The Visalaw.com Health Care Newsletter
December 2007


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1. Openers

2. Health Care News Bytes

3. The ABC’s of Healthcare Immigration – H-1C Visa for Nurses

4. Nursing Amendments and Bills in Congress

5. DOL Finds in Favor of H-1B Physician in Case Against the U.S. Department of Veteran’s Affairs

6. CGFNS to Deny VisaScreen to Applicants Who Took Tainted Philippines Exam

7. NFAP Report Critiques S. 1348

8. Asylum Denied to Health Care Workers

9. Nurse Creates Kidney Transplant Program for Latino Immigrants from Abroad

10. Bar on Unauthorized Immigrants Prevents U.S. Citizens from Obtaining Medicaid

11. Mexican Consulates Provide Healthcare Information

12. AMA Reports on Physician Shortage in Rural Areas

13. CHAMP Act Would Expand Medical Coverage to Immigrants

14. U.S. Savior: Foreign Doctors

15. Study of Nursing Shortage Impact on Patient Care
Dear Readers:

These are not the easiest times to advise clients on health care immigration matters. There are numerous crises happening simultaneously and little evidence Congress has the will to solve the problems.

First we have a blackout on nursing immigration that began early this year and continues with no immediate solution in sight. Green card backlogs for nurses run several years and the lack of a non-immigrant visa means that very few nurses are now entering the country. The Senate passed a measure as part of a budget bill that would have temporarily resolved the issue by allocating 61,000 additional green cards for nurses. But the measure was stripped out of the final bill. The odds of a measure passing soon are probably no better than 50-50. In the mean time, patients around the US are facing a severe nursing shortage and the lack of foreign nurses is actually increasing mortality rates.

On the doctor front, the news is only a little better. The doctors can still get to the US on J-1 and H-1B visas to train in residency and fellowship programs. But remaining in the US after those programs end is getting more challenging.

First, those training on H-1Bs are finding that the massive demand for H-1B visas means the only opportunities available upon conclusion of their programs are at university hospitals or non-profit facilities associated with universities. Even work in a physician shortage area is not enough for many.

For those on J-1s, the Conrad 30 waiver program expires in eight months and it is no sure bet that the program will be extended in the current political environment.

The green card situation isn’t much better. The EB-2 category for India is backlogged several years. That group constitutes by far the largest number of immigrant doctors – near 30%.
While foreign health care workers are relatively popular politically, the current poisoned atmosphere in the Capitol is a serious issue. In short, immigration is a radioactive issue and no one wants to push these bills even when they do not involve illegal immigration.

In some ways, the popularity of these groups works against them. Last summer, separate immigration bills for doctors and nurses were not allowed to proceed on their own because they are considered "sweeteners" to get tougher measures on illegal immigration passed. And even though comprehensive reform is dead, some in Congress refuse to let those bills move unless action is taken on less popular measures like the DREAM Act for unauthorized immigrants who entered as children and AgJobs for unauthorized agricultural workers.

Part of the problem is also the calendar. Right now, the legislative calendar is dominated by appropriations bills that must pass for the government to continue operating. Attempts at getting immigration bills added to these bills have not been successful despite repeated efforts. The measures must pass with 60 votes in the Senate and if any controversial measures pass, all of the less controversial items are potentially subject to being stripped out in order to avoid a fight.

So for now, the measures may have to pass as standalone bills and they must find a place on the legislative calendar. And that may mean we have to wait until 2008.

Hopefully, by the time our next newsletter is out, we’ll have something positive to report.

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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. Health Care News Bytes

The Commission on Graduates of Foreign Nursing Schools (CGFNS) is opening three new exam centers in China, in addition to the current exam site in Beijing, beginning with the July 11, 2007 CGFNS Qualifying Exam. The new exam centers will be in Shanghai, Guangzhou and Chengdu.

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Senators Harry Reid (D-NV) and Daniel Inouye (D-HI) have reintroduced a bill, which would require minimum nurse staffing ratios at certain Medicare providers. The bill, S. 73, also known as the Registered Nurse Safe Staffing Act of 2007, requires that hospitals participating in the Medicare program create a staffing system to ensure that there is a certain number of registered nurses on each shift in order to provide appropriate levels of patient care.

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On February 21, 2007, Representatives Pat Haggerty (R-El Paso) and Garnet Coleman (D-Houston) introduced H. 1707, the Texas Hospital Patient Protection Act, which would require fewer hospital patients to be assigned to each registered nurse in hospitals in the Medicare program.

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On January 29, 2007, USCIS Associate Director Mike Aytes issued a memorandum to all USCIS Service Centers regarding the extension of the Conrad State 30 Program through the passage of Public Law 109-477. The Service is directed to continue to process Conrad State 30 waivers through June 1, 2008.

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On June 22, 2007, the Department of State published its proposed rule to change fees for the J-1 Exchange Visitor Program. The new fees, which have not yet been determined, will affect applications for the designation and redesignation of exchange programs, the cost for applications and amendments to applications, change of program category, extension requests, and requests to update SEVIS status.

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At a recent meeting, the USMLE Composite Committee reviewed its policy of requiring those who failed or did not complete a Step or Step Component and wish to retake it to do so no sooner than 60 days after the previous test date.

Effective May 1, 2007, the 60-day waiting period between attempts at the same USMLE Step or Step Component will be eliminated. However, an applicant’s result from a prior attempt must be available before he or she can reapply.

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ECFMG has announced that it will change the way eligibility periods for USMLE Step 1 and Step 2 CK are assigned. These changes will take effect for applicants who submit an application on or after May 1, 2007.

When an applicant applies for Step 1 or Step 2 CK, he or she must choose a three-month period, such as January-February-March, February-March-April, etc., during which to take the exam. This three-month period is referred to as the eligibility period.
Previously, ECFMG had to receive a complete application at least one month in advance of the eligibility period selected. Now, applications do not need to be received in advance of an eligibility period to obtain that eligibility period. To select and obtain an eligibility period:

- ECFMG must receive the complete application by the 24th day of that eligibility period, AND
- The application must be processed by ECFMG by the 25th day of that eligibility period.

This policy change does not affect the way eligibility periods for Step 2 CS are assigned. When an applicant is registered for Step 2 CS, he or she is assigned a 12-month eligibility period that begins on the date that the processing of the application is completed.

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According to the American Association of Colleges of Nursing (AACN), President Bush’s 2008 budget proposal would eliminate almost $180 million from programs meant to train and educate healthcare professionals. $44 million would be taken from the Nursing Workforce Development programs. $135 million would be cut from other programs that train healthcare professionals, such as the Advanced Education Nursing Program.

While this budget does hurt these training programs, the budget also proposes to increase funding by $13 million for loan repayment and scholarship programs for healthcare professionals.

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A new website launched by the University of North Dakota Center for Rural Health displays the latest research findings by federal Rural Health Research Centers. Featured topics include access to care, health care quality, Medicare and Medicaid, critical access hospitals, health information technology and workforce. The site, which is funded by the Department of Health and Human Services, can be found at http://www.ruralhealthresearch.org/.

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According to a survey conducted by the Health Resources and Services Administration, the number of licensed registered nurses in the U.S. grew by 7.9% between 2000 and 2004, to an estimated 2.9 million. More than 83% of licensed registered nurses were employed in nursing in 2004, the highest rate since 1980.

The complete survey can be viewed at http://www.bhpr.hrsa.gov/healthworkforce/reports/rnpopulation/preliminaryfindings.htm.

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ECFMG is advising international medical graduates who need to pass Step 2 Clinical Skills (CS) of the USMLE in order to participate in the 2008 Match (in March 2008) to register as soon as possible for Step 2 CS. As of May 2007, the earliest test date available at a testing center was in September 2007.

According to the 2007 Step 2 Clinical Skills Schedule for Reporting Results, those who do not take Step 2 CS by December 31, 2007, will not have their results available in time to participate in the 2008 Match.

ECFMG is offering this advice since demand for the Step 2 CS exam is expected to be especially high during the second half of 2007 and test sessions at all test centers may be subject to scheduling restrictions that limit the number of test dates available.

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On July 23, 2007, Senator Jeff Sessions (R-AL) proposed amendment S.AMDT.2374 to Senate bill S.1642, whose purpose is to “amend the provisions of the Higher Education Act of 1965 regarding graduate medical schools located outside of the United States”. Specifically, the amendment proposes to provide federal funding to foreign medical schools to help augment the U.S. supply of physicians in order to address the physician shortage in the U.S.

One of the provisions of the amendment would require that for a school to receive financial aid, it must show that 75 percent of its graduates pass the Educational Commission for Foreign Medical Graduates’ Examination. Under current law, in order to qualify for aid, the school must show that 60 percent of its graduates pass the exam. This requirement would go into effect in two years time.

The amendment passed in the Senate on July 23.

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In July, the US Senate passed a bipartisan resolution praising Muslim-American physicians who condemned the terrorist acts in the United Kingdom. In early July, acts of terrorism were attempted at Glasgow Airport in Scotland and in London. The terrorists are alleged to have been Muslim physicians.

The Senate resolution condemns the recent attempted attacks and encourages all Muslim voices in the United States and abroad to continue speaking out against terrorism. The resolution also praises the Islamic Medical Association of North America for their public condemnation of the attacks.

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According to a survey of 44 states conducted by the Government Accountability Office (GAO), the new law requiring all Medicaid applicants to present proof of U.S. citizenship has led to a decline in Medicaid eligibility.

However, according to the study, most of this decline is not due to illegal immigrants being unable to qualify for Medicaid. Rather, the decline is attributed to U.S. citizens being unable to provide documentation of their citizenship.
The Department of Veterans Affairs (VA) has announced that it will partner with 12 nursing schools over the next three years in order to establish a nursing school to address the nursing shortage.

Effective June 14, 2007, Michigan has changed its nurse licensing procedures for international applicants.

The CGFNS Certification Program Certificate (CP) is no longer the requirement for initial licensure for internationally-educated Registered Nurses (RNs) in Michigan. Michigan now requires the CGFNS Credentials Evaluation Service (CES) Full Education Course-by-Course Report for internationally educated RNs and licensed practical nurses (LPNs) applying for licensure, who have not been licensed in another US jurisdiction for at least 5 years. Although the CGFNS Certification Program (CP) Certificate is no longer the requirement for RNs, the Michigan Board of Nursing will continue to accept CP as an alternative to the CES.

Michigan also has an English language proficiency requirement for applicants who graduated from a nursing program that was taught in a language other than English. The CGFNS CES Report prepared on behalf of internationally-educated RNs must be accompanied by the CGFNS English Language Proficiency Report, which reports the passing English scores of the applicant. LPNs have the option of either selecting the CGFNS English Proficiency Report or having their passing English scores forwarded directly to the Michigan Board of Nursing.

The Canadian Nursing Association recently issued a report outlining the importance of foreign nurses in Canada’s healthcare workforce. Like the U.S., Canada also has a nursing shortage, and like the U.S., Canada has taken steps to try to remedy this issue by increasing the number of admissions at Canadian nursing schools and improving working conditions in order to retain more nurses. However, unlike the U.S., Canada has also declared that immigration is a vital method of ensuring that there is an adequate number of nurses in the country.

As stated in the 2007 USMLE Bulletin of Information, the USMLE program has increased the limit on attempts for computer-based examinations. Examinees are now permitted up to four attempts at the same computer-based examination (Step 1, Step 2 CK and Step 3) in any 12-month period.

For Step 2 CS only, the limit on attempts will remain at no more than three attempts in any 12-month period.

The ECFMG 2008 Information Booklet and examination application materials are now available online at www.ecfmg.org.
For Step 1/Step 2 CK, applicants can use the 2008 materials to apply for Step 1/Step 2 CK eligibility periods ending in 2007 and all Step 1/Step 2 CK eligibility periods ending in 2008.

For Step 2 CS, applicants can use the 2008 application to obtain a 12-month eligibility period that begins on the date that the processing of the application is completed.

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Senator Bernie Sanders (I-VT) has proposed an amendment to H.R. 3043. The amendment would create a scholarship issued by the National Science Foundation for eligible individuals to pursue degrees in math, engineering, computer science and health care. Under the amendment, the H-1B Visa program would include an additional $3,500 fee, which would support an “American Competitiveness Scholarship” program. These merit-based scholarships will provide $15,000 for undergraduate or graduate education per student per year for up to four years. Under the proposed legislation, the number of H-1B visas granted each year would climb from 65,000 to 115,000 or 180,000, which would provide between $400 and $630 million for the scholarship each year.

3. The ABC’s of Healthcare Immigration – H-1C Visa for Registered Nurses

One of the few immigration measures passed in the last Congress was the extension of a little known nurse visa category called the H-1C. In November 2006, Congress approved legislation to extend the H-1C program for three more years. The program remains unchanged in substance.

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Late in 1999, Congress passed the Nursing Relief for Disadvantaged Areas Act, which calls for the creation of a new H-1C visa for nurses going to work for up to three years in health professional shortage areas. Up to 500 nurses per year can get the visa, but each state is limited to 25 H-1C nurses a year. Under the law, facilities interested in sponsoring nurses for H-1C visas must submit a document containing a number of attestations regarding the employment of H-1C nurses.

As with most immigration laws, the statute itself provides very little guidance on how the law will be applied, leaving it to USCIS (and as in most employment visa cases, the Department of Labor) to develop regulations. The regulations for the H-1C program became effective in September 2000.

One of the most surprising elements when the Labor Department released its regulations was a finding that based on the restrictive definition of "facility" Congress put in the statute, only fourteen hospitals in the country could be initially determined to qualify to apply for H-1C visas.

However, that was incorrect at the time and there are many more facilities that now meet the H-1C regulatory requirements.
H-1C employers must meet various attestation requirements. The attestation process is administered by the Employment and Training Administration at the Department of Labor. Enforcement of the attestations is overseen by the Employment Standards Administration’s Wages and Hours Division.

The 1999 law is very similar to a 1989 law that created the H-1A visa for nurses. That visa category expired several years ago after unsuccessful efforts to extend its life. The key differences between the two programs are that a much smaller number of H-1C visas have been allocated and that the facility where the nurse will work must be in a health professional shortage area. There are also requirements limiting a facility’s dependence on H-1C nurses (something that is hard to imagine given that only 500 H-1C nurses are permitted into the country each year, with no more than 25 allowed to work in a single state).

The Department of Labor has created an attestation form called the ETA 9081. On the form, the facility must attest to the following:

1. That it is a qualifying facility. If the ETA 9081 is the first one being filed by a facility, then the form must be accompanied by copies of the pages from the paperwork filed with the Department of Health and Human Services showing the number of acute care beds and the percentages of Medicaid and Medicare reimbursed acute care inpatient days. A copy of this paperwork must also be kept in a public access file.

2. That the employment of H-1C nurses will not adversely affect the wages or working conditions of similarly employed nurses.

3. That the facility will pay the H-1C nurse the facility wage rate.

4. That the facility has taken and is taking timely and significant steps to recruit and retain nurses in order to reduce dependence on immigrant nurses. At least two such steps must be taken unless it can show that the second step is not reasonable. Documentation of these steps needs to be included in the facility’s public access file for H-1C nurse petitions. Steps, which may be taken, can include:

   a. Operating a training program for registered nurses at the facility or financing or providing participation in a training program elsewhere.

   b. Providing career development programs and other methods of facilitating health care workers to become RNs.

   c. Paying registered nurses wages at a rate at least 5% higher than the prevailing wage for the area.

   d. Providing reasonable opportunities for meaningful salary advancement by registered nurses.

   e. Any other steps that would be considered significant efforts to recruit and retain nurses.

5. That there is not a strike or lockout at the facility, that the employment of H-1C nurses is not intended or designed to influence an election for a union representative
at the facility and that the facility did not lay off and will not lay off an RN within the 90 day period and 90 day period after the date of filing an H-1C petition.

6. That the employer will notify other workers and give a copy of the attestation to every nurse employed at the facility within 30 days of filing. E-mail attachments are acceptable.

7. That no more than 33% of the nurses employed by the facility will be H-1C nonimmigrants.

8. That the facility will not authorize H-1C nonimmigrants to work at a worksite not under its control and will not transfer an H-1C nurse from one worksite to another.

The paperwork must also be accompanied by a filing fee. After the attestation is approved by the Labor Department and used in support of an H-1C petition approved by USCIS, the employer is required to send a copy of the H-1C petition and USCIS approval to the Labor Department. Also, as noted above, the employer must create a public access file that includes the attestation and its supporting documentation. The file must be produced for any interested party within 72 hours upon written or oral request.

4. Nursing Amendments and Bills in Congress

There are a number of nurse-related bills and amendments currently being debated in Congress.

SA 3449: Amendment to HR 3043

On October 23, 2007, a nurse immigration relief amendment was included by unanimous consent in a voice vote. The provision was eventually stripped out in a conference committee and the bill was eventually vetoed by the President. But the amendment could still end up in the omnibus appropriations bill currently under consideration in Congress.

Nursing immigration ground to a halt earlier this year because of retrogression in the EB-3 green card category, the depletion of a 2005 allotment of 50,000 green cards for nurses and the lack of a non-immigrant visa category for nurses. The Senate added the measure as an amendment to H.R. 3043, the HHS-Labor budget bill. Amendment 3404, Senator Charles Schumer's Amendment, was passed as amended by Amendment 3449, introduced by Illinois Democrat Dick Durbin. The emndment provides:

- 61,000 visas for Schedule A occupations (nurses and physical therapists) and their immediate family members
- A $1500 additional fee for each of these green cards to be paid as a condition of approval of the adjustment application by USCIS or issuance of the visa by the State Department; waiver for certain facilities in disaster areas or HHS-designated health professional shortage areas.
- Brain drain provision one: nurses, physicians and other health care workers must attest that they do not owe their native country any financial obligation tied to their health care worker education (an exception is made if the
obligation was incurred by coercion or in the case of undue hardship); this provision shall take effect 180 days after passage of the bill

- A grant program is created to allow US nursing schools to increase the number of nursing faculty and students
- Brain drain provision two: Permanent resident health care workers (including doctors and nurses) will get credit toward naturalization and not be deemed to have abandoned permanent residency during time spent working in the following countries (a list will be published by DOS within six months (and DHS must publish rules within six months) of enactment of the legislation and updated annually):
  - countries eligible for International Development Association assistance
  - which are classified as "lower middle income countries" in the World Development Report for Reconstruction and Development published by the Bank for Reconstruction and Development or
  - a country determined jointly by DHS and DOS to be qualified due to special circumstances such as natural disasters or public health emergencies

These “brain drain” provisions cover doctors as well as other health care workers.

**SA 1409: Amendment to S 1348**

Senator Charles “Chuck” Schumer of New York submitted an amendment to S. 1348, the Comprehensive Immigration Reform Bill of 2007, in order to resolve the disagreement over portions of the bill concerning nurses.

The amendment, SA 1409, changes the bill to require the Department of Health and Human Services (HHS) to report to Congress on the shortage of nurses and physical therapists in the U.S. HHS is further required by the amendment to contract with the Institute of Medicine of the National Academies to determine the level of Federal investment under the Public Health Service Act that would be necessary to eliminate the shortage of nurses and physical therapists in the United States by January 1, 2015. HHS would also have to work with ministers of health of the five countries from which the highest number of nurses and physical therapists emigrated to the U.S.

SA 1409 also allows for nurses to recapture approximately 90,000 unused employment-based green cards for a fee of $1,500 per application.

**HR 1358**

Representative John Shedegg, an Arizona Republican, has introduced H.R. 1358, also known as the Nursing Relief Act of 2007, a bill that would create a new W visa for registered nurses. The new visa would have the following characteristics:

- Spouses and children could accompany the nurse to the U.S.;
- Direct consular filing possible as well as processing with USCIS in the US;
- Provides that if only thing holding up licensure of nurse is possession of Social Security number, the nurse can instead get a letter from the licensing board confirming eligibility for a license upon submitting the number;
USCIS and the Department of Labor have 90 days to issue regulations, and the law would take effect automatically if no regulations are issued by these agencies.

Additionally, like an H-1B visa, employers would have to go through a labor condition application process, pay the prevailing wage and maintain a public access file and W visas will be portable. Also, the visa would be dual intent and permanent residency processing would be permitted while in W status. There would be a cap of 50,000 visas issued each year, but the number can grow 20% per year if the cap is hit in the prior year.

W visas would be approvable for up to three years at a time with six years maximum except: 1) extensions permitted in one year increments if green card applications are pending for more than a year, and 2) one year extensions permitted if green cards are not available due to backlogs and the I-140 is approved;

According to Representative Shedd, the new visa is necessary due to the following:

1) There are more vacant nursing positions in the United States than there are qualified registered nurses and nursing school candidates to fill those positions;
2) According to the Department of Labor, the current national nursing shortage exceeds 126,000;
3) States in the West and Southwest have a disproportionate number of nursing vacancies because of rapid population growth;
4) Countries such as the Philippines, India, and China have an oversupply of nurses;
5) Major hospital systems in the U.S. spend hundreds of millions of dollars every year recruiting foreign nurses under the current immigration system;
6) Current law requires health care providers to sponsor nurses for permanent residence while the nurses remain outside of the U.S., which can take as much as 3 years; and
7) Health care providers cannot efficiently and effectively recruit qualified foreign nurses through the existing immigration process.

The bill is co-sponsored by three other Arizona Representatives - Rick Renzi (R-AZ), Jeff Flake (R-AZ) and Edward Pastor (D-AZ).

5. DOL Finds in Favor of H-1B Physician in Case Against the U.S. Department of Veteran’s Affairs

Rudranth Talukdar and Harjiinder Virdee v.
U.S. Department of Veterans’ Affairs, Medical and Regional Office Center,
Fargo, North Dakota

U.S. Department of Labor Administrative Review Board
The Department of Veterans Affairs’ Medical Center and Regional Office in Fargo, North Dakota (VAMC) hired doctors Rudranath Talukdar and Harjinder Virdee on H-1B nonimmigrant visas as primary care physicians beginning April 1999. In 2000, the physicians began working on union matters at VAMC, especially activities relating to pay inequities between H-1B nonimmigrant physicians and other VAMC physicians. Through their union work, the two became the leaders of a physician pay study.

In January 2001 the Department of Labor’s Wage and Hour Division began investigating the VAMC’s H-1B nonimmigrant physician pay practices in response to a complaint filed by one of the VAMC’s H-1B physicians. Doctors Talukdar and Virdee participated in the DOL’s investigation and represented the complaining physicians. By this time, the two had become legal permanent residents of the United States.

On March 20, 2002, the DOL determined that the VAMC had violated the INA’s H-1B provisions by failing to pay the applicable prevailing wage to ten H-1B nonimmigrant physicians. VAMC was ordered to pay these physicians back wages totaling in excess of $200,000.00. This decision was highly publicized, and resulted in a lot of negative press for the VAMC.

According to Doctors Talukdar and Virdee, from March to May 2002, they began facing increasing hostility at the VAMC. After an extremely hostile staff meeting in May 2002, Dr. Talukdar was afraid to return to work and took sick leave. He was then informed that his employment had been terminated. Dr. Virdee’s employment was also terminated two months before her contract had specified.

Both physicians felt their terminations were due to their labor union activities. When asked, the VAMC informed the physicians that their employment had been terminated due to budget constraints. However, no other physicians were terminated at this time. Additionally, no other changes were made to the VAMC’s financial practices and new physicians were hired to replace Doctors Talukdar and Virdee.

On June 3, 2002 Doctors Talukdar and Virdee filed a complaint with the DOL alleging that the VAMC had terminated their employment because of their cooperation with the DOL’s investigation. The Department of Labor’s Wage and Hour Division Administrator investigated the complaint and found no violation of the INA. Doctors Talukdar and Virdee then requested a hearing, and an Administrative Law Judge (ALJ) found that the physicians had engaged in activities protected by the INA’s employee protection provision and that VAMC had taken adverse action against Talukdar and Virdee. The ALJ awarded Doctors Talukdar and Virdee several forms of relief, including reinstatement and back pay. The VAMC then appealed this decision to the U.S. Department of Labor Administrative Review Board.

As Dr. Virdee settled her claim against the VAMC in April 2006, the Administrative Review Board made its decision regarding Dr. Talukdar only. The Board found that because Dr. Talukdar was covered by the employee protection provision of the Immigration and Nationality Act, the VAMC violated that provision by ending Dr. Talukdar’s employment in retaliation for his cooperation with the DOL investigation. The Board affirmed the ALJ’s decision and ordered the VAMC to reinstate Dr. Talukdar and pay him his back pay.

6. **CGFNS to Deny VisaScreen to Applicants Who Took Tainted Philippines Exam**
The Commission on Graduates of Foreign Nursing Schools (CGFNS) announced in February 2007 that those nurses who were sworn in as licensed nurses in the Philippines after passing the June 2006 Philippine Nurse Licensing exam are not eligible to receive a VisaScreen certificate. While these nurses are allowed to practice nursing in the Philippines, without a VisaScreen certificate, they may not practice in the U.S.

According to investigations conducted by both CGFNS and the Philippine government, it was discovered that at least 110 questions of the 500-question exam were known by large numbers of examinees and test-preparation operators in the June 2006 licensing exam.

Under U.S. immigration law, CGFNS must determine that a nurse’s education, training and licensing abroad are equivalent to that in the U.S. Due to reports of cheating and other irregularities on the June 2006 exam, CGFNS has determined that the exam is not equivalent to that required of American nurses, and the issuance of a VisaScreen certificate to a nurse who passed this version of the exam is prohibited under U.S. immigration law.

Those who passed the June 2006 exam may qualify for issuance of a VisaScreen certificate by passing the equivalents on Tests 3 and 5 on a future Philippine nurse licensing exam.

On March 2, 2007, the American Nurses Association (ANA) issued a memorandum urging the Philippine government to facilitate a retake of the nurse licensure exam without penalty for the nurses who passed the June 2006 examination.

7. NFAP Report Critiques S. 1348

In June 2007, the National Foundation for American Policy (NFAP) published its report on the point system proposed in S. 1348, the Comprehensive Immigration Reform Bill of 2007. According to the report, foreign nurses, who are urgently needed in the U.S. in order to alleviate the current nursing shortage, would not be able to enter the country under this point system.

If passed, the Senate bill’s point system would eventually eliminate family and employment-based categories of green cards, and replaces them with a merit-based system of points. Employment-based green card applicants would receive 20 points if they work in a specialty occupation, as defined by the Department of Labor. Those working in a ‘High Demand Occupation’ would receive 16 points. An applicant working in an occupation that is considered to be in the national interest would receive 8 points. An applicant could gain additional points if:

1) they receive an endorsement from the U.S. employer (6 points),
2) they have experience working for the U.S. employer (2 points per year, with a maximum of 10 points allowed), and
3) their age falls into the 25 to 39 range (3 points).

According to NFAP, the point system would reward those potential immigrants with higher ‘paper’ qualifications, such as a Master’s degree or PhD. Those with lower degrees, such as a Bachelor’s, including nurses, would score lower on the points system. The breakdown is as follows:

- MD, MBA or other advanced degree - 20 points.
- Bachelor’s degree - 16 points
- Associate’s degree - 10 points
- High school diploma or GED – 6 points

The report uses the example of an applicant with a Master’s in electrical engineering scoring a 90, while a nurse with a Bachelor’s could score between 40 to 64 points, depending on whether nursing is considered a field in high demand in the U.S.

Those who can demonstrate English proficiency skills are also rewarded. A native English speaker or an applicant who has scored a minimum of 75 on the TOEFL would receive 15 points. An applicant who scored between a 60 and 74 on the TOEFL would receive 10 points, while an applicant who passed the USCIS Citizenship Tests in English and Civics would receive 6 points.

The report also criticizes the limit on the number of immigrants to be allowed from each country. Immigrants from countries like India and the Philippines, which have a high number of immigrants each year, including most of the foreign nurses admitted to the U.S., would be limited to ten percent or less. Together with the points system, this would mean that nurses from high immigration countries would be beaten by other applicants from their own country who amass a higher score.

8. Asylum Denied to Health Care Workers

During international conflicts, the United States has always sought to aid health care workers who are trying to provide care to wounded combatants by offering these workers to apply for asylum. However, as a result of September 11, there has been an ongoing trend of USCIS challenging asylum claims filed by health care workers who have provided assistance to wounded members of what the U.S. government claims are terrorist organizations.

According to the U.S. government, providing medical assistance to members of terrorist organizations is considered to be Material support” to terrorists and can be used to deny asylum. However, in its definition of what constitutes “material support” for terrorists, Congress did not list medical treatment.
The Geneva Convention protects health care workers trying to fulfill their ethical duty to provide care to wounded combatants without regard to affiliation, known as medical neutrality. In the past, the U.S. condemned those countries who violated this right. However, its new post-September 11 stance on asylum claims seems to deny these health care providers the opportunity to provide medical care, even when forced by terrorist organizations.

In a recent asylum case, the Department of Homeland Security is appealing an immigration judge’s decision to grant asylum to a Nepalese health provider who was kidnapped twice by a Maoist group who wanted him to treat a wounded rebel. The government also rejected the asylum claim of a nurse from Colombia who was forced at gunpoint to provide medical care to members of the Revolutionary Armed Forces of Colombia.

9. Nurse Creates Kidney Transplant Program for Latino Immigrants from Abroad

Many times, when a Latin American immigrant is in dire need of a kidney transplant, a family member back home is usually the patient’s only option for an organ. While these family members are willing to donate the kidney, it is not always feasible to get the organ to the patient on time, as delays at U.S. borders are frequent.

Because of this, in addition to low organ donation rates among the large Latino community in Newark, NJ served by Beth Israel Medical Center, Columbian immigrant Tatiana Alvarez, a registered nurse at Beth Israel, created a program called “The Facilitation Program for International Living Donors.”

Under the program, if one of Nurse Alvarez’ patients has located a kidney donor in a Latin American country, she will contact the transplant center that’s nearest to the donor and request that it conduct organ-compatibility tests on the donor. If a match is established, Nurse Alvarez uses the test results to send a letter to the U.S. embassy in the donor’s country requesting that the donor be admitted to the U.S. for the transplant surgery. So far, five of Nurse Alvarez’s patients have received kidneys from an overseas donor through the program.

10. Bar on Unauthorized Immigrants Prevent U.S. Citizens from Obtaining Medicaid

Under a 2006 federal law, known as the Deficit Reduction Act, those applying for Medicaid benefits must prove that they are U.S. citizens. Applicants can demonstrate proof of citizenship by providing a passport or the combination of a birth certificate and driver’s license. While this law was intended to prevent illegal immigrants from receiving Medicaid benefits, many U.S. citizens have been inhibited from receiving Medicaid.

States including Florida, Iowa, Kansas, Louisiana, New Mexico, Ohio and Virginia have all reported declines in Medicaid enrollment, and have traced the declines to the new law. Medicaid officials across the U.S. have reported that they have denied
thousands of applications due to failure to provide adequate documentation of U.S. citizenship.

In Florida, the number of children receiving Medicaid dropped by 63,000, to 1.2 million, between July 2006 to January 2007. In Iowa, the number of Medicaid recipients dropped by 5,700 in the second half of 2006. Ohio reports the number of people receiving Medicaid declined by 39,000 to 1.3 million.

In addition to the difficulty some applicants are having in providing this documentation, Medicaid officials also say that the new requirement causes review of applications to take longer, thus delaying issuance of coverage and causing many to go without needed medical care. Georgia reported that many of its 100,000 newly uninsured U.S. citizen children of low-income families missed immunizations and preventive health visits due to application delays. The state also found that many U.S. citizen children were admitted to hospitals and intensive care units for conditions that normally would have been treated in a doctor's office. Officials across the U.S. have found that many pregnant women are going without prenatal care and some parents have been postponing checkups for their children because they do not have the necessary coverage.

Washington state is suing the U.S. Department of Health and Human Services in U.S. District Court over the law, which has made it harder to get medical coverage for infants born in the U.S. to illegal immigrants. The state is arguing that the regulation is nonsensical since every child born in the U.S. is automatically considered to be a U.S. citizen. Requiring the state to determine citizenship, and therefore eligibility for Medicaid coverage, has added to the state’s health care costs.

Until passage of the 2006 law, states had some say in deciding how to verify U.S. citizenship. Applicants had to declare in writing, under penalty of perjury, whether they were citizens. Most states required documentation, such as birth certificates, only if the other evidence suggested that an applicant was falsely claiming to be a citizen.

11. Mexican Consulates Provide Healthcare Information

Mexican consulates in the U.S. are now trying to help Mexican immigrants with basic health information through a new program called Ventanillas de Salud, or Health Windows. The program also refers Mexicans to U.S. hospitals, health centers and government programs where they can get care without fear of being turned over to immigration authorities.

The Ventanillas program was launched in 2003 in Los Angeles and San Diego as an experimental collaboration between the Mexican government and the Health Initiative of the Americas, a University of California program. Currently, the program operates in 11 U.S. cities, with a goal of expanding the program to all 47 Mexican consulates in the U.S.

Program critics say that illegal immigrants are already weakening the public healthcare system and this program allows them to receive even more benefits. However, recent research indicates that many illegal immigrants don't regularly use the public healthcare system. A Rand Corporation study published in 2006 found
that adult immigrants, particularly undocumented immigrants, use fewer healthcare resources per person than those born in the U.S.

According to the Mexican Consulate in Los Angeles, the Ventanillas program saves Los Angeles county money by encouraging immigrants to seek preventive care instead of waiting until they need expensive emergency care. Since the program began, over 286,000 Mexicans in Los Angeles have received health care information and referrals, and over 12,000 received health care services they learned about through Ventanillas.

12. AMA Reports on Physician Shortage in Rural Areas

According to the American Medical Association (AMA), there is a severe shortage of physicians in rural areas of the United States. According their statistics, the US government estimates over 35 million Americans live in medically underserved areas, and 16,000 doctors are required to immediately fill that need. However, the gap is expected to greatly increase over the next several years, to an estimated 200,000 by 2020 due to increases in the population and aging physicians.

According to the Mississippi State University Social Science Research Center, there are 280 doctors for every 100,000 people in the U.S. However, in rural areas like the Mississippi Delta, there are only 103 physicians for every 100,000 people.

While the U.S. has tried to address this physician shortage by allowing foreign-trained physicians to come and work in rural areas through programs such as the Conrad State 30 Program, post-9/11 visa restrictions have made it more difficult for foreign physicians to qualify for work visas and to obtain permanent residency. As a result, many foreign-trained physicians have chosen to leave the U.S. after their medical service commitment is up, or have chosen not to apply to come to the U.S. at all.

This drop in foreign physicians can been seen in the J visa waiver program. From 1996 to 1997, there were 11,600 J waivers granted to foreign physicians. From 2004 to 2005, that number dropped to less than 6,200, according to the Government Accountability Office (GAO).

13. CHAMP Act Would Expand Medical Coverage to Immigrants

The Children's Health and Medicare Protection (CHAMP) Act, a bill now being debated in the House of representatives, would expand the existing State Children's Health Insurance Program (SCHIP) and would expand medical coverage to the children of illegal immigrants. The CHAMP Act, which is sponsored by House Democrats, has been criticized by House Republicans due to three of the bill’s sections regarding immigrants.

If the bill is passed, under Section 132, the mandatory five-year waiting period for legal immigrants to be eligible to receive government-funded health benefits would be eliminated. Section 143 of the bill would give each state the option of requiring applicants for Medicaid and SCHIP benefits to provide proof of US citizenship,
thereby allowing immigrants to apply for these benefits as well. Section 233 of the bill would provide federal grants for translation services.

The Republicans introduced a similar bill, but their proposal would restrict how states can use federal money for health care, would limit medical benefits granted to children and would require all applicants for government funded programs to provide proof of US citizenship.

14. U.S. Savior: Foreign Doctors

This article by Greg Siskind recently appeared in USA Today on July 31.

If some of the world's healers are allied with al-Qaeda, then are any of us really safe?

Mohammed Asha and Bilal Abdulla, two of four people charged in last month's attempted car bombings in London and at the Glasgow airport, appeared in a preliminary court hearing last week. The fact that both are doctors suspected of the crimes is certainly distressing.

Though the truth of the accusations against the doctors remains unresolved, another side of the story is not being told: Foreign medical graduates in the USA are the good guys saving lives everyday. They are not our enemies.

Why haven't we heard any links of these foreign physicians to terrorism in the USA? Most likely because of the extensive background checks that all skilled workers, including doctors, undergo before being admitted. British security clearances for skilled workers are not as extensive, and the process is under review.

It might help to know some basic data:

- Physicians in the USA: 794,893.
- Foreign graduate doctors in the USA: 185,234 (from 127 countries).
- Percentage of doctors in U.S. training programs who are foreigners: 24%.

This is not a new phenomenon. Foreign physicians have made up about this percentage of our doctor population for years. A sizable portion work in medically underserved communities and small towns. This at a time when a shortage of doctors in the USA is expected to grow to as much as 200,000 by 2020.

**Few new medical schools**

Why is this shortage happening?

First, the USA has opened almost no new medical schools in the past 25 years. So you have a physician population that has remained flat serving a U.S. population that is expected to grow by 25% between 2000 and 2025. Major demographic changes in the physician population also must be considered. Nearly one-third of doctors are older than 55, with more choosing early retirement. Fifty percent of all medical school graduates are now women. That is affecting both the total hours worked each year as well as the number of specialists. Family demands are causing many women
to reduce their hours or to leave the profession when they have children. Some women doctors avoid fields with difficult call hours, such as anesthesiology and radiology.

Then there are our own demographic changes. The number of Americans older than 65 will increase to 54 million by 2020. As we age, our need for medical care increases.

Finally, as more treatment options are available and new technology is developed, Americans are more likely to seek out the services of a physician or specialist. We must grow our domestically educated physician population. But it's going to take many years to get there. From deciding to build a medical school to seeing the first doctor start private practice is approximately 15 years. You've got to build the school, go through an accreditation process, educate the doctors (four years) and put them through graduate medical training (three to seven years). Why make our shortage worse by cutting off an important source of supply? About 5,000 foreign doctors enter the USA each year, and that number is already accounted for in the 200,000 shortage figure.

Selective process

We're also losing more physicians as they finish training here. One reason is that physician shortages are growing in other countries as well. Australia and Britain have extreme shortages. Australia's shortage is so severe that it has relaxed requirements.

Many doctors are also engaged in cutting-edge research at some of the leading U.S. laboratories. One chief reason much of our best research is done by foreign graduates is because of the way they are chosen to come here. Every American medical student gets selected for residency and fellowship training programs. After that, we have 5,760 slots to fill. About a third of those go to American medical students who went abroad for medical school. The rest go to foreign nationals educated overseas.

In order to get one of those remaining slots, a foreign student will need to have finished near the top of the class of a highly reputable medical school. These bright doctors come here because we have superior training and stay here to engage in top research at hospitals that have the budgets to offer high-quality treatment. I tell you these facts because of the knee-jerk reaction I hear that we should take measures to prevent the entry of foreign-born physicians. This would be a disaster for American health care, and it would not make us safer. We need to increase physician immigration and increase the supply of U.S. medical school graduates. Otherwise, we'll face a future of rationed health care.

The solution is not to bar foreign doctors. We already vigorously screen those coming here and can increase screening as needed. American patients benefit every day from this meritocracy, and the number of lives these doctors saves will far exceed any trade-off we would get spooked by an irrational fear.

15. Study of Nursing Shortage Impact on Patient Care
A recent study of the nursing shortage shows that views on the shortage's affects on hospital patient care vary widely. The study was conducted by Vanderbilt University Medical Center’s Center for Interdisciplinary Health Workforce Studies and Massachusetts General Hospital. The researchers analyzed the results of three national surveys of registered nurses, physicians, and hospital executives.

The results of the study show that the nursing shortage has negatively impacted communication, nurse-patient relationships and timeliness of care and overall efficiency. The study further shows that there are broad differences among various health care professionals regarding approaches to improving patient care safety.

According to a majority of the Registered Nurses and Chief Nursing Officers surveyed, there were deep concerns about the impact of the shortage on prompt detection of patient complications as well as patient safety. However, most of the surveyed physicians and Chief Executive Officers did not believe nursing shortages were closely linked to failure to detect patient complications or overall worsened patient safety.

According to the authors, the study proves that hospital health care staff need to have better communication in order to improve patient care safety.

16. ECFMG Issues Notice About Fraudulent Letters of Recommendation

The Educational Commission for Foreign Medical Graduates (ECFMG) has issued a notice to all international medical graduates that the submission of fraudulent letters of recommendation to ECFMG constitutes irregular behavior. Those with allegations of irregular behavior are reviewed by an ECFMG panel and can face certain penalties.

The ECFMG Medical Education Credentials Committee, a standing committee of the ECFMG Board of Trustees, reviews all claims of irregular behavior. If an individual has been determined to have engaged in irregular behavior, the following will occur:

- The individual will have a permanent annotation included in his or her ECFMG Status Reports and Certification Verification Service (CVS) Reports;

- Information explaining the basis for the finding of irregular behavior and the resulting action will accompany every ECFMG Status Report and CVS Report and may also be provided to legitimately interested entities; and

- The decision will be reported to the Federation of State Medical Boards Board Action Data Bank, state medical licensing authorities, directors of graduate medical education programs, and to any other organization or individual who has a legitimate interest in such information.

Furthermore, an individual who is found to have irregular behavior may be further penalized by ECFMG, including being barred from ECFMG exams and having his or her Standard ECFMG Certificate withheld or revoked.

The ECFMG Medical Education Credentials Committee has recently found 12 cases of irregular behavior based on the submission of partially altered or completely fabricated letters of recommendation. In 11 of these cases, the applicant's Standard
ECFMG Certificate was revoked, and they will not be able to participate in an accredited residency program in the United States and are not eligible to take USMLE Step 3.

In order to address this issue, ECFMG is requiring all international medical students and graduates to submit original letters of recommendation. Letters must be written on official letterhead and manually signed by the author in an ink color other than black. Applicants are also advised to request that the letter writer attach an institutional seal onto the letter of recommendation.

According to ECFMG, the directors of residency and fellowship programs are responsible for verifying the authenticity of letters of recommendation. In most of the recent fraud cases, the fraudulent letters were detected by program directors.

17. Immigrant Health Care Workers Needed for Elderly Care

A recent report by Brandeis University Professor Martin Leutz, which was released by the American Immigration Law Foundation, outlines the urgent need for more immigrants in nursing homes and other long term care facilities in order to meet a dramatically expanding patient population.

Due to medical advances, the American elderly population is living longer. However, because old age is associated with disabilities and chronic illnesses such as diabetes and Alzheimer's disease, the increase in the number of elderly living longer lives requires a significant increase in healthcare support, such as orderlies, nursing aides, home health aides, etc.

In addition to a larger elderly population, the need for more direct-care health support is also due to the high turnover in the direct-care workforce. Direct-care jobs tend to be very physically demanding, but are low-paid and have few benefits like health insurance and retirement plans.

Immigration has long offset labor shortages in many different fields, including healthcare occupations. However, current U.S. immigration law provides limited opportunities for foreign paraprofessionals to work in the U.S. on a temporary basis or to come here as permanent residents. The U.S. currently offers more opportunities for skilled health care workers than it does for health care aides, who have fewer educational requirements.

18. Filipino Nurses Lose Employment Battle

Two separate decisions by the U.S. Department of Justice and the Philippines Overseas Employment Administration defeated the cause of 26 Filipino nurses who claimed that their employer, SentosaCare, had committed worker violations.

On August 31 the Justice Department's Office of the Special Counsel for Immigration-related Unfair Employment Practices dismissed the nurses' complaint that Sentosa Care discriminated against them. On September 4, the Philippines Overseas Employment Administration threw out the nurses' claims that Sentosa
tricked them into emigrating under false pretenses.

Ten of the nurses now face indictment in Long Island, New York due to their resignation, which SentosaCare says endangered the lives of its patients. The nurses’ attorney also faces charges for encouraging their resignation.

19. Government Confirms India Produces a Surplus of Health Care Workers

In a press release issued on August 31, 2007, the Indian Government confirmed the fact that the country does not have a shortage of physicians and nurses, and in fact is producing well in excess of the actual number of nurses and physicians needed to supply the country’s needs.

According to the release, information provided by the Medical Council of India (MCI) states that there are currently 683,682 registered doctors in the country. MCI further states that 30,922 physicians graduate from India’s 269 medical colleges every year.

The release also provides statistics from the National Commission on Macroeconomic and Health regarding India’s nurse workforce. According to these statistics, there are 1,597 Graduate Nursing Midwifery (GNM) Schools functioning in the country with an intake capacity of approximately 80,000 students per year.

20. Las Vegas Paper Reports on Abuse of J-1 Waiver Physicians in Nevada

According to a series of stories in the Las Vegas Sun, Nevada employers are abusing physicians who are participating in the J-1 Visa Waiver Program. The Sun interviewed 25 physicians who participated in the program, 7 of whom are still working through the program. The doctors interviewed were in Nevada, Tennessee, Utah and Arizona.

The physicians told the Sun that employers have been pulling J-1 waiver physicians out of the rural clinics where they have been assigned to work under the terms of their contracts, and placed in Las Vegas’s larger hospitals where they will generate more revenues. The Sun contends that the foreign physicians have not complained about this for fear of losing their jobs.

In addition to violating the work site terms of the contract, the Sun also reported that employers are required to work extremely long hours, and that parts of their contracts have been altered without their knowledge.

21. Chart Of Nurse Licensing Requirements By State

22. State 30 Physician Waiver Chart


23. Physician National Interest Waiver Chart


24. PHYSICIAN JOB CENTER

Siskind Susser Bland, 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.