Updated April 2023

Miscellaneous Guidelines Regarding the Section 5506 Application Process

This document provides further guidance on portions of the CMS application process for an increase in full-time equivalent (FTE) caps under Section 5506 of the Affordable Care Act. The Section 5506 application is currently completed through the Medicare Electronic Application Request Information System™, MEARIS™ MEARIS™ (cms.gov).

This document is not the comprehensive source for procedures related to Section 5506 applications. More information on the Section 5506 application process can be found in the following Federal Registers: the November 24, 2010 final rule (75 FR 72212-72238), the August 31, 2012 final rule (77 FR 53434-53448), and the August 22, 2014 final rule (79 FR 50122-50140).

For specifics regarding the Section 5506 MEARIS™ application, refer to the link "Section 5506 Application Submission Process and Questions" in the Section 5506 portion of the Direct Graduate Medical Education (DGME) webpage: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME

Please note the hospital should redact any Social Security numbers associated with resident information that is submitted as part of the Section 5506 application as well as from any correspondence, if the hospital is subsequently contacted by CMS for additional information.

Demonstrated Likelihood Criterion (DLC)

- A 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 affiliation agreement or an Emergency Medicare GME affiliation agreement.

- A hospital may not select more than one DLC on each application that is submitted. The hospital may submit applications for more than one program (or as described below a hospital may apply for the same program under two different DLCs on two separate applications), but on each application, only one DLC may be selected.

- It is possible to apply for the *same* residency program under two different DLCs. In this case, the applicant hospital should submit two separate applications for the same program for each DLC. For example, the applicant hospital and the closed hospital both trained residents in the same general surgery program, and the applicant hospital *received 10* FTE slots from the closed hospital 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 number of 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 should separately apply under DLC2 to expand the general surgery program by 5 slots. That is, the hospital should submit two separate applications, one for each DLC, respectively.

- 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.

- 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.

Documentation Supporting Ranking Criteria (RC) 1, 2, and 3

- 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.

- 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, with Social Security numbers redacted. Including the request for the temporary cap adjustment helps 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 applicant hospital 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. Under RC1, 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).

- 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 applicant hospital would have to recruit additional PGY1 residents once the displaced residents have completed their training. Again, the applicant hospital has flexibility in how it demonstrates a 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 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).

- Under RC2, the number of slots that an applicant hospital may receive is limited to the number of slots the applicant hospital received from the closed hospital under the Medicare GME affiliation agreement. For example, Hospital A and Hospital B had a Medicare GME affiliation agreement, under which Hospital A reduced its FTE cap by 5, and Hospital B increased its FTE cap by 5 so that Hospital B could 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 application, Hospital B would request 5 FTE slots under RC2.

  If the Medicare GME affiliation 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 hospital must justify why it is checking off RC2. The applicant hospital must submit a plausible explanation

and additional documentation showing that it actually received a specific number of slots from the closed hospital and 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.

Clarification Regarding Ranking Criteria (RC) 5-8

- 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. 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. RC8 is to be used when the hospital is applying to establish or to expand a nonprimary care program or a nongeneral surgery program.

FTE Counting Rules for Slots Requested

- If the applicant hospital has a program that rotates residents to one or more participating hospitals, it should be sure to only request the portion of the FTEs that are training 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).

- 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.