Hospital Inpatient Prospective Payment Systems Proposed Rule for public display on April 11, 2025. The rule contained proposed revisions to § 412.273. CMS proposed to modify the definition of *withdrawal* to only include requests made prior to the MGCRB's decision on the application. The definition of *termination* would encompass all post-decision actions; a termination is effective only for the full fiscal year(s) remaining in the 3-year period. Further, CMS proposed to modify several references to "cancelling" or a "cancellation" of a withdrawal or termination to "reinstating" or "reinstatement" of an approved reclassification. CMS would continue the current policy that requests made prior to the effective date of the reclassification must include all parties to a group application. CMS would also continue its policy that a previous MGCRB reclassification that is permanently expired would not be eligible for reinstatement.

3. Am I required to use OH CDMS to submit my MGCRB application or will paper applications be accepted?

    A. 42 C.F.R. § 412.256(a)(1) states: "An application must be submitted to the MGCRB according to the method prescribed by the MGCRB, with an

[1] Changes made since the last published version have been highlighted with gray text.

electronic copy of the application sent to CMS." Currently, the MGCRB requires all individual and group applications, as well as all supporting documentation and follow-up correspondence, to be filed electronically via the Office of Hearings Case and Document Management System ("OH CDMS").

Please reference https https://www.cms.gov/medicare/regulations-guidance/geographic-classification-review-board/mgcrb-electronic-filing for registration instructions and the system user manual. For any system access or functionality questions, please contact the OH CDMS Help Desk at Helpdesk_OHCDMS@cms.hhs.gov or 1-833-783-8255 Please register in advance, gather all supporting documentation before starting the application, and allow ample time to enter and review information before the application filing deadline.

Statewide applications are excluded from the use of OH CDMS. Relevant statewide application and affidavit forms are included at https://www.cms.gov/medicare/regulations-guidance/geographic-classification-review-board/mgcrb-rules and are to be filed in hard copy by mail or courier service. Correspondence is not accepted by email. See MGCRB Rules 2.1 and 2.2.

4. Can the provider see its application if a representative is filing on their behalf?

   A. Per MGCRB Rule 3.1, the designated case representative is the individual with whom the Board maintains contact and there may be only one case representative per application. Accordingly, OH CDMS is designed for the designated representative to submit and take action on the application. Please work with your representative if you have questions about the application.

5. Can I view the documents that were uploaded or print the application prior to submitting?

   A. Yes, OH CDMS allows users submitting the application to view uploaded documents in all parts of the application to ensure the proper documents have been provided. There is also a Review & Submit section to complete a final verification of the application. This section includes links back to the original data entry if corrections need to be made before submission to the Board. There is not a formal print function within the draft application, but once submitted a Confirmation of Correspondence is generated to document all of the data provided and documents uploaded. If a print is required prior to submission, users may print screen the application sections.

   If the submitting user identifies a different organization as the designated representative, that representative organization will not be

able to see the application until the application is submitted to the Board and the representative is formally assigned to the case.

6. What is required for a letter of representation?

   A. MGCRB Rule 3 addresses case representatives, including the requirements and responsibilities of the designated representative. A letter of representation is required whether designating an external or internal representative. The letter must be on provider's letterhead and include the following information:
      - the provider name and provider number;
      - the reclassification period;
      - full contact information for the representative (name, title organization, mailing address, telephone number, and e-mail address); and
      - full contact information of the authorizing official.

7. What information am I required to have in a submission to the MGCRB?

   A. Per MGCRB Rule 2.4, you are required to identify the case number, along with provider name and number and/or group name, as applicable. Please be as specific as possible in your requests. Parent organizations should be especially careful to specify the provider's name and number. This applies to post-decision actions as well (i.e., providers in a group application giving their permission to withdraw or terminate).

   Criteria for a complete application are addressed at MGCRB Rule 4.3 and 42 C.F.R. §§ 412.230 through 412.236, § 412.256(b).

8. How do I measure for distance requirements?

   A. The MGCRB measures the distance between the hospital and the county line of the area to which it seeks reclassification based on the shortest route over improved roads maintained by any local, State, or Federal government entity for public use. Improved roads include the paved surface up to the front entrance of the hospital because this portion of the distance is utilized by the public to access the hospital. 66 Fed. Reg. 39827, 39874 (Aug. 1, 2001). Accordingly, your map should show the distance and specific route over improved roads from the front entrance to the county line of the requested area (you need not measure beyond the county line).

9. How do I request multiple/alternative reclassifications?

   A. Per MGCRB Rule 4.5, the MGCRB allows a provider to submit multiple reclassification requests within an application in order to request different areas and/or different methodologies. Please use a single

application per provider (or group) with multiple reclassification requests rather than submitting separate applications for each reclassification request. This will facilitate the shared use of the background information across all reclassification requests and will allow clarity regarding the priority order of the requests made. In order to request multiple redesignations in OH CDMS, choose the "Add Reclassification Request" button on the Reclassification Request screen.

Priority of the requests (primary, secondary, tertiary, etc.) will be established in the order the requests were added to the application, but you will have the opportunity to change the priority order until the application is submitted to the Board. The MGCRB reviews these requests in priority order and does not consider lower priority requests following an approval of a higher priority request (for example, if the primary request is approved, the secondary and tertiary requests are not considered).

10. What is an overlapping request?

    A. The MGCRB regulations dictate that 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. 42 C.F.R. § 412.230(a)(5)(iii). Therefore, if the provider has a current approved reclassification and withdraws that reclassification, the provider must request a reinstatement of the approved reclassification rather than filing a new application to that same area.

11. What is Section 401 and how does that status impact an MGCRB application?

    A. Congress enacted Section 401 of Public Law 106-113 (codified at 42 U.S.C. § 1395ww(d)(8)) (commonly referred to as "Section 401"), which established a separate procedure whereby urban hospitals can be reclassified from urban to rural status if they meet certain criteria. Approval for Section 401 status permits the provider to use rural guidelines in its MGCRB application request, including a 35-mile proximity requirement (rather than 15 miles for urban hospitals) and the use of a 106% average hourly wage comparison to other hospitals located in the area in which the provider is located (rather than 108%).

    The MGCRB does not determine Section 401 status so the provider must supply documentation to support current approval for Section 401 status to the Board in order to utilize the rural standards. In its application, the provider must also identify the CBSA code for where the hospital is physically located, not the rural State code to which it has been reclassified under Section 401.

Also, while many Section 401 hospitals are also approved as Rural Referral Centers ("RRC"), one status does not guarantee the other. If you wish to use RRC status to allow for the use of special access provisions per 42 C.F.R. § 412.230(a)(3) or the rural referral exceptions per 42 C.F.R. § 412.230(d)(3), then you must supply the requisite support for the RRC status as indicated in the regulations.

12. How should the hospital answer the questions regarding RRC, Sole Community Hospital ("SCH") and/or Section 401 status if the status is pending?

    A. The MGCRB asks a number of background questions related to RRC, SCH, and Section 401 status. These questions must be answered for the status as of the date of the submission. If a change in status has been requested, but not yet granted by CMS, you may submit supplemental information with your application to document the pendency of the request, but the proper answer to these questions is "NO." If approval is subsequently granted, you may submit updated information through OH CDMS for the Board's consideration.

13. Where does the hospital find the correct wage data to use in the application?

    A. CMS publishes wage data at: https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wage-index-files.

14. I was not able to simultaneously file a reinstatement request when I filed my withdrawal or termination. When can I do that?

    A. Reinstatement requests are processed by the MGCRB in conjunction with the new application period. Therefore, OH CDMS will be available in mid-July through the first business day in September to file both reinstatements and new applications.

    An e-mail is issued when an application window opens. If you would like to be included on the mailing list, please register for OH CDMS. Otherwise, please check the MGCRB website at https://www.cms.gov/medicare/regulations-guidance/geographic-classification-review-board for updates.

15. When will the Board make its decisions for the filed applications?

    A. Per 42 C.F.R. § 412.276, the MGCRB has 180 days from the application deadline to issue its decisions and may do so at any time in that window.