Medicare Geographic Classification Review Board Rules

Version 3.0

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Medicare Geographic Classification Review Board

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https://www.cms.gov/Regulations-and-Guidance/Review-Boards/MGCRB/index.html

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Rule 1 MGCRB Overview

1.1 Authority

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. § 412.230.

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.

1.2 Federal Register Notices

Hospitals may obtain the average hourly wage ("AHW") 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 ("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.

1.3 Hospital or Provider

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 2 Correspondence Requirements

2.1 Application and Document Submission

Pursuant to 42 C.F.R. § 412.256(a)(1), an application must be submitted to the MGCRB according to the method prescribed by the MGCRB.

To file an individual or group application with the MGCRB, providers must utilize the Office of Hearings Case and Document Management System ("OH CDMS"). To access OH CDMS, *see* https://www.cms.gov/Regulations-and-Guidance/Review-Boards/MGCRB/Electronic-Filing.html.

To file a statewide application with the MGCRB, providers must submit a hard copy application form and affidavits. *See* Rule 7 and Appendix B.

2.2 Delivery of Materials to the Board

The Board does ***not*** accept applications or other correspondence submitted by e-mail or fax. All correspondence relating to established cases must be submitted through OH CDMS.

2.3 Simultaneous Service to CMS

A provider must simultaneously submit a copy of its application and other correspondence to CMS' Center for Medicare (CM), Hospital & Ambulatory Policy Group via e-mail at wageindex@cms.hhs.gov. Delivery to CMS does **not** constitute delivery to the MGCRB.

2.4 Caption Case Number 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.

2.5 Contact with the Board Staff

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

2.6 Ex Parte Communications

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

Rule 3 Provider Case Representative

3.1 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 to be 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.

3.2 Responsibilities

The case representative is responsible for ensuring his or her contact information is current with the Board, including a current e-mail address and phone number. The case representative is also responsible 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.

3.3 Communication with Representative

The Board's communications will be sent to the case representative, with a copy to the provider's authorizing official, via e-mail. 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.

3.4 Letter of Representation

The letter designating the case representative must be on the provider's letterhead and be signed by a person authorized to act on behalf of the provider with respect to geographic redesignations. A letter of representation is required whether designating an external or internal representative.

The letter of representation must be included as part of a complete application and 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, telephone number, and e-mail address), and
- full contact information of the authorizing official.

3.5 Withdrawal or Change of Representation

A designated representative may withdraw an appearance by filing a notice of withdrawal. Until a new letter of representation is submitted, the representative of record will default to the provider's authorizing official.

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 4 Filing an Application – General

4.1 The Geographic Redesignation Application

A hospital may apply for geographic redesignation through (1) an individual application; (2) a group application by all prospective payment hospitals in a county, and/or (3) a statewide wage index area application by all prospective payment hospitals in a state.

Providers requesting individual or group geographic redesignation through OH CDMS must submit applications and supporting documents electronically and are not required to submit separate hardcopies.

Providers requesting statewide geographic redesignation must complete and submit an original and two copies of the hardcopy application (available on the MGCRB website) and all available supporting documentation to the Board by the regulatory deadline.

4.2 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 (FFY) for which geographic redesignation is requested (usually 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.

4.3 Criteria for a Complete Application

An application is complete if the application from an individual hospital or from all hospitals in a county includes the following information: (1) the federal fiscal year for which the hospital(s) is applying for redesignation; (2) which criteria constitute the basis of the request(s) for reclassification; and (3) an explanation of how the hospital(s) meets the relevant criteria in 42 C.F.R. §§ 412.230 through 412.236, including any necessary data to support the application. 42 C.F.R. § 412.256(b).

See Rules 5.3 (Individual); 6.3 (Group); and 7.3 (Statewide) for specific identification of necessary documentation by application type.

4.4 Dismissal for Late Filing

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

4.5 Multiple Requests

A provider may simultaneously apply for geographic redesignation through an individual application, a group application, and a statewide application, but may only receive approval for one redesignation per year. Approvals are ranked in the following order: statewide, group, individual. Therefore, if the Board approves a statewide request, the Board will dismiss any group or individual applications for that provider. If there is a group and an individual application, the group approval will take precedence and the individual application will be dismissed.

Providers may also apply for redesignation to more than one geographic area within their individual or group application. In such cases, the provider(s) must submit a separate request within its application for each of the geographic areas to which it is requesting redesignation.

Unless otherwise specified, the priority of the reclassification request will be assigned in the order in which the requests were timely received. For example, the first one received will be primary and the next request will be considered secondary.

4.6 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 5 Filing an Application – Individual

5.1 General Information for an Individual Application

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

5.2 Criteria for an Individual Application

(A) A hospital 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 hospital to the requested area must be no more than 15 miles for an urban hospital and no more than 35 miles for a rural hospital. To demonstrate proximity, the provider must submit map evidence (using a nationally recognized electronic mapping service (e.g., Google Maps, Bing Maps, MapQuest) showing the shortest route over improved roads from the front entrance of the hospital 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 front entrance of the hospital. 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 hospital's employees must reside in the requested area. For employee address data, the hospital must submit current payroll records that include information that establishes the home addresses by zip code of its employees. 42 C.F.R § 412.230(b)(2) and (c)(2).

(3) *Special Access – Distance or Driving Time.* A hospital that is a rural referral center ("RRC"), a sole community hospital ("SCH"), or both as of the date of the MGCRB's review does not have to demonstrate a close proximity to the area to which it seeks redesignation. Instead, if the hospital qualifies for urban redesignation, it may be redesignated to the urban area that is closest to the hospital. If the hospital 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.

The provider must submit evidence of its current RRC or SCH status to apply under special access rules. The provider is required to notify the MGCRB immediately if the provider's status changes.

To demonstrate the closest area, the provider must submit map evidence of the shortest route over improved roads from the main entrance of the hospital 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 hospital must demonstrate that a comparison of the provider's AHW to other hospital wage costs in its own area and the requested area meet the thresholds as noted below.

(1) *Hospital 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) *Hospital 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 RRCs, special dominating hospitals, and single hospital Metropolitan Statistical Areas ("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 hospital is located and the area to which the hospital seeks reclassification. The wage data are 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 wage 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 by accessing the "Three Year MGCRB Reclassification Data" file for the appropriate FFY. Any inquiries concerning the CMS wage data should be directed to wageindex@cms.hhs.gov.

5.3 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 hospital meets the relevant criteria. Failure to provide adequate support may result in dismissal or denial of the application.

Necessary documentation for an individual application includes:

- Name of hospital
- Provider number
- Letter of representation
- Geographic address of hospital
- County in which hospital is physically located
- CBSA of the home area

- CBSA of the requested area
- Reclassification method – proximity or special access
- Demonstration of current RRC/SCH/401 status, if applicable
- Demonstration of having ever been RRC, if applicable
- Documentation from approved sources to demonstrate hospital meets relevant criteria
  - Map
    - *See* Board Rule 5.2(A) (nationally recognized electronic mapping system with turn-by-turn directions)
  - Wage Data Comparison
    - *See* Board Rule 5.2(B) (demonstration of thresholds using data from the CMS hospital wage survey used to construct the wage index)

5.4 Limitations on Individual Redesignation

The following limitations apply to redesignation:

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

(B) A hospital 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[1] ("401 status") and receives an additional reclassification by the MGCRB.

The provider must submit evidence of its ***current*** 401 status. The provider is required to notify the MGCRB immediately if the provider's status changes.

(C) If a hospital 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.

[1] 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. The Secretary of HHS promulgated regulations under Section 401 at 42 C.F.R. § 412.103.

Rule 6 Filing an Application – Group

6.1 General Information for a Group Application

All acute care prospective payment hospitals in a county may file a group application for geographic redesignation with the Board. A hospital that is the only prospective payment 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.

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.

6.2 Criteria for a Group Application

For all hospitals in a county to be redesignated to an 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 (*see* U.S. 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 an MSA as an "outlying county." The standards for designating outlying counties were identified at 75 Fed. Reg. 37246, 37250 (June 28, 2010). 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 or Core-Based Statistical Area as the urban area to which they seek redesignation qualify as meeting the proximity requirements for reclassification to the urban area to which they seek redesignation. To demonstrate, the group should attach the applicable page(s) of the U.S. Census Bureau CSA or CBSA listing. *See* OMB Bulletins as referenced in Appendix C.

(E) The aggregate AHW for all hospitals in the group must be equal to at least 85 percent of the AHW 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 AHW 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 wage 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 by accessing the "Three Year MGCRB Reclassification Data" file for the FFY for which the group is applying. Any inquiries concerning the CMS wage data should be directed to wageindex@cms.hhs.gov.

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

6.3 Requirements for a Group Application

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

Necessary documentation for a group application includes:

- County and state name
- Names, addresses, and provider numbers of all hospitals
  - Support that identifies all IPPS providers in the county
- Letters of representation for all hospitals
- Documentation from approved sources to demonstrate group meets relevant criteria
  - Map
    - *See* Board Rule 6.2(A) (adjacency requirement)
  - For rural counties
    - *See* Board Rule 6.2(C) (Census Bureau support to document that the county has been designated as an outlying county)
  - For urban counties
    - *See* Board Rule 6.2(D) (Census Bureau listing to document that the providers are in the same CSA)
  - Wage Data Comparison
    - *See* Board Rule 6.2(E) (demonstration of thresholds using data from the CMS hospital wage survey used to construct the wage index)

6.4 Limitations on Group Redesignation

The following limitations apply to redesignation:

(A) A group may not be redesignated to another area for purposes of the wage index if the pre-reclassified AHW for that area is lower than the pre-reclassified AHW for the area in which the group is located.

(B) If a group 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 group's request to a different geographic area than the area to which it is currently redesignated.

Rule 7 Filing an Application – Statewide

7.1 General Information for a Statewide Application

Section 304 of Public Law 106-554, the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Benefits and Improvement and Protection Act of 2000, provides for a process under which 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 areas wage index for redesignations.

Federal regulations at 42 C.F.R. § 412.235 contain criteria for hospitals in a state seeking a wage index redesignation. Additional information regarding statewide wage index redesignations can be found at 66 Fed. Reg. 39890-39891 (August 1, 2001).

7.2 Criteria for a Statewide Application

For all prospective payment system hospitals in a state to be redesignated to a statewide wage index, the following conditions must be met:

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

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

(C) All prospective payment system hospitals in the state must agree, through an affidavit, to withdraw or terminate an approved statewide wage index reclassification.

(D) All 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 (September 1), 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.

7.3 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 may dismiss a statewide application that does not include all prospective hospitals in the referenced state or that fails to include a proper affidavit from each hospital by the application due date.

Rule 8 Acknowledgement of an Application

8.1 OH CDMS Confirmation

Upon submission of an electronic application through OH CDMS, the system will send an immediate confirmation by e-mail. This correspondence will summarize the questions answered and documentation uploaded as part of the application submission; identify the date received by the Board; and, provide the case number associated to the newly filed case.

8.2 Board's Notice

The Board will send an acknowledgement notice addressing whether the application is either complete or incomplete. If the application contains all of the necessary elements for a complete application, the Board notifies the case representative (with a copy to CMS) that the application is complete and that the case may proceed to an MGCRB decision.

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 may result in the dismissal of the application.

8.3 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.

8.4 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 9 Board Hearings and Decisions

9.1 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).

9.2 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.

9.3 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.

9.4 Recusals

A Board 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.

9.5 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 from which the complete application is filed. 42 C.F.R. § 412.274(b)(2).

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* Rule 11.

Rule 10 Administrator's Review

10.1 Provider's Request for Review

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

The hospital or group must submit the request in writing to the CMS Administrator, in care of the Office of the Attorney Advisor ("OAA") 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. The hospital or group must also send a copy of its request to CMS' Hospital and Ambulatory Policy Group at wageindex@cms.hhs.gov.

10.2 Administrator Discretionary Review

The CMS Administrator may, at his or her own discretion, review any final decision of the MGCRB. The hospital will be notified if the Administrator decides to review a MGCRB decision and the hospital 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).

10.3 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 comments submitted under 42 C.F.R. § 412.278(b)-(c). The Administrator will issue a decision to the hospital 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 11 Withdrawals and Terminations

11.1 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 FFY 2002, FFY 2003, FFY 2008, FFY 2009 and FFY 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)).

11.2 Withdrawal of an Application Prior to Board Decision

Withdrawal of an application refers to the withdrawal of a 3-year MGCRB reclassification where the MGCRB has not yet issued a decision on the application. A request for withdrawal must be received by the MGCRB at any time before the MGCRB issues a decision on the application. 42 C.F.R. § 412.273(c)(1)(i).

11.3 Withdrawal of an Approved Geographic Redesignation

Withdrawal of an approved geographic redesignation refers to the withdrawal of a 3-year MGCRB reclassification that has been approved by the Board but has not yet gone into effect. The request for withdrawal must be received by the MGCRB within 45 days of publication of CMS' annual notice of proposed rulemaking concerning changes to the IPPS and proposed payment rates for the fiscal year for which the application has been filed. An approved withdrawal request is 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.

11.4 Termination of an Approved Geographic Redesignation

Termination of an approved geographic redesignation 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 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.

Requests 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 IPPS and proposed payment rates for the fiscal year for which the application has been filed.

11.5 Cancellations of Withdrawals and Terminations (Reinstatements)

A hospital (or group of hospitals) may cancel a withdrawal or termination in a subsequent year and request the MGCRB to 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.)

Reinstatement requests must be received 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).

11.6 Applications to a Different Area

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 that 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.

11.7 "Lugar" Hospitals

Per 42 U.S.C. § 1395ww(d)(8)), certain rural counties are considered urban for Medicare payment purposes if the counties meet certain criteria, including population density requirements and resident commuter patterns. Hospitals redesignated under this provision (commonly referred to as "Lugar" hospitals) are also eligible to apply for an MGCRB reclassification to a different area. Lugar hospitals with an MGCRB reclassification that wish to receive their Lugar wage index rather than their reclassified wage index must follow the termination/withdrawal procedures.

Appendix A: 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/Board-Rules.html:

(1) Statewide Application

(2) Statewide Affidavit

All other applications are available through the Office of Hearings Case and Document Management System. *See* https://www.cms.gov/Regulations-and-Guidance/Review-Boards/MGCRB/Electronic-Filing.html.

Appendix B: Terms and Concepts

Hospital Labor Market Areas

CMS has defined hospital labor market areas based on the Core Based Statistical Areas ("CBSAs") established by the Office of Management and Budget ("OMB"). OMB delineates metropolitan and micropolitan statistical areas according to published standards that are applied to Census Bureau data. The general concept of a metropolitan or micropolitan statistical area is that of a core area containing a substantial population nucleus, together with adjacent communities having a high degree of economic and social integration with that core.

OMB standards designate two categories of Core Based Statistical Areas ("CBSAs"), Metropolitan Statistical Areas ("MSAs") and Micropolitan Areas. MSAs are based on urbanized areas with a population of 50,000 or more and Micropolitan Areas are based on urban clusters with a population of at least 10,000 but less than 50,000.

Urban and Rural Areas

CMS uses MSAs, which contain Metropolitan Divisions, to define ***urban*** labor market areas. A Metropolitan Division is a county or group of counties within a CBSA that contains a core population of at least 2.5 million, representing an employment center, plus adjacent counties associated with the main county or counties through employment ties. CMS treats the Metropolitan Divisions of MSAs as labor market areas. Hospitals in Micropolitan Areas and outside of a CBSA are in the statewide ***rural*** labor market area.

The Board will treat hospitals in MSAs and Metropolitan Divisions as "urban hospitals" and all other hospitals as "rural hospitals" for application purposes. Hospitals located in rural counties redesignated as urban under Section 1886(d)(8)(B) of the Social Security Act ("Lugar" hospitals), although "deemed" urban to designated CBSAs themselves, are treated as "rural hospitals" for application purposes.

All applications must use the current urban identification codes and names located in the OMB bulletins at https://www.census.gov/programs-surveys/metro-micro/about/omb-bulletins.html.

Urban Hospitals Treated as Rural

Section 401 of Public Law 106-113 amended 42 U.S.C. § 1395ww(d)(8) by adding paragraph E, which created a mechanism, separate and apart from the MGCRB, permitting hospitals located in urban areas to apply to be treated as being located in the rural area of the state in which the hospital is located. *See also* 42 C.F.R. § 412.103. In the past, hospitals that were reclassified as rural under this provision were not permitted to receive an additional redesignation by the MGCRB in accordance with 42 C.F.R. § 412.230(a)(5)(ii). However, CMS has amended the regulation applicable to the MGCRB beginning with reclassifications effective for FFY 2018. The revisions permit that a hospital could acquire rural status under 42 C.F.R. § 412.103 and subsequently also apply for a reclassification under the MGCRB using distance and AHW criteria designated for rural hospitals. *See* 81 Fed. Reg. 23433 (interim final rule, Apr. 21, 2016).

Appendix C: References

Census Bureau Maps

http://census.gov/geo/maps-data/maps/statecbsa.html.

CMS Data

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html

Federal Register

https://www.federalregister.gov/

Office of Hearings Case and Document Management System

https://www.cms.gov/Regulations-and-Guidance/Review-Boards/MGCRB/Electronic-Filing.html.

Office of Management and Budget Data and Bulletins

https://www.census.gov/programs-surveys/metro-micro/about/omb-standards.html

https://www.census.gov/programs-surveys/metro-micro/about/omb-bulletins.html

https://www.census.gov/programs-surveys/metro-micro/about/delineation-files.html

Appendix D: Acronyms and Abbreviations

Acronym	Term
AHW	Average Hourly Wage
CBSA	Core Based Statistical Areas
CMS	Centers for Medicare & Medicaid Services
CSA	Combined Statistical Areas
IPPS	Inpatient Prospective Payment System
MGCRB	Medicare Geographic Classification Review Board
MSA	Metropolitan Statistical Areas
OAA	Office of the Attorney Advisor for the CMS Administrator
OH CDMS	Office of Hearings Case and Document Management System
OMB	Office of Management and Budget
RRC	Rural Referral Center
401	Section 401 of Public Law 106-113, which established a procedure whereby urban hospitals can be reclassified from urban to rural status
SCH	Sole Community Hospital

Table 1: Acronyms

Appendix E: Record of Changes

These Rules supersede the Board's previous Instructions. The Board may revise these Rules to reflect changes in the law, regulations, or the Board's policy and procedures.

Version Number	Date	Description of Change
1.0	07/20/2016	Issued for FFY 2018 application period to supersede prior annual instructions.
2.0	07/10/2017	Revised for FFY 2019 application period updates.
3.0	07/09/2018	Revised for FFY 2020 application period updates and implementation of OH CDMS.

Table 2: Record of Changes