HARRIS
IMMIGRATION LAW

Testimony of

Kristen A. Harris

Principal Attorney, Harris Immigration Law, LLC

"Is There a Doctor in the House? The Role of Immigrant Physicians in the U.S. Healthcare System"

Before the

House Committee on the Judiciary

Subcommittee on Immigration and Citizenship

February 15, 2022

Introduction

Chair Lofgren, Ranking Member McClintock, and members of the subcommittee, thank you for providing the opportunity to submit written testimony regarding the role of foreign national physicians in the U.S. healthcare system, and how our immigration system may be improved to better actualize their potential to address our nation's chronic physician workforce shortages.

My name is Kristen Harris and I am the founding attorney of the law firm Harris Immigration Law, LLC in Chicago, Illinois. My past and present professional affiliations include membership in the American Immigration Lawyers Association (AILA), the International Medical Graduate Taskforce (IMG Taskforce), and the American Health Lawyers Association (AHLA). I have served in leadership roles with these organizations, including as a member of the AILA Board of Governors and AILA Chicago Chapter Chair, as Immigration Affinity Group

Chair of AHLA, and as Advocacy Chair/Co-Chair of the IMG Taskforce from 2007 to 2017. As an attorney and a graduate of the University of Michigan Law School, I have practiced immigration and citizenship law for more than seventeen years. I have represented hundreds of hospitals, healthcare systems, physician practice groups, clinics and foreign national physicians seeking to navigate the difficult maze of the U.S. immigration system. My firm provides counsel to the American Medical Association, the Association of American Medical Colleges, and the Educational Commission for Foreign Medical Graduates on occasion with regard to physician immigration issues. However, the opinions I am expressing today are my own, and derive from my years of physician immigration practice as well as participation in physician immigration reform efforts.[*]

Throughout my years of working with U.S.-trained foreign national physicians and U.S.-based medical institutions, it has become readily apparent that our U.S. immigration system is suboptimal at best in its ability to attract and retain the most talented physicians in the world to treat and care for Americans. Some of the current inefficiencies in U.S. physician immigration are vestiges of a prior era, in the mid-1990s, when there were concerns among stakeholders about a physician surplus. This has been followed by decades of well-chronicled and chronic physician shortages in our nation, yet the outdated laws remain on the books, encoded in statute as well as regulations and administrative practice. As my testimony will reveal, the existing pathways for foreign national physicians who have been trained in the United States are limited, complicated and largely not designed to retain qualified physicians. There are important legislative reforms that have been introduced or can be proposed to rectify this problem, coupled

with administration actions to bet taken, to help ensure that our health care system is better equipped to meet the needs of all Americans.

<u>Retaining U.S.-trained Foreign National Physicians in the United States</u>

Given the chronic and increasing physician shortages experienced by our nation, which have been further exacerbated by the COVID pandemic, our country would benefit greatly from Congress improving our immigration laws to more readily retain physicians who have already completed their Graduate Medical Education (GME) training in the United States. Retaining these physicians in the United States post-GME would help ameliorate the ongoing, national physician shortage. In addition, U.S.-trained foreign national physicians already play a unique role in addressing chronic shortages within medically underserved areas and populations, often in connection with healthcare shortage-driven legislation and programs. If we expand those programs and increase the benefits for foreign national physicians to participate in such programs, we could further leverage the skills and expertise that these talented doctors provide to our nation.

Foreign National Physicians and Graduate Medical Education

Prior to beginning a U.S. GME program and even prior to participating in the National Residency Match Program (NRMP), the competitive GME placement program called "the Match," to enter such a program, all foreign national physicians must first be vetted as to formal education and clinical skills by the Educational Commission for Foreign Medical Graduates (ECFMG). Foreign national physicians who succeed in matching with a GME program generally obtain a temporary nonimmigrant visa (NIV) to enter the United States and carry out

the program.[1] Foreign nationals pursue their GME programs in the United States primarily in one of two different temporary, nonimmigrant visa statuses – J-1 or H-1B. Foreign national physicians' ability and options to remain in the United States post-GME are determined, in part, by whether they have carried out their training in J-1 or H-1B status.

Physicians Completing GME in J-1 Status; Challenges to Remaining in the U.S. Post-GME

The overwhelming majority of foreign national physicians carrying out GME in the U.S. do so in J-1 status.[2] J-1 physicians are "exchange visitors" sponsored by ECFMG[3] to participate in approved, accredited GME training programs throughout the United States.[4] The J-1 option is less costly for host GME programs than is H-1B sponsorship. Additionally, the J-1 program involves the efficiencies of ECFMG and its timely issuance of a DS-2019 between the Match in March and consular appointment prior to commencement of the Post Graduate Year (PGY) on July 1, as compared with the difficulty of attaining of an H-1B petition approval from U.S. Citizenship and Immigration Services (USCIS) in the same time frame.

All J-1 physicians carrying out GME in the United States are subject to a two-year "return requirement," requiring that they return to their home country with their newly acquired training if they wish to change to certain types of nonimmigrant status (e.g., H-1B) or seek lawful permanent residence, or "green card" status.[5] Such physicians must either fulfill or obtain

---

[1] The number of foreign national physicians who carry out GME pursuant to work authorization based on a status other than a nonimmigrant visa, such as recipients of Deferred Action for Childhood Arrivals (DACA) or those holding temporary protected status (TPS), are not statistically significant as relative to nonimmigrant visa holders. *See*, AMA-IMG Section Governing Council, International Medical Graduates in American Medicine: Contemporary challenges and opportunities (2010), tbl.13.
[2] Immigration and Nationality Act (INA) § 101(a)(15)(J), 8 U.S.C. § 1101(a)(15)(J). *See also* 8 C.F.R. § 214.2(j), 22 C.F.R. §§ 62.
[3] 22 C.F.R. § 62.27(b).
[4] There are a number of different categories of J-1 exchange visitors depending on the purpose or type of exchange. Most of the categories, including J-1 clinical physicians, are detailed in the federal regulations governing J-1 visas. *See* 22 C.F.R. §§ 62.20-62.32.
[5] INA § 212(e), 8 U.S.C. § 1182(e).

a waiver of this return requirement if they wish to remain in the U.S. in the common H-1B status after they complete their GME programs.[6]

Unlike other J-1 programs, nonimmigrants completing GME in J-1 status cannot have the home country return requirement waived based solely on a statement of no objection by their home country.[7] Instead, they must either obtain a waiver a) based on persecution of the J-1 principal or exceptional hardship to a qualifying family member[8] or b) through a service-based waiver sponsored by an Interested Government Agency.[9] Service-based options include a 3-year commitment to work at a Veterans Affairs facility or in an U.S. Department of Health and Human Services ("HHS")-designated shortage area by recommendation by a State Department of Health through the Conrad State 30 J Waiver Program. Options also include J waivers sponsored by any Interested Federal Agency.[10] Current federal agencies that sponsor such waivers include the Appalachian Regional Commission ("ARC"), the Delta Regional Authority ("DRA"), and HHS. Past participating agencies have included the U.S. Department of Housing and Urban Development (HUD) and the U.S. Department of Agriculture (USDA). If the physician does not complete the 3-year service requirement, then the physician becomes subject to 2-year return requirement once again.[11]

Nearly half of all new J-1 physicians are from either Canada, India, or Pakistan as the country of nationality or last residence, none of which have marked country conditions that

---

[6] There are other visa types, such as the O-1 visa for individuals with extraordinary ability or achievement, for which physicians are eligible prior to fulfillment or waiver of the 2-year return requirement. However, these are uncommon as relative to the H-1B visa as a basis of post-GME employment for physicians.
[7] INA § 212(e), 8 U.S.C. § 1182(e).
[8] 8 C.F.R. § 212.7(c)(5).
[9] INA § 214(l); 8 U.S.C. § 1184(l). Note: J waivers to pursue research rather than clinical service are also an option. However, given the relatively low usage of research waivers, this waiver type is not included within the discussion of other, service-based waivers provided for at Section 214(l).
[10] *Id.*
[11] INA § 214(l)(2)(B); 8 U.S.C. § 1184(l)(2)(B).

generally lend themselves to successful persecution or hardship waivers.[12] Instead, most J-1 physicians who seek to remain in the United States do so through a service-based waiver. The current options could be readily expanded and improved to facilitate retaining these physicians and leveraging their talents to address chronic healthcare worker shortages within the United States. The most popular service-based J waiver program has been the Conrad State 30 Program, so-named because each state is permitted to recommend up to 30 physician waivers per fiscal year. The more populous states, such as Texas, Florida, Massachusetts, California, and Illinois consistently receive more than 30 applications for these 30 slots, and this trend has grown. For Fiscal Year 2021, by April 2020, more than 27 states had already filled their slots or "maxed out" their program, with an additional 12 states having only a few waiver spots available, with 5 months remaining in the fiscal year.[13] Meanwhile, pursuant to most state department of health guidelines, physicians must attest throughout the process that they are not simultaneously pursuing a J waiver through an alternate or back-up path. The physicians who are not selected in a "maxed out" state must scramble to find another alternative before completing their final PGY in the U.S.

This demonstrates that despite our physician shortage, there are US GME-trained physicians available to work in shortage areas who are thwarted in efforts to remain due to limitations imposed by our immigration laws. Physicians who have played by the rules and timely filed their J waiver applications are nonetheless unable to stay and serve the medically underserved in the United States. I have witnessed this in my own practice as well as being

---

[12] ECFMG J-1 Visa Sponsorship: Top 10 Nations of Origin for Exchange Visitor Physicians 2020 Calendar Year, EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES, https://www.ecfmg.org/images/EVSP-Data_Countries_3.17.21.png (data current as of Jan. 13, 2021). *See* INA § 212(e), 8 U.S.C. § 1182(e) for criteria for persecution and hardship waivers.

[13] Letter from International Medical Graduate (IMG) Taskforce, to Jessica Stewart, Director, Agency Coordination, HHS, et. al. (Apr. 7, 2020), at p. 1 submitted as part of the record of this hearing.

aware of this happening repeatedly based on reports from physician immigration bar colleagues. For instance, my firm represents an independent, safety-net hospital; the hospital treats patients in one of the poorest cities in Massachusetts where more than two-thirds of the patients are covered through charity care, Medicaid, Medicare, or other government-based payments. The hospital opted to sponsor a primary care physician from India who was training in the U.S. in J-1 status for one of the Conrad State 30 J waivers available for Massachusetts. The hospital and physician timely filed the J waiver application while the physician was still in his final year of GME. However, more than 30 physicians applied for the 30 Massachusetts slots, and the physician – although entirely eligible for a waiver -- was simply not among the fortunate 30 to be recommended by the state department of health. When the results of the review process were announced by the state department of health, most other populous state programs had long since closed their application window, and there was not another viable geographic option for the physician and his family.[14] The physician opted to leave the U.S. to practice in Canada with the intention of settling down there rather than returning to the U.S. By way of comparison, other physicians who were granted Conrad J waivers sponsored by the same, safety-net hospital have consistently fulfilled their 3 years of service, most have remained after the 3 years, and, in one case, a Conrad J waiver physician became a part of the medical leadership team for the hospital. These U.S.-trained physicians are not ones we want to lose.

Another situation that exists is when J waiver physician candidates find their prospective employers after the very short windows of opportunity of Conrad 30 programs have closed for the fiscal year and thus are required to depart the U.S. after finishing their GME. For instance, I

[14] In many states, the Conrad program is filled on the first day of application in states that are first-come, first-served, or in the first "window" of application. In first-come, first-served states, the demand can be so high that hospitals have engaged professional line-sitters to stand in line outside the state department of health, to be in line overnight for a better place in line when the state department of health's doors open for the morning.

represent nephrology practices, a subspecialty of internal medicine focused on the diagnosis and treatment of diseases of the kidney, who would readily sponsor J waiver physicians and would otherwise be eligible but for the Conrad 30 cycle timing and demand for slots, given that the programs fill up in the fall and max out almost immediately. Additionally, nephrologist candidates are not eligible for the HHS clinical J waiver, given that they will necessarily complete a subspecialty fellowship prior to treating patients, and thus do not qualify as "primary care" physicians.[15] These doctors often have an ambit that stretches throughout wide swaths of a given state, including rural areas as well as poor inner-city neighborhoods, and safety-net hospitals as well as dialysis clinics. Based on an informal survey of a representative client's physician performance numbers, if such foreign national physicians are permitted to remain within the U.S. at the end of their GME training, any one such physician could treat over 220 unique patients per month, including hospital visits, between and among 13 different cities and townships, distributed over 5 counties, including rural areas that are so remote that the U.S. Department of Labor (DOL) does not have statistically sufficient numbers to publish a prevailing wage. The impact on patients and our healthcare system as a whole that results from not retaining even one such physician is significant, particularly for geographically diffuse, rural patient populations.

Legislative Proposals and Proposed Administrative Actions
to Facilitate GME to Post-GME Transition for J-1 Physicians

It is imperative that Congress improve the immigration system so that the United States can better retain U.S.-trained foreign physicians. One simple means of increasing the number of J-1 physicians remaining in the United States is to make changes to the Conrad 30 provisions of

[15] *See* 45 C.F.R. § 50.5(b).

the Immigration and Nationality Act (INA).[16] One recommended structural change would be to amend the current statute to permit the 30 slot-per-state limit to rise and fall as a function of demand on an individualized, state-by-state basis rather than remaining as a hard-and-fast ceiling that was last raised nearly 20 years ago, in 2002.[17] The Conrad State 30 and Physician Access Reauthorization Act (H.R. 3541) (hereinafter, the "Conrad Reauthorization Bill"), which was introduced in the House in May 2021, contains such provisions.[18] Passage of the Conrad Reauthorization Bill will bring important relief to underserved populations and J-1 physicians alike. Another legislative improvement would be to permit qualifying physicians who timely but unsuccessfully applied to a State Conrad 30 to extend their status to remain in the United States to re-apply for such service in the next fiscal year. This is a much needed legislative fix provided for in the Conrad Reauthorization Bill.[19] Another means of increasing the overall number of Conrad physicians would be to restore a Conrad 30 "slot" to an issuing state in instances when a physician relocates to another state in cases of extenuating circumstances, also provided for in the Conrad Reauthorization Bill.[20] Finally, another means of adjusting the numbers upward based on need would be the inclusion of J waivers sponsored by Academic Medical Centers, to exceed the 30 slots by up to three additional slots per state, in the event a given state has "maxed out" its default 30 slots. This is also provided for in the Conrad Reauthorization Bill.[21]

Similarly, expansion of the HHS clinical J waiver program would also help better retain U.S.-trained J physicians. At present, the program is efficiently run and has no statutory annual

---

[16] *See* INA § 214(l); 8 U.S.C. § 1184(l).
[17] *See* 21st Century Department of Justice Appropriations Authorization Act § 11018(a), Pub. L. No. 107-273 (2002).
[18] *See* Conrad State 30 and Physician Access Reauthorization Act (H.R. 3541), § 5(a) [hereinafter Conrad Bill].
[19] Conrad Bill, *supra* note 18, § 4(d).
[20] Conrad Bill, *supra* note 18, § 4(f).
[21] Conrad Bill, *supra* note 18, § 5(b).

limit or "cap," like the Conrad 30 program. Physicians and their employers need not be victims of fate or be subject to unknown demand levels prior to applying, which makes the HHS clinical J waiver program a very attractive option. However, the current program limits eligibility to facilities located in health professional shortage areas (HPSAs) that have scores of 7 or higher. In contrast, the authorizing regulations are much broader, and would permit primary care physicians to carry out their service in any "primary care Health Professional Shortage Area (HPSA) or Medically Underserved Area or Population (MUA/P)," and psychiatrists to work in any Mental Health HPSA, with no specification as to a minimum score.[22] These are all areas that HHS itself has already designated as shortage areas. Accordingly, as a matter of policy, HHS should expand its clinical J waiver program to the fullest extent of the current regulations.

Further, the program could readily be expanded beyond the current primary care limitations, so long as the healthcare service would be rendered in an HHS-designated shortage area, just as is the case with the Conrad 30 J waiver program. At present, even subspecialists meeting a critical need in underserved communities, such as nephrologists, cannot apply for a J waiver through the HHS program. Because HHS is eligible under the statute to recommend J waivers as an Interested Federal Agency, the agency should expand its program by promulgating new regulations that better reflects the broad nature of the statute. There are no restrictions in the statute that require Interested Federal Agencies to limit their programs to primary care physicians.[23]

Physicians Completing GME in H-1B Status; Challenges to Remaining in the U.S. Post-GME

Some foreign national physicians carry out their U.S. GME in H-1B status, which

[22] 45 C.F.R. § 50.5(c).
[23] *See* INA § 214(l)(1)(C)-(D), 8 U.S.C. § 1184(l)(1)(C)-(D)

presents its own immigration challenges.[24] First, most post-GME employment is subject to what is known as the "H-1B cap," the annual limit on first-time H-1B petitions.[25] Second, these physicians will generally have already expended a minimum of three years of the overall six-year limit in H-1B status by the time they complete even the most basic, primary care residency program.[26] The H-1B program as it exists requires improvements if we wish to retain U.S.-trained foreign physicians in this category.

Managing the H-1B Cap: Transitioning from Cap-Exempt to Cap-Subject H-1B Status

Virtually all physicians pursuing GME training in H-1B status do so at institutions exempt from the annual H-1B cap, such as an institution of higher education or a related or affiliated non-profit.[27] However, when they seek post-GME employment, many H-1B physicians will be subject to the annual H-1B cap because their new employer is not an institution of higher education or a related or affiliated non-profit or a nonprofit or governmental research organization.[28] In immigration terms, such physicians have not been "counted against" the H-1B cap during the course of their GME training. All H-1B petitions filed for individuals who have not previously been counted against the H-1B cap and who will be employed by cap-subject employers will be subjected to the H-1B lottery in the hopes of being randomly selected for an H-1B cap number. If they are not selected, then their ability to stay in the United States and practice medicine becomes severely limited.

[24] 8 C.F.R. § 214.2(h).
[25] The regular H-1B cap is comprised of 65,000 first-time H-1B visas for applicants who hold at least a bachelor's degree or its equivalent. An additional 20,000 H-1B visas are made available each fiscal year for individuals holding a master's degree (or higher) awarded by an accredited college or university in the United States (commonly known as the "U.S. Master's cap").
[26] 8 C.F.R. § 214.2(h)(13)(iii); 8 C.F.R. § 214.2(h)(15)(ii)(B)(1).
[27] INA § 214(g)(5)(A)-(B), 8 U.S.C. § 1184(g)(5)(A)-(B). USCIS has held that U.S. GME does not constitute a qualifying degree, and accordingly a physician is not eligible to participate in the lottery for the 20,000 visas of the "Master's mini-cap" solely as a result of GME training.
[28] INA § 214(g)(5), 8 U.S.C. § 1184(g)(5).

The distinction between whether post-GME employment can be "H-1B cap-exempt" or whether it must be H-1B "cap-subject" is critical. In each of the past several years, the forthcoming fiscal year's supply of cap-subject H-1B visas have been exhausted in the first window of opportunity preceding the start of such fiscal year. USCIS subjects all H-1B cap registrations to a random "lottery" system. Only registrations randomly selected in this lottery will be considered and adjudicated by USCIS; the remainder are summarily "rejected," without any adjudication on the merits. Last year, 308,613 registrations were received in March 2021 for the 85,000 H-1B visas available for Fiscal Year 2022.[29] Forty-eight percent (48%) of those registrations were "U.S. Master's Cap" registrations,[30] which have an inherently greater chance of selection, as they are permitted two "bites at the apple," given that their registrations participate first in the initial, general lottery for the first 65,000 visas and, if not selected, then also in the second, limited lottery for the 20,000 U.S. Masters' Cap visas.

Unfortunately, most H-1B physician candidates do not qualify for consideration under the "U.S. Master's Cap", as they routinely have obtained their medical degree from abroad and because, as currently defined in the statute, completion of GME does not qualify as a "degree."[31] As a result, nearly all foreign national physicians are on equal footing with H-1B candidates who hold just a Bachelor's degree (or the equivalent of a Bachelor's degree based on a combination of education and experience). This subjects GME physicians to a game of chance in which their odds of selection are at the lowest of all lottery participant types. If the physician's registration is not selected in the cap, then he or she will have no means to obtain an H-1B visa to continue to

---

[29] *H-1B Electronic Registration Process*, U.S. CITIZENSHIP & IMMIGRATION SERV., https://www.uscis.gov/working-in-the-united-states/temporary-workers/h-1b-specialty-occupations-and-fashion-models/h-1b-electronic-registration-process (last updated Nov. 19, 2021).
[30] *Id.*
[31] *See* INA § 214(g)(5)(c); 8 U.S.C. § 1184(g)(5)(C); 8 C.F.R. § 214.2.

work in the United States for the vast majority of healthcare sector facilities.[32]

In addition to lottery concerns, there are timing issues specific to H-1B cap petitions. Given how the law is structured, cap-subject H-1B registrations, filed in March each year, cannot request a start date prior to October 1 of the same calendar year, regardless of when the H-1B petition is approved.[33] This means that even if a physician's petition is selected in the registration process, the physician will be unable to provide patient care from end of the postgraduate year (PGY) on June 30th of a given year until work authorization is approved for the physician, at the earliest on October 1 of the same year. The loss of work authorization for the interim three months, in terms of the inability to provide patient care, particularly during a pandemic, is not negligible. Additionally, given visa backlogs at U.S. Consulates and inherent risks involved with consular processing, which have been compounded by the COVID pandemic,[34] a qualified physician can be delayed outside the U.S. who finds himself or herself in this "cap gap" situation between the end of the PGY and the start of the fiscal year.

As an additional complication, H-1B physicians seeking post-GME employment must typically have full licensure to practice in the state of service at the time the H-1B petition is adjudicated.[35] Given certain state licensure restrictions, some physicians may not be able to attain the full licensure required by an H-1B petition until after the window has closed in March

[32] The sole employment opportunities H-1B trainee physicians can pursue in the U.S. in post-GME H-1B employment where they have not won the lottery are at an "institution of higher education," a non-profit entity that is sufficiently affiliated with or related to an institution of higher education, or a qualifying research organization. *See* INA § 214(g)(5)(A)-(B); 8 U.S.C. § 1184(g)(5)(A)-(B).

[33] October 1 is the first day of the fiscal year, and hence the first effective date available. H-1B petitions may not be filed more than six months prior to the first effective date. As a result, April 1 or the first federal government business day thereafter becomes the first date of filing for a first-time cap-subject H-1B petition. *See* 8 C.F.R. § 214.2(h)(8)(iii)(A)(4).

[34] *See* American Immigration Lawyers Association, *Reopening America - How DOS Can Reduce Delays and Eliminate Backlogs and Inefficiencies to Create a Welcoming America*, June 29, 2021, available at https://www.aila.org/DOSreopening

[35] INA § 214(i)(2)(A), 8 U.S.C. § 1184(i)(2)(A); 8 C.F.R. § 214.2(h)(4)(viii).

to register for the H-1B cap. While the physician need not be eligible at the time of H-1B registration, he or she must be eligible prior to the 90-day deadline that adheres upon selection of the registration. This may not always be attained in time, depending on which "tranche" the registration is selected in[36] and the timing of the given state's licensing board.

Institutions of higher education, teaching hospitals, and other nonprofit institutions "related to or affiliated with" institutions of higher education are exempt from the cap,[37] but often encounter difficulty in convincing USCIS of such exemption. They also experience marked inconsistency in adjudications from one petition to the next filed by the same qualifying employer. Similarly, physician groups and other for-profit employers, called "third party petitioners," may file an H-1B petition exempt from the cap if the physician is to be "employed at" a cap-exempt institution.[38] These petition types have also encountered inconsistent adjudication, which could be rectified with legislative improvements, so as to better reassure physicians and their cap-exempt-eligible employers. For example, one means of standardizing adjudications for teaching hospitals would be to categorically exempt from the H-1B cap employment of a physician at any facility which hosts an ACGME-accredited residency or fellowship program.

Managing the Six-year Limit in H-1B Status

Typically, an H-1B nonimmigrant has available a total of only six years of H-1B status before he or she must depart the U.S. for at least one year.[39] Accordingly, physicians who

---

[36] USCIS conducts an initial selection of H-1B registrations and notifies selected registrants that their registration has been selected to file an H-1B cap petition. If additional H-1B visa numbers remain available after the initial selection is conducted, USCIS can conduct subsequent selections among the registrations submitted for the fiscal year.
[37] INA § 214(g)(5), 8 U.S.C. § 1184(g)(5).
[38] *Id.*
[39] INA § 214(g)(7), 8 U.S.C. § 1184(g)(7); 8 C.F.R. § 214.2(h)(13)(i).

complete a traditional, three-year base residency program in the U.S. in H-1B status will usually have only three of their six years remaining when they enter the U.S. workforce as a fully trained physician. H-1B physicians who proceed to a chief residency position and/or fellowship in U.S. GME will have exhausted four or more years of H-1B status, and subspecialist physicians can readily exhaust their 6 years of H-1B status within GME alone.

A physician's six-year limit of H-1B status may be lifted, and H-1B status may be extended in 1 or 3 year increments, but only if a qualifying employment-based application in connection with the pursuit of lawful permanent residence, (i.e., a "labor certification application" or an "I-140 immigrant petition") is submitted to the government before the end of the physician's fifth year of H-1B status.[40] If the "labor certification" path is the only qualifying application available to initiate a green card case, then significant lead time is required before the end of the physician's fifth year of H-1B status, as the DOL imposes recruitment and other pre-filing requirements that can often involve seven months or more before the labor certification can be filed. The DOL has clarified that residency and fellowship positions cannot qualify for labor certification or an immigrant petition, on the basis that these positions do not involve a "permanent" offer of employment.[41]

Legislative Proposals to Facilitate GME to Post-GME Transition for H-1B Physicians

There are several ways to ease the path for U.S.-trained H-1B physicians to remain in the U.S. that would simultaneously address chronic, specific shortages, such as rural, medically

[40] American Competitiveness in the Twenty-First Century Act of 2000 (AC21), Pub. L. No. 106-313 § 106(a).
[41] *See Matters of Albert Einstein Med. Ctr. & Abington Mem'l Hosp.* (BALCA *en banc,* Nov. 21, 2011), *available at* https://www.aila.org/infonet/balca-matter-of-einstein-and-abington-11-21-11.

.

underserved areas, as well as the nationwide physician workforce shortage more generally. First, the statute could be amended to provide H-1B cap exemption for physicians at the same facilities that are now eligible for service-based J waivers, based on a qualifying offer of employment at a VA facility or at facilities located in an HHS-designated shortage area. Because work authorization in the H-1B category is always employer-specific, if the physician resigned or was terminated from such employment, the H cap exemption pursuant to that service-based employment would cease on the date of employment.[42] Second, the statute could be amended to expand the U.S. Master's Cap to include ECFMG-certified medical degrees and/or completed U.S. GME programs as qualifying bases for eligibility.[43] Third, the statute could provide for "cap gap" relief akin to that permitted at present for students whose work authorization expires before October 1 and whose employers have filed an H-1B petition before October 1.[44] Expanding this relief to physicians the year that they complete their U.S. GME would eliminate disruption in work authorization and allow these foreign national physicians to change status in the United States, without having to depart the United States to get a new visa after their final PGY concludes on June 30th before re-entering the U.S. to start their first, cap-subject GME employment on or after October 1. This would avoid delays and uncertainty related to the consular process, which have become unprecedented during the COVID era because of continued consular backlogs and limited consular operations. An uncertain date of return for a physician candidate wreaks havoc with safety-net employers and small physician practices who are counting on scheduling every day of on-staff physician care as compared with costly locum tenens staffing. Cap gap work-authorization for U.S.-trained physicians would add a quarter of a

---

[42] *See* 8 C.F.R. § 214.2(h)(8)(ii)(F)(6)(ii) (providing for cessation of cap exemption upon termination of concurrent, cap-exempt employment).
[43] This would require amending INA § 214(g)(5)(C), 8 U.S.C. § 1184(g)(5)(C).
[44] As a point of comparison, *see* 8 C.F.R. §214.2(f)(5)(vi)(A)(providing for "cap gap" in F-1 category).

year of or more of physician coverage in what would otherwise be unproductive time until the fiscal year began on October 1.

Statutory amendments could also be made to address the 6-year "clock" issues encountered by physicians training in H-1B status. The statute could be amended to toll the remainder of the 6-year clock during a physician's subspecialty fellowship training. A physician demonstrating acceptance to an ACGME-accredited fellowship program or an ACGME-recognized nonstandard training program and H-1B qualifying employment in connection with such training would thus be able to specialize without incurring additional time against 6-year limitation on the initial stay H-1B status. The "clock" would resume on day 1 for the first post-GME employment within the United States.

Post-GME to Permanent Stay – Improving and Expanding Physician Paths to the Green Card[45]

To help address our nation's ongoing physician workforce shortage, we must improve the ability for U.S.-trained physicians to remain in the United States permanently. In immigration terms, this means expanding and improving their paths from nonimmigrant visa status to lawful permanent resident, or "green card," status.

At present, physicians pursuing an employment-based green card must do so through the preference system, which is subject to annual numerical limitations and per-country limits based upon country of birth and category of occupation. Most physicians pursue their green card in the employment-based second preference advanced degree category, also called the "EB-2

[45] The discussion of helpful legislative actions in this testimony is not intended to be exhaustive. For instance, the Healthcare Workforce Resilience Act (H.R. 2255), which was introduced in the House in March 2021, and which would provide physicians with recaptured immigrant visa numbers, would also assist in retaining U.S.-trained foreign national physicians.

category."[46] The ability for a physician to file the final step in the green card process for this category in any given month is determined by visa availability, announced by the U.S. Department of State in its monthly Visa Bulletin. Whereas for most months of most years the EB-2 category is "current" for doctors born outside of India or China, there are substantial waits for physicians born in either India or China. By significant measure, most of the physicians in the United States born abroad are from India, comprising over one-fifth of the total foreign-born physician community, with Chinese-born physicians making up slightly over 5% as the second most common foreign country of birth.[47] For instance, projecting forward future wait times based upon this month's Visa Bulletin, physicians born in India who are pursuing a green card in the EB-2 category would need to wait approximately nine years from the time of filing either the first of a labor certification application or an immigration petition until being able to file an adjustment of status application within the U.S.[48] Physicians born in China would need to wait approximately three years between the initial qualifying filing and being able to file the final step in the green card process.[49] As they wait to become lawful permanent residents, they lose agency over their own careers and may have children who will age out of the process to becoming lawful permanent residents and potentially fall out of lawful derivative status as they age.

One way to facilitate foreign national physicians obtaining lawful permanent resident

---

[46] *See* INA §203(b)(2); 8 U.S.C. §1153(b)(2). Some physicians pursue a green card in the EB-1 category, either on the basis of Extraordinary Ability or Outstanding Professor/Researcher, pursuant to section 203(b)(1)(A) and 203(b)(1)(B), respectively. However, these physicians are in the minority and the immigrant petitions in these categories are subject to markedly inconsistent adjudications by USCIS, as relative to other employment-based paths for physicians.
[47] *Which Countries Do Immigrant Healthcare Workers Come From?*, NEW AMERICAN ECONOMY RESEARCH FUND (Apr. 4, 2020), https://research.newamericaneconomy.org/report/immigrant-healthcare-workers-countries-of-birth/.
[48] *See* Visa Bulletin for February 2022,U.S. DEP'T OF STATE,https://travel.state.gov/content/travel/en/legal/visa-law0/visa-bulletin/2022/visa-bulletin-for-february-2022.html(including the priority date of January 1, 2013 for the EB-2 India "Final Action Dates" Chart and the priority date of September 1, 2013 for EB-2 India within the "Dates for Filing" Chart).
[49] *See id*. (including the priority date of March 1, 2019, for the EB-2 China "Final Action Dates" Chart and the priority date of April 1, 2019 for the EB-2 China within "Dates for Filing" Chart).

status is to exempt them from the per-country limits of the employment-based preference system entirely, which would reduce the nine-year wait and three-year wait mentioned above to zero for physicians born in India and China, respectively. This would permit such physicians to file for the final step and adjust to green card status immediately upon proving their eligibility and admissibility, as is the case for immediate relatives of U.S. citizens.[50] The "America Creating Opportunities for Manufacturing, Pre-Eminence in Technology, and Economic Strength Act of 2022''(H.R. 4521) recently passed by the House of Representatives would so amend the statute. Per section 80303 of the Act, a foreign national holding a "doctoral degree" in a qualifying program of study, including "medical residency and fellowship programs," with a pending or approved immigrant petition in the EB-1 or EB-2 category would be eligible to file the final step in a green card case pursuant to such petition, without being subject to visa retrogression or backlog from per-country limits.[51]

Alternatively, rather than exempting all physicians from the per-country quota, the statute could be amended to permit only a subset of physicians to adjust outside of the preference system, so as to increase the immigration benefits of practicing in a medically underserved area. For instance, the statute could be amended so that Physician National Interest Waiver (PNIW) physicians could adjust to green card status outside of the per-country limits; the PNIW category requires physicians to commit to and fulfill an aggregated five years of full-time service in an HHS-designated shortage area.[52] At present, the immigrant visas obtained through the PNIW path exclusively reside within the EB-2 category. As noted above, given longstanding visa

---

[50] *See* INA §201(b)(2)(A)(i); 8 U.S.C. §1151(b)(2)(A)(i).

[51] Note that whereas "doctoral degree" is not defined within the bill or elsewhere in the INA and does not track with more the traditional phrase of "advanced degree" within the INA to refer to medical degrees, it would appear the intention of the drafters to include medical degrees within the meaning of "doctoral degree," as otherwise the reference to medical residency and fellowship programs in the program of study definition would be rendered meaningless. It is anticipated this would be effectuated as part of the technical corrections process.

[52] *See* INA §203(b)(2)(B)(ii); 8 U.S.C. §1153(b)(2)(B)(ii).

retrogression, physicians born in India or China at present have years of waiting in line in the EB-2 category before being able to "adjust" to green card status. Additionally, because this path remains exclusively in the EB-2 preference category under current statute, the applicants do not have the flexibility to file their green card applications in another EB category for which they may be eligible and that has better visa availability.

For instance, in October 2020, when the wait for an EB-3 immigrant visa was much better than for an EB-2 immigrant visa due to less demand for EB-3 visas, doctors who had a labor certification-based, or PERM-based, green card case had greater flexibility than PNIW physicians who had completed five years of service in a medically underserved community. Further, because the PNIW option resides only at the EB-2 category rather than in the EB-1 or EB-3 category, physicians whose work has been proven to be in the national interest may have to wait longer to become a lawful permanent resident than their colleagues practicing outside of underserved areas or, for that matter, lesser skilled professionals whose work may not be in the national interest. Additionally, unlike the Conrad program, which includes "FLEX spots," for physicians treating medically underserved patients and populations at locations that do not otherwise qualify, the PNIW program does not at present have this flexibility. As such, there is not the incentive for FLEX J waiver physicians to remain in their communities for an additional two years under this option.

In order to expand the utility of the PNIW to address chronic physician workforce shortages, it would be most effective to permit participating physicians to apply for their green card status outside of the numerical and per-country limits on immigrant visas. This would be a significant benefit for physicians born in India and China, the top two countries of birth, as noted

above. The Conrad Reauthorization Bill provides for this.[53] Another way to improve the public healthcare benefits of the PNIW program would be to expand the qualifying service to include treatment of underserved populations at facilities that are not located within a HHS-designated shortage area, also as provided for in the Conrad Reauthorization Bill.[54] This would permit continuity of care for the patient populations served by Conrad J waiver physicians carrying out their 3-year service commitment in what are known as "FLEX slots."

Another way to improve green card access for physicians would be to remove the public recruitment and labor test requirement that currently pertains to the vast majority of employment-based physician green card cases. Most employment-based physician cases are pursued through the labor certification path, also called "PERM." The PERM path requires the sponsoring employer to test the U.S. labor market to establish that there are no able, willing, qualified, and available U.S. workers for the offered green card position.[55] The required recruitment for physicians includes two Sunday print newspapers, a 30-day job order with a State Workforce Agency, and advertising in three additional outlets, over a minimum 60-day period of recruitment.[56] This path can be financially burdensome to employers, particularly safety-net hospitals or independent physician practices operating with narrow margins, as the employer is required to pay not only for the attorney fees involved in the process but also for the costly advertisements required by the DOL, including print ads.[57]

In contrast, DOL has pre-certified certain occupations, such as registered nurses and physical therapists, known as "Schedule A occupations," where the agency has determined there

[53] Conrad Bill, *supra* note 18, §3.
[54] Conrad Bill, *supra* note 18, §6(b).
[55] *See* INA §§ 212(a)(5)(A), 8 U.S.C. §§1182(a)(5)(A); 20 C.F.R. pt. 656.
[56] *See* 20 C.F.R.§§656.17(e)-(f).
[57] 20 C.F.R.§§656.12(b).

are not sufficient U.S. workers who are able, willing, qualified, and available for the occupations.[58] Given the well-established physician shortage, DOL has a reasonable basis to add physicians to the list of such occupations. This would have the effect of enabling physicians and their employers to concurrently file the labor certification application and the immigration petition directly with USCIS, without undergoing the recruitment and labor certification process in the DOL program first. Alternatively, DOL could limit the pre-certification to those offered physician positions located in HHS-designated shortage areas.

Either one of these modes of pre-certification would be a welcome relief, as well as being legally permissible and common-sense action. Requiring employers to perform a labor market test for physicians in the midst of a well-documented, decades-long national physician shortage is unnecessary. As noted above, employers can incur significant financial costs in connection with the current labor certification process. Additionally, there are lengthy processing delays at DOL related to the labor certification application processing, and labor certification application processing times have sometimes reached up to ten to twenty months, including audit time. Avoiding these delays by permitting direct application to USCIS through Schedule A designation would better help our country retain foreign national physicians by providing them with means to adjust to lawful permanent resident status, or "green card," status more quickly.

These legislative and administrative solutions will not only address our current physician shortage, which has reached crisis levels due to the COVID pandemic, but will also send an important message to foreign national physicians that their services are essential to all Americans. By reducing delays in the green card process and removing unnecessary obstacles, U.S.-trained physicians will be less likely to take their skills to other countries either because

---

[58] *See* 20 C.F.R. §656.5.

better opportunities are available elsewhere or in order to keep their own families together.

Benefits to U.S. Healthcare System of Retaining U.S.-trained Foreign National Physicians

Retaining U.S.-trained foreign physicians is one of the best ways to ameliorate the ongoing general national physician workforce shortage. Foreign national physicians fulfill a uniquely beneficial role in the U.S. healthcare landscape. Workforce analysts have found these physicians to be more likely to provide primary care, more likely to work at Critical Access Hospitals, more likely to accept new Medicare patients, new Medicaid patients and State Children's Health Insurance Program ("SCHIP") patients, more likely to treat a higher percentage of ethnic or racial minorities, and more likely to treat patients in poverty pockets and medically underserved areas.[59] Further, J waiver physicians appear to be more likely to remain in medically underserved areas after program completion than U.S. medical graduates participating in the National Health Service Corps ("NHSC"), which is the U.S. medical graduate program most similar to service-based J waiver programs. Twenty-eight percent (28%) of foreign national physicians who obtain J waivers continue to practice in their underserved locations after five years, as compared with a retention rate of 11% for US medical graduates participating in the NHSC.[60] Our current immigration laws, such as the Conrad 30 J waiver program and the PNIW option, are already designed to attract talented foreign national physicians to serve these populations, but need to be updated to ensure that the physicians stay and continue providing care in these communities.

---

[59] THE PHYSICIAN IMMIGRATION BOOK 56-76 (Robert Aronson ed., 2011-2012 ed.).

[60] AMERICAN MEDICAL ASSOCIATION (AMA)-INTERNATIONAL MEDICAL GRADUATE (IMG) SECTION GOVERNING COUNCIL, INTERNATIONAL MEDICAL GRADUATES IN AMERICAN MEDICINE: CONTEMPORARY CHALLENGES AND OPPORTUNITIES- 15 (2010), *available at* https://www.slideshare net/drimhotep/internationalmedicalgraduatesinamericanmedicinecontemporarychallengesandopportunities.

Additionally, the quality of care provided by foreign national physicians to the U.S. population does not appear to suffer from the fact that they typically obtain their medical degree from abroad before U.S. GME training. A study conducted by Harvard University researchers of more than 1.2 million hospitalizations at U.S. hospitals nationwide found that International Medical Graduates (IMGs) (i.e., those physicians who obtained their medical degrees from abroad), had lower patient morbidity rates than their U.S. medical graduate peers.[61] Another study focused on patient outcomes comparing non-U.S. citizen IMGs as relative to U.S. citizen IMGs and U.S. medical graduates based upon in-patient records found that patients treated by non-U.S. citizen IMGs had significantly lower mortality rates than patients cared for by doctors in the latter group.[62]

Conclusion

Given our nation's ongoing national physician workforce shortage as well as chronic maldistributions, and the beneficial role foreign national physicians fulfill in our healthcare delivery system, it is imperative to improve our country's immigration law and policy to better leverage this unique resource. I have outlined here but a few legislative proposals and administrative actions that can be undertaken. No one of these taken in isolation will fix our chronic issues, and, indeed, even the creation of a multi-phase new visa, such as an "M.D." visa, would not suffice to resolve healthcare delivery issues without other simultaneous improvements outside of immigration law, such as increased funding for GME slots and the resolution of

---

[61] Yusuke Tsugawa, Anupam B. Jena, E. John Orav & Ashish K. Jha, *Quality of care delivered by general internists in US hospitals who graduated from foreign versus US medical schools: observational study*, BMJ (2017), *available at*https://www.bmj.com/content/356/bmj.j273.

[62] John J. Norcini, John R. Boulet, W. Dale Dauphinee, Amy Opalek, Ian D. Krantz&Suzanne T. Anderson, *Evaluating the quality of care provided by graduates of international medical schools,* 29(8) HEALTH AFFAIRS1461-8 (2010).

*While this testimony is my own, I gratefully acknowledge the assistance of Harris Immigration team members Sophie Novak and Denise Soriano for their assistance with related research and preparation, as well as ECFMG for information regarding immigration data on J-1 sponsored foreign national trainees.

underlying healthcare access issues. However, as a matter of public policy, in the face of an ongoing pandemic, making modest, budget-neutral modifications to our existing immigration laws is a good place to start.