

The Honorable Tommy Thompson  
Secretary  
Department of Health and Human Services  
200 Independence Ave, S.W.  
Washington, DC 20201

The Honorable Kevin Rooney  
Acting Commissioner  
Immigration and Naturalization Service  
425 I St. NW  
Washington, DC 20536

Dear Secretary Thompson and Commissioner Rooney:

We are deeply concerned that the immigration laws be administered in a manner that maximizes the availability of health care to all Americans, particularly with respect to occupations for which there is a notable shortage and with respect to Americans living in medically underserved areas. We therefore ask that HHS and INS work together to ensure that the agencies' regulations and processes do not contain administrative roadblocks to the admission of health care professionals who can help to alleviate these critical shortages.

### **Nurses**

As has been widely publicized, the U.S. is facing a shortage of professional nurses approaching crisis proportions. While there is a mechanism in place for the immigration of qualified nurses from overseas, it has proven unuseable because of the way in which it is administered. The mechanism involves the filing of an immigrant petition by a health care facility, followed by a lengthy "visa screen" process overseas before the nurse can gain admission to the U.S. The combined effect of these two steps has been a trail of red tape for nurses that stretch one or two years or more. In a time of such critical shortage, that kind of delay is unacceptable.

Therefore, we urge that the INS take the following steps to ensure that nurses are able to enter the U.S. and begin work on a timely basis:

- a. *Process "Schedule A" immigrant petitions for health care workers on a priority basis.* These petitions should routinely be processed within 30 days of the date that they are properly filed. In no event should processing take longer than 90 days from the date of filing.

- b. *Move the visa screen process from being handled overseas to being handled within the adjustment of status process.* This can be achieved by granting parole, based on significant public benefit, under INA section 212(d) (5) to any nurse (and the nurse's spouse and children) for whom an immigrant petition has been approved and who is admissible to the U.S. but for the provisions of INA section 212(a)(5)(C). The alien should then be given work authorization and the opportunity to apply for adjustment of status, a process in which the section 212(a)(5)(C) visa screen requirements can be completed.

Because the documentation of nursing competence that is part of the visa screen is redundant with the documentation of nursing competence required for an immigrant petition to be approved, the protections for patients would be intact while the nurse is working under parole status. This step would not eliminate the visa screen, which still must be completed prior to a nurse obtaining permanent residence. Rather, the step would just mean that a nurse, whose qualifications have already been demonstrated as part of the immigrant petitioning process, can actually be in the U.S. helping patients while this lengthy part of the paperwork process is being completed.

### **Physicians working in underserved areas**

We also are very concerned about the regulations issued by INS to implement the Nursing Relief for Disadvantaged Areas Act of 1999 (Pub. L. 106-95, 113 Stat. 1312), which amended the waiver of job offer provisions of §203(b)(2)(B) of the INA for physicians working within designated medically underserved areas. That legislation was passed to facilitate the employment of immigrant physicians to alleviate doctor shortages in underserved areas. We were therefore quite disappointed to see regulations that seem to be trying to limit the use of the law by imposing much more restrictive rules than were contemplated by the legislation. The following are concerns we have with the new regulations:

- a. *The statute very clearly states that the national interest waiver ("NIW") provisions should apply to ALL physicians.* The regulation, however, restricts NIW provisions solely to primary care physicians. The restriction solely to primary care is an unwarranted, unacceptable contradiction of the statutory language, and is built around a misunderstanding of the meaning of HHS statistics on underserved areas. While HHS may gather its statistics regarding underserved areas based on the presence of primary care physicians, that does not mean that only primary care physicians fall under this law.
- b. *The regulation's double compliance filing system is unwieldy and unnecessary.* Under the regulation, the physician needs to make an extra filing at the two-year mark indicating employment in a medically underserved area and then another duplicate filing at the five-year mark. Had Congress wanted this double filing system, we would have so stated, as we did with marriage-based cases and investors. The current system adds considerable burden to all parties without advancing the aims of the legislation's provisions.

- c. *The INS is incorrectly restricting the "grandfathered" cases that qualify for the three-year service obligation.* The statute simply states that a case should be grandfathered for the three-year service obligation if the case was filed prior to November 1, 1998. The Service has basically gutted this provision by restricting this provision to cases filed prior to November 1, 1998 and still pending on November 12, 1999.
- d. *The regulation impermissibly restricts the issuance of a "public need" statement to the centralized State Department of Health.* On the contrary, Congressional intent was to include departments of public health in a state, which could well exist at the county or the municipal level, in this process. Again, this specific designation in the regulation to the State Department of Health runs counter to the statutory language, which reads "department of public health in any State". It also ignores the role of a local or county department of health in assessing local healthcare needs.
- e. *The regulation introduces a requirement that the public interest attestation from a Federal agency or a "department of public health" be issued within six months of the filing of the NIW.* There is no such six-month period stated or implied in the Statute. (In contrast, Congress specifically stated that a physician who receives a waiver needs to start work in the petitioning facility within 90 days.) The result of this six-month rule is that it almost invariably eliminates the ability to use the public interest statement which was included in the J-1 waiver application as part of the NIW petition since more than six months usually lapse between waiver submission and NIW submission.
- f. *The regulation impermissibly requires a Federal agency recommending a public interest statement to attest to the practice capabilities of the foreign physician.* There is no such personal attestation requirement from a "department of public health in any State". Unquestionably, it is important that the physician be qualified to practice medicine, but these types of documents are normally issued by the licensing authorities of the states and by the certification procedures of the American Boards of Medicine. It is unreasonable to expect a Federal agency to have a personal knowledge of a physician's practice capabilities and it is furthermore unnecessary given other more appropriate sources for determining a physician's practice abilities. The Federal agency unquestionably has a role in weighing in on its belief on the need of a physician to work in a given area or practice opportunity. However, such an Agency has no experience or role in judging a physician's substantive practice capabilities.

We urge that these roadblocks to effective immigration to alleviate health care shortages be removed, and ask the agencies involved to work together to this end on an immediate basis. Thank you for your attention to these important issues.

Sincerely,