

# THE EVOLUTION OF THE CONRAD WAIVER PROGRAM: FOURTEEN YEARS OF STATE- AND FEDERAL-BASED J-1 WAIVERS TO PHYSICIANS

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This article concerns the state-based J-1 waiver program for clinical physicians—codified in the Immigration and Nationality Act (INA) at §214(l)<sup>1</sup>—or, as the J-1 waiver program is more popularly known, the Conrad State 30 waiver program. The program has been in existence for over 14 years, and has become an important planning tool for states in facilitating the recruitment and retention of physicians to designated medically underserved areas—*i.e.*, geographic areas, and even designated facilities, that traditionally have experienced difficulties recruiting sufficient numbers of physicians to serve the needs of the indigent and medically underserved.

This article focuses on the following issues:

- 1) Conrad State 30 waiver program background;
- 2) The evolution of the Conrad State 30 waiver program;
- 3) Unresolved and ambiguous issues affecting this program;

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<sup>1</sup> Immigration and Nationality Act of 1952 (INA), Pub. L. No. 82-414, 66 Stat. 163 (codified as amended at 8 USC §§1101 *et seq.*), §214(l).

4) The program as considered within its broader context of physician workforce development and health care reform; and

5) A brief consideration of issues that need to be addressed when the program comes up for renewal.

## BACKGROUND TO THE PROGRAM

As a consequence of the Health Professionals Educational Assistance Act (HPEAA),<sup>2</sup> the J-1 Exchange Visitor Program became widely and, at times, nearly exclusively utilized by nonimmigrant physicians undertaking programs of Graduate Medical Education (GME)<sup>3</sup> in the United States. To that end, along with various provisions creating financial incentives to encourage more U.S. medical school graduates to pursue careers in primary care in medically underserved areas,<sup>4</sup> the HPEAA made several amendments to the INA intended to restrict the entry of foreign physicians for employment in the profession:

- First, the HPEAA added a new ground of inadmissibility to permanent resident status for foreign physicians who had not passed the National Board of Medical Examiners (NBME) licensing exam, and had not demonstrated competency in oral and written English.<sup>5</sup>
- Second, it eliminated the eligibility of foreign national physicians to obtain employment authorization for the clinical practice of medicine

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<sup>2</sup> Health Professionals Educational Assistance Act (HPEAA), Pub. L. No. 94-484, 90 Stat. 2243 (1976).

<sup>3</sup> Graduate Medical Education (GME) refers to residency and clinical fellowship programs intended to provide physicians with advanced clinical training opportunities undertaken under the supervision of an attending physician. The completion of a program in GME at an accredited program is required for two important benefits: state licensure; and eligibility to sit for the American board exam in the physician's field of specialty medical practice.

<sup>4</sup> There are two federal systems designating medically underserved areas: Health Professional Shortage Areas (HPSAs), based strictly on the ratio of physicians to population; and Medically Underserved Areas (MUAs), identifying physician shortage situations based on four factors.

<sup>5</sup> See HPEAA §601(a), creating new INA §212(a)(32), the predecessor to present-day INA §212(a)(5)(B).

under the then-existing H-1 and H-2 visa categories.<sup>6</sup>

- Third, it also closed off availability of H-3 trainee visas for International Medical Graduates (IMGs)<sup>7</sup> coming to receive graduate medical education or training,<sup>8</sup> thereby effectively making the J-1 visa the sole route for foreign national nonimmigrant physicians to come to the United States for residencies and clinical fellowships.

Of most relevance to this article, the HPEAA added a new paragraph (iii) to INA §212(e), which categorically subjected all foreign nationals who came to the United States on a J-1 visa (or acquired J-1 status) to the two-year home residence requirement if they came “in order to receive graduate medical education or training.”<sup>9</sup> Furthermore, in contrast to waiver options for all other exchange visitors, it completely eliminated “no objection” letters from their home countries as a basis for obtaining a waiver.<sup>10</sup> Prior to the HPEAA, IMGs who came on J-1 visas most likely would have been subject to the two-year requirement based on the skills list of their country of nationality or last residence, but nevertheless could qualify for waivers on the basis of no objection letters. After passage of the HPEAA, the no objection letter was removed as a basis for obtaining a waiver recommendation, thereby enhancing the relevance of the interested government agency (IGA) waiver strategies for IMGs.<sup>11</sup> Although physicians also can qualify for waivers based on persecution and exceptional hardship, the substantial majority of physicians obtain waivers through IGA recommendations, which certainly is not surprising given the inequities and shortages currently existing in the national health care system. These inequities are addressed, at least in part, by the entry of IMGs into the physician workforce.

Under INA §212(e) as it existed prior to 1994, federal agencies had exclusive authority to recom-

mend waivers.<sup>12</sup> Conversely, states lacked the statutory authority to recommend waivers of the home residence obligation. Starting in 1994, Congress expanded IGA authority by granting the states a numerically limited authorization to recommend waivers to clinical physicians under what came to be called the Conrad State 20 program.<sup>13</sup> This presumably resulted due to:

- The traditional interest of states in safeguarding the health and welfare of their residents;
- The role of states in licensing, disciplining, and monitoring their physician workforce;
- The public interest in facilitating enhanced access to physicians;
- The close working relationships between states and local communities; and
- The perceived inadequacies of the federal IGA programs.<sup>14</sup>

At present, it is the states, rather than federal agencies, that have taken the lead in recommending waivers to IMGs, which represents a sharp difference from the previous situation. During the previous decade, the U.S. Department of Agriculture (USDA)<sup>15</sup> and, for several years, the U.S. Department of Housing and Urban Development (HUD)<sup>16</sup> maintained active waiver programs for physicians willing to take up positions in rural and inner-city communities, respectively. The states, in contrast, were relatively quiescent in recommending waivers because the waiver needs of physicians were covered adequately by federal agency interventions. In addition, the state programs initially

<sup>12</sup> S. Borene, “Every Agency Can Be An Interested Government Agency—Developing §212(e) Waiver Options for Foreign Physicians,” *Immigration Options for Doctors* (AILA 1995).

<sup>13</sup> See §220 of the Immigration and Nationality Technical Corrections Act of 1994 (INTCA), Pub. L. No. 103-416, 108 Stat. 4305. This created INA §214(k), subsequently redesignated as INA §214(l) two years later by §671 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRAIRA), Division C of the Omnibus Appropriations Act of 1996 (H.R. 3610), Pub. L. No. 104-208, 110 Stat. 3009.

<sup>14</sup> See statement of Sen. Kent Conrad, 140 Cong. Rec. at S6747 (June 9, 1994).

<sup>15</sup> See U.S. Department of Agriculture (USDA) Fact Sheet, J-1 Waiver Program, Release No. fsj-1 visa.02, reprinted and discussed in 79 *Interpreter Releases* 376 (Mar. 11, 2002).

<sup>16</sup> R. Aronson *et al.*, “Vertigo: the Dizzying Rules Governing Waivers for J-1 Physicians”, 2 *Immigration & Nationality Law Handbook* 134, 136 (AILA 2003-04 Ed.).

<sup>6</sup> See HPEAA §§601(b)(1), (b)(2).

<sup>7</sup> This term refers to foreign national physicians who have done their medical education abroad. The related and oftentimes interchangeable term of “FMG” refers to a broader class of foreign-educated physicians that include both U.S. and foreign nationals.

<sup>8</sup> See HPEAA §601(b)(3).

<sup>9</sup> See HPEAA §601(c)(3).

<sup>10</sup> See HPEAA §601(c)(4).

<sup>11</sup> See INA §212(e) (2004).

were regarded as relatively undesirable, since physician beneficiaries of state waivers faced a three-year employment obligation in the requesting medical facility. By contrast, there was no equivalent three-year obligation until 1996 for federal waiver beneficiaries.

However, with the demise of the USDA waiver program,<sup>17</sup> and in conjunction with the unwillingness of other federal agencies to fill this waiver void, the states have become the primary source of waivers for IMGs. In FY 2002, for the first time, the number of waiver recommendations issued by the states exceeded federal IGA waiver recommendations: the states recommended 686 waivers, whereas federal IGA waiver recommendations stood at 386.<sup>18</sup> In the most recently reported fiscal year, the states recommended 987 waivers.<sup>19</sup> By contrast, while the precise number of federal IGA waiver cases for clinical physicians is not available, it appears that federal agencies recommended well under 100 waivers to physicians working in designated medically underserved communities.

Given the relative inaction of federal agencies to serve as IGAs following termination of the USDA waiver program, the states have now become the predominant source of government-issued waivers to clinical physicians. With the increasing popularity of the state-based waiver programs, the number of states whose waiver programs have been oversubscribed has increased substantially. In FY 2004, 20 states reported that the number of qualifying waiver applications exceeded their allotment of waivers, representing an increase of two over the number of oversubscribed states during the preceding fiscal year.<sup>20</sup>

This shift in IGA waiver patterns from the federal agencies to the states can be attributed to a variety of factors, including:

- The expansion of the annual allotment of waiver numbers to the states from 20 to 30;

- The flexibility of the states to recommend waivers to medical specialists rather than solely to primary care practitioners;<sup>21</sup>
- The demise of the USDA waiver program with no demonstrated commitment to pick up the slack from HUD;<sup>22</sup>
- A growing receptivity by the states to maintain IGA waiver programs as part of their commitment to serving the needs of the medically underserved;<sup>23</sup>
- The fact that until recently, only beneficiaries of state-issued waivers were exempted from the H-1B quota cap;<sup>24</sup> and

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<sup>21</sup> Until the 2004 amendments discussed *infra*, federal agencies were statutorily proscribed from issuing waiver recommendations to medical specialists.

<sup>22</sup> U.S. Department of Health and Human Services (HHS) Exchange Visitor Program; Request for Waiver of the Two-Year Foreign Residence Requirement, 67 Fed. Reg. 77692 (Dec. 19, 2002). Despite the announcement of an HHS clinical waiver program, HHS has issued very few waiver recommendations, primarily owing to tight standards on the required level of medical underservice (HPSA score of 14 or above) and a restriction of the program solely to primary care physicians. See also "HHS Reopens Physician Waiver Program with Significant New Restrictions," (Dec. 24, 2003) published on AILA InfoNet at Doc. No. 03121410 (posted Dec. 24, 2003).

<sup>23</sup> At present, all 50 states plus the District of Columbia, Puerto Rico, and even Guam have implemented state waiver programs.

<sup>24</sup> At the time of the initial enactment of the Conrad State 20 program in 1994, both recipients of Conrad State 20 waivers and recipients of federal IGA waivers that carried a three-year service obligation (e.g., a waiver through the U.S. Department of Veterans Affairs (VA)) were subject to the H-1B cap (then set at 65,000). See INA §§214(g), (k) (1995). In 2000, as part of the temporary increase in the H-1B cap for fiscal years (FYs) 2001 to 2003, the American Competitiveness in the 21st Century Act (AC21), Pub. L. No. 106-313, §§101-16, 114 Stat. 1251, 1251-62, included a provision exempting Conrad State 20 physicians from the H-1B cap. See AC21 §114. The cap exemption did not apply to federal IGA waiver recipients seeking to work in underserved areas; it applied only to Conrad State 20 physicians. When the H-1B cap returned to the 65,000 level in FY 2004, there was some uncertainty as to whether the cap exemption for Conrad State 20 physicians continued; U.S. Citizenship and Immigration Services (USCIS) took the position that it did, and continued to exempt Conrad State 20 physicians from the H-1B cap in FY 2004. Federal IGA waiver recipients continued to be cap-subject, creating a disincentive for use of federal programs such as VA waivers at times when the cap was hit due to the fact that it is often June or July (close to the end of the fiscal year) when a physician seeks to change from J-1 into H-1B status to begin the three-year obligation.

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<sup>17</sup> The USDA suspended its waiver program on February 27, 2002. See "Update on USDA's Withdrawal from J-1 Waiver Program" (Mar. 6, 2002), published on AILA InfoNet at Doc. No. 02030671 (posted Mar. 6, 2002).

<sup>18</sup> R. Paral, "Health Worker Shortages & the Potential of Immigration Policy," 3 *Immigration Policy in Focus* at 7 (American Immigration Law Foundation (AILF) 2004).

<sup>19</sup> Figures provided by Connie Berry of the Texas Department of State Health Services (DSHS) in telephone conversation with the author on March 24, 2005.

<sup>20</sup> *Id.*

- The expansion of the three-year H-1B service obligation to beneficiaries of federal, rather than just state, waivers, thereby eliminating the previous preference of IMGs to seek waivers through federal rather than state agencies.<sup>25</sup>

### EVOLUTION OF THE CONRAD STATE WAIVER PROGRAM

Since its inception, the Conrad waiver program has undergone a series of amendments that, in general, have provided the states with enhanced flexibilities to facilitate the relocation of physicians to communities and practice sites in need.

#### Initial Program: 1994–1996

The expansion of IGA authority to the departments of health of the various states was spearheaded by Senator Kent Conrad (D-ND). These efforts date back to provisions passed in 1994<sup>26</sup> amending the INA to authorize state or “equivalent”<sup>27</sup> departments of health to act directly as IGAs in support of waiver requests of petitioning facilities located in the state. In addition, the new program permitted a qualifying physician to change from J-1 to H-1B status, notwithstanding the provision in INA §248(2) that otherwise prevents a change of status by any J-1 physician even after having received a waiver.<sup>28</sup>

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Very recently, parity was achieved between Conrad State 30 physicians and federal three-year-service-obligation-waiver physicians. See §1(b) of “Act to Improve Access to Physicians in Medically Underserved Areas,” Pub. L. No. 108-441, 118 Stat. 2630 (enacted Dec. 3, 2004). This law explicitly affirmed that Conrad State 30 physicians continue to be exempted from the H-1B cap and that now, recipients of federal IGA waivers to work in medically underserved areas (but not other federal IGA waivers, such as research waivers) also are exempt from the H-1B cap.

<sup>25</sup> See HIRAIRA §622(c), creating INA §214(I)(1)(D) in conjunction with HIRAIRA §671, redesignating the modified subsection (k) as subsection (I).

<sup>26</sup> INTCA §220(a).

<sup>27</sup> “State” is defined at INA §101(a)(36) to include the District of Columbia, Puerto Rico, Guam, and the Virgin Islands of the United States. The U.S. Department of State (DOS) considers these non-state jurisdictions to be “equivalent,” and accepts applications for the “State 30” program for them. A list of state or equivalent Department of Health contacts may be found at <http://travel.state.gov/StateHealthSignatories.html>.

<sup>28</sup> See INA §248(2). At present, J-1 physicians who receive a waiver on other grounds (e.g., hardship or persecution or a federal IGA waiver such as an HHS research-based waiver)

The Conrad legislation amended the INA to provide the fundamentals for all state IGA waiver programs, initially including the following provisions:

- Each state granted an annual allotment of up to 20 waivers;
- The IMG must agree to work full-time for a facility in a designated medically underserved area for at least three years;
- The IMG must fulfill the three-year service obligation working specifically in H-1B “specialty occupation worker” nonimmigrant status;
- Failure to fulfill the three-year H-1B service obligation rendered the physician ineligible for permanent residence and constituted a violation of the terms of the waiver;
- A physician could terminate employment with the petitioning employer within the mandatory three-year service obligation only upon establishing the following: (1) the presence of extenuating circumstances making continued employment unwarranted; and (2) the physician’s agreement to serve out the balance of the three-year term in another medically underserved area;
- The IMG must agree to begin work at the facility within 90 days of receiving approval of the waiver by U.S. Citizenship and Immigration Services (USCIS); and
- The physician must obtain a no objection statement from his or her home country only if contractually obligated<sup>29</sup> to that home country.

#### Creating Greater Balance Between Federal and State IGA Programs: 1996–2002

The Conrad waiver program initially was limited to the waiver programs administered by the state departments of health or their equivalent. Conversely, the federal IGA waiver programs for physicians remained subject to the general and non-physician specific IGA waiver parameters appearing in INA §212(e). As a result, there were essentially

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must obtain an H-1B visa abroad in order to work in H-1B status.

<sup>29</sup> U.S. Information Agency (USIA) regulations clarified that to be “contractually obligated,” an IMG must have been funded by the government of his or her home country. 60 Fed. Reg. at 53123 (Oct. 12, 1995); current DOS regulations at 22 CFR §41.63(e)(2) and §41.63(e)(3)(vii) do not specifically define “contractually obligated,” but utilize the language “otherwise contractually obligated” to imply a contract in addition to the normal promises made by an IMG.

two separate physician waiver systems—the one administered by the states that included a three-year service obligation, and a second system relating to the federal agencies that did not carry any legally mandated service commitment. This disequilibrium in conjunction with the activist waiver program then being administered by USDA resulted in a severe underutilization of the state-based waiver program. In addition, the federal waiver programs for physicians were criticized for their unfettered flexibility allowing physicians to depart quickly from their initial placement site, often for practice opportunities in upscale or fully served areas.<sup>30</sup>

In 1996, Congress passed legislation<sup>31</sup> that extended authorization for the Conrad program for a six-year period until June 2002. The legislation also created greater, although not total, uniformity between the federal and state waiver programs,<sup>32</sup> illustrated by the fact that the IGA waiver programs for all clinical physicians were unified in one section of the INA—INA §214(I).

Probably the single most important initiative to equalize the federal and state waiver programs was to make all beneficiaries of J-1 clinical waivers subject to a three-year obligatory employment obligation with the petitioning employer, absent extenuating circumstances and relocation to another qualifying facility for the balance of the three-year term. The ostensible intention of this blanket three-year service obligation was to ensure that physicians who received waivers would serve the public interest by providing services to medically underserved communities for an acceptable period of time.

However, the 1996 statutory amendments did not create total uniformity between the waiver programs administered by the federal agencies and the state departments of health. Rather, the 1996 amendments retained two important distinguishing features between the two waiver systems:

- The states remained subject to an annual numerical limit of 20 waivers, though there was no comparable numerical limitation imposed on federal agencies; and

- The states were granted the flexibility to recommend waivers to medical specialists, as opposed to being subject to the restriction limiting federal IGAs to primary care physicians. Although the states initially largely restricted their waiver programs to primary care practitioners (consistent with the then-prevailing doctrine of managed care for physician workforce planning), over time and with the emergence of an entirely new recognition of widespread, pervasive shortages in the physician workforce, an increasing number of states expanded their waiver programs to include specialty care physicians.

#### Expansion to 30 Waivers Per Year: 2002–2004

The Conrad state-based waiver program was extended for an additional two years through June 1, 2004, by the Department of Justice Authorization Bill of 2002. This extension included an increase in the annual waiver limit for the states from 20 to 30.<sup>33</sup> In addition, the states were retroactively granted an additional 10 waivers during 2002 for cases originating in that fiscal year.<sup>34</sup> The federal waiver programs continued to remain numerically unlimited, and continued to be restricted solely to primary care physicians.

As a general observation, while the state and federal waiver programs were becoming more similar to each other, various differences remained, including the following:

- Federal waivers remained limited to IMGs who were being hired for primary care positions. Conversely, the states had the latitude to define primary care, and to recommend waivers for medical specialists.
- U.S. Department of State (DOS) regulations prohibited federal agencies from including non-compete clauses in employment contracts between the sponsoring facility and the IMG. By contrast, employment contracts could include such a clause in state-sponsored waivers.
- Federal agencies were required to include a statement from the facility confirming acceptance of Medicaid or Medicare eligible patients and indigent uninsured patients. States were not obligated to require this statement.

<sup>30</sup> “Foreign Physicians: Exchange Visitor Program Becoming Major Route to Practicing in U.S. Underserved Areas,” 74 *Interpreter Releases* 176 (Jan. 27, 1997).

<sup>31</sup> IIRAIRA, *supra* note 13.

<sup>32</sup> See IIRAIRA §622, amending INA §212(e) and then-existing INA §214(k).

<sup>33</sup> See §11018(a) of Pub. L. No. 107-273 (2002).

<sup>34</sup> *Id.*

- Federal agencies were required to include a statement from the IMG confirming that no IGA waiver requests were pending with other federal or state agencies, and that no IGA waiver requests would be filed with other federal or state IGAs during the pendency of the waiver request being filed. States did not necessarily require this statement.
- Federal agencies required evidence of unsuccessful recruitment efforts for U.S. physicians. States were not obligated to require evidence of unsuccessful recruitment.

#### **Further Program Developments—Leveling Out the Playing Field: 2004–2008**

In 2004, the Conrad waiver program was extended in two additional two-year increments, valid until June 1, 2008.<sup>35</sup> The law continued to unify the standards governing the waiver programs of both the state and federal agencies.

With the 2004 extensions to the Conrad waiver program, the federal IGA program was modified as follows:

- Federal agencies now had the authority to recommend waivers to medical specialists rather than solely to primary care physicians. This development was entirely consistent with current trends in our national health care system that increasingly recognize the benefits to favorable health care outcomes through immediate access to medical specialists, rather than having primary care physicians serve as gatekeepers. Whereas the states had increasingly exercised their authority to recommend waivers to medical specialists, the 2004 amendments specifically recognized the eligibility of medical specialists to receive waivers under both the federal and state programs.
- Beneficiaries of federal waivers became exempt from the H-1B quota cap. Previously, only physician beneficiaries of state waivers were exempt from the H-1B quota cap (though even here there remained a certain degree of uncertainty on the issue).<sup>36</sup> As a consequence of the recurrent exhaustion of H-1B cap numbers, the public interest objectives of the J-1 waiver program were delayed and disrupted. Beneficiaries

of federally issued waivers routinely faced delays in changing into H-1B status. To prevent this, the 2004 amendments categorically recognized that physicians obtaining waivers based upon clinical services would be exempted from the H-1B quota cap.

The 2004 amendments, however, created one major enlargement in the state-based waiver program that does not have a corollary in the federal IGA system. Although the states continue to be restricted to 30 waivers per year, the 2004 amendments created a pilot program in which five of a state's waiver allotment could be issued to physicians who provided important safety net services to the indigent and the medically underserved despite the fact that their physical practice site was not located in a designated medically underserved area.<sup>37</sup>

The states have utilized these flexibility provisions (Conrad Flex 5 provisions) to varying extents. With the increased utilization of the H-1B Temporary Worker classification for purposes of GME, there has been a fall-off in the number of foreign physicians who come to the United States under the J-1 Exchange Visitor Program.<sup>38</sup> Therefore, given an overall decrease in the number of J-1 Trainees, many states have experienced a decrease in the number of waiver applications, thereby creating some receptivity to considering waiver requests for non-medically underserved areas. At present, roughly 45 states, to varying degrees, will accept J-1 waiver applications for physician placements in non-medically underserved areas. DOS has indicated that it will defer to the states in their adjudication of requests for waivers for physicians working in non-designated areas, rather than providing formal, substantive guidance on the issuance of waiver recommendations under this new initiative.<sup>39</sup>

Given that the Conrad waiver program's policy objectives are to enlarge access to physicians for the indigent and medically underserved, the states have required a qualifying physician to serve substantial numbers or percentages of these indigent and medically underserved. There are two important determi-

<sup>35</sup> Act to Improve Access to Physicians in Medically Underserved Areas, Pub. L. No. 108-441, 118 Stat. 2630, §1(b) (Dec. 3, 2004);

<sup>36</sup> See *supra* note 24.

<sup>37</sup> *Id.* at §1(d) (creating new INA §214(l)(1)(D)(ii)).

<sup>38</sup> Presentation of Stephen S. Seeling, VP of Operations, ECFMG Exchange Visitor Sponsorship Program 2008 (Sept. 23, 2008).

<sup>39</sup> DOS Memorandum to state waiver officers, (Jan. 19, 2005) (copy on file with author).

nants in adjudicating waiver requests under these flexibility provisions:

- *Nature of the medical facility.* Certain medical facilities play an important role in serving the needs of a state's indigent and medically underserved populations. For example, university systems and county hospitals serve as important safety net providers to the indigent and medically underserved, even though many such facilities are not located in designated medically underserved areas.<sup>40</sup> Specifically, they provide important outreach services to a state's vulnerable population groups, particularly in specialty and tertiary care services—practice areas not supported at a local level.
- *Physician's expected practice plan.* Unquestionably, there are quantifiable measures to judge the actual contributions of a physician to at-risk population groups within a state. In fact, probably no profession is subject to a higher burden of regulation and reporting than medicine. Therefore, it should be quite possible to evaluate a foreign national physician's expected contributions to a state's vulnerable population groups by considering such factors as:
  - The percentage or actual numbers of the physician's public aid patients;
  - The expected annual write-offs of patients who have fallen through the safety net;
  - The discounted fee arrangements extended to the indigent;
  - Medical services provided to minorities;
  - The unique practice area/substantial referral network making the physician a statewide referral source for certain medical conditions,
  - The prevalence among the poor and disadvantaged of a disease handled by the foreign national physician, etc.

### Current Wait-and-See Holding Pattern

The Conrad waiver program overall has been well-received as a highly innovative initiative, useful both for facilitating the recruitment of physicians into hard-to-fill communities, and for distributing physicians into medically underserved areas and/or

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<sup>40</sup> B. Ormand *et. al.* "Supporting the Rural Health Care Safety Net", Urban Institute (2000), available at [www.urban.org/UploadedPDF/occa36.pdf](http://www.urban.org/UploadedPDF/occa36.pdf) (last visited March 26, 2005).

areas providing substantial social benefits. Nevertheless, reauthorization efforts for the program generally have been caught up in the paralysis on immigration issues in the aftermath of Congress failing to pass comprehensive immigration reform.<sup>41</sup>

In the face of anticipated congressional inaction on any immigration-related proposal, Sen. Conrad convened a series of meetings with interested stakeholders in the process, starting in December 2007. What emerged were two sharply different views of the future direction of the program. The initial approach advocated by Sen. Conrad's office was:

- To extend the program to the extent possible;
- To build off of the legislation's current design, mostly in order to increase the number of flexibility waiver slots; and
- To gain a lengthy, if not permanent, extension of the program.

Other groups viewed the sunset of the current program as an opportunity to redesign the waiver program substantially, perhaps through the creation of a new visa classification for physicians. This new classification system proposed to cover the entire period of a physician's residence in the United States, starting from GME training, through service to medically underserved communities, and culminating, upon fulfillment of a mandatory service requirement, in the conferral of permanent resident status.<sup>42</sup>

In the aftermath of this series of deliberations, the final draft was introduced on the Senate floor by Sen. Conrad,<sup>43</sup> essentially built upon the bill's current waiver architecture and containing the following provisions:

- Exemption from the H-1B numerical limitations of INA 214(g) for physicians already in H-1B status who receive an exemption for a state department of health that essentially serves as an IGA;
- Creation of an additional pool of waiver numbers, made available in lots of five waivers per

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<sup>41</sup> See "AILA Statement on Senate Cloture Vote," published on AILA Infonet at Doc. No. 07062865 (posted June 28, 2007), discussing the late June 2007 collapse of the comprehensive immigration reform bill (S. 1639) in the Senate.

<sup>42</sup> Proposal of the American Hospital Association; notes on file with author.

<sup>43</sup> S. 2672, 110th Cong. (2008).

state, if 90 percent of the nationwide waivers are filled in a given year;

- Exemption from the numerical limitations for permanent residence under INA §201(b) for physicians who have served out their three-year H-1B service obligation—an exemption of considerable value to physicians from traditionally oversubscribed countries;
- An increase in the Conrad Flex 5 numbers from five to 10; and
- A permanent extension of the J-1 waiver program.

In the ensuing congressional term, the entire reauthorization effort fell subject to the general pattern of inaction on virtually all immigration-related proposals. Finally, a compromise was worked out that created an extension of the existing Conrad waiver program until March 6, 2009. The single change in the compromise was an increase in the annual number of Conrad Flex slots from five to 10.<sup>44</sup>

Presumably, the bill's sponsors will again take up a more extended consideration of an enlargement and redesign of the waiver program in the new Congress, although that obviously remains to be seen.<sup>45</sup>

#### CURRENT OPEN AND UNRESOLVED ISSUES IN THE CONRAD WAIVER PROGRAM

Despite the fact that the Conrad waiver program has existed now in various incarnations for over 10 years, there are still significant unresolved issues. The relevant federal administering agencies of the program went through rulemaking at the inception of this program,<sup>46</sup> and on one occasion, the legacy Immigration and Naturalization Service (INS) issued informal policy guidance.<sup>47</sup> But there has been a very regrettable failure to provide ongoing guidance

to account for the program's subsequent amendments, the emerging preeminence of the states as the source of waiver recommendations, the changes in physician workforce issues, national health care challenges (as discussed below), and the evolving expectations of the program itself in serving the needs of vulnerable population groups.

What appears here is an identification and brief discussion of 10 of the most nettlesome and unsettled issues, as defined through the experience of this author.

#### Full-Time Service in Designated Area

The statute<sup>48</sup> stipulates that the physician needs to practice on a full-time basis "only in the geographic area or areas which are designated ... as having a shortage of health care professionals."<sup>49</sup> Particularly in rural communities, a mechanistic application of this provision would preclude a physician from following a patient requiring hospitalization in a facility that is not physically located in an area designated as medically underserved. Any such prohibition would subject the physician to malpractice exposure for grossly substandard care of treatment, and compromise the patient's overall course of treatment.

Similarly, the standards are currently unclear as to the circumstances under which a physician may provide services over and above a full-time employment commitment to a designated medically underserved area, either under part-time H-1B status or working under employment authorization.

The ultimate policy of the law is to provide full-time physician services to communities and practice situations in need. Once this basic policy goal has been met, it is arguable whether there should be any additional restrictions placed on a physician who desires to work additional hours in a non-designated community.

#### Definition of "Full-time Employment"

There are a number of uncertainties as to the meaning of "full-time," particularly within the physician context. Surgeons generally are limited to roughly 20 hours of operating time per week, depending on their area of specialization. Are they working full-time for waiver fulfillment purposes? What about on-call time—a terribly onerous obliga-

<sup>44</sup> Pub. L. 110-362, 122 Stat. 4013 (Oct. 8, 2008).

<sup>45</sup> **Editor's Note:** After the author remitted this article for publication, President Obama, on March 20, 2009, signed into law another extension of the Conrad 30 program, through September 30, 2009. Pub. L. No. 111-9, 123 Stat. 989.

<sup>46</sup> 60 Fed. Reg. 26676-83 (May 18, 1995) (interim final rule of the legacy Immigration and Naturalization Service (INS)); 60 Fed. Reg. 53122-26 (Oct. 12, 1995) (final rule of USIA).

<sup>47</sup> INS Memorandum, M. Pearson, "Waivers of the Two-Year Foreign Residence Requirement Under Section 212(c) of the Immigration and Nationality Act (the Act)" (Oct. 8, 1999), published on AILA InfoNet at Doc. No. 99100490 (posted Oct. 8, 1999).

<sup>48</sup> INA §214(I) (as most recently amended on Dec. 3, 2004, by Pub. L. No. 108, 118 Stat. 2630).

<sup>49</sup> INA §214(I)(1)(D).

tion imposed on physicians who need to curtail their personal lives to remain available to patient needs? Are there any requirements for actual clinical time as opposed to administrative or consultative duties?

In general, one would think that the definition of "full-time employment" would be a function of the employment routines maintained by the petitioning facility and recognized more generally within the profession. Instead, it seems based more on a mechanistic calculation of hours. This remains, however, an open-ended and unresolved issue.

### Requirement of Service Specifically in H-1B Status

A physician beneficiary of an IGA waiver for clinical purposes needs to work for the petitioning medical facility for three years, barring the premature termination provisions of INA §214(l)(C)(ii). The statute does not mandate that this three-year service obligation be performed specifically in H-1B status. Rather, the requirement that the three years of service be completed specifically in H-1B status is a creation of the implementing regulations, although the statute does recognize the eligibility of a qualifying physician to change from J-1 to H-1B status.<sup>50</sup> However, this enlargement of change of status eligibility does not mean, necessarily, that the actual required term of employment needs to be fulfilled exclusively in H-1B status, as required under the current regulations.

As a result, USCIS should permit physicians the flexibility to satisfy the three-year service obligation using any legal work authorization—*e.g.*, on an Employment Authorization Document (EAD) card based on a pending I-485 application filed on any valid basis (whether employment-based or family-based or DV lottery-based)—particularly given their ability to maintain H-1B status subsequent to filing an adjustment application. Physicians whose J-1 waiver is under INA §214(l) are prohibited from filing an I-485 application prior to completion of three years of service in H-1B status (and no other

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<sup>50</sup> INA §214(l)(2)(A). This statutory provision seems to address only the situation in which a physician changes into H-1B status. In such cases, the physician gains H-1B cap exemption. However, the situation is less clear for physicians who process abroad for a visa instead of seeking a change of status. Are they still required to work in H-1B status? If so, do they qualify for an exemption from the H-1B cap, since the cap exemption provided for by this provision refers only to change of status situations? By extension, if a physician chooses to consular process rather than to change status, is there any H-1B service obligation at all?

status) in most cases.<sup>51</sup> But this rule does not make sense in light of INA §214(l), the objective of which is that the physician make a commitment to the community for, at minimum, the three-year period that has been deemed by the Congress to be a sufficient investment of a physician's career to justify the waiver. In many instances, the earlier filing of an adjustment of status application actually would facilitate a physician's overall integration into a community, particularly by providing the dependent family members with employment authorization. Such adjustment applications could not be approved until the physician has served out the three-year term of employment. But the physician should be permitted to at least apply for adjustment of status and obtain interim benefits such as EAD and Advance Parole. The emphasis should be on ensuring that the physician serves out the three-year term whichever way he or she is legally authorized to work, rather than mandating H-1B as the sole acceptable status for satisfying the three-year obligation.

### Split VA Appointments

Within the U.S. Department of Veterans Affairs (VA) employment context, many physicians hold joint appointments between the VA and its affiliated university. Under the VA waiver guidelines, the VA will recommend waivers based on 5/8 appointments

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<sup>51</sup> *Id.* The only exception to filing an I-485 during the three-year H-1B service period is in cases where the §214(l) physician is a primary care physician who is also the beneficiary of a National Interest Waiver (NIW) immigrant petition under INA §203(b)(2)(B)(ii), based on a commitment to serve a total of five years in the medically underserved community. In that situation, legacy INS has held that the physician (and any dependent family members) may file an I-485 application prior to completion of the three years of H-1B status. See INS Memorandum, W. Yates, "National Interest Waivers for Second Preference Employment-Based Immigrant Physicians Serving in Medically Underserved Areas or at Veterans Affairs Facilities and Section 214(l)(2)(B) of the Act" (Oct. 1, 2001), published on AILA InfoNet at Doc. No. 01101140 (posted Oct. 11, 2001), resolving the conflict between 8 Code of Federal Regulations (CFR) §212.7(c)(9)(iii) and 8 CFR §204.12(e) in favor of permitting filing of an I-485 by a §214(l) physician in this situation prior to completion of the three years of H-1B status, so long as the physician continues to work in H-1B status after I-485 filing so as to satisfy the requirements of INA 214(l). But for §214(l) physicians working as medical specialists and/or whose employers are pursuing labor certification cases instead of primary care five-year NIWs, the rule remains that the physician must complete three years of service in H-1B status prior to filing any I-485 application.

in the VA facility, so as to enable the physician to hold up to a 3/8 appointment at another facility.<sup>52</sup> Whereas the various VA facilities generally lack the budget to provide exclusive, dedicated employment, particularly for medical specialties, they benefit substantially through this cost-sharing arrangement. In addition, this split employment is not a specially created situation for foreign physicians; rather, it is a standard, widely utilized arrangement specifically calculated to best serve the medical needs of the VA in a cost-efficient and professional manner. Yet, a mechanistic application of the full-time employment obligation would eviscerate a primary objective of the legislation, which is to give qualifying veterans enhanced access to physicians. This author thinks that within the VA context, and based precisely on accepted employment patterns within VA facilities, a split employment arrangement between a VA facility and its affiliated university institution should be recognized as sufficient for fulfilling a physician's waiver obligations under INA §214(I).

#### Ongoing Exemption from the H-1B Quota Cap

The most recent amendment to the Conrad program exempts from the H-1B cap a physician who has received an IGA waiver and then changed into H-1B status.<sup>53</sup> The exemption from the H-1B cap clearly applies at the time that a physician changes from J-1 to H-1B status in order to assume the job with the petitioning employer. However, the plain language of the statute also seems to state that this H-1B cap exemption attaches personally to the physician, thereby covering subsequent changes in employment after fulfillment of the mandatory three-year service obligation. Clarification on this issue by USCIS is needed in order to allow INA §214(I) physicians who have completed their three-year obligation to plan a change of employers at a time during the part of a future fiscal year when the cap may have been met.

#### 90-Day Commencement Period

The law contains a stipulated, finite period of time for the physician to commit to the position.<sup>54</sup> But this provision of the law has been misapplied repeatedly in direct derogation of the statutory language. The law does not require the physician to

commence employment within 90 days; rather, the law requires that the "alien agrees to begin employment with the health facility or health care organization within 90 days of receiving such waiver."<sup>55</sup> (emphasis added) In short, it is an agreement to commit to the employment, rather than actually commencing the employment itself, that is required.

There are various specific reasons that might prohibit a physician from starting employment within a 90-day period of time. These include: delays in issuance of the license; the need to complete a period of residency or fellowship training (required for Board Eligibility purposes in the field of medical practice); the need to complete periods of clinical training precisely so as to enable the physician to more capably serve as a medical practitioner; personal or extenuating circumstances; etc. The law on its face seems clear that it is a commitment to the position rather than the actual commencement of employment that is required, although this interpretation has yet to be recognized uniformly by USCIS.

#### Loss of Shortage Designation

There remains uncertainty as to whether the loss of shortage designation following issuance of a waiver will result in termination of the waiver itself. The prevailing (although largely unexpressed) policy has been that such a loss in designation will not result in the termination of a previously issued waiver, despite the statutory language noting the waiver will be terminated if "the alien's employment ceases to benefit the public interest at *any time* during the 3-year period ...."<sup>56</sup> This should be clarified by USCIS to provide that the subsequent loss of shortage designation will not lead to a revocation of the waiver itself once the waiver is issued and the physician in reliance of the waiver undertakes the contemplated employment.

#### Extenuating-Circumstances Standard

A foreign national physician who has received a waiver becomes obligated to fulfill a three-year service obligation at the petitioning employer unless there are "extenuating circumstances" justifying the physician's departure. The statute cites closure of the facility or hardship to the foreign national as representative examples of "extenuating circumstances."<sup>57</sup> There have not been any meaningful

<sup>52</sup> Each 1/8 VA appointment corresponds to five hours of work.

<sup>53</sup> INA §214(I)(2)(A).

<sup>54</sup> INA §214(I)(1)(C)(ii).

<sup>55</sup> *Id.*

<sup>56</sup> INA §214(I)(3)(B) (emphasis added).

<sup>57</sup> INA §214(I)(1)(C)(ii).

clarifying instructions on this standard. This author suggests that the threshold considerations include circumstances that have arisen beyond the control of the foreign national beneficiary that make it unfair to continue in the employment relationship. This includes discriminatory working conditions (including wages) and employer demands. In many respects, the "extenuating-circumstances" standard should track the policies maintained by the U.S. Department of Labor (DOL) in its labor condition application enforcement standards, which in part are intended to prevent unconscionable employer policies directed toward foreign nationals.

### **Relocation to Another Designated Medically Underserved Area**

In its current iteration, a physician departing under the above-cited "extenuating-circumstances" standard needs also "to demonstrate another bona fide offer of employment at a health facility or health care organization for the remainder of such 3-year period."<sup>58</sup> This has been determined to require service for the balance of the three-year term specifically in a designated medically underserved area. The broader issue becomes whether the flexibility provisions now provide increased latitude for physicians to work in positions that benefit the indigent and medically underserved, but which are not designated medically underserved areas. As noted above, there are quantifiable measures to determine the physician's contributions to the indigent and the medically underserved, and the state departments of health conceivably could play a major role in sanctioning a physician's relocation to a non-designated area of public interest to serving the needs of vulnerable population groups.

### **Changeover Between VA Facilities and Medically Underserved Areas**

As noted in the previous point, the statute creates an obligation of a three-year period of service that needs to be fulfilled absent "extenuating circumstances" and relocation to a practice site serving the public interest for the balance of the three-year term. It is unclear whether there is the possibility of cross-over between physicians receiving IGA waivers through the states and the VA. Both practice situations have been recognized as serving the public interest, which seems to suggest acceptability of

meeting even the most conservative reading of a qualifying health facility or health care organization.

### **THE PHYSICIAN WORKFORCE/HEALTH CARE REFORM CONSIDERATIONS**

Ultimately, the further extension of the Conrad waiver program will depend upon its perceived effectiveness in addressing otherwise unmet health care needs of the country, and in revitalizing rural communities at risk. More specifically, the underlying considerations that are likely to guide Congress in further developing and modifying this program are:

- A consideration of the state of the physician workforce;
- The perceived need for enhanced physician coverage in designated areas; and
- The perceived contributions of IMGs in the health care system.

### **The Physician Workforce**

The prevailing notion throughout the 1990s was that there were too many physicians in the workforce.<sup>59</sup> As a result, various negative consequences for the nation were seen, including an over utilization of physician services, an escalation of national health care expenditures, a drop in physician incomes, and an overall disincentive for individuals to take up the profession of medicine. In response, there was a concerted national policy to limit the physician workforce, principally through a disinclination to fund additional medical training slots or create new medical schools. In addition, the prevailing theory was that managed care would address many of the inequities in the system, so workforce planning aimed for roughly a 50-50 split between primary care<sup>60</sup> and specialty care physicians. The goal of physician workforce planning was not to increase the numbers of physicians; rather, it was to create incentives to distribute more equitably the physician workforce so as to better serve geographic areas and population groups that traditionally had been underserved.

The current theory is vastly different. There is widespread recognition of a major and growing

<sup>58</sup> *Id.*

<sup>59</sup> Sixth Report of the Council on Graduate Medical Education (COGME) (Sept. 1995).

<sup>60</sup> Primary care generally is defined to include the areas of family practice, general practice, internal medicine, OB/GYN, and psychiatry.

shortage of physicians that affects various practice areas—in both specialties and primary care. This shortage is pervasive not only in designated medically underserved areas, but also more broadly throughout the nation.

The Council on Graduate Medical Education<sup>61</sup> anticipates a shortage of 85,000 physicians by 2020.<sup>62</sup> This is a dramatic reversal of its previous estimations.<sup>63</sup> Similarly, the American Medical Association (AMA) now has noted a shortage of physicians, and has called for an expansion in the nation's physician workforce.<sup>64</sup> A survey of medical school deans resulted in an 80 percent consensus on a stark shortage of physicians.<sup>65</sup> The Bureau of Health Professions estimates that 3,400 physicians are needed immediately to address current shortfalls in non-metropolitan Health Professional Shortage Areas (HPSAs), and that 7,000 are required to meet reasonable workforce targets in these areas.<sup>66</sup> If the current numbers of family practice graduates returns to minimally acceptable levels (they are currently at 1997 levels), the density of family practice physicians in rural America, and in the United States overall, will decline after 2010.<sup>67</sup> One study predicts that by 2020, the nation will need 200,000 physicians in order to meet patient demand.<sup>68</sup>

A number of factors regarding the physician workforce are responsible for the shortage:

- Younger physicians want to work fewer hours at the same time that the aging U.S. population requires more care.<sup>69</sup>
- There is an increased demand for specialists combined with less-restrictive managed care models.<sup>70</sup>
- Physician compensation schedules have lagged behind those in other job sectors, with the result that the applicant pool increasingly is turning to careers other than medicine, including high technology or entrepreneurial ventures.
- Physician job satisfaction levels are low due to concern over rising medical malpractice liability insurance costs and perceived need for tort reform, together with high levels of medical school debt.<sup>71</sup>
- The physician workforce itself is aging, especially in rural areas; AMA Masterfile data shows that 11 percent of active patient care general practitioners are older than age 70.<sup>72</sup>
- There is a declining interest in primary care specialties among medical students (especially in rural areas).
- The net income of primary care doctors in rural areas is less than those in urban areas because of lower reimbursement rates and greater numbers of uninsured patients in rural areas.<sup>73</sup> Also, in rural areas specifically, the shortage of physicians has been attributed to factors such as social and professional isolation, the availability of better hospitals and technology in cities, the flight to urban affluence, and a general decline in primary care practitioners.<sup>74</sup>

As for whether the increase in the number of women practicing medicine addresses the shortage (the proportion of women in allopathic family practice residencies rose from only 19 percent in 1980 to as high as 46 percent as of 2003), AMA Masterfile statistics indicate that women are less likely to practice in rural areas. Specifically, these statistics show that 16 percent of women under age 45 in family

<sup>61</sup> COGME was authorized by Congress in 1986 to provide an ongoing assessment of physician workforce trends, training issues, and financing policies, and to recommend appropriate federal and private sector efforts to address identified needs. It essentially functions as an empanelled advisory body to HHS on emerging issues in the health care system. See [www.cogme.gov/whois.htm](http://www.cogme.gov/whois.htm).

<sup>62</sup> M. Croasdale, "Federal Advisory Group Predicts Physician Shortage Looming," *American Medical News* (Nov. 3, 2003).

<sup>63</sup> *Id.*

<sup>64</sup> V. Elliott, "Physician Shortage Likely to Spread," *American Medical News* (Jan. 5, 2004).

<sup>65</sup> R. Cooper *et al.*, "The Emerging Problem of Physician Shortages: Perceptions of Medical School Deans and State Medical Society Executives" 290 *JAMA* 1 (2003).

<sup>66</sup> N. Calman *et al.*, "Physician Shortages," 22 (4) *Health Affairs* 260 (2003).

<sup>67</sup> J. Colwill & J. Cultice, "The Future Supply of Family Physicians: Implications for Rural America," 22 (a) *Health Affairs* 190, 193 (2003).

<sup>68</sup> R. Cooper *et al.*, "Economic and Demographic Trends Signal an Impending Physician Shortage," 21 *Health Affairs* 140, 148 (2002).

<sup>69</sup> Croasdale, *supra* note 62.

<sup>70</sup> *Id.*

<sup>71</sup> Elliott, *supra* note 64.

<sup>72</sup> Colwill & Cultice, *supra* note 67, at 193.

<sup>73</sup> L. G. Hart *et al.*, "Rural Health Care Providers in the United States," 18 (5) *Journal of Rural Health* 211–32 (2002).

<sup>74</sup> Colwill & Cultice *supra* note 67, at 190.

practice are located in non-metropolitan counties, as compared to 24 percent of men.<sup>75</sup>

As a general observation, surveys consistently document a decrease in job satisfaction in the physician workforce, thereby apparently leading to downward pressures on the number of new entrants into the profession and eroding the numbers of medical practitioners remaining in practice.<sup>76</sup>

### National Health Care Reform Measures

According to the National Health Service Corps, roughly 53 million Americans live in either designated medically underserved rural communities or communities lacking acceptable access to physicians.<sup>77</sup>

The shortage of physicians in rural areas is of particular concern. While 20 percent of the population of the U.S. resides in rural areas, less than 11 percent of physicians practice in rural communities.<sup>78</sup> Interestingly, however, roughly two-thirds of all Conrad waivers are issued to physicians working in rural communities.<sup>79</sup>

Despite the fact that the supply of physicians has increased over the last 20 years, the percentage of physicians practicing primary care medicine has declined.<sup>80</sup> Aging rural physicians and increases in the numbers of women physicians who are less likely to practice in rural areas are recent workforce shifts.<sup>81</sup>

Several studies have sought to determine physician practice patterns in rural areas.<sup>82</sup> Growing up in a rural area is the most important independent predictor of a physician's likelihood to pursue rural

practice.<sup>83</sup> Similarly, some data suggest that a higher debt load upon leaving training with a concomitant need for higher paying employment negatively influences the likelihood of practicing in a rural area.<sup>84</sup>

In addition, many Americans do not have adequate access to health care. This is especially true for the 43 million Americans who have no health insurance or inadequate coverage, and who therefore disproportionately enter the health care system at an advanced stage of illness rather than for preventive care, thereby further taxing physician providers.<sup>85</sup>

In light of the above, the federal government, in conjunction with the states, has initiated a series of measures intended to enhance the access of underserved population groups to physicians. These measures include:

- The creation of Federally Qualified Community Health Centers (FQHC) under §330 of the Public Health Service Act (PHSA).<sup>86</sup> While FQHCs are private, nonprofit organizations chartered to provide primary care to poor and underserved populations,<sup>87</sup> they receive funding from the Health Resources and Services Administration under §330 of the PHSA. Physicians working within FQHCs also receive enhanced Medicaid and Medicare reimbursement.
- The National Health Service Corps (NHSC) provides rural HPSAs with physicians and other clinicians. At present, there are approximately 2,700 NHSC clinician placements,<sup>88</sup> of these, physicians comprise roughly 800.<sup>89</sup> NHSC offers substantial benefits to induce U.S. physicians to practice in underserved communities, including loan repayments starting at \$50,000 plus tax assistance payments for a two-year commitment in designated medically underserved areas. The repayment provisions provide for an additional \$37,500 per year

<sup>75</sup> *Id.* at 192.

<sup>76</sup> See, e.g., D. Pathman, et. al., "Physician Job Satisfaction, Dissatisfaction, and Turnover," *Journal of Family Practice* (July 2002); E. Williams, et. al., "Physician, Practice, and Patient Characteristics Related to Primary Care Physicians," *Health Services Research* (Feb. 2002).

<sup>77</sup> See website of the American Osteopathic Association at [www.aoa-net.org/MediaCenter/nomweekphysshort.htm](http://www.aoa-net.org/MediaCenter/nomweekphysshort.htm).

<sup>78</sup> T. Ricketts, "The Changing Nature of Rural Health Care," 21 *Annual Review of Public Health* 639-57 (2000).

<sup>79</sup> Statistics compiled by the Texas Department of State Health Services, covering Oct. 2000-Sept. 2004 (copy on file with author.).

<sup>80</sup> R. Brooks et. al., "The Roles of Nature and Nurture in the Recruitment and Retention of Primary Care Physicians in Rural Areas: A Review of the Literature," 77 (8) *Academic Medicine* 790-98 (2002).

<sup>81</sup> Calman et. al., *supra* note 66, at 261.

<sup>82</sup> R. Brooks et. al., *supra* note 80.

<sup>83</sup> *Id.* at 791.

<sup>84</sup> *Id.* at 794-95.

<sup>85</sup> J. Ginsburg et. al., "The Physician Workforce and Financing of Graduate Medical Education," 128 (2) *Annals of Internal Medicine* 142 (1988).

<sup>86</sup> 42 USC §254c.

<sup>87</sup> L. Baer et. al., "The Need of Community Health Centers for International Medical Graduates," 89 (10) *American Journal of Public Health* 1573 (1999).

<sup>88</sup> See [http://nhsc.bhpr.hrsa.gov/applications/lrp\\_04/e.cfm](http://nhsc.bhpr.hrsa.gov/applications/lrp_04/e.cfm).

<sup>89</sup> K. Fink et. al., "International Medical Graduates and the Primary Care Workforce for Rural Underserved Areas," 22 (2) *Health Affairs* 255, 260 (2003).

in repayment assistance for commitments in excess of two years.<sup>90</sup>

- Physician Shortage Area Programs in medical schools work to recruit physicians to rural underserved areas,<sup>91</sup> and scholarships and loan forgiveness programs through states and federal Title VII programs also exist to supply physicians in rural underserved areas.<sup>92</sup>
- Large proportions of poor and uninsured individuals in rural areas receive care at critical-access hospitals.<sup>93</sup> These hospitals are limited-service facilities located in rural areas that receive cost-based reimbursement (and generally are distinguished from larger acute-care hospitals providing a wider range of care). As a result of a recent General Accounting Office (GAO) report calling for the easing of critical-access rules in rural areas to enable hundreds of rural hospitals to benefit from stepped-up Medicare payments,<sup>94</sup> recently enacted legislation<sup>95</sup> has expanded the capacity of critical-access hospitals to provide acute care while continuing to receive Medicare payments.<sup>96</sup>
- “Telehealth,” which is “the use of telecommunications and information technologies to provide health care services over distance, to include diagnosis, treatment, public health, consumer health information, and health professionals education.”<sup>97</sup> As global demand for health care increases, telehealth systems and technologies is one possible tool to assure high quality medical care for all people, regardless of geographic location.<sup>98</sup>

<sup>90</sup> See [http://nhsc.bhpr.hrsa.gov/applications/lrp\\_04/e.cfm](http://nhsc.bhpr.hrsa.gov/applications/lrp_04/e.cfm).

<sup>91</sup> Fink, *supra* note 89, at 260.

<sup>92</sup> *Id.*

<sup>93</sup> P. Reilly, “Reviewing Restrictions: GAO report calls for easing of critical-access rules in rural areas,” 33 (39) *Modern Healthcare* 17 (2003).

<sup>94</sup> *Id.*

<sup>95</sup> See Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066, at Title IV, Subtitle A §§401–410A.

<sup>96</sup> Center for Medicare and Medicaid Services Office of Public Affairs press release (Jan. 22, 2004); see [www.cms.hhs.gov/media/press/release.asp?Counter=948](http://www.cms.hhs.gov/media/press/release.asp?Counter=948).

<sup>97</sup> D. Brantley *et al.*, “Innovation, Demand and Investment in Telehealth,” Office of Technology Policy, U.S. Dept. of Commerce, Executive Summary at 9 (Feb. 2004).

<sup>98</sup> *Id.* at 1.

## The Role of IMGs in the Physician Workforce

What the above discussion indicates is that there is a substantial crisis in the nation’s health care system and, in particular, in providing sufficient numbers of physicians accessible to various vulnerable population groups. To this end, the federal government has undertaken a number of initiatives to stimulate and better rationalize the access to physicians. The utility of the Conrad waiver program needs to be considered as simply one additional initiative to addressing the nation’s health care needs.

Roughly one-quarter of the physician workforce consists of IMGs (both foreign citizens and U.S. citizens educated overseas), and of this number, there are just over 9,000 J-1 physicians.<sup>99</sup> There is a substantial body of evidence confirming that IMGs perform vital “gap-filling” functions—*i.e.*, that they tend to practice medicine and treat patient populations that otherwise would go unaddressed.<sup>100</sup> Specifically, IMGs disproportionately tend to practice in medically underserved areas and serve minority, immigrant, and underserved patient populations. IMGs work more frequently in the public sector and treat a higher proportion of patients with psychotic disorders. Psychiatrists with international medical degrees also treat more African American, Hispanic, and other minority patients.<sup>101</sup> It is certainly open to question whether these differing practice patterns reflect an inherent altruism of IMGs, or a realistic accommodation to immigration requirements and/or available practice opportunities.

In the past decade and a half, the various J-1 waiver programs have provided a major source of primary care physicians for rural underserved and shortage areas. The annual number of J-1 waivers granted to IMGs for practice in underserved areas increased from 70 waivers in 1990 to 1374 waivers in 1995,<sup>102</sup> and now exceeds 1,000 annually.<sup>103</sup> Roughly one-third of Conrad waivers are granted to sub-specialists, signaling that the need for medical care in underserved areas extends past primary

<sup>99</sup> S. Mick & S. Lee, “The Safety-Net Role of International Medical Graduates,” 16 (4) *Health Affairs* 141, 145 (1997).

<sup>100</sup> *Id.*

<sup>101</sup> C. Blanco *et al.*, “Practice patterns of international and U.S. medical graduate psychiatrists,” 156 *American Journal of Psychiatry* 445–50 (1999).

<sup>102</sup> *Id.*

<sup>103</sup> Paral, *supra* note 18, at 7.

care.<sup>104</sup> Two-thirds of Conrad waivers are for physicians working in rural communities.

Various studies indicate that foreign-trained doctors more often practice in rural, medically underserved areas than U.S. medical graduates.<sup>105</sup> A 2003 analysis of primary care physicians working in HPSAs (which considered both whole and partial HPSAs) showed that 3.9 percent of IMGs practice in non-metropolitan HPSAs, compared with 3.4 percent of U.S. medical graduates.<sup>106</sup> This is an impressive statistic considering that the IMG population in such areas has developed mostly within the past 10 years.<sup>107</sup> Arguably, this disproportionate level of IMG practice in designated medically underserved areas is precisely the result of immigration provisions, designed to encourage many J-1 clinicians to relocate to medically underserved areas or VA facilities in order to remain in the United States. In any case, the data indicates that immigration can and is being used to channel J-1 physicians into practice situations that traditionally have gone unstaffed within the health care system.

As for the level of competency of IMGs versus their U.S. counterparts, there is no conclusive evidence in the literature that IMGs are any less or more competent than U.S. physicians.<sup>108</sup> Despite this fact, a 2002 report found evidence that IMGs are at greater risk than U.S. physicians for exclusion by the federal government from federally funded programs such as

Medicare and Medicaid.<sup>109</sup> The report found no evidence that IMGs are less ethical in their Medicare and Medicaid billing practices than U.S. physicians; it did offer the possible explanation that some IMGs may need more assistance than U.S. physicians in deciphering and complying with complex federal billing procedures, and suggested that state and federal agencies concerned with billing fraud and abuse might find it effective to devote more resources towards educating IMGs on improved compliance with federal reporting requirements.<sup>110</sup>

A cutback in IMG presence in medically underserved communities likely would have a substantial impact on the adequacy of care at a significant number of community health centers. These health centers currently are a primary source of medical care for the indigent and the medically underserved.<sup>111</sup> As much as 15 percent of full time positions at community health centers could go unfilled if IMGs were no longer available. As such, reducing the flow in IMGs into the United States could have negative consequences, potentially endangering the ability of many community health centers to provide care for the underserved.<sup>112</sup>

#### THE FUTURE OF THE CONRAD PROGRAM

In light of the discussion above, it appears that the Conrad waiver program has been a useful initiative in addressing some of the nation's health care needs. The aim of the program is fully consistent with national objectives for enhancing the access of vulnerable population groups to physicians. The data strongly suggests that IMGs perform important "gap-filling" services, such that their practice patterns tend to flow disproportionately into practice situations not staffed by U.S. physicians. Assuming that IMGs are not more altruistic than their U.S. counterparts, the evidence is clear that the Conrad program has been an important stimulant in addressing an important national objective by linking immigration benefits to socially desirable medical practice patterns.

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<sup>104</sup> *Id.* at 8.

<sup>105</sup> Baer, *supra* note 87.

<sup>106</sup> Calman, *supra* note 66, at 261.

<sup>107</sup> It is worth mentioning again that nearly 65 percent of the IMG population are either U.S. workers or nonimmigrants not holding J-1 status. Therefore, the IGA waiver program is inapplicable for compelling their relocation to practice situations of greatest national need. This author surmises that the vast majority of J-1 physicians entering the U.S. physician workforce are beneficiaries of the IGA waiver program. This is, quite likely, precisely the cohort responsible for the relative increase in IMG presence in designated medically underserved areas. While a J-1 clinical physician can obtain a waiver based on an HHS research waiver, or through a showing of persecution or exceptional hardship to a qualifying anchor relative, these waivers are obtained far less frequently than IGA waivers.

<sup>108</sup> See S. Mick & M. Comfort, "The Quality of Care of International Medical Graduates—How Does it Compare to that of U.S. Medical Graduates?," 54 (4) *Medical Care Research & Review* 379-413 (1997).

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<sup>109</sup> W. Dow & D. Harris, "Exclusion of International Medical Graduates from Federal Healthcare Programs," 40 (1) *Medical Care* 68-72 (2002).

<sup>110</sup> *Id.*

<sup>111</sup> Baer, *supra* note 87, at 1573

<sup>112</sup> *Id.*

In considering future extensions of the program, Congress presumably will consider at least some of the following issue areas:

- An expansion of the flexibility waiver provisions, so as to enhance the ability of state health care planners to channel physicians into practice situations best serving the needs of the indigent and medically underserved;
- Either an increase in (or even an elimination of) the current allotment of a maximum of 30 waivers per state, or a national pooling arrangement so as to relieve the pressures on the waiver numbers as experienced by many of the states;
- A determination on whether the beneficial results of the state-administered J-1 waiver program in facilitating the relocation of physicians to communities at risk have become sufficiently clear so as to justify making the program either permanent or of a substantial duration;
- The fact that federal agencies have not shown a commitment to staffing community-based health care needs with foreign national physicians underscoring the traditional role of the states in serving the health care needs of its residents;
- An understanding that the Conrad waiver program is not primarily an immigration program, but rather is a health care and rural revitalization initiative, undertaken at times of pronounced shortages in the physician workforce and increased demand for physician services;
- Relief from the numerical limitations on both H-1B and permanent resident visas for physicians who have served for designated periods of time in socially important medical practices;
- An enlargement of immigration benefits both for J-1 waiver purposes and for permanent resident purposes for physicians who, while not practicing medicine in facilities that are physically located in medically underserved areas, nevertheless provide safety-net services to at-risk populations.

The states have long been regarded as the laboratories for new, innovative programs of benefit to their residents, particularly in the area of health care. The Conrad waiver program represents a creative federal-state partnership ultimately resting on the ability of the states to define their physician workforce/health care coverage needs, and to channel J-1 physicians into socially important positions serving the public interest. The states have a well-grounded understanding of community-based medical cover-

age needs, and the Conrad waiver program provides the state departments of health with an additional planning tool for local needs. While this program in its implementation to date has achieved a degree of success, its further development and enlargement hopefully will provide state health care planners with increased latitude to address certain inadequacies in the health care system.