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Miscellaneous Guidelines Regarding the Section 5506 Application Process

This document clarifies and explains portions of the CMS Application Form for an increase in FTE caps under Section 5506 of the Affordable Care Act. We are providing these procedural guidelines in an effort to improve the quality, completeness, and consistency of future section 5506 applications, and to facilitate faster, more efficient, equitable processing of those applications. The following is a list of items and issues that hospitals should use as a guide when preparing applications under section 5506. This document is not the comprehensive source for procedures related to Section 5506 applications. More information on the ACA Section 5506 application process can be found in the following Federal Registers: November 24, 2010 final rule (75 FR 722212-72238), the August 31, 2012 final rule (77 FR 53434-53448), and the August 22, 2014 final rule (79 FR 50122-50140).

a. General and Cover Letter

- 1) In the cover letter, the hospital should prominently print the name, telephone number and/or e-mail address of a contact person at the hospital that can answer questions about the application. The contact should be someone who is knowledgeable about the hospital's section 5506 application, cost report, and GME programs, so that any additional information can be retrieved as quickly as possible.

- 2) The hospital should redact any Social Security numbers associated with resident information that is included in the application (and email correspondence, if the hospital is subsequently contacted by CMS for additional information).
- 3) The hospital should mail a hard copy of the entire application to the CMS Central Office in Baltimore. Applications must be received, not postmarked, by the applicable application deadline. The application deadline is 90 days following CMS' public notice of the hospital's closure and the availability of cap slots, and that due date is specified in the notice provided to the public. After mailing the hard copy, the hospital is strongly encouraged to send an email to: ACA5506application@cms.hhs.gov. In the email, the hospital should state: "On behalf of [insert hospital name and Medicare CCN#], I, [insert your name], am sending this email to notify CMS that I have mailed to CMS a hard copy of a section 5506 application under Round [insert Round #] due to the closure of [insert closed hospital's name]. If you have any questions, please contact me at [insert phone number] or [insert your email address]." An applying hospital should not attach an electronic copy of the application to the email. The email will only serve to notify the CMS Central Office to expect a hard copy application, which should be mailed to the CMS Central Office.
- 4) For each program application, the CMS Application Form asks the applicant hospital to check off the appropriate Demonstrated Likelihood Criterion (DLC), Level Priority Category (LPC) and Ranking Criterion (RC). The hospital must include documentation supporting its reasoning for checking off the particular

DLC and RC. Guidance on the type(s) of supporting documentation that may be submitted is included under section c. below.

b. Demonstrated Likelihood Criteria

- 5) A hospital should not check off more than one DLC on each CMS Application Form that is submitted. A hospital may submit applications for more than one program (or as described under #6, a hospital may apply for the same program under two different DLCs on two separate applications), but on each CMS Application Form, only one DLC may be checked off. The hospital should choose the DLC that best fits the reason that it is applying for slots: DLC1 for starting a new program; DLC2 for expanding an existing program or taking over all or part of a program from the closed hospital; and DLC3 for slots received from the closed hospital under a Medicare GME affiliated group agreement or an Emergency Medicare GME Affiliated Group Agreement.
- 6) It is possible to apply for the *same* residency program under two different DLCs, in which case, the applicant hospital should submit two separate applications for the same program for each different DLC. For example, the applicant hospital and the hospital that closed both trained residents in the same general surgery program, and the applicant hospital *received 10* FTE slots from the hospital that closed under the terms of a Medicare GME Affiliation Agreement. The general surgery program is accredited for 20 positions, 15 of the positions are filled. In addition to continuing to train at least 10 FTE residents in the general surgery program that it had trained under the terms of the Medicare GME Affiliation Agreement with the closed hospital, the applicant hospital also wants to expand

up to the accredited 20 positions. The hospital should apply under DLC3 for the 10 slots it received under the terms of the Medicare GME Affiliation Agreement with the closed hospital, and the hospital should also separately apply under DLC2 to expand the general surgery program by 5 slots. The hospital should submit two separate CMS Application Forms -- one for each DLC, respectively.

- 7) The hospital should check off DLC2 for a program expansion, or for taking over an entire program or part of a program from the closed hospital. The program expansion can be one that is not associated with a program that came from the closed hospital (and would fall under RCs 4-8), or it may be a program expansion related to a program that was originally at the closed hospital (and would fall under RC1 or RC3). If the hospital is applying under DLC2 because of an expansion of an existing program not associated with a program that came from the closed hospital (i.e., not RC1 or RC3), the hospital should only request slots under DLC2 for positions *that are not yet filled* for the upcoming academic year, beginning July 1. If the positions have already been filled, that is not a program expansion. However, if the hospital is applying under RC1 because it permanently took over an entire program from the closed hospital, or RC3 because it permanently took over part of a closed hospital's program, then the appropriate DLC is DLC2, and the hospital can apply for slots that are already filled.
- 8) Under DLC2, if the hospital currently has unfilled positions in a residency program that has previously been approved by the ACGME, AOA, or the ABMS, and the hospital is now seeking to fill those positions, the hospital must attach

documentation clearly showing both its current number of approved positions and its current number of filled positions.

c. Clarification Regarding Documentation Supporting Ranking Criteria 1, 2, and 3

- 9) If the hospital is applying under RC1 because it permanently took over an entire program(s) from the closed hospital, it must include proof of the permanent takeover. The hospital has flexibility in how it proves the permanent takeover. For example, the applicant hospital may submit the letter from the accrediting body granting approval to permanently take over the closed hospital's program(s), if that approval letter from accrediting body is available at the time the hospital submits its application. If not available, the applicant hospital may submit its request to the accrediting body requesting approval to permanently take over the closed hospital's program(s), or any intermediate correspondence with the accrediting agency. The hospital can also include information regarding the positions it offered in the National Resident Matching Program following the date that the applicant hospital took over the entire program(s), which indicates that it is recruiting additional PGY1 residents to take the place of the displaced residents that graduated.

- 10) If the applicant hospital received a temporary cap increase under § 413.79(h) for the displaced FTE residents, it can submit a copy of the request it submitted to the Medicare contractor to receive a temporary cap increase under § 413.79(h) for the displaced FTE residents. This would help CMS identify the potential scope of the applicant hospital's permanent expansion. If no temporary cap adjustment

was received (either because there were insufficient FTE cap slots from the closed hospital, or the applicant hospital had room under its FTE resident cap at the time it took in the displaced residents), the applicant hospital can provide letters or some type of correspondence between the closed hospital (or program director and/or sponsoring institution) and the applicant hospital indicating that the latter agreed to take in the displaced FTEs. The applicant hospital can also provide a list of the names of the displaced residents (without social security numbers) and the programs in which they are training. Alternatively, the applicant hospital can provide approval letters from the accrediting body approving the move of the displaced residents to the applicant hospital.

- 11) Under RC3, merely taking in displaced residents and/or receiving a temporary FTE resident cap increase under § 413.79(h) does not demonstrate a permanent commitment to maintain the portion of the closed hospital's program. Rather, the hospital would have to recruit additional PGY1 residents once the displaced residents have completed their training. Again, the hospital has flexibility in how it demonstrates permanent commitment to maintain the number of FTE residents in the portion of the program that came from the closed hospital. For example, the applicant hospital can show approvals received from the accrediting agency to *permanently* expand its program (or programs) due to taking in residents from the closed hospital's program(s), or include information regarding positions it offered in the National Resident Matching Program following the graduation of the displaced FTE resident(s), as that would demonstrate permanent commitment to expand a program. Under RC1 and RC3, the applicant hospital should be sure not

to request more slots than it can demonstrate that it is permanently maintaining from the closed hospital's program(s).

- 12) Under RC2, the number of slots that an applicant hospital may receive under RC2 is limited to the number of slots the applicant hospital received from the closed hospital under the Medicare GME affiliated group agreement *and* whether or not those slots will continue to be used for the same program(s) at the applicant hospital. For example, Hospital A and Hospital B had a Medicare GME affiliated group agreement, which clearly stated that Hospital A is reducing its FTE cap by 5, and Hospital B is therefore, increasing its FTE cap by 5, so that Hospital B may train 5 FTEs in a surgery program. Hospital A subsequently closed, and Hospital B wants to be able to continue to train the 5 FTEs in the surgery program. Accordingly, on the CMS Application Form, Hospital B would request 5 slots under RC2. However, as explained in the November 24, 2010 Federal Register (75 FR 72220 and 72221), if the Medicare GME affiliated group agreement does not indicate that the amount by which the closed hospital reduced its FTE resident caps is the exact same amount by which the applicant hospital's FTE resident caps were increased, the applicant must justify why it is checking off RC2 by submitting a plausible explanation and additional documentation showing that the applicant hospital actually received a specific number of slots from the closed hospital and that the applicant hospital needs the same number of slots to continue to train at least the number of FTE residents the applicant hospital had trained under the terms of the Medicare GME affiliated group agreement.

d. Clarification Regarding Ranking Criteria 5-8

13) RC7 is to be used when the hospital is applying to establish or expand a program in primary care or general surgery, but it does not meet the requirements of RC5 or RC6 because it is also separately applying to establish or expand a nonprimary care or nongeneral surgery program (RC5 and RC6 require that all of the hospital's applications be for slot requests to establish or to expand a primary care and/or general surgery program). RC8 is to be used when the hospital is applying to establish or to expand a nonprimary care program or a nongeneral surgery program.

e. FTE Counting Rules for Slots Requested

14) If the applicant hospital has a program that rotates residents to one or more other participating hospitals, it should be sure to only request the portion of the FTEs that are or will be training at the applicant hospital. The applicant hospital may work with other participating hospitals to ensure that they submit separate applications to request their equivalent portion of the FTEs, such that altogether, the program *as a whole* is accounted for, in the hope that a sufficient number of slots may be awarded to each participating hospital to cover the entire program. The applicant hospital should indicate in its supporting documentation for each application that it has requested the appropriate FTE amount to account for rotations occurring at its hospital only. (The applicant hospital may reference other participating hospitals' applications so that CMS knows to review them in conjunction with the applicant hospital's applications).

- 15) When requesting slots for psychiatry-related or rehabilitation-related programs, applicant hospitals should note that the IPPS IME FTE cap and FTE count do not apply to rotations occurring in distinct part psychiatric or rehabilitation units. Hospitals should reduce the amount of IME slots requested for psychiatry-related or rehabilitation-related programs accordingly.