IMG TASKFORCE

INTERNATIONAL MEDICAL GRADUATE TASKFORCE

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Submitted via email: USCISFRComment@uscis.dhs.gov
Submitted via internet: www.regulations.com

Re: DHS Docket No. USCIS-2014-0014
Response to Request for Information on Visa Modernization

Dear Ms. Dawkins:

The International Medical Graduate Taskforce (IMGT) respectfully submits this comment in response to the Notice of the Request for Information published in the Federal Register on December 30, 2014 (the "Notice") calling for recommendations for streamlining and reforming the U.S. legal immigration system. While several of the recommendations submitted below are responsive to more than one of the queries identified in the December 30, 2104 notice, this comment is primarily written in response to the following question:

> 9. What are the policy or operational changes that could assist in creating additional immigration opportunities for high-demand professions, such as physicians?

IMGT is a national organization of immigration attorneys who are dedicated to ensuring Americans have adequate health care services by working for fair and reasonable laws relating to physician immigration. Our organization has been instrumental in supporting legislative and administrative agency efforts over the last twenty years relating to physician immigration. The IMG Taskforce's members submit the majority of immigration petitions filed on behalf of physicians in this country. The expertise of our membership makes us uniquely qualified to opine on the Administration's efforts to streamline and improve the administration of our immigration laws with respect to physicians.

To this end, we submit the following recommendations:

A. Cap Gap Relief for Physicians. This suggestion is responsive to question #9 of the Notice as well as to question #3 regarding policy and operational changes that would improve USCIS processing of H-1B petitions. We ask that Immigration and Nationality Act ("INA") Section 214(n) be interpreted to allow an individual to begin work as soon as a non-frivolous cap-subject H-1B petition is filed and to continue to work until either the denial date of the petition or through the effective date of the approved petition. The majority of H-1B physicians in U.S. residency programs train at non-profit cap-exempt institutions and finish their programs on June 30th, which is the end of the academic medicine year. Because the federal fiscal year does not begin until October 1st, physicians face a three-month gap between the end of their

training and the start of a cap-subject petition's validity, similar to the "cap gap" problem faced by F-1 students. Published correspondence between USCIS Chief, Business and Trade Services, Officer of Service Center Operations, Efren Hernandez, III and AILA member Naomi Schorr in 2007 confirmed that Section 214(n) portability allows such physicians to commence work for a cap subject employer while awaiting adjudication of the petition but stopped short of clarifying that work authorization would continue through to October 1 if the petition was approved before October 1. Efren Hernandez of USCIS acknowledged in his 2007 letter that there is a good argument for allowing work authorization to continue under Section 214(n) through October 1st and that USCIS would consider the issue, but there have been no updates since then. This relief will, in many physician cases, provide underserved communities access to physicians more quickly and is in line with previous administrative relief offered to F-1 students converting to H-1B status.

B. Common Sense Adjudication of "Affiliated or Related". This suggestion is also responsive to both questions #3 and #9 from the Notice. We urge USCIS to adopt a common-sense definition of the terms of "affiliated or related" as applied to the H-1B cap exemption provisions of American Competitiveness in the Twenty-first Century Act of 2000 ("AC-21"). Many international physicians seek employment with non-profit hospitals that are affiliated with medical schools and therefore qualify for H-1B cap exemption under AC-21. However, USCIS has never promulgated regulations implementing AC-21 and continues to import and erroneously apply the regulatory definition of the terms "affiliated" and "related" from another statute, the American Competitiveness and Workforce Improvement Act ("ACWIA"), found at 8 CFR §214.2(h)(19)(iii)(B). This definitional standard is inconsistent with the way most academic affiliation agreements are structured and therefore precludes application of the statute to many non-profit entities that are, in fact, affiliated with or related to institutions of higher education within the meaning of the statute. We recommend that USCIS issue formal guidance that would apply a standard of affiliation-based cap exemption that is consistent with the statutory intent and plain language of AC-21.

Specifically, we suggest:

- The cap exemption provisions under AC-21 were intended to be interpreted liberally to effectuate the legislative purpose of increasing the number of H-1Bs that are available to institutions of higher education and related or affiliated nonprofit entities. For this reason, USCIS adjudicators should apply the 'ordinary meaning' of the terms "affiliated" and "related" when determining whether a nonprofit entity is sufficiently connected to an institution of higher education so as to qualify for cap exemption. For example, Webster's dictionary defines "related" as "connected by reason of an established or discoverable relation" and "affiliated" as "closely associated with another typically in a dependent or subordinate position."
- Instances of qualifying relationship should include, but not be limited to, situations where the petitioner presents evidence that it is deemed affiliated with or related to an institution of higher education by another federal, state or local agency or organization for **any** purpose. For example, any nonprofit entity sponsoring, administering or hosting an "approved medical residency program" for purposes of Medicare reimbursement under 42 C.F.R. §413.75(b) should qualify for cap exemption as a pro forma matter.

- Instances of qualifying relationship should include, but not be limited to, situations where the petitioner has been accredited by a federal, state or local educational accrediting agency for an educational purpose based on its relationship with an institution of higher education. For example, any nonprofit entity that sponsors a Graduate Medical Education program accredited by the Accreditation Council for Graduate Medical Education (ACGME) or relevant accrediting body should qualify for cap exemption.

- When assessing whether a nonprofit entity qualifies for cap exemption on the basis of its relationship to an institution of higher education, USCIS should apply a totality of the circumstances test that recognizes formal and publicly stated affiliation agreements that define the respective rights and responsibilities of cooperating entities. Although shared ownership or control between the nonprofit petitioner and the affiliated/related institution of higher education is ***one*** factor adjudicators may consider when determining whether a qualifying relationship exists for cap exemption purposes, petitioners are ***not*** required to show shared ownership or control in order to demonstrate eligibility for cap exemption.

- As noted in the plain language of the statute, when the Service determines that a cap exemption applies, the exemption attaches to the ***entity*** that has been identified as a "related or affiliated nonprofit entity" and to all H-1B employees at that entity. The cap exemption is ***not*** contingent upon the H-1B beneficiary's participation in any specific activity performed within that entity. This is true regardless of whether the employee will be employed directly ***by*** the qualifying nonprofit entity, or employed by a third party to work ***at*** the qualifying nonprofit entity.

Having a clearer and more easily and consistently applied standard of affiliation-based cap exemption will reduce burdens on employers and workers who currently face tremendous uncertainty with regard to whether an H-1B petition may be approved on a cap exempt basis. Further, a clear standard will encourage those who obviously apply for the standard to seek cap exemption rather than – in the absence of surety – to file an H-1B petition under the cap. This, in turn, will help ensure that scarce cap-subject H-1B numbers are reserved for those who truly need them, reducing waste in the system and increasing visa utilization.

C. Medical licensure guidance. This suggestion is responsive to both questions #3 and #9 from the Notice. Many physicians who are completing graduate medical education in H-1B status are ineligible to apply for an unrestricted medical license until their training is complete; yet they must file the H-1B transfer petition before training is complete in order to preserve their immigration status. We request an expansion of the May 20, 2009 Barbara Velarde memo on medical licensure to allow for filing of an H-1B petition in situations where the physician is legally ineligible to obtain a medical license before the H-1B petition must be filed and be granted the full three-year period.

D. End the Application of INA Section 212(e) to J-2 spouses and children. This suggestion is responsive to question #9 from the Notice. INA §212(e) imposes a two-year home residency requirement on certain J-1 exchange visitors. The law does not extend this requirement to the spouses and children of J-1 visa holders, but the Department of State and USCIS nevertheless apply the

requirement to them. In the case of physicians, 80% of whom train in J-1 visa status, the application of §212(e) to spouses is particularly problematic as it makes it difficult for family members to secure work authorization in the same communities and often results in unnecessary trips back to the family's home country. Note that a provision clarifying that §212(e) does not cover spouses and children was included in Section 2405(e) of S.744 of the 113th Congress, a bill which the Senate passed with bi-partisan support.

If the Administration is unwilling to end the application of INA Section 212(e) to spouses, we request that USCIS at least end its practice of prohibiting a change of status from J-2 to H-1B after a J-1 waiver is granted to the J-1 principal. USCIS' current position is that J-2 spouses are ineligible to change status to H-1B until after the J-1 principal has completed his/her entire 3 year clinical J-1 waiver commitment under INA 214(l). USCIS consistently cites regulation and statute in support of this position. However, the regulation and statute do NOT prohibit a change of status for J-2 spouses following the grant of the J-1 waiver, but rather merely *permit* (not mandate) a change of status to H-4. The current practice of precluding a change of status from within the United States is tremendously disruptive and expensive for J-2 professionals, many of whom are also physicians willing to provide care in underserved communities. USCIS' flawed reading of the statute can therefore delay or deny a medically underserved community access to needed health care services.

E. Cease the application of the January 2009 "employer-employee relationship" memorandum to physicians. This suggestion is responsive to questions #3, #8 and #9 in the Notice. The 2009 Donald Neufeld memorandum interprets the term "employer-employee relationship" in H-1B petitions and greatly restricts the ability of physicians to work in employment situations common in the healthcare industry. For example, USCIS considers an employee of a physician group providing services at a community's hospital to be working at a third party worksite. In many instances, statutory schemes or business realities preclude hospitals from directly employing certain physicians. In such situations, a physician will inherently be rendering services at worksite location not owned by his or her employing entity. The application of employer-employee relationship to physician H-1B petitions also makes it extremely difficult for physicians who are employed by a solo practice corporation to be able to pursue H-1B visas. There is a very long tradition of physicians employed by solo medical practices in the U.S., particularly in rural areas that are so often underserved. We also note that the application of this memorandum to petitions filed by small medical practices or other types of small/start-up entities works counter to the Administration's stated interest in promoting immigrant entrepreneurs who create jobs and economic opportunities for Americans. We urge revocation of the memorandum or, at a minimum, end application to physicians.

F. Reform the Physician National Interest Waiver ("PNIW") Program. This suggestion is responsive to questions #3(b) and #9 in the Notice. We request updated policy guidance ensuring PNIW adjudications comply with the statute (INA 203(b)(2)(B)(ii)) and the *Schneider v. Chertoff* decision. There are several aspects of PNIW adjudication that require common sense reform. First, a physician may have completed some or all of the qualifying clinical service before filing the PNIW petition. USCIS should therefore interpret the definition of "required period of clinical medical practice" referenced at 8 CFR 204.12(c)(1) to include only the balance of time that has not yet been completed

toward the 5-year clinical service requirement at the time of filing the PNIW petition. Further, USCIS should accept any reasonable combination of evidence that demonstrates the physician's satisfaction of some or all of the clinical service requirement before filing the PNIW petition and his/her prospective intention to complete the balance of the five years (if any) after the PNIW is filed. Presently, USCIS places restrictions on acceptable evidence that are inconsistent with the statute. For example, USCIS requires an employment contract dated within 6 months of filing the PNIW petition even though the agency also acknowledges that the physician may have completed some or all of the required five years of clinical service long before the PNIW was filed, in which case the employment contract was likely executed outside this six-month period. The requirement that the PNIW be accompanied by a public interest letter (from the VA facility or state department of health) dated within 180 days of filing is equally inappropriate for the same reason. The statute requires that the physician complete an aggregate of five years of qualifying medical service. If that service was completed in whole or in part before filing of the PNIW petition, as is permissible under the statute and as USCIS acknowledged following the *Schneider* decision, then the physician should be able to file with evidence of the time already worked, *plus* an employment contract or self-employment attestation for the *balance* of remaining required employment. This is consistent with both the statute and the existing regulation and would be an easy way to improve use and administration of the PNIW program.

We would also ask the Service to issue "completion letters" to all physicians who have finished the 5-year employment commitment and provided satisfactory evidence to USCIS. At present, USCIS inconsistently issues such letters, and only for physicians who are able to file applications for permanent residence (which notably excludes Indian and Chinese physicians who are unable to apply for adjustment of status due to severe immigrant visa backlogs). The completion letter is an easy administrative benefit that provides physicians who have completed all five years of qualifying employment but who may be ineligible to adjust, peace of mind to move on to other employment opportunities with an assurance that they have satisfied the PNIW legal criteria.

G. Institute premium processing for PNIW petitions. This suggestion is responsive to questions #3(b) and #9 of the Notice. We request that USCIS institute premium processing for PNIW petitions. Unlike the "traditional" NIW petition process under INA §203(b)(2)(B)(i), the PNIW process is completely objective and relatively straight-forward to adjudicate. So long as the relevant criteria are met, the statute mandates that the PNIW "shall" be granted. INA §203(b)(2)(B)(ii)(I). As such, the PNIW is much simpler to adjudicate than other petitions for which premium processing is already available, including EB-1 petitions for Aliens of Extraordinary Ability, and the *NYSDOT* NIW petition. Having the ability to premium process a PNIW will facilitate H-1B extensions for physicians who are committed to working in underserved areas but who are ineligible to adjust and reaching the end of their normal 6 year maximum stay in H-1B status.

The PNIW beneficiary physician may also complete the qualifying employment in a non-immigrant status such as H-1B or O-1 and seek adjustment of status or an immigrant visa after having completed the full 5-year commitment. However, as most individuals do not qualify for O-1 and the availability of the H-1B is significantly limited by the annual cap, there are multiple instances in which a physician

who is not physically present in the U.S. at the time of filing the PNIW (and therefore is unable to file an adjustment of status) may be the beneficiary of an approved PNIW petition and yet unable to enter the United States to provide the medical care that is the subject of the PNIW petition. Particularly given the severe physician shortage, it seems both consistent with Congressional intent and good policy to enable physicians dedicated to treating underserved U.S. populations to enter the country and provide that care. Since the State Department cannot issue an immigrant visa in this instance, we urge USCIS to work with the State Department to develop a procedure to parole such physicians into the U.S. so that they may commence providing medical care in service of the PNIW commitment and, if eligible, file an I-485 adjustment of status application on the basis of the approved PNIW.

H. Do Not Count Applicant Derivatives Toward the Overall Immigrant Visa Quotas. This suggestion is responsive to questions #5 and #9 of the Notice. It is also in keeping with the Administration's stated goal of ensuring that administrative policies, practices and systems use all immigrant visas allocated by Congress. We echo the suggestion offered by other groups that derivative spouses and children should not be counted toward immigrant visa quotas. The Immigration and Nationality Act does not compel spouses and children be counted as separate units. Drawing from the various family and employment-based immigrant visa quotas and moving to a single family unit for counting purposes would be especially helpful for physician immigration. Indians represent the largest nationality amongst international medical graduates, and doctors from that country face waiting times that are many years later than their counterparts from other countries. This leads to considerable hardships for physicians serving medically underserved communities across the country and some make the understandable decision to simply leave the United States rather than remain here providing urgently needed care to medically underserved U.S. citizen populations.

I. Schedule A for Physicians in Federally Designated Shortage Areas. This suggestion is responsive to questions #3(b) and #9 in the Notice. We recommend that physicians with an offer of employment in a federally designated physician shortage area (i.e., Health Professional Shortage Area or Medically Underserved Area/Population) should be included among those professions listed on Schedule A as exempt from the PERM labor certification process. Physicians with full-time offers of clinical employment in areas designated by the U.S. Department of Health and Human Services as having a shortage of physicians have already demonstrated that they will be employed where there are insufficient numbers of physicians. A separate labor market test should therefore not be required before such physicians are permitted to file an immigrant petition. This change would also serve the Administration's stated goal of reducing costs, combating waste and reducing burdens on employers by relieving both the Department of Labor and sponsoring employers from having to complete and review a labor market test that is duplicative of another federal agency's findings that a shortage of qualified workers exists.

J. Permit the J-1 Waiver Physician to Fulfill Underserved Area Obligation in Any Work-Authorized Status. This suggestion is responsive to questions #4 and #9 in the Notice. INA Section 214(l)(2)(a) states "notwithstanding section 248(a)(2), the Attorney General **may** change the status of an alien who qualifies under this subsection and section 212(e) to that of an alien described in section

101(a)(15)(H)(i)(b)." (emphasis added) USCIS has interpreted the law as mandating that a physician who receives a J-1 waiver **must** serve in H-1B status. USCIS has held that service provided in other visa categories, even if the doctor is meeting all of the service obligations, will not count toward satisfying the J-1 waiver requirements. However, as long as a doctor is fulfilling his or her J-1 waiver service requirements, it should not matter what visa category is used by the doctor to fulfill that requirement. An example of such a situation is where a doctor worked on an H-1B prior to J-1 residency training and exhausted most of the six years of H-1B time available under that visa. The doctor could potentially secure an O-1 visa status or an EAD based on a pending I-485 application instead of getting an H-1B and provide services in the underserved area; however, USCIS' current policy would not permit this. This position is based on an incorrect reading of the statute rather than any policy consideration. We request that USCIS clarify that physicians may work in any employment-authorized status and not exclusively H-1B visa status.

K. Use parole power to grant employment authorization to physicians working in underserved areas. This suggestion is responsive to question #9 in the Notice. Many physicians who seek J-1 waivers to work in federally designated underserved areas (Health Professional Shortage Areas and/or Medically Underserved Areas) are unable to obtain a J-1 waiver in the year they complete their J-1 graduate medical education due to limitations on the number of clinical J-1 waivers that are available through the various state Departments of Health and restrictions or delays associated with the existing federal Interested Government Agency programs that sponsor J-1 waivers for clinical physicians. Other physicians may be willing and able to commit to completing a physician National Interest Waiver (PNIW) commitment under INA §203(b)(2)(B)(ii) but unable to file an I-485 adjustment of status application due to immigrant visa backlogs, or may be unable to begin underserved area employment in H-1B nonimmigrant status due to the H-1B cap. We request that USCIS exercise its parole authority to provide such physicians with Employment Authorization Documents (EAD) so that they may begin to provide urgently needed healthcare in underserved communities at the earliest possible moment.

In a similar vein, we ask that USCIS coordinate with the Department of State to facilitate entry and employment authorization for physicians who have filed PNIW petitions. INA Section 203(b)(2)(B)(ii) permits a physician who commits to working for 5 years in federally designated medical shortage areas or at a VA facility to be approved for a PNIW immigrant visa petition but also prohibits a physician from being granted an immigrant visa or adjustment of status approval until the 5 years of qualifying medical service has been completed. In instances where the beneficiary of a PNIW petition is in the United States and is not subject to immigrant visa retrogression, s/he may file an adjustment of status application prior to completion of the requisite 5 years of qualifying employment, but final adjudication is suspended until the 5 years of service is finished. This enables the physician to apply for an EAD that may be used as a basis to complete the qualifying employment.

L. Requirement to agree to begin employment within 90 days of receiving J-1 waiver. This suggestion is responsive to question #9 in the Notice. We ask that USCIS issue clarifying guidance confirming that the language appearing at INA §214(l)(1)(C)(ii) to the effect that the "the alien agrees to begin employment with the health facility or health care organization within 90 days of receiving such

[clinical J-1] waiver" means that the physician will begin work within 90 days of (1) having received the waiver; (2) having completed all required J-1 training for the position or; (3) having obtained the requisite work authorization needed to begin employment with the J-1 waiver sponsor, whichever is latest. Rather than tracking the "agree to begin" language of the statute, the USCIS J-1 waiver approval notices currently state that physicians with approved waivers under INA §214(l) *must* begin their J-1 waiver clinical commitment period within 90 days of the date on the USCIS approval notice. This is problematic because it is not always legally possible for physicians to begin employment within 90 days of J-1 waiver approval due to the inherently unpredictable timing of the waiver adjudication process, which is dependent on the schedules and backlogs of three different agencies (the initial Interested Government Agency, the Department of State and USCIS). Further, many state Departments of Health (the most common type of Interested Government Agency due to the popularity of the Conrad 30 J Waiver Program) require that J-1 waiver applications be filed in September and October and a physician will generally not complete the required J-1 training for the position until the end of June, which is often well after 90 days following final J-1 waiver approval. In other words, an interpretation of the "90 day" language in the statute that requires physicians to begin work within 90 days of J-1 waiver approval creates a practical and legal impossibility for many physicians and their employers. Since the statute requires physicians to "agree" to begin within 90 days rather than to *actually* begin within 90 days, USCIS has the flexibility to interpret the "agreement" to begin when the physician completes his required J-1 training and is otherwise legally authorized to begin employment. We suggest that USCIS issue policy guidance that clarifies that the "90 day" clock contemplated in the statute shall begin when the physician has completed his or her J-1 program and obtained whatever work authorization is needed to commence the J-1 waiver commitment in a legal status.

M. Reform the Veterans Administration (VA) J-1 Waiver Program. This suggestion is responsive to question #9 in the Notice. The VA's J-1 waiver program contributes to its well-documented difficulties in recruiting physicians. The program drives good candidates away by requiring re-advertising for a position each time a physician needs an H-1B extension or seeks permanent residency, which means that an international doctor's job is in jeopardy at multiple times during his or her career. Given that the VA's difficulty finding qualified doctors is common knowledge, we encourage the Administration to work with Veterans Administration Central Office, or "VACO", to end the expense and burden of recruiting prior to new immigration processes being filed.

In addition, the VA refuses to pay outside lawyers or use the agency's own lawyers to prepare and file applications and petitions, even though the Department of Labor requires the employer to pay attorney costs in the H-1B process. This VA policy leaves the physician unrepresented for this crucial part of the process. Given that the physician's entire career and future is completely dependent on this application process, this is an unacceptable risk to many physicians who have families to support. In addition, the VA insists on centralizing the waiver process in an office in Washington, DC which has resulted in slowing the already lengthy application process and making it extremely cumbersome. To improve this situation, we recommend allowing each VA hospital to prepare its own applications, and permitting immigration lawyers to prepare the J-1 waiver applications and H-1B petitions for waiver applicants.

N. Expand the Department of Health & Human Services (HHS) Clinical Waiver Program. This suggestion is responsive to question #9 in the Notice. HHS' waiver program is only open to community health centers, rural health clinics and Native American/Alaskan Native tribal member facilities. We suggest that the HHS program expand to serve hospitals and individual medical practices. The HHS program requires a HPSA score of 07, so any hospitals or physician practices that would use an expanded HHS program would still be required to demonstrate a severe physician shortage. Finally, we also recommend HHS accept applications from federal prisons and immigration detention centers as well as contractors serving such facilities since prisons and immigration detention centers find it difficult to recruit doctors. The U.S. Public Health Service of HHS is already responsible for providing physician services to federal prisons and immigration detention facilities. Expanding the HHS J-1 waiver program to include such doctors would ensure that the Public Health Service is able to achieve its mission to provide prisoners and detainees with needed health care services.

O. I-612 Approval Notice Delivery Errors. This suggestion is responsive to questions #4 and #9 in the Notice. The Vermont Service Center (VSC) consistently mails I-612 J-1 waiver approval notices to the wrong attorney. We understand this is a systems error that occurs either when the G-28 information is transmitted from the Department of State (DOS) to VSC at the time that DOS recommends the waiver; or when VSC uploads the data it receives from DOS. This problem has been on-going for many years and creates confusion and delay in receiving the I-612 notice, a necessary pre-requisite to applying for a change of status from J-1 to H-1B and for the H-1B visa at a consular post abroad. We request that the agencies devote the technical resources necessary to identify the source of the problem and correct it.

IMGT greatly appreciates the opportunity to provide comments and suggestions for administrative reform of our existing legal immigration system as we continue to await legislative action from Congress.

Thank you for your attention to this matter.

Sincerely,

Kristen A. Harris, Advocacy Co-Chair

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