



AMERICAN COLLEGE OF
OCCUPATIONAL AND
ENVIRONMENTAL MEDICINE

June 24, 2024

The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

RE: Draft Proposal to Improve Medicare Physician Training to Reduce Workforce Shortages – Implications for Occupational & Environmental Medicine Physician Training

Chairman Wyden and Members of the Bipartisan Medicare GME Working Group,

On behalf of the American College of Occupational and Environmental Medicine ([ACOEM](https://www.aoec.org)), I am writing to express strong support for your efforts to identify solutions to address our nation's current and forecasted physician workforce shortage. We agree that this issue has reached a point of critical urgency, and we are already seeing negative impacts in rural and underserved communities where patients struggle to find specialized care to improve and maintain their health. **We want to draw your attention to an aspect that is not addressed in your proposal, which we believe is critical to solving the overall physician shortage crisis holistically – medical specialty training programs for physicians that routinely receive little or no support through Direct or Indirect Graduate Medical Education (GME) payments from the Centers for Medicare and Medicaid (CMS), such as Occupational and Environmental Medicine (OEM) Residency Training Programs¹.**

Founded in 1916, ACOEM is the nation's largest medical society dedicated to promoting worker health through preventive medicine, clinical care, research, and education. The College represents Occupational and Environmental Medicine (OEM) physicians and other healthcare professionals devoted to preventing and managing occupational and environmental injuries and exposures. OEM is a board-certified specialty under the American Board of Preventive Medicine (ABPM) that identifies, prevents, and mitigates adverse effects of hazardous agents and conditions in the workplace and environment. **As of this year, there were only 3,265 board-certified OEM physicians in the U.S., with an average age of 62².** OEM represents a small fraction of the 1.1 million active physicians in our country, but the specialty is charged with securing the health and safety of our nation's current and future workforce. The current shortage of OEM physicians jeopardizes our country's preparedness and resilience to meet and overcome inevitable public health and environmental health threats as they arise.

OEM physicians are multidisciplinary experts who bridge the gap between emerging scientific discoveries and workplace practices, aiding workers, employers, and the public through care, education, training, and guidance. The core pursuit in OEM is to recognize, diagnose, treat, and prevent injury and illness arising from exposures at work, home, and elsewhere. OEM physicians work with non-medical stakeholders to resolve messy worker's compensation cases and inform risk management to mitigate the potential of costly missteps. In contrast to generic occupational health and safety approaches, OEM physicians offer tactical, evidence-based

¹ <https://aoec.org/oem/where-can-i-train-in-oem/>

² <https://www.theabpm.org/wp-content/uploads/2024/05/2024-PD-Summit-FINAL.pdf>

solutions to support high-risk workers and companies, promoting safety and operational efficiency. **OEM physicians are essential primary care providers for workers, and they are especially vital for Americans working in industries that are considered the most dangerous, which are also some of the most critical to the health of our country's economy (i.e., construction, healthcare, agriculture, transportation)**³. In short, OEM physicians help employers get Americans back to work and keep them safe on the job.

According to the 2022 guidance document, *The Future of Occupational and Environmental Medicine*, "The Centers for Medicare & Medicaid Services, which funds most residency programs in the United States proportional to time spent in clinical settings, does not fund OEM residencies to the same degree because of necessary time spent in non-clinical settings, such as pursuing a master's degree in public health, working in public health departments, visiting/evaluating worksites, and consulting with attorneys and insurers."⁴ OEM residency programs face this challenge alongside a small subset of medical specialties, such as Public Health & General Preventive Medicine. The pediatric medicine workforce faced a similar issue before the creation of the Children's Hospitals Graduate Medical Education (CHGME) program in 1999. **We strongly encourage this bipartisan working group and Congress to consider how to best support physician training for medical specialties neglected by the current Medicare GME system and explore how these specialties could be supported via strategic reforms.**

Current Federal funding from the National Institute for Occupational Safety and Health (NIOSH), the Department of Veterans Affairs (VA), and the Health Resources and Services Administration (HRSA) to support OEM programs is insufficient and declining, resulting in several OEM residency programs closing and significantly endangering the future training pipeline for OEM physicians. **While there were over 40 active OEM residency programs training physicians in the 1970s and 80s, there are only 20 active civilian OEM residency programs today** (with two additional military OEM residency programs). 95% of these OEM program closures have occurred since 2000, and absent immediate action to support the existing OEM residency programs, we expect more programs to close in the coming years. Program closures have significantly impacted the distribution of OEM physicians in the U.S., impacting heartland communities and other similar communities the hardest, as closures of rural OEM programs have led to fewer OEM physicians training and remaining in those areas where they completed their residency. Additionally, in a 2022 survey of OEM residency directors, 50% said they considered giving up the role overwhelming due to uncertainty surrounding program funding and resources for faculty.

The number of newly board-certified OEM specialists declined from a high of 229 in 1997 to only 65 physicians pursuing board certification in OEM in 2023. OEM training programs are typically only able to fund around half of the residency slots authorized by the Accreditation Council for Graduate Medical Education (104 residents in training/189 positions approved – 2023). The lack of funding for OEM training has created a significant gap in the needs of employers, public health agencies, and the workforce. Faculty to train OEM residents must be at the forefront of developing solutions for prevention, which requires robust Federal funding for

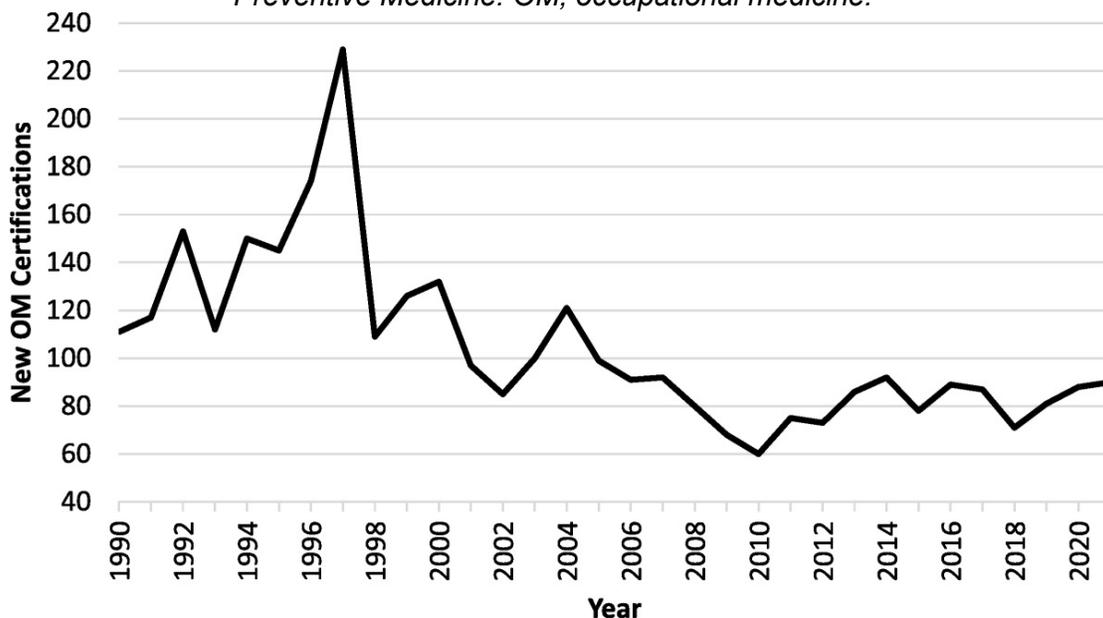
³ <https://injuryfacts.nsc.org/work/industry-incidence-rates/most-dangerous-industries/>

⁴ Green-McKenzie, Judith MD, MPH; Khan, Alya MD, MS; Redlich, Carrie A. MD, MPH; Margarin, Aisha Rivera MD, MS; McKinney, Zeke J. MD, MHI, MPH. *The Future of Occupational and Environmental Medicine*. *Journal of Occupational and Environmental Medicine* 64(12):p e857-e863, December 2022. | DOI: 10.1097/JOM.0000000000002676 Available at: https://journals.lww.com/joem/fulltext/2022/12000/the_future_of_occupational_and_environmental.23.aspx

extramural research. While interest in the OEM specialty is growing among the next generation of physicians, universities do not currently have the resources to support this demand from prospective OEM physicians.

Without additional local, regional, and national support, many American workers and businesses may lose access to the benefits of occupational and environmental medicine within a matter of years. These challenges, taken in concert with an understanding of the growing need for American businesses to have access to physicians specializing in physical, chemical, biological, and social environments of the workplace and the health outcomes of environmental exposures, underscore ACOEM's position that there is a dire need to shore up the OEM training pipeline.

Number of new certifications in OM per year, 1990–2021. Data from the American Board of Preventive Medicine. OM, occupational medicine.



According to the National Safety Council, the total cost of work injuries in 2022 was \$167 billion.⁵ Wage and productivity losses totaled \$50.7 billion, medical expenses were \$37.6 billion, and administrative expenses were \$54.4 billion. Businesses, workers, taxpayers, and the Medicare system bear these costs. Despite the widespread need for their expertise, many regions face a shortage of OEM providers, leaving workers and small businesses without access to their vital guidance. Regional expertise is critical in serving the needs of diverse industries and communities – OEM physicians ensure tailored occupational health and safety solutions are implemented rather than a one-size-fits-all approach. **We strongly feel that providing prevention-centric care to individuals and worker populations (Population Health) through OEM will generate cost savings for the Medicare system. Caring for people during their working years will deliver healthier individuals to Medicare later in life.**

OEM can provide substantial value to workers and the Medicare system by ensuring workers can return to work after work-related injuries or illnesses that may necessitate their enrollment in workers' compensation. OEM physicians are experts at helping and evaluating individuals on

⁵ <https://injuryfacts.nsc.org/work/costs/work-injury-costs/>

workers' compensation and allowing them to rejoin the workforce and continue their careers. As we know, if an individual cannot return to work after an extended period, they often transition to the Social Security and Medicare disability benefits systems. OEM physicians also play a critical role in early detection and intervention for chronic health conditions that may be work-related but do not present symptoms until later in life (post-working career) when a person is in the Medicare system. Most importantly, this type of expertise ensures that workers are getting the appropriate care at the earliest possible stage of a chronic health condition while also ensuring that the proper party is responsible for providing these benefits, as opposed to the cost being shifted to American taxpayers via increased burden on the Medicare system.

Acknowledging that the emphasis of the Bipartisan Medicare GME Working Group's proposal is on primary care residencies and psychiatry or psychiatry subspecialty residencies, **we would suggest that OEM and other preventive medicine specialties are also key medical specialties in a present state of shortage and that OEM functions as primary care for workers.** As the number of US workers continues to grow, from a labor force of 62 million people in 1950 to around 168 million today, the shortage of OEM physicians promises to worsen, leaving more workers and businesses without critical expertise today and in the future. HRSA's workforce projection for "Other Specialty Physicians," which includes OEM and other preventive medicine specialties, forecasts only 71% adequacy in 2036. We suspect the supply/demand factor for OEM will be in an even more pronounced crisis by 2036. We are providing the following feedback to questions explicitly raised in the draft proposal and are happy to provide any additional information that may be of assistance.⁶

SECTION 2. Additional and Improved Distribution of Medicare GME Slots to Rural Areas and Key Specialties in Shortage

- **How many additional Medicare GME slots are needed to address the projected shortage of physicians?**

Subject to Medicare GME formula reforms to allow Occupational and Environmental Medicine (OEM) residency programs to qualify for Medicare-funded physician residency slots, funding support for the 189 ACGME-approved residency pathway slots for OEM would significantly improve the status of the current OEM physician supply (when leveraged in concert with other available sources of funding support OEM programs receive). Supporting this small number of OEM GME residency slots via Medicare would amount to a small fraction of the costs outlaid on Medicare GME today (~\$17.8 billion supporting 194,910 FTEs in non-OEM-specialties in FY21)⁷. Still, it would enormously impact the current OEM physician supply and the value delivered by OEM physicians to the nation's workers, health system, and economy. Additional Medicare GME slots beyond the current level of ACGME-approved slots for OEM (~50% = 85 are unfilled due to a lack of funding) would be necessary to prevent a future shortage of OEM physicians to keep pace with a growing U.S. population and workforce.

- **Beyond the proposed changes to the definition of rural hospitals, is it necessary to provide further clarification in the existing statute to ensure that CMS allocates GME slots to particular categories as specified in the CAA, 2023 GME allocation formula?**

Yes, we encourage the bipartisan working group to explore options to provide alternative pathways to support medical specialties that currently receive little or no funding support from Federal GME funding through CMS due to the unique nature of their residency programs'

⁶ https://www.finance.senate.gov/imo/media/doc/052424_bipart_gme_policy_outline_for_feedback.pdf

⁷ <https://crsreports.congress.gov/product/pdf/IF/IF12583>

training requirements and needs, such as Occupational and Environmental Medicine (OEM). Preferably, these reforms could be pursued through this draft proposal or future legislative proposals that seek to remedy the nation's physician shortage crisis.

SECTION 4. Establishment of Medicare GME Policy Council to Improve Distribution of Slots to Specialties in Shortage

- **Should Congress include additional specifications for a GME Policy Council in order to improve its success in allocating GME slots to physician specialties projected to be in shortage?**

Yes, a GME Policy Council should be tasked with considering the full range of physician specialties in shortage, including those receiving minimal or no Federal GME funding through CMS. Congress should direct the GME Policy Council to provide recommendations on how to best support those specialties that are neglected/supported within the current Medicare GME system.

SECTION 7. Improving GME Data Collection and Transparency

- **It is of interest to track whether residents trained in primary care continue to practice in this specialty because primary care training is frequently a precursor to other residency training. Are there other specialties that teaching hospitals should similarly report?**

This issue is directly related to the current shortage of OEM physicians who are available to meet the needs of workers and communities across our country. Because of the low levels of OEM physicians available, it is a prevalent occurrence for primary care physicians who have completed residencies in internal, family, and other non-OEM medical specialties to practice in the field of OEM without receiving specialized training in OEM. This arrangement can cause significant challenges when a provider is faced with a work-related case, condition, or issue that was not a part of the training requirements of their non-OEM residency training and can lead to adverse health outcomes for patients if conditions are not appropriately detected, diagnosed, and treated. It can adversely impact entire worker populations if an employer organization or another entity with that authority implements a suboptimal workplace health and safety policy. As this relates to the Working Group's focus on primary care shortages, it also leads to communities having fewer core primary care physicians available to treat patients in rural and underserved communities who lack access to fundamental clinical general care.

If you have any questions or need additional information, please contact Dane Farrell (Dane@cascadeassociates.net), ACOEM's Government Affairs Representative. Thank you for your consideration, and we look forward to collaborating with the working group and the full Committee on Finance as it works to address the nation's physician workforce shortage.

Sincerely,

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President

American College of Occupational and Environmental Medicine (ACOEM)