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FLATLINING CARE: WHY IMMIGRANTS ARE CRUCIAL TO BOLSTERING OUR HEALTH CARE WORKFORCE

HEARING

BEFORE THE

SUBCOMMITTEE ON IMMIGRATION, CITIZENSHIP AND BORDER SAFETY

OF THE

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CONTENTS

OPENING STATEMENTS

WITNESSES

APPENDIX

FLATLINING CARE: WHY IMMIGRANTS ARE CRUCIAL TO BOLSTERING OUR HEALTH CARE WORKFORCE

WEDNESDAY, SEPTEMBER 14, 2022,

UNITED STATES SENATE,
SUBCOMMITTEE ON IMMIGRATION, CITIZENSHIP,
AND BORDER SAFETY,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Subcommittee met, pursuant to notice at 10:06 a.m., in Room 226, Dirksen Senate Office Building, Hon. Alex Padilla, Chair of the Subcommittee, presiding.

Present: Senators Padilla [presiding], Klobuchar, Hirono, Cornyn, and Tillis.

Also present: Senators Durbin and Grassley.

OPENING STATEMENT OF HON. ALEX PADILLA, A U.S. SENATOR FROM THE STATE OF CALIFORNIA

Chair PADILLA. Morning, everybody. Welcome to the fifth hearing of the Senate Judiciary Subcommittee on Immigration, Citizenship, and Border Safety this Congress. We're here to talk today about the critical role that immigrant health care professionals play in our Nation's health care system. And the opportunity and, frankly, the obligation we have to confront our Nation's growing shortage of health care workers.

I want to thank all of our witnesses who are here today, both in person, and we have one witness participating virtually who will speak about their personal experiences and our shared goal of improving care for millions of Americans. For that same reason, I want to thank Chairman Durbin, Ranking Member Cornyn, who will be joining us momentarily, and all the Committee staff who have worked so hard to organize today's hearing.

Today will shed light on solutions to the challenges facing our health care system. Solutions, frankly, that can save lives and have a chance to improve our immigration laws in ways that better serve the needs of our population and our economy. Americans facing obstacles to access to the standard of health care they deserve is nothing new. But in recent years it has become even harder.

Even before the COVID–19 pandemic, the United States was experiencing some concerning trends. Our population was aging with an increasing demand for care, while retirements by physicians continued to rise. Daunting student loan debts were discouraging prospective health care professionals from entering the field, and

hundreds of hospitals in rural or low-income communities were at risk of closing after struggling to recruit or retain physicians. The onset of the COVID–19 pandemic created an entirely new strain on our workforce, thrusting America's health care workers onto the front lines of a once in a century global health pandemic and accelerating burnout in an already fractured system.

Tragically, since the beginning of the pandemic to November 2021—so this was almost a year ago—at least 4,547 health care workers, including 458 nurses, have died while caring for their patients. As a result, we're now facing an even more dangerous shortage of health care workers. The Association of American Medical Colleges projects the U.S. is facing a shortage of up to 124,000 physicians by the year 2034. That means a shortage of up to 48,000 primary care physicians and more than 77,000 non-primary care physicians.

In addition, an estimated one million nurses are expected to retire in the next decade. For over 2 1/2 years of the pandemic, Americans had to put doctor's appointments and lifesaving screenings on hold. But as COVID becomes endemic and as we learn to better manage outbreaks, Americans should not be forced to further delay lifesaving care because we failed to invest in and grow our health care workforce. We have to protect our health care workers and ensure they're able to work reasonable hours, have better staffing ratios, and that they're paid adequately, and have the equipment needed to keep them safe.

Now, I'm proud to be an original co-sponsor of the National Nursing Shortage Reform and Patient Advocacy Act. But that alone won't be enough to bridge our entire health care workforce gap. The good news is there are some commonsense solutions right before us. There are thousands of highly capable health care professionals living abroad with the desire to come to America to study, train, in their profession, and work saving lives. We know immigrant health care workers can help to fill the health care workforce gap and provide critical care because in communities throughout the United States, they're already there. They're already doing it.

One in every four physicians in the United States is an immigrant. And one in every six nurses is an immigrant. Among them, there are approximately 34,000 DACA recipients and 11,600 TPS holders working in health care. And with an aging population in increasing need of care, immigrants make up over half of our physicians practicing geriatric medicine in nearly 38 percent of Americans home health aides.

So, think about this. Immigrant doctors write prescriptions. Immigrant nurses care for us at our bedsides. Immigrant health care professionals perform highly skilled procedures each and every day. And they're often the cornerstone for rural and low-income communities, places where a single foreign-born physician can be tasked with treating an entire community. They can and they want to be part of the solution to our health care workforce crisis.

However, even as we face unprecedented shortages in our health care system, the laws that limit the immigration of highly trained health care workers have gone largely unchanged since the 1990's. There continues to be significant backlogs in processing green cards for critical health care workers. There are annual caps to employ-

ment-based visa categories that have not been met and per country caps that should be updated to meet the demand of today's health care industry. And many of the federally recognized essential workers that we relied on at the peak of the COVID–19 pandemic still risk uncertainty with their legal status in America.

In our hour of need, the United States is effectively discouraging potential health care workers from trying to come to and work in the United States. That needs to change. The very first bill I introduced in the Senate, co-sponsored by Chairman Durbin and other Members of this Committee, would start to protect many of those workers at risk by providing a pathway to citizenship for over 5 million essential workers without permanent status. The Citizenship for Essential Workers Act would protect health care workers who risk their lives to keep our communities safe during the pandemic.

I'm also calling on the Senate to pass the Americans—excuse me, America's Children Act and protect documented dreamers, the children of long-term visa holders who face deportation at the age of 21 without a green card or other immigration status. Many health care professionals worry about their own children aging out of status or losing status completely if something were to happen to the primary visa holder.

And as we'll hear today, what we need are system wide reforms that incentivize and welcome immigrants into our health care workforce. I'm looking forward to hearing from all of our witnesses today about their experiences and their ideas for fixing this broken system. I'll now recognize Ranking Member Cornyn for his opening remarks.

STATEMENT OF HON. JOHN CORNYN,
A U.S. SENATOR FROM THE STATE OF TEXAS

Senator CORNYN. Well, thank you, Mr. Chairman. I enjoy working with you on these issues. But as we've discussed in private, it's hard for us to make progress on areas even where there is consensus on the topic of immigration while the border is on fire.

Last year alone, 108,000 Americans died of drug overdoses and almost all that comes across the southwestern border. Seventy-one thousand of those 108,000 were overdosed on synthetic opioids like fentanyl, the precursors of which, of course, come from Asia and then are manufactured in Mexico come across the border because the Border Patrol is overwhelmed by the volume of humanity coming across, which is, of course, part of the plan, part of the business model of the drug cartels. Overwhelm the Border Patrol. They're busy taking care of unaccompanied children and other migrants in a humane way, as we would want them to do.

But in the meantime, it takes Border Patrol off of the border where the drugs come across. And, of course, there are serious concerns, as there should be, about crime in America. And the truth is that most of these drugs are distributed by a network of gangs operating in all of our major cities and even in some of the rural parts of our country, and who are largely responsible for much of the gun violence you see in places like Chicago and elsewhere as they fight for market share and for territory.

So, for at least now, a year and a half during the course of the Biden administration, our Democratic colleagues have been in the majority. The Chairman of this Committee has unilateral prerogative to mark up any bills that he wants. But as I have told him in private, trying to work in good faith with him and the Chairman of the Subcommittee, I can't imagine a path forward until we find some way to deal with the crisis at the border, which is basically a policy problem because of the way that asylum cases are treated.

As long as catch and release is the rule, as long as our—the Biden administration refuses to detain people who are awaiting their asylum hearing and then gives them a notice to appear given the backlogs of the immigration courts, many people don't appear. And, of course, that is—that's the again, part of the plan, part of the model that is enriching some of the most dangerous transnational criminal organizations in the world.

And finally, for those people like Vice President Harris and others who think this is a problem with just the Northern Triangle and Central America, that is refuted by the fact that if you go to the Rio Grande Valley sector or the Del Rio sector of the Border Patrol, that they have as many as—people from as many as from 150 different countries detained there.

Of course, the numbers, the big numbers come from Mexico and Central America. But literally, if you have enough money, you can make your way to the southern border and claim asylum and then get placed into the interior of the United States to await your court hearing. And like I said, many people don't show up.

And finally, I know there's been some objections raised by the mayors of Washington, DC, and New York, and Chicago over transporting migrants from the border communities where they cross into their cities, each of which I believe, continue to hold themselves out as a sanctuary city. But yet, when they begin to feel some of the pressures that our border communities feel every day with many, many multiples of the numbers to deal with, they ask, as Mayor Bowser has here in Washington, DC, for the National Guard because of a crisis they're experiencing.

So, I'm—I remain an optimist. At some point, I think we will have tried everything except the real solution to the problem and which will break the log jam, which is to deal with the problem of catch and release and the broken asylum system at the border. Then maybe we can deal with things like the Conrad State 30 and Physician Access Reauthorization Act, or the Health Care Workforce Resilience Act, or maybe even provide some certainty to the DACA recipients that are anticipating a affirmance of the trial court's decision holding that that program 10 years ago started by President Obama when he said he didn't have the authority to do it.

He did it anyway. And the district judge agreed with him. He did not have that authority. And I expect that to be enormously disruptive to these young people who've done nothing wrong.

Chair PADILLA. Thank you, Senator Cornyn. Before recognizing Senator Durbin, just want to remind us all, those in the Committee room and those watching from home, that the topic of today's hearing is what I mentioned earlier, why immigrants are critical to bol-

stering our health care workforce. But Senator Cornyn does raise some legitimate concerns.

And so, for everybody's appreciation, I want to acknowledge that the vast majority of drugs that are smuggled into the United States are through land ports of entry with documented travelers, often United States citizens. In fact, statistics from the Department tells us that the Border Patrol has seized 504,000 pounds of drugs. However, only 72,000 pounds were seized by Border Patrol agents. The vast majority make up 14 percent. The vast majority was actually seized by the Office of Field Operations.

And if you know the agents, you'll appreciate the distinction. The vast majority being seized at ports of entry by more than a 7-to-1 ratio. So, the key to stopping fentanyl smuggling or other drug smuggling operations is improved screening technology at our border and better utilization of new technologies at that.

So, I'm happy to welcome the—or continue the more comprehensive conversations about immigration, the status of our border. But I'd like for us, for purposes of today to focus on today's topic and that is our health care workforce. And with that, let me recognize Senator Durbin.

STATEMENT OF HON. RICHARD J. DURBIN,
A U.S. SENATOR FROM THE STATE OF ILLINOIS

Chair DURBIN. Thank you very much, Chairman Padilla. And I want to echo your remarks. We're here to discuss a shortage of health care workers, and yet the conversation so far from the other side of the aisle has not addressed that issue. They want to talk about border security and border safety. They're important issues. I agree with the Chairman on that. But I had hoped that we would focus more of our time on actually trying to help a problem, deal with a problem that is very real across the United States, including all of our States gathered here today.

I just want to note a couple of things. Governor Abbott is putting recent entries into the United States, people who have passed the critical fear test, critical concern into the busses and sending them off to cities across the country without any warning. I visited one of those centers last Friday in Chicago at the Salvation Army. And let me spend a second or two thanking the people from the Salvation Army and all the wonderful charities that have stepped up to try to help these people who are in a desperate position.

I'm concerned about their fate, as we all should be. But I'm concerned about the Governor of Texas and his decision just to dump busloads of these people without warning into communities. We are doing our best, and we're going to deal with them in a humane and American way. But it would be helpful if they didn't become the victims in this—or pawns in this political debate at the National level. I think we ought to be a little more caring for the women and children, families and individuals who are coming across our border and are here having been judged to be legally qualified to stay until they have a hearing ultimately deciding their fate.

I met with them. I sat down. I talked to them. They're in a desperate situation. They've come, many of them, 4 or 5 months traveling to the United States, risking their lives and many of them suffering things that none of us would want to endure. I think they

should be treated in a humane American way. And that means the Governor should at least give us warning if he's going to be shipped them off to county—cities around our country.

Let me say back on the issue of health care workers. Some people look at the immigration issue and see murderers, and rapists, and drug dealers. What we're talking about today is looking at the immigration issue and seeing nurses, and doctors, and medical professionals, and caregivers. They're already here and we need more of them. I think that is a worthy topic of conversation. I traveled my State in the month of August from the city of Chicago down to the most rural areas of Illinois. The message was consistently the same.

Dr. Alur, who is here today—thank you for being here—works at the Marion, Illinois Veterans Hospital, has for 11 years. I went down to Southern Illinois Healthcare. Mack's buddy, met with him, and talked about what they're facing. They are facing a dramatic shortage in nurses, dramatic shortage in doctors. And what we're trying to do here is to try to find a solution to this. But as long as we're stuck on the issue of law enforcement, we can't even address this. I would just say this.

I'm going to go out on a limb here. And, boy, I guess I could be proven wrong. But if you can show me a nurse or doctor immigrant to this country who is now still in immigrant status, who has committed a serious crime, I'd like to know about it. I haven't heard it. Just the opposite is true. These men and women are coming to the aid of people who desperately need medical care. And to brand them as part of the surge at the border and somehow criminal in their—in some respects, I don't think is fair. I don't think it really addresses the reality of what immigrants bring to this country.

Our immigration system is broken, and the reason we haven't changed it is not for lack of effort. Everyone gathered here today has been part of that conversation. But we're a 50-50 Senate and a 50-50 Committee within the Senate, and it's difficult to find a bipartisan approach that does ring true to everyone involved in it. We've tried, and I'm afraid we haven't reached it yet, but I hope we do soon.

I want to thank the Chairman for identifying health care workers and health care professionals as one possibility. Wouldn't it be something if we did before the end of the year, a bipartisan bill that brought more doctors and nurses to America where we desperately need them right now? If we put aside all our differences on all the other things and dealt with that, wouldn't it be refreshing to the American people that we get it, that we understand the message we're receiving?

The American Hospital Association called the current hospital workforce shortage a national emergency. They project a shortage of 1.1 million nurses by the end of the year—by the end of the year. This is a critical emergency. To say that we have to solve the southern border crisis before we can consider allowing nurses to come to this country and care for Americans is just plain wrong. We need to deal with both, but we can deal with one immediately. The Association of American Medical Colleges estimates the U.S. could see a shortage of 124,000 doctors by 19—2034. That's for real.

I can tell you there are many of them that are here, these physicians already serving our communities and saving lives as we speak. And many of them, unfortunately, due to the lack of available green cards, are forced to remain on temporary visas. And as the Chairman has alluded, when their kids reach the age of 21, the protection that allowed them to stay with their parents in the United States evaporates, and they're subject to deportation.

How would you like to be a doctor going into surgery knowing that next week your daughter, who you would give anything for, could be subject to deportation? We can fix that. That's what this Committee does. This is our jurisdiction. Wouldn't it be great if before the end of the year we had a bipartisan answer to that simple challenge? I know Dr. Alur has addressed this, and he knows it personally, and we do to from the professionals in this country.

So, I'm going to conclude by just by saying there's work we can do. There are things we can achieve, and soon. The bills that have been addressed here, the Health Care Workforce Resilience Act, which I co-sponsored with Senator Cornyn, the Conrad State 30 and Physician Access Reauthorization Act, have more than a dozen Republican co-sponsors. You know what that means in terms of the Senate? That means we can hit the magic number of 60 and get this through.

Now, there are some on the other side of the aisle, not alluding to any person who's present here, but there are some on the other side of the aisle who want not one single immigrant to come to this country. I'm not exaggerating. They don't want a single one. They happen to believe that makes us stronger as a nation. I couldn't disagree more. I'm the son of an immigrant and proud of it. I think I'm doing a service to this country, and I hope that I can continue it and many more just like me. Sons and daughters of immigrants and immigrants themselves want to make America a better and safer place. That's what this hearing is all about.

Chair PADILLA. Thank you, Chairman Durbin. We're also joined this morning by Ranking Member of the Judiciary Committee, Senator Grassley. Senator Grassley, did you have an opening statement, or do you want to wait for questions?

Senator GRASSLEY. I just have questions.

Chair PADILLA. Okay. Then let's hear from our witnesses, and we'll hear from Senator Grassley very soon. Now, let me just go through some of the mechanics for the rest of today's hearing. After we introduce and swear in witnesses, they will each have 5 minutes to make their opening remarks. We will then begin with our first round of questions, and each Senator will have 5 minutes. So, I ask colleagues that we please try to remain within your allotted time.

As far as introductions go, let me start with Ms. Peterson. Ms. Sarah Peterson is the founder and principal attorney of SPS, Immigration PLLC, a law firm based in Minneapolis, Minnesota. Sarah's practiced immigration law for more than 15 years. She advises health care systems, nonprofit organizations, hospitals, and universities throughout the United States on complex immigration matters relating to the hiring of physicians, researchers, and allied health professionals. Ms. Peterson is an adjunct professor at the

University of Minnesota Law School and was a 2021-2022 policy fellow at the Humphrey School of Public Affairs.

She also actively participates in the International Medical Graduate Task Force and currently serves as the chair of the IMGT Liaison Committee. Ms. Peterson is also active in the American Immigration Lawyers Association and has been recognized as a leader in her field. We also have Sheriff Martinez with us virtually, and I'll turn to Ranking Member Cornyn to do his introduction.

Senator CORNYN. Well, thank you, Mr. Chairman. Unfortunately, I'm advised that Sheriff Martinez's video is not working correctly. He can join us by audio, and I expect him to—he will do that. But Sheriff Benny Martinez has served Brooks County, Texas, since 2009. Brooks County is where the Falfurrias checkpoint, which is one of the busiest checkpoints inland from the border where coyotes, human smugglers, will tell their—the migrants to get out of the vehicle south of the checkpoint, walk around the checkpoint, and meet them on the north side to be then transported on to their ultimate occasion.

The problem is that Brooks County cannot afford to bury all the dead migrants that die in the rough country during hot weather, especially after suffering from exposure having come from long distances. They can't afford to bury those bodies and have asked the Federal Government for assistance. Actually, Vice President Harris, when she was a Member of the Senate, and I, passed a bill which unfortunately still has not seen the money flow to Brooks County for that purpose. But I'm hopeful it will soon.

Prior to his service in Brooks County, Sheriff Martinez was a Texas State trooper from 1979 until his retirement in 2008, retiring at the rank of Sergeant. As a State trooper, he was charged with directing the State's enforcement efforts against illegal drug trafficking. And we're glad to have him here as a witness today, albeit solely by audio. Thank you.

Chair PADILLA. Thank you, Senator Cornyn. I'll now turn to Chairman Durbin for his introduction of Dr. Alur.

Chair DURBIN. I mentioned Dr. Alur a moment ago, but I want to say further. He's been a physician at the Marion Veteran Affairs Medical Center in Marion since 2011. Dr. Alur's hospital serves veterans in southern Illinois, Kentucky, Missouri, and Indiana. We love Marion, and the veterans love it even more. And thank you for 11 years of your life. I might add that Dr. Alur completed his medical degree in India, did his medical training in the United Kingdom and Philadelphia before coming to Illinois.

He is caught up in the green card backlog, and I'll have him explain that when he makes his statement. But he now has helped to co-found an organization of similar physicians who want to be part of America's future and want their family to be part of America's future. And they are stymied by the limitating—limitations in green cards available to allow that. It's time for us to drop the blinders and realize we need you, Dr. Alur, the veterans of southern Illinois and Kentucky need you and people just like you all across the United States. So, I'm glad you're here today. We're honored for your presence.

Chair PADILLA. Thank you, Chairman Durbin. Now, I'll ask our witnesses to please stand and be sworn in. Sheriff, you're on your honor. Please raise your right hand.

[Witnesses are sworn in.]

Chair PADILLA. Thank you very much. You may be seated. The record reflect the witnesses have responded in the affirmative, and now let's proceed to witness testimony. Ms. Peterson, you may begin.

STATEMENT OF SARAH K. PETERSON,
PRINCIPAL ATTORNEY, SPS IMMIGRATION PLLC,
MINNEAPOLIS, MINNESOTA

Ms. PETERSON. Good morning, Chair Durbin, Chair Padilla, Ranking Member Grassley, Ranking Member Cornyn, and Members of the Subcommittee. My name is Sarah Peterson, and I am an immigration attorney who has helped doctors and their employers navigate our complicated and outdated immigration system for almost two decades. Thank you for this opportunity to discuss the growing U.S. health care emergency and how Congress can effectively advance bipartisan, smart, and targeted reform critical to addressing the existing lack of access to health care in the United States.

The shortage of doctors in the U.S. is well-documented and continues to grow due to a variety of factors, including our aging population, which both increases the number of people seeking care as well as the numbers of doctors ready to retire. In the next decade, more than two out of five active physicians will be 65 or older. This crisis is only compounded by the increasing COVID burnout by our frontline workers. Further, in the U.S. today, more than 95 million people live in health care shortage areas. That's one third of the United States.

This number will continue to grow and by 2034, the U.S. will face a shortage of up to 124,000 doctors as that sign reflected. This number balloons if every American had equal access to Medicare and their shortages grow to over 180,000 physicians. Growing up myself in a poor rural community in central Minnesota, I saw firsthand the real effects that the lack of access to health care prepared. And for the past two decades, I have represented doctors who have heroically stepped up to fill this shortage.

International doctors are a critical part of the immediate solution to this crisis. But our outdated physician immigration laws have not seen reform for over 20 years. To be a doctor in the U.S., every international doctor must first complete U.S. medical residency or fellowship training. Over 80 percent of these doctors train in J–1 status, but then are required to leave the United States and return to their home country for 2 years. While our laws provide a small number of Conrad J–1 waivers for doctors to stay in the U.S. based on their work in underserved communities, each State only receives 38 Conrad J–1 waivers each year, which is simply not enough.

Further, our laws should encourage and reward international doctors who work in underserved communities by removing numerical quotas. What follows are concrete steps for Congress to take to address this emergency. First, pass the two bipartisan bills pending in this Committee. The Health Care Workforce Resilience

Act is a bipartisan bill led by Chairs Durbin and Cornyn. This bill is a direct recognition of the essential role international doctors have played in the national COVID pandemic and provides necessary green card relief to the international doctors who are working on our front lines.

Similarly, the Conrad State 30 and Physician Access Reauthorization Act is also a bipartisan bill led by Senators Klobuchar and Collins. Through this bill, Congress would give States the ability to grant Conrad waivers based on need, not an artificial number. Just last year alone, more than half of the States fully exhausted their supply of Conrad J–1 waivers, leaving needy Americans without access to health care. Several more States used almost all of the allotted numbers, and the demand continues to grow each year.

Doctors who are not granted a Conrad waiver in most instances must depart the U.S., potentially never to return. For example, the Mayo Clinic each year must prioritize which doctors to sponsor for its limited Conrad J–1 waiver slots, knowing that not all will be selected. Last year, 13 out of the 23 doctors at the Mayo Clinic did not receive a waiver.

One doctor, a highly influential oncologist treating breast cancer patients, has been waiting 7 years to obtain a Conrad waiver. While this doctor is lucky enough to qualify for a different work status to continue treating cancer patients in the U.S., most doctors do not qualify. For doctors who are not eligible for an alternative work status, the Mayo Clinic is forced to rescind the offer of employment, and these very doctors are almost always the ones seeking to work in the most neediest, underserved communities. This is not right.

Second, we should exempt international doctors working in underserved areas from the numerical immigrant and nonimmigrant visa quotas that no longer serves United States national interests. Doctors from India and China comprise one quarter of all international doctors in the U.S. yet face years of delay in getting their green cards.

In 2006, I began representing a primary care doctor from India on his green card process based on his work in an underserved community in Missouri, where he remains working today. Just 2 years ago, 13 years after starting this process, he finally received his green card. This doctor provided primary care in an underserved area, yet he still has to wait 13 years. Thirteen years of wondering what would happen if he lost his job. Thirteen years of renewing his temporary visa over and over. Thirteen years of not knowing what to tell his kids about their ability to remain in the U.S. long term. Thirteen years.

Similarly, the numerically limited H–1B program, which remains the primary pathway for most international doctors to work in the U.S., prevents Americans from receiving primary health care services. I work with a clinic in Southern Texas that has been trying to recruit OBGYN doctors for years to its underserved rural community. The need is so dire that this practice must bus women hours to the nearest health care facility for care, which results in delayed care, unnecessary complications, and substantial financial burden to these women and their families.

Exempting international doctors who work in underserved communities both from the green card and the H–1B quota, is a smart, simple solution that will have an immediate and profound impact on the availability of quality health care for all Americans. Lack of access to equitable health care is a United States emergency. And this bipartisan issue demands immediate bipartisan solutions. Effectuating smart immigration reform, as I have reviewed today, will allow U.S. trained doctors to help address this country's ongoing shortage of access to basic medical care.

I am lucky that despite growing up in my rural community, my community was eventually able to attract and recruit an international doctor who not only treats my family members but remains in this community after 20 years. Thank you for this opportunity to testify, and thank you for your efforts to solve this urgent health care crisis by ensuring all Americans have equitable access to the health care they deserve.

[The prepared statement of Ms. Peterson appears as a submission for the record.]

Chair PADILLA. Thank you, Ms. Peterson. We'll now turn to Sheriff Martinez. Sheriff, please proceed with your testimony.

[Pause.]

Chair PADILLA. We're having some technical difficulties. While we try to get Sheriff Martinez back on the line here, if it's okay with you, Senator Cornyn, we'll proceed with Dr. Alur and your opening statement.

STATEMENT OF DR. RAM SANJEEV ALUR, MD, HOSPITALIST PHYSICIAN, MARION VETERANS AFFAIRS MEDICAL CENTER, MARION, ILLINOIS

Dr. ALUR. Good morning, everybody. Chairman Padilla, Chairman Durbin, Ranking Member Cornyn, Ranking Member Grassley, and honorable Members of the Committee, it is an honor to speak with you today on the role of immigrant physicians in the U.S. health care system. Thank you for the opportunity.

My name is Dr. Ram Alur. I'm a physician at Marion Veterans Affairs Medical Center in Illinois. I came to the States in 2007 on a J–1 visa as an exchange visitor from India for my medical residency training. Exchange visitors are generally required to leave the United States and return to their home country after completing their residency unless they can obtain a full waiver of that requirement via commitment to work in an underserved areas for 3 years. I chose to work in an underserved area and was lucky enough to obtain a waiver to stay in the States.

More specifically, I chose to work with the Veterans Affairs because I thought I could put the training I had received in the U.S. to the best possible use by working for the largest integrated health care system and serving the most distinguished group of Americans, the veterans. I also believe that Marion was a great community to raise a family.

The Veterans Affairs Hospital at Marion is a cherished institution serving veterans from Illinois, Missouri, Kentucky, and Indiana. Even though I completed my 3-year service commitment in 2014, I continue to work there to this day as it is a great honor and privilege to serve the Nation's heroes, and I have no plans to

leave. However, the immigration system could have other plans for me.

Why are immigrant physicians important? Well, one in four physicians in the U.S. are immigrants, and immigrant physicians are more likely to serve in the rural and underserved areas than American-born doctors. There is a huge disparity in health care access and outcomes in these areas, and immigrant physicians are a critical and important solution to that problem. But due to an outdated immigration system, that solution is at risk.

I'm going to share my experience to highlight the problems faced by immigrant physicians today. Doctors like me are on a temporary work visa called H–1B. The H–1B visa only allows us to work in a specified location. Any work outside the specified location is considered a violation of a work permit. During the pandemic, I could not answer numerous calls for reinforcements near or far. Like me, there were an estimated 15,000 physicians that were restricted from being on the frontlines, providing lifesaving services.

The H–1B allows me to stay in the country with my family legally because of my valid nonimmigrant worker status. If I can't work, we can't stay. This lack of protection with death or disability on the frontlines is every temporary visa worker's nightmare. The H–1B visa also makes it difficult for us to travel outside the country. The last time my wife and I saw our aging parents was in 2019. You see, we need a visa stamped in our passports by a consulate in India in order to reenter the United States. During the pandemic, this process was risky as consulates were either not open or were taking only few appointments. We just simply could not risk traveling outside when there was a great need here.

My petition for permanent residency was approved in 2016 because it was in the national interest based on my work at the VA. However, we still have to wait for an immigrant visa number or a green card to become available. And I've been waiting 6 years, working 11 years, and been in the country for nearly 15 years. My wait could be another decade or more. Until then, my work permit or status needs to be renewed at least every 3 years, which is a huge administrative burden.

I've had to renew my status five times so far. One hiccup in this long, complicated process and my whole family will be affected. It is deeply unsettling that my daughter, who was born in India, will age out of legal status when she turns 21. It is hard to say out loud, but this is only 6 short years away. If I do not become a permanent resident by then, she will lose legal status and have to leave. Sadly, many families do not have the time I have and have gone through painful family separations.

Our family is also a victim of poor health care access. We could not find mental health services for our daughter in southern Illinois during the pandemic, and in June 2020, we decided to move to St. Louis area. But I continue to work at Marion VA and commute over 2 hours. During the same summer, my wife was restricted from driving for 6 months. For me, trying to balance home life and caring for patients was burdensome, exhausting, and unnecessary. The backlog in our immigration system and long processing delays were to blame. The time it took to process my wife's visa renewal was a trying time for our family.

While we faced some hardships, they are no worse than many other immigrant stories you've heard here before this Committee. And unfortunately, they're not welcoming to the future generations of immigrant doctors. I do not want to give up on effecting change. I want to encourage more international physicians to come in and serve in this beautiful country we call home.

So, I'm here today as a physician to share with you my on-the-ground perspective. America needs more health care workers, and immigrant physicians are a key solution to that. Unfortunately, this outdated system is a problem that will only get worse absent action from Congress, and it will impact the most vulnerable patients who've struggle with access long—long before the COVID–19 pandemic. Thank you very much for the opportunity to testify today.

[The prepared statement of Dr. Alur appears as a submission for the record.]

Chair PADILLA. Thank you, Dr. Alur. We can try one more time with the sheriff. Are you with us?

Sheriff MARTINEZ. Mr. Chairman, can you hear me?

Chair PADILLA. We can hear you now.

STATEMENT OF URBINO "BENNY" MARTINEZ,
BROOKS COUNTY SHERIFF, FALFURRIAS, TEXAS

Sheriff MARTINEZ. Thank you, sir. Chairman Padilla, Ranking Member Cornyn, thank you for the opportunity to appear before this Committee to discuss this important issue. I've been having technical difficulties. I'm up here in Arizona on the conference. I'm Ben Martinez. I'm the Brooks County Sheriff in South Texas. Brooks County Sheriff's Office has five deputies and command staff and is responsible for maintaining law and order within a rural region of 943 square miles that encompasses the county seat of Falfurrias.

Outside of the city of Falfurrias, the county consists of private ranch lands. The sandy terrain is mostly vegetative, with mesquite trees, scrub oaks, and prickly pear cactus. The county's population is about 7,400. Brooks County has the checkpoints, one of the busiest check points in the Southwest corridor, approximately 70 miles north of the U.S.-Mexican border on U.S. 281 or either 69 west. Highway 281 is the major north-south artery from the Rio Grande Valley area that leads to Houston, San Antonio, Austin, and Dallas, and other destinations throughout the interior of the United States.

United States 281 is part of the Gulf Coast corridor, which is one of the most active drug and human smuggling corridors in the United States. The Falfurrias checkpoint is one of the busiest checkpoints in the Southwest corridor in regards to undocumented crossers, apprehensions, and narcotics seizures. Because of the Brooks County geographical location, the Border Patrol checkpoint, it has their very own unique challenges.

In most cases, smugglers, coyotes, drop off undocumented crossers. They are led by the smugglers and made to walk east and west of Highway 281 to circumvent the checkpoint, moving north to private ranch lands to get picked up on Texas Highway 285 and other

roads by other smugglers, who will then transport them on the Gulf Coast corridor to cities north.

In other cases, local gang members or others seeking financial gain who live in the county drive their human and drug loads through private property by cutting locks and fences. The sad reality is that most of those who are being led through the brush by the smugglers do not survive the demanding journey. Since 2009, the county has recovered 910 bodies of undocumented crossers. That includes 119 in 2021 and 78 so far this year. We estimate that the recovery is less than half of all those who perish with conditions or health issues.

This year, we've had 30 smuggling pursuits, 42 bail outs, 32 stolen vehicles, 5 stolen guns. In addition, we nearly have 200 smuggling cases in Brooks County alone. It's costing us about $4,000 of fuel a week. We also help our landowners by repairing damaged fences, which averages approximately $600 for 100 foot of barbed wire, and into the thousands for knit and high fence wiring. The Mexican cartels and the transnational statewide gangs continue to increase the level of organized criminal activity in the Rio Grande Valley and throughout the State.

We, who live in and near border communities where drug cartels and human smugglers operations are prevalent, face additional public safety issues such as stolen vehicles, evasions, pseudo police stops, extortion, sexual assaults of illegal aliens. The gangs and cartels have contributed to the deaths of undocumented crossers on the Texas ranches and farms. Apprehensions are still skyrocketing through the Rio Grande Valley patrol sector. Totals for the month of August were nearly 28,000 encounters, bringing their Fiscal Year 2022 totals over 440,000 encounters.

There has been no change in the manpower situation, and the migrant surge and humanitarian crisis is at a constant toll on the already depleted workforce. Even with a depleted workforce, their local encounters were around 1,400 for the month in Brooks County. While Border Patrol is overwhelmed in the migrant processing duties, they aren't able to carry out their primary function by stopping the entry of contraband and dangerous criminals.

Rescues continue to keep us busy with over 305 emergency call outs so far this year. And over 1,350 individuals were provided the assistance they so desperately needed. Even with all the technology in place, there continues to be those that succumb to the elements. Good news is that the border—Falfurrias Border Patrol is pleased with the results of the new aerostat, which are flying just south of Falfurrias and providing great situational awareness and has also been credited with assisting with over 700 apprehensions.

In terms of fire, 32,000 acres of brush fires related to immigration of Brooks County, $6,000 plus in expenses to our fire department—our volunteer fire department in just immigration calls this year. The EMS related calls from January to August, 82 EMS calls related to breakdowns, three migrations actually were deceased and rushed to the hospital. Ambulances are being pulled from day-to-day operations to answer calls in remote areas where turnaround time is roughly 4 to 5 hours, leaving our constituents without emergency medical services. This puts a strain on the local

health system. The border crisis is a result of not securing the border.

When there are no consequences for unlawful entry into the United States, DHS does not adjudicate asylum cases in a timely manner and remove those who don't have valid claims. Transnational criminal organizations will continue to be able to recruit migrants, to come up here and overwhelm Border Patrol resources while they run narcotics and criminals around the back end. In closing, I want to thank you for bringing us attention to this very important topic, and I look forward to any questions you have. Thank you, sir.

[The prepared statement of Sheriff Martinez appears as a submission for the record.]

Chair PADILLA. Thank you, Sheriff. Thank you for sharing your perspective, your experience. I take it as a reminder to invest in modernizing and fixing the legal migration options, to undo the pressures for those who would consider the irregular migration that has led to so many tragedies.

The focus of today's hearing, I remind us all again, is the role that immigrants play in the health care workforce crisis in the United States of America today. And so, we're going to begin with our questions, and I'll begin with this. One thing we hear often from immigrant health care professionals is that they are restricted in where they can practice medicine due to their status. And because these professionals are often tied to a specific employer, it is difficult for them to either move within the United States for better opportunities or to serve areas that might be in more need of their expertise or their services to move to other health care facilities in emergencies like the COVID–19 pandemic.

Dr. Alur, in your testimony, you mentioned that your nonimmigrant status as an H–1B visa holder prevented you from being able to go to places like New York during the height of the pandemic, where there was an extreme shortage of doctors. Can you explain the limitations that come along with your status and how updating our immigration laws would improve the Nation's public health?

Dr. ALUR. Chairman Padilla, it's a very important question. When the pandemic took over the country, it did it in waves. New York was literally burning with the pandemic, and southern Illinois was relatively better protected. We could have stepped up and attended to the call. The Governor of New York was asking retired physicians to come back into the workforce, the students to graduate early. We could not do it because it is a violation of our work permit to work anywhere else other than what is specified.

Going to the endemic problem of physician shortage, we have services that are not available in an area, and you bring a doctor to one employer. If he's not restricted, he could go to multiple hospitals and help those hospitals during the shortage. For example, in our neighborhood when the pandemic hit us, our neighboring hospitals were losing physicians to quarantine. There was a lot of attrition because a lot of senior physicians did not continue to work.

And how would it help the United States public health? Primary care is a huge area of shortage all across the country. And again,

if a physician who has been in that country—in that community for years is still restricted to one employer, he's limited. He could probably go 50 miles across his town and do a satellite clinic maybe one day a week that would help the community there. A lot of physicians in my community who were immigrants, who did their waiver commitments, stayed there. And after they got their green cards, they have open practices all across. And improving the primary care that way will address the public health.

Chair PADILLA. Thank you, Doctor. Ms. Peterson, I know that you're well aware that the U.S. has designated 8,069 health professional shortage areas across the country for primary care. There's a map behind me that illustrates this. This has resulted in 97 million people who live in the United States in an area that has a shortage of primary care providers. In my home State of California alone, there are 643 health professionals' shortage areas for primary care, affecting over 7 million Californians.

I'm sure many of my colleagues here also represent States with significant health care workforce shortages. If you look at the map, consider that every shade of green on this map represents a shortage area.

Ms. Peterson, in your testimony, you recognize that these workforce shortages are due in large part to our increasing in aging population—our seniors, our aging health care workforce, and the stress imposed on health care workers around the country by the COVID–19 pandemic. So, drawing on your experiences, can you explain how immigrant physicians have stepped up to fill these gaps in these underserved areas and how they are part of the solution to end our health care workforce shortage emergency?

Ms. PETERSON. Thank you, Chair Padilla. Annually, over a thousand international doctors go to underserved areas and fill this need. But just on the Members of the Committee today, over two thirds of your State used all of the Conrad J–1 waiver numbers last year. And if we gave States the ability to grant these J–1 waivers based on their needs—California, you know, all of the other States, Texas—that would permit doctors like Dr. Alur to go to underserved areas and be rewarded and recognized for their work and to ensure that Americans were receiving the health care that they need by opening it up and giving States the ability to really give these waivers. And the Conrad Reauthorization Act does just that.

Chair PADILLA. Thank you. Senator Cornyn.

Senator CORNYN. Ms. Peterson, let me just ask as a preliminary question. Well, let me make a brief statement before I do that. I personally believe that legal immigration has been one of the great secrets to our success as a country. By one account, since 1783 to 2019, we've had 96 million people legally immigrate to the United States, and we're better off for it. Illegal immigration is another matter, in my view.

And as you know, many people showing up at the border these days are claiming asylum. But as an immigration attorney, do you—can you help us with a figure here? How many, how many claimants of asylum who actually appear in front of an immigration judge get that claim validated?

Ms. PETERSON. Thank you, Ranking Member Cornyn. Immigration law is like physicians. We subspecialize, and I specialize in

high skilled physician immigration, so I don't have that number, but I'm happy to provide it to you.

Senator CORNYN. Well, I think it's somewhere around 85 to 90 percent do not qualify. But the problem is because of the huge backlogs and the fact that the Biden administration releases people into the interior of the United States, some of them show up in Chicago, some of them—they go to all four corners of the United States. And Sheriff, if you're still with us, I'm referring to your written statement here. When you say that there are no consequences for unlawfully entering the United States, could you explain what you mean by that?

Sheriff MARTINEZ [continuing]. From the——

Senator CORNYN. We can hear you now.

Sheriff MARTINEZ. It's the fact that—okay, good—they're not prosecuting cases. We're not following the rule of law. There's nothing—no consequences, they're going to keep coming. And that's the issue. You know, here at the checkpoint, they just stopped a truck tractor with 115 in the trailer—115 occupants—which, you know, you can see the same scenario that occurred in San Antonio, with those 53.

Prior to that, 12 months ago, we had 73 in a trailer and the Federal guidelines were not met. So, that particular driver, we pick them up and prosecute them ourselves. You know, we're kind of educating the criminals as to what they can get away with. And I know this is about health care. I get that. But until we secure the border, until we shut that border down and start peeling off, I know that not every, not—you know, they talk about immigration. The issue is, is that not everyone is going to come in and stay in stash houses like they do here in the Rio Grande Valley sector.

You know, where you have 200 people in a stash house. That's definitely in a health crisis. Okay? When we pick up bodies, we're testing for COVID. We have 20 percent of them tested for COVID. And those bodies are walking in with a group. So, the rest of them get away. We got 20 percent of COVID. Guess what? That group is going into the interior of the United States until we secure this border.

Brooks County's a Democratic County. I'm a Democratic sheriff. And it's just absurd how we try to mix things together here. I, for instance, will have sexual assault cases, females in the brush. Okay? So, what I do, I work with immigration attorneys. I sign off on their waiver and they stay in the United States. Okay? The fact is, we're not going to be able to prosecute anyone because they're not going to actually say, "Okay, this is the person that did it."

But we work along closely with Border Patrol and their intel group, you know, and talking about narcotics and businesses and the port of entry, it's simple. Those are actual narcotics that you can count. And I know this because when I did my covert operations with DEA and Customs back then, we used to prosecute, and they're still doing it. They're using the river. Those are amounts that you can't count on. You don't count those.

It's just like the getaways. You don't know how many getaways, you know, are fleeing. I don't understand how we're mixing this whole operation into immigration. I have a friend of mine that's been waiting for 20 years to get his citizenship. Twenty years. You

know what? All this is about policy. Work on policy. You know, reach over the aisle and work on policy. Fix it, and we won't have this fricking conversation. This is horrible. What I've just been listening, it's horrible. I don't get this.

I'm a Democrat, and here we are going through all this issues, this green card issues, the same thing. Why does it take 20 years to become a citizen of the United States? Why does it take so long to get a green card? You know, we're talking about health issues. We don't have a hospital in Brooks County. We have three different hospitals that Border Patrol work with and we work with. They're out of Kingsville, which is 30 minutes away, and Corpus Christi.

We cannot mix this together. We have to decipher this. We have to reach over the aisle and get this thing fixed. I mean, it's frustrating for all the sheriffs along the Southwest corridor, and I think you all understand how frustrated I am, because I've been dealing with this since 2009. And I'm yet to have any Democrat come to my office, sit down so I can show them all the books I got of all the dead bodies, all the parents, all the family members that come to my office crying because they lost their loved ones of 10 years ago.

I'm sorry. I think I went off a little bit. This is frustrating. It just bothers me, what I'm listening to. It's not—we need to divide this issue. We need to separate. I get it. Well, you know, we're all immigrants. I get that. So was I. So were my grandparents, so. But it's the right way to do it. There's a right way to do it. And I think everyone ought to just get together and put some common sense into this issue. Thank you.

Chair PADILLA. Thank you, Sheriff.

Senator CORNYN. Thank you.

Chair PADILLA. Thank you, Senator Cornyn. And it sounds like an invitation, and I'd be happy to accept to work together to reinvest in the very departments and agencies that are charged with considering and processing these applications regardless of what the outcome would be. We've got to maintain due process. And I think we share the desire to significantly reduce the backlogs that have only grown for years and years in all categories of immigration applications.

So, coming back to the topic at hand for today's hearing, the role of immigrants in the health care workforce, I now recognize Senator Durbin for questions.

Chair DURBIN. I just want to say that I thought the sheriff's comments were impassioned and genuine and reflected the reality of the almost impossible job we've given him on our border with so many others. Our border's under siege. There's no question about it. When I sat down in Chicago last Friday with a family that started out from Venezuela on May 15th—father, 32 years old, mother 22, a 5-year-old daughter, and a 1-year-old daughter. And they set out to walk to America.

It took them months to finally reach the Texas border. And in the meantime, the worst possible things happened to them. They were beaten and they were robbed. And they were abandoned in a Panamanian jungle for nine nights. And the man said, "I thought we were going to die." And yet they pressed on. They were desperate to come to the United States because, he said, "I couldn't

feed my family in Venezuela." And I think that desperation brought on by poverty, or violence, or climate change is the reality of the moment.

The question is, can we construct a system for legal immigration that says to this doctor and to many others like him, "You are welcome in America. We need you in America. We thank you for being here in America. And we want you to have your family with you," and to have confidence that they can realize the American dream, too? And says to workers like this man from Venezuela, "Yes, you can come in, but you're going to be legally recognized when you come in and what you're going to do here."

Perhaps you're going to work on that dairy farm in northern Illinois that's going to close down if they don't get foreign workers or the orchard in southern Illinois where they desperately need foreign workers. It is our failure, our failure in this Committee and in this Congress to establish legal immigration that has led to this desperate plunge by these people to come forward and risk their lives to do it, to cross our border. They are not here for—the ones I met were not here for any illegal purpose whatsoever. They just wanted a chance to work.

How many times I heard that over and over again? Dr. Alur, your work in the Marion Veterans Hospital. Are there other foreign-trained physicians in that hospital?

Dr. ALUR. Almost every department in Marion Veterans Affairs Medical Center has immigrant doctors. I don't speak for the VA. I'm speaking about my experience. We looked at the whole region, the southern Illinois, when we initially met our Congressman in 2017 to give him an idea the important of immigrant doctors. No department in southern Illinois right from Mount Vernon until Metropolis would function without immigrant doctors.

Chair DURBIN. That point is so important for Members on both sides of the aisle. We love our veterans. You're right. They're our Nation's heroes. We promised to stand by them when they came home. And yet, the men and women who do that, we treat so badly when it comes to their devotion to our country and their yearning to be part of its future.

Make you go through all the traps you have to go through year after year after year, uncertain as to whether, as you've mentioned, you're going to miss one little step and be judged ineligible for any future service to our country. That's not fair to you, and it's not fair to your family, and it's not fair to the veterans you serve. I will tell you—we know, others may not here—Marion is in a rural part of Illinois, a limited population area of Illinois. Attracting doctors there is harder than it is in Chicago or St. Louis, the veterans' facilities, and those of you who serve there, we especially are grateful.

But I think we need to take into consideration just what kind of contributions you make. Ms. Peterson, this is maybe out of your area, but I want to put it in a plug for one thing that—before my time runs out here. I am embracing foreign-trained immigrant nurses, and doctors, and medical professionals, and I think they're essential to our future. But at the same time, we need to have more homegrown medical professionals, nurses and doctors in the

United States. Can you comment on efforts that are underway, if you know of any along those lines?

Ms. PETERSON. Yes, it's a little bit out of my scope, Chairman Durbin, but what I can add is that you're right, this is a multi-faceted approach, and we do need to continue to grow and educate U.S.-born physicians and nurses. But what we're talking about today is an immediate solution to fix our urgent health care crisis in the United States.

Chair DURBIN. Spot on. That's exactly right. And I'll mention one other thing. In the American Rescue Plan, where some in a room did not vote for and some did, we put a billion dollars into scholarships and loan forgiveness for the National Health Service Corps. And the National Health Service Corps focuses on underserved areas. These are physicians we hope will be attracted to those areas, but we need to expand the graduation rates of our medical professionals. The boomers insist on it. And I happened to be close to that age group. Thank you, Mr. Chairman.

Chair PADILLA. Thank you, Chairman Durbin. Couldn't agree more. And I think to tackle that also pressing issue, it's both tackling the affordability of medical school education and the capacity of medical schools across the country to keep up with our growing and aging population. Next for questions is Senator Grassley.

Senator GRASSLEY. I don't think I have to repeat what Senator Cornyn has said about the problems, the political problems of solving this issue. They could go away fast if the border was secure. And, you know, three and three tenths million people already in 18 months of this administration crossing the border. And then we have the absurd statements by Vice President Harris, quote, unquote, "the border is secured." I think I've heard Secretary Mayorkas say the same thing.

So, Sheriff, I know that you also personally witnessed this impact at the open border. I guess you've already made a strong statement in regard to that. So, my first question is you've previously attributed migrant deaths to quote, "the false compassion of open border," end of quote. I think that's a superb description of what we're seeing at the southern border. I'd like to have you elaborate on that phrase.

Sheriff MARTINEZ. Yes, sir. What's occurring here is just they're being taken advantage of, and they're being left to die, you know? It's not a good death because they know they're dying. And what I mean by that, it's not a quick death and that they're just going to die, as you would in a crash. But, you know, we get lots of 911 calls when you hear the last desperate voice on them saying that, you know, tell my mom I love them, tell my sister, my wife, children, whatever the case may be.

We just picked up a 15-year-old that we recovered from the brush. And that's not only—you know, Brooks County has numerous deaths, but now the whole Southwest corridor is experiencing it. I got bodies from every county, Texas, in my morgue. I have a morgue myself in Brooks County that we house other bodies that are recovered from the different counties because it's a surge. And until we secure that border, until that is shut down completely, then we can start working on everything else.

And I understand the health issues. I understand what they're trying to say. But it's policy. The policy says, "Come over." And that's the rhetoric. That's been that narrative that's occurring right now. The narrative says come over. Well, guess what? We need to do it correctly. This is why I said the rule of law. It's got to be done correctly. I'm a Democrat, but it's just pathetic how things are going currently along the border and on the Southwest corridor.

Senator GRASSLEY. You've talked about the role played by transnational criminal organizations in migrant deaths that we've seen at the border. Like to have you tell me, how common is it in your county to come across migrants who are in need of medical care and attention.

Sheriff MARTINEZ. I did—I did visit with the secretary twice, sir. He was down in McAllen, and I visited with him twice. And I told him what we needed. We needed a simple triage so we can get the assit—medical assistance that they need quickly. And I haven't heard anything back from them. So, we need that. And I know what we need in Brooks County. They're just not listening to some of the sheriffs, including me, as to what's needed.

And this is just for a quick fix. We don't have a hospital in Brooks County. Everything has got to get flown out to different hospitals that can manage these type of issues. But a triage would definitely help to—maybe assist in—you know, Border Patrol, there are gentlemen that are EMTs. They apply IVs. But by the time they apply that IV, sometimes it's just too late and they succumb to the heat or to the cold. I mean, we've picked up five bodies at one time, at one time when we had the freeze back several years ago. They're all stuck together. I mean, that's just not right.

Senator GRASSLEY. My last question. Could you describe how transnational criminal organizations handle migrants who get sick or experience health problems? And more broadly, to what extent you are able, can you comment on the impact that migrants in need of care have on the local health care infrastructure in your area?

Sheriff MARTINEZ. Well, in my area—and comments to that, in my area we don't have that because we don't have a hospital. But what it does take is the fact that our ambulance services that have to go out to the ranch lands, pick them up and then transport them, that leaves our community open to other issues that we have. Our county is elderlies. They over 60, 65, 70, probably 80's. So, they need the medical assistance locally. But when we're out there treating them, then that—that becomes an issue.

Now, as far as the transnational gang members, they just leave them there. If someone just happens to get hurt, they get sick, they're gone. They're on their own. They fend for themselves. Now, thanks to Border Patrol, we have a lot of placards up there, probably over 200 placards, and put in different areas. We have beacons. Everything that can be done has been done in Brooks County to save lives.

I work closely with the consulate. There's four consulates I work closely with and then on McAllen office and we give them a lot of literature to forward down south so they can understand what's going to happen to them if they come in into the United States, if they come into Brooks, the dangers that might be happening. So,

everything has been out there. The outreach is there. You know, the fact is, the transnational gang members, they just don't care. It's all money for them.

Chair PADILLA. Thank you, Senator Grassley. And colleagues, I'd like to share just on the topic and the concerns raised by Senator Grassley and the sheriff. I was just down at the southern border in California during our August work period. And what I saw offered by the State of California and partner non-governmental organizations, together with the Border Patrol, was nothing short of incredible.

The University of California, San Diego, has actually provided medical screening and stabilization for newly arrived asylum seekers to the San Diego County since December 2018. So, this isn't a short-term pilot project, this has been going on for a while. The program screens for conditions that would threaten the health of either the individual or the community. Medical screening for conditions of public health significance is done on all asylum seekers at the time of arrival from scabies to monkeypox. And I'm happy to report that there has not been a single case of monkeypox found during the screening of all the asylum seekers.

In fact, asylum seekers they have found are generally healthy. For example, in August 2022, just last month, of the 5,492 guests seen at the shelter hosted by Jewish Family Services, only 20 were sent to an emergency room. That's 0.4 percent. This is—this has improved from our previous low rates from December 2018 to March 2020, when less than 1 percent of arrivals needed to be seen in an emergency room.

So, I recognize that the California numbers may not be exactly representative of the whole border, but the less than 1 percent statistic hardly sounds like an overwhelming drain on public health resources. Aside from the numbers I just offered, this model of Federal agencies working in partnership with States and NGO's to improve border safety and treat asylum seekers with dignity. With that, let me recognize Senator Hirono for her questions.

Senator HIRONO. Thank you, Mr. Chairman. There was a time in 2013 when this Committee spent around 2 weeks marking up a comprehensive immigration bill that addressed some critical needs in both the legal and illegal immigration situation, both of which systems are broken. I hope that at some point we can get back to that kind of a perspective. And clearly, we have some bipartisan bills that will help.

Sheriff Martinez, I hear your frustration clearly. We need to address the issues in the border that deals with another Committee's jurisdiction also. But today, I would like to focus on the dire need in our country for health care workers. If there's one thing that the pandemic showed was the importance of the essential workers of whom many of them, of course, are doctors, are nurses, are health care workers stretched thin to the brink of exhaustion during the 2-years of the pandemic and still not over.

So, in fact, just recently in Hawaii, our Governor signed an emergency rule authorizing out-of-State nurses to temporarily practice in Hawaii without obtaining a license from the State. And we have a shortage of some 732 physicians, 732 physicians affecting our State. Pretty much right now. So, yes, thank you, Ms. Peterson, for

focusing us on the immediacy of the challenges. What kind of steps have medical facilities had to take because of the shortages in the health care workforce that you can share with us?

Ms. PETERSON. Thank you, Senator Hirono. The immigration process is complicated. It involves multiple different Federal agencies, a lot of paper, a lot of time, and a lot of money. I have so many physician clients who have a job offer from a health care facility that wants to hire the physician, and they can't because we don't have enough numbers. It's not the right time. The list goes on. And so today, you know, the Conrad reauthorization bill provides so many reliefs to our system for my clients, for doctors like Dr. Alur, to be able to recruit and retain physicians.

Senator HIRONO. That is a bipartisan bill.

Ms. PETERSON. Absolutely bipartisan.

Senator HIRONO. Does it lift the cap for the Conrad 30 program?

Ms. PETERSON. It does not. What it does is it looks at the States that use all of their 30 waiver numbers. And if they use them, then each year there's an add on so that the States can really control and supply the J–1 waivers that they need for their application.

Senator HIRONO. Would you support lifting the cap or increasing the cap substantially?

Ms. PETERSON. The demand is so great. And as I said, two thirds of the States that the Senators on this Committee represent fill every year. And so, I do think that the Conrad bill provides a smart solution to be able to give States back the power to get the numbers that they need.

Senator HIRONO. Well, how much longer do you think, for both of you, can our health care system and that includes a VA system where there are major shortages, I know of doctors and nurses. How long can these systems continue to use the kind of quick patches, such as a Governor issuing an emergency order for a problem that needs long-term investment and policy changes? Dr. Alur.

Dr. ALUR. Senator Hirono, thank you for the question. It's a very important question. I don't speak for the VA, but this is my experience. The shortage is already an emergency. When we try to, from a rural area, when we try to get a veteran out to a hospital that can provide them services, often there are no beds because they're all working at reduced capacity because they don't have nurses.

Often, there are no doctors for 2 hours or so. So, we are already in an emergency. I know the COVID pandemic has given a stress test of sorts to the healthcare system here, and we haven't recovered from that. Combine to that, the rural areas which have more aging population and aging doctors are projected to face even more shortage than the urban areas. And it has to be fixed now. There's really no time.

Senator HIRONO. Ms. Peterson, the nurses in Minnesota have gone on strike because there aren't enough nurses to safely provide care for the patients. So, are we going to see more of those kinds of actions by nurses and other health care providers who are just totally up to here with what is being asked of them?

Ms. PETERSON. I think we'll see that. I also think that the stress falls on patients. Just a week ago, I was told that one of my family members has to wait over 2 months to see a cardiologist. And I'm not alone. This experience was just backed up by a survey that

looked at 15 major metropolitan communities, DC included, that says the average wait time for a physician is 30 days. And that depends on where you live and the specialty that you're seeking care from.

So, in addition to the stress on the doctors and nurses, it's impacting us. It's impacting my family, and it's impacting your family. It's urgent. And we need to address that through smart immigration reform.

Senator HIRONO. Ms. Peterson, you mentioned that your support for two bipartisan bills that we could push, and I would ask the Chairman to, and the Ranking Member, to focus our minds on getting those bills, bipartisan bills, passed this session. Thank you.

Chair PADILLA. Thank you, Senator Hirono. Senator Tillis.

Senator TILLIS. Thank you, Mr. Chairman, for holding this hearing. I don't even know if I'll have time to ask you all any questions, but I do want to talk a little bit about how we resolve a series of crises that I think we have. There's no question we have a health care crisis. I was just down at a hospital, an institution you all would recognize, one of the most admired health care institutions in the United States, down in North Carolina. They have 80 beds that they can't make available because they don't have the nursing staff. We all know the pyramid. You got to have nurses in order to staff a room. We don't have them.

Capacity that's lost because we don't have health care workers. We have a food security crisis. Now, getting away from health care, there's an agriculture group meeting with my staff right now. I'll guarantee you. The first issue, the top issue that they have our resources to actually work, and meat processing facilities, picking delicate fruits, doing the kinds of things that we need, labor force. We have a food security crisis. We have a housing crisis.

The cost of labor has gone up astronomically. The length of time it takes to build a house has gone up. The cost of affordable housing has gone up and made less affordable because we don't have labor inputs there. But we also, contrary to what Vice President Harris said this week, we have a border crisis. The border is not secure. And 80 percent of the people that are crossing the border do not have a valid asylum claim. That is not, in my opinion, that's buried out by facts of the adjudication process someone goes through.

When they claim credible fear, they go through the process, are adjudicated as not having a credible claim. So, how do we solve all these crises? We recognize we have a problem at the border. We have labor input problems, and we solve the problem as a group. It will not be done in isolation. The bipartisan bills that Senator Hirono talked about, I agree with on its face. They don't have a prayer of getting passed unless we look at this more holistically.

If we take a look, Ms. Peterson, at just even trying to process I—in North Carolina, we use up our caps. I track it very closely. We have dozens of cases of trying to get nurses here on work visas. And it's frustrating. I know it's got to be frustrating for the outside. Imagine how frustrating it is for a Senate office having to go through that just to make sure that we can get as many beds open as possible.

But we keep talking around the strategy that is necessary to solve the problem. Those bills are not going to get passed. They're not going to get—they're not even going to get a chance to be voted on on the floor—likely not unless we do the work to come up with a comprehensive solution that recognizes if we reduce future flows, we're going to have more resources to process visas. Just imagine if two thirds of the future flows went away, how many other resources could be freed up to focus on legal immigration, guest worker programs, the kinds of things that you're looking at.

And I know your head's about probably about to explode going, "Yes, but that's not my problem." It is our problem, and we have to solve it. And there are some simple solutions for solving it. And we have come so damn close so many times only to not get into the end zone. We have to recognize that there are people on both sides of the aisle who are willing to work together to address these worker shortages.

But not a single one of us, or at least me, I won't speak for my colleagues, will, unless we fix the underlying problem with border—border security and 2 million plus people coming across the border illegally every year. We can do that with asylum reform. We could reduce the future flows overnight. We could shift resources to value added processes like addressing these worker shortages that go across every sector. And if we all take the time to do that, stop talking past each other, recognize that all of us are going to have to make some difficult political decisions, we can fix us.

This is not rocket science. This is something we know what the fixes are. And this Committee has a role to play in it. Other Committees have a role to play in it. But Congress has a responsibility to do this. And I hope that before the end of this Congress, we can stop talking past each other, deal with the asylum issues that are, I think, probably the primary concern that Senator Cornyn and I have, and we're ready to address these empirically driven shortages in critical areas, not only health care, but across the spectrum of sectors in the United States.

And I, for one, hope that we get it done before the end of this Congress. I do recognize your problem. We feel it every day in North Carolina. And I'm going to do everything I can to help be a part of the solution. Other people need to step up. Thank you. I yield back my second.

Chair PADILLA. Thank you, Senator Tillis. I'm going to take that second just to thank you, because I think the public does deserve to hear that you have been engaged on this issue and in our conversations and over striving to—we have yet to find the common ground that enough of us right here can vote, to have a final work product approved by the Senate as a body that would be meaningful and helpful.

The frustration that only mildly share publicly is in some conversations you've got in the direction of, well, like if you try to be too global, too comprehensive, it's all going to fall apart. Yet at the same time, I hear, well, this is too narrow, it's not big and robust enough, so we can't do this. So, finding that balance is what we're striving for. Obviously, we haven't found it yet. Not yet, but I'm not giving up. I appreciate you not giving up.

Senator TILLIS. Yes. Mr. Chairman, I would just say, just for you all, if we don't get this thing done before the end of this Congress, my guess is we're 5 years away from getting another opportunity, and I hope people pay attention to that.

Senator CORNYN. Mr. Chairman, you allow me just 30 seconds?

Chair PADILLA. Sure. Senator Cornyn.

Senator CORNYN. I think we can talk this thing for the next 20 years and never reach a conclusion. Or we could do what Senator Tillis and I have asked the Chairman of the Judiciary Committee to do that the Committee with jurisdiction over immigration matters has scheduled a markup. Bring a bill before the Committee, have an amendment process, which we—as part of that process and see if we can come up with a majority of Senators who would find a bill that they would support.

If we just continue to talk about this, we're never going to get this resolved. We've been talking about for—DACA for 10 years and never gotten it resolved. So, we have the tools available to us. But the only person who can convene that markup would be the Chairman of the Committee. And so, I hope our Democratic colleagues would support us in that effort. Thank you.

Chair PADILLA. Senator Klobuchar.

Senator KLOBUCHAR. Well, thank you very much, Chairman, and thank you very much for taking on this issue. And this is something that I appreciated, Senator Tillis, Senator Cornyn, your support for a number of these immigration measures, including the Conrad 30 bill that Senator Collins and I introduced. We now have 26 bipartisan co-sponsors, including Senator Ernst, Senator Rosen, on this Committee, the two of you, as well as Senators Durbin, and Coons, and Blumenthal.

And I thank our witnesses. I really want to—I don't think our economy can withstand it if we don't move. My State has the lowest—as Ms. Peterson well knows, lowest unemployment rate in the country. We don't have enough workers all the way down the line and some combination—and I've been here. Your point, Senator Cornyn, when we have been able to pass an immigration bill that would have fixed a lot of this. We got it through the Senate with bipartisan support, a comprehensive immigration bill, and then, unfortunately, it did not pass in the House.

I've seen a bill passed in the House and not here. And I'm hoping that third time's a charm and we simply cannot wait. As pointed out by Senator Durbin, national shortage of as many as 124,000 physicians. In Minneapolis, there's one doctor for every 304 people. And, you know, we're the land of 10,000 lakes, as well as 10,000 medical clinics, as you know, along with Mayo, so many University of Minnesota that we're so proud of. But in rural northwestern Minnesota, there's only one doctor for every 686 people.

That is why I took on Kent Conrad's Bill many, many years ago to be able to allow for more doctors that are studying at our great medical clinics, medical schools throughout the country to be able to stay for their residency and the like. And I would like to expand that. The legislation reauthorizes and expands the Conrad 30 program that has brought more than 15,000 doctors to underserved areas, including rural and urban in the last 15 years. Ms. Peterson, by the way, thank you for graduating with degrees from the Uni-

versity of Minnesota, working, I understand, at the law school. Where were you born in Minnesota?

Ms. PETERSON. Wisconsin, but lived in Minnesota.

Senator KLOBUCHAR. Did you see the Vikings and Packers game?

Ms. PETERSON. I did.

Senator KLOBUCHAR. You can imagine I was happy with the outcome. My mom came from Wisconsin, so all is good. So, could you talk about how, in your experience, what role do immigrant doctors who have been trained in the U.S. play in providing essential medical care to rural and underserved communities?

Ms. PETERSON. Yes. Thank you, Senator Klobuchar. I mean, I think a statistic that's really telling is that 28 percent of these international doctors who go into underserved areas stay there well past their 5 years as compared to 11 percent of U.S. doctors. And I think that's telling because we need to expand our programs to continue to reward and recognize international doctors who are going into these communities like Dr. Alur. They're building lives.

They are staying there long term. A doctor who came to my small town has been there for over 20 years. He's built his life there. And so, we have a shortage. It's documented and we have the vehicle to immediately address it, which is your bill, Senator Klobuchar.

Senator KLOBUCHAR. Okay. Can you talk about why reauthorizing the program would be, in your words, a win-win?

Ms. PETERSON. It gives States the ability to control the doctors that they can place. It also encourages and rewards physicians like Dr. Alur to work in underserved areas by helping them get over the H–1B numerical cap, which this year alone, we had over 480,000 people apply for 85,000 numbers. So, it also rewards physicians on the green card side of things for going into underserved communities. And these are three very critical components to ensuring that Americans are getting the access to health care they need.

Senator KLOBUCHAR. I note that recently the United Kingdom introduced a health care visa program that fast tracks visas for health care workers, not just doctors. And Canada, which is very close to our borders, also offers an expedited pathway to permanent residency for doctors. I note that in Great Britain they have a conservative prime minister. They had one with Boris Johnson, they have one with Liz Truss, yet they're moving ahead on this. Could you talk about why this is a problem for the U.S., if you want to chime in, doctor. If we lose, not just we don't keep people here, we're losing them to other countries.

Dr. ALUR. Thank you, Senator Klobuchar, for your leadership. Great question. My personal experience, I've shared my burdens here. If I was to talk to a doctor who's hoping to come here or who's planning to stay after training, I would tell him, it's fantastic to work here. My experience working with the veterans is very rewarding, very satisfying. But if they listen to my family's troubles and if they have to talk to their families and then say, a doctor has been working here for 11 years, he's been in the country for 15 years. This is the prime of his youth when he can do a lot. Should we go here?

And I'll leave it to your imagination, what would their families say. As a physician, this is fantastic. As a family, the way the sys-

tem is currently, how would it help? I want to extend this to say what would happen if people get green cards. I have a example of a pediatrician from my community who finished his waiver in 2008, went on to build six practices, employ 18 providers, employ 48 employees, and served pediatrics in my community. Thank you.

Senator KLOBUCHAR. And just to make clear, our bill updates modernize the program by allowing States to bring in more doctors and then additional incentives for doctors to continue serving an underserved area for up to 5 years. And I think that also would make a tremendous—tremendous difference. So, I just, again, want to thank both of you, want to thank Senator Padilla and Senator Cornyn for holding this hearing.

We can't wait. Whether we do a bill that's focused on parts of this, I know that Senator Rounds valiantly tried to do a bill, during the—I was part of the group during the Trump administration, and we had a number of Republicans on board. And then we were, in my mind, got punched by the administration. Yet with many Republicans having been willing to support it here, this is our chance. We've got to move quickly. And thank you for bringing this, Senator Padilla, to our attention, and then Ms. Peterson, as well as Dr. Alur, thank you very much. Thanks, Senator.

Chair PADILLA. Thank you, Senator Klobuchar. I know the clock is ticking. We have votes open, but there are a couple of more questions I want to raise and have responses for the record. I'll try to be brief. The lack of access to health care in rural communities is a serious emergency. According to data tracked by the University of North Carolina Chapel Hill, 182 rural hospitals have closed since 2005, leaving residents in those areas no options but to forgo receiving health care or to travel long distances to see a doctor.

Dr. Alur, in your testimony, you mentioned at the Veterans Affairs Hospital where you work is located in Marion, Illinois, a town with a population of about 17,000. You also mention that your hospital serves veterans from a number of States, including Missouri, Kentucky, and Indiana. Can you briefly describe what health care disparities you've witnessed in your work and how those disparities impact individuals living in rural areas in particular?

Dr. ALUR. Thank you, Chairman Padilla. Our veterans come from 2 hours, 2 1/2 hours away, going past emergency rooms and hospitals to receive care at the VA. It's such a cherished institution. Once we get the veterans, we take care of what we can take care of there. It's a small hospital. The shortage in the community glares at us once we try to transfer veterans to places that need. We expurse no effort, energy, or expense in getting care to the veterans.

And like I alluded before, hospitals are closed. Whoever is in the community whoever is coming to a hospital for a problem is at an advanced stage because they don't have access to primary care. And that's a huge problem. The pediatrician I was talking about who is established a huge practice there, he is having to recruit out of his expertise so that he can provide care. So, he's recruiting psychologists, he's recruiting dental assistants so that that shortage is compensated. The disparities are projected to even get worse as aging physicians retire. So, the outcomes are already poor. We have

to act now so that we can arrest the decline and secure the rural areas.

Chair PADILLA. Thank you. If you don't mind, I'd like to ask a slightly more personal question, Dr. Alur. You've mentioned that moving a substantial distance away from work in order to put your daughter's needs first. You shared that in the testimony you submitted. You also mentioned the trials and tribulations that you and your wife have faced navigating our complex immigration laws. But yet, despite all of that, you remain committed and steadfast in your passion for your work, the work that you do serving our Nation's veterans.

I'd like to thank you again for the work that you do in your service. And I just want to hear from you. What would obtaining a green card mean for you and your family?

Dr. ALUR. Thank you, Chairman Padilla. One word I would say is stability. We've been working in the community. We've been living in the community. But we are not really part of the community. We don't belong there because we are still temporary immigrant workers. Stability to my family, to my children, especially my daughter, who will age out if I don't get a green card in 6 years. Stability to my patients. Travel is a problem.

Being on a visa, if I leave the country and if I can't come in, there is a gap. That has been the case with many immigrant physicians in our organization. Freedom from simple day-to-day restrictions like not able to drive. Right now, there is a physician in East Tennessee, a real rural country. A gastroenterologist is not able to drive because of his visa problem. He's decided to relocate. His children and wife are already gone. He says he cannot take calls because he can't go to the hospital if there is a bleeder in the hospital.

There is a liver transplant program director in Iowa City right now who is not seeing patients because his immigration process is screwed up. He's not doing anything since Monday. His patients are waiting. All these restrictions and problems we face are actually—they reflect on the patients. They reflect on the communities. One day of work I can't do is care delayed for many patients. Thank you.

Chair PADILLA. Thank you. Senator Cornyn, any final questions?

Senator CORNYN. Mr. Chairman, I don't have any more questions. I do want to thank all of our witnesses for being here. I have no doubt that the problems that you've identified are real, and we have it within our power to fix them. If we can find the political will to do so. But just as I believe the testimony of Ms. Peterson and Dr. Alur are real and valid concerns, I believe the concerns expressed by Sheriff Martinez are equally real and valid.

And the message that I have tried to communicate to Chairman Durbin and my friend, Senator Padilla, is that there will be no solution to—your issues that you've highlighted as much as I would like for us to be able to do that until we find a solution to what's happening at the border now.

What's happening at the border is simply unsustainable. I talked about the drug deaths associated and distribution of those drugs by criminal gangs across the United States. It's completely intolerable, and the burden should not fall to the States like mine or other bor-

der States like Senator Padilla's to deal with it. This is a Federal responsibility, but the only way we can do that is if we actually do our job here, which is not just to talk about it, it's actually to do something.

And that doing something means marking up legislation, trying to build consensus and then get it to the President's desk. And we can't do that as long as all we're doing is talking. So, thank you very much for being here. I hope that I hope that we can make some progress here. And thanks to Sheriff Martinez for joining us remotely and dealing with the huge challenges that border communities in Texas deal with 24 hours a day, 365 days a year. Thank you.

Chair PADILLA. Thank you, Senator Cornyn. There's one last question I'd like to ask, and then we'll proceed with the closing statement. But after listening to all the testimony today, one thing is made clear. It was frankly clear before today's hearing. Our outdated immigration laws are not working. Period. In addition to the other impacts of a broken immigration system, we attempted to focus today on how it's exacerbating the crisis that is our health care workforce shortage.

So, Ms. Peterson, can you just comment briefly on how if Congress does not act swiftly to remedy this outdated system, what are the implications for the health of Americans across the country?

Ms. PETERSON. Thank you, Chair Padilla. I'd like to go on record by saying, I think we can do both. I think we can deal with our border crisis and deal with the urgent health care shortage crisis in the United States. Because if we don't do both immediately, the numbers will continue to grow. At the beginning, we were talking about, you know, the 124,000 shortages of doctors over the next several years. It's only going to continue to grow.

And what that translates into is Americans are going to continue to have longer wait times, have worse patient outcomes in terms of complications, more financial burdens. It will continue to compound. And it's not just the rural and the underserved anymore. It's all of us in the urban areas. It's your family's and mine. Thank you.

Chair PADILLA. Thank you. I actually think that's a great note to begin to conclude, because we can do both. We must do both. But to utilize one situation, policy, issue, or challenge to keep us from making progress, bipartisan progress, on a clear crisis is unconscionable. I want to, before concluding, read aloud a number of statements that have been submitted into the record and I'll read who they are from.

We have received statements for the record from the American Association of International Health Care Recruitment, the American College of Physicians, the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, the Cato Institute, the Educational Commission for Foreign Medical Graduates, the Health Care Leadership Council, National Hospice and Palliative Care Organization, National Immigration Law Center, Southern Illinois Health Care, Upwardly Global and World Education Services. So, without objection, these statements will be included, and the record will close 1 week from today.

[The information appears as a submission for the record.]

Now, as this hearing concludes, I want to thank our witnesses again for joining us today, as well as Chairman Durbin, Ranking Member Cornyn, and our fellow Committee Members. As I mentioned at the outset, today's hearing was not just about fixing our immigration system or about providing support to the health care workers who need it. It's about tackling the crisis of our health care workforce shortage. It's about saving lives.

It was my hope today that in order to address an issue as important as saving American lives, that we could stand united to reform our system. That was the spirit that all the Members of the Committee showed up with. I want to make sure I make one thing clear before I close this hearing.

The border has nothing, I repeat, nothing to do with the fact that we all need to hire up to 124,000 doctors by 2034 to fill current workforce gaps. We have a health care workforce shortage that is affecting millions of Americans. And there are productive solutions to address this. Two bipartisan bills which Ms. Peterson raised today, each of which have 25 bipartisan co-sponsors.

And I'll note, I know he just left, and this is meant respectfully, Senator Cornyn is the lead on one of them. But instead of utilizing our time today to focus on meaningful change, we were met with repeatedly a misleading narrative. It's a frustrating pattern among many of my Republican colleagues. Now, I, too, was at the border just a few weeks ago. Among—on the itinerary that day was a Border Patrol ride along, in addition to visits to ports of entry and detention facilities.

So, let me be clear. Our border is secure. Let me also be clear about this point. People presenting themselves at the border seeking asylum is a legal right that they have. But the reality is it's the process that's broken and it is in need of reform. But many of my Republican colleagues are only interested in fearmongering. That's what I keep hearing. And if the only solution that the offer is to completely close the border, it's a nonstart.

I was interested in hearing the Ranking Member speak today about working in good faith. We've been able to do so on a number of other issues. And he's right. We do need Republicans to work in good faith to help millions of Americans and to reform our immigration system. But working in good faith is acknowledging that we can do two things at once. Good faith is coming to the table to engage with experts, and to respect and recognize data from our departments and agencies. Good faith is not showing up at a national workforce shortage hearing and focusing on statistics about gun violence in Chicago.

Good faith is seeing a complex issue facing our health care workforce and coming together to find common ground that will save lives or to advance solutions when we've already found that common ground, solutions that enjoy bipartisan support and not find excuses to not move those forward. But when Republican colleagues actually want to talk about solutions to improve our immigration system so that we uphold our Nation's values and our economy, then absolutely, I am more than ready and willing to listen. And I can say the same for Chairman Durbin.

Now, that starts with being honest about cruel and misguided policies like Title 42 and MPP that are unlawful and have only created more bottlenecks and put more people in danger. And as I said earlier in the hearing, we need to improve the legal migration pathways to undo the pressure on irregular migration. Legal migration pathways used to be a bipartisan issue, and they weren't conflated with border reform. Once upon a time. And we have bipartisan solutions just sitting here in front of us waiting to be passed.

So, it's a shame for this Nation. It's a disservice, frankly, and especially those in underserved areas when it comes to health care, that Republicans won't let us move the needle forward even onto solutions they support. For the 95 million Americans living in an area with a shortage of health care professionals, including those living in Sheriff Martinez's County, we cannot afford to wait.

It's not just health, it's lives that are at stake because every day that this workforce gap exists is another day that a loved one has to travel hundreds of miles for a doctor's appointment, or friend has to wait too long for a lifesaving preventative screening if they can get to a health care provider at all.

What we've heard today leaves no doubt, we cannot address this shortage without reforming our immigration laws. There are thousands of highly qualified health care professionals already living in the United States who can join our health care workforce. As we heard from Dr. Alur, immigrant physicians are eager to serve the rural and underserved areas of our country that so desperately need care.

And as Ms. Peterson pointed out, Congress can make reforms to allow more physicians to not just come to the United States but remain in the United States after they complete their training. Congress can make more visas available for health care workers by recapturing unused visas in years past. And Congress can make exceptions to numerical caps to specifically address health care workforce shortages. For the sake of our Nation's health, we must act swiftly to pass laws that will provide much needed reforms to our broken immigration system and bring care to communities in need.

So, I want to thank again all of our witnesses for your participation here today, all my colleagues who attended and participated here today. And with that, this hearing is adjourned.

[Whereupon, at 11:57 a.m., the hearing was adjourned.]

[Additional material submitted for the record follows.]

A P P E N D I X

Miscellaneous submissions:

Statement of Dr. Ram Alur
Physicians for American Healthcare Access

Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce

September 14, 2022

Hearing Before the
United States Senate
Committee on the Judiciary
Subcommittee on Immigration, Citizenship, and Border Safety

My name is Dr. Ram Alur. I am an internal medicine physician at the Marion VA Medical Center in Marion, Illinois, and one of the founders of Physicians for American Healthcare Access (PAHA). Chair Padilla, Ranking Member Cornyn, and Honorable Members of the Committee, thank you for the opportunity to share my experience as an immigrant physician in the United States.

The United States has a severe shortage of health care workers. We are facing a growing shortage of doctors, particularly in rural areas, which has been exacerbated by the COVID-19 pandemic. The reality is this health care worker shortage existed before the pandemic, and will continue to perpetuate health inequities in rural and underserved areas absent action from Congress.

I came to the United States in 2007 for medical residency training at Hahnemann University Hospital in Philadelphia. In 2011, I joined Marion VA Medical Center as an internist and hospitalist physician. It is truly an honor to care for this nation's military heroes, and play a key role in ensuring high quality care at the Marion VA Medical Center, a VA hospital built in response to veteran's groups calling for greater access to health care in the region 80 years ago.[i] Today, Marion is a modest sized city of 17,000 in southern Illinois, but critically located as we see VA patients from Illinois, Missouri, Kentucky, and Indiana. One can easily appreciate the magnitude of our work when treating such a diverse group of military heroes.

Because I did my residency training as a J-1 exchange visitor, after completing my residency I was required to either return to India for two years or obtain a waiver from the J-1 two-year home country residence requirement. In 2011 I applied for a waiver because it represented the best opportunity for me to continue practicing medicine beyond my training in the United States. At the time, I was not sure I would receive the waiver, and since the process took several months, I contemplated whether I would need to return to India or seek further career opportunities in the United Kingdom or another country. When my waiver was granted, I was relieved and excited to be fulfilling a career dream of practicing medicine in the United States. The reason I was granted a J-1 waiver was because of my commitment to practice for at least three years as a physician in a VA hospital. While I completed my three-year service obligation in 2014, I elected to stay at the VA in Marion because I found the work to be professionally challenging and rewarding, but also because the situation in Marion seemed right for my family, and it was a wonderful place to start a family.

Working in a small town in a rural area makes you a better physician because you have to meet the needs of patients with limited access to other specialists and resources. As an internist, I feel I have to be at my best in order to deliver for patients with varying needs. It is incredibly satisfying to take care of veterans who travel near and far for their health care needs. I have now practiced at the Marion VA Medical Center for eleven years and I have no plans to leave.

As you know, and as I have seen in my work, America faces a serious problem of healthcare disparities which impact rural areas and low-income urban communities. Rural Americans are fifty percent more likely to die from heart disease, cancer, or stroke, and unintentional injury or death. Children in rural areas with mental or behavioral disorders are also at a disadvantage compared to children in other areas. Forty-six million Americans live in rural areas, and would benefit from sustained attention on improving access to health care services.[ii]

A challenge that rural physicians and our patients often encounter is that patients travel very long distances for health care services. This includes primary, specialty, and emergency care. These long distances make it harder for people to receive routine care and lack of access contributes to negative health outcomes. It is why programs like Conrad 30 exist and have been utilized by states for 25 years. Conrad 30 is a J-1 waiver program that allows the two year home country requirement to be waived if a state health department provides a letter that it is in the "public interest" that the doctor remain in the U.S. These physicians must meet other specific eligibility criteria as well. From a purely public health standpoint, rural Americans deserve better access to health care and J-1 waiver programs, such as the Conrad 30 program, help states to mitigate healthcare access issues in underserved areas.

As a physician, I had no hesitation in making a commitment to practice in an underserved area upon completing my residency. My J-1 waiver commitment allowed me to practice in the United States in an area of great need, working alongside other highly trained and dedicated health care workers. However, when I made my commitment to serve at the Marion VA I did not yet understand how the U.S. immigration system would impact me professionally and would also impact my family.

For many international physicians, the pathway to permanent residency will take over a decade, potentially spanning one's entire career, limiting our career mobility, and jeopardizing the immigrant status of our children. Doctors on temporary H-1B visas need to have their work visa renewed at least every three years through an uncertain petition process in which the employer, not the doctor, needs to file the essential paperwork. The process is a huge administrative burden to the employer and the employee with multiple agencies involved and currently is very protracted. I've had to renew my status five times so far to be able to continue working here. In 2016, my application for permanent residence as a physician of national interest was approved, but I have to wait at least a decade before I receive a green card due to the backlog. This was not the intent of Congress when they conceived of the physician national interest waiver program.

This process has caused great disruption to our lives. Our driving licenses are only valid for the duration of the visa. Due to delays in processing my wife's H-4 dependent visa, she could not drive for six months during the worst of the pandemic. This was a time when I was in and out of COVID units and ICUs, and

had to attend to both the needs at home and my patients at the VA. Tragically, the pandemic isolation and restricted mobility of my family was very distressing for my adolescent child. She was in dire need of mental health services, but was a victim of poor access to the mental health services where we lived. My wife's inability to drive made seeking services for her that much more difficult. So we decided to move to the St. Louis area so my child could get the services she needs. While the decision was an easy one to make because my child's needs come first, St. Louis is two hours from the Marion VA. But, as I hope you can tell from my testimony so far, I am beyond committed to my work at the Marion VA and my patients there. So despite the commute, I have continued to work there since we moved in 2020, alternating weeks that I spend in St. Louis and Marion. I am dreading the next visa renewal process, as it would be a nightmare situation if my wife was unable to drive for potentially months at a time again. When we lived in the Marion area, we were able to manage the situation, but it would be truly unworkable now. I shouldn't have to think about compromising the much needed healthcare for my daughter so that I could be closer to a job that I love, or vice versa. Our outdated immigration system needs reform. Plain and simple.

From my perspective, my family and I have no protections as temporary work permit holders. If I were to become ill and unable to work, my existence as a permit holder ceases and my wife and daughter have no grounds to stay in the United States legally. Before the pandemic, we thought unexpected medical illness and motor vehicle accidents posed the biggest potential threats to our status. But, throughout the pandemic, my family has gone to incredible lengths and made great sacrifices to help me maintain my temporary worker visa. The last time my wife and I saw our aging parents and our children saw their grandparents was in 2019. That is incredibly hard on both of us but the reality of our situation. If I leave the US to see my parents in India, I need a visa to return which has to come from a consular office outside the United States. In recent years, the wait times to secure an appointment ranged from months to years long, making it difficult to plan and secure a safe return to my patients.

I co-founded Physicians for American Healthcare Access (PAHA) in the hopes of addressing the difficulties physicians like me face in providing care to our patients due to outdated immigration laws. For nearly five years, PAHA and its members have been working tirelessly to call attention to health care workforce issues, and explain how the U.S. immigration system makes it harder for highly skilled international physicians to practice in this country that desperately needs them. A recent analysis from the Association of American Medical Colleges projects the United States could see an estimated shortage of up to 124,000 physicians by 2034.[iii] Simply put, Congress must act to improve the pipeline for physicians working in underserved areas.

For many physicians like me, the prospect of coming to the U.S. and enduring the long wait for a green card while working and raising a family is not practical. According to the Cato Institute, there are more than 1 million petitions for working immigrants and their families approved and they are waiting for their green cards.[iv] Cato estimates that more than 200,000 Indians who have petitions approved could die of old age before they receive permanent legal status. This personally affects me in that my adolescent daughter, who has lived here since six months of age, will age out of status in six years if I do not become a permanent resident.

The green card backlog for physicians is a burden we live with because our mission and training centers on our patients. But this situation keeps immigrant physicians, their families and ultimately their patients in limbo. Throughout the COVID-19 pandemic, the restrictions on our immigration status placed great strain on our communities when we could not lend our expertise to other communities in need. Doing so would risk violating one's visa which could result in deportation. Unfortunately, many of these challenges are not easily solvable and will take time and federal investment. There are a number of bipartisan solutions that would make it easier for American physicians to pursue their residencies, as well as improve our immigration system to incentivize international physicians to practice in underserved areas long-term.

Given the massive shortfall of doctors that is going to get worse in the next several years, Congress should be pursuing a wide variety of solutions. This includes expanding medical school slots and making it possible for more Americans to pursue a career as a physician. It also includes funding more residency slots to make room for those new doctors. Finally, it requires reforming immigration laws to strengthen our workforce with highly qualified international physicians. This is needed because it can take up to 15 years before a physician is educated and trained and can actually begin treating patients. Immigration changes can help bridge this long gap.

The Conrad 30 J-1 Visa Waiver Program provides each state with up to 30 slots for international medical graduates completing their residencies. Bipartisan legislation would improve this long-standing program, clarifying the pathway to a green card for eligible physicians and allowing states to expand their program if certain conditions are met.[v] This is meant to further incentivize highly-trained physicians to practice in areas that struggle to recruit American physicians. It would also mean that more international physicians trained here are more likely to continue practicing in the United States beyond their residency.

To address the green card backlog and health care worker burnout, the Healthcare Workforce Resilience Act is bipartisan legislation which would help clear this longstanding backlog, and provide needed reinforcements in hospitals facing severe shortages.[vi] This is particularly urgent given longstanding processing issues at USCIS, which prevents qualified immigrants from receiving their green card. In FY 21, an estimated 66,781 employment-based visas went unused.[vii]

These solutions would make a significant difference in communities that lack access to meaningful health care services, and ensure that the pipeline of future physicians remains robust as we seek to strengthen our health care system after a grueling two and a half years fighting COVID-19.

Thank you for the opportunity to testify on this important issue.

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[i] National Register of Historic Places Registration Form. Marion Veterans Administration Hospital District. OMB No. 1024-0018.
[ii] https://www.cdc.gov/ruralhealth/about.html
[iii] https://www.aamc.org/news-insights/press-releases/aamc-report-reinforces-mounting-physician-shortage
[iv] https://www.cato.org/publications/immigration-research-policy-brief/backlog-skilled-immigrants-tops-1-million-over

[v] https://www.congress.gov/bill/117th-congress/senate-bill/1810
[vi] https://www.congress.gov/bill/117th-congress/senate-bill/1024
[vii] https://www.uscis.gov/green-card/green-card-processes-and-procedures/fiscal-year-2022-employment-based-adjustment-of-status-faqs

Prepared Testimony by Urbino "Benny" Martinez

Brooks County Sheriff, Falfurrias Texas

U.S. Senate Committee on the Judiciary Subcommittee on Immigration, Citizenship and Border Security

on

Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce

Washington, D.C.

September 14, 2022

Introduction

Chairman Padilla, and Ranking Member Cornyn, thank you for the opportunity to appear before this Committee to discuss this very important issue.

My name is Benny Martinez. I'm the Brooks County Sheriff in South Texas. The Brooks County Sheriff's Office, has five deputies and Command Staff, and is responsible for maintaining law and order within a rural region of 943 square miles that encompasses the county seat of Falfurrias. Outside of the city of Falfurrias, the county consists primarily of privately owned ranchland. The sandy terrain is mostly vegetated with mesquite trees, scrub oaks, and prickly pear cactus. The county's total population is about 7400.

Background

Brooks County has a U.S. Border Patrol checkpoint, known as the Falfurrias checkpoint that is approximately 70 miles north of the U.S/Mexico border on U.S. Highway 281. U.S. Highway 281 is a major north/south artery from the Rio Grande Valley area that leads to Houston, San Antonio, Austin and Dallas and other destinations throughout the interior of the United States.

United States Highway 281 is part of the Gulf Coast corridor, which is one of the most active drug and human smuggling corridors in the United States. The Falfurrias checkpoint is one of the busiest checkpoints in the southwest corridor in regards to undocumented crosser apprehensions and narcotic seizures.

Because of Brooks County's geographical location and the Border Patrol checkpoint, it has its own very unique challenges. In most cases, smugglers/coyotes drop off undocumented crossers. They are led by the smugglers and made to walk east and west of United States Highway 281, moving north through private ranch lands, to then get picked up on Texas Highway 285 and other roads by other smugglers who will then transport them on the Gulf Coast corridor to cities north. In other cases, local gang members or others seeking

financial gain, who live in the county, drive their human and drug loads through private property by cutting locks and fences.

The sad reality is that many of those who are being led through the brush by the smugglers do not survive their demanding journey. Since 2009, the county has recovered **910** bodies of undocumented crossers, that includes **119** in 2021 and **78** so far this year. We estimate that we recover less than half of all those who perish, which constitutes a health crisis.

Rescues continue to keep the county busy with nearly **300** emergency call ins so far this year and **1,300** individuals provided the assistance they so desperately needed.

This year we've had **30** smuggling pursuits, **43** bailouts, **32** stolen vehicles, and five stolen guns. In addition, we've had nearly **200** smuggling cases in Brooks County. It is currently costing the county $4,000 a week on fuel, patrolling for illegal traffic. We also help our landowners by repairing damaged fences, which averages approximately $600 for 100 feet of barbed wired fencing, and into the thousands for net and high fence wire.

The Mexican cartels and the transnational and statewide gangs continue to increase the level of organized criminal activity in the Rio Grande Valley and throughout the state. We, who live in and near border communities where cartel drug and human smuggling operations are prevalent, face additional public safety issues such as felony vehicle evasions; pseudo police stop; extortion, sexual assaults of illegal aliens. The gangs and cartels have contributed to the deaths of undocumented crossers on Texas ranches and farms.

Apprehensions are still skyrocketing throughout the Rio Grande Valley Border Patrol Sector. Totals for the month of August were nearly **28,000** encounters, bringing FY22 totals over **440,000** encounters. There has been no change in their manpower situation and the migrant surge and humanitarian crisis is a constant pull on their already depleted workforce. Even with a depleted workforce, their local encounters were around **1,400** for the month. While Border Patrol is overwhelmed with migrant processing duties, they aren't able to carry out their primary function of stopping the entry of contraband and dangerous criminals.

Rescues continue to keep us busy with over **305** emergency call-outs so far this year and over **1,350** individuals were provided the assistance they so desperately needed. Even with all the technology in place, there continues to be those that succumb to the elements.

Good news is that Falfurrias Border Patrol is pleased with the results of the new aerostats, which are flying just south of Falfurrias, and are providing great situational awareness, and has already been credited with assisting with over **700** apprehensions.

Fire and EMS Calls

Fire related numbers from January 1, 2022 – August 1, 2022

- 32,000 acres in brush fires related to immigration in Brooks County
- $60,000 plus in expenses to our fire department in just immigration calls this year (fuel, breakdowns, equipment, etc.)

EMS related numbers from January 1, 2022 – August 1, 2022

- **82** EMS calls related to breakdowns
- **3** migrant deaths in route to hospital

Ambulances are being pulled from day-to-day operations to answer calls in remote areas where turnaround time is roughly 4 to 5 hours leaving our constituents without emergency medical services. This puts a strain on the local health system.

The border crisis is the result of not securing the border. When there are no consequences for unlawfully entering the United States, and DHS does not adjudicate asylum cases in a timely manner and remove those who don't have valid claims, transnational criminal organizations will continue to be able to recruit migrants to come up here and overwhelm Border Patrol resources while they run narcotics and criminals around the back end.

Conclusion

In closing, I want to thank you for bringing attention to this very important topic and I look forward to any questions you have.

Testimony of

Sarah K. Peterson

Principal Attorney, SPS Immigration PLLC

"Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce"

Before the

Senate Committee on the Judiciary

Subcommittee on Immigration, Citizenship, and Border Safety

September 14, 2022

Introduction

Chair Padilla, Ranking Member Cornyn, and members of the Subcommittee, thank you for providing this opportunity to submit written testimony regarding the vital role International Medical Graduates ("IMGs")[1] and international nurses play in the provision of urgently needed healthcare to Americans. My testimony will focus on how we can effectuate smart immigration reform that will allow IMGs, international nurses, and other healthcare professionals to help address this country's ongoing shortage of access to medical care, ensuring that all Americans are able to access basic, primary medical care regardless of where they live in the United States.

My name is Sarah Peterson and I am the founding attorney of SPS Immigration in Minneapolis, Minnesota. I have exclusively practiced employment-based immigration and citizenship law for more than sixteen years focusing on physician immigration. I have represented healthcare systems, physician practice groups, clinics, universities, and foreign national physicians as they navigate through the complex U.S. immigration system. I teach an advanced immigration course at the University of Minnesota Law School as an Adjunct Professor and have been actively involved throughout my career both locally and nationally in effectuating smart immigration policy reform. I hold joint degrees in Law and Public Policy from the University of Minnesota Law School and the Hubert H. Humphrey School of Public Affairs, and I was a 2021-2022 Policy Fellow in the Humphrey School of Public Affairs Policy Fellows Program. Growing up in one of the poorest counties in Central Minnesota and having family who still lives in these rural communities, I have witnessed firsthand the impact of, and issues created by, the lack of access to healthcare in rural America. The opinions I am expressing today are my own and are based on my almost two

[1] Previously referred to as Foreign Medical Graduates or "FMGs," IMGs who are physicians who attend or have graduated from a medical school located outside the United States or Canada. https://www.nrmp.org/intro-to-the-match/the-match-terms-and-topics/?utm_source=search_results_page&utm_campaign=nrmp_search_page&utm_term=IMG%20definition, last visited September 5, 2022. This includes U.S. citizens who have graduated from a medical school outside the U.S. or Canada and excludes foreign-born physicians who have graduated from a medical school in the U.S. or Canada.

decades of physician and allied health immigration practice and experience advocating for smart immigration reform.[i]

The Growing Crisis of a Lack of Access to Basic Medical Care, Especially in Rural and Underserved Urban America

While this hearing is before the Subcommittee on Immigration, Citizenship, and Border Safety, I would submit to you that this hearing is not about immigration. The problem we are trying to solve is not one of immigration; it is instead an effort to solve the growing crisis of access to the most basic level of medical care in the United States, for all Americans. This hearing is about the way targeted, sensible immigration reform provisions can ensure access to desperately needed physicians and nurses in the United States, particularly in rural and underserved urban communities. With our rapidly aging U.S. population, a shortage of trained U.S. physicians and nurses, and a greater insured population following the Affordable Care Act ("ACA"), compounded by the ongoing COVID-19 pandemic burnout, demand for medical care is growing at an unprecedented pace.[2] At the same time, the U.S. is simply not training enough U.S. physicians or nurses to meet this serious need.

A recent Association of American Medical Colleges ("AAMC") study confirms the current and future dire state of the U.S. physician shortage.[3] The AAMC projects that physician demand in the U.S. will continue to grow faster than supply, leading to a projected total physician shortage of between 37,800 and 124,000 physicians by 2034.[4] The AAMC breaks down this figure further by projecting a shortage of primary care physicians of between 17,800 and 48,000 by 2034 and a shortage of medical specialists of between 21,000 and 77,100 physicians.[5] Further consider that the U.S. Department of Labor just released the latest unemployment figures and the unemployment rate plunged to 3.5%, matching a 53-year low.[6] These alarming statistics demonstrate the increased difficulties American will continue to experience when trying to access basic medical care.

Discussing this study, AAMC Chief Health Care Officer Dr. Janis Orlowsi confirmed that, according to data from the U.S. Health Resources and Service Administration ("HRSA"), "there is a shortage right now."[7] She continued with this clear message from physicians to Congress and the federal government:

> *"Wake up. Look at what the shortage is, and—if we are going to affect the worsening shortage that we anticipate in 10 to 15 years—we must act today."…"It is absolutely needed."*[8]

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[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7006215/, last visited September 5, 2022.
[3] "The Complexities of Physician Supply and Demand: Projections From 2019 to 2034," https://www.aamc.org/media/54681/download, last visited September 5, 2002.
[4] *Id*.
[5] *Id*.
[6] https://blog.dol.gov/2022/08/29/how-the-department-of-labor-is-celebrating-the-strength-of-americas-workforce-this-labor-day, last visited September 5, 2022.
[7] "Doctor shortages are here – time to act, Drs. Harmon [AMA President] and Orlowski [AAMC chief health care officer]weigh in," *AMA Moving Medicine* podcast, https://ama-moving-medicine.simplecast.com/episodes/doctor-shortages-are-here-time-to-act-drs-harmon-and-orlowski-weigh-in, https://www.ama-assn.org/practice-management/sustainability/doctor-shortages-are-here-and-they-ll-get-worse-if-we-don-t-act, last visited September 5, 2022.
[8] *Id*.

While these shortages have plagued rural and underserved urban areas for decades, they are now also becoming more common across the nation. Smart immigration reform, as it relates to physicians, nurses, and allied healthcare workers, is the surest mechanism to ensure that all Americans have access to nearby, timely healthcare.

Having practiced employment-based immigration law focusing on physician and allied health immigration for almost two decades, I have witnessed the shortage of physicians in the U.S. steadily grow, compounded by the aging U.S. population, COVID-19 pandemic, and burnout. During the COVID pandemic, IMGs were essential in the U.S.' fight to keep people in emergency rooms and intensive care units alive.[9] Because of our already-present shortage of physicians, the American Medical Association ("AMA") confirmed that the pandemic "forced states to recall retired physicians, expand scope of practice, and temporarily amend out-of-state licensing laws."[10] Yet we have seen few legislative or administrative fixes to address this ongoing and growing crisis. Experts from the AMA agree that if the U.S. does not address this physician shortage, more patients will continue to experience delays in access to primary care, which will particularly impact rural, marginalized, and low-income populations. Despite this, 25% of licensed doctors in the U.S. are IMGs, making it clear that IMGs play a critical role in the U.S.' provision of health care.[11] But this isn't enough, and we are running out of time. We should be doing more to support IMGs through smart immigration reforms.[12]

The ongoing physician shortage particularly impacts Americans living in rural and underserved urban communities. As of June 30, 2022, over 7,956 Primary Medical areas are designated as Health Professional Shortage Areas ("HPSAs"). This designation means that the people living in the area lack access to the number of providers required for the provision of the most basic preventative primary medical care services.[13] More than 83 million people in the U.S. currently live in a designated primary-care HPSA, and more than 14,800 practitioners are needed to remove the HPSA designation.[14] Often, American physicians are not attracted to these shortage areas and it is IMGs who address health inequities by serving in these rural and underserved urban areas.[15]

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[9] https://immigrationforum.org/wp-content/uploads/2020/04/coronavirus-sta_45607438pdf.pdf, last visited September 5, 2022; and, https://www.tandfonline.com/doi/full/10.1080/20009666.2021.1915548, last visited September 5, 2022.
[10] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2022-2-14-AMA-Statement-for-the-Record-re-Immigration.pdf, last visited September 5, 2022.
[11] https://www.ama-assn.org/education/international-medical-education/how-imgs-have-changed-face-american-medicine, last visited September 5, 2022.
[12] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7599012/, last visited September 5, 2022. But note, there were 1,433 fewer U.S. citizen and non-U.S. citizen IMGs who registered for the 2022 Match, compared with the 2021 Match. See, https://www.ama-assn.org/medical-students/preparing-residency/2022-match-again-sees-record-numbers-take-peek-behind-data.
[13] https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport, last visited September 5, 2022.
[14] https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D, last visited September 5, 2022.
[15] Lower salaries and lack of cultural opportunities in rural areas are top reasons physicians cite as reasons for not wanting to work in rural and underserved urban areas. The AMA Journal of Ethics, https://journalofethics.ama-assn.org/article/higher-pay/2009-05, last visited, September 5, 2022. Why rural America doesn't attract doctors, https://www.advisory.com/daily-briefing/2014/09/02/why-rural-america-doesnt-attract-doctors, last visited September 5, 2022.

Doctors, by themselves, aren't enough. Anyone who has ever been to a hospital knows the critical role that nurses and other health care workers play in providing medical care, and how hospitals, clinics, and doctor's offices would be unable to function without them. While the U.S. Department of Labor ("DOL") has designated nurses and physical therapists as shortage occupations ("Schedule A") so that employers do not need to test the U.S. labor market to pursue the green card process, there are few viable pathways for nurses to actually work in the U.S. while undergoing the permanent resident process. Not only are IMGs and international nurses crucial to the provision of primary and preventative medical care in the U.S., but it also makes strong economic sense as these IMGs and international nurses often remain in the community long-term. This, in turn, has a positive impact on local businesses and overall community vitality.

I represent a health care center in southern, rural Texas. This health care center has been simply able to recruit an OB/GYN physician for several years. Despite its best efforts to attract a physician to provide care, women are faced with either forgoing care altogether of having to drive over four hours to the nearest health care center to access care. Unfortunately, this story is not unique as 35 counties in Texas have no doctor at all. This very crisis is repeating itself over and over again across the United States, and it is getting worse.

Despite these clear unmet needs affecting tens of millions of Americans, our current immigration system for IMGs and nurses is outdated, complicated and difficult to maneuver, even for experts in this field. A series of concrete legislative and administrative reforms would be a major step forward that will help the U.S. better address the physician and nurse shortage crisis and ensure that all Americans have access to medical care.

The Historical Role of High Skilled Physicians & International Nurses in Addressing the Ongoing Shortage of Medical Care

Dr. Osaf Ahmed, an IMG from Pakistan who came to the United States in 1995, practices in Show Low, a small city in eastern Arizona. Dr. Ahmed treats 10 to 20 patients each day, many of them elderly people unable to travel 3 ½ hours to Phoenix to seek medical care. Like many IMGs, Dr. Ahmed came to this rural area through the "Conrad 30" program, and-- like many IMGs placed in rural and underserved areas all around the United States – he stayed. He stayed because he wanted to provide care for people who need it; people who without him may have no other option for obtaining the medical care they need. Dr. Ahmed notes that while he is proud of where he is from, he is even prouder of where he is today. This is the IMG success story – one of so many.[16]

The United States has a long and rich tradition of employing IMGs to serve our healthcare shortage needs.[17] However, in the 1970's, Congress was concerned that there might be too many IMGs compared to U.S. physicians, so it passed the Health Professionals Educational Assistance Act ("HPEAA") of 1976, in part to address

[16] https://cronkitenews.azpbs.org/2018/11/20/international-doctors-vital-to-arizona-rural-communities/, last visited September 5, 2022.

[17] For a comprehensive review of the U.S. immigration system for IMGs, see Kristen Harris' Testimony in "Is There a Doctor in the House? The Role of Immigrant Physicians in the U.S. Healthcare System," before the House Committee on the Judiciary Subcommittee on Immigration and Citizenship, February 15, 2022, https://docs.house.gov/meetings/JU/JU01/20220215/114411/HHRG-117-JU01-Wstate-HarrisK-20220215.pdf, last visited September 5, 2022.

this concern.[18] Through this legislation, Congress implemented a variety of measures aimed to not only increase the number of U.S.-trained physicians, but also to more strictly govern the role of IMGs in the United States. Additionally, Congress sought to direct IMGs, to the extent possible, to practice in rural and underserved urban areas.

Through the HPEAA, Congress also mandated that all IMGs who trained in J-1 status were categorically subject to the Immigration and Nationality Act ("INA") Section 212(e)[19], which requires physicians to return to their home country for two years after undergoing Graduate Medical Education ("GME") in the U.S.[20] At that time, Congress sought to not only protect U.S. physicians but also ensure that IMGs were well-trained and working predominantly with medically underserved patients. This is how INA Section 212(e) has become *the* legislation that has shaped the entire course of physician immigration for the past fifty years.

Over time, and due to a variety of factors, the medical programs at which IMGs trained began to increasingly require IMGs to train in J-1 status rather than sponsoring IMGs to enable them to train in H-1B status. This also coincided with a downward shift in the number of U.S. physicians being trained and a heavier reliance on IMGs. The result is the current system where the U.S. is simply not training enough U.S. physicians and IMGs are heavily relied upon to fill this increasing gap. Because most of these IMGs now require a J-1 waiver of the two-year home residence requirement to avoid having to leave the U.S. after completing their training, it is important to understand how the J-1 waiver process works.

One of the most recent and important advances in J-1 waiver law happened in 1994, through bi-partisan legislation championed by Senator Kent Conrad (D-ND). To address the staggering physician shortages in North Dakota, and to harness the ability to retain U.S.-trained physicians, Senator Conrad championed what became known as the "Conrad State 20" J-1 waiver legislation[21] because he saw an opportunity to complement the U.S. medical system using U.S.-trained foreign-national physicians. Specifically, Senator Conrad opined:

> *My proposal [for a State Conrad program] is by no means the entire solution to our health care needs in rural America. We must do more to reform our graduate medical education system so that our Nation produces more primary care practitioners. And we must provide additional incentives for physicians, nurse practitioners, physician's assistants, and others to practice in rural America. But the proposal I am introducing today will make a very real contribution to augmenting the physician supply in rural areas that need qualified physicians.*[22]

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[18] https://files.eric.ed.gov/fulltext/ED148192.pdf, last visited September 5, 2022.
[19] 8 USC Section 1182(e).
[20] Compare Clinical Physicians to the rest of the J-1 occupations that do not have a mandatory two-year home residence requirement categorically, but rather are subject on a case-by-case basis in the event of being listed on the corresponding skills list or government funding.
[21] Currently known as the Conrad State 30 J-1 waiver program.
[22] 140 Cong. Rec. at S6747.

Nearly 30 years later, the only modernization we have seen to this program was to increase the limit to 30 IMGs per state in 2002.[23] As a result, State Conrad 30 programs are oversubscribed, and Senator Conrad's creative J-1 waiver solution no longer provides enough J-1 waiver numbers to meet the demand. Over this same timeline, the U.S. Census Bureau estimates the country's population increased by 23 million people from 2010 to 2020.[24] The U.S. population is projected to climb further -- to 363 million by 2034, with 22.9 million—or two-thirds of the growth—estimated to be people 65 or older who will require more care as they age. Further, a recent survey conducted by the Mayo Clinic shows that "One in five physicians say it is likely they will leave their current practice within two years. Meanwhile, about one in three doctors and other health professionals say they intend to reduce work hours in the next 12 months."[25] They found that "burnout, workload, fear of infection, anxiety or depression due to COVID-19 and the number of years in practice were associated with intent to reduce work hours or leave."[26] These statistics evidence the direct and unrelenting physician and nursing shortage faced by the U.S., a growing U.S. population, especially over the age of 65, and the need for Congress to immediately effectuate smart immigration reform to address this growing crisis.

I have watched firsthand how J-1 waiver usage has evolved over my career. In my early years of practice, State Conrad J-1 waiver numbers were commonly available year-round. However, over time, the State Conrad Waiver programs have become more and more competitive, forcing state Departments of Health to implement administrative review programs including conducting lotteries or developing selection criteria to help determine and prioritize the most dire and urgent healthcare needs. Consider that in Fiscal Year 2021, the most recent year with available data, 23 states completely filled all 30 slots, meaning U.S.-trained international physicians who needed waivers were turned away and employers who desperately needed to add physicians to their team were left without access to candidates who could have filled those vacancies.[27] Additionally, eight states received more than 25 J-1 waivers, putting us closer than ever most states not having enough Conrad waivers to meet healthcare demand.[28] This isn't a local or regional problem – it is a national crisis. Rather than giving state Departments of Health the ability to ensure that all underserved communities have access to essential healthcare, states are forced to determine how to allocate the limited numbers, often not driven by need but rather through an administratively neutral means – sometimes as random as first-come, first-served or a lottery – to administer the high demand for too few numbers. The impact on IMGs willing to work in these rural and underserved areas is also dire as often physicians believe they have found a rewarding opportunity only to learn in the spring – right before their GME training program ends – that their waiver was not selected due to the shortage of numbers. This leaves them

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[23] 21st Century Department of Justice Appropriations Authorization Act § 11018(a), Pub. L. No. 107-273 (2002).
[24] https://www.ama-assn.org/practice-management/sustainability/doctor-shortages-are-here-and-they-ll-get-worse-if-we-don-t-act, last visited September 5, 2022.
[25] *Mayo Clinic Proceedings: Innovation, Quality & Outcomes,* "COVID-Related Stress and Work Intentions in a Sample of U.S. Health Care Workers," https://www.mcpiqojournal.org/article/S2542-4548(21)00126-0/fulltext, last visited September 5, 2022.
[26] *Id.*
[27] https://3rnet.org/Portals/0/adam/Basic%20Content/QxXpO-cnfkeKBY1XymXi7Q/Content/FFY%202021%20-%20October%202020%20to%20September%202021.pdf.
[28] *Id.*

scrambling for alternative options, of which there are few, and many end up leaving the U.S. altogether. Further, given these dire statistics regarding the lack of viable J-1 waiver numbers, many desperate healthcare facilities simply forego altogether the J-1 waiver program as it is expensive, takes significant time, and is ultimately unreliable in terms of ensuring the healthcare facility will actually be able to employ the sponsored IMG. This results in my clients in Minnesota to Indiana, Florida, California, and many more states, being simply unable to recruit sufficient physicians to staff their needs because there is not a workable mechanism to waive the two-year home residence requirement necessary to timely and reliably attain work authorization. The inevitable outcome of this crisis is that American patients suffer longer patient wait times and untreated medical issues. It is patients turning up in Emergency Rooms with illnesses that could have been avoided by basic preventative care, and increasing costs for hospitals, towns, states, and the American taxpayer.

In line with Senator Conrad's original reason to create the Conrad program, which was a bi-partisan effort then and remains so today,[29] we must build on and expand his legislation - which is now almost 30 years old - to retain physicians who have completed U.S medical training to increase healthcare access for Americans living in rural and underserved urban areas. Because 212(e) is the primary statutory driver for IMGs immigration journey, it is important to improve existing laws by legislatively and administratively providing access to more J-1 waiver options. This will, in the short term, allow U.S.-trained IMGs to continue to provide basic, primary medical care to the most underserved, rural, and indigent Americans. Additionally, for these physicians to remain in the U.S. long-term, it is important to revise the "green card" process to ensure that these IMGs have a viable pathway to stay in the U.S. and in the communities in which they have built their lives. This is smart immigration policy.

The Immigration Journey for IMGs & International Nurses is Lengthy, Unpredictable, and Difficult to Navigate

The immigration journey of an IMG is complex and lengthy and depends largely on whether the IMG undergoes GME in J-1 status or H-1B status. It also depends on their country of birth, both for J-1 waiver options and "green card" pathways.[30] If the IMG is in J-1 status for Graduate Medical Education ("GME"), the physician generally requires a J-1 waiver to remain in the U.S. to treat patients and once granted, in most instances, the physician will work in H-1B status to treat patients in an underserved rural or underserved urban community for a minimum three-year period.[31] The physician must then be sponsored by their employer for the "green card" process to remain and practice medicine in the U.S. long-term. If the physician instead completes medical training in the U.S. in H-1B status, the physician risks using all six-years of permitted initial H-1B status before successfully

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[29] *See*, "Creation of the Conrad Waiver Program," Immigration Options for Physicians, 3rd Edition, P. 55 – 62.

[30] Indian citizens not only are the second highest number of IMGs training each year, closely behind Canada, but they also face the longest backlog in their ability to achieve permanent resident status, or their "green card," due to country limits in immigrant visa availability. *See*, ECFMG J-1 Visa Sponsorship: Top 10 Nations of Origin for Exchange Visitor Physicians 2020 Calendar Year, EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES, https://www.ecfmg.org/resources/2020-EVSP-Data-Nations.pdf, last visited September 5, 2022.

[31] There are J-1 waiver options for IMGs who can document that having to return to their home country would impose exceptional hardship on their U.S. citizen spouse or child, or, that the physician himself or herself would face persecution on account of race, religion, or political opinion should he or she be required to return to their home country. These options do not require three years of service in an underserved area. *See* INA § 212(e), 8 U.S.C. § 1182(e); 8 C.F.R. § 212.7(c)(5).

completing the "green card" process, leaving few viable options to remain in the U.S.

The immigration journey of international nurses in the U.S. commonly means the nurse has received a Bachelor of Science in Nursing (BSN) from a U.S. university[32] and then has one year of post-degree work authorization ("OPT") during which the nurse must either achieve "green card" status or depart the U.S. However, only 8% of international students pursue healthcare degrees. Alternatively, employers can sponsor nurses living abroad through the "green card process" ultimately requiring an interview at a U.S. Consulate to be able to travel to the U.S. on a green card. This is a lengthy and complex process, exacerbated by the COVID-19 pandemic, which means it could be years before the nurse is eligible to enter the U.S. to work.

How Congressional Action Can Immediately Ensure Healthcare Equity for All Americans

There are a variety of simple, targeted, and common-sense legislative reforms that will make this immigration journey more predictable for IMGs and permit employers to recruit and employ critically needed physicians and nurses more robustly. This will help to immediately address the growing shortage of access to healthcare currently faced by rural and underserved urban Americans. Thus, it is imperative that Congress immediately act to pass the following two pending bills that have strong and consistent bi-partisan support, in both the Senate and House, and further U.S. interests in ensuring the provision of primary healthcare to all Americans:

- Conrad State 30 and Physician Access Reauthorization Act, S.1810 (H.R.3541)
- Healthcare Workforce Resilience Act, S.1024 (H.R.2255)

CONRAD STATE 30 AND PHYSICIAN ACCESS REAUTHORIZATION ACT

I would like to personally thank Senator Klobuchar for championing the Conrad State 30 and Physician Access Reauthorization Act ("Conrad Reauthorization Bill") by being the original sponsor of this bill, and I would like to thank Ranking Member Cornyn, and Senators Tillis, Coons, and Blumenthal for co-sponsoring this legislation. I would like to thank Ranking Member Cornyn and Senators Tillis, Feinstein, Coons, and Booker for co-sponsoring the Healthcare Workforce Resilience Act. Passage of these bi-partisan bills will bring important relief to underserved populations and J-1 physicians and international nurses alike.

The Conrad Reauthorization Bill provides much needed and long overdue reforms to help increase access to healthcare in underserved areas by amending the current statute to permit the 30 J-1 waivers provided to each state to rise and fall based on a state-by-state need rather than limiting each state to 30 waiver slots. This legislation also smartly permits qualifying physicians who timely but unsuccessfully applied to a State Conrad 30

[32] Only 3% of the approximate 1.1 million international students were enrolled in U.S. institutions in school 2019-20 pursued health professions, such as nursing. https://www.migrationpolicy.org/article/international-students-united-states-2020#fields_study. Last visited, September 5, 2022.

waiver program – due to the shortage of numbers - to extend their status to remain in the United States and re-apply for such service in the next fiscal year, which is another opportunity to ensure access to healthcare.[33] The Conrad Reauthorization Bill also restores a Conrad 30 number to an issuing state in instances when a physician relocates to another state in cases of extenuating circumstances.[34] Finally, the Conrad Reauthorization Bill permits J-1 waivers sponsored by Academic Medical Centers to exceed the 30 slots by up to three additional slots per state, in the event a given state has "maxed out" its default 30 slots.[35]

I have seen first-hand the absurd results that come from the rigid rules of our current, outdated system. Had it been in place just last year, this legislation would have been incredibly helpful to one my clients who sought to employ a U.S.-trained anesthesiologist at a hospital in Illinois. That hospital at which they sought to employ the anesthesiologist was literally *across the street* from the border of a designated underserved urban area. In that case, because the clinic itself was not physically located in the underserved area – although the anesthesiologist was serving the same patient demographics – the physician was not granted a J-1 waiver due to the badly oversubscribed Illinois J-1 waiver program that receives well over 30 applications each year. Given the shortage of anesthesiologists in the U.S., this lack of access to a J-1 waiver means that patient wait times for critical surgical procedures are delayed when employers cannot readily employ U.S. trained anesthesiologists due to the artificial and outdated limit on Conrad J-1 waiver numbers and rigidly applied rules.

Further, the Mayo Clinic each year must prioritize which doctors to sponsor for the limited Conrad J-1 waiver slots, knowing that not all will be selected. Last year, the Mayo Clinic had 23 physicians that needed Conrad Waivers and only received 10. One doctor, a highly influential oncologist treating breast cancer patients, has been waiting 7 years to obtain a waiver. Another physician resigned after 5 unsuccessful attempts to be selected for the limited Conrad J-1 Waiver slots and returned to his home country. This physician was one of the very few physicians worldwide who had unique training and skillset to treat complex gastroenterology disorders. The Mayo Clinic, as one of the leading gastroenterology departments in the world, now faces a gap in clinical staff training which results in patients, including those from medically underserved areas, facing longer wait times to see a specialist with this skillset. This is just one example of the many outstanding physicians that have resigned from the Mayo Clinic due to the limited availability of Conrad J-1 waivers. Alternatively, if a doctor has no other temporary work options, the Mayo Clinic is forced to rescind the offer of employment, and these positions are almost always in the underserved areas where the need is greatest. The U.S. should encourage and support, through smart immigration reform, the ability of states to grant J-1 waivers based on need.

There currently exists the Physician National Interest Waiver ("PNIW") which can allow a physician who works full-time for five years in a designated rural or underserved area to move forward in the green card process.[36] However, this does not solve the problem of the employment-based green card backlog, where

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[33] Conrad Bill § 4(d).
[34] Conrad Bill § 4(f).
[35] Conrad Bill § 5(b).
[36] INA §203(b)(2)(B)(ii); 8 U.S.C. §1153(b)(2)(B)(ii).

individuals born in China or India often have to wait 15 to 20 years for a green card "number" in the quota to become available – even if they are granted a PNIW. The Conrad Reauthorization Bill fixes this problem, and permits physicians who practice in a designated rural or underserved urban area to be exempt from the annual numerical green card limit.[37] This would have immediate and immense impact on physicians born in India or China who have completed GME in the U.S. and commit to working in rural and underserved urban areas, and who otherwise might need to wait upwards of 15 to 20 years to get a green card. Further, this bill importantly expands the PNIW green card program to align with the J-1 waiver program by providing benefits to physicians who, while not physically working in a federally designated rural or underserved urban area, provide care to patients who live in federally designated rural or underserved urban areas.[38]

Finally, the Conrad Reauthorization Bill provides "cap gap" relief for J-1 trainees, like that provided to F-1 students working in OPT status, whose work authorization expires before October 1 and whose employers have filed a cap-subject H-1B petition selected in the registration period. Expanding this relief to physicians would provide employers with quicker access to necessary healthcare and allow these foreign national physicians to change status in the United States, without having to depart the United States, obtain a visa, and only be permitted to re-enter the U.S. months later. Cap gap work-authorization for U.S.-trained physicians would add a quarter of a year or more of badly needed physician coverage and is smart immigration reform.

HEALTHCARE WORKFORCE RESILIENCE ACT

The Healthcare Workforce Resilience Act is another key piece of bi-partisan legislation for smart immigration reform. It affords U.S.-trained physicians and desperately needed nurses an immediate and viable pathway to remain in the U.S. permanently. This legislation would recapture 40,000 unused employment-based visas from prior years and reallocate 15,000 visas to physicians and 25,000 visas to nurses to bolster our healthcare workforce and ensure U.S. patients retain access to the care they deserve and continue to need during this unprecedented public health crisis. This will be important especially to our frontline medical workers born in India or China who otherwise are facing a delay of up to 15 years or more to become "green card" holders.[39] Without adding a single new green card number to the overall quota, and instead by recapturing numbers already authorized years ago by Congress but never used, passage of the Healthcare Workforce Resilience Act will bring important relief to physicians and nurses who have been working on our front lines.

While these two bi-partisan bills provide necessary and immediate relief, they are merely necessary short-term enhancements and do not solve the larger issues faced by international physicians and nurses, nor to the U.S. employers trying to employ them to address the U.S. healthcare crisis. Congress can and should do more.

Create a Lasting and Long-term Solution to the Problem of Healthcare Equity for All Americans

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[37] Conrad Bill § 3.
[38] Conrad Bill § 6(b).
[39] I provide a more detailed explanation of this delay later in this testimony.

PROVIDE H-1B CAP EXEMPTION FOR ANY IMG OR INTERNATIONAL NURSE WORKING IN A DESIGNATED RURAL OR UNDERSERVED URBAN AREA

Congress should amend the INA to provide H-1B cap exemption for physicians working at facilities located in an HHS-designated shortage area. The H-1B is the very same visa competed for each year by software companies in Silicon Valley and hedge funds in New York, and the demand for H-1Bs is growing every year. Indeed, the United States Citizenship and Immigration Services ("USCIS") has reported that for fiscal year 2023 it received more than 480,000 entries in the H-1B lottery for just 85,000 spots, an increase of more than 150,000 entries from the prior year.[40] Many employers seeking to hire an IMG or international nurse in H-1B status to work in a rural or underserved urban area are competing head-to-head with Google, Apple, Microsoft, and other large technology companies. By exempting IMGs and international nurses who choose to work in a designated rural or underserved urban area, we can both provide an important incentive to those doctors and nurses who choose to work in areas that desperately need healthcare, while also providing the hospitals, clinics, and local medical practices with far greater certainty in being able to obtain the necessary physicians and nurses needed to provide care. Providing this common-sense and cost-neutral carve out would provide greater access to health care for patients of international nurses and IMGs who underwent their GME in H-1B status, and it would make choosing to work in an underserved rural or urban area a more attractive choice to those doctors and nurses who don't want to "play the H-1B lottery."

PROVIDE AN IMMIGRANT VISA CAP EXEMPTION FOR ANY IMG OR INTERNATIONAL NURSE WORKING FOR FIVE YEARS IN AN UNDERSERVED AREA

The green card process is lengthy and difficult for any high-skilled immigrant. But compound the process with J-1 waivers, licensing issues, and a growing shortage of physicians and nurses generally, and we have an outdated system that does not easily facilitate the transition for needed healthcare workers from temporary work authorization to permanent resident status, or the "green card."

For IMGs and international nurses born in India or China, this problem is especially vexing. Consider the story of Dr. Pranav Singh, a critical care physician practicing in Mason City, Iowa, a small city with a population of around 27,000 that is nearly a two-hour drive from Des Moines.[41] Dr. Singh arrived in the U.S. in 2006 and has been working his way through the U.S. immigration system ever since. Because of the extensive backlogs experienced by people born in India in the green card process, and with a 16-year-old daughter who would likely lose her ability to remain in the U.S. once she turns 21 (at which time she is no longer considered Dr. Singh's dependent), Dr. Singh made the difficult decision to return to India. Dr. Singh obtained a job with a telemedicine

[40] https://www.uscis.gov/working-in-the-united-states/temporary-workers/h-1b-specialty-occupations-and-fashion-models/h-1b-electronic-registration-process, last visited September 5, 2022.
[41] https://www.americanbazaaronline.com/2021/10/24/tired-of-green-card-backlog-indian-doctor-returns-home-447509/, last visited September 5, 2022.

company in India, and Mason City lost a badly needed critical care physician. This happened because Dr. Singh and his family could see no light at the end of the tunnel, and ultimately needed the stability that a constant renewal of temporary visas does not bring. The story of Dr. Singh is just one of thousands of doctors and nurses who are growing weary with the outdated U.S. immigration process and its failure to recognize the essential contributions they make to the United States.

While there are preliminary foundational steps in the green card process, the ability for any high skilled immigrant to file the final step in the green card process is determined by a limited supply and strong demand of the 140,000 employment-based immigrant visa numbers available each year. These are allocated through a complex configuration determined by country of birth and education/training. The U.S. Department of State, through its monthly Visa Bulletin, tells individuals when they may be eligible to file,[42] and then USCIS determines at an even more granular level who can actually file.[43] Because this visa allocation system limits each country in the world to only 7% of the overall available 140,000 numbers, physicians from countries that are our highest contributing sources of high-skilled talent – like India and China – face substantially longer wait times to achieve green card status than their peers from other countries. Considering that physicians born in India comprise almost 22% of the total foreign-born physician community, and physicians born in China comprise over 5%,[44] the significant delays in wait times negatively impact these physicians who face a myriad of issues. These include children who "age out" and are unable to achieve immigration benefits under their parents, instability in their careers and ability to pursue career advancements, inability to independently obtain government research funding so vital for their livelihood, and a variety of other stressful factors, not experienced by their peers born in other countries. Physicians born in India currently will likely need to wait over 10 to 15 years from the time they begin their green card journey to be eligible to file an adjustment of status application within the U.S. and physicians born in China likely need to wait approximately three years.[45]

Congress can solve this problem with a simple, effective, and common-sense change to the law that will help to ensure that underserved rural and urban areas will have greater access to needed medical care. While the Conrad Reauthorization Act referenced above would make certain small carve outs for doctors who qualify for a Physician National Interest Waiver, Congress should solve the broader problem of access in underserved rural and urban areas to both doctors and nurses by amending INA Section 203(b)[46] to create an exemption to the employment-based green card quota for those doctors and international nurses who work for at least five years in

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[42] https://travel.state.gov/content/travel/en/legal/visa-law0/visa-bulletin.html, last visited September 5, 2022.
[43] https://www.uscis.gov/green-card/green-card-processes-and-procedures/visa-availability-priority-dates/adjustment-of-status-filing-charts-from-the-visa-bulletin, last visited September 5, 2022.
[44] https://research.newamericaneconomy.org/report/immigrant-healthcare-workers-countries-of-birth/, last visited September 5, 2022.
[45] Visa Bulletin for September 2022, https://travel.state.gov/content/travel/en/legal/visa-law0/visa-bulletin/2022/visa-bulletin-for-september-2022.html, last visited September 5, 2022.
[46] 11 USC 1153(b) "Preference allocation for employment-based immigrants."

a designated underserved rural or urban area.[47] This would create the kind of long-term relief necessary to address the serious healthcare shortage these communities are facing.

Additional Statutory Fixes to Advance Healthcare Equity through Smart Immigration Reform

There are additional cost-neutral, smart immigration reform steps Congress can and should take to improve health equity in the United States. First, Congress should expand the H-1B U.S. Master's Cap exemption to include ECFMG-certified medical degrees and/or completed U.S. GME programs as qualifying bases for eligibility.[48] The Master's Cap exemption reserves 20,000 H-1B numbers each year for individuals who have completed at least a Master's level educational program at a U.S. college or university.[49] U.S. GME programs are at shortest, three years and at most, eight years of advanced, post-MD training, which is directly in line with policy interests Congress intended when it created the U.S. Master's Cap exemption. By amending INA § 214(g)(5)(C) to clarify that GME programs qualify for the master's Cap exemption, Congress can show that the United States values doctors just as much as it values software engineers.

Additionally, Congress should amend the statute to address the H-1B 6-year limit for physicians undergoing GME training in H-1B status, by tolling the three-year H-1B remainder of the 6-year limit once a physician completes the foundational three-year residency. IMGs who demonstrate acceptance to an ACGME-accredited fellowship program or an ACGME-recognized nonstandard training program and H-1B qualifying employment should be permitted to toll the last three years of H-1B eligibility until they complete the subspecialty training. These physicians would then be eligible for the final three years of the statutory 6-year H-1B status immediately after completing the subspecialty training. This would serve as a necessary bridge for physicians training in H-1B status by eliminating the frequent situation where physicians undergo GME training in H-1B status but run out of time to complete the full course of subspecialty training and still need time to achieve green card status.

REINSTATE AND EXPAND THE H-1C CLASSIFICATION SO INTERNATIONAL NURSES HAVE A VIABLE NON-IMMIGRANT OPTION TO WORK IN THE U.S.

In January 2022, Governors from across the country called in the National Guard to assist health care providers because 1,118 hospitals—more than 1 in 6 hospitals in America[50] —reported serious nursing shortages.[51]

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[47] I provide details below on additional legislative and administrative reforms that would permit international nurses to work during this five-year period.
[48] This would require amending INA § 214(g)(5)(C), 8 U.S.C. § 1184(g)(5)(C).
[49] INA Section 214(g)(5)(C).
[50] American Hospital Association, "Fast Facts on U.S. Hospitals," available at https://www.aha.org/statistics/fast-facts-us-hospitals (last accessed April 2022). *See also*, https://www.nursingworld.org/practice-policy/workforce/. Further, About 194,500 openings for registered nurses are projected each year, on average, over the decade. Many of those openings are expected to result from the need to replace workers who transfer to different occupations or exit the labor force, such as to retire. https://www.bls.gov/ooh/healthcare/registered-nurses.htm.
[51] Rachael Levy, "Health care workers are panicked as desperate hospitals ask infected staff to return," *Politico*, January 10, 2022, available at https://www.politico.com/news/2022/01/10/doctors-covid-staff-shortage-526842, last visited September 5, 2022.

By March 2022, almost every state in the country had implemented executive actions to address this shortage of nurses.[52] Compounding this issue is the COVID-19 pandemic, as nurses are leaving the profession amid the "extreme and sustained demands of caring for unvaccinated, hospitalized patients during the COVID-19 pandemic."[53] A recent study by American Association of Critical-Care Nurses ("AACN") confirmed that 66% of nurses feel their experiences during the pandemic have caused them to consider leaving nursing.[54]

Smart immigration reform can provide an immediate and cost-neutral approach to solve this problem. In 1999, Congress created, through the Nursing Relief for Disadvantaged Areas Reauthorization Act ("NRDAA"), the H-1C nonimmigrant temporary worker classification specifically to address the shortage of nurses in the U.S. by permitting international nurses coming to the United States to perform services as a registered nurse in a health professional shortage area as determined by the Department of Labor ("DOL").[55] This program required administration and oversight from both DOL and legacy INS. However, on December 21, 2009, the NRDAA sunsetted and has not been reauthorized.

To qualify for an H-1C visa, RNs had to possess full and unrestricted nursing license in the country where the nursing education was obtained or must have received a nursing education and license in the United States. They were also required to be licensed in the State in which they sought to practice and to have passed the Commission on Graduates for Foreign Nursing Schools ("CGFNS") exam, or have held a full and unrestricted license to practice as a registered nurse in the state where they were to work, or have held full and unrestricted registered nurse's licensure in any state and have received temporary authorization to practice as a registered nurse in the state where they were to work. Employers were required to: be a "subpart D" hospital under the Social Security Act; be in a HPSA; have at least 190 acute care beds; have a Medicare population of no less than 35%; have a Medicaid population of no less than 28%; and, be certified by the DOL.[56]

Congress could, and should, immediately reauthorize the NRDAA to facilitate the ability for Employers to hire and employ RNs. Congress should also raise the annual numerical limit beyond the historical 500 to a more reasonable number such as 20,000 per year, to meet real-world, current nursing shortages in the United States.

BRING THE TWO-YEAR HOME RESIDENCE REQUIREMENT FOR PHYSICIANS IN LINE WITH ALL OTHER J-1 OCCUPATIONS

The concern about IMGs taking jobs away from U.S. physicians was the impetus of Congress legislating the two-year home residence requirement for all clinical IMGs who receive GME in J-1 status in the U.S. This concern has not only since disappeared, but it is also at this point well-established that the U.S. simply cannot train enough

[52] National Council of State Boards of Nursing, "State Response to COVID-19," available at https://www.ncsbn.org/State_COVID-19_Response.pdf.
[53] https://www.aacn.org/newsroom/hear-us-out-campaign-reports-nurses-covid-19-reality, last visited September 5, 2022.
[54] *Id*.
[55] https://www.uscis.gov/archive/h-1c-registered-nurse-working-in-a-health-professional-shortage-area-as-determined-by-the-department, last visited September 5, 2022.
[56] https://www.uscis.gov/archive/h-1c-registered-nurse-working-in-a-health-professional-shortage-area-as-determined-by-the-department#:~:text=To%20qualify%20for%20an%20H,to%20practice%20within%20the%20state, last visited September 5, 2022.

physicians to meet our current need. Nevertheless, despite this perpetual shortage, Congress still *de facto* subjects IMGs to the two-year home residence requirement at INA Section 212(e). All other J-1 occupations are subject only after the U.S. Department of State's Waiver Review Division, Visa Office, Bureau of Consular Affairs, consults with foreign governments and overseas posts to determine if the country has a shortage of a particular occupation.[57] Given that the United States is suffering from an acute, decades-long shortage of physicians, and that the HPEAA was passed largely due to the fact that there were more IMGs than the U.S. population needed at that time, Congress should now modernize INA section 212(e) to bring it in line with all other J-1 occupations. If a physician can show that their home country does not object to the physician being granted a waiver of the 2-year home residence requirement, it should be waived. This is the same approach taken with engineers, teachers, finance professionals, and all other J-1 professions. It should be applied to doctors as well, rather than treating them differently and more strictly.

Administrative Actions to Improve the Provision of Health Care in Rural and Underserved Urban Areas

While the legislative changes noted above are exceptionally important to a long-term solution to ensure access to basic medical care for all Americans, Congress can also effectuate necessary relief through highlighting and supporting administrative and regulatory changes to the relevant federal agencies. There are several smart, cost-neutral, and effective administrative actions that would greatly improve access to urgently needed healthcare in rural and underserved urban communities, without the need for the passage of legislation.

EXPAND THE HHS CLINICAL J-1 WAIVER PROGRAM

The HHS clinical J-1 waiver program is an effective way for primary care physicians to practice in rural and underserved urban areas. This program has no statutory annual limit but limits eligibility to facilities located in the most acute underserved rural and urban America and only permits primary care physicians in Internal Medicine, Family Practice, OB/GYN, Psychiatry, Pediatrics, and Hospitalists to apply.

HHS' authorizing regulations are much broader, however, and would permit primary care physicians to carry out their service in any "primary care Health Professional Shortage Area ("HPSA") or Medically Underserved Area or Population ("MUA/P")," and psychiatrists to work in any Mental Health HPSA, with no specification as to a minimum score.[58] As these are all areas that HHS itself has already designated as shortage areas, as a matter of policy, HHS should expand its clinical J-1 waiver program to the fullest extent of the current regulations. Additionally, the program could readily be expanded beyond the current primary care fields, so long as the healthcare service would be rendered in an HHS-designated shortage area. There is a pervasive shortage of medical specialists in rural and underserved urban areas and yet medical specialists are unable to utilize the HHS J-

[57] 74 FR 20107, https://www.federalregister.gov/documents/2009/04/30/E9-9657/2009-revised-exchange-visitor-skills-list, last visited September 5, 2022.
[58] 45 C.F.R. § 50.5(c).

1 waiver program.[59] Because HHS is eligible under the statute to recommend J-1 waivers as an Interested Federal Agency, it should revise its regulations to expand J-1 waiver eligibility to medical specialists.[60]

ENCOURAGE ALL FEDERAL REGIONAL COMMISSIONS TO ENACT J-1 WAIVER PROGRAMS

Congress has authorized seven federal regional commissions and authorities to address instances of major economic distress in certain defined socioeconomic regions, including improving access to critically needed healthcare. Five of these seven are currently active, yet only three of these seven have active J-1 waiver programs. Congress should encourage the remaining regional commissions and authorities to actively create and administer J-1 waiver programs to ensure the neediest Americans have access to primary healthcare.

ADD MEDICAL DOCTOR AND BACHELOR OF SCIENCE IN NURSING TO THE STEM OPT LIST OF OCCUPATIONS

Another smart and simple administrative reform that would provide significant relief is to revise the rules governing work authorization for students who graduate from a U.S. university. In 2016, the Department of Homeland Security ("DHS") updated the regulations governing post-completion Optional Practical Training ("OPT") to provide an additional 24 months of work authorization for students who graduate from a U.S. college or university with a STEM degree, as long as their employer participates in the E-Verify program.[61] This regulation recognized the tremendous importance to the United States of students with education in science, technology, engineering, and math, and has allowed engineers, computer scientists, physicists, and others with a STEM degree to remain in the U.S. for a longer amount of time applying their skillsets to the benefit of the U.S.[62] However, despite the fact that a Bachelor of Science in Nursing ("BSN") and a Doctor of Medicine ("MD") both involve extensive study of science, neither a BSN nor a U.S. MD are designated as STEM fields eligible for the 2 year extension of OPT.[63] By simply treating these educational programs in the U.S. as the scientific disciplines that they are, these students can be provided with an opportunity to work and receive additional on-the-job training while also providing badly needed medical care to Americans who need it. This would not require the passage of any new statute by Congress and could be effectuated through a simple change to the administrative rules governing a program that is already in place.

DESIGNATE IMGS WORKING IN A FEDERALLY QUALIFIED UNDERSERVED AREA AS A "DOL SCHEDULE A" OCCUPATION

Dr. Daniel Dahle is a physician in Bieber, California. At age 71, he has delayed retirement for years

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[59] See, https://www.aamc.org/data-reports/students-residents/interactive-data/table-c2-number-individuals-who-completed-residency-and-are-practicing-medically-underserved-areas.
[60] *See* INA § 214(l)(c); INA § 214(l)(D). See also, 45 CFR Part 50.5(b), https://www.govinfo.gov/content/pkg/CFR-2009-title45-vol1/pdf/CFR-2009-title45-vol1.pdf. Last visited September 5, 2022.
[61] 8 CFR 214.2(f)(10)(ii)(C).
[62] https://www.uscis.gov/working-in-the-united-states/students-and-exchange-visitors/optional-practical-training-extension-for-stem-students-stem-opt, last visited September 5, 2022.
[63] https://www.ice.gov/doclib/sevis/pdf/stemList2022.pdf, last visited September 5, 2022.

because it is so difficult to recruit new family practitioners to come to rural California for their medical careers. By 2030, the state of California will be in dire need of primary care doctors, and the problem will be particularly difficult in agricultural areas like the Central Valley. This is the kind of shortage that has caused Dr. Dahle to delay retirement again and again. [64]

However, despite this known shortage, and despite the fact that HHS already designates specific areas in each state as underserved shortage areas, most employers seeking to obtain a green card for a foreign-national doctor for one of those small towns or underserved urban areas are required to first complete a 16 to 18 month long process known as PERM labor certification.[65] In essence, those employers have to go through a lengthy process just to show what they and HHS already know – that there aren't enough U.S. doctors in the community.

There is, however, a sensible and easy-to-implement solution to this problem that doesn't require any new legislation. The DOL's Office of Foreign Labor Certification ("OFLC") has pre-certified certain occupations as having a severe shortage of U.S. workers, referred to as "Schedule A occupations."[66] Currently, registered nurses and physical therapists are classified as such.[67] However, given the documented U.S. physician shortage spanning more than two decades, DOL could simply add physicians working in HHS-designated shortage areas to the list of shortage occupations. This would help employers more quickly sponsor physicians for permanent resident status, without having to expend significant time, money, and resources to test a local labor market that already evidences current and significant shortages. Permitting employers to skip entirely a labor market test through DOL's designation of physicians working in HHS-designated shortage areas as a Schedule A occupation would be smart immigration reform that will help the U.S. retain foreign national physicians by providing them with means to adjust to lawful permanent resident status, or "green card" status, more quickly.

Conclusion

IMGs and international nurses are not only a short-term solution to help solve the lack of access to medical care in the United States, but they are also a long-term solution. Beyond the urgent need for more physicians based on these pervasive shortages, IMGs positively impact the communities in which they work. J-1 waivered physicians are more likely to remain in medically underserved areas after program completion than U.S. medical graduates participating in the National Health Service Corps. Twenty-eight percent (28%) of foreign national physicians who obtain J-1 waivers continue to practice in their underserved locations after five years, as compared with a retention rate of 11% for U.S. medical graduates participating in the NHSC.[68] In fact, it is often

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[64] https://calmatters.org/projects/californias-worsening-physician-shortage-doctors/?smid=nytcore-ios-share, last visited September 5, 2022.
[65] https://www.dol.gov/agencies/eta/foreign-labor/programs/permanent, last visited September 5, 2022.
[66] https://www.ecfr.gov/current/title-20/chapter-V/part-656/subpart-B/section-656.5, last visited September 5, 2022.
[67] *Id*.
[68] American Medical Association (AMA)-International Medical Graduate (IMG) Section Governing Council, International Medical Graduates in American Medicine: Contemporary Challenges and Opportunities-15 (2010), https://www.slideshare.net/drimhotep/internationalmedicalgraduatesinamericanmedicinecontemporarychallengesandopportunities, last visited September 5, 2022.

IMGs who are the only qualified, U.S.-trained physicians providing care in their area, seeing patients who drive for hours to access care.[69] Access to healthcare in rural America is vital to stabilizing and ensuring the viability of many rural U.S. communities. Given that many IMGs remain in these communities long-term, they are essential to ensuring viability in rural and underserved urban communities.

Through targeted, simple, and smart immigration reform, Congress can help solve the problem of access to medical care in the United States. The U.S. is facing an ongoing and pervasive shortage of physicians and nurses, and the integral role IMGs and international nurses play in the delivery of basic and acutely needed healthcare is documented. I have outlined several legislative and administrative actions that I urge Congress to immediately pursue to ensure these IMGs and international nurses are able to continue to provide desperately needed medical care in the U.S. The U.S. needs to be bold and swift in enacting these modest, bi-partisan, budget-neutral enhancements to our existing immigration laws. This is smart immigration policy.

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[i] While this testimony is my own, I gratefully acknowledge the support of SPS Immigration team members Elizabeth Storey, Jenny Patrias, and Yer Vang for their assistance with related research and preparation.

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[69] https://money.cnn.com/2018/06/08/news/economy/immigrant-doctors-green-card-backlog/index.html, last visited September 5, 2022.

Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce

Questions for the Record

Submitted by Senator Cornyn

September 21, 2022

Questions for Urbino "Benny" Martinez

1. In 2020, Congress passed and the President signed into law the *Missing Persons and Unidentified Remains Act*, Pub. L. No. 116-277. Congress appropriated $5 million for grants authorized under this Act for Fiscal Year 2022. What impact will this funding have in Brooks County? What improvements, if any, should the Department of Justice make to the process for applying for these grants?

2. How has Brooks County specifically, and Texas more generally, been uniquely affected by the crisis along the southern border? Have certain locations along the southern border been impacted more seriously or differently?

Questions for the Record from
Senator Thom Tillis for Dr. Ram Sanjeev Alur

1. How will recapturing unused visas help to reduce the immediate green card backlog for essential healthcare workers?
According to recent estimates, there are between 13,250 and 14,230 physicians of Indian origin currently in green card backlogs.[1] These are physicians primarily serving underserved populations and are integral to their hospitals or clinics due to the recruitment and retention environment in many underserved areas. If Congress were to recapture unused visas, these backlogged physicians would receive a green card enabling them to focus entirely on their patients and assuming a larger health care role in their practice and community long-term. Currently, the process for renewing ones temporary H1-B visa is highly problematic, causing significant disruptions for physicians and their families. These disruptions can also affect patients if a physician has to take time away from work to file their renewal, or is unable to drive due to a delay in processing a renewal, meaning delays in treatment. As the country confronts a growing shortage of health care workers, recapturing green cards would help to alleviate the workforce strain many health care systems are experiencing.

Physicians in the green card backlog can only work in the position filed by their employer, meaning they cannot pick up shifts at a nearby hospital or volunteer during a state or national public health emergency. These rules are impacting access for patients, both during the height of the pandemic and amidst severe labor shortages, and should compel Congress to consider whether the green card backlog impacting essential health care workers serves any purpose that benefits communities, patients, or the broader immigration system.

2. Looking into the future, how will recapturing unused visas help to fill the known workforce shortages we face in the healthcare industry?
As noted above, clearing the green card backlog is as much practical policy as it is strategic. U.S.-trained international physicians are highly sought after, and many countries are actively recruiting international health workers with offers of a clearer pathway to citizenship. Countries like Canada[2] and the United Kingdom[3] are actively exploring ways to tap foreign health care workers to address shortages, and France granted citizenship to over 12,000 essential workers for their contributions during the pandemic.[4] These policies are particularly appealing to international physicians stuck in the green card backlog.

For physicians training here, knowing they are not entering a historic backlog should increase the likelihood that they will practice here, which largely occurs in underserved areas. It will also empower physicians working in a variety of settings to take on more responsibilities, such as starting their own practice or accepting shifts in nearby communities.

This is particularly important in rural and underserved areas where physicians tend to be older. In rural communities, the number of physicians under 50 years of age has decreased dramatically over the last 20 years. In 2017, more than half of rural physicians were at least 50 years old, and more than a quarter

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[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7599012/
[2] https://www.cbc.ca/news/politics/healthcare-workers-burnout-1.6492889
[3] https://www.theguardian.com/society/2022/aug/19/overseas-hiring-spree-planned-for-care-homes-in-england-amid-winter-fears
[4] https://www.schengenvisainfo.com/news/france-12000-foreign-essential-workers-granted-with-citizenship-for-their-contribution-during-covid-19/

were at least 60 years old.[5] In addition, we know that rural communities have worse health outcomes than their urban counterparts.[6] This combination of factors should compel Congress to take action.

On the nursing side, the prospect of adding 25,000 qualified nurses to the workforce would dramatically improve the shortages facing nursing in the United States. As noted by the American Hospitals Association (AHA), each year, the United States grants green card status to up to 140,000 employment-based (EB) immigrants and their family members. Typically, nurses are in the EB-3 category, which totals 27.6% of the worldwide limit or up to 40,040 immigrants. These totals result in around 10,000-12,000 nurses per year being admitted to the United States.[7] To put another way, recapturing 25,000 visas for qualified nurses, if passed in the bipartisan Healthcare Workforce Resilience Act, would significantly reduce shortages that cannot be reduced as quickly through other solutions, such as by investing in and expanding nursing graduate programs.

3. Can you please discuss how the Conrad 30 program effectively serves the needs of underserved communities in North Carolina and across the country?
North Carolina has a fantastic Conrad 30 program. Between FY2014-2018, the North Carolina Office of Rural Health, which administers the Conrad program, placed 126 primary care and subspecialist physicians in underserved areas of North Carolina in the following specialties: family medicine, internal medicine, pediatrics, psychiatry, surgery, hospitalist, cardiology, and oncology, among others. Of those physicians, 94% were placed in Health Professional Shortage areas. North Carolina estimates that the J-1 physicians generated $79.5 million in economic impact over that span.[8]

The Conrad 30 program is a state-run program that allows each state to allocate slots to best meet the needs of their state. In North Carolina, 20 of the 30 slots are reserved for primary care physicians practicing in underserved areas. These physicians are typically family practice, general internal medicine, general pediatrics, Obstetrics/Gynecology (OBGYN), or Psychiatry. The remaining 10 slots are known as flex spots, which may be used by physicians working in non-designated shortage areas or limited to primary care.

As of FY18, North Carolina has 87 counties designated as health professional shortage areas and 90 counties designated as medically underserved areas. The Office of Rural Health leverages the Conrad 30 program by placing the overwhelming majority of its J-1 physicians in shortage areas. Reauthorizing the Conrad 30 program would clarify the incentives for physicians and make it possible for North Carolina to place more physicians throughout the state.

4. How can USCIS use its existing authorities to improve visa processing for essential healthcare workers?
USCIS should work with the State Department to permit certain visa holders with expiring visas to renew their visas without going abroad. This policy would limit the potential disruption in care for patients being served by physicians in the backlog, and make it easier for employers who depend on international health care workers.

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[5] https://www.auis.edu/wp-content/uploads/2019/08/Disparity-Rural-Physician-Workforce-NEJM.pdf
[6] https://www.cdc.gov/ruralhealth/about.html
[7] https://www.aha.org/testimony/2022-09-14-aha-senate-statement-flatlining-care-why-immigrants-are-crucial-bolstering-our
[8] https://www.ncdhhs.gov/media/8620/open

Doctors on temporary H-1B visas need to have their work visa renewed at least every three years through an uncertain petition process in which the employer, not the doctor, needs to file the essential paperwork. The process is a huge administrative burden to the employer and the employee with multiple agencies involved and is currently very protracted. The Administration should be doing everything in its power to prioritize the processing of health care workers who will be alleviating workforce shortages.

September 28, 2022

The Honorable Alex Padilla
Chair
Subcommittee on Immigration, Citizenship and Border Safety,
Committee on the Judiciary
United States Senate
Washington, D.C. 20510

The Honorable John Cornyn
Ranking Member
Subcommittee on Immigration, Citizenship and Border Safety,
Committee on the Judiciary
United States Senate
Washington, D.C. 20510

Dear Chair Padilla and Ranking Member Cornyn:

On behalf of the American Academy of Family Physicians (AAFP) and the 127,600 family physicians and medical students we represent, I applaud the committee for its continued focus on strengthening the health care workforce. I write in response to the hearing: "Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce" to share the family physician perspective and the AAFP's policy recommendations for ensuring that we have a robust primary care workforce to address our nation's current and future health care needs.

Primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes. As such, the AAFP has long been concerned about the shortage of primary care physicians in the U.S., particularly the supply of family physicians, who provide comprehensive, longitudinal primary care services for patients across the lifespan, including chronic disease management, treatment of acute illnesses, and preventive care. It is projected that we will face a shortage of up to 48,000 primary care physicians by 2034.[i]

Family physicians are acutely aware of the current shortage of primary care physicians across the country and the important role International Medical Graduates (IMGs) play in addressing this shortage. In fact, nearly 21 million Americans live in areas of the U.S. where foreign-trained physicians account for at least half of all physicians.[ii] The COVID-19 pandemic has also highlighted the urgency of building and financing a robust, well-trained, and accessible primary care system in our country. The AAFP urges the committee to consider the following recommendations.

Role of IMGs in Addressing Health Equity

IMGs play a vital role in caring for some of the most vulnerable populations in the U.S. IMGs make up more than 22 percent of active family physicians, and they are more likely to practice in rural, low socio-economic status, and non-white communities.[iii, iv] In fact, IMGs are twice as likely to practice in health professional shortage areas.[v] By increasing the number of visas available to IMGs these vulnerable populations will be better served and the overall health care system will be bolstered. **We urge Congress to pass the *Health Care Workforce Resilience Act* (S. 1024) to recapture 15,000 unused employment-based physician immigrant visas from prior years to enable physicians to have the support they need and our patients to have the care they deserve.**

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The lack of a diverse physician workforce has significant implications for public health. Physicians who understand their patients' languages and understand the larger context of culture, gender, religious beliefs, sexual orientation, and socioeconomic conditions are better equipped to address the needs of specific populations and the health disparities among them. Several studies show that racial, ethnic and gender diversity among physicians promotes better access to health care, improves health care quality for underserved populations, and better meets the health care needs of our increasingly diverse population.[vi, vii] Data shows that IMGs add significantly to the diversity of the physician population. Among IMGs with Education Commission for Foreign Medical Graduates certification, all races and ethnicities are substantially represented and, as a group, the percentage who are people of color is much higher than that of U.S. medical graduates.[viii] Therefore, IMGs help to diversify the physician workforce, decrease health disparities, and improve health outcomes. **We urge Congress to continue consider IMGs as an important way to diversify the physician population to meet the growing needs of our diverse patient population.**

Conrad 30 Waiver Program Reauthorization
Currently, resident physicians from other countries working in the U.S. on J-1 visa waivers are required to return to their home country after their residency has ended for two years before they can apply for another visa or green card. The Conrad 30 Waiver Program allows these physicians to remain in the U.S. without having to return home if they agree to practice in an underserved area for three years.

Many communities, including rural and low-income urban districts, have problems meeting their patient care needs and depend on the physicians in this program to provide health care services. Over the last 15 years, the program has brought more than 15,000 foreign physicians to underserved and rural communities. With communities across the country facing physician shortages, the Conrad 30 Waiver Program ensures that physicians who are often educated and trained in the U.S. can continue to provide care for patients during the COVID-19 crisis and beyond. **We urge Congress to pass the *Conrad State 30 & Physician Access Act* (S. 1810) to provide needed stability for the Conrad 30 Waiver Program.**

Thank you in advance for consideration of our recommendations. The AAFP looks forward to working with the committee to develop and implement policies to strengthen the primary care workforce. Should you have any questions, please contact John Aguilar, Manager of Legislative Affairs at jaguilar@aafp.org.

Sincerely,

Sterling N. Ransone, Jr. MD FAAFP

Sterling N. Ransone, Jr., MD, FAAFP
Board Chair, American Academy of Family Physicians

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[i] IHS Markit Ltd. *The Complexities of Physician Supply and Demand: Projections From 2019 to 2034*. Washington, DC: AAMC; 2021.
[ii] American Immigration Council. Foreign-Trained doctors are critical to serving many U.S. Communities. 2018. Available at: https://www.americanimmigrationcouncil.org/sites/default/files/research/foreigntrained_doctors_are_critical_to_serving_many_us_communities.pdf

[iii] American Medical Association. (2021, October 19). *How IMGs have changed the face of American Medicine*. American Medical Association. Retrieved February 15, 2022, from https://www.ama-assn.org/education/international-medical-education/how-imgs-have-changed-face-american-medicine
[iv] IHS Markit Ltd. *The Complexities of Physician Supply and Demand: Projections From 2019 to 2034*. Washington, DC: AAMC; 2021.
[v] Traverso, G., & McMahon, G. T. (2012). Residency training and international medical graduates: coming to America no more. *JAMA*, *308*(21), 2193–2194. https://doi.org/10.1001/jama.2012.14681
[vi] Cooper LA, Powe NR. Disparities in patient experiences, health care processes, and outcomes: the role of patient-provider racial, ethnic, and language concordance. The Commonwealth Fund. Accessed October 19, 2021.
[vii] Poma PA. Race/ethnicity concordance between patients and physicians. J Natl Med Assoc. 2017;109(1):6-8.
[viii] Norcini JJ, van Zanten M, Boulet JR. The contribution of international medical graduates to diversity in the U.S. physician workforce: Graduate medical education. J Health Care Poor Underserved. 2008; 19:493–499

201 Chicago Avenue
Minneapolis, Minnesota 55415

Tel: (612) 928-6100
Fax: (612) 454-2744

AAN.com

September 20, 2022

The Honorable Alex Padilla
Subcommittee on Immigration, Citizenship, and Border Safety
Senate Committee on the Judiciary
Washington, DC 20510

The Honorable John Cornyn
Subcommittee on Immigration, Citizenship, and Border Safety
Senate Committee on the Judiciary
Washington, DC 20510

Statement for the Record on "Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce"

Dear Chair Padilla and Ranking Member Cornyn:

The American Academy of Neurology (AAN), the world's largest association of neurologists representing over 38,000 professionals, is strongly committed to improving the care and outcomes of persons with neurologic illness in a cost-effective manner. One in six people lives with a brain or nervous system condition, including Alzheimer's disease, Parkinson's disease, stroke, epilepsy, traumatic brain injury, ALS, multiple sclerosis, and headache.

The AAN thanks the Subcommittee on Immigration, Citizenship, and Border Safety for hosting the upcoming hearing titled "Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce." The AAN strongly supports strengthening the health care workforce by utilizing the skills of immigrant physicians who completed their training in the United States to assist in the growing shortage.

The United States is facing a shortage of between 54,100 and 139,000 physicians by 2034 that will likely be exacerbated by rising rates of physician burnout and early retirement due to the COVID-19 pandemic.[1] Now, more than ever, it is critical that we ensure our nation's health care workforce can meet the needs of the American people. Additionally, as the significant impacts of Long COVID for millions of Americans are emerging, having a sufficient workforce to address the additional demand for neurologic care is critical. According to a recent study, one-third of patients diagnosed with COVID-19 may develop psychiatric or neurologic disorders within six months, including depression, anxiety, strokes, and dementia.[2] That same study found that among COVID-19 patients admitted to an intensive care unit (ICU), the incidence of developing a psychiatric or neurologic disorder increased to 46%.

[1] https://www.aamc.org/news-insights/press-releases/aamc-report-reinforces-mounting-physician-shortage

[2] https://journals.lww.com/neurotodayonline/Fulltext/2021/06030/6_Months_After_COVID_19_Infection,_1_in_3_Develop.4.aspx

Given the magnitude of COVID-19 cases across the US, the impact of neurologic symptoms is likely enormous, making the need for neurologists ever-growing.

Furthermore, the population of the United States is also expected to grow by 10.6% by 2034, with a 42.4% increase of individuals aged 65 years and older, and a 74% increase of individuals aged 75 years and older. As life expectancy continues to rise, more Americans will develop chronic neurologic conditions such as Parkinson's disease, dementia, and Alzheimer's disease, which require specialized care.

The Conrad State 30 and Physician Access Reauthorization Act

International medical graduates (IMGs) are an important part of the US neurology workforce, with 31.5% of active neurologists being IMGs. However non-US IMG resident physicians training in the US on J-1 visas are required to return to their home country for two years after their residency has ended before they can apply for a work visa or green card. The Conrad 30 program provides 30 waivers per state to allow these physicians to remain in the US without having to return home for two years if they agree to practice in a medically underserved area for three years. With communities across the country facing physician shortages, the Conrad 30 program helps physicians who are educated and trained in the US continue to care for patients. We encourage the Subcommittee to advance **The Conrad State 30 and Physician Access Reauthorization Act (S. 1810/ H.R. 3541)**, which would reauthorize the Conrad 30 program for an additional three years, as well as make several key improvements to the program, including creating a process to gradually increase the number of waivers while requiring additional employment protections.

Healthcare Workforce Resilience Act

The AAN also encourages the Subcommittee to review the **Healthcare Workforce Resilience Act (S. 1024/ H.R. 2255)**, a bill that would reallocate 15,000 visas for foreign-born physicians and 25,000 visas for foreign-born nurses to practice in the United States. The Healthcare Workforce Resilience Act would provide much-needed stability to foreign-born physicians already practicing in the United States who are stymied by the green card backlog due to per country caps. According to one AAN member from India who has worked in an underserved area of Tennessee, based on "current wait times, it may take several decades for me to get a green card. Due to my visa status, me and my family face significant uncertainties regarding work and life in America." These qualified health professionals, including neurologists, will help fill shortages as our nation's health systems continue their "all hands-on deck" response to COVID-19. In addition, these highly trained medical professionals will provide life-saving care in many of our nation's underserved communities.

In conclusion, the AAN thanks you for your leadership on these important issues. If you have any questions or require additional information, please do not hesitate to contact Derek Brandt, Director of Congressional Affairs at *dbrandt@aan.com*. We look forward to working with you as we all strive to improve access to timely care for all Americans with neurologic conditions.

Sincerely,

Orly Avitzur, MD, MBA, FAAN
President, American Academy of Neurology

AAIHR
American Association of International Healthcare Recruitment

Statement of Patty Jeffrey
President
American Association of International Healthcare Recruitment

On:
"Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce"

Before the Senate Judiciary Committee's Subcommittee on Immigration, Citizenship, and Border Safety

September 12, 2022

The American Association of International Healthcare Recruitment is pleased to submit this statement for the record to the Senate Judiciary Committee's Subcommittee on Immigration, Citizenship, and Border Safety on the extraordinary contributions of foreign-educated clinicians to US healthcare.

As the preeminent nonpartisan advocate for international healthcare workers and the health systems that rely on them, the AAIHR is uniquely positioned to comment on immigrants' essential role in delivering world-class healthcare in this country.

The AAIHR is the largest and leading business league of international healthcare staffing organizations in the United States. Our members are the silent lynchpin of America's over-stressed healthcare system, meeting long-term staffing needs in every corner of the country.

International nurses placed by our members become deeply-rooted fixtures of their new communities. Consider the story of Gigi Roy, a Filipino-born RN who emigrated to the United States in 2014 through a long-term placement opportunity with one of our members.

After demonstrating equivalent or higher education and passing US licensure and English language proficiency exams, Mrs. Roy's husband and children moved to Fairfield, California, where there is an estimated shortage of 40,000 nurses. [1] Together, they built a new American life. After visiting the site of the 9/11 terrorist attack in New York, Mrs. Roy's daughter was moved to serve her adopted country by enlisting in the United States Air Force. Tragically, Airman Patricia Roy died while on active duty and was posthumously awarded the Air Force Achievement Medal in recognition of her outstanding service. To honor Airman Roy's unfulfilled wish of becoming a nurse like her mother, her father, Gigi's husband, enrolled in nursing school and now holds a leadership role in the healthcare field. [2]

Mrs. Roy's story is one of hundreds of thousands of immigrant nurses who stepped into the breach of America's persistent and acute staffing shortage. Many nurses chafe at the term hero because, they say,

they're simply doing their job and following their passion. But that's precisely what these immigrant nurses are: heroes, but for whom our delicate healthcare system would collapse.

Healthcare staffing by the numbers

Demand for healthcare has never been higher, thanks to a growing and aging population. At the same time, staffing has never been so strained.

By 2025, global management consultancy McKinsey & Company estimates the US nursing staffing gap will balloon upwards of 20 percent, making for a shortage of as many as 450,000 necessary nurses.[3] To bridge this yawning gap, the US would need to more than double the number of nurse graduates for at least three years without losing any to attrition once in the workforce.

Unfortunately, that's not possible. In 2020, 80,000 qualified nursing school applications were rejected, according to a study by the American Association of Colleges of Nursing. [4] Nursing schools were forced to reject these otherwise qualified candidates because of a chronic shortage of nurse educators, limited clinical placement opportunities, and insufficient classroom space. [5] The United States has neither the professors nor desks to train the next generation of nurses.

By necessity, US health systems have looked overseas to cobble together a nurse workforce.

In 2007, labor economists estimated that foreign-educated nurses represented seven percent of the US registered nurse (RN) workforce. [6] One in six RNs treating patients today is an immigrant, accounting for roughly 16 percent of the total workforce as health systems struggle to respond to rising demand for care and Baby Boomer retirements. [7]

In a national survey of RNs conducted by the AAIHR last year, 78 percent of nurses said staffing in their unit had reached "unsafe levels." [8] Thirty-nine percent of all survey respondents reported a patient workload increase of three or more.

The US meeting or missing its annual goal of training or internationally recruiting hundreds of thousands of new nurses could mean the difference between life and death for ordinary patients. Model nurse staffing mix is one of the strongest predictors of positive patient outcomes, whereas understaffed units carry increased patient safety events, morbidity, and mortality. One study by the National Institute of Nursing Research (NINR) found that increasing a nurse's workload by just one patient increases the risk of patient mortality by seven percent. [9]

Hurdles to nurse immigration

Despite the urgency to staff patient bedsides, immigration laws don't make it easy for qualified international nurses to emigrate or for desperate-to-staff hospitals to hire them. These rules require foreign-educated nurses living abroad to secure an offer of employment before initiating the permanent resident application process, which often takes a year or more and must be completed before entering the country.

This lengthy process is unlike those for other high-skilled employment fields, like tech workers, who are already living and working in the US on work visas while awaiting green card consideration.

Beyond statutory obstacles, there are other systemic challenges, such as consular staffing. Before a nurse's green card is approved, US embassy and consulate staff conduct in-country exit interviews. But as the coronavirus limited intake capacity to a trickle, a bottleneck of more than 5,000 paperwork-ready immigrant nurses blossomed in the Philippines, the Caribbean, and Africa. [10] The backlog cleared, but not before months of US hospitals closing beds and units from an acute lack of nurses. [11,12]

Results in a more educated and stable nursing workforce

Higher nurse education is associated with lower mortality and failure to rescue rates. [13]

Immigrant nurses are statistically better educated than their US-born peers. Owing to immigration regulations, virtually all foreign-educated nurses arrive in the US with a bachelor's degree. [14] Meanwhile, just 57% of their native-born peers have earned a bachelor's degree. [15]

One 2020 paper published in the Journal of Nursing Economics found that not only did the presence of international nurses not lead to a decrease in collaboration among nurses and with physicians, but they positively affected overall retention rates because they are more likely to remain in the same unit longer than native-born peers. [16] Taken together, this combination of higher-than-average education and a propensity to remain at the bedside, immigrant nurses have a demonstrable, positive impact on patient care.

Bipartisan legislative solutions to accelerate nurse immigration

Today, there are thousands of qualified international nurses who have passed background checks, US licensure, and English language exams but cannot complete their visa applications because of green card apportionment rules.

In March 2021, US Senators Dick Durbin, John Cornyn, Patrick Leahy, Todd Young, Chris Coons, and Susan Collins introduced the *Healthcare Workforce Resilience Act* to help meet the unprecedented staffing challenges facing the US healthcare system.

The HWRA proposes recapturing and reallocating 25,000 previously issued but unused immigrant visas for nurses and another 15,000 for doctors. All clinicians would be required to pass licensure and English language exams, have a spotless overseas record, and have graduated from an equivalent international medical program. The proposal is supported by dozens of organizations, including the American Hospital Association, the National Rural Health Association, and the American Medical Association. [17]

Ethical recruiting principles

AAIHR
American Association of International Healthcare Recruitment

We recognize the rights of foreign-educated nurses to lawfully emigrate to countries of their choosing. Affirming an international nurse's agency in immigration provides enormous benefits to the clinician, their family, their country of origin, and their new home.

The ethical recruitment of these nurses is central to our mission. As a condition of membership in the AAIHR, member organizations must adhere to a strict and detailed code of ethics. Violations of this policy are reviewed and mediated by an independent oversight panel. We believe this comprehensive approach ensures that international nurses are treated with the dignity they deserve.

Our policies ask that international recruiters think of the sustainability of healthcare services within source countries; that members comply with all applicable immigration, wage, and labor laws; that members be transparent in the contracting process; that they honor all commitments made to clinicians and their families; and that they adhere to credentialing standards.

While the AAIHR is the largest and leading business league of international healthcare recruiting agencies, we do not represent all actors in this space. We strive to lead by example.

Conclusion

American healthcare would have collapsed through the pandemic without the enormous contributions of immigrant nurses, who make up one in six practicing RNs today.

The worst of the coronavirus is behind us, but the nurse staffing crisis is worse than ever. Honor the tireless dedication of America's millions of foreign-educated nurses by getting them the reinforcements they need.

The AAIHR commends the Subcommittee on Immigration, Citizenship, and Border Safety for examining the role immigrant nurses play in US healthcare. On behalf of the hospitals we serve, we urge your support for common-sense solutions to the staffing crisis.

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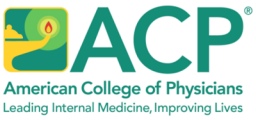

Statement for the Record
American College of Physicians
Senate Committee on the Judiciary, Subcommittee on Immigration, Citizenship and Border Security
Hearing on "Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce"
September 14, 2022

On behalf of the American College of Physicians (ACP), we appreciate this opportunity to submit a statement about the forthcoming hearing that will examine the important role of immigrants in the U.S. health care system. We would like to provide the physician perspective on this critical workforce issue and offer recommendations on ways to reduce the shortage of physicians in this country and expand access to care for our patients in underserved areas. We applaud the leadership of both Chair Padilla and Ranking Member Cornyn in convening this hearing.

The American College of Physicians (ACP) is the largest medical specialty organization and the second largest physician membership society in the United States. ACP members include 160,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge, clinical expertise, and compassion to the preventive, diagnostic, and therapeutic care of adults across the spectrum from health to complex illness. Internal medicine specialists treat many of the patients at greatest risk from COVID-19, including the elderly and patients with pre-existing conditions such as diabetes, heart disease and asthma.

The Physician Workforce Shortage

The COVID-19 global pandemic continues to take a heavy toll on virtually all aspects of the U.S. economy and health care system, including physicians. Internal medicine specialists have been and continue to be on the frontlines of patient care during the pandemic. Many physicians were asked to come out of retirement to provide care, and there continues to be an increasing reliance on medical graduates, both U.S. and international, to serve on the frontlines in the fight against COVID-19.

According to the Association of American Medical Colleges (AAMC), before the Coronavirus crisis, estimates were that there would be a shortage of 17,800 to 48,000 primary care physicians by 2034. A report by the National Academy of Sciences, Engineering and Medicine calls on policymakers to increase our investment in primary care as evidence shows that it is critical for achieving health care's quadruple aim (enhancing patient experience, improving

population, reducing costs, and improving the health care team experience). Now, with the closure of many physician practices and near-retirement physicians not returning to the workforce due to COVID-19, it is even more imperative to assist those clinicians serving on the frontlines by adopting measures to expand the role of International Medical Graduates (IMGs) in the physician workforce.

IMGs play an integral role in the delivery of care to patients across this nation, both under the J-1 training and H-1B work visa programs. IMGs including H-1B physicians, are more likely to practice in underserved areas and become primary care physicians, making them critical to addressing worsening physician shortages[1][2]. Additionally, a study by Penn Medicine researchers indicated that patients who shared the same racial or ethnic background as their physician were more likely to be satisfied with their care and give the maximum patient rating score. ACP believes that a diverse, equitable, and inclusive physician workforce is crucial to promote equity and understanding among clinicians and patients and to facilitate quality care, and it supports actions to achieve such diversity, equity, and inclusion, as noted in its 2021 position paper on *Disparities and Discrimination in Health and Health Care*.

Expanding the Physician Workforce

Congress plays an important role in supporting programs that facilitate access to care by expanding the physician workforce. The College stands ready to work with lawmakers to advance legislation toward that end, and we urge Congress to expedite passage of these bills:

- **The Conrad State 30 and Physician Access Reauthorization Act (H.R. 3541, S. 1810)** The federal Conrad 30 waiver program allows J-1 IMGs trained in the United States to remain in the country after completing their residency if they practice in an underserved area for three years. ACP supports this bipartisan legislation that would extend the authorization for the program for three years and would simplify the process for obtaining a visa, enhance important workplace protections for physicians, and increase the number of waivers available to states beyond the current allotment of thirty waivers, if certain requirements are met. We also appreciate that the bill would allow spouses of doctors in this program to work in the United States. We support the reauthorization of this program without delay, and also believe that it should be made permanent to give physicians with J-1 visas certainty that they may continue to practice in underserved areas. We urge Congress to consider the permanent reauthorization of the Conrad 30 J-1 visa waiver program in the context of broader immigration reform consistent with our position paper on *National Immigration Policy and Access to Health Care*.

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- **The Healthcare Workforce Resilience Act (H.R. 2255, S. 1024)**
  ACP supports this bipartisan legislation that would recapture 40,000 unused visas and use them to provide additional green cards to 15,000 physicians and 25,000 professional nurses. The visas, which would not count towards the annual limit and would be recaptured from a pool of over 200,000 employment-based visas left unused between 1992 and 2020 would provide a pathway to employed-based green cards and quickly address one of the health care system's most pressing needs. By recapturing a limited number of unused visas from prior years and allocating them, this legislation offers the advantage of not only addressing the physician shortage that existed before the pandemic but recognizing that the shortages are growing more severe as the need for clinicians becomes greater with each passing day. It is an extremely timely response to the continued risk imposed by the COVID-19 pandemic. We remain concerned that many internal medicine physicians who are working in this country with approved temporary immigration status are facing delays in obtaining their employment green cards, due to a backlog in the green-card approval process. Physicians with temporary immigration status may face limitations in the number of hours they can work and treat patients at a time when their help is needed to care for patients with COVID-19.

- **The Dream and Promise Act of 2021 (H.R. 6)**
  ACP supports this legislation that would provide a pathway to U.S. citizenship for undocumented individuals, who were brought to the United States when they were children. Without the full protections afforded to them by the Dream and Promise Act, these students and physicians could potentially be forced to discontinue their studies or their medical practice and may be deported. We are especially troubled by the plight of these individuals because they are needed in the medical field to treat an increasingly racially and ethnically diverse patient population and have the background to fulfill the cultural, informational, and linguistic needs of patients.

  ACP has long-standing policy supporting the federal Deferred Action for Childhood Arrivals (DACA) program that grants protections from deportation for undocumented individuals who were brought to the United States when they were children if they meet certain residency requirements. Without the protections granted by DACA, we remain greatly concerned about the possible future deportation of undocumented medical students, residents, fellows, practicing physicians, and others who came to the United States through no fault of their own.

Executive Action on Public Charge

ACP is also pleased that the U.S. Department of Homeland Security (DHS) published a final rule on September 8, 2022 that restores a responsible public charge policy ensuring that immigrants who qualify for safety net programs can seek health care, food and nutrition assistance, housing or other help without putting their immigration applications at risk. The final rule will be effective on December 23, 2022. Pending a more thorough review of the final rule, ACP

supports this action by DHS as a positive step forward in supporting the health and well-being of the immigrant population.

Conclusion

ACP appreciates this opportunity to comment on these important issues that will help expand the physician workforce and improve access to care. If we can serve as a resource on policies that impact health care delivery or primary care, please feel free to contact Jonni McCrann at jmccrann@acponline.org.

STATEMENT FOR THE RECORD

Subcommittee on Immigration, Citizenship, and Border Safety
"Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce"
September 14, 2022

Chairman Padilla, Ranking Member Cornyn, and distinguished Members of the Subcommittee on Immigration, Citizenship, and Border Safety, thank you for the opportunity to share the perspectives of the American Health Care Association and the National Center for Assisted Living (AHCA/NCAL) regarding immigrants and our health care workforce. AHCA/NCAL represents more than 14,000 skilled nursing facilities (SNF), assisted living (AL) and intellectual and developmental disabilities (ID/DD) communities across the country that provide care to approximately five million people each year.

We appreciate you holding a hearing around this important matter. It is no secret that long-term care (LTC) provider communities, which include SNFs, ALs and ID/DD centers, have been inordinately impacted by the pandemic. While clinical advancements continue to save and improve lives, the workforce challenges these communities face are persistent.

Exacerbated by the pandemic, LTC facilities are facing a historic labor crisis, losing more than 406,000 caregivers since the beginning of the pandemic, and workforce levels are at a 15-year low.[1] SNF and AL communities are facing some of the worst job losses among all health care professions, and the shortage is impacting access to care for our nation's seniors and individuals with disabilities. Hundreds of LTC centers shuttered across the country, often due to staffing shortages. These closures are devastating to residents, their families, staff and the entire health care system.

AHCA/NCAL has long been supportive of immigrants who make up a vital portion of our nation's LTC workforce. In fact, approximately 1 in 4 direct care workers were born outside the U.S.[2] Projections show the country will require an additional 3.5 million long-term care health workers by 2030.[3] For these reasons, AHCA/NCAL strongly supports the bipartisan Healthcare Workforce Resilience Act (S. 1024/H.R. 2255) that was specifically noted during the hearing, which would recapture unused visas from previous fiscal years for doctors, nurses, and their families. This legislation allows the entry of nurses with approved immigrant visas and allows physicians with approved immigrant petitions to adjust their status, so that they can help our nation fight COVID-19 and have a durable immigration status.

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In addition to setting aside these previously unused visas for physician and nurses, S. 1024/H.R. 2255 also would require the U.S. Department of Homeland Security and the State Department to expedite the processing of recaptured visas for highly trained nurses. Ensuring an adequate supply of nurses and physicians to help get through the COVID-19 pandemic and rebuild our health care workforce is critical, and we look forward to working with members of Congress to get this legislation signed into law.

It is also important to note that AHCA/NCAL has led and endorsed various efforts to expediate immigrant visa processing to bring health care workers to the U.S. The association has been working closely with national refugee organizations to open career doors for our new neighbors. Moreover, AHCA/NCAL supports common-sense immigration reform that expands opportunities for immigrants to work in the LTC profession.

If you have any questions around our support for the Healthcare Workforce Resilience Act or some of the many workforce efforts AHCA/NCAL is focused on, please contact AHCA's Senior Vice President of Government Relations, Clif Porter, at cporter@ahca.org or NCAL's Executive Director, LaShuan Bethea, at lbethea@ahca.org.

American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

Statement

of the

American Hospital Association

to the

Subcommittee on Immigration, Citizenship, and Border Safety

of the

Committee on the Judiciary

of the

United States Senate

"Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce"

September 14, 2022

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to submit this statement for the record as the Subcommittee on Immigration, Citizenship, and Border Safety of the Committee on the Judiciary examines the importance of improving the immigration process in order to help alleviate America's health care workforce shortage.

The COVID-19 pandemic and its aftermath are still impacting the nation's health care system, even as many Americans seek a "return to normal" with respect to managing transmission of the virus. As of this month, there have been more than 95 million cases of cases of COVID-19 in the U.S., over 5.2 million hospitalizations, and more than 1 million deaths. While fewer patients are being admitted for COVID-19 treatment now than during the pandemic's peak periods, many hospitals are still experiencing significantly constrained capacity and high patient acuity, as those patients that put off treatment during the pandemic are now seeking care.

Our hospitals and health systems — and their hard working teams — have been subject to enormous pressure as they continue serving their patients and communities throughout the pandemic. These challenges are severe: more clinicians are leaving the health care field due to burnout and retirement, thereby exacerbating already critical shortages. Hospitals are increasingly paying higher wages to keep and recruit enough staff. This is occurring at a time when many hospitals and health systems are facing significant financial constraints. While the U.S. must do more to invest in training the next generation of health care workers, we believe recruiting qualified immigrants, and expediting their entry into the country, is an effective short-term approach that deserves support from Congress.

HEALTH CARE WORKFORCE CHALLENGES

While managing workforce pressures were a challenge for hospitals even before the pandemic, these challenges have only grown more acute. The incredible physical and emotional toll that hospital workers have endured in caring for patients during the pandemic has, among other issues, exacerbated the shortage of hospital workers. Hospitals have had to rely on contract labor resources, which increase workforce costs even more. Hospitals also have incurred significant costs in recruiting and retaining staff, which have included overtime pay, bonus pay and other incentives.

The workforce shortage is at a critical juncture. According to the most recent data, 778 hospitals in the U.S. (18.5% of reporting hospitals) report anticipating critical staffing shortages within the week of September 8. Nurses, who are critical members of the patient care team, are one of the many health care professions that are currently in shortage. The U.S. Bureau of Labor statistics is projecting 203,200 openings for registered nurses for each of the next 10 years due to the need to replace workers who move to other occupations or retire. Currently there are not enough nurses graduating from U.S. schools to meet this demand. According to the American Association of Colleges of Nursing, American nursing schools turned away over 80,000 qualified applicants from baccalaureate and graduate programs in nursing in 2019 alone due to an insufficient number of qualified faculty, clinical sites, classroom space, clinical preceptors and budget constraints. The low salaries for nursing faculty also are not commensurate with their level of educational preparation (i.e., master's degree level, or above), thereby making recruitment a challenge.

The shortage also extends to physicians practicing in the U.S. Data from the Association of American Medical Colleges projects a shortage of 124,000 physicians by 2034, including primary care physicians as well as specialists, such as pathologists, neurologists, radiologists and psychiatrists. While the aging of the U.S. population and the physician workforce drives some of the projected shortage, much of it stems from the caps on Medicare-funded residency slots imposed by Congress 25 years ago as a cost-saving measure. While the number of medical school graduates has increased significantly over the past two decades, Medicare-funded training opportunities for these graduates have remained frozen at 1996 levels. Furthermore, the caps have created imbalances that favor allocation of slots toward lower-cost and higher-reimbursement specialties, rather than more urgently needed primary care and behavioral health. While

some hospitals are self-funding a portion of their residency slots, this model is not sustainable in the long-term.

SKILLED IMMIGRANT WORKFORCE

One of the short-term strategies used to ease pressure on the workforce shortage in the U.S. is the use of immigrant health care workers, which primarily include nurses and physicians. Recent studies show that 18.2% of U.S. health care workers were born outside of the U.S. For example, 29% of U.S. physicians are born in other countries, and almost 7% are not U.S. citizens. Similarly, foreign-born nurses account for 15% of registered nurses in the U.S., according to a report by the Institute for Immigration Research at George Mason University.

Foreign-trained nurses and doctors do not displace American workers. Instead they play critical roles in ensuring the health of the communities our hospitals serve. They are highly qualified and required to meet our nation's standards for education, English fluency and state licensure.

Foreign educated nurses (FENs) seeking to work in the U.S. gain entry via two pathways. They can apply for an H-1B Temporary Work Visa, but this option is limited to nurses who hold a four year degree or higher and can fulfill specialized roles, such as in critical care, emergency departments or cardiology. Most FENs instead opt to apply for legal permanent resident (LPR) status, or a green card, to be granted employment based (EB) immigration for themselves and their family members. Each year, the United States grants green card status to up to 140,000 EB immigrants and their family members (though this limit can be increased by the addition of unused visa numbers from the prior fiscal year). There are additional caps on each category for EB workers, and nurses are usually placed in the EB-3 category for "Skilled workers, professionals, and other workers," which totals 28.6% of worldwide limit or up to 40,040 immigrants. In practice, these restrictions result in around 10,000-12,000 nurses per year being admitted to the U.S., as most green cards go to professionals who are already residing in the states.

For physicians to practice in the U.S., they must complete one to three years of graduate medical education (GME), even if they have foreign training and already completed medical residency in their home country. Some states eased licensing restrictions during the COVID-19 pandemic and may consider continuing this flexibility after the public health emergency (PHE) to help address the staffing shortages. In order to pursue U.S.-based GME, the physician must apply for a J-1 visa. Once the educational component is completed, the individual is required to leave the U.S. and fulfill a two-year home-country physical presence requirement. In order to waive this obligation, a foreign medical student can apply for a waiver through the Conrad 30 Waiver Program. The program is available in all 50 states, the District of Columbia, Puerto Rico, and Guam, and they can sponsor up to 30 international medical graduates each year for a J1 waiver. Each state has developed its own application rules and guidelines for these waivers, but all J-1 graduate students are required to, among other conditions, fulfill a three-year commitment to practice medicine in an H-1B nonimmigrant

status at a health care facility located in an area or serving a population designated by the U.S. Department of Health and Human Services as a Health Professional Shortage Area, Medically Underserved Area, or Medically Underserved Population.

Despite the challenges in hiring immigrant health care workers in hospitals and health systems, our members are increasing their efforts to utilize this resource to help alleviate some of the staffing shortages, especially in rural and underrepresented areas. A study published in JAMA last year looked at the characteristics of non–U.S.-born health care professionals (HCPs) and found that "Overall, non–U.S.-born HCPs worked more hours, were more likely to work at night and in skilled nursing and/or home health settings, and were more likely to reside in medically underserved areas than U.S.-born HCPs … These findings suggest that non–U.S.-born HCPs are making significant contributions to health care in the U.S." The study also noted that immigrants contribute to the racial and ethnic diversity of the U.S. health care workforce.

AHA Advocacy

In spring of 2021, the U.S. State Department announced a new visa prioritization system that relegated nurses and health professionals to the last tier. In June of last year, in the midst of the COVID-19 pandemic, the AHA urged the State Department to give foreign-trained nurses seeking immigrant visas priority for processing to address the backlog of immigrant visas for eligible FENs. This effort resulted in a new directive to U.S. embassies and consulates in September 2021 to prioritize "as emergencies on a case-by-case basis the immigrant visa cases of certain health care professionals who will work at a facility engaged in pandemic response." Thus health care staff who planned to work at a facility engaged in COVID-19 response and had an approved U.S. immigrant visa petition, with a current priority date for an Immediate Relative, Family Preference, or Employment-Based Preference case, could request an emergency visa appointment. By November 2021, the State Department rescinded the tier-based prioritization system and gave embassies and consulates "broad discretion" to determine how to organize visa appointments. The November directive, as well as proactive efforts by consulates in countries such as the Philippines from which a majority number of nurses enter the U.S., have helped alleviate some of the backlogs in processing nurse visas. But the challenges remain.

Policy Recommendations

The slow processing of immigrant visas for foreign-trained nurses exacerbates the nation's workforce shortages. The AHA believes the State Department and its National Visa Center, along with the U.S. Department of Homeland Security's U.S. Customs and Immigration Service (USCIS), can and should alleviate this situation by ensuring efforts are made to prioritize and expedite the visa issuance process for eligible nurses. We ask Congress to work with the State Department and USCIS to achieve this goal. We also would ask Congress to consider the following legislative initiatives to improve the immigration process for health care workers:

- Pass the bipartisan Healthcare Workforce Resilience Act (S.1024/H.R. 2255), which would make up to 40,000 unused visas available to nurses and physicians who petition for such a visa up to 90 days after the end of the COVID-19 PHE. We would encourage the modification of this legislation to allow the visas to be available beyond the PHE.
- Reauthorize and make improvements to the Conrad 30 program. We support The Conrad State 30 and Physician Access Reauthorization Act (S. 1810/H.R. 3541) that reauthorizes the program for three years, increases state allocations to 35 physicians per year and provides flexibility to expand the number of waivers in states where demand exceeds that limit.
- Support the visa recapture provisions included in the fiscal year (FY) 2023 DHS Appropriations Act (H.R. 8257/S. 4678) that allow unused employment- and family-based visas from FYs 1992-2022 to remain available in FY 2023.

In addition to the suggestions outlined above, we encourage Congress to help address domestic health care workforce shortages by:

- lifting the cap on Medicare residency positions, as well as addressing the shortages of substance use disorder treatment providers by adding 1,000 Medicare-funded training positions in approved residency programs in addiction medicine, addiction psychiatry or pain medicine;
- providing resources to increase nursing student and faculty populations, as well as support educational programming at schools of nursing;
- providing continued and increased funding for the Health Resources and Services Administration's title VII and VIII programs, including the health professions program, the National Health Service Corps and the nursing workforce development program, which includes loan programs for nursing faculty; and
- expanding the loan program to allied professionals and targeting support for community college education to programs that help address health care work force shortages.

Finally, we appreciate Congress enacting earlier this year the AHA-supported Dr. Lorna Breen Health Care Provider Protection Act, which aims to prevent suicide, burnout and behavioral health disorders among health care professionals. We encourage Congress to provide robust funding for these programs during the appropriations process for FY 2023.

Thank you for this opportunity to submit comments to the Subcommittee. Our hospital and health systems look forward to working with you to improve and sustain the health care workforce so that we can continue to serve all of our patients and communities.

STATEMENT

of the

American Medical Association

to the

U.S. Senate

Subcommittee on Immigration, Citizenship, and Border Safety

Re: Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce

September 14, 2022

Division of Legislative Counsel
(202) 789-7426

STATEMENT

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The American Medical Association (AMA) appreciates the opportunity to submit the following Statement for the Record to the U.S. Senate Subcommittee on Immigration, Citizenship, and Border Safety as part of the hearing entitled, "Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce." The AMA commends the Subcommittee for focusing on the critically important issue of physician immigration and workforce shortages. Prior to the COVID-19 pandemic, the U.S. was already facing a rising shortage of physicians largely due to the growth and aging of the general population and the impending retirement of many physicians.[1] This shortage was dramatically highlighted by the lack of physicians in certain key areas, especially rural and underserved communities, during the COVID-19 pandemic, which forced states to recall retired physicians, expand scope of practice, and temporarily amend out of state licensing laws.[2] However, none of these adjustments will fill the physician shortage gap long term. As such, additional physicians, in the form of international medical graduates (IMGs), are greatly needed. IMG's often serve in rural and medically underserved communities, providing care to many of our country's most at-risk citizens. As the largest professional association for physicians and the umbrella organization for state and national specialty medical societies, the AMA is committed to ensuring that there is proper access to physicians for all patients and that physicians are well supported in their role as leader of the health care team. If immigration barriers for physicians are reduced, it will help to increase the number of physicians in the U.S. which will lead to healthier communities and ultimately a healthier country as access to much-needed medical care increases.

The cap on Medicare support for graduate medical education must be raised.

As U.S. medical schools have increased enrollment, residency training positions at teaching hospitals have not kept up with the larger pool of applicants, limited by the cap on Medicare support for graduate medical education (GME). As discussed below, workforce experts predict that the U.S. will face a significant physician shortage for both primary care and specialty physicians over the next 13 years if training positions are not expanded. Yet, while new medical schools are opening, and

[1] https://www.aamc.org/news-insights/press-releases/new-findings-confirm-predictions-physician-shortage.
[2] https://www.nashp.org/states-address-provider-shortages-to-meet-the-health-care-demands-of-the-pandemic/.

existing medical schools are increasing their enrollment to meet the need for more physicians, federal support for residency positions remains subject to an outdated cap from 1996 that falls dramatically short of the needs of the U.S. population.

When Congress enacted the Balanced Budget Act of 1997 it placed a limit (or cap) on the funding that Medicare would provide for GME.[3] This meant that most hospitals would receive direct medical education (DGME) funding and indirect medical education (IME) support only for the number of allopathic and osteopathic full-time equivalent (FTE) residents it had in training in 1996.[4] As U.S. medical schools have increased enrollment, residency training positions at teaching hospitals have not kept up with the larger pool of applicants, limited by the cap on Medicare support for graduate medical education. According to the Association of American Medical Colleges (AAMC), there has been a 52 percent increase in medical student enrollment since 2002,[5] but only a 17 percent increase in funded GME slots.[6] Though, for the first time since 1996, 1,000 new Medicare-supported GME positions were provided in the Consolidated Appropriations Act, 2021,[7] many more Medicare-supported GME positions are needed to alleviate the physician shortage. **Therefore, it is crucial that we invest in our country's health care infrastructure by providing additional GME slots so that more physicians can be trained, and access to care can be improved.**

Additionally, "Cap-Flexibility," which would allow new and current GME teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), would being to help to remedy the physician shortage we are currently experiencing.

As the nation faces a pandemic and physician shortages, sustained long-term investments in our physician workforce are necessary to help care for our nation's most vulnerable populations.

The U.S. is currently facing significant and prolonged physician shortages.

The United States is suffering from a major physician shortage, with forecasts of a widening gap that will continue to grow over the next decade. It is projected that by 2032, there will be a 50 percent growth in the population of those ages 65 and older, compared with only a 3.5 percent growth for those ages 18 or younger.[8] Partly due to this phenomenon, by 2033 the United States will experience a shortage of between 54,100 and 139,000 physicians. This number includes a projected primary care physician shortage of between 21,400 and 55,200, as well as a shortage of non-primary care specialty physicians of between 33,700 and 86,700.[9] As such, there is a growing need for a larger physician workforce that the U.S. cannot fill on its own, in part due to the fact that the U.S. physically does not have enough people in the younger generation to care for our aging country. Furthermore, the pandemic has put an incredible strain on our health care system and this crisis has drastically exacerbated physician shortages in many rural and underserved communities across the U.S.

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[3] https://www.congress.gov/bill/105th-congress/house-bill/2015.
[4] https://www.ama-assn.org/education/improve-gme/compendium-graduate-medical-education-initiatives.
[5] https://www.aamc.org/news-insights/us-medical-school-enrollment-rises-30.
[6] https://www.ncbi.nlm.nih.gov/books/NBK248024/.
[7] https://www.congress.gov/bill/116th-congress/house-bill/133/text.
[8] https://www.aamc.org/download/472888/data/physicianworkforceissues.pdf.
[9] AAMC (2020, June) The Complexities of Supply and Demand: Projections from 2018 to 2033. Retrieved from AAMC:https://www.aamc.org/system/files/2020-06/stratcomm-aamc-physician-workforce-projections-june-2020.pdf.

Health Professional Shortage Areas (HPSAs) are used to identify areas, populations, groups, or facilities within the United States that are experiencing a shortage of health care professionals. According to the latest data released by the Health Resources & Services Administration (HRSA), 88 million people live in primary medical HPSAs in the U.S.[10] The HRSA estimates that an additional 33,887 providers are required to eliminate all current primary care, dental, and mental health HPSAs.[11] With the existing and projected physician shortage, and the increased demands that have been placed on physicians during the pandemic, additional support for programs like the Conrad 30 Waiver Program,[12] with an incentive to increase medical school enrollment and place providers in underserved communities, is desperately needed.

If we compare the states where the most H-1B physicians are providing care and the states with some of the highest COVID-19 cases, the stark need for more physicians becomes apparent. For example, as of September 2020, North Dakota had the highest per capita of COVID-19 cases and deaths of any state.[13] North Dakota also has the highest percentage of H-1B physicians in their workforce.[14]

Top States Where H-1B Physicians are Providing Care[40]	**Number of Physician LCAs[41]**	**States with Increasing COVID-19 Cases[42]**
New York	1467	2,499 new positive cases per day
Michigan	945	4,109 new positive cases per day
Illinois	826	6,362 new positive cases per day
Ohio	606	3,590 new positive cases per day
Pennsylvania	602	2,235 new positive cases per day
Texas	343	6,886 new positive cases per day
California	309	4,372 new positive cases per day
Indiana	244	3,618 new positive cases per day

Note: Abbreviation: LCA, labor condition application. Total certified physician LCAs by State. Physician LCAs certified in 2016.

Ensuring access to a robust, uninterrupted frontline health care workforce is critically important. As such, the AMA believes that the U.S. should promote an increase of IMGs and that current IMGs should not be hampered by additional unnecessary regulations in the midst of working to recover from COVID-19.

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[10] The U.S. Department of Health & Human Services, Bureau of Health Workforce Health Resources and Services Administration (HRSA), Bureau of Health Workforce, Fourth Quarter of Fiscal Year 2020, Designated HPSA Quarterly Summary. Data as of September 30, 2020. See also, https://bhw.hrsa.gov/shortage-designation/types.

[11] https://data.hrsa.gov/topics/health-workforce/shortage-areas.

[12] https://www.uscis.gov/working-in-the-united-states/students-and-exchange-visitors/conrad-30-waiver-program.

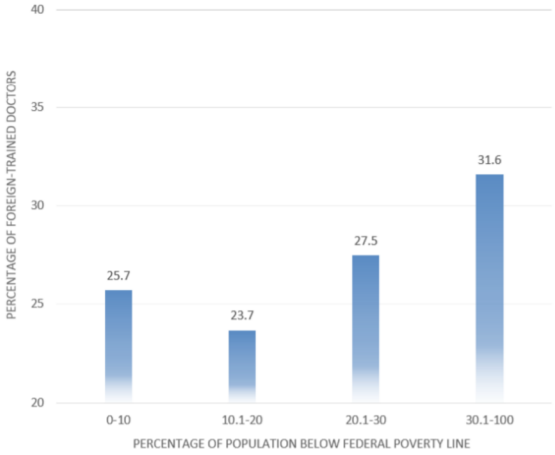
[13] The U.S. Department of Health & Human Services, Bureau of Health Workforce Health Resources and Services Administration (HRSA), Bureau of Health Workforce, Fourth Quarter of Fiscal Year 2020, Designated HPSA Quarterly Summary. Data as of September 30, 2020.

[14] JAMA Network, Peter A. Kahn, MPH, ThM, et al., Distribution of Physicians With H-1B Visas By State and Sponsoring Employer, June 6, 2017. https://jamanetwork.com/journals/jama/fullarticle/2620160?resultClick=1.

Even after the public health emergency ends, **the AMA strongly urges Congress to consider the importance of IMGs in providing medical care to U.S. citizens, especially our most at risk citizens in rural and medically underserved communities across this country who rely on J-1 and H-1B physicians to provide much needed primary and specialty health care services.**

The 2019 State Physician Workforce Data Report found that nationally, almost 25 percent of active physicians providing care in the U.S. are IMGs. Likewise, more than 20 million people live in areas of the U.S. where foreign-trained physicians account for at least half of all physicians.[15]

Foreign-trained Doctors Serving U.S. Population by Poverty Level[16]



Source: American Immigration Council analysis of data from the American Medical Association, U.S. Healthcare Resources and Services Administration, 2010 U.S. Census, and 2006-2010 American Community Survey.

The escalating physician shortage over the last 20 years, coupled with the COVID-19 pandemic, should serve as an alarm that the U.S. needs to increase its number of physicians to ensure we can care for patients in both the short- and long-term. **The AMA firmly believes that as we continue to face a mounting physician shortage in the U.S., Congress should be promoting and easing the way for IMGs in our workforce.**

J-1 and H-1B physicians are valuable assets to the U.S. medical system.

In 2017, nearly 30 percent of medical residents in the U.S. were IMGs, with about half working as physicians in the U.S. on non-immigrant visas, such as J-1s.[17] These non-U.S. citizen IMGs play a

[15] https://www.americanimmigrationcouncil.org/sites/default/files/research/foreigntrained_doctors_are_critical_to_serving_many_us_communities.pdf.
[16] https://www.americanimmigrationcouncil.org/sites/default/files/research/foreign-trained_doctors_are_critical_to_serving_many_us_communities.pdf.
[17] https://www.americanprogress.org/article/immigrant-doctors-can-help-lower-physician-shortages-rural-america/.

vital role in caring for some of the most vulnerable populations in the U.S. For example, foreign-trained physicians are more likely than U.S.-trained physicians to practice in lower income and disadvantaged communities.[18] As such, it is important to support and create pathways for these physicians to be able to continue to remain in the U.S. and care for their patients. **Therefore, foreign trained physicians and medical residents should be prioritized during the visa process to enable the U.S. to, in the short-term, more effectively fight COVID-19 and, in the long-term, ensure the physician shortages in our rural and underserved communities are remedied.**

J-1 physicians

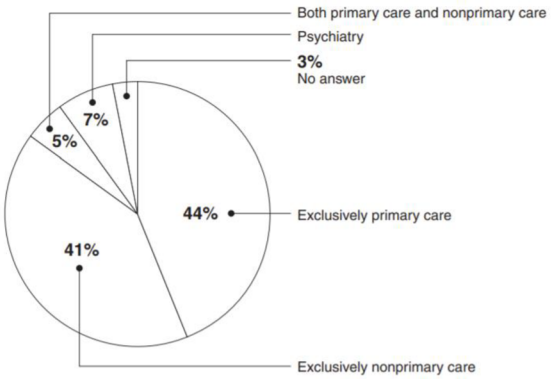
A prospective exchange visitor must be sponsored by a U.S. Department of State (DOS) designated program sponsor to be admitted to the United States in the "J" nonimmigrant category or to participate in an exchange visitor program. The DOS-designated sponsor, which for all J-1 physicians is the Educational Commission for Foreign Medical Graduates (ECFMG), will issue the prospective J-1 physician a Form DS-2019, Certificate of Eligibility for Exchange Visitor (J-1) Status. The DS-2019 permits a prospective exchange visitor to apply for a J-1 nonimmigrant visa at a U.S. embassy or consulate abroad, or seek admission as a J-1 nonimmigrant at a port of entry.

Due to this process, J-1 physicians are already a carefully monitored cohort. Since ECFMG sponsors all J-1 physicians, it coordinates closely with U.S. teaching hospitals and with the U.S. DOS throughout each academic year to ensure that J-1 physicians comply with all federal requirements. Additionally, under the current process, J-1 physicians are required to apply to ECFMG to extend their visa sponsorship on an annual basis.

Currently, there are more than 12,000 physicians from 130 countries engaged in residency or fellowship training in J-1 status at approximately 750 teaching hospitals in 51 U.S. states and provinces. J-1 physicians not only serve as vital members of health care teams at the institutions where they train, but also lend a diversity of thought and experience that is invaluable to U.S. health care. As such, over the past 10 years, more than 10,000 J-1 IMGs have worked in underserved communities.[19] Moreover, according to a 2005 Government Accountability Office report, 44 percent of J-1 physicians provided primary care services in underserved communities across this country.

[18] https://www.americanimmigrationcouncil.org/sites/default/files/research/foreign-trained_doctors_are_critical_to_serving_many_us_communities.pdf.
[19] https://www.kunr.org/post/visa-program-enables-foreign-doctors-work-underserved-communities#stream/0.

Specialties Practiced by Physicians for Whom States Requested J-1 Visa Waivers, Fiscal Year 2005[20]



Source: GAO survey of states, 2005.

Note: Percentages are based on 956 waivers requested by 52 states in fiscal year 2005. Puerto Rico and the U.S. Virgin Islands did not request waivers that year. Psychiatry is reported as a separate medical specialty because some states' J-1 visa waiver programs have requirements for psychiatrists that differ from those for other physicians.

The Institute of International Education estimates that during the 2018 academic year, international students alone had a positive economic impact of $44.7 billion from tuition and fees, food, clothing, travel, textbooks, and other spending. If these students and exchange visitors choose another country over the United States due to overly burdensome immigration laws, then the reduced demand could result in a decrease in enrollment of U.S. medical schools, therefore, negatively impacting school programs in terms of forgone tuition and other fees, jobs in communities surrounding schools, and the U.S. economy.

The number of J-1 physicians participating in U.S. training programs has grown 62 percent over the past decade, illustrating that these physicians have become an essential part of the U.S. health care system, education system, and economy. These residents come from over 130 different countries, attend 1,200 different medical schools, and are selected through a competitive process to join U.S. residency and fellowship programs through the National Resident Matching Program. As such, J-1 physicians bring valuable cultural and intellectual diversity to their U.S. training programs.

However, residency training requires a minimum of three years of training and as many as seven years for surgical specialties. As such, physicians experience numerous immigration hurdles that they must overcome just during their medical education and residency. If programs cannot count on J-1 physicians for uninterrupted training and patient care, they may choose to invest in other, less qualified candidates. This will likely mean that fewer J-1 physicians will apply to U.S. medical schools and residencies knowing that they are unlikely to be matched due to administrative burdens. As such, medical school and residency programs could become less competitive which will likely diminish the overall quality of the U.S. physician workforce. However, if smoother pathways are created for IMGs, including paths to provide service in exchange for waiving the home country return requirement, the positive impacts on U.S. health care will be great, particularly in rural and

[20] https://www.govinfo.gov/content/pkg/GAOREPORTS-GAO-06-773T/pdf/GAOREPORTS-GAO-06-773T.pdf.

urban medically underserved areas of the country where J-1 physicians represent a much higher percentage of the trainee and practicing physician workforce.

H-1B physicians

The H-1B visa program was established by Congress to provide an avenue for employers to hire a skilled foreign worker in a specialty occupation. In general, if there are no available U.S. workers to fill a position, then a firm's labor need goes unmet without substantial investment in worker recruitment and training. Accordingly, importing needed workers allows companies to innovate and grow, creating more work opportunities and higher-paying jobs for U.S. workers. As such, the H-1B nonimmigrant visa program allows U.S. employers to temporarily employ foreign workers in specialty occupations. A "specialty occupation" is defined by statute as an occupation that requires the theoretical and practical application of a body of "highly specialized knowledge," and a bachelor's or higher degree in the specific specialty, or its equivalent, as a minimum for entry into the occupation in the U.S.[21]

Since all physicians are required to complete education and training that far exceed an undergraduate degree, there can be no doubt that physicians meet the education requirement. Moreover, since physicians undergo anywhere between three and seven years of residency to expand their knowledge of a specific area of medicine the "highly specialized knowledge" requirement described by statue has also been met. As such, H-1B physicians clearly deserve the "specialty occupation" designation and are critical to filling a gap in our workforce that the U.S. cannot fill on its own.

H-1B physicians fulfill a vital and irreplaceable role. In some specialties, such as geriatric medicine and nephrology, IMGs make up approximately 50 percent of active physicians.[22] In other areas IMGs make up about 30 percent of active physicians including in more specialized areas of medicine such as infectious disease, internal medicine, and endocrinology.[23] Thus, H-1B physicians already are required to, and do, meet a very high threshold, and fulfill a need that the U.S. cannot fill on its own.

Immigration barriers

J-1 physicians were surveyed by ECFMG in late 2019 and asked to describe challenges to their well-being. Responses were received from 7,817 physicians and showed that fluctuating immigration laws contribute to a unique set of stressors for this cohort. Further, 63 percent of male respondents reported that visa and immigration concerns were among the top issues impacting their wellness.[24] This is not surprising given the massive fluctuation in immigration laws over the past few years and the significant increase in wait time associated with many immigration forms. For example, overall U.S. Citizenship and Immigration Services (USCIS) average processing times have increased by 46 percent over the past two fiscal years and 91 percent since fiscal year 2014.[25] As such, a number of administrative changes could help to increase the number of physicians in the U.S. and decrease the stress that IMGs face when applying for visas and green cards. For example, physician J-1 visas

[21] *See* 8 U.S.C 1101(a)(15)(H)(i)(b), 1184(i).
[22] https://www.aamc.org/data-reports/workforce/interactive-data/active-physicians-who-are-international-medical-graduates-imgs-specialty-2017.
[23] *Id.*
[24] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2020-10-26-Duration-of-Status-Comment-Letter-FINAL.pdf.
[25] AILA Policy Brief: USCIS Processing Delays Have Reached Crisis Levels Under the Trump Administration, January 30, 2019, https://www.aila.org/infonet/aila-policy-brief-uscis-processing-delays.

could be granted premium processing rights or some other form of expediated processing. With the delays that were caused by COVID-19 and the difficulties that some consulates are facing, a number of J-1 physicians over the past two years have come close to, or completely missed, their residency start date, putting their training spot in jeopardy. Additionally, Congress could work with DHS to institute a process by which physicians already in the U.S. in valid visa status would receive expedited processing when seeking a change of status through USCIS to either begin a U.S. residency or assume a position in an underserved area of the U.S. Furthermore, at the end of training, supplementary avenues could be presented to residents that would make it easier to avoid the two-year home country return requirement. That way, U.S. trained physicians can stay and practice in the U.S. where they are greatly needed and where considerable time and resources have been put into their training.

Moreover, currently, IMGs with an H-1B status are restricted in terms of the facilities in which they are permitted to work. Also, any work outside the strict limits of the H-1B petition is a violation of the physician's H-1B status. In situations where an employer needs an IMG who possesses H-1B status to work at additional locations, the employer is required to file an amended petition, which is a time-consuming and costly process for the employer. In the current public health emergency, when many IMG physicians are severely restricted in their work locations and in the type of care they can provide (under the terms of their H-1B petitions), some nonimmigrant status physicians have seen their normal worksites closed or have been furloughed. As a result, some IMGs have been unable to work at a time when their services are greatly needed throughout the U.S. Allowing IMG physicians to serve at multiple locations and facilities will provide greater access to health care for millions of Americans. As such, **it would be greatly beneficial to permit IMG physicians currently practicing in the U.S. with an active license and an approved immigrant petition, to apply and quickly receive authorization, to work at multiple locations and facilities with a broader range of medical services for the duration of the COVID-19 pandemic and for other public health emergencies that may arise.**

Finally, it would be immensely helpful if physicians who served five years in an underserved community would either be granted an EB-1 status or green cards that are specifically designated for physicians. This would help to decrease the physician green card backlog, incentivize IMGs to remain in the U.S. and serve in underserved communities, and would help to ensure stability in the workforce for those IMG physicians who are already working in the U.S. The AMA has other immigration ideas that could help to streamline the immigration process for physicians and would be happy to work further with the Subcommittee in this area.

Legislation that could help to alleviate the current and impeding physician shortage.

The AMA has been a strong supporter[26] of the Conrad 30 program, and H.R. 3541/S. 1810, the "Conrad State 30 and Physician Access Reauthorization Act," for more than a decade.[27] Currently, resident physicians from other countries working in the U.S. on J-1 visas are required to return to their home country after their residency has ended for two years before they can apply for another visa or a green card. Established in 1994 by former Senator Kent Conrad (D-ND) and reauthorized numerous times by Congress since its inception, the Conrad 30 program allows these physicians to remain in the U.S. without having to return to their home country if they agree to practice in an

[26] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-5-27-Letter-to-House-re-Support-for-Conrad-State-30-and-Physician-Access-Reauth-Act.pdf.

[27] The AMA has been a strong supporter of the Conrad 30 program in previous congressional sessions (2019, 2017, 2015, 2013, 2012).

underserved area for three years. The "30" refers to the number of physicians per state that can participate in the program. As such, Conrad 30 is a valuable program that ensures that physicians, who are often educated and trained in the U.S., can continue to provide care for their U.S. patients.

Despite the success of the Conrad 30 Waiver program, additional improvements are needed to make the policy function even better. As a result, Congress should expeditiously pass H.R. 3541/S. 1810, "the Conrad State 30 and Physician Access Reauthorization Act." If enacted, this legislation would enhance the underlying stability of the program by reauthorizing the Conrad 30 waiver policy for an additional three years. The bill also makes targeted improvements by requiring greater transparency in employment contract terms, outlining a process for providing up to 45 waivers per state, and protecting spouses and children of physicians who participate in the program. Most importantly, the legislation provides physicians who practice in underserved areas or at Department of Veteran's Affairs facilities for five years priority access within the green card system, thereby helping to address the current physician green card backlog.

IMGs are an important part of our U.S. health care teams and serve on medical front lines across the country. Consequently, the ability to recapture 15,000 unused employment-based physician immigrant visas from prior fiscal years would further enable our U.S. physicians to have the support they need and our U.S. patients to access the care they deserve during this unprecedented public health crisis.[28] As such, the AMA supports[29] H.R. 2255/S. 1024, the "Healthcare Workforce Resilience Act." This legislation would recapture 15,000 unused employment-based physician immigrant visas and 25,000 unused employment-based professional nurse immigrant visas from prior fiscal years as a way to bolster our U.S. physician workforce and ensure U.S. patients retain access to the care they deserve during this unprecedented public health crisis.

To further protect patient access to care, the AMA urges Congress to invest in additional Medicare-funded GME positions. Physicians are a vital part of our health care infrastructure, and it is critical that we train more in order to meet the needs of our diverse and growing nation, ensure patient access to care, and prepare for the next public health crisis. As such, the AMA supports[30] H.R. 2256/S. 834, the "Resident Physician Shortage Reduction Act." This bill would gradually raise the number of Medicare-supported GME positions by 2,000 per year for seven years, for a total of 14,000 new slots. A share of these positions would be given to hospitals with diverse needs including hospitals in rural areas, hospitals serving patients from health professional shortage areas, hospitals in states with new medical schools or branch campuses, and hospitals already training over their caps.

In addition, the AMA strongly supports H.R. 4014/S. 2094, "the Physician Shortage GME Cap Flex Act," bipartisan legislation that helps address the national physician workforce shortage by providing teaching hospitals with an additional five years to set their Medicare GME cap if they establish residency training programs in primary care or specialties that are facing shortages. As the nation continues to grapple with the opioid crisis, AMA also supports H.R. 3441, "the Substance Use

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[28] Much of our advocacy work related to H-1B visa holders has been with the Administration. On March 31, 2021, the AMA sent the U.S. Department of Homeland Security a letter identifying several regulations relating to immigration that we urged the Biden Administration to review and revoke, modify, or supersede.

[29] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-4-7-Letter-to-House-re-Healthcare-Workforce-Resilence-Act-(1).pdf.

[30] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-3-24-House-GMAC-Sign-on-Resident-Physician-Shortage-Reduction-Act-of-2021-FINAL.pdf.

Disorder Workforce Act"/S. 1438, the Opioid Workforce Act," which provides 1,000 additional Medicare supported GME positions in hospitals that have, or are in the process of establishing, accredited residency programs in addiction medicine, addiction psychiatry, or pain medicine.

Conclusion

The U.S. health care workforce relies upon physicians from other countries to provide high-quality and accessible patient care.[31] The physician workforce shortage is well documented, and the pandemic has only served to magnify these workforce issues and other structural problems. The AMA thanks the Subcommittee for this hearing and for the careful consideration of solutions to improve the physician shortage in this country. We look forward to working with the Subcommittee and Congress to seek bipartisan policy solutions that will ensure that patients are provided the best care and that immigration barriers are addressed to resolve the physician workforce shortage and preserve patient access to care.

[31] https://www.supremecourt.gov/DocketPDF/17/17-965/40128/20180327105855912_17-965%20Amicus%20Br.%20Proclamation.pdf.

September 14, 2022

The Honorable Alex Padilla, Chair
Subcommittee on Immigration, Citizenship,
and Border Safety
United States Senate
Washington, DC 20510

The Honorable John Cornyn, Ranking Member
Subcommittee on Immigration, Citizenship,
and Border Safety
United States Senate
Washington, DC 20510

Dear Chairman Padilla, Ranking Member Cornyn and Subcommittee Members:

Thank you for holding this important hearing, **"Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce"**. We are pleased to submit a statement for the record to share the views of the senior living industry on the very important issue of workforce shortages in the long-term care industry. As you consider proposals to address shortages in the health care industry through immigration reform, it is critical that you include the senior living front line, caregiver, in demand and other essential workers who care for and service our nations older Americans. Senior living plays a significant role in the greater health care system and these workers are key to maintaining health and wellbeing of the residents they serve, thereby reducing the need for more critical services or hospitalization. When residents are safe, the overall health care system benefits.

The American Senior Housing Association (ASHA) is a national organization of over 500 companies involved in the operation, development, investment, and financing of the entire spectrum of seniors housing – independent living, assisted living, memory care, and Continuing Care Retirement Communities (CCRCs). Our members' communities serve a wide range of seniors, from those who require assistance with activities of daily living (ADL) such as eating, bathing, and dressing, to those with significant needs associated with Alzheimer's disease and age-related dementia. Our members are on the front lines when it comes to serving frail seniors providing 24/7 expert care, supportive services, dining, housekeeping, and myriad activities that promote wellbeing and social interaction. Senior living offers a valuable and much needed option for aging seniors and their families in need of care that is community based.

Worker Shortages are Critical, and the Impact is More Profound in Senior Living and Long-Term Care Communities

The senior living industry is facing an unprecedented shortage of workers. This shortage has been exacerbated by COVID-19. With the flood of retirements, childcare needs, and change of professions, we know this shortage will only intensify going forward given the characteristics of the U.S. aging population. People are living longer and requiring more care. The shortage of positions is across the board including direct caregivers, nurses, housekeepers, dining staff and more. In fact, long term care has been the hardest hit industry in the health care sector and continues to experience substantial job losses while according to BLS data, other sectors such as hospitals and physicians have nearly reached or surpassed pre-pandemic staffing levels.

These are hard jobs but very rewarding and meaningful. They are best suited for those with a passion for serving older Americans. It can be emotionally draining to care for those in the twilight of their lives,

share their frustration and fears, and still assure that they are getting the very best care. Without these caregivers, our seniors will suffer. The dedicated caregiver that works in our senior living communities are the unsung heroes of the American workforce. However, there are simply not enough native-born workers to meet the current and future demand and left unresolved will ultimately impact the ability to care for older adults.

With an estimated loss of 400,000 jobs in nursing homes and assisted living between February 2020 and March 2022, 10,000 people turning 65 every day and 70% of them projected to need some level of long-term care; and an estimated 11 million unfilled jobs in the U.S. in all industries; it is time to look beyond our borders and give immigration reform serious attention.

Key Reasons to Advance Immigration Policies to Bolster the Senior Living Workforce

- The United States is an aging nation. The growing number of older adults and increased longevity are the two primary factors spurring demand for long-term services and supports. The growing population of older Americans is driving the demand for caregiver and other front-line long-term care workers. By 2030, when all boomers will be 65 and older, they will make up 21% of the population, up from 15% today. There are simply not enough U.S. workers to take care of the increasing elderly population

- In contrast to the rapid expansion of the older adult population, the population of adults aged 18 to 64 is expected to remain relatively static, which means that there will be fewer potential paid and unpaid caregivers available to support older adults.

- There are more job openings today than people to fill them. Further it is expected that between now and 2028, the direct care workforce will need more than 1.3 million new workers. Longer term solutions must be prioritized in Congress especially as 10,000 people turn 65 every day, many of whom will likely need long term care as they age.

- Social Security and Medicare become more difficult to fund as the working-age population declines relative to the elderly population. The economic impact is significant unless steps are taken now to mitigate the risk posed to these programs.

- As the number of seniors needing long-term care expands, the number of family members available to provide that care is contracting — a consequence of baby boomers having fewer children than their parents.

- More than 6.2 million people aged 65 and older live with Alzheimer's today. By 2025, the number is projected to reach 7.2 million— a 16% increase. While the majority of these people receive care from family members and friends, approximately 40% of residents in senior living suffer from Alzheimer's or related dementia. Support must be available for these communities as well as family caregivers who without help, are at greater risk for anxiety, depression, and poorer quality of life than caregivers of people with other conditions.

It is Time for a Long-Term Care Worker Visa and Relief in Other Programs to Meet the Demand for Senior Care.

There are numerous nonimmigrant visa categories for people traveling and working in the U.S. but none of them are suited for the caregiver, dietary aid, med tech and other critical positions in the long-term

care industry. It is time that immigration reform be given the attention it deserves as a means of not only meeting the senior care workforce needs but to strengthen our overall economy.

There are many policy options on the table that should be pursued by Congress and/or the Administration that will address the workforce shortage in senior care. ASHA encourages your support for the following:

(1) Create a visa category for the front line, in demand long term care worker,

(2) Improve employment authorization for migrants who apply for asylum,

(3) Expedite processing of work applications for those in the US and are in a status that allows them to work but are unable because of delays at DHS that are taking in some cases 8-12 months,

(4) Create a pilot program within the existing H2-B visa category for same worker,

(5) Include long term care workers in future allocation of unused "green cards", and

(6) Grant DACA recipients and TPS workers permanent legal status.

Conclusion.

Throughout the pandemic, long term care, front line, essential workers have proven themselves to be a truly important part of our nation's critical infrastructure and crucial part of the backbone of our society. It is clear, we need to increase the number of workers to care for our seniors. There are many talented immigrants who are willing to enter the senior living or other long-term care sector but are faced with insurmountable roadblocks. These workers should be given the opportunity to make a career, a good living and a difference in their own lives and the lives of others. If we are to meet the expectations set for us, policymakers must act now to expand access to new pools of staff and take steps to encourage employment in long-term care.

We look forward to working with you on this critically important issue. Thank you for your consideration of our views and recommendations.

Sincerely,

David Schless
President & CEO

ARGENTUM
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Argentum

Statement for the Record

Senate Committee on the Judiciary, Subcommittee on Immigration, Citizenship, and Border Safety

"Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Healthcare Workforce"

September 14, 2022

On behalf of Argentum, the leading national association representing assisted living, memory care and senior living communities, I commend the committee for holding this hearing, "Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Healthcare Workforce." Two million of our nation's seniors call their assisted living community home.

Assisted living offers seniors dignity and choice in where and how they age, as well as socially engaging lifestyles focused on the social determinants of health. The average age in assisted living is 85; most residents need assistance with three or more daily life activities. If these communities did not exist, 61% of residents may be forced into a nursing home facility at double the financial cost. Over 90% of assisted living residents report high satisfaction and value in their care.

As this committee discusses workforce shortages throughout our healthcare system, one shortage eclipses all others: the shortage of the workforce needed to care for the unprecedented aging of our nation's population. The crisis that exists today will elevate to catastrophic levels if Congress and the Administration does nothing to prepare.

In less than 12 years, for the first time in our nation's history, there will be more seniors than children. With 10,000 Americans turning age 70 each day and *all* Baby Boomers turning 65 or older by 2030. This seismic demographic shift will transform the U.S. from an aging society to an aged society.

More startlingly, U.S. Census projections show that Americans aged 85 and older—the group predominately requiring the most care—will nearly *quadruple* between 2000 and 2040 and will continue to increase by nearly 200% in a sixty-year span. With the individual risk of Alzheimer's and dementia doubling in each year over age 80, by 2050, the number of seniors with cognitive impairment will increase five-fold, resulting in a massive need for care services as families struggle to deliver these specialized needs.

The perfect storm is forming. With nearly 70% of the U.S. population needing some form of long-term care as we age, a caregiver workforce shortage crisis already exists. Exacerbated by the pandemic, there is a current shortage of nearly half a million caregivers. 96% of assisted living communities face current staffing shortages. By 2025, there will be a shortage of 1.4 million caregivers just in the assisted living and senior living communities alone. This number DOES NOT include the enormous shortages expected in nursing home, home health and other types of geriatric care. Senior care workforce needs are diverse. Senior care encompasses all types of health care and non-health career paths - - direct caregiver, nurse, CNA, nutritionists,

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gerontologists, management, technology specialists, to just name a few - - each with its own workforce shortage challenges.

Simply put, based on the seismic shift in our nation's demographics, there will not be enough care providers for our nation's seniors. A pipeline of workers and training of workers is needed and construction on that pipeline must start now.

Argentum is prepared to work with you on advancing solutions to ensure that a caring, high quality, and thoroughly vetted workforce will be there for our nation's seniors when they will need them most. Common-sense immigration is not the only solution needed to confront this crisis, but it's a critical part of the solution. The United States has long relied on foreign-born direct care workers. Today, 22% of caregivers in assisted living communities are immigrants, and more work in a variety of roles that support assisted living communities.

Argentum strongly supports common-sense and targeted modifications to our current immigration system, such as: streamlining application processes and wait times for direct care workers; re-developing visa exchange programs with a focus on the needs of the aging; and creating public-private partnership programs that offer career path training in the long-term care continuum for those who are displaced from their country by natural disaster or war.

The projected workforce crisis in long-term-care also necessitates bolder action. Argentum strongly supports the establishment of a permanent visa category specifically for direct care workers. We would be honored to work with the Committee to establish the rigorous criteria and training requirements that should dictate such a program.

Thank you for holding this important hearing. We are eager to discuss proposed solutions to this crisis and look forward to working with you to get them done. If you have any questions or would like to discuss further, please contact Maggie Elehwany at melehwany@argentum.org.

Sincerely,

James Balda
President & CEO
Argentum

Association of American Medical Colleges
Statement for the Record
before the
Senate Committee on the Judiciary
Subcommittee on Immigration, Citizenship, and Border Safety
hearing, titled
"Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce"
September 14, 2022

Thank you for the opportunity to submit a statement for the record on behalf of the AAMC (Association of American Medical Colleges) regarding the importance of physician immigration to the U.S. health care system, including the critical role physicians from other countries play in safeguarding our nation's health and well-being by alleviating physician workforce shortages in underserved communities and diversifying our health care workforce to help improve the health of all. To that end, the AAMC recommends expanding the State Conrad 30 J-1 visa waiver program and enacting a permanent pathway to citizenship for Deferred Action for Childhood Arrivals (DACA) participants, among other immigration reforms to recruit and retain physicians, as delineated below.

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members comprise all 156 accredited U.S. medical schools; 14 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and nearly 80 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and the millions of individuals across academic medicine, including more than 191,000 full-time faculty members, 95,000 medical students, 149,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened the AAMC's U.S. membership and expanded its reach to international academic health centers. The AAMC also supports improving the immigration pathway for students, researchers, faculty, and other health professionals in addition to physicians.

The AAMC works closely with the Educational Commission for Foreign Medical Graduates (ECFMG), the sole U.S. Department of State-designated sponsor for foreign national physicians engaged in U.S. residency and fellowship training programs on J-1 visas. To practice in the U.S., physicians from other countries must complete rigorous educational curricula and U.S. examinations. The ECFMG verifies credentials and screens the individuals themselves in partnership with the Specially Designated Nationals (SDN) list maintained by the Office of Foreign Assets Control of the U.S. Department of Treasury. Only then are fully qualified

physicians from other countries eligible to apply and to compete for medical residency positions at U.S. teaching hospitals.

The U.S. health care workforce and the patients they serve rely on physicians from other countries, particularly in rural and other underserved areas. According to AAMC analysis of American Medical Association 2020 physician practice data, approximately 23% of active physicians practicing in the U.S. identified as foreign born, many of whom are now U.S. citizens or permanent residents. Their contributions are more profound than just a number indicates. Physician diversity has been widely recognized as key to excellence in medicine and quality care. Physicians from other countries have a unique cultural perspective — not just based on their nationality, race, or ethnicity, but also regarding the immigrant experience, which can affect patients' health and their health care experiences.

The importance of physicians from other countries is amplified as a result of growing nationwide health workforce shortages. The Health Resources and Services Administration (HRSA) estimates that in June 2022 the U.S. had a shortage of 16,477 primary care physicians and 7,632 mental health providers;[1] other specialties also are experiencing current shortages that are not measured by HRSA. The AAMC projects the overall physician shortage will grow to a total of between 37,800-124,000 physicians by 2034, including shortages of primary care physicians between 17,800-48,000 and a deficit of between 21,000-77,100 physicians across non-primary care specialties.[2] AAMC's workforce projections assume steady levels of physician immigration—significant reductions of physicians from other countries would drive up these projected shortages.

The academic medicine community has responded to consistent shortage projections and, since 2002, the number of first-year students in medical schools has grown by nearly 35% as schools expanded class sizes and 30 new schools opened;[3] currently, there are six additional medical schools that have applied to be considered for accreditation.[4] While U.S. medical schools continue to increase enrollment, medical school enrollment without commensurate increases in graduate medical education (GME) residency positions has no effect on the size of the workforce because GME training is required for licensure and medical practice in all states (and is critical to ensuring patient safety and quality of care). The entrance of physicians from other countries is also limited by the number of overall GME positions available. The AAMC supports the Resident Physician Shortage Reduction Act of 2021 (H.R. 2256, S. 834) to add 14,000 Medicare-supported GME positions over seven years. To partially address this need, the AAMC was pleased to see the end of the nearly 25-year freeze on Medicare funding for GME with the Consolidated Appropriations Act, 2021 (P.L. 116-260), which will add 1,000 new Medicare-supported GME positions.

Physicians from other countries are not displacing graduates of U.S. medical schools. According to the National Residency Matching Program (NRMP), in 2021, 92.8% (19,866) of seniors from

[1] https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport
[2] https://www.aamc.org/media/54681/download
[3] https://www.aamc.org/media/9936/download
[4] https://lcme.org/directory/candidate-applicant-programs/

U.S. MD schools matched to residency programs.[5] After the NRMP Supplemental Offer and Acceptance Program (SOAP), only 552 U.S. MD seniors were left without a position in 2020. Studies have shown that more than 99% of all U.S. medical school graduates enter residency or enter full-time practice in the United States within six years after graduation.[6] Comparatively, in 2021, 54.8% (4,356) of non-U.S. graduates of international medical schools matched to residency programs.

Residency program directors seek the best candidates, regardless of citizenship status or national origin, through a highly competitive selection process, and after rigorous evaluation some students may be unable to find a residency position in the United States. Numerous factors can contribute to a student not matching, including not being competitive in first-choice specialty; medical licensure exam scores; poor interviewing or interpersonal skills; not applying to, interviewing for, or ranking enough programs; concerns raised in the Medical Student Performance Evaluation (also known as the "Dean's Letter"); professionalism concerns; school reputation; or poor SOAP strategy.[7,8]

The AAMC provides regularly updated resources, tools, effective practices, and other materials to support students, medical school advisors, and program directors in the residency selection process. U.S. medical schools assist unmatched students with residency application guidance, finding residency vacancies, mental health support services, student debt management, and in pursuing master's degree programs or additional research and clinical experiences to enhance their competitiveness. The AAMC is deeply committed to improving the transition from medical school to residency — from the beginning of a student's specialty research and selection process through the completion of residency and on to clinical practice. Supporting the well-being, training, professional development, and equitable treatment of all medical students and residents is critical to the health of the nation.

Predictable, expedient, and efficient immigration processes for physicians and teaching hospitals improve U.S. health care and benefit patients.

Thousands of physicians from other countries who are currently in the U.S. treating patients and roughly 4,300[9] new immigrant physicians who match each year to medical residency programs at U.S. teaching hospitals encounter significant barriers to remain in or enter the country. This is because the U.S. immigration and visa systems are not optimally designed for the health professions and the extended continuum of medical education, training, and state licensure. For example, the 3-month window between when physicians match to residency programs in late March and program start dates on or around July 1, requires certainty in U.S. Citizenship and

[5] https://www.nrmp.org/wp-content/uploads/2021/08/MRM-Results_and-Data_2021.pdf
[6] Sondheimer HM, Xierali IM, Young GH, Nivet MA. Placement of US Medical School Graduates Into Graduate Medical Education, 2005 Through 2015. JAMA. 2015;314(22):2409–2410. doi:10.1001/jama.2015.15702
[7] Sondheimer HM. Graduating US Medical Students Who Do Not Obtain a PGY-1 Training Position. JAMA. 2010;304(11):1168–1169. doi:10.1001/jama.2010.1316
[8] Bumsted, Tracy MD, MPH; Schneider, Benjamin N. MD; Deiorio, Nicole M. MD Considerations for Medical Students and Advisors After an Unsuccessful Match, Academic Medicine: July 2017 - Volume 92 - Issue 7 - p 918-922 doi: 10.1097/ACM.0000000000001672
[9] https://www.nrmp.org/wp-content/uploads/2021/08/MRM-Results_and-Data_2021.pdf

Immigration Services (USCIS) processing that will enable new medical residents to enter the country in a timely fashion, start training, and treat patients. As a result, premium processing for additional fees has become the norm, yet even premium processing has been suspended in 2015, 2017, and 2019 during this critical window between matching and program start dates, creating disruptions and uncertainty.

Most physicians from other countries enter the U.S. for residency training on temporary nonimmigrant J-1 "exchange visitor" or H-1B "specialty occupation" visas. Both visa pathways have pros and cons. While the AAMC believes the J-1 visa is the most appropriate pathway for residency training and supports a balanced approach that prevents international "brain drain," the 2-year home-country return requirement can pose a very substantial barrier for retaining physicians that U.S. teaching hospitals have invested in training. The H-1B visa does not have a 2-year home-country return requirement, but is designed for temporary employment, more expensive than J-1 visas, subject to numerical caps, and sometimes not long enough to cover the full duration of residency training.

Recently, teaching hospitals and H-1B applicants have been subject to additional requests for evidence (RFE) that often necessitate hiring immigration attorneys and drive up costs. Frequently, these RFEs are regarding H-1B prevailing wage data, which is incongruent with medical residency where all residents in the same training year at the same teaching hospital have the same stipend level rather than a traditional salary. In fact, using regional or market data beyond the institution-level can unintentionally require different stipends for these physicians than their peers. Ultimately, prevailing wage determination for medical residents is an unnecessary and counterproductive administrative burden for teaching hospitals.

The COVID-19 pandemic has further illustrated the importance of physicians from other countries, as well as how immigration reforms can help improve access to care. Emergency immigration policy changes improved patients' access to physicians by exempting providers from certain COVID-19 travel restrictions, extending visa stays, and allowing temporary flexibility for practice location or switching employers. In light of this success, ongoing workforce shortages, and multiple public health crises, Congress should consider expanding some of these reforms and/or making them permanent. For example, we were pleased the USCIS published guidance expediting the issuance of Employment Authorization Documentation for essential health care workers in response to COVID-19, and we believe this should be standard practice. Increasing predictability for physicians from other countries and their employers, reducing backlogs or prioritizing physician applications, and streamlining physician processing throughout the immigration pathway ultimately benefits most the U.S. patients these providers will treat.

AAMC urges Congress to permanently authorize and expand the State Conrad 30 J-1 visa waiver program.

The State Conrad 30 J-1 visa waiver program has been a highly successful program for underserved communities to recruit both primary care and specialty physicians after they complete their medical residency training. This program allows up to 30 physicians per state to

remain in the U.S. in underserved communities (including rural and urban community health centers) after completing medical residency on a J-1 visa, which otherwise requires physicians to return to their home country for at least 2 years.

At minimal administrative cost to the federal government, the Conrad 30 program has brought more than 15,000 physicians to underserved areas over the last 15 years. That is comparable to (if not more than) the National Health Service Corps (NHSC) scholarship and loan repayment programs for U.S. citizens. Yet while Congress has rightly recognized the vital role the NHSC plays in caring for our nation's most vulnerable patients by steadily increasing funding, most recently with $800 million in supplemental funding in the American Rescue Plan, Conrad 30 waiver limits have not been increased in two decades. The Conrad 30 program also allows states and governors more flexibility in specialty choice and practice location to recruit physicians with the most appropriate skills where they are most needed.

The AAMC endorses the bipartisan Conrad State 30 and Physician Access Reauthorization Act (H.R. 3541, S. 1810), which among other improvements would allow Conrad 30 to expand beyond 30 slots per state if certain nationwide thresholds are met. We applaud this bipartisan reauthorization proposal for recognizing these physicians as a critical element of our nation's health care infrastructure, and we support the expansion of Conrad 30 to help overcome hurdles that have stymied growth of the physician workforce.

Importantly, H.R. 3541 would also allow three Conrad 30 slots per state to be used by academic medical centers, permit "dual intent" for J-1 visa physicians seeking graduate medical education, and establish new employment protections and a streamlined pathway to a green card for Conrad 30 participants.

AAMC urges Congress to enact legislation for a permanent pathway to citizenship for DACA participants.

AAMC supports a permanent pathway to citizenship for individuals with DACA status, including approximately 34,000 health care providers.[10] Medical school applicants and matriculants with DACA status continue to increase year after year, with more than 200 currently enrolled in medical school or completing their residency training. DACA and the corresponding work authorizations for the 34,000 health care providers enhance our nation's health care capacity at a time we can ill-afford to lose valuable personnel. As 33 health professional education organizations presciently warned the Supreme Court in an October 2019 amicus brief:

> The risk of a pandemic … continues to grow, since infectious diseases can spread around the globe in a matter of days due to increased urbanization and international travel. These conditions pose a threat to America's health security—its preparedness for and ability to withstand incidents with public-health consequences. To ensure health security, the country needs a robust health workforce. Rescinding DACA, however,

[10] https://www.americanprogress.org/article/the-demographic-and-economic-impacts-of-daca-recipients-fall-2021-edition/?_ga=2.263308748.1987884036.1644598394-852236830.1644598394

> would deprive the public of domestically educated, well-trained, and otherwise qualified health care professionals who have been provided education in reliance on their ability to continue to work in the United States as health care professionals.[11]

The COVID-19 pandemic has also pulled back the curtain on longstanding social, economic, and health inequities in the United States that providers participating in DACA can help address. Health professionals with DACA status encompass a diverse, multiethnic population, who are often bilingual and more likely to practice in underserved communities hit hardest by a pandemic.

The AAMC urges Congress to pass a permanent pathway to citizenship for individuals with DACA status, such as the bipartisan Dream Act of 2021 (S. 264) or the House-passed American Dream and Promise Act of 2021 (H.R. 6). These bills would ensure that these undocumented Americans are able to continue their employment, education, training, and research in the health professions.

AAMC supports reducing green card backlogs and prioritizing health care workers.

AAMC supports addressing the backlog of applications for green cards by lifting per country caps that are impeding physicians entering the U.S. from certain countries. At the same time, we are concerned that limiting the aggregate number of green cards each year only shifts the problem from one country to another. This is particularly problematic for nurses who, depending on state licensure requirements, may not be eligible for H-1B specialty occupation visas and instead apply directly for immigrant visas and green cards, potentially facing decade-long wait times while overseas.

To break these backlogs, the bipartisan Healthcare Workforce Resilience Act (H.R. 2255, S. 1024) would authorize the recapture of unused immigrant visas and redirect them to 25,000 immigrant visas for professional nurses and unused 15,000 immigrant visas for physicians. Importantly, these visas would be issued in order of priority date, not subject to the per country caps, and premium processing would be applied to qualifying petitions and applications.

Thank you again for the opportunity to submit this statement for the record on the importance of physicians from other countries and the critical roles they play in the U.S. health workforce. Ultimately, our nation's health security depends on access to providers and maintaining a sufficient physician workforce, through reasonable, predictable immigration policies that help recruit and retain foreign physicians from diverse backgrounds to rural and other underserved communities. The AAMC looks forward to working with the Senate Judiciary Committee and Congress on a balanced approach to immigration and citizenship policy that attracts individuals who want to contribute to improving the health of our nation and people everywhere.

[11] https://www.aamc.org/media/37271/download?attachment

A Passionate Voice for Compassionate Care

September 14, 2022

The Honorable Alex Padilla
Chair
Senate Judiciary Subcommittee on
Immigration, Citizenship and Border Safety
U.S. Senate

The Honorable John Cornyn
Ranking Member
Senate Judiciary Subcommittee on
Immigration, Citizenship and Border Safety
U.S. Senate

Dear Chairman Padilla and Ranking Member Cornyn:

We welcome today's hearing "Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce" as a hopeful sign that Congress recognizes the importance of the immigrant community to the health care workforce and will work vigorously to provide pathways to citizenship and expanded employment opportunities for these crucial employees.

The Catholic Health Association of the United States (CHA), the national leadership organization of more than 2,200 Catholic health care systems, hospitals, long-term care facilities, service providers and organizations, is uniquely situated to advocate on behalf of the immigrant health care workforce. As an organization grounded in the mission and values of the Catholic Church, we believe that regardless of legal status, immigrants possess inherent human dignity and inalienable worth which should be respected and supports public policies that are essential to promoting and protecting that inherent dignity and worth. And as health providers, we also know the importance of the immigrant workforce to our health care organizations and to the ability of both Catholic and all other health care providers to continue to meet the health care needs of all Americans.

As the CEOs of the nation's Catholic health systems have stated, immigrants in our facilities working "as nurses, physicians, aides, dietary workers and facility professionals…are a part of what makes American health care great." Additionally, immigrants are a vital part of the workforce providing services to the elderly and others in need of long-term care, helping older and vulnerable Americans receive the services they need in our facilities as well as in their homes and communities. Our member organizations celebrate the contributions these employees have made to our health ministry and provide a wide array of programs to assist them in their work and in their integration into American society and culture.

CHA supports two vital pieces of legislation in the current Congress to help the immigrants working in Catholic health care and their families lead better and more secure lives, as well as to ensure that our immigration system is changed to help facilitate the entry of future health care workers. The American DREAM and Promise Act (H.R. 6) would provide additional protections and a pathway to citizenship for young undocumented immigrants in the Deferred Action for

1625 Eye Street NW, Ste. 550 Washington, DC 20006 *phone* 202.296.3993 *fax* 202.296.3997 **www.chausa.org**

Childhood Arrivals program (DACA) as well as Temporary Protected Status (TPS) holders, some of whom work in our health care facilities. CHA also supports the U.S. Citizenship Act (S. 348), to assist DACA and TPS recipients as well as provide an earned pathway to citizenship for approximately 11 million undocumented persons. According to the Migration Policy Institute, immigrants ranging from naturalized citizens, legal permanent residents and temporary workers to TPS recipients and those in the DACA program accounted for nearly 18 percent of the 14.7 million people in our nation working in a health-care occupation. As members of the Senate are undoubtedly aware, the lingering effects of the global pandemic have left many health care organizations with severe staffing shortfalls, which are not expected to ease anytime soon. Congressional action to provide employment security and a firmer basis in our society for these immigrants is one vital way of helping to address our nation's health care workforce challenges.

Thank you for highlighting the importance of immigrants working to provide health care for our nation. We look forward to joining with you and all members of Congress to ensure that their participation in the health care system and contributions to the health and well-being of all Americans are not only appreciated but also encouraged through legislative action.

Sincerely,

Sr. Mary Haddad, RSM
President and CEO

1625 Eye Street NW, Ste. 550 Washington, DC 20006 *phone* 202.296.3993 *fax* 202.296.3997 **www.chausa.org**

September 14, 2022

The Honorable Alex Padilla
Chair
Subcommittee on Immigration, Citizenship, and Border Security
Committee on the Judiciary
United States Senate
Washington, D.C. 20510

The Honorable John Cornyn
Ranking Member
Subcommittee on Immigration, Citizenship, and Border Security
Committee on the Judiciary
United States Senate
Washington, D.C. 20510

Dear Chair Padilla, Ranking Member Cornyn, and distinguished Senators:

My name is Jeffrey A. Singer. I am a Senior Fellow in Health Policy Studies at the Cato Institute. I am also a medical doctor specializing in general surgery and have been practicing that specialty in Phoenix, Arizona for over 40 years.

I would like to thank the Subcommittee on Immigration, Citizenship, and Border Security for convening a hearing on Wednesday, September 14, 2022, titled "Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce." I appreciate this opportunity to provide my perspective, as a health care practitioner and policy analyst, to assist this committee in its assessment of existing policies that obstruct well-trained immigrant physicians, eager to deliver health care services to Americans, from doing so. I had the privilege and pleasure of providing my viewpoint on this same topic to the Subcommittee on Immigration and Citizenship of the Committee on the Judiciary of the United States House of Representatives when it conducted hearings on this issue on February 15, 2022. I welcome the opportunity to share those same thoughts with the Subcommittee on Immigration, Citizenship, and Border Security of the Committee on the Judiciary of the United States Senate today.

The COVID-19 pandemic brought more clearly into focus this nation's growing need for more health care practitioners. Governors implemented emergency measures aimed at alleviating the shortage by admitting health care practitioners licensed in other states to render care to the states' residents. In some cases, such as with New Jersey, the governor permitted physicians trained, licensed, and experienced in other countries to render care, under supervision, to the state's residents.[1] With the crisis receding, most emergency measures have come to an end and the regulatory regime regarding healthcare practitioners has returned to the status quo ante.

Even without the pandemic, the United States already needed more physicians. The United States ranks behind most developed countries in physicians per capita.[2] The shortage of health care practitioners broadly—and the physician shortage more specifically—can be mitigated to some degree if more international medical graduates and licensed and experienced practitioners in other countries would be able to come to the United States and become part of our nation's physician workforce. There are two separate problems that stand in the way: (1) state licensing

laws make it difficult for foreign physicians to obtain licenses; and (2) complicated and restrictive immigration regulations make it difficult for foreign-born and educated physicians to work in states independent of state licensing requirements. I will address both issues here.

A cumbersome approval process begun in the late 1950s places daunting obstacles in the way of International Medical Graduates (IMGs) who want to practice in the U.S., keeping tight reins on the already short supply of doctors.[3] The process is overseen by the Educational Commission for Foreign Medical Graduates (ECFMG), a non-profit organization established in 1956 to "evaluate the readiness" of IMGs to enter graduate medical education programs (residencies and fellowships) in this country.[4] (Graduates of Canadian medical schools are not considered IMGs.) The American Medical Association and the American Hospital Association soon recognized the ECFMG as the standard for evaluating IMGs entering the U.S. healthcare system and serving patients in hospitals. The ECFMG obtained responsibility for visa sponsorship of Exchange Visitor physicians (J-1 visas).

Graduates of medical schools outside of the U.S. and Canada must become certified by the ECFMG before they can enter U.S. graduate medical programs. This means they must receive their diplomas from an ECFMG-approved medical school, pass Steps 1 and 2 of the three-step U.S. Medical Licensing Examination (USMLE), complete a graduate medical education program, and then pass Step 3 of the USMLE. State licensing requirements vary regarding IMGs.[5] Some require more years of graduate medical education training than they require from graduates of U.S. and Canadian medical schools before they grant them a license. Most issue licenses to graduates of U.S. and Canadian medical schools after the applicants have passed Step 2 of the USMLE and several don't require these licensees to pass Step 3 to maintain their license.

IMGs who received their diplomas a while ago, however, and have been practicing medicine outside of the U.S.—often for many years—must go through the same process as a fresh medical school graduate. This means they must pass the ECFMG certification—including taking and passing all three steps of the USMLE—and go through a residency training program **all over again.** Then they must apply for state medical licenses. Many very experienced foreign-trained doctors take positions in ancillary medical fields, such as nurse, lab technician, and radiology technician instead of starting all over again. Some enter residency programs in a specialty completely different than the one they are practicing, to be able to work as a doctor in this country. And some, sadly, even work in industries or fields in which their years of training and experience go unutilized.

The Canadian provinces, Australia, and most European Union countries have a provisional licensing system whereby experienced foreign doctors are allowed to practice under the supervision of a licensed domestic physician for a designated period. When the supervisory period is complete, and contingent on passing the same exams required of domestic physicians, they are granted an unconditional license. In many cases they are required to practice for a certain period in an underserved area.[6]

America's patients would benefit greatly if state lawmakers reformed licensing laws to make it easier for IMGs who complete an accredited U.S. graduate medical program to obtain a license to

practice within the state. They would also benefit if state lawmakers would create provisional licensing programs for licensed and experienced physicians who were trained and practice in other countries. Governor Phil Murphy of New Jersey patterned a public health emergency measure on the provisional license model.

However, despite any reforms that state lawmakers might enact, federal immigration laws remain an obstacle for their smooth implementation.

For example, under present law, IMGs who obtained a J-1 visa must return to their country after completing their graduate medical training in the U.S. and may not apply to return to the U.S. for 2 years.[7] It is unfortunate that these well-trained physicians cannot stay in the country they've called "home" for several years and deliver care to its residents. Under the Conrad 30 J-1 Visa Waiver program, IMGs who complete their postgraduate training and receive a job offer in a medically underserved area in the U.S. may obtain a waiver of the requirement to return home. However, each state is granted just 30 Conrad waivers, and different state regulations affect the usage of these spots. In some states the 30 waivers are rapidly exhausted, while in others they are underutilized.

Furthermore, the physician who works under a Conrad waiver must seek employer sponsorship of an H-1B visa. The H-1B visa program has a cap of 85,000 visas issued per year. Then, in most cases, the physician needs to request that their employer obtain an extension of the H-1B status as well as petition for the physician to receive a green card. This is often easier said than done, because the employer has no guarantee that the physician will stay on after fulfilling the requirements of the Conrad waiver and therefore has no incentive to cooperate.

IMGs who've trained in the U.S. may also obtain a Physician National Interest Waiver (NIW). After again obtaining a letter of need from a state, the NIW allows physicians to apply directly for a green card after serving 5 years in a medically underserved area without the need for an employer-sponsor. But state requirements vary considerably. During that 5-year window the IMG must obtain an H-1B visa through the H-1B lottery and, after that, a green card—both of which are capped.

Meanwhile, experienced and licensed physicians in other countries—some of whom may even be on the faculty of foreign medical schools—must win H-1B visas through the lottery to work in the U.S. and, eventually, obtain a green card under the green card caps if they hope to stay here permanently. The low employer-sponsored green card cap was last updated in 1990, and special limits on immigrants based on birthplace are causing physicians from India and China to face extremely long waits. Many India-born physicians will die waiting for a green card.[8]

While Congress has no constitutional authority to intervene in state licensing matters, Congress can facilitate state lawmakers who seek to reform state licensing requirements for IMGs and foreign physicians by removing immigration law barriers that impede the effectiveness of state licensing reform.

One way to do this would be to remove the requirement that J-1 visa holders must return to their country of origin for at least two years after they complete their postgraduate training. They should be allowed to apply directly for a green card that would take effect once the J-1 visa expires. At a minimum, Congress should adopt this reform for any physician who works for three years in a medically underserved area without involving state governments.

Congress can—and should—also eliminate the cap on H-1B visas or create an extra allotment of H-1B visas designated for foreign healthcare professionals who now must compete for H-1B visas with other applicants in highly-skilled fields. Likewise, the cap on green cards should be eliminated or an extra allotment created for foreign healthcare professionals. Congress should also guarantee green cards to the family of any healthcare worker if the worker dies while still in a temporary status—a tragedy that is a regular occurrence in the United States.[9]

These past two and a half years have exposed many weaknesses in our healthcare system. State and federal emergency measures were implemented as workarounds but, unfortunately, were mostly temporary. Congress should not wait for the next pandemic before it addresses these weaknesses. An obvious place to start is by addressing the healthcare work force available to a population that continues to grow and age.

Reforming immigration laws that stand in the way of people from other countries who want to provide health care services to Americans is a good place to start.

Respectfully submitted,

Jeffrey A. Singer, MD, FACS
Senior Fellow
Department of Health Policy Studies
Cato Institute

[1] https://www.phillyvoice.com/new-jersey-coronavirus-emergency-medical-license-foreign-doctors-covid-19/
[2] https://www.kff.org/health-costs/press-release/the-u-s-has-fewer-physicians-and-hospital-beds-per-capita-than-italy-and-other-countries-overwhelmed-by-covid-19/#:~:text=Compared%20to%20Italy%20and%20Spain,Spain%20%E2%80%93%20but%20more%20licensed%20nurses.
[3] https://www.ama-assn.org/education/international-medical-education/practicing-medicine-us-international-medical-graduate
[4] https://www.ecfmg.org/about/history.html
[5] https://www.fsmb.org/step-3/state-licensure/
[6] https://www.royalcollege.ca/rcsite/credentials-exams/assessment-international-medical-graduates-e see also https://scholarlycommons.law.wlu.edu/wlulr-online/vol76/iss2/1/ and http://www.harvard-jlpp.com/wp-content/uploads/sites/21/2019/02/Larkin-Final.pdf
[7] 8 U.S. Code § 1182(e)
[8] https://www.cato.org/blog/employment-based-green-card-backlog-hits-12-million-2020
[9] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2780929

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Intealth Supplemental Statement for the Record before the Senate Committee on the Judiciary, Subcommittee on Immigration, Citizenship and Border Safety hearing titled "Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce"
September 14, 2022

Thank you for inviting the Educational Commission for Foreign Medical Graduates (ECFMG®), a member of Intealth™, to provide comment to the Senate Judiciary's Subcommittee on Immigration, Citizenship, and Border Safety hearing focused on immigrant physicians and their role in ensuring that U.S. communities have access to the health care they need and deserve. As the sole organization in the United States charged with both certifying the credentials of physicians who attend medical schools outside of the United States and Canada and sponsoring foreign national physicians for participation in the U.S. Department of State's BridgeUSA exchange visitor program, ECFMG is uniquely qualified to comment on the contributions of international medical graduates (IMGs) to U.S. health care.[1] ECFMG, a non-governmental, tax exempt entity, was formed over seventy years ago to be the only organization to certify physicians who graduated from medical schools outside of the United States and Canada and aim to engage in supervised patient care in the United States. Through its many programs and services, ECFMG does the following:

- Certifies the readiness of IMGs to participate in U.S. programs of graduate medical education (GME) through an evaluation of their qualifications.
- Identifies the needs of IMGs to become acculturated into U.S. health care.
- Verifies credentials and provides other services to health care professionals worldwide.
- Expands knowledge about international medical education programs and their graduates by gathering data, conducting research, and disseminating the findings.
- Facilitates the entry of thousands of foreign national physicians to the United States on J-1 visas annually.

ECFMG certification remains the standard by which IMGs are vetted. In administering its certification program, ECFMG is guided by three mindful principles:

- To assure the U.S. public that IMGs who are involved in supervised patient care are appropriately certified and hold credentials that have been primary source verified;
- To assure residency program directors there is an adequate pool of qualified IMG applicants;
- To facilitate, and not impede, IMGs seeking professional career advancement.

Currently, all U.S. states require IMGs to hold ECFMG certification and to have one to three years of training before being eligible for an unrestricted medical license. While not an ECFMG mandate, our organization supports these requirements, because the residency training outside of the United States is very heterogenous and frequently not regulated. In order to engage in U.S. training, as required for entry into practice and licensure in

[1] The IMG cohort includes both U.S. citizen and non-U.S. citizen graduates of international medical schools. Foreign national physicians, regardless of country of medical school, require visas to participate in U.S. GME. See https://www.ecfmg.org/evsp/about.html.

the United States, foreign national physicians are selected through a highly competitive matching program and have their eligibility status verified by ECFMG prior to being selected by U.S. program directors.

U.S.-trained foreign national physicians often transition to practice in this country upon completion of GME and serve the most vulnerable populations by providing essential primary care to underserved areas of the United States. In many cases, foreign national physicians who remain in the United States also continue to contribute to health care in their home countries through research, teaching, and other collaborative efforts with health care professionals abroad. Thus, ensuring that qualified physicians have opportunities to enter the United States and complete training is essential to both U.S. and global health care.

Physician Immigration is Critical to U.S. Health Care

In 2022, 4571 foreign national IMGs matched to first-year U.S. residency positions via the National Resident Matching Program® (NRMP®).[2] Of these, roughly two-thirds entered U.S. GME in June/July 2022 sponsored by ECFMG in the J-1 visa category of "alien physician." In addition, more than 10,000 physicians continued their U.S. training in 2022 under ECFMG J-1 sponsorship. The 13,000+ physicians currently being sponsored by ECFMG hail from more than 135 different countries and are engaged in residency or fellowship training at more than 730 teaching hospitals in 51 U.S. states and provinces. J-1 physicians not only serve as vital members of health care teams in the states, cities, and institutions where they train, and also lend a diversity of thought and experience that is invaluable to U.S. health care. Furthermore, many J-1 physicians who complete their training remain lawfully in the United States under the Conrad 30 program to work in medically underserved or health professions shortage areas of the country. Most often, they serve these communities as primary care specialists. Policymakers must carefully consider how proposed regulatory changes could impact the communities they serve, the pipeline of qualified physicians, particularly primary care physicians, and at risk populations in the United States.

Foreign National Physicians are Vital to the Delivery of Primary Care

There are more than 230,000 IMGs in training or practice in the United States, comprising nearly 25 percent of the U.S. physician workforce.[3] While the cohort of doctors who are foreign-trained varies significantly by medical specialty, multiple studies have shown that foreign national IMGs are more likely to practice in primary-care fields compared to U.S.-medical school graduates. This is particularly relevant in light of the expected shortage of both primary-care doctors and specialists in the United States to continue in the coming years. The United States is suffering from a growing physician shortage with forecasts of a widening gap that will continue to grow over the next decade. The Association of American Medical Colleges (AAMC) predicts that, by 2033, the United States will experience a shortage of between 54,100 and 139,000 physicians. This number includes a projected primary care physician shortage of between 21,400 and 55,200 as well as a shortage of non-primary care specialty physicians of between 33,700 and 86,700.[4] With more than 40 percent of IMGs working in primary care, our country cannot afford to adopt any policies that will deter foreign national physicians from coming to the United States for training and/or discourage U.S. teaching hospitals from selecting them to join their programs.

Foreign National Physicians Serve Vulnerable Populations

Foreign national physicians play a significant role in filling medical shortfalls in disadvantaged communities because of the large disparities in access to health care that exist in the United States. A 2018 report by the

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[2] NRMP. (2022, May). Results and Data 2022 Main Residency Match. Retrieved from NRMP: https://www.nrmp.org/wp-content/uploads/2022/05/2022-Main-Match-Results-and-Data_Final.pdf
[3] Source: American Medical Association (AMA) Masterfile, 2021
[4] AAMC. (2020, June). The Complexities of Supply and Demand: Projections from 2018 to 2033. Retrieved from AAMC: https://www.aamc.org/system/files/2020-06/stratcomm-aamc-physician-workforce-projections-june-2020.pdf

American Immigration Council found that:

- In areas with the highest poverty rate, where more than 30 percent of the population lives below the federal poverty rate, nearly one-third of all doctors are foreign-trained.
- Where per-capita income is below $15,000 per year, 42.5 percent of all doctors are foreign-trained.
- Where 75 percent or more of the population is non-white, 36.2 percent of the doctors are foreign-trained.
- Where 10 percent or less of the population has a college degree, nearly one-third of all doctors are foreign trained.[5]

As this Subcommittee considers what reforms would best serve the U.S. public, the fact that physicians born in and/or educated in other countries are integral to the delivery of U.S. patient care, particularly in vulnerable populations, must be understood.

Conclusion

The ability of foreign national physicians to train and, ultimately, practice in the United States is crucial to ensuring an adequate physician workforce in the United States. Because of the disparity in medical education around the world, graduates of international medical schools are required to hold a valid ECFMG Certificate and complete some training in a U.S. GME program before being licensed to practice medicine in this country. They are selected for those GME programs through a competitive and fair NRMP Match. The NRMP Match allows program directors in the United States to select and rank the applicants they deem to be most qualified. In addition, the structure of GME, specifically accreditation requirements set forth by the Accreditation Council for Graduate Medical Education (ACGME), prevents U.S. training programs from discriminating against and/or treating foreign nationals unfairly. As a result, physicians from other countries are provided with opportunities for robust educational and cultural experiences while making valuable contributions to U.S. health care and the communities they serve.

Through its many programs and services, Intealth presently serves as a world leader in promoting quality health care globally — serving physicians, members of the medical education and regulatory communities, health care consumers, and those researching issues in medical education and health workforce planning. Furthermore, Intealth serves as the primary source for physician immigration data in the United States.

Thank you again for the opportunity to provide this supplemental statement. For additional information, please contact Tracy Wallowicz, Vice President, External Affairs and Chief of Staff, Intealth, at twallowicz@intealth.org.

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[5] American Immigration Council (2018, January). Foreign-trained Doctors are Critical to Serving Many U.S. Communities. Retrieved from American Immigration Council: https://www.americanimmigrationcouncil.org/research/foreign-trained-doctors-are-critical-serving-many-us-communities

September 12, 2022

The Honorable Alex Padilla
Chair
Senate Committee on Judiciary
Subcommittee on Immigration
and Citizenship
Washington, D.C. 20515

The Honorable John Cornyn
Ranking Member
Senate Committee on Judiciary
Subcommittee on Immigration
and Citizenship
Washington, D.C. 20515

Dear Chair Padilla and Ranking Member Cornyn:

On behalf of the Healthcare Leadership Council (HLC), we thank you for holding a hearing on, "Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce."

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century healthcare system that makes affordable high-quality care accessible to all Americans. Members of HLC – hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, post-acute care providers, homecare providers, and information technology companies – advocate for measures to increase the quality and efficiency of healthcare through a patient-centered approach.

As you know, the COVID-19 pandemic has exacerbated the ongoing shortage of healthcare workers in America, leaving many healthcare facilities short staffed even as the number of COVID-19 cases decrease. In addition, the United States faces a physician shortage of up to nearly 124,000 physicians by 2034, including shortfalls in both primary and specialty care.[1] This shortfall could disproportionately affect rural and underserved communities. The 46 million Americans who live in rural areas often have trouble accessing care due to a shortage of healthcare workers and long distances to healthcare services that can be made more challenging by difficult terrain and severe weather. As a result, rural residents overall suffer poorer health outcomes and are at greater risk of dying from heart disease, cancer, unintentional injuries, chronic lower respiratory disease, and stroke than their urban counterparts. Without congressional

[1] The Complexities of Physician Supply and Demand: Projections From 2019 to 2034, Association of American Medical Colleges (June 2021) https://www.aamc.org/media/54681/download?attachment

action, workforce shortages are likely to worsen and, consequently, the state of health for people across America may worsen as well.

As Congress looks further into supporting the healthcare workforce and the role of immigrants in the healthcare system, HLC encourages passage of H.R. 2255/S. 1024, the "Healthcare Workforce Resilience Act" to provide green cards or permanent residency to foreign medical professionals such as immigrant nurses and physicians. Under the bill, U.S. Citizenship and Immigration Services would recapture up to 25,000 immigrant visas for nurses and 15,000 immigrant visas for physicians which will help strengthen health systems' capacity as we continue to combat the pandemic, the growing opioid crisis, and other significant health challenges.

We also recommend Congress reconsider a provision in H.R. 4521, the "America Creating Opportunities to Meaningfully Promote Excellence in Technology, Education, and Science (COMPETES) Act," to exempt foreign citizens with doctoral degrees in STEM fields from annual country visa caps. The passage of this provision would allow highly trained foreign physicians to stay in the United States after finishing medical school to provide care to patients in underserved areas across America. It is estimated this provision could benefit 3,000 to 5,000 STEM doctorates and would expedite an applicant's approval for a green card visa by five to ten years.[2]

In addition, HLC believes it is imperative to support immigration policies that enable the entry of qualified medical professionals into the United States and encourages Congress to take the following actions to strengthen the healthcare workforce during and beyond the COVID-19 public health emergency.

- Improve and streamline the process to fully vet, highly qualified foreign trained healthcare workers to be brought to the United States.
    - Authorize virtual interviews or waive the immigrant visa interview process for nurses.
- Support legislation that recaptures immigrant visas for nurses and physicians.
- Direct the Department of Homeland Security to take the following actions to increase the supply of physicians during the national emergency:
    - Temporarily suspend the enforcement of the two-year home residency requirement for any J-1 medical resident or fellow who is willing to work full time in a Health Professional Shortage Area or Medically Underserved Areas and Populations or in a medical field that is directly treating COVID-19 patients or assisting in the battle against COVID-19. This should not be restricted to just the Conrad 30 Waiver program. There are many other Interested Government Agency Waivers including Appalachian Regional Commission, Delta Regional Authority VA Waivers, and Health and Human Services Waivers.

[2] Study: Rethink immigration policy for STEM doctorates, Cornell University (January 2021) https://news.cornell.edu/stories/2021/01/study-rethink-immigration-policy-stem-doctorates#:~:text=They%20said%20the%20data%20suggests,but%20disproportionate%20contributions%20to%20innovation.

- Permanently exempt from the annual H-1B cap any physician and other certain healthcare workers (as long as they are H-1B classifiable positions) involved in direct patient care.
- Extend the status and work authorization of any H-1B physician beyond the normal six-year limit if they are filling an unmet workforce need.
- Immediately grant Employment Authorization Document (EAD) approval to any physician or healthcare worker whose EAD card is about to expire, or whose application for renewal is pending or grant work authorization based on a Receipt Notice of an I-765 Application.
- Temporarily suspend the Visa Screen Certificate or equivalent requirement for healthcare professionals in light of the shortage of qualified medical personnel available to practice in the United States.

Thank you again for your efforts to bolster the healthcare workforce by addressing immigration challenges. HLC looks forward to continuing to collaborate with you on this important issue. If you have any questions, please do not hesitate to contact Debbie Witchey at (202) 449-3435 or dwitchey@hlc.org.

Sincerely,

Mary R. Grealy
President

NHPCO
Leading Person-Centered Care

1731 King Street
Alexandria, VA 22314
nhpco.org
tel. 703.837.1500
fax. 703.837.1233

September 14, 2022

The Honorable Alex Padilla
Chair
Subcommittee on Immigration, Citizenship, and Border Safety
Senate Committee on the Judiciary
224 Dirksen Senate Building
Washington, D.C. 20510

The Honorable John Cornyn
Ranking Member
Subcommittee on Immigration, Citizenship, and Border Safety
Senate Committee on the Judiciary
224 Dirksen Senate Building
Washington, D.C. 20510

Dear Chair Padilla and Ranking Member Cornyn:

Thank you for holding today's hearing, entitled *Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce*.

The National Hospice and Palliative Care Organization, a membership organization of more than 4,000 hospice locations representing nearly 60,000 hospice professionals and hundreds of thousands of volunteers dedicated to caring for patients and families across the country, sincerely appreciates the Subcommittee's attention to important issues impacting our nation's health care workforce.

Hospice and palliative care have been facing pervasive labor shortages for years. Unfortunately, we have recently seen hospices close and heard of patient referrals being denied due to inadequate staffing. Federal action is needed to ensure that individuals with serious and life-limiting illness can continue to access quality end-of-life care in the years to come. As an organization, NHPCO has supported several legislative proposals aimed at alleviating these shortages – including efforts to improve immigration policies and make it easier for trained health professionals to work in the United States.

NHPCO is proud to have endorsed the *Healthcare Workforce Resilience Act* (S. 1024), introduced by Ranking Member Cornyn. This legislation allows U.S. Citizenship and Immigration Services to "recapture" unused work visas, enabling up to 25,000 nurses and up to 15,000 doctors to apply for visas.

Immigrants are an integral part of the health care workforce. However, current immigration processes are labor- and time-intensive, which hinders hospices' ability to recruit and retain from this workforce. Training and education pathways must be built into immigration policies. We need to renew a pathway specifically for those with a health background and training to come and work in the United States. Failing to fix our current system could result in more eligible patients dying while waiting for hospice care without enough professionals to provide it.

We are grateful for your leadership and recognition of the important role immigrants play in our health care workforce. Should you have any questions, please don't hesitate to reach out to Logan Hoover, Vice President of Policy and Government Relations (lhoover@nhpco.org).

Sincerely,

Ben Marcantonio
COO and Interim CEO

Statement of the National Immigration Law Center

Submitted to Senate Committee on the Judiciary's Subcommittee on Immigration, Citizenship, and Border Safety
"Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce"
Wednesday, September 14 at 10:00AM

Dear Chairman Padilla, Ranking Member Comyn and Members of the Subcommittee,

Thank you for holding this important hearing on a topic of importance to both immigrant communities and our health care system. The National Immigration Law Center (NILC) is the leading advocacy organization in the U.S. dedicated to defending and advancing the rights and opportunities of low-income immigrants and their families. We use litigation and policy advocacy, narrative change, and movement building, to create the cultural and political conditions so everyone can live a healthy and safe life, with dignity and respect. Through our work, we know that immigrants play a critical role in both the capacity of our health care system and in serving the health needs of immigrant communities.

Our country is facing the enormous challenge of addressing decades of failed immigration and immigrant policies, including continued healing from the brutality of immigration policy under the prior administration and its catastrophic handling of the worst global pandemic we have faced in a century. Both have caused sustained harms to our health care workforce by limiting who can enter the country and causing enormous stress on those who have worked at the front lines of the pandemic response. At the same time, barriers in law and policy have led to health disparities faced by immigrants themselves, who, when they are able to access care, often cannot find culturally competent providers. Too often the immigrants facing disparities are also those ensuring our emergency care systems don't collapse or providing long term aid for our loved ones. Therefore, for the sake of everyone's health, Congress must pass legislation to strengthen our immigrant health care workforce, and the health of that workforce, to ensure everyone can thrive.

Restrictions on Immigration Restrict Our Health Care Workforce

The Trump administration used blunt instruments to inflict harm on immigrant communities and U.S. citizens alike, reducing the number of health care workers and beyond that who were able to enter the country. Intentionally cruel and restrictive policies included the discriminatory Muslim and African bans; decimation of our refugee resettlement program, destabilizing the future of millions of people who have relied on the protections under Deferred Action for Childhood Arrivals (DACA) and Temporary Protected Status (TPS) policies, gutting legal immigration channels, bars to accessing asylum and the refugee program, and the creation of a public charge wealth test.[1] In addition to attempting to stifle immigration, the public charge rule also chilled immigrant use of health and economic support programs.[2] While it is crucial to emphasize the distinctive cruelty of the Trump Administration it is important to acknowledge that the approach of those four years was also possible because Congress has failed to seize opportunities to enact permanent solutions and protections for noncitizens.

As this hearing recognizes, immigrants play vital roles as members of our essential workforce, helping to preserve our critical infrastructure so that health care can be administered to our ailing community

[1] Shear, Michael D., "Trump and Aides Drove Family Separation at Border, Documents Say," New York Times, Jan. 14, 2021, https://www.nytimes.com/2021/01/14/us/politics/trump-family-separation.html.
[2] "Research Documents Harm of Public Charge Policy During the COVID-19 Pandemic," Protecting Immigrant Families, August 2021, https://pifcoalition.org/wp-content/uploads/2022/05/Documenting-the-Harm-2021.pdf

members and vaccines can be researched, manufactured, distributed, and administered so we can fully recover from this pandemic.[3] With an estimated 54,100 and 139,000 shortfall of needed physicians and over 500,00 nurses in the next decade, we cannot continue to let extremist forces dictate our immigration policy.[4]

Approximately one-fifth of the essential workforce responding to the COVID pandemic—22.9 million people-- is comprised of immigrants[5] Among all essential workers, regardless of immigration status or nationality, 28 percent of physicians, 24 percent of dentists, and 38 percent of home health aides, are immigrants.[6] An estimated 40% of medical scientists in pharmaceutical research and development and 40% of cancer researchers are immigrants.[7] Of the estimated 22.9 million immigrant essential workers, about five million of such workers are undocumented, and almost one million are immigrant youth or so-called "Dreamers".[8] It is estimated that 131,300 essential workers are TPS holders, who, on average, have lived in the United States for 22 years.[9] Yet, these essential workers who are helping us combat the pandemic-- at great risk to themselves and their families-- continue to live in immigration limbo, never knowing what tomorrow will bring.

Yet workers in low-paid industries, including staff in hospitals or long-term care providers, are disproportionately affected by violations of labor protection laws, with immigrant and migrant workers who have precarious immigration status experiencing higher rates of these violations.[10] When workers want to speak up about such labor violations, they fear retaliation from their employers and risk drawing the attention of immigration enforcement authorities to themselves. One study demonstrated that workers who are unwilling to complain about safety violations on the job due to immigration enforcement concerns face greater job hazards and higher workplace injury rates.[11] If we expect immigrants to make up for gaps in our health care work force and provide quality services, we need to provide them with certainty of immigration status and protection of labor laws.

We also need to expand more legal channels for people to be able to immigrate to the U.S, including and beyond allowing more immigrants destined to work in health care professions. This includes expanding

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[3] "Immigrant Essential Workers are Crucial to America's COVID-19 Recovery," FWD.us, Dec. 16, 2020, https://www.fwd.us/news/immigrant-essential-workers/.

[4] "The Complexities of Physician Supply and Demand: Projections From 2018 to 2033," American Association of Medical Colleges, June 2020, https://www.aamc.org/media/45976/download?attachment
Zhang, Ciaoming et al, "United States Registered Nurse Workforce Report Card and Shortage Forecast: A Revisit," American Journal of Medical Quality, May/June 2018, https://pubmed.ncbi.nlm.nih.gov/29183169/

[5] Center for Migration Studies (CMS), "US Foreign-Born Essential Workers by Status and State, and the Global Pandemic," https://cmsny.org/publications/us-essential-workers/.

[6] Batalova, Jeanne, "Immigrant Health-Care Workers in the United States," Migration Policy Institute, May 14, 2020, https://www.migrationpolicy.org/article/immigrant-health-care-workers-united-states-2018

[7] "Immigrants in Healthcare: Keeping Americans Healthy Through Care and Innovation," George Mason University, Institute for Immigration Research, June 2016, https://www.immigrationresearch.org/system/files/health_care_report_FINAL_20160607.pdf.

[8] "Immigrant Essential Workers are Crucial to America's COVID-19 Recovery," FWD.us, Dec. 16, 2020, https://www.fwd.us/news/immigrant-essential-workers/.

[9] Prchal Svajlenka, Nicole, and Jawetz, Tom, "A Demographic Profile of TPS Holders Providing Essential Services During the Coronavirus Crisis," Center for American Progress, April 14, 2020, https://www.americanprogress.org/issues/immigration/news/2020/04/14/483167/demographic-profile-tps-holders-providing-essential-services-coronavirus-crisis/

[10] Moyce, S. & Schenker, M., 2018. "Migrant Workers and Their Occupational Health and Safety", https://www.annualreviews.org/doi/full/10.1146/annurev-publhealth-040617-013714; Southern Poverty Law Center, "Close to Slavery: Guestworker Programs in the United States," https://www.splcenter.org/sites/default/files/d6_legacy_files/downloads/publication/SPLC-Close-to-Slavery-2013.pdf; Centro de los Derechos del Migrante, "Ripe for Reform: Abuses of Agricultural Workers in the H-2A Visa Program", https://cdmigrante.org/wp-content/uploads/2020/04/Ripe-for-Reform.pdf.

[11] Grittner ‚Amanda and Matthew Johnson, "When Labor Enforcement and Immigration Enforcement Collide: Deterring Worker Complaints Worsens Workplace Safety", January 2, 2021, https://drive.google.com/file/d/1VUv-XPrsvJCPPOo27Yqqs26XhVtZjtrg/view

our family-based immigration system, the diversity visa program and refugee and asylum programs, as well as employment-based avenues for those seeking to immigrate to the U.S. for work. Family unity and reunification is crucial to promoting the health and well-being, integration and long-term stability of families and communities, as is ensuring a robust workforce that can address the needs of our country and economy. Existing policies have left over 4 million people stuck in a backlog and facing unconscionably long wait times to reunite with their family members or receive employment visas.[12] We also believe that legislation removing immigration barriers for health care workers should focus on the spectrum of health work, not solely highly educated specialty providers.

As we work to strengthen our health care system through increased immigration, we should also ensure we do not perpetuate stigmatizing patterns of the past, such as the complex history around Filipino nurses who make up a disproportionate share of nursing roles and were targeted for recruitment to make up for gaps in the health care system but subsequently have faced racism and health disparities.[13] Congress must ensure that immigration reform legislation creates full pathways to citizenship for new immigrants, does not restrict their ability to benefit from public assistance programs or otherwise treat immigrant workers simply as bodies to put on the frontlines.

Immigrant Health Care Workers Are Critical for Serving Growing Immigrant Communities

Immigrant health care workers are important not only to help fill large gaps in our health system, but because they can be vital sources of culturally competent care for the ever-growing diversity in this country. Immigrants experience stark disparities in health care outcomes and a health care workforce that can share and understand their experiences is an important component of achieving health equity. If immigrant health care workers experience high uninsured rates or worse health care outcomes, our health care system suffers as well.

Despite constituting 13.7% of the U.S. population, immigrants face extreme barriers to accessing the basic needs and health care programs their tax dollars pay for.[14] Green card holders authorized to live in the United States permanently face a waiting period of five years without access to crucial health care and economic supports. DACA recipients, TPS holders, and most other non-naturalized immigrants are entirely ineligible for most federal benefits programs.[15] Because of these exclusionary policy decisions, immigrants are uninsured at substantially higher rates than the U.S.-born. Among lawfully present immigrants, 26% are uninsured, compared to nine percent of U.S. citizens. For undocumented immigrants, the uninsured rate rises to 42%.[16] Even U.S. born citizen children of immigrants are uninsured at twice the rate of their peers.

Many immigrants face unique health challenges because of their immigration status. Children suffer lifelong trauma and associated health consequences when their parents are deported.[17] One report of COVID contact tracing efforts in San Diego found that fear of immigration enforcement spurred Latino's

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[12] "Annual Report of Immigrant Visa Applicants in the Family-sponsored and Employment-based preferences Registered at the National Visa Center as of November 1, 2021," U.S. Department of State, November 2021. https://travel.state.gov/content/dam/visas/Statistics/Immigrant-Statistics/WaitingList/WaitingListItem_2021vF.pdf

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[15] Overview of Immigrant Eligibility for Federal Programs, National Immigration Law Center, updated October 2021, https://www.nilc.org/wp-content/uploads/2015/11/tbl1_ovrvw-fed-pgms.pdf.

[16] "Health Coverage of Immigrants," Kaiser Family Foundation, April 8, 2022, https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/.

[17] Farhang, Lili; Heller, Jonathan; Hu, Alice; and Satinsky, Sara, "Family Unity, Family Health: How FamilyFocused Immigration Reform Will Mean Better Health for Children and Families," June 3, 3013, https://humanimpact.org/wp-content/uploads/2017/09/Family-Unity-Family-Health-2013.pdf

refusal to participate.[18] Latino high school students report depression, anxiety and symptoms of post-traumatic stress disorder out of fear that they or a family member will be deported.[19] It is especially concerning that, because of the barriers they face, immigrants may struggle to access COVID vaccines, despite promises that they should be available regardless of immigration status.[20] These differences in access to health and basic needs programs contribute to disparities in health outcomes, especially racial health disparities considering the high percentage of immigrants within communities of color.[21]

Health care workers who understand these experiences because they or their communities share them can provide more culturally competent care in response. Research shows that patients prefer doctors who share their demographic background.[22] Having a doctor with a shared background also improves a variety of medical indicators for many patients, but the lack of a diverse health care workforce presents challenges in achieving this as an option for many people.[23] These findings carry over to immigrants, who benefit from having a doctor who can understand their experiences.[24] 44% of Hispanics say that a major reason that their community has worse health care outcomes is because of communication problems from language and cultural differences.[25] As the proportion of immigrants in our population increases, we need a diverse workforce to match their needs.[26]

Conclusion

Our under resourced health care system and immigrant communities depend on the ability of immigrant health care providers and workers to thrive. Yet, between our restrictive immigration laws and punitive barriers to health care for foreign born people, current policy only makes things worse. More than a third of health care workers who died in the first year of the pandemic were born outside of the United States.[27] Research shows that when doctors are forced to provide inequitable care to immigrants, their burnout is accelerated.[28] Congress must take swift action by passing truly inclusive, people-centered and effective legislation that will put people on a fair path to citizenship and repeals restrictions on immigrants' ability to address their own health needs.

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[19] Capps, Randy etl al, "Immigration Enforcement and the Mental Health of Latino High School Students," Migration Policy Institute, September 2020, https://www.migrationpolicy.org/research/immigration-enforcement-mental-health-latino-students

[20] Semotiuk, Andy, "Immigrants Slow To Get Covid-19 Vaccine As Impediments Block Their Access," Forbes, September 1, 2021, https://www.forbes.com/sites/andyjsemotiuk/2021/09/01/immigrants-slow-to-get-covid-19-vaccine-as-impediments-block-their-access/?sh=60d115755333

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SIH

Administration
t 618.457.5200
f 618.529.0568

Attention:
Subcommittee Chair Alex Padilla
Ranking Member John Cornyn
Chairman Dick Durbin
Ranking Member Chuck Grassley

Senate Subcommittee on Immigration, Citizenship, and Border Safety in the Senate Judiciary Committee

Statement Submitted by Rex Budde, President and CEO
Southern Illinois Healthcare

September 14, 2022

Thank you Subcommittee Chairman Padilla, Ranking Member Cornyn, Chairman Durbin and Ranking Member Grassley, and all the members of the Subcommittee on Immigration, Citizenship, and Border Safety in the Senate Judiciary Committee for holding this most important hearing. On behalf of Southern Illinois Healthcare (SIH) we wish to express our deep appreciation for the privilege of presenting the profound impact our system has and continues to experience relative to the issue of healthcare workforce shortages.

The Mission of SIH is to improve the health and well-being of all the people in the communities we serve. For the first time in my 22 years at SIH, that Mission is in jeopardy. SIH is also one of the largest employers in the region. We have over 4,000 employees at SIH. Beyond our medical mission, the salaries our employees earn are a critical economic resource for the area.

I thought it important to provide an update on where we stand, as we work to meet the financial challenge before SIH. First, a reminder as to why we are in this situation. Last year the staffing agencies manipulated the pandemic to create huge profits for themselves by raising rates up to 300%. They then aggressively recruited away from providers a large quantity of staff, mostly nursing. This action has significantly raised the operating expenses for providers.

The burden created by the exorbitant staffing costs and the nursing shortages, along with significant increases in the costs of supplies has crippled SIH's financial performance. This is made all the more difficult because SIH takes care of all who ask for help. I am proud of the fact we do not pick and choose based upon a patient's ability to pay for their care.

Our Operating Performance is as follows (March 31st Fiscal Year):

	Initial Budget	Thru July	Year End Projection w/o improvements	Year End Projections with improvements
Hospital Corp.	$(23,456,000)	$ (2,528,000)	$ (4,337,000)	$ 18,277,000
Physician Corp.	$(65,572,000)	$(20,283,000)	$(60,284,000)	$(57,273,000)
SIH TOTAL	$(89,028,000)	$(22,811,000)	$(64,621,000)	$(38,996,000)

SIH has done the following to help offset the increase in costs and improve financial performance:

- Reduced agency from over 200 to 97 agency nurses currently in use
- Closed beds to reduce need for agency staff
- Received various grants from FEMA and other agencies
- State of Illinois granted a Provider Tax holiday of 3 months
- Reinstituted 340B at Harrisburg Medical Center
- Work on improving departmental productivity
- Wage freeze for all staff
- Reductions in premium pay programs to staff for extra shifts
- Contract Revisions for employed physicians
- Reviewing overhead costs for reductions
- Reviewing all supply contracts for savings
- Placed on hold $200 million dollars in construction projects

We are making progress but have more to do in reaching our goal of restoring financial profitability at SIH. We have dropped our budgeted losses from $89 million dollars to $39 million dollars. We continue to review all avenues to further improve and stabilize our finances.

We currently have 248 open nursing positions and are exploring many opportunities to improve recruitment. We have developed a scholarship program for students with bachelor's degrees to pursue the Southern Illinois University of

Carbondale accelerated BSN program. We also closely work with our Community Colleges to help them expand their nursing programs. However, recruitment continues to remain a daunting challenge, especially in our rural area. One challenge the Committee must discuss is how to support developing more nurse educators. Nursing schools struggle with having enough faculty as they cannot match the pay rates qualified nurses can earn outside of education.

Please understand, closing beds, which we were forced to do, is not part of our Mission. Southern Illinois is not an affluent area and SIH is a critical provider of healthcare services for our region. We have also had to put aside large construction projects that would have employed hundreds of laborers to build the new facilities. These are unprecedented actions we have had to take and are very frustrated that we are forced to make this decision instead of focusing our efforts on the needs of the communities we serve.

I am aware that the Committee is looking into several pieces of legislation that will help address workforce shortages. The Healthcare Workforce Resilience Act along with the Conrad State 30 and Physician Access Reauthorization Act will help healthcare providers access critically needed staffing. **Please continue to assess the condition of healthcare providers to help us avoid a true collapse in the ability to care for patients**.

I deeply appreciate the opportunity to provide some insight as to the difficult challenges facing SIH. Please let me know how I might be of service as we work together to solve these difficult challenges.

UpwardlyGlobal

A Resource for Skilled Immigrants.
An Opportunity for America.

New York
505 8th Avenue, Suite 1704
New York, NY 10018
T: 212.219.8828 F:
646.417.5517

"Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce"

September 14, 2022

Upwardly Global (UpGlo) commends the Judiciary Committee for holding a hearing during this critical time for our country's healthcare system. UpGlo is the first and longest-serving organization focused on advancing the meaningful inclusion of immigrants and refugees who have international credentials into the U.S. workforce. With offices in four major cities, UpGlo works with thousands of job seekers across the country every year to support their full inclusion in the U.S. workforce. Our work with immigrant and refugee medical professionals guides this statement.

In all of the Committee Members' states, there are communities experiencing lack of access to healthcare due to the shortage of physicians and nurse practitioners. It is projected that by 2033, the United States will be 139,000 physicians short of the needed amount.

There is particularly a need to meet healthcare demands in underserved communities, including immigrant communities and other communities of color. Under COVID-19, hospitalization rates amongst Black and Hispanic communities across the U.S. were at least double the national average, and death amongst the older Black and Hispanic population were two times as high as the non-Hispanic white population.

While the demand for physicians is high, the United States does have the resources to meet this need, in the form of work-authorized immigrant and refugee professionals who are in the U.S. but have been trained abroad. There are 2.3 million recently-arrived, college-educated immigrant and refugee professionals in the U.S. today with degrees in high-demand fields like technology, administration, healthcare, and other skilled professions; 165,000 are internationally-trained medical professionals who are unemployed or severely underemployed.

We are underutilizing this talent.

Most of these medical professionals are sidelined due to licensing rules that fail to recognize their expertise and require costly and time-consuming examinations and residencies. UpGlo has worked to address these limitations and provide support for medical professional through the following avenues:

1. Encourage Establishment of Paid Internship and Returnship Programs
Together with New York-Presbyterian, one of the largest academic medical centers in the country, Upwardly Global has co-designed and launched a paid, mid-career internship program to on-ramp internationally-trained immigrants into open roles in the healthcare sector. The model addresses staffing needs with a new, diverse pool of talent; equips our medical system to have a greater, more equitable impact on health access and outcomes in under-served communities; and offers alternative career pathways for immigrants with international credentials and experience.

2. Highlight and Encourage Improved State Licensing Laws
Upwardly Global is also working with legislators, regulators, healthcare providers and grassroots and national organizations in several states, including Washington and Illinois, to make it easier for immigrants and refugees eager to share their talents and skills. Recently, this has taken the form of urging states to ease restrictions and allow internationally-trained medics to serve during the COVID-19 pandemic. Licensing reform should be supported in tandem with critical local actors and hospitals.

3. Fund community based organizations that support training, relicensing and connections to employers
There are Offices of New Americans in many cities around the country that should be funded with the mandate to support immigrants and refugees who come to the U.S. with international healthcare credentials. We are working with ONA in New York State on their Pathways program in a direct service and capacity building role – a model program to this end. Critical federal agencies should also direct funding to this group of largely invisibilized immigrants and refugees. We are working with the Office of Refugee Resettlement right now to support Afghans with international credentials – an example of targeted focus.

Although these initiatives have significantly improved opportunities for immigrant and refugee medical professionals and have helped to ease the burden on the healthcare system in certain states, more work can and needs to be done on the federal level. By taking these critical steps, we can ensure that thousands of immigrant and refugee physicians are able to contribute their skills and talents while simultaneously addressing the physician shortage in underserved communities and across the United States.

Rebecca Neuwirth
Executive Vice President
Upwardly Global

Statement of World Education Service (WES) and the Refugee Advocacy Lab

Submitted to the Committee on the Judiciary, Subcommittee on Immigration, Citizenship, and Border Safety

Hearing, Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce

About World Education Service and the Refugee Advocacy Lab

World Education Services (WES) is a non-profit social enterprise dedicated to helping international students, immigrants, and refugees achieve their educational and career goals in the United States and Canada. Through WES Global Talent Bridge, the organization joins with institutional partners, community-based organizations, and policymakers to help immigrants and refugees who hold international credentials fully utilize their talents and education to achieve their academic and professional goals. Through its grantmaking, impact investing, and partnerships, the WES Mariam Assefa Fund seeks to advance economic and social inclusion for immigrants and refugees.

The Refugee Advocacy Lab is an initiative hosted at Refugees International and co-founded with the International Refugee Assistance Project (IRAP), International Rescue Committee (IRC), and Refugee Congress. The Lab's mission is to grow the movement for U.S. leadership on refugee protection and inclusion. We do so by developing strategic communications resources; championing inclusive policies; and advancing the field through diverse partnerships, capacity building and refugee leadership development.

Immigrant and Refugee Health Care Professionals Alleviate Shortages

A growing body of research reveals that the COVID-19 pandemic disproportionately impacted immigrant communities and communities of color, exacerbating critical health care shortages and long-standing disparities in access to health care in the United States.

The U.S. faces a mounting shortage of health workers. Simultaneously, thousands of internationally trained immigrant and refugee health workers are impeded from working in their professions. The Bureau of Labor Statistics estimates that each year through 2030, there will be nearly 195,000 vacancies for registered nurses.[1] The Association of American Medical Colleges

[1] "Registered Nurses : Occupational Outlook Handbook." U.S. Bureau of Labor Statistics. U.S. Bureau of Labor Statistics, September 8, 2022. https://www.bls.gov/ooh/healthcare/registered-nurses.htm.

projected that "physician demand will grow faster than supply, leading to a projected total physician shortage of between 37,800 and 124,000 physicians by 2034."[2]

A pipeline of qualified health workers stands ready to join the U.S. health workforce. The Migration Policy Institute (MPI) estimates that there are 263,000 immigrants and refugees with health-related degrees in the U.S. who are currently underemployed or unemployed. More than 6 in 10 of these individuals are internationally educated.[3]

Unnecessary Barriers Prevent Workforce Reentry

Despite their extensive international health care training and clinical experience, immigrant and refugee health workers who earned credentials in another country often face daunting obstacles to reentering the workforce. These highly qualified workers are unable to practice in their fields in the U.S. without meeting requirements that are onerous, time-consuming, and expensive—and in some cases unrelated to their competency. Health workers who obtained their credentials in another country often have to repeat years of graduate medical training. They also have to undergo lengthy and costly credential evaluation processes, and meet English language proficiency requirements that do not reflect the language skills needed on the job.

In the U.S., eleven states[4] have taken steps to meet critical workforce needs by addressing these barriers and providing alternative pathways to practice that recognize credentials earned abroad. Similarly, in Canada, some provinces provide pathways to licensure for eligible International Medical Graduates through competency-based assessments.

Lubab Al-Quraishi and Rona Inayat

Lubab Al-Quraishi graduated from a top medical college in Baghdad, Iraq, and worked as a licensed pathologist for 18 years, saving countless lives until her own security was threatened. In 2014, she resettled with her family in the United States. Seeking safety cost Lubab her career: Barriers to licensure, including time-consuming and costly medical exams and clinical training, prevented Lubab from rebuilding her medical career. To support her family, she took a job at a restaurant.

In 2020, New Jersey granted Lubab a temporary medical license that allowed her to support the state's COVID-19 pandemic response by caring for patients in a nursing home. However, the license has since expired. Lubab now works as a pathologist's assistant. Lubab detailed her story in a recent article.[5]

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[5] Al-Quraishi, Lubab. 'Cheap Labor': If Refugee Physicians Can Be Given Temporary Licenses During Covid Then It's Time to Recognize Overseas Doctors' Training. Period." July 30, 2021. https://americanmuslimtoday.com/details/ae89d0d8-0c03-4cf9-bc64-cd51ee008799.

Rona Inayat worked for three years as a nurse in Afghanistan before completing a medical degree and practicing as a physician for two years. When ongoing political instability threatened her security, Rona moved to Kabul, where she worked with both the United Nations and USAID. She resettled to the U.S. three years ago, but systemic barriers to licensure have prevented her from working as a physician. Limited recognition of her credentials and experience from Afghanistan mean that she needs to repeat her education and training to practice medicine in Washington State.

Rona is taking steps to rebuild her career in health care. She has worked as a medical interpreter and a patient care coordinator intern. She recently completed coursework to become a medical assistant and phlebotomist, and works part-time while studying to earn an associate degree in the U.S.

Equity and Inclusion Lead to Improved Health Care Outcomes

Policies that ensure equity and inclusion for immigrants and refugees in the U.S. health care workforce will not only break down barriers to employment for qualified health workers, but also address inequities in the country's health care system.

Studies show a direct correlation between a health care system that reflects the ethnic and racial backgrounds of patients and improved health outcomes. Patient-provider concordance, or patients being treated by providers of the same skin color and cultural background, results in statistically significant improvements in patient treatment and recovery.

However, the 2020 U.S. Census revealed that while just 58 percent of the U.S. population is White (non-Hispanic), more than 68 percent of current registered nurses are White. Additionally, only 5.8 percent of doctors identify as Hispanic versus 18.5 percent of the general population, and 5 percent of doctors identify as Black versus 13.4 percent of the general population, leaving those communities with very few options for concordant care. Immigrants and refugees with backgrounds in health care are well positioned to help address these disparities, offering in-demand skills, multilingual abilities, and cultural competence.

Federal Legislation Can Address Barriers to Entry

Action is critical. As policymakers work to bolster the health care workforce in the U.S., it is imperative to ensure that immigrant and refugee health workers have access to equitable and inclusive career pathways.

We urge the Senate to introduce companion bills for the Immigrants in Nursing and Allied Health Act of 2022, the International Medical Graduate (IMG) Assistance Act of 2022, and the Professional's Access to Health (PATH) Workforce Integration Act of 2022. These bills would help alleviate health care workforce shortages across the country and reduce employment barriers for immigrants who want to work in the healthcare field.