

The Visalaw.com Health Care Immigration Newsletter
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Siskind Susser serves immigration clients throughout the world from its offices in the US, Canada, Mexico, Argentina and the People's Republic of China. To schedule a consultation with the firm by telephone or in-person, go to <http://www.visalaw.com/intake.html>.

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1. Openers
2. Ask Visalaw.com for Healthcare Workers
3. Health Care News Bytes
4. The ABC's of Healthcare Immigration – The Delta Regional Authority J-1 Physician Waiver Program
5. President Expands SCHIP to Cover Children of Legal Immigrants
6. Employer Compliance and Healthcare
7. AAMC Publishes Report on Physician Shortage Through 2025
8. Need for More Primary Care Physicians
9. Cuban Doctors Face Problems in Bringing Their Families to the US
10. AAIHR Comments on President Obama's Remarks on Foreign Nurses
11. DOD Recruiting Immigrant Doctors and Nurses for the Military
12. Senator Conrad Introduces Major Physician Immigration Bill
13. Chart Of Physical Therapist Licensing Requirements By State
14. State 30 Physician Waiver Chart
15. Physician National Interest Waiver Chart
16. Physician Job Center

1. Openers

Dear Readers:

Health care immigration in the US is still in a crisis state and Americans pay the price when they lack access to needed health care providers.

For physicians, the Conrad 30 J-1 waiver program hangs by a thread. The program expired last September and was renewed for just six months. Last month, Congress extended the program for just six more months. For doctors who entered on H-1B visas rather than J-1s, they face H-1B caps that largely mean those doctors are limited to a very narrow range of employment opportunities when they complete their training – mainly universities, non-profit research hospitals and some non-profit hospitals that have close relationships with universities (such as teaching hospitals). Doctors seeking work in underserved communities generally are not eligible for H-1B cap exemptions. Senator Conrad has introduced a bill that would remediate many of these problems, but it will take a big effort to get the bill passed anytime soon.

Doctors have also faced a series of new challenges as USCIS has taken what can only be described as hostile positions that threaten physician immigration all together. For example, USCIS denied 120 green card applications last fall and winter for physicians who possessed the MBBS medical degree, a degree offered in 40 countries and possessed by over 100,000 doctors in the US. USCIS argued that the degree was not equivalent to a US medical degree despite the fact that all of the state licensing boards and the Educational Commission on Foreign Medical Graduates agree that the MBBS is equivalent to the MD. Despite the fact that doctors have started winning their appeals of these denials (and USCIS has had not victories), USCIS still refuses to reopen and approve all of the cases.

USCIS has also started denying many H-1B cases for doctors working at non-profit employers claiming that the relationships with universities that serve as the basis for the H-1B cap exemption are not sufficient. Examiners at the USCIS CSC claim that the doctors must show that they are playing an integral role in the activity that is the basis for the relationship between the employer and the college despite the fact that there is nothing in the regulations or statute stating such a requirement. Particularly worrisome is that USCIS is denying visas for teaching hospitals for medical residents and fellows, something that jeopardizes health care delivery in the US.

On the nursing front, the situation is not much better. Congress has failed to get past the politics to pass a nurse visa immigration bill that has been negotiated and has the support of employers, organized labor and Republicans and Democrats. If the bill was actually voted on, it would easily pass. The bill would provide a substantial number of additional nursing green cards and end the blackout on nursing immigration that has gone on for more than two years.

USCIS is not helping the situation by suddenly making H-1Bs much harder again for nurses to obtain after taking a relatively sensible view on these applications over the last year.

And we're experiencing trouble for physical therapist applications now that USCIS is taking the surprising position that PTs require master's degrees and without the degree they are ineligible for H-1B visas. State licensing laws generally require a bachelors degree. This is one example of USCIS completely ignoring its own arguments espoused in other cases in order to find a reason to deny petitions. For many years, USCIS routinely denied H-1B applications for nurses because state licensing laws only require a two year associates degree. Now they deny PT petitions in spite of state licensing laws. Neither position was correct, but at a minimum, USCIS should not be able to have it both ways.

Fortunately, a group of employers has taken the impressive step of suing USCIS and requesting a judge to order the agency to stop ignoring the consensus position in the health care community that a bachelors degree is appropriate for entrée in to the PT profession.

The common theme here is that the fact that there is a serious shortage in several health care professions – a shortage that is not going to be alleviated to any great extent by the rise in general unemployment in the US – is being ignored by Congress and the White House's executive agencies. Those that care about health care in American need to be vigilant and remind Congress that immigration and labor politics shouldn't get in the way of instituting measures that will ensure that Americans have needed access to health care professionals.

In firm news, in May, LexisNexis will release the 2009 edition of Greg Siskind's J-1 Visa Guidebook. The book can be ordered online at www.lexisnexis.com.

We remind readers that we do not charge employers and recruiters of health care employees for consultations and that policy extends to individual physicians as well. Please feel free to call our office at 901-682-6455 to arrange for an appointment with me or one of my colleagues.

Kind regards,

Greg Siskind

2. Ask Visalaw.com for Healthcare Workers

If you have a question on immigration matters, write Ask-visalaw@visalaw.com. We can't answer every question, but if you ask a short question that can be answered concisely, we'll consider it for publication. Remember, these questions are only intended to provide general information. You should consult with your own attorney before acting on information you see here.

Q - I was on J-1 visa then J-1 waiver for one year in Missouri. After that I decided to go back to the Middle East, I'm now in the UAE. However my home country is Lebanon.

Is it really important to work in your home country for 2 years

Can I apply for a visa and come back to the USA in 2 years? what kind of visa?

A - Unfortunately, the rules are pretty strict about working in your home country or your last country of residence prior to coming to the US. Unless you go back to the correct location, you are barred from getting an H or L visa or getting permanent residency. You might be able to reenter the US in another visa category like an O-1 visa, but you will need to consult with your immigration lawyer to advise on the prospects for success.

Q - I have lost my DS-2019 form and want to apply for a J-1 waiver. Is there a way to retrieve a duplicate copy of the form? I readily admit that I'm subject to the home residency requirement.

A - Unfortunately, the State Department is very strict on the requirement to submit a copy of the DS-2019 form(s) with the J-1 waiver application. I am aware of cases, however, where a Training History Report from the program sponsor summarizing all of the major program details has been accepted.

Note that the form is produced with four copies - one for the applicant, one for the sponsor, one for the State Department and one for USCIS. The State Department usually will not cooperate in providing a copy. USCIS will often provide the form as part of a Freedom of Information Act request, but you should expect to wait a long, long time - perhaps more than a year - for the FOIA request to be handled. So it is best to focus on finding your copy or seeing if you can get your program sponsor to find a copy.

Q - A while back I heard that USCIS was opening up health care worker certifications for nurses to organizations other than CGFNS. What happened?

A - A few years back, USCIS accepted applications for a few months from organizations that wanted to issue certifications to health care workers as required by the 1996 Immigration Act. No new organizations have actually been approved and the Commission on Graduates of Foreign Nursing Schools is still the only approved organization to issue health care worker certificates.

3. Health Care News Bytes

The US House of Representatives has passed HR 1127, extending the Conrad State 30 Program. The program expired on March 6th and this bill will allow it to continue until September 30, 2009. The measure passed on a suspension vote.

The bill was then referred to the Senate, who passed the bill. The bill is now before the President for signature into law.

Arizona Republicans Jeff Blake and John Shadegg and Democrat Ed Pastor have introduced HR 1001, a bill creating a "W" visa that would allow up to 50,000 nurses to enter the US each year in non-immigrant status. The bill has been introduced previously and it is not clear yet that it will be marked up in the House Immigration Subcommittee.

In remarks at the White House Health Summit, President Obama discussed the nursing shortage with Congresswoman Lois Capps, a former nurse. At the forum, the President outlined his proposed budget increase for nursing education in the US in hopes of ending the country's dependence on foreign nurses.

According to the President, it makes no sense that the US must import foreign nurses in order to meet its health care needs. Congresswoman Capps commented that the foreign nurses are vital because the US does not have adequate education and training facilities for nurses.

President Obama agreed that the US is not doing enough to train and retain American nurses, stating that they are not sufficiently compensated, they do not have adequate working conditions and nursing faculty are poorly paid.

The Center to Champion Nursing in America has launched the Champion Nursing Coalition, a diverse group of health care consumer, payer and provider organizations that will work to educate Americans about the nation's severe nursing shortage and its impact on health care quality, access and cost.

4. The ABC's of Healthcare Immigration – The Delta Regional Authority J-1 Physician Waiver Program

In 2000, President Clinton signed legislation creating the Delta Regional Authority, a federal-state partnership designed to promote economic development and improve the quality of life for the people of the Mississippi River Delta region. President Bush appointed the DRA's first Chairman Pete Johnson who has continues to serve in this role. One of the program's chief objectives is to improve health care for impoverished communities in the 252 counties under the DRA's jurisdiction. Because the region has faced persistent physician shortages for many years, Chairman Johnson established a J-1 waiver program to attract international physicians to the DRA's many communities. The program has helped dozens and dozens of communities throughout the Delta region.

Which states and counties are covered?

The DRA covers counties and parishes in Alabama, Arkansas, Illinois, Louisiana, Mississippi, Missouri and Tennessee. The counties and parishes in the region follow

the Mississippi River up to Southern Illinois. The exception is Alabama which has a number of counties included as well. The following counties are covered:

Alabama

Barbour Choctaw Dallas Hale Marengo Pickens Washington	Bullock Clarke Escambia Lowndes Monroe Russell Wilcox	Butler Conecuh Greene Macon Perry Sumter
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Arkansas

Arkansas Bradley Clay Crittenden Desha Grant Izard Lawrence Lonoke Monroe Poinsett Randolph Stone Van Buren	Ashley Calhoun Cleveland Cross Drew Greene Jackson Lee Marion Ouachita Prairie Searcy St. Francis White	Baxter Chicot Craighead Dallas Fulton Independence Jefferson Lincoln Mississippi Phillips Pulaski Sharp Union Woodruff
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Illinois

Alexander Hamilton Johnson Pope Saline Williamson	Franklin Hardin Massac Pulaski Union	Gallatin Jackson Perry Randolph White
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Kentucky

Ballard Carlisle Fulton Hickman Lyon McLean Trigg	Caldwell Christian Graves Hopkins Marshall Muhlenberg Union	Calloway Crittenden Henderson Livingston McCracken Todd Webster
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Louisiana

Acadia Assumption Bienville Claiborne DeSoto Evangeline	Allen Avoyelles Caldwell Concordia East Carroll Franklin	Ascension Beauregard Cameron Catahoula East Baton Rouge East Feliciana
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Iberia Grant Jefferson Davis Lincoln Morehouse Ouachita Rapides Red River St. Charles St. John the Baptist Tangipahoa Vermillion Washington West Feliciana	Iberville Lafourche Livingston Natchitoches Plaquemines Richland St. Helena St. Landry St. Mary Tensas Webster West Baton Rouge Winn	Jackson Jefferson La Salle Madison Orleans Pointe Coupee St. Bernard St. James St. Martin Union West Carroll
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Mississippi

Adams Benton Claiborne Covington Grenada Humphreys Jasper Leflore Marion Panola Rankin Sunflower Tippah Walthall Wilkinson	Amite Bolivar Coahoma Desoto Hinds Issaquena Lafayette Lincoln Marshall Pike Sharkey Tallahatchie Tunica Warren Yalobusha	Attala Carroll Copiah Franklin Holmes Jefferson Lawrence Madison Montgomery Quitman Smith Simpson Tate Union Washington Yazoo
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Missouri

Bollinger Carter Douglas Iron New Madrid Oregon Perry Ripley St. Francois Texas Wright	Butler Crawford Dunklin Madison Ozark Phelps Scott Ste. Genevieve Washington	Cape Girardeau Dent Howell Mississippi Pemiscot Reynolds Shannon Stoddard Wayne
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Tennessee

Benton Crockett Fayette Hardin Henry	Carroll Decatur Gibson Haywood Lake	Chester Dyer Hardeman Henderson Lauderdale
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Madison Shelby	McNairy Tipton	Obion Weakley
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What is the role of state health departments under the DRA program?

The DRA adjudicates its waiver cases, but because it is a partnership between the federal government and eight states, the DRA seeks the input of state health agencies when it reviews waiver petitions. State health agencies are notified about waiver applications in their respective states and are given a timeframe in which to submit comments.

What are the recruiting requirements?

Employers are required to undertake a good-faith effort to recruit an American physician in the same salary range, without success, for 60 days before submitting the waiver petition to the DRA. Recruiting must be undertaken at three levels:

1. National Level: Newspapers with national circulation (e.g. USA Today) or medical journals (e.g. New England Journal of Medicine).
2. State level: Major in-state newspaper (e.g. Jackson Clarion Ledger), local newspapers or magazines, or in-state medical journals or publications.
3. Letters to in-state medical schools.

The DRA will also consider additional documentation such as online recruiting.

What level of commitment must the physician make?

The physician must agree to work for at least three years in a community in a DRA county or parish. The physician must provide medical care for not less than forty (40) hours a week and the work location must be a site in a Health Professional Shortage Area (HPSA), Mental Health Professional Shortage Area (MHPSA), Medically Underserved Area (MUA), or Medically Underserved Population (MUP). Only psychiatrists can base a waiver on working in an MHPSA.

What kinds of physicians qualify for DRA waivers?

DRA waivers are available to primary care physicians (general or family practice, general internal medicine, pediatrics, obstetrics/gynecology and psychiatry). Waivers are also available to physicians working in specialty medicine, but additional requirements must be met including:

- Providing a letter from the waiver sponsor outlining the reasons a physician with the particular specialty is needed in the area and containing information on the availability of the specialty services such as the closest location where the specialty is available, whether public transportation is available and evidence that the specialty practice would be viable.
- A description of the service area demographics
- A letter of support regarding the need for the specialty from the Chief Medical Officer of the facility where the J-1 doctor will provide services

- Two letters of support regarding the need for the specialty from local primary care physicians or facility representatives (the person writing the letter may not be affiliated with the waiver sponsor)
- Any other evidence documenting the shortage such as letters of support from other specialists or local health officers in the service area.

Note that the DRA prefers a physician to patient ration of 2000 to 1 or worse when evaluating whether a shortage is severe enough to merit a waiver.

Does the DRA permit restrictive covenants and non-compete clauses?

Contract terms such as non-compete clauses or restrictive covenants that take effect *after* the contract term is over are barred. DRA rules do, however, require a liquidated damages clause be included.

What is the liquidated damages clause that must be incorporated in to the employment agreement?

The following language must be incorporated in to the employment agreement (note that the contract may include an additional liquidated damages clause as long as it is independent of this language):

LIQUIDATED DAMAGES CLAUSE

Any breach or non-fulfillment of conditions will be considered a substantial breach of this agreement by you. If there is such a breach (NAME OF EMPLOYER) may, at its option, terminate this agreement immediately. In addition, it is agreed that (NAME OF EMPLOYER) will be substantially damaged by your failure to remain at (NAME OF EMPLOYER) in the practice of medicine for a minimum of three years and that, considering that precise damages are difficult to calculate, you will agree to pay (NAME OF EMPLOYER) the sum of \$250,000.00 if you fail to fulfill any portion of your minimum three-year contract. Should you perform any portion of the employment contract, you agree to pay a pro rata share based upon the number of months you failed to fulfill (i.e. \$6,945.00 per month). In addition to liquidated damages, (NAME OF EMPLOYER) will recover from you any other consequential damages, and reasonable attorney fees costs and expenses, due to the failure to provide services to (NAME OF EMPLOYER) for a minimum of three years, EXCEPT THAT, the full-time practice of medicine at another licensed medical facility, in Health Professional Shortage area (as defined by the United States Public Health Service) with the Delta Regional Authority (as defined by DRA) shall be considered the same a fulltime practice of medicine at (NAME OF EMPLOYER) for purpose of this paragraph. In the event of a dispute under this paragraph, either party may submit this matter to binding arbitration.

The parties agree in consideration of compliance with the forgoing, to indemnify and hold harmless the Delta Regional Authority and / or any person, firm or corporation now or hereafter acting as agent for the DRA in any capacity, and any successors in any such capacities and successors and assigns of DRA, from and against any loss, claim, damage and expense in connection with, or arising out of, compliance with the waiver application set forth herein or any other litigation.

What are the DRA rules regarding providing care to indigent and elderly patients?

The DRA requires that physicians agree to provide health services to people without discriminating because they are unable to pay or they are paying through Medicaid, Medicare or a state equivalent indigent health care program. Facilities should also provide care on a sliding fee payment arrangement for uninsured, low income patients and post this notice publicly in the facility.

The head of the sponsoring facility must also sign a statement noting

- The facility is in a Health Professional Shortage Area, Medically Underserved Area, Medically Served Population, or Mental Health Professional Shortage Area (including the shortage designation ID number, the Federal Information Processing Standards county code and census tract or block numbering area number or the 9-digit zip code of the area where the facility is located)
- The facility's record of serving Medicare, Medicaid and indigent patients for the last three years and the facility's intention to continue serving the population
- The current patient-to-physician ratios in the practice area broken down geographically and demographically
- The name of the physician, area of study and how these skills will impact the patients at the facility

What is the application fee for a DRA waiver application?

\$3000 payable via a check or money order made out to the Delta Regional Authority. The fee is non-refundable, but a partial refund (up to 50%) may be requested if a withdrawal request is submitted within twenty calendar days after the DRA receives the application. The check should be placed in a letter-sized envelope stapled to the G-28 or the employer's cover letter if there is no G-28.

What is the timeline for adjudicating a DRA J-1 waiver?

The DRA requests the opinion of the state health agency in the state where the physician will work before granting the waiver. The state agency is given 45 days to respond. The DRA will issue a recommendation within 60 days of the date the application is initially received.

How does the DRA verify the physician and employer are complying with the program rules?

The DRA requires the physician and the facility administrator to sign a "Physician Employment Verification Form" during the physician's first week of employment. The document is to be returned to the DRA along with documentation of the physician's H-1B status and proof of the doctor's possession of a license if a license wasn't submitted with the original J-1 application.

The DRA will send a site survey form every six months during the employment agreement to verify that the physician is working at the correct location and also to collect information on the patient population being served. The survey must be

returned within 15 business days from the issued date on the survey form. Failure to return the form will result in the DRA notifying USCIS and/or DOS.

The DRA also conducts random, unannounced site visits during the three year employment period and will report compliance violations, as appropriate, to the USCIS and/or DOS

Will the DRA sponsor National Interest Waivers?

Yes. But applicants must have previously been granted a DRA J-1 waiver or be applying for a J-1 waiver. The application should contain the following:

- A physician must submit a contract with a term of at least five years committing the physician to work in a DRA underserved county or parish.
- A support letter from the physician's employer
- A statement from the physician explaining the reason for pursuing the NIW
- An attorney letter stating, "to the best of their knowledge, the information in the application is truthful, and that he/she believes the applicant is eligible for a NIW".

Where can I learn more information about the DRA J-1 and NIW programs?

The DRA posts all information about the program on its web site at <http://www.dra.gov/programs/doctors/> .

5. President Expands SCHIP to Cover Children of Legal Immigrants

Two years ago, former President George W. Bush blocked legislation that would expand the State Children's Health Insurance Program (SCHIP). In February 2009, President Barak Obama signed the legislation to expand the program, which will now be able to provide government-subsidized insurance to 4 million mostly low-income children.

The program will reduce the number of uninsured children in America by about half over the next 4 1/2 years and increase the number of children covered by the program to 11 million. The measure is primarily funded by increasing the federal tax on cigarettes to \$1 a pack.

The expansion of SCHIP will now allow states to provide insurance to the children of legal immigrants who have been in the country for less than five years and loosen identification requirements for those enrolling.

6. Immigration Compliance and the Healthcare Employer

[Note: The following article by Greg Siskind was recently published by Bloomberg].

In 1986, Ronald Reagan signed into law the Immigration Control and Reform Act. The new law is remembered for the so-called "amnesty" that allowed nearly three

million immigrants illegally residing the country to gain permanent residency. The law had a flip side as well. It created a system requiring employers to act as deputies of the federal government by checking the identification and work authorization documents of all newly hired employees through the use of a new government form – the I-9. The politically sensitive topic of how to deal with the future needs for immigrant workers was set aside during the 1986 legislative debate.

The plan for legalizing millions of immigrants and, in exchange, making it a lot tougher for employers to hire illegal workers was supposed to provide a lasting solution to the immigration dilemma facing the country. But almost instantly it became obvious that illegal immigration was continuing and that IRCA was not having the intended effect of preventing unauthorized workers from finding employment. And that's likely because the immigrants legalized in the program had already been absorbed in to the economy.

During the prosperous '90s, the public largely ignored the issue of immigration. But the prosperity of those years also led to faster job growth than the domestic supply of workers could match. And so the number of illegally present immigrants shot up to an estimated 12 million. Employer enforcement during the decade remained largely theoretical as the number of worksite raids and government audits of I-9 records remained very low.

The 9/11 terrorist attacks and the economic downturn that followed marked the beginning of a new anti-immigrant wave in the country that led to efforts by Congress to impose strong new immigration enforcement laws. President Bush, like Ronald Reagan nearly two decades before, tried to push through an immigration reform deal that would legalize workers and also dramatically ram up immigration enforcement. But those efforts failed and the Bush Administration instead decided to address employer compliance first and then when illegal immigration was demonstrably under control, try again for legalization.

The result has been a dramatic crackdown on employers that is making headlines on a daily basis. The numbers tell the story. In federal fiscal year 2002, there were 25 criminal arrests and 485 administrative arrests associated with worksite immigration enforcement. In fiscal year 2008, there were 1,103 criminal arrests and 5,184 administrative arrests.

While people may think that immigration enforcement is something only of concern to construction companies and restaurants, all employers – including health care employers – need to be cognizant of the new enforcement environment and a variety of new laws and regulations.

Here are a couple of examples of employer compliance nightmares that have come across my desk in the very recent past:

Example A

Hospital X employs a Canadian nurse who entered the US five years ago on a TN visa. The nurse's stay expired after a year, but the nurse didn't bother to renew her authorized stay in the US and the hospital didn't bother to ask about it. Consequently, the nurse was working four years illegally before the hospital discovered the problem when the nurse brought the matter to her employer's attention.

The hospital had an I-9 on file for the nurse, but it failed to re-verify the nurse's immigration status as required under IRCA. So in addition to the nurse being in illegal status, the hospital had also violated the rule requiring re-verification of the nurse's visa paperwork on her form I-9.

The consequences are serious. First, had the hospital re-verified the I-9 in a timely manner, they would have been alerted to the need to file an extension of the TN visa, something that would have kept the nurse in status and working legally. Second, an IRCA violation would have been avoided. And finally, and perhaps most worrisome, the hospital may be liable to being found to have knowingly employed the nurse illegally under a theory of "constructive knowledge". The hospital is located in a state that now allows for the revocation of a business license for an employer that knowingly employs illegally present workers. So, at least in theory, the hospital's license to operate could be pulled.

Example B

Hospitals and health care employers are also frequently bought and sold in corporate acquisitions. Unfortunately, immigration is rarely addressed in the due diligence. However, an I-9 review conducted as part of that process can help identify visa transfers that must occur prior to closing or, in some cases, workers who will be rendered out of status by virtue of the transaction and which may not be transferred.

In an asset acquisition of Hospital X, an I-9 audit reveals that there are a dozen doctors on H-1B visas employed by the hospital. Hospital X is a non-profit employer affiliated with a local university and the H-1B physicians are exempt from the H-1B cap as a result. But the acquiring employer is a for-profit entity and the new employer does not want to assume any liabilities from the selling company. Unfortunately, the new employer may not be eligible to file transfer applications. And at the moment of the signing of the closing documents, the twelve doctors are potentially illegal aliens. Aside from the immigration mess, one can reasonably foresee litigation from some seriously damaged physicians.

Health care human resource managers need to be cognizant of a number of developments in the immigration employer compliance arena. The following is a roundup of the hot topics in the field.

I-9s

Effective April 3, 2009, USCIS will be requiring employers to complete a new Form I-9. The form was originally set to take effect on February 3, 2009, but the new Obama Administration issued a 60 day moratorium on the implementation of all new rules. The new I-9 is largely similar except that it removes certain kinds of expired documents from the list of acceptable forms of proof of employment authorization. The new form can be found online at <http://www.uscis.gov/I-9>.

A big trend emerging in I-9s is the switching over to electronic I-9 systems from the traditional paper formats. USCIS began permitting the use of electronic I-9 systems when it issued a regulation in 2004 allowing for such systems for the first time. There are now more than a dozen electronic I-9 vendors offering systems that involve either the installation of software on a company's computers or a web-based subscription setup. For a list of vendors and contact details, email me at gsiskind@visalaw.com.

There are a variety of benefits that make electronic I-9 systems worth considering including:

1. The systems generally prevent employees and employers from signing out of a form until it is properly completed
2. Some of the systems are "intelligent" and ensure that the answers in the form are consistent (such as allowing only the appropriate document to be provided for Section 2 by the worker based on the status they listed in Section 1)
3. Some systems allow for certain sections of the form that are the same from applicant to applicant to be pre-filled to save time.
4. Some systems have help buttons located by each question to help employees and employers figure out how to properly complete the form
5. Employers with multiple sites can more easily monitor I-9 compliance at remote locations
6. Reverification is automated and employers are less likely to incur liability for failing to update an I-9. Some systems send emails when it is time to re-verify. Some of the systems also track visa and I-94 expiration dates.
7. Employers can integrate the system with E-Verify so that the entire process is automated
8. Using an electronic I-9 system reduce the risks of identity theft from the robbery of paper I-9 records (something I have recently had reported by more than one client).
9. An electronic I-9 system can make it easier to respond quickly to an ICE audit.
10. Electronic I-9 systems can be integrated with payroll and employee database systems which can make it easier to determine when I-9s can be purged.
11. Instructions can appear in multiple languages making it easier for employees with weak English skills to complete the form.
12. Electronically retained I-9s are more easily searchable and can save time over having to track down a specific employee's paper I-9.

There are some disadvantages worth noting. First, the systems are not 100% secure (though the law requires vendors to incorporate security measures). The systems don't totally stop identity theft since a person can present doctored identification and employment authorization paperwork. Paper I-9s are free (aside from costs for storage, training, etc.). And like any web-based software product, there are risks if an employer goes out of business. An employer should be sure to have back ups on their own system to avoid problems.

E-Verify

You may have seen advertising from the Department of Homeland Security touting the E-Verify electronic status verification system (formerly called the Basic Pilot Program). E-Verify is a free, Internet-based system that confirms the legal status of newly hired employees. The system, a creation of the 1996 Immigration Act, compares Social Security Number and DHS immigration databases to the employee's name and other Form I-9 information. The system is fast – it takes just a few seconds to process – and will either confirm an employee's authorization to work or issue a tentative non-confirmation.

The controversy in the system largely centers around the accuracy of the databases. A recent report indicated that a high percent of naturalized US citizens show up in the system as being unauthorized to work, though DHS claims they have much improved the system. Many employers are reluctant to use the system because they agree to allow DHS and the Social Security Administration to make unannounced inspection visits.

E-Verify has been in the news a great deal over the last few months. The authorization for the program expired last September and Congress only saw fit to authorize it for six more months. As of the writing of this article, it is not clear whether the program will be extended beyond its March 6, 2009 authorization date.

Supporters of the program attempted to push through a measure that would have mandated E-Verify be used by employers receiving stimulus money in the giant package approved by the Congress in February 2009. In fact, such a provision passed in the House only to be stripped out in conference.

President Bush issued an Executive Order in 2008 mandating a high percentage of federal contractors – estimated at 167,000 employers – use E-Verify as a condition of their government contract. The regulation implementing that order has been challenged in the courts and the implementation date for the rule has now been pushed back to May 21, 2009. The rule covers contractors with contracts worth at least \$100,000 and their subcontractors with contracts worth at least \$3,000.

While DHS has not released a breakdown by industry of how many contractors are to be affected by the new rule, hospitals and health care companies will no doubt be affected in large numbers. Many, for example, have significant contracts to provide health care services to federal employees.

State laws

Over the last two years, nearly two dozen states have passed employer sanctions laws. And the pace of state lawmaking activity in this area has not slowed this year with a number of additional states considering such legislation.

The laws themselves are the subject of great controversy since many argue that the Constitution preempts states from regulating immigration. And, indeed, many of the tougher laws are now the subjects of battles in the courts. Nevertheless, employers need to assume that the laws are going to survive.

The laws vary, but there are a few common themes:

- Barring employers that knowingly hire unauthorized immigrants from doing business with the state
- Revoking business licenses of employers that knowingly hire unauthorized immigrants
- Mandating E-Verify use by all employers, just contractors or just public employers
- Subjecting employers to fines or jail time for knowingly hiring unauthorized workers
- Creating a private right of action against employers for workers displaced by an unauthorized immigrant

For an overview of activity in each state, see the attached chart.

No match rule

In August 2007, the Bush Administration released a rule describing the obligations of employers who receive letters from the Social Security Administration that employees' names do not match the Social Security Numbers on record at the SSA or who receive a letter from DHS after an I-9 audit indicating that their workers may not be authorized to work. The rule provides a "safe harbor" procedure for employers to avoid a finding of having constructive knowledge that an employee is unauthorized to work by virtue of having received a no-match letter.

Almost immediately after the rule was released, a lawsuit was filed jointly by a group of organizations that included the US Chamber of Commerce, the American Civil Liberties Union and the AFL-CIO. A California US District Court judge agreed that DHS failed to meet administrative law requirements in the way it issued the rule and he enjoined the agency from implementing the regulation. DHS attempted to address the judge's concerns and re-issued a final regulation last fall, but the judge has not dropped the injunction (arguing that it wanted to give the new President an opportunity to weigh in). A final decision in the case could come this spring.

Assuming the Obama Administration is interested in proceeding with the regulation (and there is no indication that it is not interested in issuing the rule), employers will be required to

1. Within 30 days, check its records to see if the error was the employer's fault
2. If this doesn't resolve the error, the employer must notify the employee within 30 days and the employee should attempt to correct the problem.
3. If 90 days pass without a resolution of the discrepancy, the employer must have the employee complete a new Form I-9 (without a social security card being used to prove employment authorization).

If the discrepancy is not resolved and the employee's identity and work authorization are not verified, the employer must either terminate the employee or face the risk that DHS will find constructive knowledge of lack of employment authorization. And an employer in this instance would face potential enforcement action from DHS.

Some experts believe as many as 4,000,000 workers could be working under false social security numbers, a number of whom are likely working for the nation's health care employers.

Conclusion

Recent statements by Secretary of Homeland Security Janet Napolitano indicate that the new President will continue President Bush's tough policies on employer compliance with the nation's immigration laws. Even if a major immigration reform bill passes legalizing millions of illegally present immigrants, this will likely be paired with even tougher employer enforcement rules. The nation's health care employers have so far not been in the headlines, but they are far from immune from being subject to tough enforcement measures. And the environment is likely to get even tougher.

State Immigration Employer Compliance Laws

Type of Law	States
General bar on employers knowingly hiring unauthorized immigrants	AZ, CO, MS, MO, NH, SC, TN, WV
Revocation of business licenses of employers knowingly hiring unauthorized employees	AZ, MS, MO, SC, TN, VA, WV
Requires all employers in the state to use E-Verify	AZ, MS, SC
Requires all public employers in the state to use E-Verify	AZ, GA, MN, MO, MS, NC, RI, SC, VA
Requires all public employers to use either E-Verify or an equivalent government or third party status verification	OK, UT
Requires employers contracting with public employers to use either E-Verify or an equivalent government or third party status verification	OK, UT
Requires employers contracting with public employers to use either E-Verify or possess a qualifying state drivers license	SC
Bars employers in the state from using E-Verify	IL
State agencies are barred from contracting with employers who knowingly employ unauthorized immigrants	AR, CO, ID, MA, MO, SC, TN
Requires businesses contracting with state agencies to certify employees are legal	AR, CO, MA, MO, OK, SC, TN, VA
Requires business contracting with state to use E-Verify	AZ, CO, GA, MN, MO, MS, RI
Requires companies receiving subsidies or economic incentives from state agencies to certify all employees are authorized to work	CO, IA, MN, MO, PA, TX
Requires companies receiving economic incentives to use E-Verify	AZ
Employers using E-Verify gave favorable treatment in securing subsidies or economic incentives from state agencies	MN
Requires that public employer's employees by US citizens, permanent residents or have the right to work in the US for any employer	HI
E-Verify is a safe harbor protecting employers from prosecution for knowingly hiring unauthorized immigrants	AZ, MS, MO, OK, SC, TN
Employers requesting more or different documents than required under IRCA's Form I-9 are committing a civil rights violation	IL
Requires employers using E-Verify to sign a state law attestation	IL
Requires employers post a notice about state laws if they use E-Verify	IL
In considering a bid, a state agency may consider a potential contractors' use of non-citizens employees and whether the use of such employees would be detrimental to state residents or the state economy.	MI
Employers are required to maintain file copies of all documents reviewed as part of the Form I-9 process	CO
Employers subject to fines and jail sentences for violating state law	CO, NV, OK, WV
State harboring and transporting laws targeting employers	MO, NV, OK, SC, UT
Wages paid to unauthorized immigrants may not be deducted on employers' state income tax returns	CO, GA, MO, SC, WV
Requires employers to certify to the state that all employees are authorized	CO

Requires employers to withhold income tax payments for independent contractors who provide a taxpayer identification number	CO, GA
Creates a private cause of action for US employees when employer terminates to hire an unauthorized employee	OK, MS, SC, UT
Makes it a felony to accept unauthorized employment	MS

7. AAMC Publishes Report on Physician Shortage Through 2025

The Association of American Medical Colleges (AAMC) has recently issued a report on the physician shortage through the year 2025. According to the report, by 2025 there will be a shortage of 124,000 to 159,300 physicians. Due to a number of factors, such as population growth and aging, demand for physicians will outpace the supply of physicians. The AAMC declares that providing more educational and training opportunities for physicians will not be enough to address these shortages.

According to the report, even though the supply of physicians is projected to increase between now and 2025, the demand for physicians is projected to increase even more sharply. The US Census Bureau projects that the US population will grow by more than 50 million (to 350 million) between 2006 and 2025. This factor alone is likely to lead to a substantial increase in the demand for physician services.

The report also states that physician shortages are likely to be seen in a number of ways, including longer wait times for appointments, increased travel to get care, shorter appointments with physicians, expanded use of non-physicians for care and higher prices.

According to the AAMC, a 30 percent expansion in medical school enrollment and an increase in graduate medical education positions will not eliminate the shortage. An increase in the number of physicians must also include other actions, such as changes in how physician services are delivered, in order to address the shortage.

The report declares that there are several factors that could worsen the shortage significantly over the next few years. These factors include if the US does not implement significant healthcare delivery system reforms and/or improve healthcare efficiency and effectiveness, or if the US implements universal health coverage, or if the flow of foreign medical graduates slows significantly.

The AAMC report makes the following suggestions:

- The US should continue to promote an increase in medical school capacity and the availability of graduate medical education positions as part of a broad strategy to address physician shortages;
- The US should promote efforts to more effectively use the limited number of physicians through the use of non-physician clinicians and other health professionals, and to improve physician productivity;
- Recognize and respond to physician life-style concerns, such as promoting flexible scheduling. Given the large number of physicians over age 55, their decisions as to retirement will have an enormous impact on the number of physicians in the US.

The complete report can be found at:

https://services.aamc.org/Publications/showfile.cfm?file=version122.pdf&prd_id=244&prv_id=299&pdf_id=122

8. Need for More Primary Care Physicians

In a recent opinion piece in *Modern Healthcare*, Richard Scheffler, professor of health economics and public policy at the University of California at Berkeley, and director of the Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, declared that more primary care physicians are needed in order to address the physician shortage in the US. He states that the US needs comprehensive health policy reforms that will encourage an efficient, cost-effective and quality healthcare system, and this can be done by attracting physicians to practice primary care.

Professor Scheffler is of the opinion that the US physician shortage can be better addressed not by increasing enrollment in medical schools, but by attracting more physicians to primary care. Experts have shown that people living in areas with more primary care physicians have better overall health than those living in areas with less primary care physicians, even with accounting for age and income differences. These experts have also found that areas with more primary care physicians also have much lower healthcare costs.

According to Professor Scheffler it costs \$1 million to train one physician. Physicians who have just graduated from medical school typically owe \$150,000 to \$200,000 in school loans. Because of this, these physicians routinely choose medical fields with a high earning potential, and these fields are not primary care positions.

In addition to higher salaries, specialty medical fields are more attractive to physicians since they have more regular schedules and there are fewer pager calls from patients on nights and weekends. Professor Scheffler also cites a national survey of medical students from September 2008, showing that only 2% of medical students were considering general internal medicine as a career.

In his article, Professor Scheffler affirms that physicians will be attracted to practicing primary care if the system rewards them for doing so. Inducements such as debt relief for those willing to practice primary care will help attract physicians, as well as reforming health care payments to using a single payment for a group of related services.

Patients' payments should also be used to cover preventive care and health education, which will encourage greater use of health professionals such as physician assistants and nurse practitioners. This will mean better schedules and fewer pager calls for primary care physicians, thereby relieving some of the pressures off of these physicians.

9. Cuban Doctors Face Problems in Bringing Their Families to the US

Two years ago the US implemented a measure allowing physicians who defected from Cuba to seek asylum in the US. Upon receiving legal permanent resident (LPR)

status, the physicians can then petition for their families to join them in the US. However, while the US has approved the petitions for the physicians' families to come to the US, the Cuban government is preventing these family members from leaving the country.

The Cuban government has posted physicians in foreign countries such as Bolivia, Pakistan and Venezuela in order to provide humanitarian relief. Many times, these physicians then apply at US embassies for asylum in the US under the Cuban Medical Professional Parole Program. While many of these asylum applications are approved and the physicians are then able to immigrate to the US, their families left behind in Cuba are not able to join them in the US since the Cuban government is denying them exit visas.

The Cuban government's stance is that these are the family members of deserters, and they therefore cannot be allowed to leave Cuba. In addition, these family members face harassment in other forums, such as being bullied in school or the workplace for being the child or spouse of a defector.

Defectors from Cuba are barred from returning for seven years, and they are therefore prevented from even visiting their families.

10. AAIHR Comments on President Obama's Remarks on Foreign Nurses

The American Association of International Healthcare Recruitment (AAIHR) an organization of US based international healthcare recruitment service providers which has the stated goal of promoting legal, ethical, and professional practices for international healthcare recruitment, has commended President Obama on his remarks at the White House Health Summit on foreign nurses and the nursing shortage. AAIHR praised President Obama's public recognition of the United States' nursing shortage and his commitment to addressing the shortage in a bipartisan manner.

In its comments on the President's speech, AAIHR stated that it agrees with the President that solving the nursing shortage requires increasing the faculty and training resources at nursing schools, as well as increased federal funding for domestic nurse training and retention. However, AAIHR also stated that increased federal funding is not an immediate solution to increasing the number of nurses. An immediate measure to addressing the shortage issue is the recruitment and placement of foreign nurses.

The AAIHR went on to describe its support for bipartisan legislation that would provide both immediate and long-term solutions to the nursing shortage. The Emergency Nurse Supply Relief Act of 2008, introduced by Representatives Wexler (D-FL) and Sensenbrenner (R-WI), would allow a limited number of qualified immigrant nurses to fill vacancies in the US health care system, while also providing significant funding for domestic nurse training and retention.

11. DOD Recruiting Immigrant Doctors and Nurses for the Military

In December 2008, the US Department of Defense (DOD) announced the launch of a pilot program to recruit about 1,000 foreign health care workers and language and cultural specialists to serve in the US military. The program targets those without green cards but who do have visas and work permits. People sought for the program include doctors, nurses, other health care professionals and those proficient in certain foreign languages and associated cultures.

Past DOD programs have failed to attract enough medical practitioners, so the DOD is now focusing on attracting foreign nationals.

The goal of the pilot program is to assist the DOD in maintaining its requirement of about 24,000 doctors, dentists and nurses for military services. According to the DOD, the military is short about 1,000 personnel in the fields of medicine, nursing and dentistry.

The pilot program provides successful applicants with a way to accelerate naturalization. Applicants are required to commit to specific periods of military service.

About 8,000 immigrants sign up for the US military each year, and there are currently approximately 29,000 non-citizens serving in the U.S. military.

Physicians and nurses interested in the program are welcome to contact Greg Siskind at gsiskind@visalaw.com for more information.

12. Senator Conrad Introduces Major Physician Immigration Bill

Senator Kent Conrad (D-ND), the original sponsor of the Conrad 30 J-1 program, has introduced S. 628, a bill that would make a number of changes to the physician immigration system. The bill's text can be found at <http://www.thomas.gov/cgi-bin/query/z?c111:S.628>. The following is a summary of the bill's major components:

The Conrad State 30 program allows foreign doctors on J-1 visas to obtain a waiver of the J-1 requirement to return to their home country for two years, if they agree to serve for 3 years in an underserved area in the U.S. Each state is allowed 30 such waivers. In recent years, almost 1000 additional doctors annually have begun practicing in underserved communities in all 50 states as a result of the Conrad 30 program. The Conrad State 30 Improvement Act would make this successful program permanent and implement various reforms intended to increase the number of the doctors in underserved areas. Below is a section-by-section summary of the bill.

Section 1. Title – Conrad State 30 Improvement Act

Section 2. Permanent Authorization - Make the Conrad 30 program permanent. Since its inception in 1994, the program has been repeatedly reauthorized on a temporary basis.

Section 3. H-1B Participation & Increase in Per State Allotment

H-1B Participation – Allow doctors who come to the U.S. on an H-1B visa to obtain a Conrad 30 waiver slot, but not in a “flex” slot which allows doctors to practice outside of underserved areas, as long as they treat patients from underserved areas. Currently, only J-1 doctors are eligible for the program. There would be no new slots created initially; the H-1B doctors would simply be incorporated into the current 30 waiver per state system. H-1B doctors do not have a requirement to return home, so in return for their 3 years of service in the Conrad 30 program, these doctors would receive an exemption from:

- a) H-1B caps (helpful for those doctors who originally obtained an H-1B visa through a cap-exempt employer, but wish to stay in the U.S. when their employment with such employer terminates, and would thus be subject to the H-1B caps if seeking employment with a non-exempt employer);
- b) the 6-year limit on H-1B visas (though their visa would be capped at 6 additional years); and
- c) green card caps (*see Section 4 below*).

Increase in Per State Allotment – If 90% percent of the nationwide waivers are filled in given year, the number of waivers allowed per state would increase to 35. Then if 90% of the adjusted total of nationwide waivers were filled, the per state allotment would increase to 40, and so on indefinitely. Only states that received at least 5 waivers in any of the three previous years would be included when calculating the 90% threshold.

Section 4. Green Card Cap Exemption – Green card cap exemptions for doctors who have completed the Conrad 30 program. Due to current caps, many doctors face extremely long waits to obtain green cards, because a very high percentage of doctors come from heavily oversubscribed countries, such as India. A cap exemption would provide an important incentive for doctors to practice in underserved communities.

13. Chart Of Physical Therapist Licensing Requirements By State

Linked at <http://www.visalaw.com/IMG/charts.html>.

14. State 30 Physician Waiver Chart

Linked at <http://www.visalaw.com/IMG/state30.html>.

15. Physician National Interest Waiver Chart

Linked at <http://www.visalaw.com/IMG/NIW.html>.

16. PHYSICIAN JOB CENTER

Siskind Susser, through its numerous health clients and its working relationships with physician recruiting firms, is able to assist international medical graduates seeking employment opportunities in the US with our employer clients interested in going through the visa application process. We do not charge physicians or our employer and recruiter clients for these services. If you are interested in our help, please e-mail us at eschachter@visalaw.com. If you are an employer or recruiter interested in listing a position in our newsletter, please also e-mail us at gsiskind@visalaw.com or call Greg Siskind at 901-682-6455.

For a listing of physicians seeking positions requiring visa sponsorship, go to **www.visalaw.com/quickbase.html**. For more information on any of these candidates, please email us at gsiskind@visalaw.com with the physician's candidate number in the subject line of your email.