

Immigration Issues Impacting the Training, Recruitment, and Employment of Foreign Physicians by Academic Medical Centers

Member Briefing, January 2015

Teaching Hospitals and Academic Medical Centers
Practice Group and Immigration Affinity Group

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The United States has an increasing shortage of trained physicians available to treat a growing and aging patient population.¹ Experts predict that the ongoing implementation of the Affordable Care Act (ACA) will intensify this shortage.² The ACA provides access to health care coverage for millions of previously uninsured Americans, yet includes virtually no new sources of funding for Graduate Medical Education (GME) by which to increase the U.S. physician population. According to the American Medical Association, approximately one in four physicians in the United States is an International Medical Graduate (IMG)—i.e., a physician whose medical degree was obtained outside of the United States.³ Most IMGs are foreign nationals rather than U.S. citizens or Lawful Permanent Residents (LPRs). As a result, Academic Medical Centers (AMCs) seeking to train or hire IMGs are well-advised to familiarize themselves with the immigration-based recruitment and employment restrictions attendant upon hiring foreign national physicians.

This Member Briefing provides a brief primer of the two primary nonimmigrant statuses (J-1 and H-1B) in which foreign nationals receive GME at AMCs. This Member Briefing also discusses the recruitment and employment considerations specific to hiring foreign national IMGs after their completion of GME in the United States. Finally, this Member Briefing discusses recent developments regarding the immigration fees and costs borne by AMCs and other employers of foreign national physicians.

¹ See Reports of the Association of American Medical College, *Recent Studies and Reports on Physician Shortages in the US* (Oct. 2012), available at www.aamc.org/download/100598/data/recentworkforcestudies.pdf, and *The Complexities of Physician Supply and Demand: Projections Through 2025* (2008), available at <https://members.aamc.org/eweb/upload/The%20Complexities%20of%20Physician%20Supply.pdf>. See also American Medical Association (AMA) Discussion Paper, entitled *International Medical Graduates in U.S. Medicine: Contemporary challenges and opportunities* (2013), available at <http://nycsprep.com/pdf/international-medical-graduates.pdf>.

² Hofer, A.N., Abraham, J.M. and Moscovice, I., *Expansion of Coverage under the Patient Protection and Affordable Care Act and Primary Care Utilization*, MILBANK QUARTERLY 89: 69–89 (2011); Kirch, D.G., Henderson, M.K. and Dill, M.J. (2012), *Physician Workforce Projections in an Era of Health Care Reform*, ANNUAL REVIEW OF MED. 63: 435–45 (2012).

³ See Position Paper of the AMA-IMG Section Governing Council, entitled *International Medical Graduates in American Medicine: Contemporary Challenges and Opportunities* (2010).

Overview: Nonimmigrant Status of Foreign National Physicians in GME Programs

Although both J-1⁴ and H-1B⁵ nonimmigrant visa classifications allow for the temporary employment of foreign national physicians in GME programs, these classifications differ significantly from one another in terms of the AMC's roles and responsibilities, required fees, administrative burden, and flexibility of employment of the IMG physician.

J-1 Status in GME

J-1 physicians are “exchange visitors” sponsored by the Educational Commission for Foreign Medical Graduates (ECFMG)⁶ to participate in approved GME training programs at accredited AMCs throughout the United States.⁷ In theory, these physicians come to the United States to attain new medical knowledge and learn techniques that they will share with their home countries upon completion of their GME programs. To qualify for the J-1 visa, J-1 physicians must obtain a Statement of Need from their country of nationality or most recent legal permanent residence. The Statement of Need is verification that the physician's home country has a need for training in the subspecialty in which the physician will receive GME in the United States. All J-1 physicians receiving GME in the United States are subject to a two-year “return requirement” to return to such country with their newly acquired training.⁸ Such physicians must either fulfill or obtain a waiver of this requirement if they later determine that they wish to change to certain types of nonimmigrant status (e.g., H-1B) or seek lawful permanent residence in the United States after they complete their GME programs. Throughout the course of their clinical training, J-1 physicians' stays in the United States are extended on a year-by-year basis pursuant to continued authorization by ECFMG. The default limit for a total length of stay for a GME physician in J-1 status is the earlier of seven years or the typical duration of the IMG's program of intended

⁴ Immigration and Nationality Act (INA) § 101(a)(15)(J), 8 U.S.C. § 1101(a)(15)(J). See 8 C.F.R. § 214.2(j) (2013), 22 C.F.R. § 62 (2014).

⁵ INA § 101(a)(15)(H), 8 U.S.C. § 1101(a)(15)(H). See 8 C.F.R. § 214.2(h)(2013).

⁶ 22 C.F.R. § 62.27(b)(2014).

⁷ Importantly, there are a number of different categories of J-1 exchange visitors depending on the purpose or type of exchange. Most of the categories, including J-1 clinical physicians, are detailed in the federal regulations governing J-1 visas. See 22 C.F.R. § 62 (2014).

⁸ INA § 212(e), 8 U.S.C. § 1182(e).

training as determined by the American Board of Medical Specialties.⁹ To obtain an extension beyond such time requires a showing of “exceptional need” by the IMG’s home country.¹⁰ The visas for J-1 physicians in GME are not subject to an annual quota.

H-1B Status in GME

AMCs also may sponsor foreign national IMGs for GME training in H-1B visa status.¹¹ While the majority of U.S. employers seeking first-time private sector H-1B visas are subject to an annual limit (H-1B cap), most AMC-sponsored H-1B visas for GME training are exempt from this limit.¹² AMCs often are comprised of myriad related entities. The entity that will employ or control the physician seeking H-1B status must serve as the “sponsor” of the foreign national physician. Sponsorship in this context requires that the entity, usually the AMC itself, file an H-1B petition with U.S. Citizenship and Immigration Services (USCIS), employ the physician as a W-2 employee, and otherwise comply with statutory and regulatory requirements related to wages, government reporting, working conditions, and benefits. The petition must include proof that the GME candidate has attained the appropriate, required state licensure; passed all steps of the U.S. Medical Licensing Exam (USMLE); and obtained ECFMG certification. The AMC may request only up to a three-year period of stay in any given petition, but USCIS may limit the approval to one year if the GME candidate is restricted to a temporary or training license in the state of intended employment.¹³ Although the period of H-1B stay is renewable, there is an initial six-year limit to a given physician’s H-1B status.¹⁴ This six-year limit can be extended by progress towards lawful

⁹ 22 C.F.R. § 62(e)(2014) Duration of Participation:

- (1) The duration of an alien physician's participation in a program of graduate medical education or training . . . is limited to the time typically required to complete such program.
- (2) Duration of participation is limited to seven years unless the alien physician has demonstrated to the satisfaction of the Secretary of State that the country to which the alien physician will return at the end of the additional specialty education or training has an exceptional need for an individual with such additional qualification.

¹⁰ *Id.*

¹¹ 8 C.F.R. § 214.2(h)(2013).

¹² The H-1B “cap,” as well as exemption from the cap, is discussed in greater detail in Initial Hire of H-1B Physicians Post-GME below.

¹³ 8 C.F.R. § 214.2(h)(4)(v)(E)(2013).

¹⁴ INA § 214(g)(4), 8 U.S.C. § 1184(g)(4).

permanent residence, or “green card status,” usually sponsored by the physician’s current or future¹⁵ employer, preferably prior to the end of the physician’s fifth year of H-1B status. However, most H-1B trainees have limited options for pursuing LPR status until they have an offer of permanent employment—as discussed below in more detail.

Issues and Outlook for J-1 vs. H-1B Status

In recent years, the J-1 option for GME has grown in popularity relative to the H-1B option. This shift has largely been driven by factors that immediately impact the AMCs hosting the GME programs, rather than by the IMG physicians’ long term U.S. career considerations. While the physician’s preference rarely is taken into account, individual physicians who are provided the option often will seek sponsorship for H-1B status over J-1 status.

AMCs generally find the J-1 option more user-friendly than the H-1B option. Unlike the H-1B option, the J-1 option does not require that the AMC pay any governmental fees or, typically, attorney fees. The sole fees involved with the J-1 GME option consist of the annual administrative fee paid by the foreign national physician to ECFMG, a one-time initial Student and Exchange Visitor Information System (SEVIS) fee paid by the physician to establish a SEVIS record, and the visa fees paid by the foreign national to the U.S. consulate abroad. The J-1 program does not require licensure of the physician prior to application for a visa at the consulate¹⁶ and requires only that the IMG have passed Step 1 (Basic Science) and Step 2 (Clinical Knowledge and Clinical Skills) of the USMLE. In addition, GME trainees in J-1 status have no means of being lawfully employed by any outside, third-party entity to “moonlight” as locums or otherwise.

The J-1 option, however, is not without its own administrative costs and limitations. A GME program participating in the J-1 program must meet reporting requirements to

¹⁵ In *Matters of Albert Einstein Med. Ctr. and Abington Mem’l Hosp.* (11/21/2011), Department of Labor’s (DOL’s) Board of Alien Labor Certification Appeals found that AMCs and other employers cannot sponsor physicians in GME programs of finite duration as such positions are not sufficiently “permanent” for purposes of pursuing lawful permanent residency.

¹⁶ ECFMG requires an undertaking that the physician will attain required licensure prior to commencing training in J-1 status.

ECFMG and requires appointment of at least one administrator per institution or program to serve as a liaison (Training Program Liaison or TPL) with ECFMG. In addition, ECFMG requires participating programs to ensure that their J-1 residents and fellows maintain appropriate health and other insurance for themselves and dependent family members in the United States. Furthermore, if an AMC seeks to train J-1 physicians in newly formed subspecialties and/or those that will require more than seven years of GME, then the program's success is subject to each J-1 physician's ability to prove the "exceptional need" of the physician's home country for the subspecialty.¹⁷

Finally, J-1 status is not popular with foreign national IMGs who intend to return to their home countries yet also wish to maintain the possibility of remaining in the United States upon completion of their GME programs. As noted above, unless waived, training in J-1 status requires that physicians return to their home country for two years immediately following GME completion to be eligible for certain types of status that would enable them to remain and pursue a career in the United States. Therefore, there is much demand for various types of J-1 waivers among J-1 visa-holders who seek to remain in the United States.

Personal J-1 waivers are available for those who can demonstrate that they will be persecuted in their home countries, as well as those who can demonstrate that their departure will cause "exceptional hardship" to a qualifying U.S. citizen or LPR spouse or child.¹⁸ Although persecution and hardship waivers are not subject to a quota, their adjudication involves a subjective set of criteria that can be difficult to predict. Moreover, the legal standards for persecution and exceptional hardship-based J-1 waiver cases are not easily met. J-1 persecution waiver applicants must show that they "would be" subject to persecution if forced to return home,¹⁹ a higher standard than that which asylum applicants must meet, who only need to demonstrate a "well-founded fear of"

¹⁷ 22 C.F.R. § 62(e)(2)(2011).

¹⁸ *Id.*

¹⁹ *Supra* note 8.

persecution.²⁰ The standard for showing qualifying “exceptional hardship” is similarly high and difficult to establish,²¹ and the physician must demonstrate that such hardship will result regardless of whether the qualifying relative returns “home” with the exchange visitor or whether the relative remains in the United States and is separated from the foreign national.

In addition, federal Interested Government Agencies (IGAs) may recommend a J-1 waiver on behalf of a clinical physician actively and substantially involved in a program or activity sponsored by, or of interest to, that agency, such as providing clinical care to underserved communities.²² Such agencies include the Appalachian Regional Commission (ARC), the Delta Regional Authority (DRA), the U.S. Department of Health and Human Services (HHS),²¹ and the Veterans Administration. Successful IGA waivers often hinge on an IMG’s employment in an area within the purview of these agencies.

State health departments recommend the most popular type of clinical service-based J-1 waivers for physicians through the Conrad 30 Waiver Program (Conrad 30 program). Under this program, each state is allotted 30 J-1 waiver slots per Fiscal Year (FY) to allocate based on the needs of the state to GME graduates who agree to provide three years of direct patient care at a facility located in an HHS-designated underserved area. In addition, at the option of any given state’s health department, up to ten of the 30 new slots available per FY are permitted to be allocated to physicians who will work at facilities located outside of such areas, provided they serve populations residing in such areas.²³ Demand for Conrad 30 waivers has become fierce in recent years due to increased numbers of J-1 physicians in GME. Increasingly, states with popular Conrad

²⁰ Pursuant to INA § 208(a)(1), an individual who is physically present in the United States can apply for asylum if they meet the INA’s definition of “refugee.” Pursuant to INA § 101(a)(42), a refugee is defined as someone who is “unable or willing to return” to their home country “because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a social group, or political opinion.”

²¹ See *Silverman v. Rogers*, 437 F.2d 102, 107 (1st Cir. 1970) and *Gras v. Beechie*, 221 F. Supp. 422, 424 (S.D. Tex. 1963) (finding that mere family separation will not satisfy the hardship standard).

²² *Id.*; 22 C.F.R. § 41.63(c).

²³ Immigration and Nationality Technical Corrections Act of 1994, Pub. L. No. 103-416, 108 Stat. 4305 (1994); INA § 214(I), 8 U.S.C. § 1184(I). Of the 30 Conrad waiver slots allocated to each state, ten may be used as “Flex” slots for those physicians serving populations which, while not located in federally designated underserved areas, are located in areas serving a patient population experiencing a medical or physician shortage.

30 programs exhaust their annual limit of 30 “slots” within the first day or other applicable initial application period of the program’s FY.

Due to the challenges involved with attaining a waiver of the J-1 return requirement, foreign national physicians sometimes will seek to limit their participation to GME programs that offer H-1B sponsorship. Further, the J-1 option may likely wane in popularity among foreign national physicians as they learn of colleagues unable to obtain J-1 waivers to work in their first-choice states or locales in the United States following their GME programs. Clearly, there often is tension between the J-1 program’s goal to foster exchange and the career aspirations of the physician who may wish to preserve the option of later establishing a career within the United States.

In October 2014, the U.S. Department of State (DOS) promulgated final regulations relating to J-1 visitor exchange programs with a request for comment, to become effective January 5, 2015.²⁴ The regulations increase reporting requirements incumbent upon sponsoring programs, such as ECFMG. This may have the effect of, in turn, increasing reporting responsibilities of AMC Training Program Liaisons to ECFMG. In addition, the rule increases the medical and accident insurance coverage required of J-1 physicians and their J-2 family member dependents. Further, the final rule will subject J-2 dependents to the 212(e) home-country return requirements incurred by the J-1 principal for the first time by definition.²⁵ While the changes to the J-1 program, pursuant to the rule, may create further disincentives for both the AMC training programs and the physician, the regulations will not likely offset the trend favoring J-1 over H-1B for GME.

The H-1B option has its own advantages and disadvantages for AMCs. As one advantage, H-1B physicians matched into a GME program cannot be denied a visa at the consulate due to presumed “immigrant intent” to remain in the United States long term. Whereas a J-1 visa physician must persuade a U.S. consular officer of the

²⁴ Exchange Visitor Program—General Provisions, 79 Fed. Reg. 60293 (Oct. 6, 2014) (to be codified at 22 C.F.R. pt. 62).

²⁵ *Id.*

physician's strong ties to the country and intention to return, an H-1B visa applicant is permitted to have an intention to eventually permanently immigrate to the United States.

The H-1B category has the added benefit of being more flexible than the J-1 in terms of the H-1B resident's employment by additional AMC-related entities during the GME period.²⁶ If there is a need and mutual desire for residents or fellows to augment their training program with appropriately licensed off-campus employment at an outpatient clinic or the like, it may be more readily obtained through the H-1B option. In addition, and perhaps most importantly, if an AMC wishes to maintain the option of hiring IMG residents or fellows into its own system post-GME, the AMC will be much more readily able to do so if the physician completed GME exclusively in H-1B status.

However, the H-1B category also has disadvantages for AMCs. The H-1B option requires the employer or a third party other than the physician employee to pay the related H-1B immigration fees and costs, which include attendant attorney fees and filing fees required by USCIS. In the distant past, some immigration practitioners interpreted the relevant regulations to permit a foreign national physician to contribute to some portion of the overall costs and to require an AMC to pay only certain governmental filing fees. At this point however, after five years of H-1B employer site visits conducted by the USCIS Fraud Detection and National Security (FDNS) Directorate, the immigration agency has made its position clear that the physician candidate is not to pay any fees to secure H-1B status. This position is consistent with a U.S. Department of Labor (DOL) regulation that defines attorney fees and other costs connected with the H-1B program as business expenses that must be borne by the employer,²⁷ as well as audits by DOL's Wage and Hour Division and a recent Sixth Circuit decision discussed [below](#). Such government audits also have underscored that USCIS has an expansive view of what constitutes a "material change" in employment, necessitating the filing of an amended petition with USCIS as required by regulation.²⁸

²⁶ This discussion exclusively is within the parameters of an immigration law perspective. Foreign national physicians are subject to the same licensure restrictions as U.S. citizens in terms of limited training licenses and the like.

²⁷ 20 C.F.R. § 655.731(c)(9)(ii)(2009).

²⁸ 8 C.F.R. § 214.2(h)(11)(i)(A)(2013).

As an additional complication, the H-1B cap has been reached quickly in recent years, sometimes within the first week of availability which is, in turn, six months prior to the relevant USCIS FY that runs from October 1-September 30. This means that by the time the National Resident Matching Program (NRMP or Match) results are released in March, cap-subject H-1B visas are no longer available for July of the same year. Therefore, IMGs seeking to carry out their training in H-1B status must be sponsored for employment at AMCs that are both nonprofit entities and affiliated with institutions of higher learning, which are exempt from the H-1B cap, to obtain an H-1B visa in time to join their peers at the commencement of the traditional GME year in July.

Although H-1B visas do not have a home residence return requirement like their J-1 counterparts, IMGs who come to the United States on H-1B visas are able to hold such nonimmigrant status for only six years. Thus, physicians who seek training lasting longer than six years may be unable to complete their training. Similarly, physicians whose training requires six or more years (e.g., cardiologists, medical oncologists, and similar subspecialists) may not have enough H-1B time to complete their training if they worked as a chief resident or in another temporary position between their residency and fellowship training. Thus, although other immigration options for such physicians may exist, it is imperative that AMC staff responsible for vetting candidates for GME are aware of the timing issues associated with the H-1B visa status, so that they can identify IMGs who may be unable to fulfill the program training requirements.

Hiring Foreign National Physicians Post-GME

AMCs hiring foreign national IMGs upon completion of their GME programs must confront the challenges presented by J-1 physicians subject to the two-year return requirement, or, alternatively, H-1B physicians subject to the H-1B cap and the six-year limit. Further, given the ever-increasing shortage of fully trained physicians, AMCs, as well as other employers, often are presented with the need to provide additional incentives, such as sponsorship for LPR or green card status, to remain competitive in their recruitment of a sufficient workforce where many of the “best and brightest” candidates are foreign national physicians. Fortunately, AMCs can leverage certain

elements unique to their entity status in the recruitment and hiring of foreign national IMGs following their completion of U.S. GME programs.

Initial Hire of J-1 Physicians Post-GME

To hire J-1 physicians directly upon their completion of GME programs, AMCs are encouraged to identify such physicians well before their final year of GME training. If such a physician has been fortunate enough to obtain a waiver of the two-year return requirement based on persecution or hardship, then an AMC may hire the IMG directly upon the IMG obtaining an H-1B visa. However, most physicians will pursue a J-1 waiver through the Conrad 30 Waiver Program. As noted above, the Conrad 30 program generally requires an employer/employee three-year commitment of full-time employment in an HHS-designated shortage area or, under a FLEX waiver, at a facility that serves a sufficient percentage of patients from underserved areas. Generally, FLEX waiver eligibility is established through a patient origin study, or zip code analysis of patient encounters, to document that a sufficient number of patients reside in federally designated Health Professional Shortage Areas (HPSAs) or Medically Underserved Areas/Populations (MUA/Ps). States generally give preference to facilities located in HPSAs and MUA/Ps and to primary care physicians, which puts FLEX facilities and specialists at a disadvantage. It is important that AMCs consult with immigration counsel early in the process of recruiting a J-1 physician who requires a Conrad 30 waiver.

Practice note: Dual representation is more frequent in the context of immigration practice than almost any other legal subspecialty in the health care field. Accordingly, AMC counsel should identify and define the attorney-client relationship with particular care from the onset of a given immigration matter, including the parameters of that relationship and the source of fees and costs. If the AMC works with a designated immigration attorney or attorneys, the physician should be notified, and representation agreements should detail the nature of the dual representation, including a provision addressing future potential conflicts of interest.

Important considerations should be taken into account in drafting the requisite employment agreement due to federal requirements and state health agency rules. For example, the employment agreement should contain an easily identifiable three-year term and require the IMG physician to work at least 40 hours per week. In addition, some states prohibit restrictive covenants that otherwise often are included in physician contracts. As the Conrad 30 Waiver Program is premised on the principal of attracting and retaining much-needed physicians to underserved populations, many states prohibit non-compete provisions that restrict the IMG's employment in the underserved area during or after the three-year service term.

Finally, the three-year service commitment associated with Conrad 30 J-1 waivers must be carried out in H-1B status, rather than in any lawful status. This means that any J waiver employer must be prepared to serve as an H-1B sponsor, with the attendant roles and responsibilities. Fortunately, all physicians granted a Conrad 30 waiver are categorically and personally exempt from the H-1B cap.²⁹ As a result, these physicians may commence work as soon as an H-1B petition is approved, without concern as to whether the annual limit of H-1B cap-subject visas has previously been reached for the year.

AMC Concerns Regarding Hiring J-1 Physicians Post-GME

AMCs can encounter limitations in hiring J-1 physicians immediately after they complete their GME training in the United States. The Conrad 30 J-1 waiver process has become so competitive in recent years that typically an employment agreement should be signed and in place prior to the commencement of the program's FY, which begins on October 1 in most states. AMCs are at a slight disadvantage in the Conrad 30 program, given that AMCs often seek specialist physicians, which typically the Conrad 30 program disfavors in preference of primary care physicians, and given that AMCs rarely are located in rural areas, which several state health departments favor over urban areas for J-1 waivers recommendations. In addition, some of the most robust AMCs are

²⁹ INA § 214(l)(2), 8 U.S.C. § 1184(l)(2).

not located within HHS shortage areas nor serve a sufficient number of patients from HHS shortage designations at their primary campuses. Further, AMCs typically do not operate Federally Qualified Health Centers (FQHCs) to which HHS awards clinical physician IGA J waivers.³⁰ Finally, most AMCs are not located within the geographical ambit of the federal IGA J-1 waiver programs administered by ARC or DRA.

Initial Hire of H-1B Physicians Post-GME

Virtually all physicians pursuing GME training in H-1B status do so at institutions exempt from the annual limit, or cap, of 65,000 new H-1B visas. In colloquial terms, such physicians have not been “counted against the H-1B cap.” As a result, such physicians’ post-GME employment will either be subject to the annual limitation of 65,000 H-1B visas per FY³¹ or their post-GME employer will need to establish that the new employment is independently exempt from the H-1B cap due to nonprofit status and a qualifying affiliation or relationship with an institution of higher education.

The distinction between whether an employer may sponsor a cap-subject or cap-exempt H-1B petition is critical. In the past two years, the year’s supply of cap-subject H-1B visas has been exhausted in the first five business days of April. All such petitions were subject to a random “lottery” system. Further, cap-subject H-1B petitions cannot request a start date prior to October 1 of the same calendar year, regardless of the timing of approval. As an additional complication, given certain state licensure restrictions, some physicians will not be able to attain the full licensure required by an H-1B petition until after the supply of new cap-subject H-1B visas has been exhausted for the year.

³⁰ HHS entertains and recommends research-based J waivers as an IGA, with respect to which AMCs are uniquely suited as employer-sponsors. To date, this has been a limited program for IMG physicians in comparison with waivers based on clinical service.

³¹ INA § 214(g)(1)(A), 8 U.S.C. § 1184(g)(1)(A). An additional 20,000 H-1B visas per year are available for those who obtained a Master’s degree or higher from a U.S. institution of higher education. INA § 214(g)(5)(C). Almost no IMG is eligible to participate in this “Master’s mini-cap quota”, as USCIS has held that U.S. GME does not constitute a qualifying degree.

Hiring H-1B Candidates Post-GME—AMCs' Strategic Advantage

AMCs have a competitive advantage over other employers recruiting H-1B physicians because most AMCs are exempt from the H-1B cap and the attendant lottery. Congress exempted from the annual H-1B limit foreign nationals employed at an “institution of higher education,” a “related or affiliated nonprofit entity,”³² or a nonprofit or governmental research organization.³³ Thus, for years, AMCs and teaching hospitals have been able to claim H-1B cap exemption as nonprofits affiliated with institutions of higher learning. In 2010, USCIS began questioning such institutions’ ability to meet the definition of “related or affiliated nonprofit entity” where no “shared ownership and control” existed. However, in 2011, USCIS issued interim guidance that it would give deference to its prior determinations of cap exemption.³⁴ Since the issuance of this interim guidance, most AMCs have been able to re-establish some semblance of normalcy. Given the continued acquisition of non-AMC facilities by for-profit entities and health care systems that render such facilities unable to claim H-1B cap exemption for their physicians, AMCs’ continued H-1B cap exemption presents a unique recruitment advantage when hiring foreign national IMG physicians.

AMC-related employing entities that are not themselves cap-exempt may nevertheless successfully file cap-exempt H-1B petitions on behalf of GME graduates. IMG physicians will be exempt from the cap if “employed at” a cap-exempt institution, even if the physicians are employed *by* a third-party petitioner. However, USCIS has imposed an additional requirement that the IMG’s employment *at* the cap-exempt institution “directly and predominately further the normal, primary, or essential purpose, mission, objectives or function of the qualifying institution, namely, higher education.”³⁵ Thus, it is

³² INA § 214(g)(5)(A), 8 U.S.C. § 1184(g)(5)(A).

³³ INA § 214(g)(5)(B), 8 U.S.C. § 1184(g)(5)(B). The rationale of this exemption, as detailed in the legislative history, applies to AMCs. Indeed, according to the congressional notes, “U.S. universities are on a different hiring cycle than other employers. The H-1B cap has hit them hard because they often do not hire until the numbers have been used up; and because of the academic calendar, they cannot wait until October 1, the new fiscal year, to start a class.” S. Rep. No. 106-269, at 2 (2000).

³⁴ USCIS’ March 18, 2011 Press Release, USCIS, H-1B Cap Exemptions Based on Relation or Affiliation. Importantly, such interim guidance does not cover AMCs and similar institutions that are sponsoring an H-1B for the first time so would not have a prior determination of cap exemption from USCIS.

³⁵ USCIS Memorandum, M. Aytes, “Guidance Regarding Eligibility for Exemption from the H-1B Cap Based on §103 of the American Competitiveness in the Twenty-First Century Act of 2000 (AC21) (Public Law 106-313)” (Jun. 6, 2006). The “nexus” requirement arguably is *ultra vires* as the statute makes no

important for an AMC-affiliated physician group or other third-party petitioner to establish that IMGs will spend most of their time working at the AMC and that there will be a “nexus” between their work and the mission of the cap-exempt institution. As clinical physicians at AMCs often are involved in the teaching and oversight of medical residents and students, establishing this link ought not to prove an insurmountable challenge.

Hiring Foreign National Physicians Post-GME—Additional Considerations

IMG physician candidates frequently present AMCs and other employers with requests for lawful permanent residence, or green card sponsorship. This is an additional type of immigration sponsorship typically above and beyond that which is required for the immediate (and temporary) employment authorization of the recruited physicians. Increasingly, physician candidates present these requests as part of the recruitment process for initial post-GME employment, given the increased bargaining power presented by an ongoing physician shortage, as well as the multi-year wait in store for physicians given the current processing delays in the green card process, most markedly for those born in India. Additionally, the successful recruitment of IMGs who have exhausted most of their allotted six years of H-1B time may depend on the employer’s willingness and ability to commence the green card process quickly. Involving immigration counsel prior to any green card undertaking is critical to establishing the parameters of the offered position and the green card sponsorship terms and conditions.

Green Cards for Physicians—A Brief Overview

Physicians pursue three main employment-based paths to the green card: (1) labor certification (Program Electronic Review Management or PERM) applications, in which the employer must demonstrate that it has tested the labor market (through bona fide

reference to the type of work that must be pursued at the cap-exempt institution at which the individual is employed.

recruitment efforts) and was unable to find minimally qualified, willing, and available U.S. workers³⁶ for the position and that it will pay the IMG the prevailing wage in the area of intended employment;³⁷ (2) physician National Interest Waivers (NIWs), in which the IMG may self-petition, but must agree to provide clinical services for five years in a federally designated underserved area or a Veterans Affairs hospital;³⁸ and (3) immigrant petitions based on more-subjective criteria related mostly to the IMG's individual qualifications and accomplishments, including EB-1 Extraordinary Ability and Outstanding Professor/Researcher petitions and research-based NIW petitions.³⁹ Each path has its own level of employer administrative burden, involvement, and costs, ranging from the labor certification application path at the highest, and the self-petitioned EB-1 Extraordinary Ability and research-based NIW petitions at the lowest. Determining the viable path and conditioning sponsorship on post-hire probationary periods or the like is advisable prior to entering into any contractual or other commitment for green card sponsorship.

In addition, the law requires that AMCs and other employers who pursue lawful permanent residence on behalf of IMG employees pay all costs associated with the above-mentioned PERM labor certification application.⁴⁰ Such costs include attorney fees, as well as the cost of conducting bona fide recruitment to test the labor market.

Recent Development: Employer Payment of Fees and Costs Associated with Immigration Benefits

As noted above, over the last several years, government audits by both DOL and the USCIS FDNS Directorate have made it abundantly clear that both agencies hold employers liable for all legal fees and costs associated with securing H-1B status on an employee's behalf. A recent Sixth Circuit case affirmed this interpretation and expanded

³⁶ DOL regulations define a "U.S. worker" as a U.S. citizen, U.S. national, LPR, refugee, asylee, or those granted status of an alien lawfully admitted for temporary residence under 8 U.S.C. §§ 1160(a), 1161(a) or 1255a(a)(1). See 20 C.F.R. § 656.3 (2005).

³⁷ 20 C.F.R. § 656.17 (2005).

³⁸ INA § 203(b)(2)(B), 8 U.S.C. § 1153(b)(2)(B).

³⁹ INA § 203(b), 8 U.S.C. § 1153(b).

⁴⁰ 20 C.F.R. § 656.12(b) (2007).

the potential employer liability for costs associated with other immigration benefits. On August 20, 2014, in *Kutty v. U.S. Department of Labor*, the Sixth Circuit affirmed an enforcement action by DOL holding an employer liable for back wages and expenses incurred by IMG physician employees in obtaining J-1 waivers and H-1B visa status.⁴¹ The employer, Mohan Kutty, MD, owned a number of medical clinics in Tennessee and Florida that employed—through a number of corporate entities—17 physicians, first in J-1 status, and then in H-1B status. According to the decision, Kutty repeatedly and clearly breached basic salary requirements of contracts with several physicians as well as the H-1B program. The court imposed liability and fines not only on the corporate employer, but also personally against the individual shareholder owner of the company. Specifically, the Sixth Circuit held that the costs of obtaining H-1B status—including attorneys’ fees—are business expenses that cannot be borne by the employee.⁴² This component of the decision merely reinforced the USCIS position that had become clearly articulated through the multi-year execution of the above-articulated employer site visits by the USCIS FDNS Directorate. Thus, the decision did little to upset the current understanding with regard to payment of H-1B fees.

However, the Sixth Circuit also affirmed the finding that the costs of obtaining J-1 waivers similarly are business expenses that cannot be borne by the employee, a marked departure from prior guidance and holdings. The underlying application, Form DS-3035, filed with the DOS Waiver Review Division, is specific to an individual physician for recommendation of a waiver personal to the physician, and is filed independently by the physician rather than the employer. Additionally, the application made to a given state health agency as part of the Conrad 30 program or to another IGA is recommended for approval in the name of an individual physician, rather than in the name of the employer. Further, unlike the H-1B petition, DOL does not issue any corollary regulations or alternative sub-regulatory guidance regarding any restrictions on which party may pay for a J-1 waiver application.

⁴¹ *Kutty v. U.S. Department of Labor*, 764 F.3d 540 (6th Cir. 2014).

⁴² Importantly, the court did not address whether DOL exceeded its statutory authority in speaking to costs associated with filings made to, and governed by, regulations of another agency, the U.S. Department of Homeland Security, as this issue was not raised below in appellant Kutty’s pro se representation.

Outlook

Given that the Sixth Circuit found that employers should pay for fees and costs that DOL had not previously addressed, now there is increased concern of “cross-pollination” of the requirements that employers bear the costs and fees associated with immigration benefits of all types, not solely those articulated in DOL regulations and/or guidance. As such, although the *Kutty* decision was narrowly drawn on the particular facts of the case before the Sixth Circuit, employers currently are encouraged to consider paying all fees and costs involved with a service-based J waiver. In the realm of physician hiring, an offer to pay for all attendant immigration fees and costs provides a recruitment advantage, and, coupled with compliance value, increasingly is deemed worthwhile.

**The authors would like to thank Eleanor M. Fitzpatrick, MA, Exchange Visitor Sponsorship Program Director, ECFMG, and Christopher Wendt, JD, Immigration Counsel Chair of the International Personnel Practice Group for the Mayo Clinic, for their helpful contributions to this Member Briefing. The views expressed herein are solely those of the authors, as are any errors. AHLA would like to thank the Teaching Hospitals and Academic Medical Centers Practice Group and the Immigration Affinity Group of the Labor and Employment Practice Group for sharing this Member Briefing with the Hospitals and Health Systems and In-House Counsel Practice Groups.*

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