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March 9, 2026

**The Honorable Vern Buchanan, Chairman**

Health Subcommittee  
Committee on Ways and Means  
U.S. House of Representatives  
Washington, DC 20515

**The Honorable Lloyd Doggett, Ranking Member**

Health Subcommittee  
Committee on Ways and Means  
U.S. House of Representatives  
Washington, DC 20515

**RE: Health Subcommittee Hearing on “Advancing the Next Generation of America’s Health Care Workforce”**

Dear Chairman Buchanan and Ranking Member Doggett,

On behalf of the Infectious Diseases Society of America (IDSA), we appreciate the opportunity to provide comments for the record following the Health Subcommittee’s Feb. 24, 2026, hearing on “Advancing the Next Generation of America’s Health Care Workforce.” IDSA is a community of 13,000-plus clinicians, scientists and public health experts working together to solve humanity’s smallest and greatest challenges, from tiny microbes to global outbreaks. We appreciate the Subcommittee’s attention to critical health care workforce challenges, including their severity in rural communities.

We want to highlight the severe shortage of infectious diseases (ID) physicians and the urgent need for policy solutions to strengthen this essential specialty. Some of the broader policies under discussion will not address the unique challenges facing ID, and we look forward to working with you on both broad and targeted solutions. ID recruitment levels are far below nearly all other medical specialties. **Nearly 80% of U.S. counties do not have a single ID physician, leaving large geographic areas with no local access to specialized ID care. The pipeline of new ID physicians is also inadequate: In the most recent subspecialty match, only 45% of ID training programs filled their available positions, while most other specialties filled 90%-100% of their programs.<sup>1</sup> ID physicians on average earn even less than general internal medicine physicians, despite years of additional training.**

ID workforce challenges are substantially worse when it comes to access to pediatric ID physicians. The pediatric population (those individuals under 18 years of age) make up 25% of the U.S. population and, in many areas, adult-trained ID physicians are only comfortable taking care of individuals 12 years of age and older, making it very difficult to find care for young infants and children.

**Policy solutions: Bio-Preparedness Workforce Pilot Program and protection of ID reimbursement**

To stabilize and strengthen the infectious diseases workforce, particularly in rural and underserved communities, IDSA urges Congress to pursue targeted policy interventions that directly address both workforce pipeline challenges and reimbursement barriers.

<sup>1</sup> Infectious Diseases Society of America. *State of ID: Assessing ID Workforce Shortages in the United States*. Infectious Diseases Society of America, 2024, <https://www.idsociety.org/globalassets/idsa/id-workforce/idsa-state-of-id-brief.pdf>.



First, we urge the Subcommittee to protect access to ID care by exempting nonprocedural services, such as those provided by ID physicians, from the practice expense cuts implemented in the 2026 Medicare Physician Fee Schedule. This could be achieved through standalone legislation and through language in the FY 2027 appropriations bill that directs the Centers for Medicare & Medicaid Services to exempt nonprocedural services. Without such action, the cuts will further erode already inadequate compensation for ID services, accelerate workforce attrition and undermine hospitals' ability to sustain antimicrobial stewardship, infection prevention and complex infection management programs that are foundational to patient safety and high-quality care. This approach is also supported by societies representing emergency medicine and hospital medicine.

Second, we urge members of the Subcommittee to request \$5 million for the Bio-Preparedness Workforce Pilot Program at the Health Resources and Services Administration in FY 2027. This authorized program would provide targeted loan repayment to infectious diseases and other emergency preparedness health professionals in exchange for service in health professional shortage areas, medically underserved communities or federal facilities such as Department of Veterans Affairs medical centers, community health centers and Ryan White-funded HIV clinics. By offsetting the burden of educational debt, the program would make ID careers more financially feasible and create powerful incentives for physicians to practice in communities that currently lack access to ID expertise. IDSA also encourages members of the Subcommittee to co-sponsor H.R. 4445, the Public Health and Bio-Preparedness Workforce Loan Repayment Reauthorization Act sponsored by Reps. Jason Crow, Mariannette Miller-Meeks, Lori Trahan and Brian Fitzpatrick, which would reauthorize the Bio-Preparedness Workforce Pilot Program.

Together, these policies, loan repayment through the Bio-Preparedness Workforce Pilot Program and protection of ID reimbursement, would make meaningful progress toward addressing the ID workforce crisis. They would help ensure that every community, including rural and underserved areas, can benefit from the expertise of ID physicians in preventing and treating infections, combating antimicrobial resistance, and responding to current and future public health threats.

### **Critical role of ID physicians in patient care and national security**

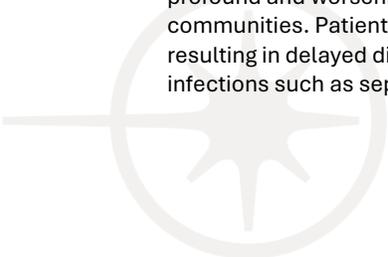
Infectious diseases physicians are essential to the safe delivery of modern health care. Nearly every type of care provided to individuals of all ages in hospitals, including organ and bone marrow transplants, cancer chemotherapy, joint replacements, cesarean sections, surgeries and the growing use of biologics, carries a risk of infection, making ID specialists a critical component of safe health care. ID care is essential in the neonatal population and those young infants with congenital heart disease and gastrointestinal abnormalities.

When patients with serious infections are managed by an infectious diseases physician, studies have shown they experience shorter hospital stays, lower mortality and lower overall health care costs, including Medicare expenditures. ID physicians lead antimicrobial stewardship programs that optimize antibiotic prescribing, reduce unnecessary drug use, prevent adverse events such as *Clostridioides difficile* infection and slow the development of antimicrobial resistance. They also direct infection prevention and control programs that reduce health care-associated infections, protect vulnerable patients and safeguard health care workers.

The role of ID health professionals extends well beyond individual patient care to core public health and national security functions. ID physicians and other ID experts are on the front lines of community preparedness and response to outbreaks, bioterror attacks and other destabilizing infectious disease events, including emerging pathogens and re-emerging threats such as measles, tuberculosis and drug-resistant organisms. Having ID experts at the local level is crucial to building trust with patients and communities. They collaborate closely with local and state health departments to conduct surveillance, investigate outbreaks and translate rapidly evolving scientific information into practical guidance for clinicians, hospitals and communities. National biodefense plans assume the availability of a robust ID workforce; without sufficient ID specialists, these plans cannot be effectively operationalized at the bedside or in the community.

### **ID workforce crisis: Rural and underserved communities bear the greatest burden**

Despite the central role of infectious diseases physicians in modern health care and preparedness, the United States faces a profound and worsening ID workforce crisis. This shortage directly and disproportionately harms rural and medically underserved communities. Patients in these areas often must travel long distances, or forgo care altogether, to access ID consultation, resulting in delayed diagnosis and treatment, prolonged hospitalizations, and worse outcomes and higher costs for serious infections such as sepsis, endocarditis (heart valve infections), osteomyelitis (bone infections) and complicated pneumonia.





Hospitals without on-site ID physicians may be unable to support advanced services, such as transplantation, complex oncology and high-risk surgical procedures, because they cannot safely manage the infectious risks associated with these interventions.

The ID workforce crisis also undermines public health capacity in rural and underserved communities. Without ID expertise, hospitals and health systems may lack robust antimicrobial stewardship programs and infection prevention and control infrastructure, contributing to higher rates of health care-associated infections and accelerating antimicrobial resistance. Communities that already experience disparities in access to primary and specialty care are thus further disadvantaged by limited access to ID physicians.

### **Financial barriers to recruiting and retaining ID physicians**

A central driver of the ID workforce shortage is the substantial financial disincentive associated with pursuing a career in infectious diseases. ID physicians are the third lowest-paid specialty, earning less on average than general internal medicine physicians despite completing an additional two to three years of specialized fellowship training. New physicians typically graduate with significant medical education debt, and many are unable to choose lower-paid cognitive specialties like ID when they can substantially improve their financial security by entering higher-paid procedural fields.

Recent changes to Medicare and Medicaid reimbursement, particularly in the practice expense component of the 2026 Medicare Physician Fee Schedule, have exacerbated these longstanding financial challenges. The revised methodology was intended to increase payments to “independent” office-based clinicians; however, it has resulted in substantial unintended reductions for facility-based ID physicians, who provide the majority of inpatient and hospital-based ID care. **IDSA analyses, consistent with data from the American Medical Association, indicate that overall ID reimbursement is reduced by approximately 6%, with facility-based ID physicians facing average cuts near 9%.<sup>2</sup>**

These cuts come on top of an already undervalued payment structure for cognitive, nonprocedural services, which rely heavily on evaluation and management codes. This will lead to reductions in critical programs that support safe, value-based care such as antimicrobial stewardship programs, infection prevention, outpatient parenteral antimicrobial therapy services and telehealth outreach to rural facilities. Furthermore, the combination of low baseline compensation and new reimbursement cuts makes infectious diseases an even less viable career path for trainees and threatens the sustainability of existing ID practices, particularly in safety-net and rural settings exacerbating the workforce challenges.

While IDSA strongly supports improving reimbursement for office-based physicians, including ID specialists and primary care physicians, this objective must not be achieved by shifting resources away from facility-based ID physicians who are essential to inpatient care, outbreak response and high-acuity services. The diversity of patient needs, including complex inpatient infections, post-acute transitions of care and outpatient management of serious infections, requires a payment system that adequately supports ID physicians across all practice settings.

### **Testimony from hearing witnesses**

IDSA appreciates the opportunity to respond to the testimony presented at the Feb. 24 hearing and to underscore how the issues highlighted by the witnesses intersect with the urgent need to strengthen the infectious diseases workforce.

Jason Shenefield, MBA, FACHE, highlighted the operational and financial pressures faced by hospitals striving to maintain access to essential services while navigating workforce shortages. These pressures are acutely felt in the context of infectious diseases care, where hospitals must support antimicrobial stewardship, infection prevention and complex inpatient consultation services, functions that are often not directly reimbursed and are further strained by recent Medicare practice expense cuts that disproportionately impact facility-based ID physicians. **We urge the Subcommittee to view protection of ID reimbursement and support for ID workforce programs as core strategies to help hospitals maintain safe, high-quality care and sustain access in rural and underserved areas.**

Thomas Mohr, DO, underscored the importance of recruiting medical students into specialties that align with community needs and ensuring that training pipelines respond to regional workforce gaps. Infectious diseases clearly fits this priority: Vast regions of the country lack ID specialists, yet students often receive limited exposure to ID role models and face substantial financial disincentives to entering the field. Federal policies that couple enhanced ID training opportunities with loan repayment for service

<sup>2</sup> Infectious Diseases Society of America. “Changes to Medicare Physician Fee Schedule Include Cut for ID.” *Infectious Diseases Society of America*, 4 Nov. 2025, [www.idsociety.org/news--publications-new/articles/2025/changes-to-medicare-physician-fee-schedule-include-cut-for-id/](https://www.idsociety.org/news--publications-new/articles/2025/changes-to-medicare-physician-fee-schedule-include-cut-for-id/).



in shortage areas, such as the **Bio-Preparedness Workforce Pilot Program**, would help align the physician pipeline with the needs of rural and underserved communities.

Jennifer Trilk, PhD, FACS, DipACLM, highlighted the value of preventive and lifestyle-oriented care and the importance of team-based approaches to improving population health. ID physicians are essential partners in these efforts, as prevention and early management of infectious diseases, appropriate vaccine use and antimicrobial stewardship are foundational to community health and to the long-term sustainability of our health care system. Ensuring that communities have access to ID experts strengthens the broader workforce's ability to prevent avoidable infections, reduce hospitalizations and protect patients with chronic conditions who are at highest risk of severe infectious complications.

Andrew Racine, MD, PhD, FAAP, spoke to the pediatric workforce and the need to preserve access to high-quality care for children. Pediatric infectious diseases expertise is critical to protecting children from vaccine-preventable diseases, emerging infections and complex conditions such as congenital infections, serious bacterial illnesses and infections associated with other complex conditions such as cancer. Yet pediatric ID faces many of the same financial and recruitment challenges as adult ID, including low reimbursement relative to training length, leading to unfilled fellowship positions and limited access in many regions. Addressing systemic reimbursement and workforce barriers for ID will directly benefit children by strengthening capacity to prevent, detect and manage serious infections in pediatric populations.

Collectively, the hearing witnesses underscored that workforce policy must be intentional, data driven and aligned with community needs. **IDSA urges the Subcommittee to ensure that infectious diseases physicians and other ID professionals are explicitly included in workforce initiatives, funding programs and payment reforms designed to advance the next generation of America's health care workforce, particularly for rural and underserved communities that currently lack access to this critical expertise. We welcome the opportunity to work with you on these critical efforts.**

#### **Conclusion**

The infectious diseases workforce is a critical national asset that supports safe, high-quality health care, protects public health and underpins U.S. preparedness and biosecurity. Yet severe workforce shortages, driven by low compensation, rising educational debt and worsening reimbursement cuts, are leaving vast regions of the country without access to ID physicians, particularly in rural and underserved communities. By funding the Bio-Preparedness Workforce Pilot Program and exempting nonprocedural services from harmful practice expense reductions, Congress can take concrete steps to strengthen the ID workforce and ensure that all Americans benefit from timely, high-quality ID care. Should you have any questions or wish to discuss these recommendations further, please contact Amanda Jezek, IDSA's senior vice president for public policy and government relations, at [ajezek@idsociety.org](mailto:ajezek@idsociety.org).

Sincerely,

A handwritten signature in black ink that reads "Ronald G. Nahass". The signature is written in a cursive, flowing style.

Ronald G. Nahass, MD, MHCM, FIDSA  
President  
Infectious Diseases Society of America

