The Honorable Patty Murray
Chair
Committee on Health, Education,
Labor and Pensions
U.S. Senate
Washington, DC 20510

The Honorable Richard Burr
Ranking Member
Committee on Health, Education,
Labor and Pensions
U.S. Senate
Washington, DC 20510

April 9, 2021

Dear Chairwoman Murray and Ranking Member Burr:

Thank you for seeking recommendations to address workforce needs of the health care and public health sectors. The Infectious Diseases Society of America (IDSA) and HIV Medicine Association (HIVMA) greatly appreciate your leadership and attention to these important issues, and we are pleased to offer recommendations to strengthen the infectious diseases (ID) workforce for patient care, research, and public health. We would welcome the opportunity to participate in upcoming Committee discussions and hearings and to work with you to advance shared priorities.

IDSA represents more than 12,000 infectious diseases physicians, scientists and other public health and health care professionals who specialize in the prevention, diagnosis and treatment of infectious diseases. Our members are on the front lines of the COVID-19 pandemic, caring for patients, designing and updating infection prevention, diagnostic testing and patient management protocols, collaborating with state and local health departments on communications and mitigation efforts, leading health care facility responses, and conducting research to develop new tools for the prevention, diagnosis and treatment of COVID-19. Our members are also integral to responses to antimicrobial resistance, HIV, viral hepatitis, infections impacting immunocompromised patients (e.g. patients receiving cancer chemotherapy or transplantation), and emerging infectious diseases.

Background: Threats to the Infectious Diseases Workforce

The ID physician workforce was already stretched before COVID-19. A June 2020 study in the *Annals of Internal Medicine* found that 208 million Americans live in areas with little or no access to an ID physician. The number of applicants to ID fellowship training programs declined by 21.6% from 2011-2016. The last few years saw only modest improvements that have plateaued. In 2020, only 75% of infectious diseases training programs were able to fill all of their slots, while many other internal medicine subspecialties (cardiology, rheumatology, gastroenterology, hematology, oncology,

pulmonology and critical care) were able to fill from 96% to 100% of their training programs. IDSA surveyed internal medicine residents in 2014 and found financial concerns were the chief barrier to pursuing a career in ID. Data published by *Medscape* in 2020 indicate that average annual salaries for ID physicians are below all other medical specialties except pediatrics, family medicine, endocrinology and public health, and even below the average salary for general internal medicine, although ID training and certification requires an additional two to three years of study and training. Salaries for the highest-paying specialties are nearly double the salaries for ID physicians. Given that the average medical student debt is $200,000, the ID specialty is a financially infeasible choice for many.

As the COVID-19 pandemic has underscored, a strong ID workforce is central to our preparedness for pandemics and other emergencies and to provide optimal medical care for patients receiving cancer treatment, transplants, and surgery for which infectious complications are a significant threat.

In addition to providing life-saving direct patient care, the ID physician workforce serves as a cornerstone for the clinical trial and public health infrastructure. With adequate planning and support, ID physicians in the community can be enabled to identify and recruit disproportionately impacted populations into clinical trials, participate in surveillance programs, assist with education and public messaging and equitable dissemination of vaccines, testing and therapeutics. We are pleased to offer the following recommendations to help ensure the necessary pipeline of ID physicians to meet patient care, research, and public health needs.

Background: Ending the HIV Epidemic and Addressing Health Inequities

The COVID-19 pandemic has brought to the forefront the health inequities long experienced by people at risk for and living with HIV. Although remarkable advances in HIV prevention and treatment have allowed people with HIV to live long and healthy lives, still around 40% of people with HIV in the United States are not benefiting from treatment that would keep them healthy and prevent HIV transmission to others.

The federal *Ending the HIV Epidemic initiative*, launched in 2019, aims to address these disparities in the U.S. by expanding access to the highly effective tools to effectively prevent and treat HIV in the most heavily impacted areas of the country. The success of this initiative, that aims to achieve a 90% reduction in new infections by 2030, will require an expanded and qualified HIV clinical workforce.

ID specialists represent 60% of the HIV physician workforce with internists and family medicine physicians also playing a critical role along with nurse practitioners and physician assistants. A Centers for Disease Control and Prevention study predicted a shortage of HIV clinicians starting in 2019 – a gap which is widening in parts of the country. A study of the HIV workforce in 14 southern states found that more than 80% of those states' counties had no experienced HIV clinicians, with the disparities being the greatest in rural areas. Nearly 50% of the 48 counties and two metropolitan areas targeted in the *Ending the HIV Epidemic initiative* and all but one of the seven target states, are in the South, where clinical workforce shortages are most acute. Interventions are urgently needed to draw clinicians to practice HIV in these underserved areas.

Proposals: Loan Repayment

Reducing student loan burden is an important strategy to strengthen the ID workforce. IDSA greatly appreciates that Congress increased the annual loan repayment limit for the NIH loan repayment program from $35,000 to $50,000 as part of the *21st Century Cures Act* and that Congress granted CDC authority to provide loan repayment for individuals participating in CDC fellowship programs, such as the Epidemic Intelligence Service, as part of the *Pandemic and All Hazards Preparedness and Innovation Act*. These efforts have provided essential support for ID researchers and public health professionals but significant gaps remain. IDSA and HIVMA offer the following recommendations for targeted loan repayment opportunities aimed at areas of greatest need.

- **Establish a new bio-preparedness and ID physician loan repayment program**: We recommend establishing a loan repayment program with two categories of eligibility:

    1. Health care professionals who spend at least 50% of their time engaged in bio-preparedness and response activities, including developing response and surge capacity plans and protocols, collaborating with state and local health departments, training health care facility personnel, purchasing and managing equipment for bio-emergencies, infection prevention and control, and antimicrobial stewardship; or
    2. Physicians who have completed an infectious diseases fellowship training program or is board certified or board eligible in infectious diseases, and practices in a health care professional shortage area or an area that meets criteria to be identified by the Secretary of Health and Human Services (HHS) to identify infectious diseases physician shortage areas.

- **Reauthorize and Strengthen the Public Health Workforce Loan Repayment Program:** Section 776, PHSA established a loan repayment program to assure an adequate supply of public health professionals who agree to serve two years in a local, state, or tribal health department. The program's authority lapsed in 2015 and was not funded. This program would be helpful to ensure critical public health activities are properly staffed. We support S. 3737, introduced by Sens. Smith and Booker in the 116th Congress, which would accomplish these goals.

- **Establish a New Loan Repayment Program for HIV clinicians:** Support the introduction and passage of the HIV Epidemic Loan-Repayment Program (HELP Act) in the Senate (recently introduced in the House of Representatives by Rep. Lisa Blunt Rochester as H.R. 2295) which would offer loan repayment to HIV clinicians and dentists for service in Ryan White-funded clinical settings and health professional shortage areas.

Proposal: NIH/NIAID Physician-Scientist Training

The National Institutes of Health (NIH) and National Institute for Allergy and Infectious Diseases (NIAID) are critical sources of funding to support the training of ID physician scientists. IDSA and HIVMA are engaging with NIAID to strengthen training, including by providing more resources for mentorship, greater opportunities for clinicians in non-academic settings to participate in clinical trials, and more funding to support early stage investigators, particularly from underrepresented groups. We encourage the Committee to direct NIAID to enhance ID physician-scientist training programs and to authorize additional funding to address these goals.

Proposals: Physician Reimbursement

We recognize that physician reimbursement issues do not fall within the jurisdiction of the HELP Committee. As you are leading efforts to strengthen the health care workforce, however, we believe that the Finance Committee could pursue policies to complement your efforts.

- **Create Outbreak Activation Authority:** We also recommend the creation of a mechanism, similar to the existing trauma activation policies, to reimburse for the significant work performed to respond to a public health emergency involving an infectious disease outbreak. This work is currently non reimbursable and includes maintaining specialized equipment and other supplies necessary for managing an influx of patients; assembling teams of the necessary clinical professionals to immediately diagnose, treat, and manage the care of such patients; repurposing areas of facilities to manage a growing influx of outbreak patients; coordinating preparation and response activities with state and local public health authorities; providing updates and guidance to the community; and coordinating with human resources to ensure well-being of healthcare facility staff. An outbreak activation payment would allow the Secretary to designate existing codes as well as create new codes or modifiers for certain activities that are relevant to a particular outbreak situation. In addition, the Secretary could designate a specific "bump up" of the reimbursement of such codes during the declared emergency period in a local area or on a national level if warranted.

- **Ensure Appropriate Updates to Inpatient E/M Codes:** IDSA and HIVMA appreciate that the Centers for Medicare and Medicaid Services (CMS) finalized long overdue updates to valuation and documentation requirements for outpatient evaluation and management (E/M) codes, and we thank Congress for providing additional resources to minimize cuts to physician reimbursement associated with these updates due to budget neutrality rules. Inpatient E/M codes, which account for a significant portion of ID physician care, however, remain undervalued and out of date. We urge Congress to continue working with CMS and the medical community to ensure appropriate updates to inpatient E/M codes that better reflect the complexity of care provided and adequately capture care that is not currently reimbursed.

IDSA and HIVMA thank you for your leadership in addressing the urgent need to strengthen our health care and public health workforce and for this opportunity to provide input. We look forward to working with you. If we may assist you in any way, please contact Amanda Jezek, IDSA Senior Vice President for Public Policy & Government Relations at ajezek@idsociety.org or Andrea Weddle, HIVMA Executive Director at aweddle@hivma.org.

Sincerely,

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