Overview of Residency Programs Selected for CAA Sec. 126 Round Three Graduate Medical Education Slots

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Introduction

Physician shortages in rural and underserved areas remain a critical challenge in the US health care system. Evidence shows that physicians trained in rural settings are more likely to practice in rural areas,[1] making rural residency training a promising approach to address these shortages. Despite the documented benefit of rural settings, less than 2% of Medicare-funded residency training occur in rural areas.[2] In response to rural shortfalls and other graduate medical education needs, the Consolidation Appropriation Act, 2021 included Section 126, which allocates 1000 new residency slots, over five years (200 slots each per year starting in fiscal year 2023 for Direct Graduate Medical Education (DGME) and Indirect Graduate Medical Education (IME)).[3] Allowing rural hospitals an opportunity to secure additional Medicare payment slots can help fund and sustain older rural programs that did not reach their full training capacity when their cap was set in the fifth year after launching their program.

To apply for these slots hospitals must meet at least one of the four eligibility criteria:[3]

1) be located in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act) or be reclassified as rural for payment purposes under section 1886(d)(8)(E) of the Social Security Act;
2) be training over their DGME and/or IME Medicare payment cap;
3) be located in one of the 39 states and territories with a new medical school;
4) be training residents at training sites located in geographic Health Professional Shortage Areas (HPSAs).

After identifying all the eligible hospitals and their proposed training sites, the Centers for Medicare & Medicaid Services (CMS) distributes the 200 available slots for DGME and IME based on the HPSA scores of the training sites using both geographic and population HPSA scores.

CMS released data on the 109 hospitals that received residency slots via the third round of Section 126 distributions on November 21, 2024.[3] This analysis builds on our previous examination of first and second round awardees[4,5] and uses newly released CMS data to identify the rural status of the training sites of the selected residency programs.

Methods

The CMS data included residency program Accreditation Council for Graduate Medical Education (ACGME) unique identification codes. We merged the residency programs ACGME ID codes with the publicly available 2024 ACGME Accreditation Data System (ADS) and American Medical Association FREIDA databases to identify the training sites for each residency program with linkable accreditation IDs. After linking data sources, we analyzed a total of 101 programs (8 programs were too new to have linkable ACGME ID codes). For each program we compared the number of required training months at

rurally located sites using current ADS data to determine the total number of months residents train at each location.

We were primarily interested in the rurality of the hospitals receiving additional slots. It is important to note that a hospital's *geographic* rurality may differ from its *programmatic* rurality; there are multiple options by which a hospital may be considered rural even if it's not physically located in a rural area. Furthermore, there are multiple ways to define rural. We merged geocoded training site data for each residency program with the Federal Office of Rural Health Policy (FORHP) Rural Counties and Census Tracts list (2021) and the Inpatient Prospective Payment System (IPPS) 2025 County to CBSA Crosswalk File. Following the data merge, we identified whether a training site was 1) in a CMS geographically rural area as defined in section 1886(d)(2)(D) of the Social Security Act, also referred to as non-metro areas, 2) in a FORHP-designated geographically rural area, or 3) considered rural by CMS due to reclassification. We summarized training site data at the program level to determine what percentage of time residents spent in geographically rural areas completing required rotations.

Hospital and Program Level Analysis

Most hospitals receiving residency slots in round 3 of CAA Sec. 126 slot distribution are categorized as Rural Referral Centers (RRCs) by Medicare. As shown in Table 1, PPS hospitals with no special payment classification represented the next most common hospital category with 36 receiving slots. Four of the hospitals receiving residency slots are geographically located in non-metro areas. Additionally, two hospitals were located in FORHP rural areas that were not located in non-metro areas. Of these 109 hospitals, 72 have special rural payment classification under Medicare, 68 of them through rural reclassification under section 1886(d)(8)(E) of the Social Security Act. Table 2 presents median DGME and IME slots per program and Table 3 summarizes the program characteristics. The majority of programs receiving slots were associated with psychiatry, family medicine, and internal medicine specialties.

Table 1. Hospital Characteristics

Hospital Category	Number of Hospitals	Number classified as rural under Medicare (reclassified)	Number located in FORHP rural area	Number located in non-metro area
Rural Referral Center (RRC)	60	58 (57)	1	1
Prospective Payment System (PPS)	36	3 (3)	1	0
Sole Community Hospital/Rural Referral Center (SCH/RRC)	7	7 (5)	2	2
Sole Community Hospital (SCH)	4	4 (3)	2	1
Children's Hospital (CH)	2	0 (0)	0	0
Total	109	72 (68)	6	4

Reclassification status for the two children's hospitals was not included in the 2025 FY Impact File. Location data obtained from Sheps Center list of U.S. Hospitals (2023) https://www.shepscenter.unc.edu/programs-projects/rural-health/list-of-hospitals-in-the-u-s/

Table 2. Median Slots Per Program

Type of Slot Received	Median (IQR)
DGME Slots	2.00 (0.38-2.94)
IME Slots	1.94 (0.44-2.96)

Table 3. Program Characteristics

Residency Specialty	Number of Programs	Total DGME Slots	Total IME Slots
Psychiatry	22	49.44	31.26
Family Medicine	21	37.88	36.09
Internal Medicine	16	26.39	31.06
Surgery	9	20.47	18.69
Neurology	7	11.38	16.42
OBGYN	5	13.79	16.01
Pediatrics	5	3.96	9.21
Emergency Medicine	3	5.48	7.94
Internal Medicine-Pediatrics	3	8.22	9.53
Anesthesiology	2	3.39	3.39
Hematology and Medical Oncology	2	5.08	3.00
Physical Medicine and Rehabilitation	2	1.75	3.5
Addiction Medicine (Multidisciplinary)	1	1.00	1.00
Child Neurology	1	2.92	0.00
Complex General Surgical Oncology	1	2.00	2.00
Endocrinology, Diabetes, and Metabolism	1	0.96	0.00
Forensic Psychiatry	1	0.64	0.64
Gastroenterology	1	0.00	2.67
Infectious Disease	1	0.00	0.19
Neuroendovascular Intervention (Neurology)	1	1.00	0.00
Ophthalmology	1	3.33	3.33
Pediatric Neurology	1	0.92	0.00
Pulmonary Critical Care	1	0.00	3.00
Vascular Surgery	1	0.00	1.07
Total	109	200.00	200.00
More than 50% training in non-metro areas*	Yes - 7	6.80	15.20
	No - 94	193.20	184.80

**Calculated from ACGME Program Data found in WebADS (searched 12/06/2024) and the total percentage training in non-metro training sites are calculated from the total number of months required by specialty.*

Training Site Level of Analysis

There were 101 out of 109 residency programs with accreditation IDs provided by CMS that matched to ACGME training site data, representing a total of 406 training sites. Among these, 31 sites were located in non-metro areas, while 43 sites were situated in FORHP rural areas. As shown in Table 4, a total of 14 residency programs had at least some training in non-metro sites whereas 21 programs had at least some training in FORHP-designated rural areas. Seven residency programs trained their residents for 50% or greater in non-metro areas and nine residency programs trained their residents for 50% or greater in FORHP designated rural areas. Among the seven rural training programs with 50% or greater time in non-metro areas, there were one PPS hospital, three SCH/RRCs, one SCH, and two RRCs. Among these seven hospitals, four hospitals were located in non-metro areas, with two hosting internal medicine programs and two hosting family medicine programs.

Table 4. Section 126 Round 3 Awardees Training Residents in Non-Metro Areas

Hospital Name	Hospital Payment	State	Specialty	Percent of Training in non-metro sites*	DGME Slots Awarded	IME Slots Awarded
Baptist Memorial Hospital-Golden Triangle	RRC	MS	Internal Medicine	100	2.75	2.75
Marshfield Medical Center	SCH	WI	Internal Medicine	100	0.00	3.00
Blessing Hospital	SCH/RRC	IL	Family Medicine	98.61	0.00	3.00
Portneuf Medical Center	SCH/RRC	ID	Family Medicine	66.67	0.00	3.00
Pitt County Memorial Hospital	PPS	NC	Family Medicine	61.11	2.83	2.83
Upper Allegheny Health System	SCH/RRC	NY	Family Medicine	58.33	0.62	0.62
St. Mary's Medical Center	RRC	WV	Surgery	53.33	0.60	0
Duke University Hospital	RRC	NC	Psychiatry	6.25	0.85	0.85
Forrest General Hospital	RRC	MS	Family Medicine	5.56	1.96	2.92
Ascension St. Mary's of Michigan	RRC	MI	Psychiatry	4.17	0.38	0.38
Iowa Methodist Medical Center	RRC	IA	Emergency Medicine	2.78	2.75	2.75
Hennepin County Medical Center	PPS	MN	Emergency Medicine	2.78	2.73	2.73
Saint Francis Medical Center	RRC	IL	Surgery	1.67	3.19	4.75
Piedmont Athens Regional	PPS	GA	Internal Medicine	1.39	2.96	2.96

**Calculated from ACGME Program Data found in WebADS (searched 12/06/2024) and the total percentage training in non-metro training sites are calculated from the total number of months required by specialty. Programs that train more than 50% training in non-metro areas are shaded in gray color.*

Compared to our analysis of the round 2 awardees, the round 3 awards showed an increase in the number of rural hospitals receiving payment slots, rising from 2 to 4 (non-metro only) or 2 to 6 (non-metro and FORHP-rural), and an increase in the number of rural programs with more than 50% training in non-metro areas, rising from 3 to 7. Although this represents a substantial increase from the prior year, the first three rounds of distribution have not fully achieved a large expansion of GME in geographical rural areas. Less than 5% of the first three rounds of Section 126 payment slot distribution have reached geographically rural hospitals.[4-5] In this analysis of round 3 awards, of the 72 hospitals that are considered rural by CMS, 68 are not *geographically* rural; they are only considered rural for payment purposes. Only two of those 105 metropolitan hospitals are in FORHP-designated rural areas.

The RRPD Technical Assistance Center hosted a webinar in January 2024 in collaboration with CMS and HRSA to educate rural hospitals and others interested in rural GME in the application process. Another educational session was hosted in January 2025. For more information on launching and sustaining rural residencies, please visit www.ruralgme.org.

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