Questions for the Record from
Senator Thom Tillis for Dr. Ram Sanjeev Alur

1. How will recapturing unused visas help to reduce the immediate green card backlog for essential healthcare workers?

According to recent estimates, there are between 13,250 and 14,230 physicians of Indian origin currently in green card backlogs.[1] These are physicians primarily serving underserved populations and are integral to their hospitals or clinics due to the recruitment and retention environment in many underserved areas. If Congress were to recapture unused visas, these backlogged physicians would receive a green card enabling them to focus entirely on their patients and assuming a larger health care role in their practice and community long-term. Currently, the process for renewing ones temporary H1-B visa is highly problematic, causing significant disruptions for physicians and their families. These disruptions can also affect patients if a physician has to take time away from work to file their renewal, or is unable to drive due to a delay in processing a renewal, meaning delays in treatment. As the country confronts a growing shortage of health care workers, recapturing green cards would help to alleviate the workforce strain many health care systems are experiencing.

Physicians in the green card backlog can only work in the position filed by their employer, meaning they cannot pick up shifts at a nearby hospital or volunteer during a state or national public health emergency. These rules are impacting access for patients, both during the height of the pandemic and amidst severe labor shortages, and should compel Congress to consider whether the green card backlog impacting essential health care workers serves any purpose that benefits communities, patients, or the broader immigration system.

2. Looking into the future, how will recapturing unused visas help to fill the known workforce shortages we face in the healthcare industry?

As noted above, clearing the green card backlog is as much practical policy as it is strategic. U.S.-trained international physicians are highly sought after, and many countries are actively recruiting international health workers with offers of a clearer pathway to citizenship. Countries like Canada[2] and the United Kingdom[3] are actively exploring ways to tap foreign health care workers to address shortages, and France granted citizenship to over 12,000 essential workers for their contributions during the pandemic.[4] These policies are particularly appealing to international physicians stuck in the green card backlog.

For physicians training here, knowing they are not entering a historic backlog should increase the likelihood that they will practice here, which largely occurs in underserved areas. It will also empower physicians working in a variety of settings to take on more responsibilities, such as starting their own practice or accepting shifts in nearby communities.

This is particularly important in rural and underserved areas where physicians tend to be older. In rural communities, the number of physicians under 50 years of age has decreased dramatically over the last 20 years. In 2017, more than half of rural physicians were at least 50 years old, and more than a quarter

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7599012/
[2] https://www.cbc.ca/news/politics/healthcare-workers-burnout-1.6492889
[3] https://www.theguardian.com/society/2022/aug/19/overseas-hiring-spree-planned-for-care-homes-in-england-amid-winter-fears
[4] https://www.schengenvisainfo.com/news/france-12000-foreign-essential-workers-granted-with-citizenship-for-their-contribution-during-covid-19/

were at least 60 years old.[5] In addition, we know that rural communities have worse health outcomes than their urban counterparts.[6] This combination of factors should compel Congress to take action.

On the nursing side, the prospect of adding 25,000 qualified nurses to the workforce would dramatically improve the shortages facing nursing in the United States. As noted by the American Hospitals Association (AHA), each year, the United States grants green card status to up to 140,000 employment-based (EB) immigrants and their family members. Typically, nurses are in the EB-3 category, which totals 27.6% of the worldwide limit or up to 40,040 immigrants. These totals result in around 10,000-12,000 nurses per year being admitted to the United States.[7] To put another way, recapturing 25,000 visas for qualified nurses, if passed in the bipartisan Healthcare Workforce Resilience Act, would significantly reduce shortages that cannot be reduced as quickly through other solutions, such as by investing in and expanding nursing graduate programs.

3. Can you please discuss how the Conrad 30 program effectively serves the needs of underserved communities in North Carolina and across the country?

North Carolina has a fantastic Conrad 30 program. Between FY2014-2018, the North Carolina Office of Rural Health, which administers the Conrad program, placed 126 primary care and subspecialist physicians in underserved areas of North Carolina in the following specialties: family medicine, internal medicine, pediatrics, psychiatry, surgery, hospitalist, cardiology, and oncology, among others. Of those physicians, 94% were placed in Health Professional Shortage areas. North Carolina estimates that the J-1 physicians generated $79.5 million in economic impact over that span.[8]

The Conrad 30 program is a state-run program that allows each state to allocate slots to best meet the needs of their state. In North Carolina, 20 of the 30 slots are reserved for primary care physicians practicing in underserved areas. These physicians are typically family practice, general internal medicine, general pediatrics, Obstetrics/Gynecology (OBGYN), or Psychiatry. The remaining 10 slots are known as flex spots, which may be used by physicians working in non-designated shortage areas or limited to primary care.

As of FY18, North Carolina has 87 counties designated as health professional shortage areas and 90 counties designated as medically underserved areas. The Office of Rural Health leverages the Conrad 30 program by placing the overwhelming majority of its J-1 physicians in shortage areas. Reauthorizing the Conrad 30 program would clarify the incentives for physicians and make it possible for North Carolina to place more physicians throughout the state.

4. How can USCIS use its existing authorities to improve visa processing for essential healthcare workers?

USCIS should work with the State Department to permit certain visa holders with expiring visas to renew their visas without going abroad. This policy would limit the potential disruption in care for patients being served by physicians in the backlog, and make it easier for employers who depend on international health care workers.

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[5] https://www.auis.edu/wp-content/uploads/2019/08/Disparity-Rural-Physician-Workforce-NEJM.pdf
[6] https://www.cdc.gov/ruralhealth/about.html
[7] https://www.aha.org/testimony/2022-09-14-aha-senate-statement-flatlining-care-why-immigrants-are-crucial-bolstering-our
[8] https://www.ncdhhs.gov/media/8620/open

Doctors on temporary H-1B visas need to have their work visa renewed at least every three years through an uncertain petition process in which the employer, not the doctor, needs to file the essential paperwork. The process is a huge administrative burden to the employer and the employee with multiple agencies involved and is currently very protracted. The Administration should be doing everything in its power to prioritize the processing of health care workers who will be alleviating workforce shortages.