House Energy and Commerce Committee Hearing:
"Supporting Tomorrow's Health Providers: Examining Workforce Programs Under the Public Health Service Act"
Testimony of the Infectious Diseases Society of America (IDSA) President William Powderly, MD, FIDSA and HIV Medicine Association (HIVMA) Chair Wendy Armstrong, MD, FIDSA
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The HIV Medicine Association (HIVMA) and the Infectious Diseases Society of America (IDSA) thank the Committee for examining the extension of funding for the National Health Service Corps (NHSC) and the Teaching Health Center Graduate Medical Education (THCGME) program, as well as reviewing legislation that reauthorizes PHSA Title VII health workforce and Title VIII nursing workforce education and training programs. We want to take this opportunity to call attention to the steep decline of young physicians pursuing ID/HIV specialty training. We urge you to address this issue to help secure the future of the ID/HIV workforce.

The Infectious Diseases Society of America (IDSA) represents more than 10,000 physicians, scientists and other health care professionals who specialize in infectious diseases. Housed within IDSA, HIVMA is an organization of more than 5,000 clinicians and researchers who are working on the front lines of the HIV epidemic. Ensuring adequate HIV and Infectious Diseases medical and public health workforce capacity are priorities of both organizations.

Infectious Diseases physicians play critical roles throughout the health care and public health system. They work to prevent, diagnose, treat and conduct research on infections and serious conditions that affect us all and that know no geographical boundaries. ID is a diverse field with ID physicians leading efforts to respond to:

- emerging viral outbreaks, such as Zika, Chikungunya and Ebola;
- drug resistant infections, such as methicillin-resistant *Staphylococcus aureus* (MRSA), carbapenem-resistant Enterobacteriaceae (CRE) and multidrug-resistant gonorrhea;
- the urgent need for appropriate prescribing of antibiotics to prevent drug resistance and *Clostridium difficile* infections;
- serious infections requiring ongoing care including HIV/AIDS and viral hepatitis;
- infections, in addition to HIV and hepatitis C, related to injection drug use, such as endocarditis, bone infections and bacteremia; and
- infections associated with organ transplantation and chemotherapy treatments for malignancy.

We are deeply concerned that since 2011, there has been a steep decline in the number of physicians applying for ID program slots resulting in an increasing number of programs that do not fill through the National Residency Matching Program. In 2016, fewer than half of ID programs filled their fellowship position through the Match and more than one third of fellowship positions across programs went unfilled. Most other specialties fill all or nearly fill all of their fellowship positions through the Match.

Significant student loan burden—on average about $200,000—is understandably driving many young physicians toward more lucrative specialties. Over 90% of the care provided by ID physicians is considered evaluation and management (E/M) services. These face-to-face, cognitive encounters are undervalued by the current payment systems compared to procedural practices (e.g., surgical specialties, cardiology, and gastroenterology, etc.). This has led to a significant compensation disparity

between ID physicians and specialists who provide procedure-based care.

We urge the Committee to seek opportunities to support and to incentivize medical professionals to enter into the vital fields of HIV and infectious diseases. One important strategy would provide loan repayment and loan forgiveness opportunities to ID and HIV physicians managing medically underserved patient populations (as examples, those affected by hepatitis C, HIV, and the opioid epidemic) and those working in public health roles. We urge the Committee to revisit long stymied efforts to update the criteria and the methodology that are utilized to determine eligibility for and allocation of HRSA's roughly $1.2 billion in resources for health professions education, training and recruitment among designated underserved populations. The current rules have not been updated since the 1970s, and they do not take into account our nation's changing demographics and important current public health challenges including the devastating impact of the opioid and injection drug use (IDU) epidemics in many underserved rural communities.[1] The IDU crisis has resulted in a burgeoning risk of HIV and hepatitis C (HCV) outbreaks as well as an urgent need for expanded overdose and substance use prevention and treatment services.

Expanding Access to Hepatitis C Treatment in Rural and Underserved Areas

The National Academy of Sciences recently convened an expert committee to consider a strategy for eliminating viral hepatitis in the U.S. by 2030.[2] This report concluded that it was possible to eliminate viral hepatitis as a public health issue but only if a number of barriers were addressed, including the shortages of physicians treating hepatitis C in rural and medically underserved areas. Infectious disease trained physicians play an important role in caring for patients with hepatitis C, including the management of direct acting antivirals that cure most patients of hepatitis C. IDSA co-authors with the American Association for the Study of Liver Diseases *HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C*. Given the urgent need to increase the pool of providers treating hepatitis C and the potential to eliminate the disease, we strongly encourage the availability of incentives such as loan forgiveness to increase hepatitis C treatment capacity in rural and underserved areas.

The Intersection of Infectious Diseases and the Opioid Epidemic

Infectious disease specialists also are on the frontlines of the opioid epidemic working to prevent and to treat HIV and hepatitis among individuals who inject drugs in addition to other serious infections common in this population, such as endocarditis and blood stream infections. In the absence of or the delay in instituting effective treatment, viral infections especially can rapidly spread within an injection drug using community. Increasing the availability of infectious diseases experts in the 220 counties identified by the Centers for Disease Control and Prevention as being at risk for HIV and hepatitis C outbreaks linked to injection drug use is an important component of an effective response to the opioid epidemic.[3] Incentives such as loan forgiveness for infectious diseases physicians and other providers with the appropriate expertise to respond to the opioid epidemic should be considered to prevent infectious disease outbreaks in underserved areas, like what occurred in Scott County, Indiana.

Loan Forgiveness and Ryan White-funded Clinics

By way of background, from September, 2010 through October, 2011, HIVMA was among the diverse stakeholders in an HRSA-negotiated rulemaking process mandated by the Patient Protection and

Affordable Care Act to update both methodology and criteria for designation of Medically Underserved Areas (MUPs) and Health Professional Shortage Areas (HPSAs). In the process, we urged that a new rule defining medical underservice should recognize clinics and communities that are serving people with HIV. This is based on the rationale that improving access to quality HIV care and building HIV medical provider capacity are key foundations for helping the people with HIV who live in households with incomes at or below the federal poverty level that account for nearly 50% of all infected.[4] Many still experience significant stigma and discrimination. In addition, a large majority (75%) of people with HIV receive multi-disciplinary care in Ryan White-funded clinical settings. While an increasing number of Ryan White-funded clinical sites are affiliated with Federally Qualified Community Health Centers, many continue to either be free-standing community-based clinics or affiliated with an academic health center.

A HRSA-sponsored study released in August, 2016 projected a deficit in the supply of HIV medical providers relative to demand for HIV care and treatment services, due to a combination of trends:

1) An increase in the number of newly diagnosed cases each year coupled with a low mortality rate among the currently diagnosed population; and
2) An insufficient number of clinicians entering the HIV workforce relative to the number of clinicians leaving the HIV workforce because of retirement and mortality.[5]

The Centers for Disease Control and Prevention's (CDC) Medical Monitoring Project also published a study in 2016 projecting that within the next five years the numbers of new physicians trained in HIV care will fall significantly short of the numbers necessary to provide appropriate treatment to an estimated 30,000 additional patients each year.[6] The study also found that nearly half of HIV physician experts practice at facilities receiving Ryan White Program funding, providing care for nearly three quarters of all patients with HIV – highlighting the importance of bolstering the Ryan White Program medical workforce.

While the Negotiated Rulemaking Committee was not able to achieve consensus, in its final report[7] it did approve a final proposal that specifically named safety-net clinics disproportionately providing primary care to special populations, such as HIV patients, as being eligible to receive NHSC recruits if they document insufficient provider capacity. The proposal also included a short cut for clinics that focus on HIV, LGBT and disability populations to be eligible to apply for community health center funding.

While we understand the challenges related to making any changes to the existing model for designating MUPs/HPSAs, including the need to avoid disruptions in care delivery, we believe it is incumbent on Congress to ensure that HRSA's allocation of scarce safety net health care workforce resources is aligned with today's most pressing health care needs. An adequate workforce of infectious disease/HIV clinicians and public health professionals that can respond to the HIV, HCV and opioid epidemics and other infectious outbreaks are vital to improving the public health of our nation.

ID Physicians in Public Health Departments

There is a critical need for ID physicians in public health departments. The top four most common activities performed at local health departments are all related to infectious diseases. The areas that benefit from involving ID physicians include communicable disease surveillance, tuberculosis screening, adult and childhood immunizations. ID physicians are also responsible for HIV and hepatitis C screening,

surveillance and prevention efforts at many health departments. ID physicians working in these roles are not currently eligible for federal loan repayment programs except the Public Service Loan Repayment program that requires 10 years of public service before loan repayment may be initiated. This is a much higher bar than the National Health Service Corps. We urge the Committee to consider opportunities to strengthen loan repayment options for ID physicians who work in public health.

Thank you for your consideration of our views, and please regard us as a resource in the important work of the Committee. We can be reached through Andrea Weddle of HIVMA staff aweddle@hivma.org or Amanda Jezek of IDSA staff at ajezek@idsociety.org.

[1] Jurisdictions Determined to be Experiencing or At-risk of Significant Increases in Hepatitis Infection or an HIV Outbreak Due to Injection Drug Use Following CDC Consultation, Centers for Disease Control and Prevention, https://www.cdc.gov/hiv/risk/ssps-jurisdictions.html (information current as of January 10, 2017).
[2] National Academy of Sciences. A National Strategy for the Elimination of Hepatitis B and C. March 2017.
[3] Van Handel, M et al. County-Level Vulnerability Assessment for Rapid Dissemination of HIV or HCV Infections Among Persons Who Inject Drugs, United States. JAIDS . 73(3): 323–331.
[4] Blair, JM, et al. Behavioral and Clinical Characteristics of Persons Receiving Medical Care for HIV Infection — Medical Monitoring Project, United States, 2009. MMWR. June 20, 2014 / 63(ss05);1-22.
[5] The HIV Clinician Workforce in the United States: Supply and Demand Projections from 2010 to 2015, Boyd Gilman, Ph.D., Ellen Bouchery, M.S., Paul Hogan, M.S., Sebastian Negrusa, Ph.D., Sylvia Trent-Adams, Ph.D., and Laura Cheever, M.D., August, 2016.
[6] Qualifications, Demographics, Satisfaction, and Future Capacity of the HIV Care Provider Workforce in the United States, 2013-2014. John Weiser, Linda Beer, Brady T. West, Christopher C. Duke, Garrett W. Gremel, and Jacek Skarbinski. Clin Infect Dis. (2016) doi: 10.1093/cid/ciw442 First published online: June 29, 2016.
[7] Negotiated Rulemaking Committee on the Designation of Medically Underserved Populations and Health Professional Shortage Areas Final Report to the Secretary (10/31/11)