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Via Electronic Submission (www.regulations.gov)

January 29, 2015

Laura Dawkins
Chief of the Regulatory Coordination Division
USCIS Office of Policy and Strategy
20 Massachusetts Avenue NW
Washington, DC 20529–2140

Re: Department of State, Department of Homeland Security Notice of Request for Information (DHS Docket No. USCIS-2014-0014)

9. What are the policy or operational changes that could assist in creating additional immigration opportunities for high-demand professions, such as physicians?

Dear Ms. Dawkins:

Thank you for this opportunity to comment on barriers facing “high-demand” immigrating physicians as the U.S. faces national workforce shortages.

The Association of American Medical Colleges (AAMC) is a not-for-profit association representing all 141 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 148,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

Typically, U.S. residency training or “graduate medical education” (GME) is required for immigrating physicians to practice in any state. While many improvements can be made to streamline the physician immigration process (as recommended by the International Medical Graduate Taskforce), the AAMC believes the primary barrier for graduates of international medical schools to practicing in the U.S. is the cap on Medicare support for GME imposed by the Balance Budget Act of 1997. Eliminating this bottleneck in the medical education pipeline is critical to improving physician immigration and addressing national workforce shortages.

U.S. Physician Workforce Shortages

A number of factors indicate that the U.S. faces a significant physician shortage by 2025 and beyond, spanning evenly across both primary and specialty care.¹ These shortages are largely a

¹ AAMC. 2012. *Physician Shortages to Worsen Without Increases in Residency Training*. Washington, DC. Retrieved from:

www.aamc.org/download/153160/data/physician_shortages_to_worsen_without_increases_in_residency_tr.pdf

result of our aging patient population battling multiple chronic conditions, an influx of up to 32 million newly insured individuals entering the health care system with previously untreated conditions, and the looming retirement of current practitioners.²

Despite successful efforts of existing and new U.S. medical schools to increase enrollment, residency training positions at teaching hospitals have not grown at the same pace, limited by the cap on Medicare support for GME imposed by the Balanced Budget Act of 1997. Hence, while demand for health care services will grow, there will not be commensurate growth in supply, leading to shortages.

Though shortfalls will affect all Americans, the most vulnerable populations in underserved areas will be the first to feel the impact of the deficit of physicians (e.g., the Department of Veterans Affairs, Medicare and Medicaid patients, rural and urban community health centers, and Indian Health Service).

U.S. Medical School Enrollment

In 2013, the number of students enrolled in their first year of medical school exceeded 20,000 for the first time.³ The AAMC expects that in the 2018-2019 academic year, enrollment in medical schools will have increased by 30 percent over their 2002-2003 levels, in response to physician shortage projections.⁴ Enrollment at osteopathic medical schools has grown even more rapidly, with classes increasing 11.1 percent in 2013 over the prior year;⁵ the number of osteopathic medical schools has doubled from 20 in 2003 to 40 in 2014.⁶

The AAMC is concerned that the number of U.S. medical graduates may soon exceed the number of first-year residency positions. After the 2014 Main Residency Match and Supplementary Offer and Acceptance Program, 412 U.S. seniors remained unmatched to a residency program.⁷ Similarly, the number of 2013 U.S. M.D. (20,055) and D.O. (6,449) enrollees totals 26,504 — perilously close to the 26,678 PGY-1 ACGME residency positions offered through the Match in 2014.⁸

² *Id.*

³ AAMC. 2013. *Medical School Applicants, Enrollment Reach All-time Highs*. Washington, DC. Retrieved from: www.aamc.org/newsroom/newsreleases/358410/20131024.html

⁴ AAMC. 2014. *Results of the 2013 Medical School Enrollment Survey*. Washington, DC.

⁵ AACOM (American Association of Colleges of Osteopathic Medicine). 2013. *Fast Facts about Osteopathic Medical Education*. Retrieved from: www.aacom.org/docs/default-source/data-and-trends/2013-PrelimE-Report-FF.pdf?sfvrsn=8

⁶ American Association of Colleges of Osteopathic Medicine (AACOM). 2014. *U.S. Osteopathic Medical Schools by Year of Inaugural Class*. www.aacom.org/docs/default-source/data-and-trends/u-s-osteopathic-medical-schools-by-year-of-inaugural-class-nbsp-.pdf?sfvrsn=0

⁷ Signer, M. 2014. NRMP Presentation to National Group on Student Affairs [PowerPoint slides, slide number 23]. Retrieved from: www.nrmp.org/wp-content/uploads/2014/05/GSA-2014-Web-Post.pdf

⁸ National Resident Matching Program (NRMP). 2014. *Results and Data: 2014 Main Residency Match*. Retrieved from: <http://www.nrmp.org/wp-content/uploads/2014/04/Main-Match-Results-and-Data-2014.pdf>

International Medical Graduates

Graduates of international medical schools or “international medical graduates” (IMGs) are a substantial part of GME, totaling approximately one-quarter of physicians entering the U.S. workforce. Roughly 6,400 positions in the 2014 Match were filled by graduates of international medical schools, over 50 percent of whom are not U.S. citizens.⁹

As the intersection between qualified medical graduates and available training opportunities approaches, some observers have suggested that training programs could accommodate the increasing number of U.S. medical school graduates by preferentially or exclusively accepting M.D. and D.O. graduates of U.S. medical schools.¹⁰ It is important to note that this type of proposal would have no effect on the physician shortage. Under such a plan, the total output of physicians would remain the same. Preventing IMGs from completing residency training simply would ensure that only U.S.-educated medical graduates are able to practice in the United States, even as the nation faces significant physician shortages in the next decade.

Losing this cohort of physicians also would have significant implications for a number of rural and underserved communities that currently rely on IMGs, who often practice in such areas as a condition of remaining in the United States. The J-1 “exchange visitor” visa allows medical students from other countries to attend residency training in the United States, requiring physicians to practice for at least two years in their home country after completing their U.S. residency. The Conrad State 30 J-1 visa waiver program (“Conrad 30”) enables state agencies to recruit these physicians to underserved areas for three years in exchange for waiving the home country practice requirement.

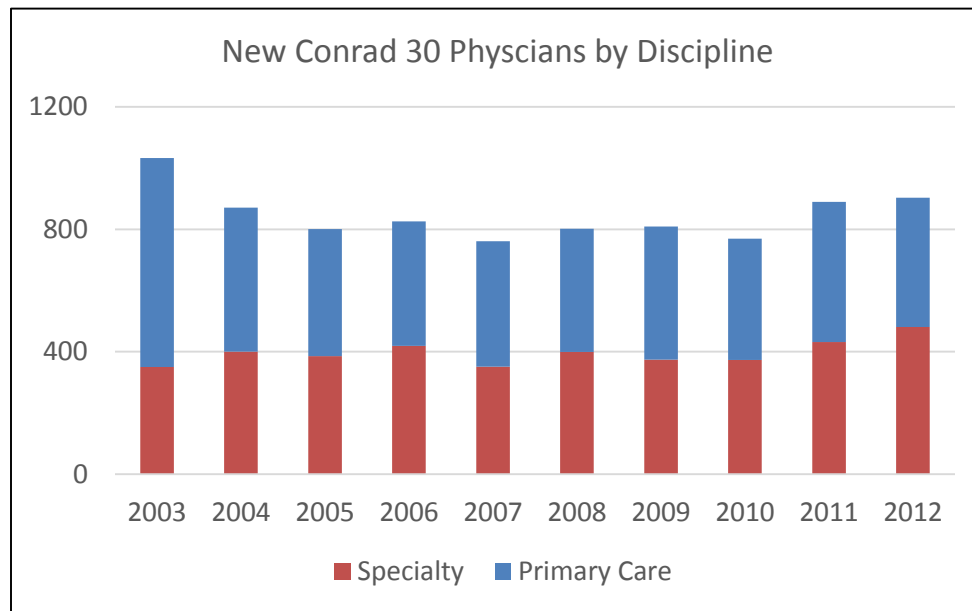
State agencies have some discretion in shaping their Conrad 30 programs to address states’ priorities and some latitude in determining what specialties are needed, provided that they demonstrate, according to their own criteria, shortages in the specialties they recruit. Currently, as depicted in Figure 1, non-primary care specialties constitute approximately half of Conrad 30 waivers requested by state agencies.¹¹ These patterns suggest that IMGs not only help address primary care needs, but fill deficits in specialty care as well.

⁹ *Id.*

¹⁰ Daschle, T. 2015. Academic medicine in a transformational time. *Academic Medicine*. 90(1):11-13.

¹¹ AAMC analysis of data from Texas State Department of Health annual survey of state Conrad 30 programs.

Figure 1: States Use Conrad 30 Waivers to Fill Shortages in Specialty and Primary Care



Source: AAMC analysis of data from Texas State Department of Health annual survey of state Conrad 30 programs

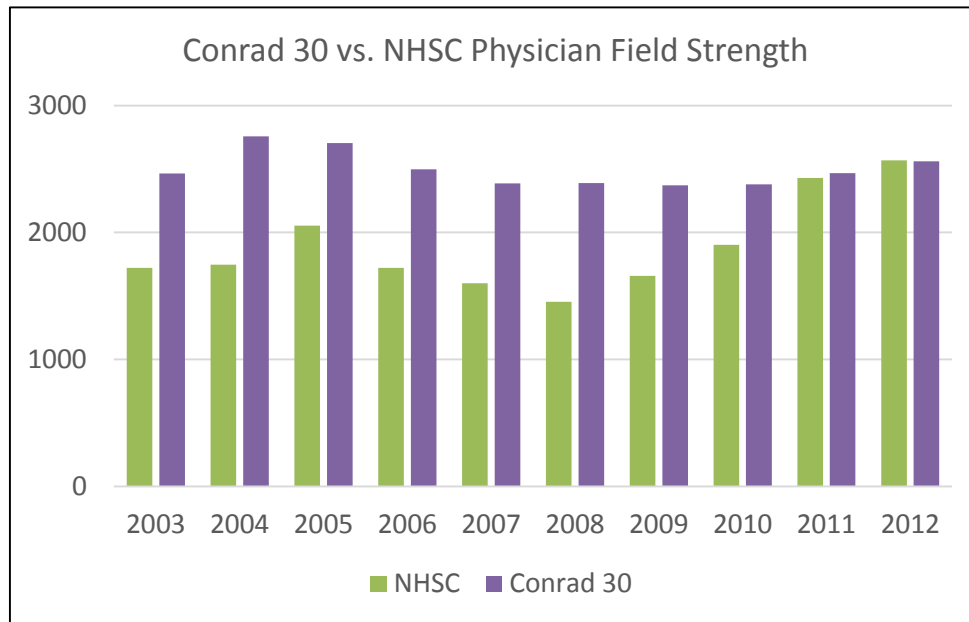
In 2012, approximately 2,500 physicians practiced in underserved communities in nearly every state under the Conrad 30 program.¹² To put this into context, nationwide, Conrad 30 programs recruit physicians to underserved areas at levels comparable to the National Health Service Corps (NHSC) — which, like the Conrad 30 program, provides incentives to practice in underserved communities. In fact, Conrad 30 programs historically have out-performed the NHSC, which is limited by its annual appropriation (see Figure 2).

Because the NHSC recruits practitioners through scholarships and loan repayment, the Conrad 30 program accomplishes a similar goal at a lesser cost to the government. Reducing the proportion of IMGs in the U.S. workforce thus would create a recruitment deficit resulting from a decrease of Conrad 30 physicians. Moreover, because the NHSC is limited solely to primary care, the program would not be able to fully compensate for the loss of Conrad 30 physicians, nearly half of whom practice non-primary care specialties, a challenge for many underserved communities.

Recognizing that the nation can do a better job at recruiting U.S. physicians to underserved areas, the AAMC workforce recommendations assume sustaining an appropriate level of physician immigration. The AAMC supports a balanced physician immigration policy that prevents international “brain drain,” and endorses the J-1 exchange visitor visa as the most appropriate pathway for residency training. These recommendations also enable the country to fulfill its responsibility to share world-class U.S. medical knowledge more globally by preserving opportunities for some number of U.S.-educated IMGs to return to their home countries.

¹² *Id.*

Figure 2: Conrad 30 & NHSC Recruit Physicians to Underserved Areas



Source: AAMC analysis of data from HRSA and Texas State Department of Health annual survey of state Conrad 30 programs

The AAMC believes that such policies should be considered with sensitivity to health care needs beyond those of the U.S. population and extending to the home countries of IMG physicians. It should be noted, however, that the ethical challenges associated with such policies are multifaceted. For example, such concerns often assume that IMGs would not immigrate to the United States under other circumstances. Indeed, while employing health professionals from other countries presents a complicated set of concerns, it similarly is not straightforward to consider the dilemma that results from forcing qualified medical graduates to pursue other careers in the United States while American communities struggle to recruit practitioners with the graduates' expertise.

AAMC Recommendations

The country cannot afford to wait until the physician shortage takes full effect, as the education and training of each physician takes more than a decade. Physician shortages will persist even if the Medicare funding caps are lifted today, given the severity of the problem and a likely modest rate of change in the delivery and payment systems.

Accordingly, the AAMC's physician workforce policy recommendations recommend that Congress increase the number of Medicare-supported GME training positions by at least 4,000 new positions each year. Training an additional 4,000 physicians a year would allow the nation to increase its expected supply of doctors by approximately 30,000 by the end of the decade—meeting approximately one-third of the expected shortage. This represents an expansion of approximately 15 percent over current training levels, which would provide a sufficient number of positions to accommodate U.S.-educated doctors, while allowing for IMGs to continue to occupy about 10 percent of training positions.

The success of this recommendation is based on the expectation that the other two-thirds of the shortage can be resolved through changes to the delivery system, technology improvements, and other enhancements to care.

Consistent with these policy recommendations, the AAMC endorsed GME expansion bills in the 113th Congress that would direct new GME funding to shortage specialty residency programs and prioritize communities that have invested in new medical schools. These bills include the *Resident Physician Shortage Reduction Act* (S. 577 and H.R. 1180) and the *Training Tomorrow's Doctors Today Act* (H.R. 1201).

Thank you again for this opportunity to highlight the impact of the Medicare GME cap imposed by the Balance Budget Act of 1997 on physician immigration and workforce shortages. Should you have any further questions or require additional information, please contact Matthew Shick <mshick@aamc.org> at 202-862-6116.

Sincerely,

A handwritten signature in black ink, appearing to read 'Atul Grover', with a stylized flourish extending from the bottom.

Atul Grover, M.D., Ph.D.
Chief Public Policy Officer