Accreditation Council for Graduate Medical Education

Statement for the Record

before the

House Judiciary Committee

Subcommittee on Administrative State, Regulatory Reform, and Antitrust hearing

"The MATCH Monopoly: Evaluating the Medical Match Residency Antitrust Exemption"

May 14, 2025

The Accreditation Council for Graduate Medical Education (ACGME) appreciates the opportunity to submit a statement for the record regarding the May 14, 2025 hearing before the House Judiciary Subcommittee on Administrative State, Regulatory Reform, and Antitrust, entitled "The MATCH Monopoly: Evaluating the Medical Match Residency Antitrust Exemption".

Our comments are organized as follows:

1. BACKGROUND AND OVERVIEW
2. PHYSICIAN WORKFORCE
3. ACGME PROCESS
4. ADDITIONAL POINTS TO ADDRESS
5. CONCLUSION

PLEASE NOTE that the ACGME is not seeking to respond to every factual error or mischaracterization that arose in the written or oral testimony, or in submitted materials.

BACKGROUND AND OVERVIEW

The ACGME is an independent, 501(c)(3) not-for-profit organization established in 1981. The ACGME develops and applies professional educational standards (requirements) as a basis for accreditation – to help ensure that physicians educated and trained in the United States are prepared to deliver safe, high-quality medical care to all Americans.

Graduate medical education (GME) refers to post-MD/DO education in a specialty ("residency training") or subspecialty ("fellowship training") of medicine. The ACGME accredits more than 13,393 residency and fellowship programs across 146 specialties and subspecialties in the US – with 162,644 residents and fellows currently in training. The ACGME also accredits more than 900 Sponsoring Institutions, including Federally Qualified Health Centers, community clinics, community hospitals, and academic medical centers.

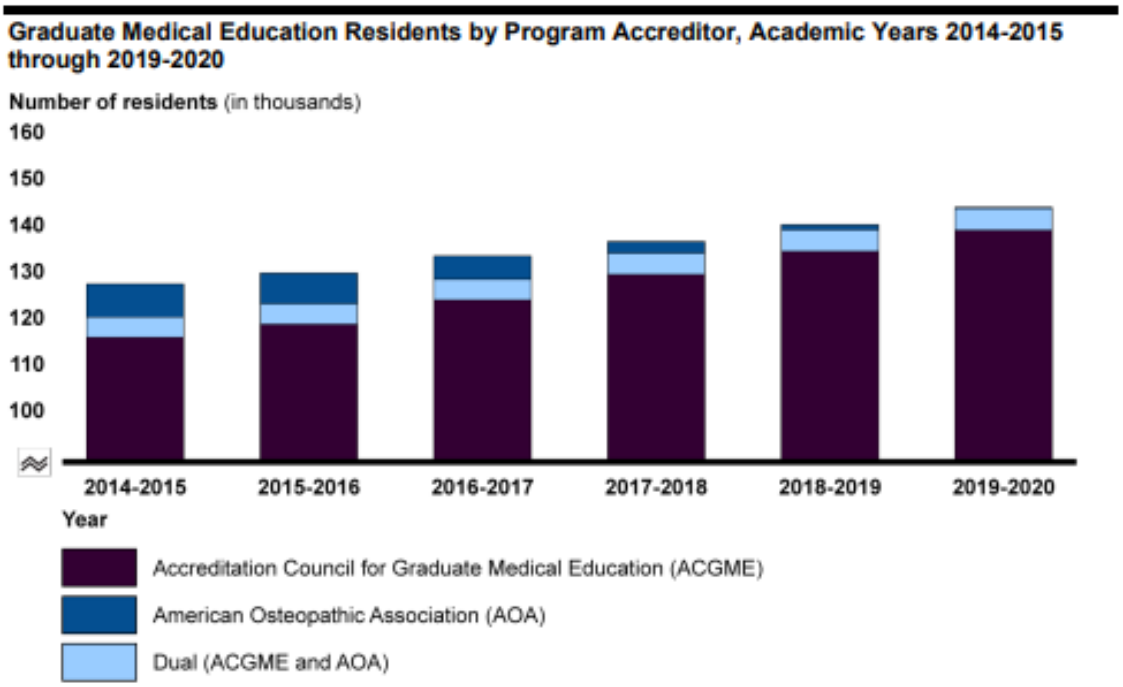
The organization's work relies heavily on the efforts of more than 800 volunteers, including physician specialists, medical educators, and public representatives, together contributing ~65,000 hours per year.

Accreditation aims to ensure that GME programs incorporate a range of educational experiences and provide assessment and feedback to each resident/fellow so that they complete their training with achievement of the competencies necessary for unsupervised practice in their specialty or subspecialty.

Confirming "substantial compliance" with ACGME standards is core to the process of accreditation. Since health care continually evolves, the ACGME's standards (Institutional Requirements, Common Program Requirements, and specialty-/subspecialty-specific Program Requirements) are periodically updated through a detailed, iterative process involving physician and medical education experts and members of the public, with additional input invited from the medical community and the public before proposed standards are adopted.

The integration of allopathic and osteopathic GME into a single accreditation system was stimulated by requests from the osteopathic community with strong support among its members. The transition to a single accreditation system was implemented between 2015 and 2020. Of note, by 2020, 98.6% of American Osteopathic Association (AOA)-approved programs that applied were accredited by the ACGME, and 99.3% of osteopathic medical students graduating that spring and seeking GME training were successfully placed.

Nominees from the AOA and Association of American Colleges of Osteopathic Medicine (AACOM) have been integrated into influential ACGME roles, including 10 current Board members, a former Board Chair, and Co-Chair of the Common Program Requirements Task Force. A Government Accountability Office follow-up evaluation of the transition to a single accreditation system demonstrated positive impact on GME and the physician workforce.



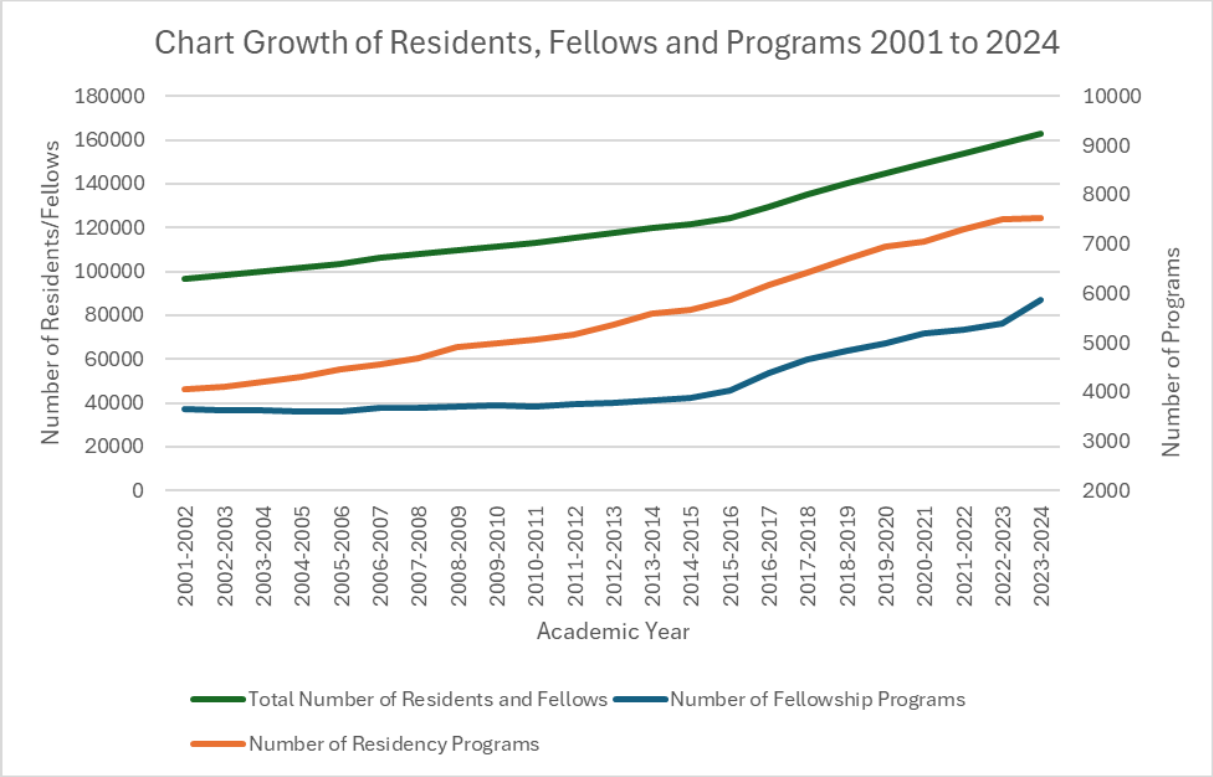
Source: GAO analysis of data from the Accreditation Council for Graduate Medical Education and the American Osteopathic Association. | GAO-21-329

Finally, related to the purview of this hearing, it is important to note that the ACGME has *no accreditation standards or expectations relating to participation in the National Residency Matching Program (NRMP) Match, San Franciso Match, or any other match*. While the ACGME sets the eligibility requirements for appointment to an ACGME-accredited program, focused on necessary prerequisites, *the ACGME does not oversee the process of residency/fellowship selection,* which is conducted at the program and institutional levels.

PHYSICIAN WORKFORCE

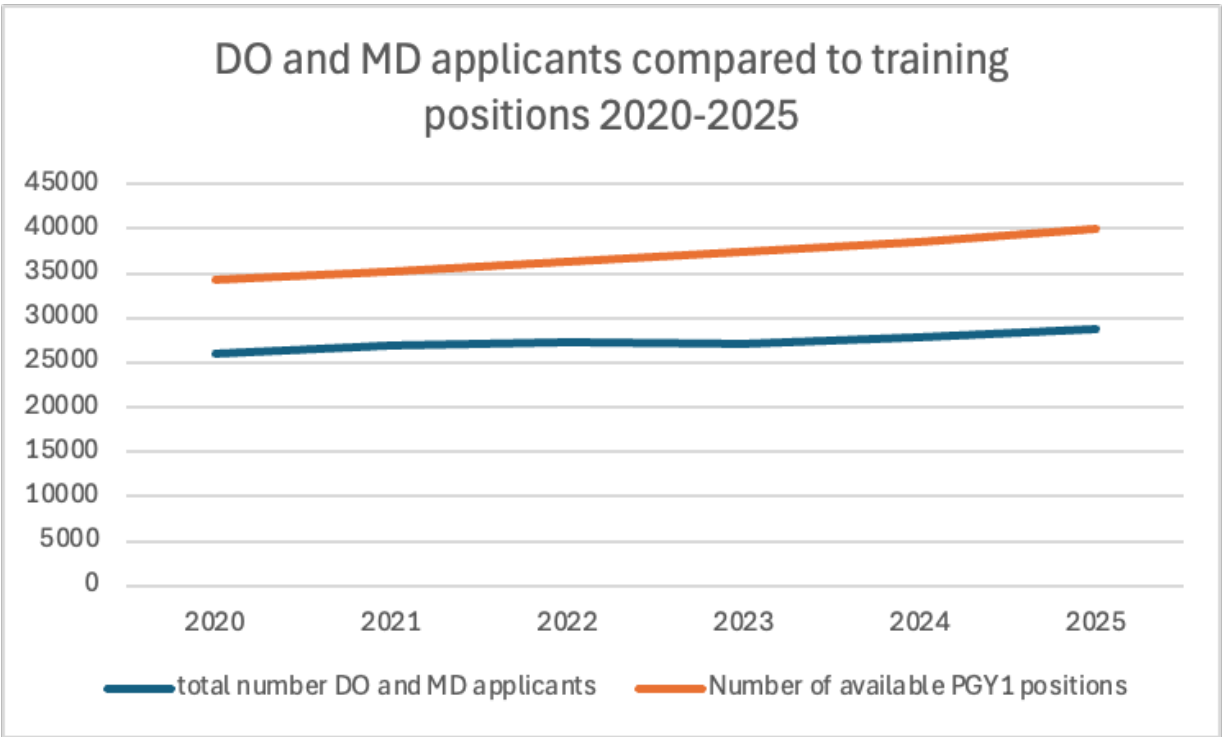
The Subcommittee's March 14 letter asserted that "the ACGME and the MATCH form a bottleneck to the physician workforce, reducing the number of American doctors." As demonstrated below, this is simply not true.

First, the number of accredited programs and of accredited resident and fellow positions continue to steadily increase, despite the funding limitation imposed by Medicare's "cap" on GME positions in 1997. This growth has occurred across specialties, types of Sponsoring Institutions, and geographic locations. The graph below shows the growth of GME programs and positions over the 23 years that the ACGME has been collecting data.



Source: ACGME Data Resource Book

Second, the number of entry positions in ACGME-accredited programs consistently exceeds the number of graduating US medical students, as shown in the figure below, refuting the idea of a bottleneck. NRMP data for 2025 indicates 28,760 US MD and DO applicants and 40,041 first-year GME positions.



Source:NRMP® Releases Results for 2025 Main Residency Match | NRMP

Testimony that "Each year, thousands of medical students fail to match with an ACGME-accredited residency through the MATCH process" deserves comment. In fact, **93.5% of MD and 92.6% of DO 2025 Match applicants were placed into GME programs** this year. Some students fail to match because they apply in highly selective specialties for which they are not competitive. Students may also limit the number and/or location of programs to which they apply, reducing opportunities to secure a position. In those cases, many students may secure a GME position in the days/weeks following the Match or apply successfully in a subsequent cycle.

Third, the ACGME does not determine or limit the number of GME slots available in the United States, or the proportion of slots devoted to various specialties/subspecialties. Programs and Sponsoring Institutions decide on the number and specialty/subspecialty distribution of GME positions they wish to offer, and the ACGME's only role is to determine the sufficiency of educational resources to educate and train the requested number of residents/fellows. (The ACGME sets a program resident/fellow "complement" as the maximum number of approved positions based upon the available educational resources, including faculty and specialty-specific patient experiences.) The vast majority of program expansion requests – 95% overall – are approved (source: *ACGME Data Resource Book* 2021-2024. Program and Sponsoring Institution decisions about program size are heavily influenced by financial constraints; other considerations include clinical volume,

availability of supervising physicians, and sufficiency of qualified GME applicants to the given program.

Additional witness testimony relating to the ACGME and the physician pipeline deserves attention:

- Concerns about withdrawal of accreditation were raised in testimony and in discussion with the subcommittee. ***The ACGME's responsibility to withdraw accreditation, in the rare event when that is warranted, impacts only a tiny fraction of GME:*** 0.15% of accredited programs lose accreditation each year (annual average, AY 2021-AY 2024). These data include voluntary withdrawals, where a program exits the accreditation process on its own. Also, some programs experiencing withdrawal of accreditation are able to implement improvements and successfully regain accreditation.

  Testimony asserted that, "According to ACGME data, 42 programs closed or were withdrawn during the 2021-2022 academic year, and that number rose to 64 in 2022-2023, signaling an alarming upward trend. In 2019-2020 alone, 102 programs closed or withdrew, many of them smaller, community-based programs…" **This is misleading**, as 2019-2020 was the last year of the transition to a single accreditation system and programs that did not complete the process for transition from Initial Accreditation to Continued Accreditation were withdrawn. *Several of these programs had no residents or fellows.* Historically the closure rate for AOA-approved programs was 10% per year, while during the transition to a single accreditation system, only 3.5% of the previous AOA-approved programs that applied had accreditation withdrawn.

  Additional testimony referring to withdrawal of accreditation asserted that at the "height of COVID" a "program director, didn't want to get a vaccination. And because of that, there was a mandate from ACGME that required the program directors to have vaccinations." In fact, ***the ACGME never had a mandate or a requirement concerning vaccination for program directors, faculty members, or residents/fellows*.**

- A witness testified, "When residents leave their current programs and are unable to transfer in elsewhere to complete their training, federal taxpayers lose their significant financial investment in that resident." Resident transfers have little relevance to the physician workforce, and the ACGME has no role in evaluating or approving resident/fellow transfer requests. The ACGME does understand that some program requests for an increase in the resident/fellow complement – particularly requests for a temporary increase – may relate to such a transfer request. The ACGME tries to be

maximally flexible: over the past four academic years, ***99% of programs seeking a temporary increase have been approved***.

When residents lose access to their education and training because of a hospital closure, the ACGME helps in rapidly addressing the need for temporary complement increases at accepting programs and works with specialty program director groups and internal data sources to help residents/fellows identify programs that may have capacity to accept them. This process was used when Hahnemann Hospital closed due to bankruptcy in 2019, initially leaving more than 500 residents without a program.

- We agree with testimony that, "Policymakers should consider a broader inventory of tools and levers that can shape not just the initial supply of new physicians but also facilitate how all health care providers can deliver more accessible, effective, and affordable care." The opportunity to use federal funding incentives to shape the physician workforce, particularly with respect to specialty and geographic distribution, deserves close attention. This opportunity was highlighted in several national committee reports, including the Institute of Medicine's 2014 report "Graduate Medical Education that Meets the Nation's Health Needs" (https://nap.nationalacademies.org/resource/18754/GME-RB.pdf).

ACGME PROCESS

Some testimony indicated concern with accreditation-related administrative burden, especially as it impacts rural programs. The ACGME recognizes that accreditation involves some level of administrative effort and cost and is focusing intensively on reducing both – as it publicly committed to doing in February 2025. Initial steps toward reducing administrative burdens have been determined and will be announced soon.

The ACGME is also working to:

- increase the importance of outcome measures (vs. process measures) in the accreditation process;
- challenge long-held assumptions and expectations about physician education and training that are not evidence-based; and,
- stimulate and facilitate innovation in GME.

ADDITIONAL POINTS TO ADDRESS

RURAL GME

In 2019, the ACGME established a Medically Underserved Areas/Populations and GME unit to promote GME programs in rural and urban underserved areas. A recent *Health Affairs* publication, "Physician Training In Rural And Health Center Settings More Than Doubled, 2008–24," noted that, "Importantly, the ACGME's strategic framework and program for medically underserved areas and populations, which was established during the transition to a single accreditation system, is actively supporting graduate medical education development in rural, FQHC, and other underserved areas."

A 2024 *Academic Medicine* paper (from the ACGME's CEO and colleagues) outlines federal, state, and institution-based efforts to strengthen and expand rural GME as an important measure toward improving health in rural America. The authors also propose new mechanisms and relevant incentives for expanding rural GME.

Testimony raised concern that the ACGME's requirements disadvantage rural GME programs because rural provider organizations are less likely to have sufficient resources or educational infrastructure. As noted above, the ACGME and its new CEO have demonstrated a commitment to supporting rural GME. Committees and task forces currently working on updates of the Institutional Requirements and the Common Program Requirements are being urged to consider more flexible and nuanced requirements – avoiding "one size fits all" – especially where common requirements create burden for programs in underserved areas, as described in the ACGME Medically Underserved Areas and Populations framework, also established in 2019. (See Medically Underserved Areas and Populations.)

ACGME ROLE IN RESIDENT APPLICANT CONTRACTS

In the context of reevaluating the NRMP's antitrust exemption, one witness proposed consideration of, "More modest proposals… Ensuring that all medical resident applicants have the opportunity to review the terms of their prospective contracts, with accurate and accessible information, before they must enter into any binding agreements." *While the ACGME does not set resident/fellow salaries or benefits,* ***there is a longstanding ACGME Institutional Requirement (IV.B.3.) addressing this, so that candidates can use the information in comparing programs***: "An applicant invited to interview for a resident/fellow position must be informed, in writing or by electronic means, of the terms,

conditions, and benefits of appointment to the ACGME-accredited program, either in effect at the time of the interview or that will be in effect at the time of the applicant's eventual appointments." Elements that must be shared with the applicant resident/fellow at the time of interview include stipends, benefits, professional liability and disability coverage, vacation and leave policies, and availability of health insurance.

CONCLUSION

We appreciate the opportunity to clarify and, where necessary, correct the record of the May 14 hearing. Health care delivery in the United States is complex and continues to evolve. The education and training of new physicians is essential to the quality of our health care in the future: it too must evolve. The ACGME recognizes this and continues to examine and enhance its standards and streamline its processes. The ACGME believes it plays an important, positive role assuring and enhancing physician education and training in the United States.