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

GROUP APPLICATION

Reclassification Period: Federal Fiscal Years 2018 – 2020

Please read the MGCRB rules before completing this application.

This application must be completed and received by the MGCRB by **September 1, 2016**. Failure to comply will result in dismissal.

This application must also be sent to CMS via e-mail at wageindex@cms.hhs.gov. Delivery to CMS does not constitute delivery to the MGCRB.

General Information

Group Information

County: _____

State: _____

CBSA Code of Current Area: _____

CBSA Name of Current Area: _____

Representative Information

Identify the representative contact for all communications regarding the application:

Name: _____

Organization: _____

Address: _____

_____

City, State, Zip: _____

E-mail Address: _____

Telephone Number: _____

Listing of Providers

Under a tab labeled "Providers," the group representative must provide a listing of all participating acute care inpatient prospective payment system ("IPPS") hospitals in the county. The listing is to be submitted in the following format:

Column A	Column B	Column C	Column D	Column E
Provider Number	Provider Name	Provider Address	Did provider file an Individual Application? (Y/N)	Is provider an urban hospital currently classified as rural by CMS under 42 C.F.R. § 412.103? (Y/N or Status Pending)

Under a tab labeled "Representative" or "Rep," attach a letter of representation for each participating provider in accordance with Board Rule 2.4.

Note: The Board will rule on a statewide request first and then the group reclassification request before it reviews any individual reclassification request. If the Board approves the reclassification for the group, it will dismiss any individual reclassification application filed by providers participating in this group.

Reclassification Request

Requested Area

CBSA Code of Requested Area: _____

CBSA Name of Requested Area: _____

Wage Computations

Under a tab labeled "Primary," attach the group's aggregate hourly wage computations using the 3-year averages of wages and hours (i.e., 85 percent comparison). Per 42 C.F.R. §§ 412.232(c) and 412.234(b) the rounding of numbers is not permitted to meet the qualifying wage comparison percentage standards.

Note: If the group has a secondary reclassification request, attach a supplemental form indicating the CBSA code and name of the requested area and include the group's aggregate hourly wage computations **under a tab labeled "Secondary."**

Background Questionnaire

Note: All required documentation as noted by the questions below must be annotated with the applicable question number and included **under a tab labeled "Background."**

1. Are all the acute care inpatient prospective payment system ("IPPS") providers in the county listed as members of the group?

   ☐ Yes ☐ No

   Attach support that identifies all the IPPS providers in the county.

   If no, attach an explanation that identifies which provider(s) are excluded and the basis for the exclusion.

2. Is the county in which the providers are located adjacent to the area to which the group is requesting reclassification?

   ☐ Yes ☐ No

   Attach map support showing the location of the group's county and the location of the requested area.

3. If the county in which the providers are located is a rural area, does it meet the standards for redesignation to an urban area as an "outlying county" under 42 C.F.R. § 412.232(b)?

   ☐ Yes ☐ No ☐ N/A

   If yes, attach Census Bureau support showing that the county has been designated as an outlying county.

4. If the county in which the providers are located is an urban area, is it part of the CSA or CBSA that includes the urban area to which the group is requesting reclassification?

   ☐ Yes ☐ No ☐ N/A

   If yes, attach the Census Bureau CSA or CBSA listing.

5. Are the providers in the group also members of a statewide wage index area request?

   ☐ Yes ☐ No

6. Is the group requesting an oral hearing?

   ☐ Yes ☐ No

   If yes, attach a letter of rationale for the oral hearing request.

Certification Statements

☐ *I certify that the application is filed in full compliance with the statutes, regulations, and Board rules.

☐ *I understand that an omission, misstatement, or error made in the group application and supporting information may be grounds for denial of the group application.

☐ *I certify that I am authorized to file an application on behalf of the listed group.

Signature: _____

Representative Name: _____

Organization: _____

Date: _____