Assessment of the Arizona Department of Health Services
Bureau of Health Systems Development Administration of
the Conrad 30 J-1 Visa Waiver Program

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Introduction:

The expanding population of the United States, augmented by the growing challenge of recruiting and retaining physicians, has created a major problem in many U.S. communities. The population demographics of this nation have changed significantly over the last century due to changes in economic and agricultural practices—these changes have created a robust set of challenges for the face of healthcare (Taylor and Martin, 2001). Far too many rural and inter-city communities have experienced, and continue to experience, a massive deficiency in the number of primary care physicians per person (Cross, 2007).

Communities that have too few healthcare practitioners are defined as being “medically underserved” by one or more of the following federal designations: Health Professional Shortage Area (HSPA), Medically Underserved Area (MUA), or Medically Underserved Population (MUP). In 1994, federal legislation was passed as an attempt to combat the growing physician shortage by initiating the Conrad State 30 Program. Under this law, each of the 50 U.S. states would be provided with up to 30 J-1 Visa Waivers (from the U.S. State Department) to place International Medical Graduates in federally designated underserved locations.

An International Medical Graduate (also known as a Foreign Medical Graduate or FMG) is lawfully allowed to pursue his or her graduate medical training (i.e. residency, fellowship, or specialty training) in the United States with a State Department authorized J-1 Visa. These physicians are graduates of undergraduate medical schools outside of the U.S. and do not have full citizenship; however, the J-1 Exchange Visitor Visa allows them to “by-pass” typical immigration laws in order to lawfully pursue and obtain graduate medical training in the U.S. Upon completion of graduate medical training, the physician is expected to return to his or her
home country for two years before applying for a permanent visa in the U.S. With a J-1 Visa Waiver, the requirement of returning to the physician’s home country for two years is waived. Although specific regulations and conditions of the waiver vary by State, the physician is required to practice in a federally designated HSPA, MUA, or MUP. Prior to the authorization of waivers by the U.S. Department of State, the requesting state or an alternate sponsored U.S. government agency determines how to manage and sponsor their 30 physician applicant slots.

This report will address a number of issues relating to the J-1 Visa Waiver Program. It will begin by commenting on the growing need for the J-1 Visa Waivers and how policies that address healthcare workforce shortages can impact communities. Next, an overview of the Arizona Bureau of Health Systems Development Workforce J-1 Visa Waiver Program recruitment efforts will be provided. Additionally, a synopsis of the current legislation on the Federal and State-level codes and statutes will be presented. Finally, this information will be compiled to provide future policy recommendations that may be considered to improve efficiency, address potential problems, and better serve those Arizonans that are in most need. An overview comparison of the efficacy and characterizing elements of the J-1 Visa Waiver Program as it is administered in Arizona and 25 additional states, with similar population dispersion characteristics, is also found in the appendix.

**Healthcare Workforce Shortages and Community Needs:**

**What is a HPSA?**

According to the federally designated Health Professional Shortage Area criteria, a community must: “be a rationally-fit location to deliver health services; have a population-
provider ratio greater than a predetermined threshold; and healthcare resources in surrounding areas must be unavailable because of distance, overutilization, or access barriers.” The specific determination of “community size” and population-to-provider ratio threshold varies from program to program. In Arizona, an area with a population-to-provider ratio of 3,000 persons per physician is considered “high needs.” Federally, the shortage designation lies at 2,000 persons per physician, 3,000 persons per dentist, and 10,000 persons per mental health provider. Given the Federal criteria, there are 65 million people living in 6,204 different primary care HPSAs; these HPSAs would require 16,643 primary care practitioners to meet the need (HRSA.gov, 2009).

Figure 1: Arizona HPSA designations (February 2010); courtesy ADHD Bureau of Health Systems Development
Does a HPSA classification fully address the needs of the community?

The HPSA alone is a wonderful tool; however, when policies are at stake and large fiscal budget distributions are determined by a “needs algorithm,” the HPSA may be considered to be oversimplified. Many States, local health departments, and government entities have developed a more schematic approach for determining which populations are “medically underserved.” Arizona employs the Arizona Medically Underserved Area (AzMUA) designation, which consists of the totaled score for each Primary Care Area of 14 weighted items (ranging from transportation scores to infant mortality scores) to equal a Primary Care Index. A robust index, such as the Primary Care Index, provides a more comprehensive measure of need and provides policy makers with a stronger assessment tool. As the AzMUA closely aligns with HPSA designations in Arizona (a federal requirement for administration of the J-1 Visa Waiver Program), ADHS should consider frequently consulting AzMUA PCAs in order to ensure that communities most in need are receiving the support of a J-1 physician.

Figure 2: AzMUA designations (February 2010); courtesy ADHS Bureau of Health Systems Development
Where are HPSAs?

There are several HPSA clusters located within the urban regions of Arizona; however, a large portion of HPSAs lie in rural areas. Although there are many different definitions to describe “rurality,” there is clear evidence that rural communities are underserved. Although 21 percent of the U.S. population lives in rural areas, only 11 percent of physicians practice there (U.S. DHHS, 1996). For many reasons, rural communities tend to lack the medical support system that urban areas have. Namely, rural communities find it difficult to attract and retain physicians.

Why is rural different?

Over 200 years ago, the U.S. was founded during agrarian colonial times when rural places were generally thought to be more healthy than urban ones; however, changes in infrastructure, agriculture, politics, and economics have shifted the demographics of the U.S. from a rural existence to one that is dominated by urban living (Geyman et al, 2001). Over the next 40 years, the U.S. population is expected to go from 305 million to 364 million, but the rural population will go from 50 million to 38 million, thus dropping to 9.6 percent of the U.S. population (UN Population Division, 2007). This out-migration has already led to significant disparities among rural populations. Current data shows rural residents are slightly older (with 18% enrolled in Medicare compared to 15% in urban areas) and with lower income (with an average per capita income of $19,000 compared to $26,000 among the urban population) than urban segments of the population (Klugman and Dalinis, 2008). In general, rural (presented as nonmetropolitan classification of less than 50,000 residents) populations are poorer, have higher
unemployment rates, and are less educated than metropolitan populations (Ricketts, 1999; Baugher and Lamison-White, 1996; ERS, 1997; Day and Curry, 1996).

In addition to socioeconomic factors, people in rural communities tend to have overall poorer health than their urban counterparts. They are more likely to have chronic or life-threatening disease and to face significant mental health issues, including substance abuse and seasonal affective disorder (Roberts et al, 1999; Bushy, 1994). The rural population also has a higher proportion of residents who require more health services and has a higher proportion of environmental and occupational hazards; additionally, rural communities experience higher rates of infant mortality and suicide (National Center for Health Statistics, 2001; Roberts et al, 1999).

Why are there not enough physicians practicing in rural areas or HPSAs?

Decades ago, when health officials first began to notice the disparities in rural and underserved communities, they believed the answer was to build health centers and physicians would be attracted to practice in rural areas (Starr, 1982). Unfortunately, researchers and policymakers alike have found that filling the provider shortages in rural and underserved communities is more complex than simply building hospitals and clinics (Klugman and Dalinis, 2008). In fact, the opposite has happened. Not only has the shortage not been reduced, but over the past 30 years the number of rural hospitals has decreased; resulting in fewer hospital beds and less tertiary care medicine available to rural communities (Ricketts and Heaphy, 2000).

For many physicians, the rural and/or underserved practice environment is not an attractive option. The rural physician works longer hours and has more patients, more rural physicians are general practitioners than their urban counterparts, and they make less money (AMA, 1996; Frenzen, 1996). Clinics in rural and underserved areas often lack many of the
resources that urban-hospital trained physicians may expect—medical equipment, technology, physician support teams, and prompt access to specialist consultation are commodities that are often unavailable in these settings (Klugman and Dalinis, 2008).

The vast majority of both undergraduate and graduate medical training takes place in large urban teaching hospitals—this education model does not encourage students to pursue practice in rural or underserved communities. Receiving training in a high-tech, high-resource environment results in students less willing to practice in environments that lack this infrastructure. The reduction is graduate medical education funding and creation of much less fiscally favorable rural health delivery scene is likely to cause some rural providers to leave rural practice and new graduates to avoid rural towns (Geyman et al, 2001).

The high price tag of medical education, combined with the perceived excitement of practicing in a medical sub-specialty, has resulted in fewer graduates entering primary care—the branch of highest need in most HPSAs. Despite the rapid population growth that has occurred, the number of U.S. medical graduates has not increased significantly to keep up with the demand. Rural physicians are also faced with financial challenges—while the nation’s largest towns and cities have health care safety nets of publicly subsidized clinics and hospitals, most small rural towns do not have any publicly funded health centers; thus, much of the safety net is an informal one of private practitioners who give away care to the medically needy (Geyman et al, 2001).

Fewer physicians decide to practice in rural areas can be attributed to personal and family reasons. The increasing numbers and percentages of medical school graduates who are female has presented a challenge, as women physicians are significantly less likely to locate in rural locations than their male counterparts (with the smaller the town the less likely to locate there)
(Doescher et al, 2000). Additional deterrents, for both males and females, are often the challenge of finding reasonable employment for a spouse and desirable school systems for children.

**What can the J-1 Visa Waiver provide?**

The J-1 Visa Waiver has the capability of filling the gap. There is a well documented shortage of physicians, especially primary care providers, in rural and inter-city HPSAs. These communities are experiencing significant health disparities because of shortages—these disparities will continue to be exasperated as long as current demographics continue as projected. Meanwhile, there are many FMGs that are eager to begin practicing in the U.S. immediately after completing graduate medical training. The J-1 Visa Waiver places highly trained physicians in underserved communities which helps to provide access to care for thousands of people each year.

![Figure 3: Practice Settings for J-1 Physicians in Fiscal Year 2005(GAO, 2006)](image)
Arizona Department of Health Services: Bureau of Health Systems Development J-1 Visa Waiver Program:

What is ADHSs role in the process?

In Arizona, the J-1 Visa Waiver Program is administered by ADHS Bureau of Health Systems Development. This office handles the entire process: from determining and managing Health Professional Shortage Areas and/or Medically Underserved Area/Population designations to reviewing submitted applications and sponsoring J-1 physicians for U.S. Department of State approval. For an interested physician or facility, nearly everything can be accessed from the webpage: http://www.azdhs.gov/hsd/visa_waiver.htm.

How does the ADHS administration of the J-1 Visa Waiver Program compare to other states?

In compiling this report, the J-1 Visa Waiver Programs of 26 states where reviewed and compared to strategically assess a best practices criteria. Comparisons are based on criteria such as: projected ease of use for provider/facility, clarity of procedure, rules and guidelines, and policy framework. Under these criteria, the ADHS J-1 Visa Waiver Program is one of the best reviewed. The website is very easy to use and clearly directs physicians and facility representatives to any resources necessary to the process; overall, the ease of use ranks at approximately number three out of 26. The clarity of the process is very strong with all requirements clearly outlined in a step-wise manner and important points made with “bold or underlined” designations; clarity ranking is at least in the top five because little room is left for ambiguity. Rules and guidelines are extremely important to any J-1 Visa Waiver Program as they should be thorough, encompassing, and provide guidance for “what-if” scenarios; however, they must also be concise and avoid an overly bureaucratic process that deters valuable applicants.
The ADHS rules and guidelines rank in the top ten of surveyed states because they are specific, and structured to avoid abuse/fraud, but still clear, and free from discouraging bureaucracy. Lastly, the policy framework within the ADHS program is a definite strong point, again because of the clear and efficient rules and guidelines. Although not much can be deciphered from a limited analysis of policy framework it is difficult to rank the Arizona policy compared to other states; however, states such as Idaho and Oregon with J-1 Visa Waiver Program Statutes have the easiest, least ambiguous policy framework.

What are the basic guidelines to the J-1 Visa Waiver Program in Arizona?

In addition to following the federal codes and statutes pertaining to the J-1 Visa Waiver (as outlined in the following section), Arizona has specific guidelines that are followed to effectively administer the program. The application cycle begins each year on October 1st and closes on November 30th (the cycle will be reopened at a later date if there are still slots to be filled). At least 22 slots are designated for primary care physicians or psychiatrists and up to seven slots are available to specialists (with one slot open to be used at the discretion of ADHS). Each service site is limited to two approved J-1 physicians per site per year. Service sites must include in contract the contains a “Non-Compete Clause,” three-year 40 hour min./week agreement, and an agreement that the contract will not be changed or amended for entire three-year period. Fully completed applications are reviewed and scored based off a provided rubric, with ADHS being granted full discretion as to which applications are selected for approval. Decisions are typically made within 10-12 weeks of the closing of the application cycle. If approved the physician must begin full time employment within 90 days of receiving waiver.
Although there are more specific logistical requirements, this outlines the basic process and guidelines.

**National Rules and Statutes:**

The J-1 Visa can be obtained by a non-citizen in any one of the following categories: physician, professor & research scholar, trainee, international visitor, government visitor, college & university student, and short-term scholar. The J-1 Visa program is administered by federal Department of State and Department of Homeland Security’s Citizenship and Immigration Services (USCIS) and allows FMGs to come to the U.S. under an educational exchange program for up to seven years. Upon expiration, the physician must return to his or her home country for at least two years before applying for a permanent U.S. visa. These policies are outlined in the Immigration and Nationality Act Section 212(e). The U.S. Department of State does require a lengthy application process and tightly monitors the use of J-1 Visas, but the key point (for purposes of this document) is that physicians are required to return to their home country for two years after completing their training.

In 1994, Senator Kent Conrad of North Dakota created the “Conrad 20” to address the shortage of physicians in medically underserved areas (legislation was reauthorized in 2004 and the number of state sponsored waivers was increased to 30, making it the “Conrad 30”). Under this legislation each of the 50 U.S. states (acting as “an interested government agency”) is given some flexibility to implement its own guidelines for the sponsoring of up to 30 J-1 exchange visa physicians to be granted a J-1 Visa Waiver. This waiver can be granted to J-1 visa physicians after (or near) the completion of their graduate medical training to waive the requirement for
them to return to their home country for two years prior to seeking permanent U.S. citizenship. The U.S. Department of State is the only governing body that can grant a J-1 Visa Waiver, but the implementing states are given some freedom as to how to administer the program and determine placement of their 30 allotted waivers. The federal requirements are outlined in detail in the Code of Federal Regulations – Title 22: Foreign Relations, Part 41: Visas (22 CFR 41.63).

In general, the national guidelines are as follows: 1) a full-time offer of employment (40 hours per week) as a primary care physician in a health professional shortage area or medically underserved area in a particular State; 2) a letter of support from a particular State Director of Health (or designee) supporting the physician’s Conrad 30 request; 3) a “no objection” letter from the foreign physician’s home country; 4) a three-year employment contract (such employment contract shall not include a non-compete clause enforceable against the physician); 5) a letter from the facility that wishes to hire the physician stating HPSA or MUA status and services to Medicare, Medicaid, and indigent uninsured patients; and 6) the physician must submit Form DS 3035 along with a non-refundable $215 processing fee to the U.S. Department of State.

The Department of State makes it very clear that it is the physician’s responsibility to ensure that all requested documents are submitted (even if third party is used). Additionally, the physician is expected to understand that their J-1 program was funded by the foreign government; therefore, the physician will need to obtain a no-objection letter. Also, if the physician does not fulfill the three year commitment under the terms as described in the Conrad 30 waiver, the physician will be subject to the two-year home residency requirement. The Department of State also requires that documentation of unsuccessful efforts to recruit an
American physician to fill the vacancy be provided by the facility seeking the employment of the J-1 physician.

Figure 4: Number of J-1 Visa Waivers allocated per State in 2005 (GAO, 2006)

**Evolution of the Conrad 30 J-1 Visa Waiver Program:**

In the early 1970s, the J-1 Visa policy was widely criticized for encouraging FMGs to immigrate to the U.S.—creating a “brain drain” of physicians from developing nations (AMA, 2010). Congress responded in 1976 through the early 1980s by tightening partisan immigration policies. “Preferential immigration” was reformed and the number of waivers greatly decreased.
J-1 Visa physicians were still coming to the U.S. for graduate medical training, but when training was complete they returned to their home country to fulfill the two year return requirements. In 1994, when the Conrad 30 Amendment to the Immigration and Naturalization Act was enacted, there was a significant influx of waivers. Between 1983 and 1992, 660 waivers were granted; between 1994 and 2003, the United States Department of Agriculture requested approximately 3,000 waivers (AMA, 2010).

Initially, the Conrad 30 was structured so “an interested U.S. government agency” could request the waiver and sponsor the physician. This is still the case, but there has been a considerable shift in which agency will be the interested government party. As mentioned above, the USDA was the primary player in the process; however, after the events of September 11, 2001 there was a need to address security risks by completing thorough background checks on all applicants and USDA would no longer request waivers. The states are now the primary source of waiver requests for physicians to practice in underserved areas, accounting for more than 90 percent of waivers in 2005 (GAO, 2006). During the years 2003-05, an average of 1,000 waivers were requested each year; however, there has been much debate over the last five years about how many waivers should be granted. The number of waivers individual state requests varies significantly: in 2005, one-quarter of states requested the maximum 30 waivers, while slightly more than a quarter requested fewer than 10 (GAO, 2006). Eighty percent of states—including many of those that requested the annual limit or close to it—reported the 30 waiver limit to be adequate and thirteen percent reported the limit to be less than adequate. Interestingly, of the 44 states that did not always request the limit, 25 reported that they would be willing to have their unused waiver allotments redistributed to some degree (GAO, 2006).
Periodically, Congress is required to reauthorize the Conrad 30 legislation in order to continue the program. The program was first extended in 1996 until 2002\(^1\). In 2002, the program was extended until 2004, while additionally amending previous legislation and increasing the number to 30\(^2\). In 2004, the program was extended to 2006\(^3\); then, the Conrad 30 was again extended until 2008\(^4\). On March 10, 2008, Representative Zoe Lofgren (D-CA) introduced H.R. 5571, which would extend the program until June 1, 2013. On October 8, 2008, the extension was signed into law as Public Law No: 110-362, by George W. Bush (Ester, 2008).

Figure 5: States’ and Federal Agencies’ Requests for J-1 Visa Waivers for Physicians

![Graph](image)

*Figure 5: States’ and Federal Agencies’ Requests for j-1 Visa Waivers (GAO, 2006)*
J-1 Visa Waiver Problems/Challenges:

Brain drain:

For many years, opponents to allowing FMGs to practice in the United States have claimed that the U.S. is creating a “brain drain” on developing nations by recruiting their much needed physicians for our own selfish needs. Drugger argues: whether a rural community is in a resource-poor or resource-rich area, or a developed or developing country, also influences its relative level of advantage or disadvantage. Another important consideration is that rural areas in developed countries are often pressed to recruit practitioners from other countries, but the consequences are often threatening to health care in resource-poor countries left behind by the practitioners (Drugger, 2004; Ovrill and Stilweil, 2004). Despite the “no objection” requirements of the U.S. Department of State, some feel that the U.S. is violating basic rights of social justice with the J-1 Visa Waiver.

Revolving Door:

Nearly all individuals interviewed for this project, as well as experts in the field, comment on the phenomenon they refer to as the “reversing door.” Despite the large recruitment efforts, many HPSAs have a difficult time retaining physicians once they have them. The J-1 Visa Waiver has had some success with retention—many physicians remain at the facility that originally recruited them or transfer to another HPSA community after the three year requirement is fulfilled—however, the retention rates are not as high as desired. Some point to difficulty in adjusting to life in a community that lacks the cultural diversity the J-1 physicians experience in the larger urban areas they trained. Additionally, some communities are more
inviting to different cultures—some communities even have high concentrations of J-1 physicians form a particular country, allowing the physician and his or her family to feel “at home.” There is usually less diversity within rural communities—although there is considerable diversity across rural communities from one part of the country to another—and rural residents tend to share more values than their urban counterparts (Klugman and Dalinis, 2008; Roberts et al, 1999). Whatever the reason, the revolving door issue is one of the biggest challenges that the J-1 Visa Waiver Program has to face.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Number of states conducting activity</th>
<th>Percentage of states conducting activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required periodic reports by the physician or employer</td>
<td>40</td>
<td>75</td>
</tr>
<tr>
<td>Monitored through regular communication with employers</td>
<td>21</td>
<td>40</td>
</tr>
<tr>
<td>Monitored through regular communication with physicians</td>
<td>19</td>
<td>30</td>
</tr>
<tr>
<td>Conducted periodic site visits</td>
<td>18</td>
<td>34</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>17</td>
</tr>
</tbody>
</table>


Note: Reported activities are for the 53 states that requested any waivers in fiscal years 2003 through 2005. Puerto Rico did not request waivers during that period.

Not all states that requested waivers conducted monitoring activities. Six states, which collectively accounted for about 13 percent of all state waiver requests in fiscal year 2005, reported that they conducted no monitoring activities in that year.

Figure 6: Fraud or Abuse Monitoring (GAO, 2006)

**Abuse:**

In some cases the use of J-1 Visa Waivers has been abused. As Marshall Allen of the Las Vegas Sun has reported, some facilities will hire J-1 physicians under false pretenses and force them to work at a hospital for higher reimbursement rates despite the contract agreement to serve an HPSA underserved community (Allen, 2007-2009). Additionally, employers are in some cases paying physicians less than “far market value.” Although these instances appear to be rare,
with over 4,000 physicians practicing nationally under J-1 Visa Waivers, the threat of abuse is eminent and must always be monitored.

**Community Health Centers:**

Community Health Centers (CHC) are vital to health care in the United States. CHCs serve as the safety net for the U.S. health system. In 2005, CHCs provided more than 50 million visits to more than 15 million people in more than 3500 communities nationally (Proser M. et al, 2005). In Arizona there are 16 organizations operating 132 sites and serving 356,094 people (NACHC, 2008). In 2007, the clients served by Arizona CHCs were predominately of low socioeconomic status with 74% at or below 100% of federal poverty level and 94% under 200% federal poverty level (NACHC, 2008). Physician recruitment in CHCs is heavily dependent on the J-1 Visa Waiver Program with over 535 J-1 physicians in CHCs; however, CHCs still have an amazing shortage of 428 vacant FTEs for family physicians nation-wide (Rosenblatt et al, 2006). With the Community Health Center Initiative laid out during the Bush administration, CHCs have seen increased difficulty in recruiting sufficient numbers of primary care physicians. Overall, CHCs put a considerable amount of strain on the J-1 Visa Waiver Program as there is considerable need in such a concentrated sector; this becomes increasingly difficult when each location can only receive a set number of J-1 physicians each year. This becomes considerably more frightening when one considers the recent budget cuts to AHCCCS and the proposed cuts to Graduate Medical Education—the already frail safety net will likely see considerably more strain.
Native American Tribes:

Much of the Arizona Tribal land is designated as HPSA. Reservations have a massive land mass in Arizona; however, there is a considerable lack of facilities and minimal private health care. There are few primary care providers on the reservation, but tribes continue to have trouble addressing this issue even with the J-1 Visa Waiver Program because of difficulty recruiting. The reasons for difficulties are attributable to: isolated facilities with lack of access, too few housing options, and simply that Non-Indians do not really want to live on the reservation (interview with Tribal Liaison). This presents a problem for the J-1 Visa Waiver Program because the 29% land mass of Arizona that is possibly in greatest need of providers is the most difficult to address.

Figure 7: J-1 Physician Specialties in 2005 (GAO, 2006)
Utilization:

Despite strong recruitment tactics, there are many understaffed facilities that still are not aware of the J-1 Visa Waiver Program as an option to address their shortage. Although many states experience a high volume of applicants each year, many states are unable to fill 10 of the 30 slots. On the contrary, some states feel that they do not have enough J-1 Visa Waivers for the demand presented by underserved communities. Full and efficient utilization should be a goal for any Primary Care Office or “interested government agency.”

![Image of Table 2: Number of Additional J-1 Visa Waiver Physicians States Estimated Needing per Year, 2006]

Table 2: Number of Additional J-1 Visa Waiver Physicians States Estimated Needing per Year, 2006

<table>
<thead>
<tr>
<th>State</th>
<th>Estimated number of waiver physicians needed beyond annual limit of 30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kentucky</td>
<td>5</td>
</tr>
<tr>
<td>Arkansas</td>
<td>10</td>
</tr>
<tr>
<td>Iowa</td>
<td>10</td>
</tr>
<tr>
<td>Louisiana</td>
<td>10</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>10</td>
</tr>
<tr>
<td>West Virginia</td>
<td>10</td>
</tr>
<tr>
<td>California</td>
<td>20</td>
</tr>
<tr>
<td>Michigan</td>
<td>20</td>
</tr>
<tr>
<td>Arizona</td>
<td>25</td>
</tr>
<tr>
<td>New York</td>
<td>30</td>
</tr>
<tr>
<td>Texas</td>
<td>50</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>200</strong></td>
</tr>
</tbody>
</table>


Note: Data are from the 11 states that reported needing additional J-1 visa waiver physicians beyond the current annual limit of 30.

Although 10 states reported requesting the annual limit of 30 waivers in each of fiscal years 2003 through 2005, the large majority (44 states) did not. When asked to provide reasons why they did not use all 30, many of these states reported that they received fewer than 30 applications that met their requirements for physicians seeking waivers through their state J-1 visa waiver programs. Some states, however, offered further explanations, which touched upon difficulties attracting physicians to the state, low demand for waiver physicians among health care facilities or communities, and mismatches between the medical specialties communities needed and those held by the physicians seeking waivers.

Figure 8: National “Shortage” of J-1 Visa Waivers in 2005 (GAO, 2006)
Policy Recommendations and Best Practices:

Even in the most efficient and effective program, there is room for improvement with the goal of maximum utilization. The following is a list of best practices and/or possible policy recommendations that may be considered by the ADHD Bureau of Health Systems Development to maximize the J-1 Visa Waiver Program:

- Bi-annual monitoring of the physician and employer. Such monitoring may include, but is not limited to: number of patients seen, number of hours worked, types of patients (payment and demographic), compliance with original contract, and satisfaction with the situation. Although monitoring in the form of a report is likely the easiest, phone and “drop-in” inspections/visits are more effective if feasible. As the goal is physician recruitment and retention in underserved areas, the objectives should not only be to monitor for fraud, but to help ensure all stakeholders are satisfied and willing to proceed past three-year commitment.

- Regular consultation of the AzMUA designations when determining which areas are in most need of J-1 physicians.

- Consider allowing small rural clinics in frontier areas (that may be unsure of three-year budget outlook) to “sublet” their contract with a J-1 physician. These clinics may be in great need of providers, but fearful of applying because of possible budget shortfalls in the long term.

- Circulation of information and use of brochures at conferences and medical education symposiums to ensure that all clinics are aware of the J-1 Visa Waiver Program as an option if they are experiencing recruitment difficulties.

- Requiring that facilities that request J-1 physicians submit detailed retention plans. Research shows that many J-1 physicians leave the original practice site because disagreements with facility, difficulty adjusting to the community, lack of employment for spouse, lack of educational opportunities for children, and simple discomfort.

- Implement higher fees on applicants in order to pay for the program administration. States assessed had fees ranging from the standard $215 that must be submitted to the
Department of State to $2,500 (refunded if applicant is not selected to be sponsored for a waiver)—in the most extreme case, Texas has a fee of $5,000 (listed in rules/guidelines, but not currently using. Requiring a $1,000 fee per applicant would likely not be too high to deter J-1 physicians (as cost is made up quickly through U.S. practice vs. practice abroad), but it is nearly sufficient to pay for an additional FTE in the Bureau office.

- Transferring rules and guidelines into State Statutes may be helpful in avoiding possible future legal troubles. Disputes between the health department and clients can be costly and time consuming—transferring these processes into law can remove this burden and prevent future misinterpretations or liabilities. If this option is being considered, suburb model legislation to follow would be those of Texas, Idaho, and/or Oregon (providing political environment affords this).

- Although a small change, consider utilizing online application that allows applicant (or representative) to type response directly into pdf, prior to printing. This is only for clarity in penmanship and ease of reviewers, as well as applicant.

- Disqualify practice sites that have previously defaulted on a J-1 Visa Waiver contract, or any other NHSC or loan repayment program, from applying for a J-1 physician. In other words, do not allow sites that are under sanction to receive a J-1 physician until designated time period or appeal process is complete.
References:


1. Illegal Immigration Reform and Immigrant Responsibility Act of 1996, P.L. 104-208, division...


## Appendix 1: Comparison Qualitative Data from 26 selected similar States (high rural or western)

<table>
<thead>
<tr>
<th>State</th>
<th>Selection Procedure</th>
<th>“Stand-out” Policy</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>Sub-specialty selection made on 1st come 1st serve basis (based on community need)</td>
<td>N/A</td>
<td>None</td>
</tr>
<tr>
<td>Alaska</td>
<td>Deputy Commissioner of Health and Social Services submits recommendation to Dept of State when all forms are obtained</td>
<td>N/A</td>
<td>Limited info available--very low utilization</td>
</tr>
<tr>
<td>Arizona</td>
<td>Scoring process (Described elsewhere)</td>
<td>N/A</td>
<td>Very easy to navigate</td>
</tr>
<tr>
<td>Arkansas</td>
<td>N/A</td>
<td>N/A</td>
<td>Website provides little info/do not appear to be utilizing program</td>
</tr>
<tr>
<td>California</td>
<td>HSPA, MUA, or MUP designations</td>
<td>N/A</td>
<td>Website has little info</td>
</tr>
<tr>
<td>Colorado</td>
<td>Priority given to primary care physicians in shortage areas; however discretion is applied to determine if specialists and/or non-underserved (without federal designation) areas present strong evidence of need;</td>
<td>Detailed physician retention plan must be provided; periodic monitoring through on-site visits, telephone calls, or written reports (due every six months)</td>
<td>Nice sample brochure available (promotion material); PCO is very thorough, yet only 8-9 J-1 per year (ave.)</td>
</tr>
<tr>
<td>Idaho</td>
<td>Underserved facility is allotted no more than 2 J-1 physicians/year; department holds discretionary role; facility must be open 12 mos.; priority given to primary care--discretion used to determine need and place accordingly</td>
<td>Formal State legislation/codes</td>
<td>If State statute is desired, this code serves as great model/outline</td>
</tr>
<tr>
<td>Illinois</td>
<td>50% allocated to primary care physicians willing to work in rural area in 1st &amp; 2nd Quarters of fiscal year; max 2 applications per facility in 1st &amp; 2nd quarter (priority to facilities that have not previously had waivers approved); priority is need based</td>
<td>Semi-annual verification (six months) to ensure physician is still practicing under terms of the original agreement</td>
<td>&quot;fill-in&quot; style PDF application, very easy to navigate webpage and process</td>
</tr>
<tr>
<td>Indiana</td>
<td>1st preference given to primary care and psychiatrists; closely following a HPSA scoring rubric</td>
<td>J-1 physician can check application status online</td>
<td>Clear directions</td>
</tr>
<tr>
<td>Iowa</td>
<td>Priority based on geographic area and the number and types of patients treated; however, discretionary based on physician potential to increase access to care for Iowans; FQHC have priority; scoring rubric is applied to determine need/priority</td>
<td>Annual monitoring (number of patients served and insurance status)</td>
<td>Clear directions</td>
</tr>
<tr>
<td>Kentucky</td>
<td>Safety net providers given priority; active participants in Kentucky Physician’s Care Program also given preference; 2000:1 or above ratio; discretionary selection process</td>
<td>N/A</td>
<td>Link on front page of website; easy to interpret and complete</td>
</tr>
<tr>
<td>Minnesota</td>
<td>Discretionary (no other info)</td>
<td>&quot;Complete state process may take up to 30 days&quot;; Facility must present long term detailed plans for retention of the physician</td>
<td>Mediocre website; strong outline but not much guidance or specifics</td>
</tr>
<tr>
<td>Missouri</td>
<td>Priority given to primary care (w/option of including emergency)</td>
<td>Provide department two reports per year detailing number and clear statutes and detailed directions relating to</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>Details</td>
<td>Commitment Requirements</td>
<td>Directions/Documentation</td>
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<tr>
<td>Montana</td>
<td>Preference given to primary care providers and some psychiatrists; discretionary review; FQHC can apply for several, otherwise limits are imposed on employers that submit multiple applications</td>
<td>Employer or owner of practice site who has previously defaulted on a J-1 visa waiver contract, or any other NHSC or loan repayment program is not eligible to request a waiver; retention plan intended to meet the physician’s professional and lifestyle needs must be included; practice site must submit report detailing compliance every six months</td>
<td>Very detailed directions including guidance on how to find employment locations and various “extra steps” that can be helpful; great model—very thorough</td>
</tr>
<tr>
<td>Nebraska</td>
<td>Discretionary; priority given to higher shortage areas, but up to 10 applications (“flex slots”) will be reviewed from non-shortage areas</td>
<td>State of Nebraska review and sponsorship decision is made within two weeks; service provider is closely monitored for timely response to referrals from safety net providers, follow up on any complaints that practice does not see patients, and other means of tracking surveillance, etc.</td>
<td>Clear description; recent (2008) program evaluation documentation online</td>
</tr>
<tr>
<td>Nevada</td>
<td>Discretionary; priority given to higher shortage areas, but up to 10 applications (“flex slots”) will be reviewed from non-shortage areas; scoring rubric is applied; max 70% allotted for Clark County; Up to five of the total slots may be reserved for staffing emergencies</td>
<td>Primary Care Advisory Council (PCAC), a seven member council appointed by the Health Division Administrator, has been established to make recommendations regarding recruitment, placement, monitoring, and to maintain a transparent process(es); annual summary report must be submitted by the facility, in addition to an on-site review by the NSHD or designee; exit surveys are mailed to J-1 physicians 60 days prior to the end of their commitment; long-term retention plans must be included</td>
<td>Extremely extensive directions and program; exhaustive use of legal terms and regulations; possibly makes program too bureaucratic; however, strong in program control</td>
</tr>
<tr>
<td>New Mexico</td>
<td>Completely discretionary; preference given to underserved and primary care designations</td>
<td>Sites in which the Candidate would be sole physician medical provider present are not eligible under the program criteria; two to three applications are reserved for; discretionary targeting of “special priority needs;” NMDOH reserves the right to monitor any obligated service at any time during three year period, in addition to an annual report that must be filed by the facility</td>
<td>Link to J-1 Visa Waiver Program is not readily accessible</td>
</tr>
<tr>
<td>North Dakota</td>
<td>Five non-HPSA slots are assigned first come, first serve, based on need—if a site receives one of these waivers in one year, they will not</td>
<td>Employer or owner of practice site who has previously defaulted on a J-1 visa waiver contract, or any other NHSC or loan repayment program is not eligible to request a waiver; retention plan intended to meet the physician’s professional and lifestyle needs must be included; practice site must submit report detailing compliance every six months</td>
<td>Limited info available online</td>
</tr>
</tbody>
</table>
receive priority the next year; discretionary selection procedure

loan repayment program is not eligible to request a waiver; retention plan intended to meet the physician’s professional and lifestyle need

<table>
<thead>
<tr>
<th>State</th>
<th>Selection Criteria</th>
<th>Review Process</th>
<th>Waiver Program Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oklahoma</td>
<td>N/A</td>
<td>N/A</td>
<td>No information provided on website</td>
</tr>
<tr>
<td>Oregon</td>
<td>Discretionary based on needs of the state in House Bill 2151; however, applications for 2010 will be on first come first serve basis</td>
<td>Department will review completed application and notify the applicant of the results within 15 business days; facility must submit report every six months and Department auditors must be allowed access to health care facility and physician records; 20% of total patient visits must be Medicaid, Oregon Health Plan, and low income, uninsured (200% or less FPL); DHS typically mails J-1 promotional material to FQHC once or twice per year; 87.5% of J-1 physicians continued practicing with that same employer after completing contractual obligations</td>
<td>Possibly the best model J-1 Visa Waiver Program in the country; details are thorough, evaluation is immaculate, and administration is relatively non-bureaucratic (see Program Summary on webpage)</td>
</tr>
<tr>
<td>South Dakota</td>
<td>First come first serve</td>
<td>Ability to check the status of application online; J-1 physician may opt to practice down to a minimum of 16 hours per week direct patient care (if spending remainder of time on select other activities)</td>
<td>Clear description</td>
</tr>
<tr>
<td>Texas</td>
<td>Prioritized to areas of greatest need; however, somewhat discretionary in determination of priority</td>
<td>Well established policies from states statutes to department rules; despite regulations, policies and processes are not overly bureaucratic; strong model for legislation; power point links to physician responsibilities provides a strong education component</td>
<td>Several department level rules: identified priorities (for waiver recommendations) for next FY must be published on website by May 1; Application fee is returned to candidate if all 30 slots are full (50% is returned in candidate withdrawals application); Flex 10 applications will be considered on a first come first serve basis starting March 2nd if there are still slots available;</td>
</tr>
<tr>
<td>Utah</td>
<td>Only HPSA, no MUA/MUP designations</td>
<td>Will not support waivers at sites where physician is in supervisory position to owner/employer, where owner/employer is in default to NHSC, or where owner/employer has breached the terms of a J-1 visa waiver contract within the last two years; detailed retention plan must be included; Each health care facility may make up</td>
<td>Application status check link is included; legislation is very basic, yet succinct</td>
</tr>
<tr>
<td>State</td>
<td>Description</td>
<td>Requirements</td>
<td>Notes</td>
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<tr>
<td>Washington</td>
<td>After April 1, any unfilled waivers become available to either primary care or specialist physicians on a first come first serve basis; Specialist waivers must follow special criteria to demonstrate needs; discretionary review process with priority given to areas of need--follow a ranking system based on type/area of facility; however this procedure is combined with a hybrid first come first serve policy</td>
<td>Specialists must have a 5 year contract with employer; Applications will undergo full review by the department within two weeks; Status of application link is provided; Six month semi-annual reports must be submitted by physician and employer</td>
<td>Great website with very in-depth legislation; serves as a great policy model; updated regularly--transparent with status</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>First come first serve; however discretion is applied for specialty J-1 physicians to determine need</td>
<td>N/A</td>
<td>Non-designated area or flex slots must document that 40% of the total number of specialty patients in the past year be from surrounding designated areas (exceptional need and public interest)</td>
</tr>
<tr>
<td>Wyoming</td>
<td>N/A</td>
<td>N/A</td>
<td>No information available online</td>
</tr>
</tbody>
</table>