April 2012

Miscellaneous Guidelines Regarding the Section 5506 Application Process

When we reviewed the applications under the first round of section 5506, we realized that there were a number of areas in the application process and in the CMS Evaluation Form that could benefit from clarification and reiteration. 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, in addition to the policy established in the November 24, 2010 final rule (75 FR 722212), when preparing applications under section 5506:

a. General and Cover Letter

1) In the cover letter, the hospital should make sure to prominently put the name and telephone number and/or e-mail address of a contact person at the hospital that we can call or email should we have any questions. The contact person should be the person who is knowledgeable about the hospital's section 5506 application, cost report, and GME programs, so that if we need more information, it can be retrieved as quickly as possible.

2) Be sure to redact any social security numbers associated with resident information that you include in your applications (and email correspondence, if CMS subsequently contacts you for additional information).

3) Please send a copy of your entire application only to the CMS Central Office in Baltimore (do not send a copy to the CMS Regional Office). Applications must be received, not postmarked, by the applicable application deadline.

4) For each program application, the CMS Evaluation Form asks the applicant to check off the appropriate Demonstrated Likelihood Criterion (DLC), Ranking Criterion (RC), and Level Priority Category (LPC). The applicant hospital must include documentation supporting why it checked off the particular DLC, RC, and LPC. Guidance on the type(s) of supporting documentation that may be submitted is included under section c. below.

b. Demonstrated Likelihood Criteria

5) Do not check off more than one DLC on each CMS Evaluation Form you submit. 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 Evaluation Form, only one DLC may be checked off. Choose the one that best fits the reason why the hospital is applying for slots (Generally, 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; DLC3 for cap relief to cover already filled positions; and DLC4 for slots received from the closed hospital under a Medicare GME affiliation 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 applications for the same program for each different DLC. For example, a program may be accredited for 20 positions, 15 of the positions are filled, and the hospital wants to expand up to the accredited 20 positions. The hospital may also be over its FTE caps by at least 15 FTEs. The hospital may apply under DLC2 to expand the program by 5 slots, and separately under DLC3 for cap relief for the 15 slots. As stated under item #5, in this

case, the hospital should submit two separate CMS Evaluation Forms, one for each DLC, respectively.

7) DLC2 is 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 4-7), 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, July 1. If the positions have already been filled, that is <u>not</u> a program expansion. However, if the hospital is applying under RC1 because it 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 its current number of approved positions, and its current number of filled positions.

9) DLC3 is intended for general cap relief; that is, to cover already filled positions that are in excess of the applicant hospital's FTE resident caps. It is only to be used when requesting slots for *already filled positions not* associated with slots from the closed

hospital—*hence, cap relief.* If the hospital is simply applying for cap relief, which is DLC3, for various programs, then it does not need to specify a program at the top of the first page of the application form. The applicant hospital may write "Various Programs—Cap Relief." The Ranking Criterion to be used for DLC3 is RC7 (or as proposed in the FY 2013 IPPS proposed rule, RC8).

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

10) If the hospital is applying under RC1 because it permanently took over an entire program(s) from the closed hospital, the applicant hospital must include proof of the permanent takeover. The hospital has flexibility in how it proves permanent takeover. For example, the applying 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 applying hospital submits its application, or if not available, the applying 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. It could 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), to indicate that it is recruiting additional PGY1 residents to take the place of the displaced residents that graduated.

11) Under RC3, merely taking in displaced residents and/or receiving a temporary FTE resident cap increase under § 413.79(h) does not demonstrate 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 could 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. If the applying hospital did receive a temporary cap increase under § 413.79(h) for the displaced FTE residents, the hospital could 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 applying 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 could 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 could provide a list of the names of the displaced residents (without social security numbers) and the programs in which they are training. The applicant hospital could also provide approval letters from the accrediting body approving the move of the displaced residents to the applicant hospital.

12) Under RC1and 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). As we explain in the November 24, 2010 Federal Register (75 FR 72219), assumption of a program or part of a program from a closed hospital must be "seamless;" there cannot have been a point at which the assumption of the program was interrupted. Therefore, in order to qualify under RC3, the applying hospital must have permanently expanded its program, or be in the process of permanently expanding its program, *immediately* following the completion of the displaced residents' training (see 75 FR 72221-2). For example, if a hospital took in three displaced residents in pediatrics, and it then immediately recruits another three residents for its pediatrics program to replace the three displaced residents right after the displaced residents graduate, then, all other things being equal, the hospital can apply for three FTE slots under RC3. However, if the hospital decides to only permanently expand its pediatrics program by two residents, and recruits only two residents to take the place of the three displaced pediatrics residents, the hospital can only apply for two FTEs under RC3.

13) Under RC2, in general, 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 affiliation 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 affiliation 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 its section 5506 application, 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 affiliation agreement does not obviously 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 affiliation agreement.

d. FTE Counting Rules for Slots Requested

14) If the applicant hospital has a program that rotates residents to one or more other participating hospitals, be sure to only request the equivalent of the residents that are or will be training at the applicant hospital. The applicant hospital may work with those 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, keep in mind that the Inpatient PPS IME FTE cap and FTE count do not apply to rotations occurring in distinct part psychiatric or rehabilitation units. Therefore, reduce the amount of IME slots requested for psychiatry-related or rehabilitation-related programs accordingly.