INTERNATIONAL
MEDICAL
GRADUATE
TASKFORCE

To Whom It May Concern:

The International Medical Graduate (IMG) Taskforce is comprised of professionals in medicine and law who are dedicated to helping Americans in rural and other physician-shortage areas obtain the basic medical services they so desperately need and deserve. We share a deep desire to ensure that Americans in underserved areas and underserved populations of the United States receive adequate health care services. Members of the IMG Taskforce lend their unique expertise in physician immigration matters to promote the best interests of international medical graduates in these areas.

We work on behalf of universities, teaching hospitals, medical centers, and clinics of all sizes, and on behalf of international medical graduates seeking necessary authorizations.

The IMG Taskforce has been a major force in the physician immigration legislation and policy over the last several years. This year we are focusing on our efforts on preserving and improving the Conrad Waiver Program, correcting technical flaws in the Program, and providing incentives for physicians to work in medically underserved areas.

The Conrad State 30 Program began as a pilot program in 1994 and since then the program has provided increased medical care to tens of millions of otherwise medically underserved Americans in Rural areas and low-income populations by attracting U.S. trained International Medical Graduates (IMG) physicians who agree to a three-year service period. Under the program, each state department of public health may recommend up to 30 new IMG physicians per year for participation in the program, to provide full-time medical care at no direct cost to state or federal government.

The IMG Taskforce will be meeting with legislators during our annual Physician Lobby Day on Wednesday, February 20 to advocate for improved Physician Access in these underserved areas, as well as other legislative measures to mitigate current and impending physician shortages.

We ask for your support by joining us in extending and improving this important program.

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About Our Organization

The international Medical Graduate (IMG) Taskforce comprises professionals in medicine and law who are dedicated to helping Americans in rural and other physician- shortage areas obtain the basic medical services they so desperately need and deserve. Among other goals, we strive to educate national and state policy makers, administrative officials, and the American public on the need for fair and reasonable laws for allowing international medical graduates to become licensed as physicians and to begin or continue their medical careers in the United States. We work on behalf of universities, teaching hospitals, medical centers, and clinics of all sizes, and on behalf of international medical graduates seeking necessary authorizations. Given the inherent complexities and constant shifting of underlying laws and policies, we also collegially support each other. Ultimately, we share a deep desire to ensure that American in underserved areas and underserved populations of the United States receive adequate health care services.

A central goal of the IMG taskforce is to educate national and state policy makers, administrative officials, and the American public on the need for fair and reasonable laws that allow international medical graduates to become licensed physicians and to begin or continue their medical careers in the United States. To this end, we develop key relationships with legislators and policy makers in both federal and state government agencies in order to ensure that the needs of international medical graduates are considered in the development of policy and law. Members of the IMG Taskforce lend their unique expertise in physician immigration matters to promote the best interests of international medical graduates in these areas.

The IMG Taskforce has been a major force in the physician immigration legislation and policy over the last several years. Current advocacy efforts seek to address the need for Conrad 30 reauthorization, visa retrogression, nonimmigrant and immigrant visa caps, and other issues of concern to international medical graduates their patients and their employers.

IMG TASKFORCE

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March 2012

U.S. PHYSICIAN SHORTAGES & IMG-BASED LEGISLATIVE SOLUTIONS

Physician Shortages

- Millions of Americans in rural areas and low-income urban communities experience persistent, severe physician shortages.

- Physician residency slots have remained artificially frozen at 1997 levels, while the U.S. population continues to increase in size and age. This has resulted in a current physician shortage of thousands of physicians across specialties, particularly in primary care specialties.

- The US will soon face an epic shortfall of physicians nationwide, with or without the repeal of health care reform. The American Association of Medical Colleges had predicted a shortfall of 39,600 physicians by 2015 prior to health care reform. After the enactment of health care reform, the AAMC updated its predication to a gap of 63,000 physicians within the same timeframe.

The Gap-Filling Role of IMGs

- U.S.-trained international medical graduates, or "IMGs", can help mitigate existing and impending physician shortages.

- IMGs, and particularly IMGs who are in the U.S. on temporary, non-immigrant visas have provided a gap-filling role within the physician workforce. Visa-holder IMGs are more likely than their U.S. counterparts to
  - serve medically undeserved populations, including minority, rural and low-income urban populations;
  - accept Medicare, Medicaid and SCHIP patients;
  - provide direct patient care; and
  - specialize in primary care.

- IMGs are key to the success of rural Critical Access Hospitals, physician residency programs, and several other safety net providers.

Legislative Proposals

Our organization urges bi-partisan, budget-neutral legislative improvements to leverage IMGs as a resource, largely through technical corrections within the context of existing legislation. None of the legislative proposals we promote require federal or state governments to compensate IMG physicians for their services.

Legislative Goal: Increase Physician Access for the Medically Underserved

- **Conrad 30 J Waiver Program – Reauthorization and Expansion (S. 1979)**
  The Conrad 30 J Waiver Program has attracted thousands of IMG physicians into rural and inner city areas and has provided tens of millions of medically underserved Americans to

physicians since its establishment in 1994. We support the Conrad State 30 Improvement Act (S. 1979), for permanent reauthorization and expansion of the program.

- **Physician National Interest Waiver Improvements**
  The Physician National Interest Waiver category provides a 5-year path to lawful permanent residence, or the "green card", for IMGs who work in medically underserved areas and at Veterans Administration facilities. We support legislative corrections that would permit Conrad 30 J Waiver and other physicians to remain in their underserved communities, including specialists, physicians carrying out FLEX-based service, and physicians who provide service under more than one single 5-year contract.

Legislative Goal: Mitigate Physician Shortage in U.S.

- **Resident Physician Shortage Reduction Act of 2011 (S. 1627)**
  While U.S. medical education is finally expanding, such expansion is meaningless as a path to mitigating current and impending physician shortages if CMS-funded residency slots continue to remain frozen at 20th Century levels. We enthusiastically support the Resident Physician Shortage Reduction Act, which would increase the total available slots by 15,000 residency slots, to bring the U.S. physician supply closer to the actual and future needs of a growing and aging population.

Legislative Goal: Correct Current Legislative and Adjudicative Inefficiencies

IMGs and the health care facilities that employ them require clear and consistent rules in order to best serve the American public.

- **Legislative Clarification of H-1B Cap Exemptions**
  We support incorporating into law a list of easily identifiable public interest facilities for H-1B cap exemptions, including teaching hospitals, community health clinics, Critical Access Hospitals, Federally Qualified Health Centers and other safety net providers. This would promote year-round continuity of care for the vulnerable populations served by such institutions.

- **Legislative Clarification of H-1B "Employment"**
  Physicians often must render medical services at more than one location and at facilities not wholly owned by their employers. Immigration has recently questioned such arrangements as akin to "job shops" and subjected physician petitions to complex, multi-factor tests. We support a simple, readily verifiable definition of H-1B employment for physicians to promote their ability to treat patients on an as-needed, where-needed basis.

- **Correct Current Legislative Inefficiencies**
  Physicians and their employers are negatively impacted by inconsistencies in the current patchwork quilt of immigration law. We support a one-time set of legislative corrections relating to dual intent, M.B.B.S. degrees, LCME-accredited medical graduates, and U.S. graduate medical education as equivalent to other U.S. graduate education.

An Act to improve access to physicians in medically underserved areas and enhance the public's access to the services of American-trained international physicians.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This subtitle may be cited as the "Physician Access Act"

SECTION 2.
MODIFICATION OF VISA REQUIREMENTS WITH RESPECT TO INTERNATIONAL MEDICAL GRADUATES.

(a) PERMANENT AUTHORIZATION OF CONRAD 30 PROGRAM.

Section 220(c) of the Immigration and Nationality Technical Corrections Act of 1994 (8 U.S.C. 1182 note) is amended by striking "and before September 30, 2015."

(b) EASING ENTRY FOR PHYSICIANS SEEKING GRADUATE MEDICAL TRAINING

Section 214(b) is amended by striking "(other than a nonimmigrant described in subparagraph (L) or (V) of section 101(a)(15), and other than a nonimmigrant described in any provision of section 101(a)(15)(H)(i) except subclause (b1) of such section)" and inserting "(other than a nonimmigrant described in subparagraph (L) or (V) of section 101(a)(15), other than a nonimmigrant described in any provision of section 101(a)(15)(H)(i) except subclause (b1) of such section and other than an alien coming to the United States to receive graduate medical education or training as described in Section 212(j) or to take examinations required to receive graduate medical education or training as described in Section 212(j))."

(c) EASING ABILITY OF PHYSICIANS TO SERVE IN MEDICALLY UNDERSERVED AREAS

Section 214(l)(2)(A) shall be amended by striking "an alien described in section 101(a)(15)(H)(i)(b) of this title." and inserting "any status authorized for employment under this title."

(d) INCENTIVES FOR PHYSICIANS TO PRACTICE IN MEDICALLY UNDERSERVED COMMUNITIES

Section 214 of the Immigration and Nationality Act (8 U.S.C. 1134) is amended

(1) in subsection (l) in subparagraph (C) --

(I) in clause (i), by striking "and" at the end;

(II) by striking clause (ii) and inserting the following:

"(i) the alien demonstrates a bona fide offer of full-time employment, at a health care organization, which

employment has been determined by the Secretary of Homeland Security to be in the public interest;

`(ii) the alien agrees to begin employment with the health facility or health care organization in a geographic area or areas which are designated by the Secretary of Health and Human Services as having a shortage of health care professionals by the later of the date that is 90 days after receiving such waiver, 90 days after completing graduate medical education or training under a program approved pursuant to section 212(j)(1), or 90 days after receiving nonimmigrant status or employment authorization, and agrees to continue to work for a total of not less than 3 years in any status authorized for such employment under this subsection unless--

`(I) the Secretary determines that extenuating circumstances exist that justify a lesser period of employment at such facility or organization, in which case the alien shall demonstrate another bona fide offer of employment at a health facility or health care organization, for the remainder of such 3-year period;

`(II) the interested State agency that requested the waiver attests that extenuating circumstances exist that justify a lesser period of employment at such facility or organization in which case the alien shall demonstrate another bona fide offer of employment at a health facility or health care organization so designated by the Secretary of Health and Human services, for the remainder of such 3-year period; or

`(III) if the alien elects not to pursue a determination of extenuating circumstances pursuant to subclause (I) or (II), the alien terminates the alien's employment relationship with such facility or organization, in which case the alien shall be employed for the remainder of such 3-year period, and 1 additional year for each termination, at another health facility or health care organization in a geographic area or areas which are designated by the Secretary of Health and Human Services as having a shortage of health care professionals;'

"(iii) an alien whose employment terminates during the 3-year service period shall have a period of not less than 120 days to submit an application or petition to commence employment at another contracting health facility or health care organization and the alien shall be considered to be maintaining lawful status in an authorized stay during that period; and"'; and

(2) in paragraph (2)(A), by inserting "described in section (212)(e)(iii)" after "status of an alien"; and by adding at the end the following:

"(4)(A)(i) All States shall be allotted a total of 35 waivers under paragraph (1)(B) for a fiscal year if, during the previous fiscal year, the total number of waivers awarded to all the States is at least 90

percent of the total number of the waivers available to the States that received 5 or more such waivers.

"(ii) When an allocation has occurred under clause (i), all States shall be allotted an additional 5 waivers under paragraph (1)(B) for each subsequent fiscal year if, during the previous fiscal year, the total number of waivers awarded to all the States is at least 90 percent of the total number of the waivers available to the States that received 5 or more such waivers.

"(B) Any increase in allotments under subparagraph (A) shall be maintained indefinitely, unless in a fiscal year, the total number of such waivers granted is 5 percent lower than in the last year in which there was an increase in the number of waivers allotted pursuant to this paragraph, in which case—

"(i) the number of waivers allotted shall be decreased by 5 for all States beginning in the next fiscal year; and

"(ii) each additional 5 percent decrease in such waivers granted from the last year in which there was an increase in the allotment, shall result in an additional decrease of 5 waivers allotted for all States, provided that the number of waivers allotted for all States shall not drop below 30

(C) If at least 90 percent of the total number of waivers allotted under paragraph (1)(B) to a State were granted during any 1 of the 3 previous fiscal years, then the allotment of such waivers in the current fiscal year shall be increased from 30 to 35 for each such State. Such allotments shall be further increased in increments of 5 each time such 90 percent threshold of the adjusted allotment level is reached.

"(D) Any increase in allotments under subparagraph (C) shall be maintained indefinitely in future years, unless in a fiscal year, the total number of such waivers granted is 10 percent lower than in the last year in which there was an increase in the number of waivers allotted pursuant to this paragraph, in which case –

"(i) the number of waivers allotted shall be decreased by 5 per such State beginning in the next fiscal year; and

"(ii) each additional 10 percent decrease in such waivers granted from the last year in which there was an increase in the allotment, shall result in an additional decrease of 5 waivers allotted per such State, provided that the number of waivers allotted per such State shall not drop below 30."

(E) In no event shall any State be allotted a number of waivers that exceeds 30 waivers above the adjusted nationwide base number of waivers established by operation of paragraphs (4)(A) and (4)(B) above.

(5) An alien granted a waiver under paragraph (1)(C) shall enter into an employment agreement with the contracting health facility or health care organization that--
`(A) specifies the maximum number of on-call hours per week (which may be a monthly average) that the alien will be expected to be available and the compensation the alien will receive for on-call time;
`(B) specifies whether the contracting facility or organization will pay for the alien's malpractice insurance premiums, including whether the employer will provide malpractice insurance and, if so, the amount of such insurance that will be provided;
`(C) describes all of the work locations that the alien will work and a statement that the contracting facility or organization will not add additional work locations without the approval of the Federal agency or State agency that requested the waiver and
`(D) does not include a non-compete provision.

(e) RETAINING PHYSICIANS IN MEDICALLY UNDERSERVED COMMUNITIES

Section 201(b)(1) of the Immigration and Nationality Act (8 U.S.C. 1151(b)(1)) is amended by adding at the end the following:

"(F) Alien physicians who have completed service requirements of a waiver under 203(b)(2)(B)(ii), including those alien physicians who completed such service before the date of the enactment of this subparagraph, and any spouse or child (as defined at section 101(b)(1)) of such alien physician. Nothing in this subparagraph may be construed (i) to prevent the filing of a petition with the Secretary of Homeland Security for classification under this paragraph or section 204(a) or the filing of an application for adjustment of status under section 245 by an alien physician described in this subparagraph prior to the date by which such alien physician has completed the service described in section 214(l) or worked full-time as a physician for an aggregate of 5 years at the location identified in the section 214(l) waiver or in an area or areas designated by the Secretary of Health and Human Services as having a shortage of health care professionals; or (ii) to permit the Secretary of Homeland Security to grant such a petition or application until the alien has satisfied all the requirements of the waiver received under section 214(l).".

(f) TECHNICAL CORRECTIONS TO H-1B REQUIREMENTS FOR ALIEN PHYSICIANS

Section 212(j) of the Immigration and Nationality Act is amended by striking paragraph (2) and inserting

"(2) An alien who is a graduate of a medical school as defined in section 101(a)(41) and who is coming to the United States to perform services as a member of the medical profession may not be admitted as a nonimmigrant under section 101(a)(15)(H)(i)(b) unless –

(A) the alien is coming pursuant to an invitation from a public or nonprofit private educational or research institution or agency in the United States to teach or conduct research, or both, at or for such institution or agency,

(B) the alien is coming to pursue graduate medical education or training, or

(c) the alien has been approved for a license to practice medicine in the jurisdiction of the United States in which the alien has an offer of employment."

(g) ENHANCEMENTS OF THE WAIVER PROGRAM. –

(1) Section 214(l)(1)(D) of the Immigration and Nationality Act (8 U.S.C. 1184(l)(1)(D)) further amended by striking at (3)(ii) "; and" inserting at the end of D(3)(iii) the following:

" and;
(iv) in the case of a request by an interested State agency, the head of such agency determines that the alien is to practice medicine in an "academic medical center" as defined by 42 C.F.R. Section 411.355(e)(2) (without regard to whether such facility is located within an area designated by the Secretary of Health and Human Services as having a shortage of health care professionals) and the State agency determines that the alien physician's work is in the public interest and the grant of such waiver would not cause the number of the waivers granted on behalf of aliens for such State for a fiscal year (within the limitation in subparagraph (B)) in accordance with the conditions of this clause to exceed 10."

(2) Interested State agencies may exceed the waiver limit of this subparagraph for alien physicians agreeing to serve patients residing in counties designated by the President as major disaster areas under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§ 5121-5206 (Stafford Act). Waiver requests on behalf of physicians serving patients in these designated counties shall not be required to meet the requirements of subparagraph (D)(iii) of paragraph (1)."

(h) PHYSICIAN NATIONAL INTEREST WAIVER CLARIFICATIONS –

(1) Section 203(b)(2)(B)(ii)(I)(aa) of the Immigration and Nationality Act (8 U.S.C. 1153(2)(B)(ii)(I)(aa)) is amended by striking "agrees to work full time as a physician" and inserting "agrees to work on a full-time basis practicing primary care, specialty medicine, or a combination thereof ".

(2) Section 203(b)(2)(B)(ii)(I)(aa) of the Immigration and Nationality Act (8 U.S.C. 1153(2)(B)(ii)(I)(aa)) is further amended by striking "; and" and inserting "or in a facility or facilities that serve patients who reside in one or more geographic areas designated by the Secretary of Health and Human Services as having a shortage of health care professionals (without regard to whether such facility or facilities are located within such a designated geographic area); and"

(3) Section 203(b)(2)(B)(ii)(I)(bb) of the Immigration and Nationality Act (8 U.S.C. 1153(2)(B)(ii)(I)(bb)) is amended to read as follows "if the alien physician is pursuing such waiver based upon service at a facility located outside of a geographic

area designated by the Secretary of Health and Human Services as having a shortage of health care professionals, then a Federal agency or a local, county, regional or State department of public health must determine the alien physician's work was or will be in the public interest".

(4) Section 203(b)(2)(B)(ii)(II) of the Immigration and Nationality Act (8 U.S.C. 1153(B)(ii)(II)) is amended by adding at the end the following:

"The five years of service shall be counted from the date the alien physician begins work in the shortage area in any legal status and not the date an immigrant visa petition is filed or approved. Such service shall be aggregated without regard to when such service began and without regard to whether such service began during or in conjunction with a course of graduate medical education. An alien physician shall not be required to submit an employment contract with a term exceeding the balance of the five-year commitment yet to be served, nor an employment contract dated within a minimum time period prior to filing of a visa petition pursuant to this subsection. An alien physician shall not be required to file additional immigrant visa petitions upon a change of work location from the location approved in the original national interest immigrant petition. Physicians who meet the requirements of Section 214(l)(1)(B)(ii) of the Immigration and Nationality Act (8 U.S.C. 1184(l)(1)(B)(ii)) shall only be required to work full time as a physician for an aggregate of 3 years (not including the time served in the status of an alien described in section 101(a)(15)(J))."

(i) NONIMMIGRANT PUBLIC INTEREST SERVICE INCENTIVES FOR ALIEN PHYSICIANS

(1) Section 214(g)(5)(B) of the Immigration and Nationality Act (8 U.S.C. 1184 (g)(5)(B) is amended by striking "or"

(2) Section 214(g)(5)(C) of the Immigration and Nationality Act (8 U.S.C. 1184(g)(5)(C)) is amended by adding at the end "or;

(D) is an alien physician who is employed (or who has received an offer of employment)

(i) in an area or areas designated by the Secretary of Health and Human Services as having a shortage of health care professionals (including those designated as Health Professional Shortage Areas, Medically Underserved Areas, and/or Medically Underserved Populations), and a Federal agency or a Local, Regional or State Department of Public Health has determined that the alien physician's work in such an area or at such facility is in the public interest.

or

(ii) at any of the following facilities–

((a)) any hospital or medical facility which provides ACGME-accredited graduate medical education, AOA-accredited graduate medical graduation and/or which hosts a program that receives graduate medical education payments from CMS.

((b)) a health care facility under the jurisdiction of the Secretary of Veterans Affairs.

((c)) a Federally qualified health center (as defined

in section 1905(l)(2)(B), of the Social Security Act) or "FQHC look-alike" (as defined by the Department of Health and Human Services).
((d)) a community mental health center (as defined in section 1861(ff)(3)(B) of the Social Security Act).
((e)) a rural health clinic, as defined in section 1861(aa) of the Social Security Act.
((f)) a health center operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act)
((g)) a teaching health center as defined at section 478(A) of the Public Health Service Act.
((h) a facility that the Secretary of Health and Human Services has deemed eligible to receive assignments of National Health Service Corp personnel at any point since the enactment of the National Health Service Corps Revitalization Amendments of 1990 (P.L. 101-597).
((i)) an academic medical center as defined 42 C.F.R. Section 411.355(e)(2).
((j))) an entity receiving funds under title X of the Public Health Service Act.
((k)) a facility that has received certification as a Critical Access Hospital.
((l)) any hospital or medical facility which engages in established curriculum-related clinical training of students registered at any institution of higher education (as defined in section 1001(a) of Title 20). It shall not be necessary that the H-1B employee engage in any direct instruction or participation in such training programs."

(j) TECHNICAL CORRECTION REGARDING ADVANCED DEGREE FOR PHYSICIANS

Section 203 (b)(2)(A) of the Immigration and Nationality Act (8 U.S.C.1153(b)(2)(A)) is amended by adding at the end:

"An alien physician holding a foreign medical degree that has been deemed sufficient for acceptance by an accredited U.S. medical residency or fellowship program is a member of the professions holding an advanced degree or its equivalent."

(k) CLARIFICATION OF QUALIFYING H-1B EMPLOYMENT FOR LICENSED PROFESSIONALS

Section 214 of the Immigration and Nationality Act (8 U.S.C.1184) is amended by adding at the end:

"(s) 'Intending employer' defined

For purposes of section 101(a)(15)(H)(i)(b) of this title, the term "intending employer" of a beneficiary, where such beneficiary is a professional licensed by or eligible for a professional license from a State of the United States,

means a person, firm, corporation, contractor, or other association or organization within the United States (regardless of ownership interest, if any, of beneficiary in such entity) which:

(1) engages a person to work within the United States;

(2) has submitted employer attestations to the Department of Labor pursuant to a labor condition application filed with regard to such person; and

(3) has an Internal Revenue Service Tax identification number."

(l) RELIEF FOR PHYSICIANS AFFECTED BY REACHING THE ANNUAL ALLOTMENT OF H-1B VISAS

A physician completing graduate medical education or training as described in Section 212(j) as a nonimmigrant described section 101(a)(15)(H)(i) shall have such nonimmigrant status automatically extended until October 1 of the fiscal year for which a petition for a continuation of such nonimmigrant status has been submitted in a timely manner and where the employment start date for the beneficiary of such petition is October 1 of that fiscal year. Such physician shall be authorized to be employed incident to status during the period between the filing of such petition and October 1 of such fiscal year. However, the physician's status and employment authorization shall terminate 30 days from the date such petition is rejected, denied or revoked. A physician's status and employment authorization will automatically extend to October 1 of the next fiscal year if all visas as described in section 101(a)(15)(H)(i) authorized to be issued for the fiscal year have been issued.

(m) APPLICABILITY OF INA SECTION 212(E) TO SPOUSES AND CHILDREN OF J-1 EXCHANGE VISITORS

A spouse or child of an exchange visitor described in section 101(a)(15)(j) of the Immigration and Nationality Act shall not be subject to the requirements of section 212(e) of the Immigration and Nationality Act.

INTERNATIONAL MEDICAL GRADUATE TASKFORCE

Summary of Physician Access Language for CIR 2013

1. The Conrad 30 program expires every few years unless reauthorized. Section 2(a), p.1 provides for permanent authorization of the Conrad 30 J Waiver Program in order to make this clearly beneficial Program permanent, rather than requiring continual reauthorizations.

2. Each state is currently only allowed to sponsor up to 30 physicians per year for Conrad waivers. Larger states and states requiring more physicians to serve in medically underserved areas often require more than 30 spots. Section 2(d)(2), pp.2-3 provides the mechanism for the upward adjustment of Conrad 30 slots as needed state-by-state. If any state uses 90% (27 initially) of the slots, it will be eligible for 5 additional slots each subsequent year, with a capped formula to ensure no state uses a significantly disproportionate number.

3. Academic medical centers provide much needed medical and research services and improvements. Section 2(g)(1), p.5 provides up to ten separate waiver opportunities at medical centers at the discretion of the state dept. of health.

4. Disaster relief efforts usually require additional medical professionals to provide much needed services for a temporary period. Section 2(g)(2), p.5 provides the mechanism for state dept. of health to use their discretion to sponsor Conrad 30 physicians outside of base 30 waivers for disaster relief in order to provide emergency assistance in situations like the Katrina disaster.

5. Section 2(d)(1), p.2 provides for physician protection provisions such as extenuating circumstances and grace period (S. 1979). This allows physicians to transfer to different facilities in underserved areas if the state DPH attests to extenuating circumstances, or if the physician agrees to serve an additional (fourth) year.

6. Some employers may require Physicians to provide unreasonable services, without advance notice. Section 2(d)(2), p.4 provides additional Physician protection provisions utilizing contractual requirements (S. 1979). This requires employers to require reasonable notice regarding issues such as on-call hours, compensation, and multiple work locations.

7. Due to processing times at the various government levels, physicians must apply early in order to secure a J-1 Conrad waiver. However, there is the requirement that these physicians begin their service within 90 days of the waiver approval regardless of whether or not these physicians have completed their required medical training, or received their full medical licenses. Section 2(d)(1), p.2 clarifies the 90-day requirement for J waivers by clarifying that physicians should begin work within 90 days of completing their graduate medical training.

8. Physicians are currently required to complete their 3 year service in only H-1B status. Many physicians have less complex and costly means of obtain employment authorization. Section 2(c), p.1 provides a technical correction permitting physicians to complete their J waiver service in any

authorized employment status (rather than limited to H-1B). This will provide flexibility for physicians and employers to choose among appropriate and cost-effective visa options.

9. Section 2(m), p.8 Clarification that derivative spouse and children of J-1 not subject to the 2- year home residency requirement. To allow spouses of J-1 physicians the same flexibility as those in other visa categories.

Physician National Interest Waiver and Permanent Resident Status Improvements

10. Section 2(h)(1), p.5 NIW fix to clearly include specialists. Codifying rules confirmed in litigation.

11. Physicians applying for permanent residence based on the PNIW program must work at facilities located in designated underserved areas. This prevents many physicians who provide much needed medical services to patients who live in these underserved areas. Section 2(h)(2-3), pp.5-6 provides an expansion of the NIW program to include FLEX service. This will allow physicians to apply for permanent residence by providing service to underserved populations without the requirement that the facility they are employed at be located within designated underserved area(s). This provides the same flexibility as allowed in the Conrad Waiver Program.

12. Section 2(h)(4), p.6 NIW clarification re timing of 5 years of service. To clarify that NIW physicians are not required to sign contracts that exceed five total years of service.

13. The current visa backlog for physicians from India is almost nine years, causing uncertainty and instability for them and their families. Section 2(e), p.4 provides for the exemption from the per-country immigrant visa limit for physicians who provide 5 years of service in designated underserved areas. This provision is primarily to provide incentive for Indian physicians, who are subject to extremely long visa backlogs, to work in underserved areas with the possibility of obtaining a green card in a reasonable period of time.

H-1B Improvements

14. Physicians usually complete their graduate medical training at the end of June and they usually find employment with employers who are subject to the H-1B cap. Due to the H-1B regulations, these physicians are not eligible to begin work until October 1st thus leaving them with a gap in status and without work authorization. Section 2(l), p.8 provides H-1B "cap gap" parity for U.S.-trained physicians. This is to give the same protection to physicians that are given to international students, allowing them to apply for H-1B status and work when there is a gap caused by an early depletion of H-1B numbers.

15. Private employers who are subject to the H-1B numerical cap and are located in designated underserved areas cannot employ many physicians who received their graduate medical training with H-1B status. Section 2(i), pp.6-7 provides for H-1B cap exemption for physicians serving in HHS shortage designation areas and/or public interest facilities. This will encourage international physicians to work in underserved areas, even if they are not using the Conrad Waiver Program.

16. Many J-1 physicians cannot enter the U.S. in order to take their required exams or participate in graduate medical education or training since they must demonstrate that they do not have immigrant intent when applying for entry. Section 2(b), p.1 provides for the technical correction

to allow dual-intent for J-1 physicians seeking entry for pre-qualified exams or for graduate medical education or training.

17. Canadian physicians who graduated from qualifying medical schools are able to obtain full medical licenses but they are not eligible for H-1B visas due to the examination requirements of the visa. Section 2(f), pp.4-5 provides technical corrections for licensed Canadian physicians who are graduates of medical schools accredited by U.S. Dept. of Education/LCME to allow Canadian physicians who have already met the U.S. state licensing requirements to become visa eligible.

18. The immigration service has strict rules as to the type and amount of education that qualifies an individual to apply for permanent residence in the higher EB2 preference category. After litigation, USCIS agreed that MBBS degrees and other degrees allowing physicians to obtain full medical licenses qualify as advanced degree for the EB2 category. Section 2(j), p.7 provides clarification regarding MBBS/advanced degree issue for EB-2 category.

19. H-1B visas currently have restrictions designed to regulate third-party employers such as IT-staffing companies but these restrictions should not apply to physician employers. Section 2(k), p.7 provides a definition of "Employer" for physicians or licensed professionals to allow physicians who work in traditional physician groups to work in emergency rooms and other facilities that do not technically employ them, without the restrictions designed to regulate IT staffing-companies.

Miscellaneous Improvements

20. STEMM concept – include U.S.-trained physicians with other highly skilled occupations receiving STEM-based legal immigration incentives and benefits to address nationwide physician shortage. The specific language for this concept is not yet included in the proposed Physician Access Language. This would recognize the medical profession as a critical occupation affecting our economy in the coming years.

IMG TASKFORCE

INTERNATIONAL MEDICAL GRADUATE TASKFORCE

Concept List – 2/14/2013 Draft IMG/ Physician Access Language for CIR

1. permanent authorization of Conrad 30 J Waiver Program (Section (2)(a)); p. 1
2. mechanism providing for upward adjustment of Conrad 30 slots (Section 2(d)(2)); pp. 2-3
3. mechanism providing up to ten separate waiver opportunities at academic medical centers at discretion of state dept. of health (Section 2(g)(1)); p. 5
4. mechanism providing for inclusion of disaster relief for Conrad 30 service at discretion of state dept. of health outside of base 30 waivers (Section 2(g)(2), at p. 5
5. physician protection provisions – extenuating circumstances and grace period (S. 1979)(Section 2(d)(1)); p. 2
6. physician protection provisions – contractual requirements (S. 1979)(Section 2(d)(2)); p. 4
7. clarification of 90-day requirement for J waivers (Section 2(d)(1)); p. 2
8. technical correction permitting J waiver service to be carried out in any authorized status (rather than limited to H-1B) (Section 2(c)); p. 1
9. clarification that derivative spouse and children of J-1 not subject to 2-year return requirement (Section 2(m)), p. 8
10. NIW fix to clearly include specialists (Section 2(h)(1)); p. 5
11. NIW expansion to include FLEX service (Section 2 (h)(2-3)); pp. 5-6
12. NIW clarification re timing of 5 years of service (Section 2(h)(4)); p. 6
13. exemption from per-country immigrant visa limit for physicians undergoing 5 years of service in MUAs/MUPs/HPSAs (Section 2(e)); p. 4
14. H-1B "cap gap" parity for U.S.-trained physicians (Section 2(l)), p. 8
15. H-1B cap exemptions for physicians serving in HHS shortage designation areas and/or public interest facilities (Section 2(i)); pp. 6-7
16. technical correction for dual intent for physician Js, to put on par with physician Hs, and for physicians seeking entry for pre-qualified exams (Section 2(b)); p. 1
17. technical corrections for licensed Canadian physicians who are graduates of medical schools accredited by U.S. Dept. of Education/LCME (Section 2(f)); pp. 4-5
18. clarification regarding MBBS/advanced degree issue for EB-2 category (Section 2(j)); p. 7
19. "employer" definition for physicians or licensed professionals (Section 2(k)); pp. 7-8
20. STEMM concept – include U.S.-trained physicians with other highly skilled occupations receiving STEM-based legal immigration incentives and benefits to address nationwide physician shortage

United States Senate

WASHINGTON, DC 20510

January 9, 2012

Dear Colleague:

We write to urge you to co-sponsor S. 1979, the Conrad State 30 Improvement Act. Since its inception in 1994, the Conrad 30 Program has brought over 9,000 doctors to rural and underserved communities in all 50 states. S. 1979 will reauthorize this successful program, and make several significant improvements as well.

The Conrad 30 Program permits each state to sponsor up to 30 foreign-born, American-trained doctors to practice in medically underserved areas. In exchange for at least three years of service in these communities, the program allows for the waiver of certain visa requirements to enhance these doctors' ability to more quickly pursue permanent residency, without raising annual green card caps. This program has been instrumental in attracting hundreds of doctors each year to practice in communities that have the most difficulty in finding qualified doctors. Studies indicate that one doctor can add more than 20 jobs and over $1 million in economic activity to a rural community.

In addition to reauthorizing the Conrad 30 Program, S. 1979 would expand health care access by allowing H-1B doctors, in addition to J-1 visa doctors, to be eligible for participation in the program. This would increase the number of qualified doctors available to provide care in underserved areas. As participants, these H-1B doctors would be exempted from H-1B caps. Additionally, S.1979 improves the Conrad 30 Program by protecting foreign doctors from potential abusive practices by employers, and for the first time, provides a way for the number of waiver slots available to states to increase.

The Conrad 30 Program is a popular program that has successfully expanded access to quality health care for Americans in every state for almost two decades. We ask that you join us in extending and improving this important program. If you would like to co-sponsor S. 1979 or have questions, please contact Justin Schardin in Senator Conrad's office at 224-1895, or Darby O'Donnell in Senator Moran's office at 228-6973.

Sincerely,

Kent Conrad

KENT CONRAD
United States Senate

Jerry Moran

JERRY MORAN
United States Senate

SENATOR
KENT CONRAD
DEMOCRAT - NORTH DAKOTA

December 12, 2011

Contact: Sean Neary or Chris Gaddie
(202) 224-2043

Senator Works to Bring More Docs to Rural America

Conrad Looks to Extend Program that Fills Shortage of Health Care Professionals

Washington – Senator Kent Conrad today introduced bipartisan legislation to extend the Conrad State 30 program, a national initiative he launched 17 years ago to bring doctors to areas plagued by a shortage of physicians.

"We face a critical shortage of doctors in rural America today. Many communities in rural parts of North Dakota — and across the nation — are unable to attract qualified physicians. As a result, families are forced to travel great distances for routine health care. That is unacceptable," Senator Conrad said.

Senator Conrad created the popular State 30 program through legislation he first introduced in 1994. Under the program, foreign-born but American-trained doctors provide health care to people living in underserved communities for at least three years in exchange for an extension of their stay in the United States. Since its inception, the Conrad 30 Program has been extended multiple times and brought more than 9,000 doctors to rural and underserved communities in all 50 states.

The legislation introduced by Senator Conrad today calls for permanent authorization of the Conrad 30 program. The legislation also provides additional incentives for more doctors to participate in the program. In addition, the legislation provides a way for the number of waiver slots available to states to increase beyond the current 30.

The reauthorization bill also includes new provisions that provide greater protections to Conrad 30 physicians. Senator Conrad drafted those provisions after reading an article in the *Las Vegas Sun* last year that detailed physician abuse by certain Nevada employers. Under the new provisions, doctors can exit their contracts with their Conrad 30 employers, as long as they agree to an additional year of service in another rural or underserved area.

"Conrad 30 has improved access to quality health care for Americans in every state for almost two decades. We must extend this vital program so that it can continue to allow patients to access vital services right in their hometowns," Senator Conrad said.

The physician shortage in America is a growing crisis. By 2020, some projections show the nation may fall short by as many as 200,000 doctors. This shortage will be felt hardest in rural areas in North Dakota — and across the nation.

Senator Conrad's reauthorization bill is co-sponsored by Senator Jerry Moran (R-Kan).

INTERNATIONAL MEDICAL GRADUATE TASKFORCE

December 12, 2011

FOR IMMEDIATE RELEASE

Contact: Roberta Freedman (202) 772-0913

Conrad State 30 Improvement Act

Reauthorization and Expansion of Key Service-Based Physician Placement Program

Washington, DC -- The Conrad State 30 Improvement Act (S. 1979) was introduced today by Sen. Kent Conrad (D-ND), with co-sponsorship by Sen. Moran (R-KS). If passed, the Act would expand and permanently reauthorize the existing Conrad State 30 Program.

The Conrad State 30 Program began as a pilot program in 1994, as the Conrad State 20 program. The program has provided increased medical care to tens of millions of otherwise medically underserved Americans in rural areas and low-income populations by attracting U.S.-trained International Medical Graduate (IMG) physicians who agree to a three-year service period. Under the program, each state department of public health may recommend up to 30 new IMG physicians per year for participation in the program, to provide full-time medical care at no direct cost to state or federal government. Participating physicians are paid solely by their sponsor employers in the private and public sectors.

Timely passage of the Conrad State 30 Improvement Act is vital to avoid disruption of the program. Without passage of the Act, the Conrad State 30 Program will end on September 30th, 2012.

The IMG Taskforce enthusiastically supports the Conrad State 30 Program to complement efforts to increase the number of American medical graduates. The program provides a budget-neutral, effective approach to mitigating chronic physician shortages in the U.S. Our organization also supports the improvements to the program contained within the bill. These include additional paths to physician participation, increased physician retention mechanisms, the ability for smoother operation due to technical fixes, and strengthened self-enforcement mechanisms.

On March 30th, 2012, the IMG Taskforce will meet with legislators during our annual Physician Lobby Day to advocate for the Conrad State 30 Improvement Act, as well as other legislative measures to mitigate current and impending physician shortages.

The International Medical Graduate (IMG) Taskforce is a nationwide coalition of professionals in medicine and law dedicated to helping Americans, including in rural and other physician-shortage areas obtain the basic medical services they so desperately need and deserve. Our members work on behalf of universities, teaching hospitals, medical centers, and clinics of all sizes, and on behalf of IMG physicians seeking necessary authorizations. For more information, visit www.imgtaskforce.org.

American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

March 6, 2012

The Honorable Kent Conrad
530 Senate Hart Building
Washington, DC 20510-6275

Dear Senator Conrad:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 42,000 individual members, the American Hospital Association (AHA) is pleased to support your bill, the Conrad State 30 Improvement Act (S. 1979). The legislation reauthorizes and improves the current J-1 visa waiver program to enable foreign physicians to remain in the United States and serve patients in medically underserved areas.

Under current law, foreign physicians admitted to the United States on a J-1 visa to participate in graduate medical education programs are required by section 212(e) of the Immigration and Nationality Act (8 U.S.C. 1182(e)) to return to their home countries or last permanent residences for two years before they are eligible for an immigration status change allowing them to continue their work as physicians in the United States. The Conrad State 30 Program allows state health departments to request J-1 visa waivers for up to 30 foreign physicians per year to work in federally designated Health Professions Shortage Areas (HPSA) or Medically Underserved Areas (MUA). First enacted in 1994 (P.L. 103-416), this program has been integral to bringing medical care to many of the most underserved areas of our country.

Access to health care is a critical issue for our nation. Currently, more than 20 million Americans live in areas where there is a lack of physicians to meet their medical needs. Our nation's rural and inner city hospitals struggle to recruit and retain physicians, and the supply of primary care providers in such areas is steadily decreasing. In many areas of our nation, the Conrad State 30 physician is the only source of primary health care.

Unfortunately, the authorization for the Conrad State 30 Program remains temporary and the latest extension will expire on June 1, 2012. Without immediate and timely reauthorization, many of our communities that have benefited from a Conrad State 30 physician may find themselves without access to physician services.

S. 1979 would make the Conrad 30 program permanent, providing needed certainty to this source of physician supply for underserved areas. The bill also provides flexibility to expand the number of waivers in states where the demand exceeds the current limit of 30 per year. It also provides incentives for physicians who receive their training in H-1B status to participate in the program. Lastly, the bill clarifies standards for organizations employing Conrad 30 physicians.

The AHA urges a swift enactment of S. 1979 and we stand ready to work with you and your colleagues to accomplish this goal.

Sincerely,

Rick Pollack

Rick Pollack
Executive Vice President

ACP

AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE | *Doctors for Adults®*

January 26, 2012

The Honorable Kent Conrad
United States Senate
Washington, D.C. 20510

Dear Senator Conrad:

On behalf of the American College of Physicians (ACP), representing 132,000 internists and medical students who specialize in the primary and comprehensive care of adolescents and adults, I am writing to applaud your efforts to expand and permanently reauthorize the Conrad State 30 J-1 visa waiver program through the "Conrad State 30 Improvement Act" (S.1979). The College has long recognized the value of international medical graduates (IMG's) and their contributions to health care delivery in this country. Many IMGs provide care in medically underserved areas by participating in J-1 visa waiver programs, including Conrad 30.

The College supports your proposed reforms in S.1979 including, eliminating the need for repeated reauthorization of the Conrad 30 program. The College is also supportive of the provision in your legislation that will increase the number of Conrad 30 J-1 waivers to address the increased demand for such waivers by states, while maintaining a well-balanced national distribution. We are also pleased that you included our recommendation to allow a 120 day grace period for new employment if a physician is terminated due to extenuating circumstances. In addition, your proposed green card cap exemption would provide an important incentive for international medical graduates to practice in underserved communities.

Based on feedback from our members who are current or former Conrad State 30 participants, we continue to urge you to include the following additional changes to your legislation.

- A universal and simplified state and federal J-1 visa application process
- Distribution of J-1 visa physicians in the most medically underserved areas based on the total population of the state instead of the current set number of 30 physicians per state regardless of need and population
- A mechanism to report and investigate possible work-related abuses encountered by IMG physicians without fear of retribution

The College thanks you for your leadership on this important matter and your sustained commitment to expanding access to physicians in medically underserved areas. Pending your willingness to address our suggestions, as noted above, we would be pleased to fully endorse your legislation and look forward to working with you to advance it through Congress.

Sincerely,

Virginia Hood

Virginia Hood, MBBS, MPH, FACP
President

25 MASSACHUSETTS AVENUE, NW, SUITE 700, WASHINGTON, DC 20001-7401, 202-261-4500, 800-338-2746
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IMG TASKFORCE

INTERNATIONAL MEDICAL GRADUATE TASKFORCE

March 2, 2012

The Honorable Kent Conrad
United States Senate
530 Hart Senate Office Building
Washington, DC 20510

The Honorable Jerry Moran
United States Senate
354 Russell Senate Office Building
Washington, DC 20510

Dear Senators Conrad and Moran,

On behalf of the International Medical Graduate (IMG) Taskforce, I wish to express our organization's enthusiastic support for S. 1979, the "Conrad State 30 Improvement Act", which would permanently authorize and improve the important, service-based Conrad 30 J Waiver Program. The Conrad State 30 Program has provided increased medical care to tens of millions of otherwise medically underserved Americans in rural areas and low-income populations by attracting U.S.-trained International Medical Graduate (IMG) physicians who agree to a three-year service period.

The IMG Taskforce is a nationwide coalition of professionals in medicine and law dedicated to helping Americans, especially those in rural and other physician-shortage areas, obtain the basic medical services they so desperately need and deserve. Our members work on behalf of universities, teaching hospitals, medical centers, and clinics of all sizes, and on behalf of IMG physicians seeking necessary authorizations, including J waiver applications. As such, members of our organization have occupied a front row seat from which to observe the stellar success of the Conrad State 30 Program since its inception as a pilot program (the Conrad State 20 Program) in 1994. We have witnessed the increased medical care to diverse, underserved populations – from low-income urban communities receiving care at hospitals in our nation's toughest neighborhoods to farming communities served by rural health clinics. We have been gratified by those instances, time and again, in which IMG physicians and their families become part of the local communities and continue to treat the medically underserved, even after fulfilling the 3-year service period required by the program.

The IMG Taskforce enthusiastically supports the Conrad State 30 Improvement Act as an important measure to complement efforts to increase the number of American medical graduates. Under the Act, the program would continue to provide a budget-neutral, effective approach to mitigating chronic physician shortages in the U.S. Our organization also supports the improvements to the program contained within the bill. These include additional paths to physician participation, increased physician retention mechanisms, the ability for smoother operation due to technical fixes, and strengthened self-enforcement mechanisms to better protect the integrity of the system.

Sincerely,

Gregory Siskind, Chair
IMG Taskforce

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NATIONAL RURAL HEALTH ASSOCIATION

Government Affairs Office
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202-639-0550
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Senator Kent Conrad
530 Hart Senate Office Building
Washington, DC 20510-3403

Senator Jerry Moran
354 Russell Senate Office Building
Washington, D.C. 20510

Senators Conrad and Moran,

The National Rural Health Association (NRHA), a nonprofit organization of 21,000 members representing the health interests of rural Americans, applauds the introduction of S. 1979, the Conrad State 30 Improvement Act. Your bill provides incentives for physicians to practice in rural settings and makes great strides in the delivery of vital health care services in rural America.

As you know, rural America faces significant barriers with access to healthcare. Rural populations are, per capita, older, sicker and poorer than their urban and suburban counterparts. Rural facilities encounter higher percentages of Medicare beneficiaries, under-insured, and self-payer patients than their urban counterparts. Lack of financial incentives for physicians and non-physician practitioners and many other unique factors have long contributed to a huge shortage of rural health care workforce and, therefore, meaningful access for all rural Americans. Your legislation will help hospitals, clinics and group practices overcome some of these barriers and, thereby, increase health care access in rural America.

Rural health care facilities are not only critical access points for rural Americans, but they serve as a vital cog in the rural economy. Studies have shown that one physician can bring up to 20 additional jobs and over $1 million in economic activity to rural communities. Your legislation will go far in ensuring that rural Americans have access to care and will infuse local communities with needed jobs and an educated workforce.

The NRHA supports your efforts to help these vital professionals and ensure meaningful access to care for rural Americans. If you have any further questions please do not hesitate to call David Lee on my government affairs staff at 202-639-0550 or by e-mail at dlee@nrharural.org. We thank you for sponsoring this important legislation. You are truly stalwart champions for rural America.

Sincerely,

Alan Morgan, CEO
National Rural Health Association

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

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DAVID L. LAKEY, M.D.
COMMISSIONER

April 6, 2011

The Honorable Kent Conrad
United States Senate
530 Hart Office Building
Washington DC 20510

Dear Senator Conrad:

On behalf of the 50 states and four districts and territories, we want to express our appreciation and gratitude for your sponsorship and support of the Conrad 30 J-1 Visa Waiver program. Your vision to author a bill that would allow foreign medical graduates an opportunity to remain in the U.S. and improve access to health care services in rural and underserved areas has made a difference to all of us.

During the past 10 years, more than 8,000 Conrad 30 waiver recommendations have been requested by the 54 Conrad 30 programs. The result of these waivers is increased access for over 28 million people. Just over 45 percent of the waiver recommendations were for rural communities. This is three times more than the percent of people living in rural America.

From an administrative position, to give states the authority to follow federal legislation but develop the details of their own Conrad 30 program to best suit the needs of the state, has made this program unique. This flexibility allows states to set priorities for underserved areas and types of specialists.

Texas, one of many states that follow up with the Conrad 30 physicians both during and after the three-year obligation, has heard inspiring stories from physicians who stay at their waiver location and love their communities and the patients they serve. We also hear from the patients who are provided excellent health care and readily accept the physicians. A drive through rural Texas seeing medical office signs naming the physicians at work probably makes people ask "who are all these doctors and how did they get here?" The answer is often the Conrad 30 program. Additionally, in many areas the Conrad 30 physicians have improved the practice environment to the point that recruiting and retaining new physicians is much easier, again improving access for the community.

Thank you for the vision that created this program and for your thoughtful consideration for amendments and changes over the years. It has been such a pleasure to work with you and your staff. You should know that this is a program that makes a difference in many lives.

Sincerely,

Connie Berry
On behalf of 54 Conrad 30 Program Offices