



Overview of Residency Programs Selected for CAA Sec. 126 Round Four 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 training, 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 1,000 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; and
- 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 95 hospitals that received residency slots via the fourth round of Section 126 distributions on December 18, 2025.³ This analysis builds on our previous examination of first, second, and third 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 2025 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, the analytic sample for residency program and their training sites included 88 unique programs (95 observations); four programs were duplicated, and three 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 *administrative* 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 most recent Federal Office of Rural Health Policy (FORHP) Rural Counties and Census Tracts list and the Inpatient Prospective Payment System (IPPS) 2026 County to Core Based Statistical Area (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 administratively 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

As shown in Table 1, the most common hospital category receiving residency slots in round 4 of CAA Sec. 126 slot distribution are categorized as Rural Referral Centers (RRCs) by Medicare. PPS hospitals with no special payment classification represented the next most common hospital category with 38 receiving slots. Three of the hospitals receiving residency slots are geographically located in non-metro areas. Of the 95 hospitals, 63 have special rural payment classification under Medicare, 60 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)	49	45 (44)	1	1
Prospective Payment System (PPS)	38	14 (13)	1	1
Children’s Hospital (CH)	4	0 (0)	0	0
Sole Community Hospital/Rural Referral Center (SCH/RRC)	3	3 (3)	0	0
Medicare Dependent Hospital (MDH)	1	1 (0)	1	1
Total	95	63 (60)	3	3

Reclassification status for the four children’s hospitals was not included in the 2026 FY Impact File. Location data obtained from Sheps Center list of U.S. Hospitals (2024) <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	2.50 (0.42-3.08)
IME Slots	2.58 (0.42-3.00)

Table 3. Program Characteristics

Residency Specialty	Number of Programs	Total DGME Slots	Total IME Slots
Psychiatry	18	49.54	37.37
Family Medicine	15	28.32	31.37
Internal Medicine	14	18.07	28.52
Surgery	8	13.22	16.02
Pediatrics	6	11.68	5.77
Neurology	5	10.28	13.14
Anesthesiology	4	8.87	6.37
Emergency Medicine	3	8.34	8.34
Interventional Radiology - Integrated	3	13.84	13.84
OBGYN	3	7.03	10.58
Child and Adolescent Psychiatry	2	2	3.54
Pulmonary Disease and Critical Care	2	0.34	3.75
Child Abuse Pediatrics	1	0.11	0
Dermatology	1	2.33	2.33
Endocrinology, diabetes, and metabolism	1	0	0.63
Hematology and Medical Oncology	1	3	3
Maternal-fetal medicine	1	0	1.26
Neurological Surgery	1	4.17	4.17
Orthopedic Surgery	1	4	0
Otolaryngology	1	4	4
Plastic Surgery - Integrated	1	4.74	5
Psychiatry-Family Medicine	1	5	0
Transitional Year	1	1	1
Urology	1	0.11	0
Total	95	200.00	200.00
More than 50% training in non-metro areas*	Yes- 3	11.61	9.52
	No-89	181.61	184.15

*Calculated from ACGME Program Data found in WebADS (searched 01/26/2026) and the total percentage training in non-metro training sites are calculated from the total number of months required by specialty. Since three programs do not have ACGMEID, the total for programs, DGME slots and IME slots do not sum to overall total.

Training Site Level of Analysis

There were 88 out of 95 residency programs with unique accreditation IDs provided by CMS that matched to ACGME training site data, representing a total of 329 unique training sites. Among these, 14 sites were located in non-metro areas, while 22 sites were situated in FORHP rural areas. As shown in Table 4, a total of 6 residency programs had at least some training in non-metro sites whereas 11 programs had at least some training in FORHP-designated rural areas. Three residency programs trained their residents for 50% or greater in non-metro areas. Among the three rural training programs with 50% or greater time in non-metro areas, there were two PPS hospitals and one RRC. Among these three hospitals, two hospitals were located in non-metro areas, with two hosting family medicine programs and one hosting internal medicine programs.

Table 4. Section 126 Round 4 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	100.00	3.00	3.00
Rochester General Hospital	PPS	NY	Family Medicine	94.44	0.06	0.00
United Memorial Medical Center	PPS	NY	Family Medicine	94.44	0.94	0.94
Larkin Community Hospital Palm Springs Campus	PPS	FL	Family Medicine	5.56	2.83	2.83
Forrest General Hospital	RRC	MS	Family Medicine	3.89	2.03	0.00
Iowa Methodist Medical Center	RRC	IA	Emergency Medicine	2.78	2.75	2.75

*Calculated from ACGME Program Data found in WebADS (searched 01/26/2026)) 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 3 awardees, the round 4 awards showed a decrease in the number of rural hospitals receiving payment slots, reducing from 4 to 3 (non-metro only) or 6 to 3 (non-metro and FORHP-rural). Further, the number of rural programs with more than 50% training in non-metro areas reduced from 7 to 3, while those with more than 50% training in FORHP rural areas declined from 9 to 4. Taking four rounds together, Section 126 distributions have not significantly expanded GME in geographical rural areas. Less than 5% of the first four rounds of Section 126 payment slot distribution have reached geographically rural hospitals.⁴⁻⁵ In this analyses of round 4 awards, of the 63 hospitals that are considered rural by CMS, 60 are not *geographically* rural; they are only considered rural for payment purposes.

The RRPD Technical Assistance Center hosted a [webinar in January 2026](#) in collaboration with CMS and HRSA to educate rural hospitals and others interested in rural GME in the application process. For more information on launching and sustaining rural residencies, please visit www.ruralgme.org.

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