United States General Accounting Office

GAO

Report to Congressional Committees

December 1996

FOREIGN PHYSICIANS

Exchange Visitor Program Becoming Major Route to Practicing in U.S. Underserved Areas

GAO
75 years
1921 - 1996

GAO/HEHS-97-26

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-271030

December 30, 1996

Congressional Addressees

Placing enough physicians in underserved areas remains a longstanding problem in the United States, despite many attempts to resolve the situation. To address this problem, a growing number of locations are turning to non-U.S. citizens who have just completed their graduate medical education in the United States. These physicians generally enter the United States under an exchange visitor program administered by the United States Information Agency (USIA). Their visas, called J-1 visas, require them to leave the country when their medical training is done, but this requirement can be waived at the request of a federal agency or a state. This waiver is usually accompanied by a requirement that the physician practice for a specified period in an underserved area.

The growing use of these waivers is not without controversy. The Department of Health and Human Services (HHS) is the main federal agency responsible for addressing physician shortages and medical underservice. HHS has taken the position that the J-1 visa is a way to pass advanced medical knowledge to other countries and that waivers of the J-1 visa requirement should not be used as a means to address medical underservice in the United States.[1] Instead of using waivers to address underservice, HHS administers its own federal programs specifically for this purpose, particularly the National Health Service Corps (NHSC). Some other groups, including the Pew Health Professions Commission and the Institute of Medicine's Committee on the U.S. Physician Supply, believe that allowing foreign physicians to remain in the United States after completing their graduate medical education could contribute to a general oversupply of physicians, which could drive up medical costs.[2] Many communities that need physicians, however, are using these waivers to address physician shortages, stating that they could not recruit qualified physicians without doing so.

[1]See 45 C.F.R. 50.3(a)(1995). This position was reiterated in an August 1995 letter from the Secretary of HHS to the heads of other federal agencies. However, HHS does request waivers for physicians and scientists engaged in critical biomedical research.

[2]See Pew Health Professions Commission, Critical Challenges: Revitalizing the Health Professions for the Twenty-First Century (San Francisco: University of California San Francisco Center for the Health Professions, 1995) and Institute of Medicine, The Nation's Physician Workforce: Options for Balancing Supply and Requirements (Washington, D.C.: National Academy Press, 1996).

To provide information that would be useful to the Congress in addressing this issue, we conducted a self-initiated study focused primarily on the following questions:

- How many foreign physicians with J-1 visas receive waivers, where do they practice, and what are their medical specialties?
- Do federal agencies and states effectively coordinate policies and procedures for granting these waivers?
- To what extent are foreign physicians who receive waivers complying with waiver requirements to practice in underserved areas?

To conduct this work, we developed two surveys addressing the extent to which states and federal agencies used waivers to meet physician shortages. One polled all states to determine the size of their programs for requesting waivers. The other surveyed health care facilities for a random sample of physicians who received waivers. These surveys provided more complete information than was available from participating agencies, including USIA, the Immigration and Naturalization Service (INS), and the federal agencies requesting waivers for physicians. We supplemented this work with reviews of existing data, interviews with agency officials and others involved with the waivers, and field work in three states.[3] Appendix I explains our methodology in more detail.

Results in Brief

The number of waivers for physicians with J-1 visas to work in underserved areas has risen dramatically in the past few years, from 70 in 1990 to over 1,300 in 1995. Requesting waivers for physicians with J-1 visas has become a major means of providing physicians for underserved areas; in 1994 and 1995, the number of waivers processed for these physicians equaled about one-third of the total identified need for physicians in the country. In the process, a program to transfer knowledge to other countries has partially given way to a domestic placement effort that now includes professional recruiters and immigration attorneys. Almost all these waiver physicians have primary care medical specialties and they are practicing in 49 states and the District of Columbia. Their practice locations range from health centers in public housing projects to private practices affiliated with for-profit hospitals.

This growing domestic placement effort is rudderless. While only one agency was requesting waivers to address physician shortages in 1990,

[3]We included waivers granted to physicians for practicing in underserved areas only. As such, we did not include in our analysis physicians whose waivers were requested by the Department of Veterans Affairs (VA) or physicians whose waivers were requested by other agencies for research purposes .

nearly 30 federal and state agencies were processing waiver requests for physicians from hospitals, health centers, and other health care facilities by 1995. Among them, no agency has clear responsibility for ensuring that placement efforts are coordinated. The agencies have generally operated independent of one another, resulting in overlap and oversupply, which has led to the accumulation of more physicians than needed to remove shortage designations in some states. Although the federal agencies are now working together informally, they still have differing policies, overlapping jurisdictions, and varying communication with the states. The coordination problem is compounded by the policy differences between HHS and the agencies requesting waivers for physicians. HHS believes that the physicians should return home after completing their training to meet the intent of the exchange visitor program, and the other agencies view the waiver provision as a means to secure physicians to meet the health care needs of their constituents.

While more than 9 of every 10 physicians whose waivers were processed between 1994 and 1995 were practicing at their locations in January 1996, controls are somewhat weak for ensuring that physicians continue to meet the terms of their agreements. Analysis by us and the Appalachian Regional Commission's (ARC) Inspector General found instances in which physicians were not practicing at the facility where agencies believed them to be or were not practicing full-time in the underserved areas for which their waivers were granted. In addition, even when the physicians and facilities follow the agencies' rules, the rules do not restrict physicians from working with those segments of the population that already are adequately served—for example, working in a location that has been identified as having an underserved migrant group, but treating other segments of the population instead.

Proposed regulations published by USIA and developed in working with the informal interagency group, coupled with recent amendments to the Immigration and Nationality Act would address many of the coordination and compliance problems, but not all of them. This report contains matters for congressional consideration that would resolve some of these problems, including clarification of federal policies, management of the program, and improvement of monitoring and enforcement penalties.

Background

J-1 visas allow foreign nationals to participate as exchange visitors in cultural and educational programs in the United States. USIA is responsible for managing the J-1 visa program and designates organizations as

program sponsors. In 1995, over 9,000 foreign physicians with J-1 visas were in the United States for graduate medical education or training. These exchange visitors constituted about one-tenth of all individuals receiving graduate medical education (see app. II). Because many exchange visitors are in the United States for several years for graduate medical education and training, each year a few thousand new physicians receive J-1 visas and enter the United States to begin graduate medical education and training while a few thousand complete their training.

To ensure that the J-1 visa program works as intended in passing learning and experience to other countries, the Congress has imposed restrictions on J-1 visa holders, including physicians in graduate medical education. These physicians are required to return to their home country (or to their country of last legal residence) for at least 2 years after completion of training. However, they may obtain a waiver of this requirement and remain in the United States. For most physicians, the waivers are requested on their behalf by a federal agency or by a state agency or department that is responsible for public health issues.[4] These federal agencies and states generally request waivers of the 2-year foreign residence requirement so that the physicians can practice for several years in underserved areas (see table 1).[5] The federal agencies and states submit these requests to USIA.

[4]For simplicity, we will refer to these state agencies or departments as states.

[5]Physicians with J-1 visas may also obtain a waiver if INS determines that the return to their home countries would create an exceptional hardship to their spouse or child (who must be a U.S. citizen or lawful resident alien) or if the return would subject them to persecution because of race, religion, or political beliefs. However, these individuals are not required to practice medicine in an underserved area, so we did not include physicians who received waivers under these provisions in our review. See app. III for additional information on the 2-year foreign residence requirement and the waiver provisions that have evolved since the exchange visitor program was authorized in 1948.

Table 1: Conditions for Waivers for Physicians With J-1 Visas

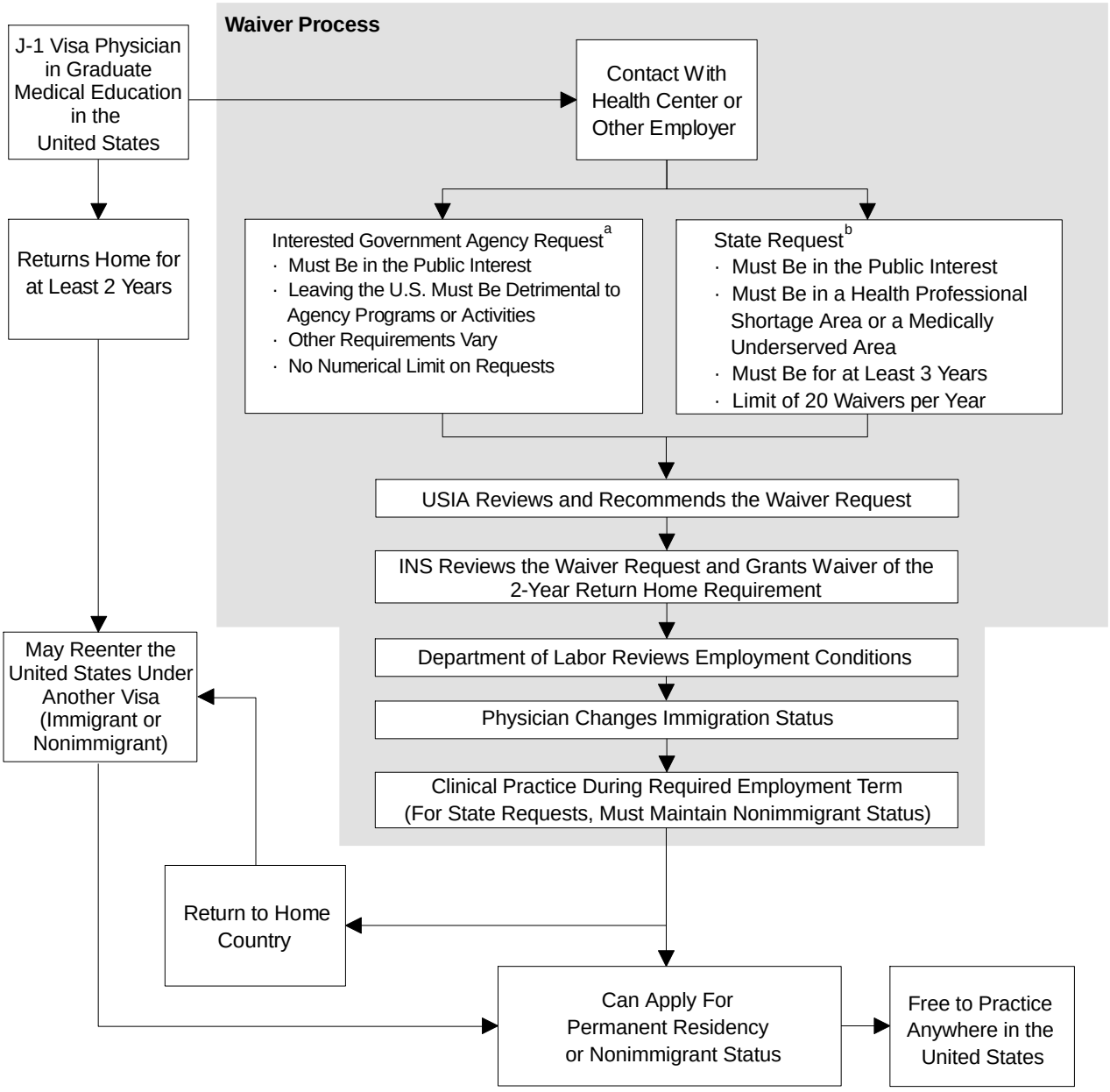
Interested U.S. government agencies[a]	State agencies or departments responsible for public health issues
For whom can they request waivers?	
J-1 visa exchange visitors, including those in graduate medical education or training, who are participating in a program or activity sponsored by or of interest to the agency	J-1 visa exchange visitors in graduate medical education or training
What are the conditions for approving the request?	
(1) The waiver is in the public interest and (2) compliance with the foreign residence requirement would be detrimental to a program or activity of interest to the agency	(1) The waiver is in the public interest, (2) the physician agrees to practice medicine for at least 3 years in an area designated by the Secretary of HHS as having a shortage of health care professionals,[b] and (3) the physician has a bona fide offer of full-time employment and agrees to begin work within 90 days of receiving the waiver
How many waivers can be granted each fiscal year?	
No limit	Each state, regardless of size or identified physician need, is limited to 20 new waivers for physicians each year

[a]Amendments in the Omnibus Consolidated Appropriations Act, 1997, impose additional requirements not in effect at the time of our review on physicians sponsored by interested U.S. government agencies so that their responsibilities are now more consistent with those of physicians sponsored by states. However, the amendments did not impose any annual limits on the number of waivers (see app. III).

[b]These include (1) geographic areas, population groups, and health care facilities that HHS has designated as Health Professional Shortage Areas and (2) Medically Underserved Areas or Populations, those designated by HHS as having shortages of health care services based on factors such as physician-to-population ratios, infant mortality, and poverty rates.

USIA reviews the program, policy, and foreign relations aspects of the case and forwards its recommendations to the INS Commissioner. For waiver requests made by interested U.S. government agencies or states, INS may only grant the waiver if USIA submits a favorable recommendation. Figure 1 illustrates the waiver process.

Figure 1: J-1 Waiver Process



[a]Amendments in the Omnibus Consolidated Appropriations Act, 1997, impose additional requirements on interested U.S. government agency requests (see app. III).

[b]The physician must also have a bona fide offer of full-time employment, agree to begin work within 90 days of receiving the waiver, and fulfill the required 3-year employment contract with the sponsoring health care facility named in the waiver application.

While HHS is the federal agency responsible for addressing physician shortages it does not use waivers to do so. HHS endorses the philosophy that exchange visitors return home after completing their training to make their new knowledge and skills available to their home countries. As a result, HHS does not support waivers for physicians to remain in the United States to practice in underserved areas.

Instead, HHS administers other federal programs, such as NHSC, to address physician shortages in the United States. NHSC supplies physicians and other health professionals to underserved areas primarily by (1) awarding scholarships to students who agree to serve in a shortage area after their health professions training is complete and (2) repaying a set amount of educational loan debt for each year of service in a shortage area.[6] On December 31, 1995, 848 NHSC physicians and 685 other NHSC professionals who received scholarships or federal loan repayment were practicing in underserved areas of the country.[7]

In addition to NHSC, HHS has other programs to address medical underservice. For example, HHS provides federal grant funding to community health centers that are required to accept all patients regardless of their ability to pay.

Use of Waivers Has Grown in Size and Scope

Begun as an exceptions policy, the number of physicians receiving waivers of the 2-year foreign residence requirement for J-1 exchange visitors has grown more than tenfold in the past 5 years. Several factors have contributed to the increase: more hospitals and other facilities have found the waiver to be a means to fill their empty positions; more agencies and states are making requests; and physicians are actively seeking waivers, in some cases allegedly paying recruiters and immigration attorneys to find

[6]Our previous report, National Health Service Corps: Opportunities to Stretch Scarce Dollars and Improve Provider Placement (GAO/HEHS-96-28, Nov. 24, 1995), discusses the NHSC scholarship and loan repayment programs. We found that overall, when compared to the scholarship program, the NHSC loan repayment program offers a better long-term investment of scarce federal resources to address shortages of primary care providers.

[7]In addition to the scholarship and federal loan repayment programs, NHSC also supports physicians and other health professionals through a state loan repayment program and other efforts. Including these NHSC providers, 2,226 NHSC physicians, dentists, and other health care providers were practicing in underserved areas as of September 30, 1996, of which 1,267 were physicians.

them a position. Waiver physicians are practicing in virtually every state; most are primary care physicians.

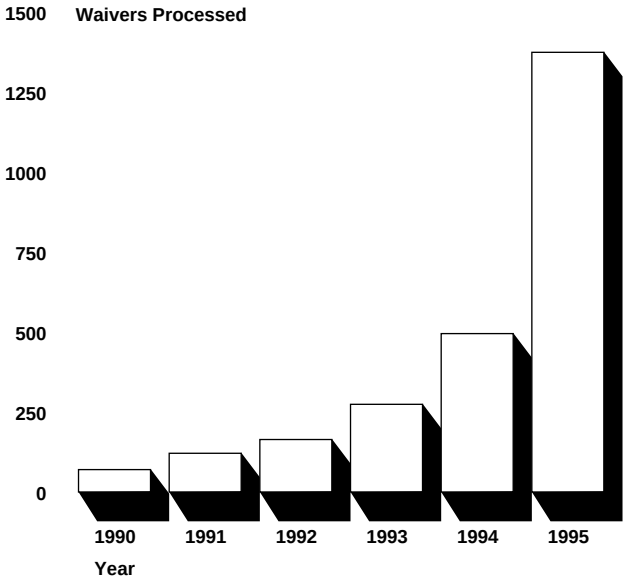
The Number of Waivers Has Increased Significantly

The number of waivers being processed for physicians to practice in underserved areas each year has grown from 70 in 1990, to 1,374 in 1995 (see fig. 2).[8] In 1995, the number of waivers being processed for physicians was greater than the number of NHSC physicians (1,267) practicing in underserved areas, and it was enough to offset about 27 percent of the total physician shortage identified by HHS. Indications are that in 1995, about half of the foreign physicians that were supposed to return home were granted waivers of this requirement to practice in an underserved area in the United States.[9]

[8]Numbers were determined from data from requesting federal agencies and states on waiver requests submitted to USIA. While USIA data showed similar trends, we relied on data from requesting agencies because USIA did not maintain data specifically on waivers for physicians to practice in underserved areas. We excluded from our analysis those physicians whose waivers were requested by VA and physicians whose waivers were requested by other agencies for research purposes.

[9]To estimate the number of physicians who would be required to return home, we counted the number of physicians sponsored as exchange visitors in graduate medical education and training in the 1994-95 academic year who were not sponsored in the 1995-96 academic year. We compared this to the number of physicians whose waivers were processed in 1995, to obtain a rough estimate of the percentage of physicians who were supposed to return home but who received waivers to practice in underserved areas in the United States. See app. I for additional information on our methodology.

Figure 2: Number of Waivers Processed for Physicians With J-1 Visas, 1990-95



Note: Numbers determined from federal agency and state data on waiver requests sent to USIA for physicians to practice in underserved areas, excluding requests for physicians to conduct research and requests from VA.

Why do facilities want to employ foreign physicians through the use of the waivers? In responding to our survey and during our visits to health centers, physician offices, clinics, and other health care facilities where these physicians were practicing, many officials said that their facilities had turned to these physicians because they were unable to recruit U.S. physicians. For example, the administrator of a county public health unit in Florida commented that most U.S. physicians are not willing to work in rural areas, but she has found many physicians with J-1 visas who had excellent references and credentials and who were willing to practice there. She said it would be a "travesty" to health care in rural areas if these waiver physicians were not available. Other reasons cited for hiring these physicians are their superior foreign language skills and cultural familiarity with a facility's patient population. For example, several physicians received waivers to practice at a migrant health center in Eastern Washington. These physicians were recruited, in part, because they are native Spanish speakers, which enables them to effectively treat the center's Spanish-speaking patients.

The sudden increase in the number of waivers being processed in 1994 and 1995 probably reflects the fact that facilities had additional places to turn to for requesting the waivers. By 1995, four U.S. government agencies and 23 states were requesting waivers of J-1 visa requirements for physicians. Before 1993, the only agency requesting waivers for a number of physicians to practice in underserved areas was ARC. ARC began requesting waivers in the 1980s for physicians to practice in Appalachia.[10] However, ARC requested around 200 or fewer waivers per year, peaking at 266 waivers in 1993. In addition to ARC, since 1993 the Department of Transportation (DOT) has requested waivers for a handful of physicians to practice in one rural area where the U.S. Coast Guard operates.[11]

The rapid growth in waivers began in late 1993 and 1994, when the U.S. Departments of Agriculture (USDA) and Housing and Urban Development (HUD) began requesting them for physicians to serve their rural and urban constituents. Senior officials at both agencies said that they initially responded to a constituent request to support a specific physician; however, their offices were subsequently flooded with requests for waivers for other physicians. Agency officials said that they would like to limit the number of waivers processed by their agencies, but have not found a way of effectively restricting them.

The number of waivers also increased because the authority for states to request waivers was passed in 1994, and 23 states requested waivers in calendar year 1995.[12] As a result of the entry of these federal agencies and states, physicians seeking waivers were no longer limited to practice locations in Appalachia and areas serving DOT personnel; instead, they could practice in rural and urban areas across the country. However, HUD officials have recently decided to reassess the department's waiver policy and stopped accepting requests after August 30, 1996, to conduct a review. Table 2 shows the number of waiver requests submitted to USIA by each agency in 1995 and the reason for the requests. For information on the number of waivers requested by each agency since 1990, see appendix V.

[10]The Appalachian region includes specific counties in 13 states. See 40 U.S.C. App. 403(1994).

[11]VA has also requested waivers for physicians. However, because these physicians practice in VA facilities and not in underserved areas, they were not included in our review.

[12]On a fiscal year basis, our survey of states regarding J-1 waivers for physicians found that 20 states had requested waivers in fiscal year 1995 and 34 states had requested or planned to request waivers in fiscal year 1996. See app. IV for our survey results.

Table 2: Requests for Waivers for Physicians, by States and Federal Agency, 1995

Requesting agency	Waivers requested	Reason for requesting waivers
ARC	157	To assist residents of Appalachia in having access to quality, affordable health care
DOT	1	To enable physicians to practice in a rural area where the U.S. Coast Guard operates
HUD[a]	375	To assist indigent, medically underserved urban residents with access to quality, affordable health care as part of HUD's mission to create communities of opportunity
USDA	752	To address the needs of underserved rural areas with shortages of physicians as part of USDA's responsibility for coordinating and providing federal services to rural communities
States[b]	89	To enable physicians to practice in areas designated by the Secretary of HHS as having a shortage of health care professionals—other reasons vary by state
Total	**1,374**	

[a]HUD stopped accepting new requests in August 1996 in order to review its waiver policy.

[b]States were first authorized to request waivers in October 1994.

Another factor in the increase in waivers may be the interest among physicians with J-1 visas themselves. Health care facility officials, as well as state and federal health officials, said that they have been inundated with inquiries from physicians who would like to obtain a waiver by working in a shortage area. In addition, officials at several facilities said that they were contacted by professional recruiters or immigration attorneys regarding the availability of a physician to meet their facility's needs if the physician could obtain a waiver. Some facility officials and physicians reported paying up to $25,000 in immigration attorney or recruiter fees for assistance in matching a physician with a facility and processing the waiver. During our site visits to facilities where physicians who had received waivers were practicing, physicians cited several reasons why they wanted waivers, including that (1) they would not be able to apply the medical skills they had learned in the United States in their home countries, (2) they were concerned about violence in their

home countries, (3) they wanted to serve in an underserved area, (4) their families and relatives were in the United States, and (5) they had a general desire to stay in the United States.

Waiver Physicians Practice Throughout the Country in a Variety of Settings

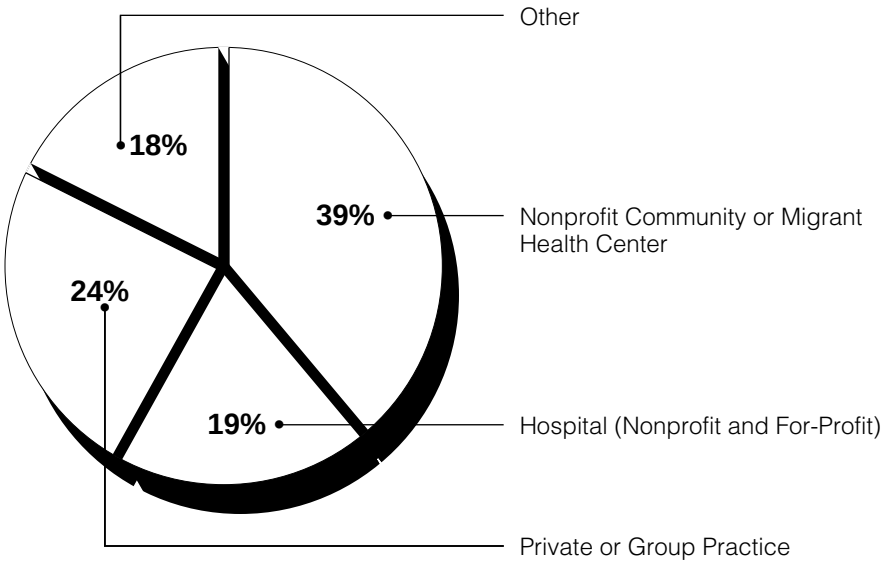
In 1996, waiver physicians were practicing in 49 states and the District of Columbia—every state except Alaska.[13] However, the degree to which they are relied on to relieve physician shortages varies greatly from state to state. To measure the extent of this reliance, we compared the number of waivers granted or in process in 1994 and 1995 with the number of physicians identified by HHS as needed to remove the shortage area designations in a state.[14] In five states (Alabama, Kansas, Kentucky, North Dakota, and West Virginia), the number of physicians for whom waivers were processed equaled more than 75 percent of the number of physicians needed to remove these designations in the state. In other states, such as California, such physicians equal less than 10 percent of the identified need.

Physicians with waivers are practicing in a variety of settings. Our survey results show that more than one-third of physicians who received their waivers through federal agencies are practicing in nonprofit community or migrant health centers and about one-fourth are in a private or group practice. The rest are practicing in hospitals, for-profit health centers, or other settings (see fig. 3). See appendix VI for more detailed information on the results of our survey of facilities.

[13]Although Guam, Puerto Rico, and the U.S. Virgin Islands are also authorized to request waivers for physicians to practice in underserved areas, they had not done so at the time of our review.

[14]See app. I for more detailed information on our methodology.

Figure 3: Practice Settings of Waiver Physicians Practicing on January 1, 1996



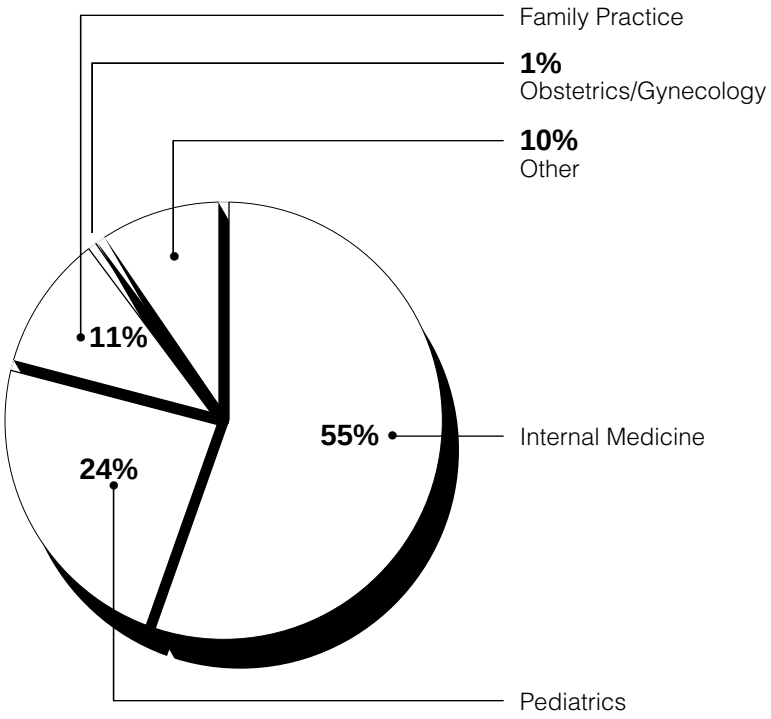
Note: Other includes for-profit health centers, rural health clinics, and other facilities.

Note: Determined from survey results for physicians whose waivers were processed by federal agencies in 1994 and 1995.

Most Waiver Physicians Have Primary Care Specialties

Using our survey results, we estimate that almost all physicians practicing on January 1, 1996, whose waivers were processed through federal agencies were practicing in primary care specialties. Overall, more than half of them were practicing in internal medicine (see fig. 4). The other major primary care specialties were pediatrics and family practice.

Figure 4: Practice Specialties of Waiver Physicians Practicing on January 1, 1996



Note: Determined from our survey results for physicians whose waivers were processed by federal agencies in 1994 and 1995.

We estimate that one-third of the waiver physicians who had primary care specialties also had subspecialties. The most prevalent subspecialty was nephrology (medicine concerned with kidney disease), which was reported for about 7 percent of the primary care physicians. Other subspecialties included infectious diseases, cardiology, and gastroenterology. Requesting facilities and state officials had mixed views on the usefulness of subspecialties for meeting their needs. Officials from some states said that physicians with subspecialties are not as desirable because they may not remain in the area to practice primary care. In fact, several states have policies to not request waivers for physicians who have subspecialties. On the other hand, officials at some facilities said that they recruited specific physicians, such as a nephrologist, because their subspecialties enabled them to meet the needs of their patient populations.

Waivers Are Not Coordinated Effectively Across Participating Agencies and States

Requests for waivers for physicians with J-1 visas are not coordinated effectively among the agencies and states or with other medical underservice programs, such as NHSC. No single entity is responsible for coordinating practice locations of waiver physicians and HHS, perhaps the most logical candidate for doing so, opposes the way in which the waivers are being used. Because no single entity is responsible for coordinating physicians' practice locations, the requesting agencies set up varying policies for requesting the waivers. Because of the lack of coordination, the number of waivers processed for physicians to practice in some states has been more than the amount needed to alleviate the identified physician shortage in that state.

No Agency Is Responsible for Managing Waivers to Address Physician Shortages

No single agency has management responsibility for use of the waivers to address physician shortages. While USIA and INS must recommend and approve all waivers of the 2-year foreign residence requirement for physicians requested by interested government agencies and states, USIA and INS officials said that they recommend and approve virtually all waiver requests. USIA officials said that while they check for required documentation, they almost always rely on the interested government agencies' assertions that the waivers are in the public interest. INS officials said that refusal of the waiver is extremely rare if USIA has given a favorable recommendation. INS officials said that they are not in a position to second-guess USIA or the interested government agency as to whether the public interest would be served if the waiver was granted.

Although HHS is the federal agency responsible for addressing physician shortages, it is not responsible for managing the use of waivers for physicians and does not support waivers for physicians to practice in underserved areas. Specifically, an HHS regulation states that it will not request a waiver

> "when the application demonstrates that the exchange visitor is needed merely to provide services for a limited geographical area and/or to alleviate a local community or institutional manpower shortage, however serious."[15]

The current Secretary of HHS has reiterated the department's position on waivers for physicians with J-1 visas. In an August 1995 letter to the heads of USDA, HUD, and ARC, the Secretary stated

[15]See 45 C.F.R. 50.3(a)(1995).

"In summary, this Department has viewed the J-1 visa to be a means of sharing advanced medical knowledge and allowing the benefits of training to accrue to the home country. The Department does not view waivers as a mechanism to help resolve the problems of shortage areas."

Federal Agency and State Policies Are Not Consistent

Without any overall management of the use of waivers, waiver policies vary considerably between agencies, leading in some cases to "shopping" by the physicians seeking a waiver to obtain the most advantageous terms. Policies vary with regard to such matters as eligible practice locations and state involvement and the consequences of the physician's failure to complete the agreed-upon length of service. For example, ARC restricts physicians to practice locations in federally designated Health Professional Shortage Areas, while the physicians who received waivers through USDA and HUD have been allowed to practice in other areas, including designated Medically Underserved Areas. ARC officials said that they excluded the Medically Underserved Area designations because (1) this designation is not an accurate measure of physician shortage; (2) the designations have not been updated; and (3) including them would allow physicians to practice in virtually any location in Appalachia.[16] Federal agency and state officials also said that and our review found cases where physicians or their immigration attorneys were shopping between agencies; that is, requesting waivers through multiple agencies at the same time.

State health officials commented that they would like consistency in waiver policies across federal agencies. One state health official commented that participation of multiple federal agencies has resulted in confusing and sometimes contradictory program guidelines and has placed a burden on states to coordinate programs.

Largely Autonomous Efforts Lead to Coordination Problems

Thus far, the various efforts to use waiver physicians to address medical underservice have operated largely independent of each other and of other programs to address medical underservice. By 1995, there were nearly 30 federal agencies and states processing requests for waivers for physicians with J-1 visas. Most of them were operating independent of one another.

[16]Our prior report, Health Care Shortage Areas: Designations Not a Useful Tool for Directing Resources to the Underserved (GAO/HEHS-95-200, Sept. 8, 1995), identified a number of weaknesses in HHS' Health Professional Shortage Area and Medically Underserved Area designation systems. Among them was the lack of periodic review and update of Medically Underserved Area designations. In addition, one state we visited for this assignment reported that (1) 90 percent of the state's federally designated Medically Underserved Areas had not been reevaluated for more than 10 years and (2) HHS has not acted upon proposed deletions of these designations.

The four federal agencies have no formal process for coordinating their waiver requests and they have overlapping jurisdictions. For example, while USDA's policy has been to request waivers for rural areas and HUD's policy has been to request waivers for urban areas, the two agencies have not agreed on which areas are rural and which are urban. As a result, we found some locations, such as Buffalo, New York, and Decatur, Illinois, where USDA requested waivers for one or more physicians and HUD requested waivers for additional physicians to practice in the same city and in some cases the same facility. There is no mechanism for each federal agency to know how many waivers the other has requested to address the physician shortage in an area.

Coordination is also lacking between state and federal efforts. State health officials do not always know where physicians receiving waivers through federal agencies are practicing and, therefore, they cannot coordinate these placements with state programs to address medical underservice. While ARC requires that facilities' requests for waivers come through the states, other agencies do not. This leads to situations where the states are unaware of the level of placements that are occurring. For example, health department officials in Texas, which does not request waivers for physicians under the state authority, did not know how many physicians received waivers through federal agencies to practice in the state. As a result, when we scheduled our visits to practice sites in Texas, state officials were surprised to find out that federal agency records showed over 20 waiver physicians practicing in El Paso.

Waivers for physicians also are not well-coordinated with other programs addressing underservice, such as those operated by HHS. One such program is NHSC. When combined with NHSC physicians, federal agencies and states have requested waivers for more physicians than are needed to remove the shortage designations in some states. We found that for eight states, the number of physicians who received waivers in 1994 and 1995 (or had waivers in process), combined with the number of NHSC physicians in service at the end of 1995, exceeded the number of physicians needed to remove the shortage area designations in the state. (See app. VII for more information on the identified need, number of waivers being processed, and the number of NHSC physicians practicing in each state.) Without information on the number of physicians needed in the area and the number of NHSC and waiver physicians already addressing that need, federal agencies and states will not know if the needs of an area are already being met when considering whether or not to request a waiver for a physician.

Another HHS program with which physician waivers are not well-coordinated is the Community Health Center program.[17] This means that federal agencies and states may not know of problems identified by HHS when considering requests from community health centers. For example, waivers were requested through HUD for several physicians to practice at a health center that had its HHS funding discontinued due to financial management problems. When requesting the waivers for these physicians, HUD officials did not know that HHS had identified problems with the health center. As a result, they could not take those problems into consideration when deciding whether the waivers were in HUD's and the public's interest.

Coordination between the agencies involved in the requests and other programs to address medical underservice is important, because not all the agencies processing the waiver requests have expertise in addressing health care issues. For example, USDA and HUD officials involved in the waiver requests said that their offices lacked expertise in health issues. In USDA, waivers for physicians are processed in the department's Agricultural Research Service by an office that has experience processing waiver requests for a small number of research scientists who were in the United States as exchange visitors. At HUD, the waivers were processed in the Office of the Deputy Assistant Secretary for Intergovernmental Relations.

Most Physicians Comply With Agreements but Controls Are Weak

Although most physicians who obtain waivers of their J-1 visa foreign residence requirement are apparently complying with the terms of their service agreements, weak controls mean there is little to deter physicians or their employers from failing to comply if they choose to break these terms. For example, we found instances in which a physician never practiced at the intended facility, unbeknownst to the agency processing the request.

Most Physicians Are Complying With Agreements, but Some Are Not

Including all current waiver physicians when assessing compliance with requesting agency policies can present somewhat of a misleading picture, because so many of these physicians have been at their jobs for a relatively short time, in many cases for less than 1 year.

[17]HHS funds community and migrant health centers to provide primary care services to medically underserved populations, including the poor, uninsured, minorities, women, children, and the elderly.

To provide a more accurate picture of whether physicians stay for the full term of their agreement, we analyzed those physicians whose waivers had been requested through ARC from 1990 to 1992. We estimate that 90 percent completed the minimum employment period required by ARC, which was 2-years,[18] for the facility that requested the waiver.[19] On January 1, 1996, over one-fourth (28 percent) were still practicing at the same facility that requested the waiver and nearly half of these (13 percent) had been there for more than 4 years.

We also examined the shorter-term compliance record of all physicians practicing on January 1, 1996, after receiving waivers through federal agencies between 1994 and 1995. We estimate that 96 percent of them were working at the facility for which the waiver was requested. The remaining 4 percent had left or did not plan to work at that facility. Although this percentage is similar to the percentage of ARC physicians who did not complete their 2-year agreements, the percentage may grow because many of the physicians had completed only a fraction of their employment contract by the start of 1996.[20] For example, none of the physicians with waivers through HUD had been practicing for more than 1 year by that date.

Reasons for Failure to Comply With Agency Policies Rested Partly With Facilities, Partly With Physicians

For the physicians in our sample and in the states we visited, several reasons they were not practicing at the location for which the waiver was requested had to do with changes made by the facility that initiated the request. We found cases in which a facility made the request and then determined that the physician was no longer needed. In at least one case, it appears that the employer made this determination before the waiver was even granted, but the physician still received the waiver. Here are examples in which the facility changed its mind:

- In letters asking USDA to request waivers for three physicians, a clinic in Illinois said that the physicians were needed to help meet an urgent

[18]ARC increased the minimum employment period from 2 to 3 years in 1995 to be consistent with the 3-year minimum employment period required for waivers requested through the states.

[19]Of the physicians that did not work for 2 years at the facilities for which ARC requested a waiver, we found at least a portion had worked in other shortage areas in Appalachia. Although these physicians may have helped to address physician shortages in these areas, they did not address the particular situation that ARC deemed to be in the public interest. In addition, because ARC did not know where they were practicing, ARC could not effectively coordinate physician practice locations with other waiver requests and with other agencies' and states' programs.

[20]As an example, we found that at least 4 of the physicians in our 1994 to 1995 survey sample had left the facility after January 1, 1996, before practicing there for the required 2 to 3 years. One was practicing in another shortage area; the others are discussed in our examples.

primary care delivery crises in the rural community where the practice site was located. Six months after one of the physicians began working there, she was terminated because the clinic had determined that it was overstaffed. She is now practicing in another city in Illinois that has an identified shortage of physicians who serve Medicaid patients. The second physician was transferred from the location on the waiver request to another location that is not in a federally designated shortage area.[21] The third physician was practicing only part-time at the practice site for which the waiver was requested. He said that because there were not enough patients in that location, he spends about half his time working at the main clinic in Champaign, Illinois.

- A medical group asked HUD to request waivers for three physicians to work at a practice purchased from a retiring physician outside of Atlanta. When we called the practice site, we were told that only one of the three was practicing there. An official from the medical group said that the practice no longer had enough patients to support these physicians. As a result, one physician never worked at the site, one physician worked a brief period and then went to practice at a prison in Michigan, and one physician remained to work for the new employer after the practice was sold. INS officials said that waivers had been approved for all three physicians, including the one who was never employed there. Before we notified them, HUD officials were unaware that the facility had been sold and that two of the physicians were not practicing there.

We also found instances in which the reason for not meeting the requirements of an agreement resulted from the physician's actions. For example, in two separate cases, physicians were fired when they refused to complete the requirement for working 40 hours a week at the requesting facility. In one instance, the fired physician notified USDA that he was going to practice at another hospital and when USDA officials told him he could not because the hospital was not in a shortage area, the physician broke off contact with them. The facility official said that he had heard that the physician was pursuing additional graduate medical education in the United States. In the second instance, the facility reported the physician's firing directly to INS, which revoked his nonimmigrant work status.

Reviews conducted by ARC's Inspector General have disclosed similar instances in which conditions of agreements were not met. Six of eight reviews conducted by the Inspector General from 1994 to 1995 found that contrary to ARC policy, some physicians were not practicing primary care

[21]This location is in a state-designated shortage area, which has a lower physician-to-population ratio than a federally designated area.

at least 40 hours per week in a Health Professional Shortage Area. Instead, employers were using the physicians in subspecialty practices or in locations not designated as shortage areas.

Monitoring Varies Among Federal Agencies and States

Agency controls to help ensure that physicians comply with waiver agreements vary among the federal agencies and states. These controls range from periodic reports and site visits, to reliance on employers to enforce the employment contracts. For example, ARC requires the facilities to verify and the waiver physicians to certify that they are complying with ARC policies. In addition, the ARC Inspector General conducts site visits to the physicians' practice locations. In contrast, while HUD and USDA officials said that they had started or planned to start requiring periodic reports, officials at both agencies said that they do not have the staff resources to monitor physician compliance. These officials said that because the use of waivers to address physician shortages is not authorized or funded as a program, their agencies do not have the resources available to effectively manage it as a program.

In its site visits to monitor compliance, ARC's Inspector General attributed most of the problems identified to the employers. However, for waivers requested through both federal agencies and states, the applicable federal laws and regulations do not specify penalties against employers that fail to comply with agency policies. ARC tries to address this shortcoming by requiring employers to sign a statement certifying that they will comply with the waiver policy, and applications from employers found to be in violation of the policy receive additional scrutiny to ensure that the problems have been corrected.

Proposed Regulations and Recent Legislation Could Improve Coordination and Enforcement

The growth in the number of waiver physicians has not gone unnoticed by federal agency officials and legislators. They have recently taken actions that could address some of the coordination and compliance problems identified. A group of federal agency officials has met informally to discuss waiver requests and USIA has proposed regulations to make the waiver requests more consistent. In addition, recent amendments to the Immigration and Nationality Act impose additional requirements for waivers obtained through federal agencies. The new regulations, if finalized, and the 1996 amendments could address many of the coordination and compliance problems, but not all of them.

Agency Efforts Are Under Way to Improve Coordination

Recognizing the need for better coordination, officials from USIA, INS, HHS, and the requesting federal agencies have been meeting since late 1995 to discuss the use of waivers to address physician shortages. The officials formed an informal interagency group that has discussed revising regulations addressing waiver requests.[22] USIA, in working with the other agencies, published a proposed regulation in the Federal Register on September 5, 1996.[23] In the preamble to the proposed regulation, USIA noted that with the entry of USDA and HUD into the waiver process, inconsistency in the administration of waiver requests among the different agencies has created some confusion. For a request by a U.S. government agency, the regulation would condition approval on the physician's commitment to practice primary care for at least 3 years in a designated Health Professional Shortage Area or a Medically Underserved Area or to practice psychiatric care in a mental health Health Professional Shortage Area. To prevent physicians from shopping between agencies, the foreign medical graduate would have to certify that he or she is only requesting a waiver through one agency.

Recent Amendments Require More Consistent Policies

The Omnibus Consolidated Appropriations Act, 1997,[24] included amendments to the Immigration and Nationality Act that create greater consistency among waiver efforts by subjecting state and federally sponsored waiver physicians to the same statutory requirements. The amendments strengthen penalty provisions for federally sponsored waiver physicians by prohibiting them from obtaining permanent residence or U.S. citizenship without completing the required 3-year agreement. If they fail to complete the 3-year agreement, they must fulfill the 2-year foreign residence requirement.[25] These changes (1) make the waiver conditions much more consistent, which may help to alleviate the confusion cited by agency officials, and (2) help to strengthen controls with regard to penalties for waivers requested through federal agencies.

Some Problems Would Remain Unaddressed

While the efforts of the interagency group and enactment of the 1996 amendments should improve coordination of the waiver requests for

[22]DOT, on the other hand was not included in this interagency group. DOT has only requested waivers for one location and does not have formal agency policies regarding the waivers.

[23]See 61 Fed. Reg. 46,745 (1996).

[24]P.L. 104-208 (1996).

[25]Physicians whose waivers were obtained through states have been subject to these requirements since 1994.

physicians with J-1 visas, they will leave several problems unaddressed. Specifically, they do not address the following issues:

- Fully coordinating with other underservice programs or with waiver requests by other agencies. The amendments neither designate an agency as responsible for managing the waivers nor require the waivers to be coordinated with HHS programs such as NHSC or the Community Health Center program. Among federal agencies and states requesting the waivers, the problems of overlapping jurisdictions and the lack of information on the practice locations of waiver physicians could result in more physicians practicing in an area than are needed, as identified by HHS; a continued need for physicians in other areas; and a lack of coordination with state efforts to address physicians shortages. In addition, although HHS has started to collect information on the number of physicians practicing under waivers in an area, there is no directive for this information to be used or shared in making decisions on waivers for physicians or other federal assistance.
- Ensuring that the use of waivers for physicians is a last resort. In an effort to ensure that the employers have a true need for a physician, ARC, USDA, and HUD policies, as well as the proposed USIA regulations, require the facilities to provide some documentation of past recruitment efforts. This procedure, however, does not ensure that the use of waivers for physicians is the option of last resort for areas with physician shortages. In some cases it appears that other qualified physicians are available, but the facility prefers to hire the physicians with J-1 visas. For example, officials from one multispecialty clinic told us that they interviewed several applicants for a specialist physician position, including candidates who were not under J-1 visas, but they chose the physician with a J-1 visa and obtained a waiver because he was the most qualified. The use of waivers is now a ready means for acquiring physicians, some of whom are being actively marketed by the physicians themselves or placement specialists such as recruiters. The current statute and regulations do not require waivers to be used only as a last resort.
- Monitoring compliance. It is unclear whether agencies would devote sufficient resources to effectively monitor compliance. USDA, for example, relies on employers to enforce the employment contracts, citing a lack of staff resources to conduct its own monitoring. However, as we and ARC's Inspector General found, many of the examples of physicians who failed to comply with agency policies resulted from actions taken by the employers. As a result, a reliance on employers to do the policing does not appear adequate to prevent the kinds of situations we found. HUD officials

also said that their monitoring efforts were limited by the availability of staff resources.

- Addressing the needs of the medically underserved. Under existing procedures, locating a waiver physician in a medical shortage area is no guarantee that the needs of the underserved will be addressed. An area's underserved may be only a specific part of the population (such as migrant workers or low-income people), and not all federal agencies' and states' policies contain requirements or monitoring to ensure that a physician's practice includes such groups. For example, if the underserved part of the population is low-income, the requesting agencies' and states' policies do not all require that a waiver physician in such an area accept Medicaid, have a sliding fee scale, or accept anyone for services regardless of his or her ability to pay. In one area where the identified need was care for migrant farm workers, a waiver physician was in a group practice a block away from a federally funded migrant health center. A senior official at the migrant health center said that the waiver physician did not impact the center's patient load because they both served different patient populations.
- Establishing penalties against a facility for failing to comply with agency policies. The new regulations and the 1996 amendments do not establish any penalties for employers who fail to comply. The ARC Inspector General noted that the most significant programmatic issue that surfaced during that office's review was the limited accountability of employers and the lack of potential actions against employers who did not use physicians with waivers in accordance with the intended purposes noted in the program.

Conclusions

The use of waivers for physicians with J-1 visa requirements has become so extensive that this exception policy now resembles a full-fledged program for addressing medical underservice in the United States. Many health care facilities and states cite examples of the utility of these waivers in providing a qualified physician for an underserved area. However, while the agencies involved in processing the waivers are operating with the best of intentions, the growing use of waivers is not being managed as a program, and this is having detrimental results.

- Federal efforts to address physician shortages are not coordinated among the federal agencies or with the states. Several agencies, including those not traditionally involved in physician supply issues, have set up de facto physician supply programs using their existing authority and agency resources.

- Despite some improvements, monitoring efforts to ensure that physicians fulfill the terms of their agreements remain spotty.
- Accountability for reducing the actual conditions of underservice is limited. Physicians can practice in underserved areas but not actually target their efforts to that part of the population that is underserved.

The rapid growth in waivers for physicians makes this an opportune time for the Congress to reassess what it wants the waiver provision to accomplish. The running disagreement between HHS and other federal agencies about the role of waivers in addressing physician shortages in underserved areas needs resolution, and better coordination and management of the overall effort are needed if it is to be continued.

Matters for Congressional Consideration

If the Congress wants to continue to address medical underservice in the United States through the use of waivers for physicians with J-1 visa requirements, it should consider requiring that the use of such waivers be managed as a program. Specifically, the Congress should consider the following:

- Clarifying how the use of waivers for these physicians fits into the overall federal strategy to address medical underservice. This should include determining the size of the waiver program and establishing how it should be coordinated with other federal programs.
- Designating leadership responsibility for managing the program. This responsibility could be given to a single federal agency, such as HHS; to several federal agencies, for example, through a memorandum of understanding; or it could be delegated to the states.
- Establishing penalties against facilities that fail to comply with requirements of the waiver.
- Directing the entity(ies) managing the program to implement procedures and criteria for the selection and placement of physicians and for monitoring compliance with waiver requirements. These procedures and criteria could include requiring the state to clearly support the use of the physician for addressing unmet need and to show that it has sought other options for fulfilling this need.

Agency Comments and Our Evaluation

We provided a draft copy of this report to seven agencies that are involved with waivers for physicians to practice in underserved areas.

- ARC, USDA, and USIA provided formal written comments (see apps. VIII, IX, and X). These comments indicate general agreement with our conclusions and matters for congressional consideration.
- HUD and Justice (the parent department for INS) chose not to provide formal comments. However, we discussed our findings with HUD and INS officials, and they raised no objections to our findings or matters for congressional consideration. DOT has had limited involvement in waivers for physicians with J-1 visas and did not have comments on the draft report.
- HHS did not submit formal comments by the end of our 30-day comment period. However, the Director of the department's Office of International Affairs (who also chairs the department's Exchange Visitor Waiver Review Board) informed us that his office had fully reviewed the draft report and was in general agreement with the findings. Regarding our matters for congressional consideration, he said that HHS favored the option of delegating responsibility for the waivers to the states.

The three agencies that provided formal written comments also expressed their support for the need for better coordination between the participating agencies, states, and other programs to address medical underservice. One agency, USDA, also expressed concern about the lack of available funding to operate its program effectively. USDA suggested that an alternative to funding the program from appropriated research funds would be to initiate a fee-for-service type application fee to offset operational costs, which would require legislation to authorize the collection and utilizations of fees.

We concur that any entity involved in managing waiver requests for physicians should commit adequate resources for oversight and operational support to ensure that the physicians address unmet needs for physician resources. Although we did not examine financing options for managing the waivers in our review, we did note that a few states, such as Michigan, have been requiring user fees of up to $500 per application.

We also received comments on technical matters from several of the agencies, which we considered in preparing our final report.

We are sending copies of this report to the Secretaries of Agriculture, Health and Human Services, Housing and Urban Development, and Transportation, as well as the Director of the United States Information Agency, the Federal Co-Chairman of the Appalachian Regional

Commission, and the Attorney General. We also will make copies available to others on request. Please contact me on (202) 512-7119 if you or your staff have any questions. Major contributors to this report are listed in appendix XI.

Bernice Steinhardt
Director, Health Services
Quality and Public Health Issues

List of Addressees

The Honorable Nancy L. Kassebaum
Chairman
The Honorable Edward M. Kennedy
Ranking Minority Member
Committee on Labor and Human Resources
United States Senate

The Honorable Alan K. Simpson
Chairman
The Honorable Edward M. Kennedy
Ranking Minority Member
Subcommittee on Immigration
Committee on the Judiciary
United States Senate

The Honorable Michael Bilirakis
Chairman
The Honorable Henry A. Waxman
Ranking Minority Member
Subcommittee on Health and Environment
Committee on Commerce
House of Representatives

The Honorable Lamar S. Smith
Chairman
The Honorable John Bryant
Ranking Minority Member
Subcommittee on Immigration and Claims
Committee on the Judiciary
House of Representatives

Contents

Abbreviations

ACGME	Accreditation Council for Graduate Medical Education
AMA	American Medical Association
ARC	Appalachian Regional Commission
COGME	Council on Graduate Medical Education
DOT	Department of Transportation
ECFMG	Educational Commission for Foreign Medical Graduates
HHS	Department of Health and Human Services
HUD	Department of Housing and Urban Development
INS	Immigration and Naturalization Service
NHSC	National Health Service Corps
USDA	United States Department of Agriculture
USIA	United States Information Agency
VA	Department of Veterans Affairs

Scope and Methodology

To accomplish our objectives, we interviewed (1) federal agency officials responsible for requesting the waivers at ARC, HUD, USDA, and DOT; (2) HHS officials in the department's Office of International Affairs and the Health Resources and Services Administration; (3) officials responsible for processing the waiver requests at USIA and INS, including INS service centers; (4) officials from the Department of Labor and the State Department; and (5) officials from the Educational Commission for Foreign Medical Graduates (ECFMG), the National Association of Community Health Centers, the American Medical Association (AMA), the Council on Graduate Medical Education (COGME), and the U.S. Commission on Immigration Reform. We also reviewed relevant legislation, studies, and policy documents and conducted two mail surveys: one of the states regarding the use of waivers of the J-1 visa foreign residence requirement for physicians in their states, and another of the facilities that requested such waivers for physicians. We obtained and analyzed data on requests for waivers for physicians from USIA and the requesting federal agencies and reviewed a small sample of case files.

We also visited three states—Washington, Texas, and Georgia. We selected these three states for a cross-section of states where waiver physicians were practicing: Washington was quick to establish a state program; Texas had a large number of physicians with waivers through federal agencies but the state was not requesting waivers; and Georgia had a state program as well as physicians whose waivers were requested through ARC, HUD, and USDA. During our site visits, we met with state and other health officials, visited 14 sites where waiver physicians were practicing, and interviewed health care facility officials and 20 physicians who received waivers. We selected the sites in order to visit physicians in a variety of practice settings, including federally funded community and migrant health centers, a health center serving residents in public housing, city and county health departments, a capitated-rate program for the Medicare- and Medicaid-eligible elderly, and private and group practices affiliated with both public and for-profit hospitals.

We conducted our work between November 1995 and September 1996 in accordance with generally accepted government auditing standards.

Number of Waivers

To determine the number of waivers for physicians granted at the request of ARC, USDA, and HUD, we requested copies of the agencies' databases. Each database contained information about when the agency requested that USIA recommend the waiver. We used the date that the agencies sent

the request to USIA in our calculations because neither USIA nor INS has a cost-effective means of identifying waiver requests by occupation and USIA and INS officials said that they recommended or approved virtually all the physician waiver requests made by the interested U.S. government agencies. While we did not review the agencies' computer-based systems, we did review the requesting agencies' data for consistency and accuracy and selectively compared the agency data with that held by USIA. We obtained information on the waiver requests made by DOT from its Office of the General Counsel. We obtained information on state requests for waivers from our survey of states regarding waivers for physicians and follow-up telephone calls to state officials. Our scope did not include waiver requests from VA or requests from other agencies for physicians to conduct research.

Because the agencies requesting waivers do not consistently track the practice dates of the physicians, we could not identify the number of physicians in practice at any given point in time. Instead, we used the dates that the agencies and states submitted their requests for waivers to USIA and assumed that those physicians whose waivers were requested in 1994 or 1995 were either already practicing at the facility listed in agency data on December 31, 1995, or had their waivers in process to begin practicing shortly thereafter. We compared this number with (1) the number of physicians needed to remove the primary care Health Professional Shortage Area designations in the state on December 31, 1995, and (2) the number of NHSC physicians (who received NHSC scholarships or NHSC federal loan repayment in return for practicing in an underserved area) who were practicing on December 31, 1995. We obtained these data from HHS' Health Resources and Services Administration. We also compared the number of waivers with the number of NHSC physicians practicing in underserved areas on September 30, 1995, including NHSC physicians who did not have NHSC scholarship or federal loan repayment obligations.

To estimate the number of physicians who completed graduate medical education and training in 1995 who would be subject to the 2-year foreign residence requirement, we subtracted the number of exchange visitor physicians who were continuing applicants in the 1995-96 academic year from the number of physicians sponsored by ECFMG in the prior academic year. While this number is not exact because it may include a small number of physicians who were involved in research and some physicians who did not complete their training, it does represent a reasonable estimate of the number of exchange visitor physicians with J-1 visas who

completed graduate medical education or training who would be required to return home without a waiver to remain in the United States. The number of waiver requests for physicians to practice in underserved areas that the agencies sent to USIA in 1995 (1,374) is about 64 percent of this figure. Therefore, we estimate that half of the physicians who were supposed to return home after completing their graduate medical education or training received waivers to practice in underserved areas in the United States instead.

Survey of Health Care Facilities

To identify characteristics of the physicians who received waivers of the J-1 visa foreign residence requirement and to measure the compliance and retention of these physicians, we selected a random sample of 40 from 355 physicians for whom ARC requested waivers between 1990 and 1992. Because most federal agencies only began requesting waivers in the past several years, we also selected a random sample of 211 of 1,994 physicians for whom ARC, DOT, HUD, and USDA received waiver requests in 1994 and 1995 (this was a stratified sample, including 40 of 362 ARC requests; 2 of 2 DOT requests; 49 of 477 HUD requests, and 120 of 1,153 USDA requests). We sent a questionnaire to the contact person at the facility that had requested the waivers, using the information provided by the federal agencies. For each physician, we asked the contact person to tell us (1) if the physician worked or planned to work at the facility; (2) if the physician was working at the facility as of January 1, 1996; (3) if the physician left and the date he or she stopped working at the facility; (4) whether or not the physician obtained permanent residency during his or her employment; and (5) the physician's medical specialty, subspecialty, and practice setting. We received responses for 39 of the 40 physicians in our 1990 to 1992 ARC sample and for 200 of 211 physicians in our 1994 to 1995 samples (38 of 40 ARC physicians, 2 of 2 DOT physicians, 49 of 49 HUD physicians, and 111 of 120 USDA physicians).

We used the survey results of the 1990 to 1992 ARC sample to estimate the rate of completion of ARC's required 2-year contract among all waiver physicians whose waivers were requested between 1990 and 1992. We counted those physicians who worked for at least 1.75 years as meeting the ARC minimum contract period at that time, which was 2 years. We used 1.75 years of practice as our measure of compliance to allow for vacation and other leave. At a 95-percent confidence level, the rate of compliance among the 1990 to 1992 requests is at least 80 percent and the percent still at the requesting facility on January 1, 1996, is at least 19 percent.

We used the survey results of the 1994 to 1995 samples to estimate the rate of compliance, to date, of physicians whose waiver requests were received by ARC, DOT, HUD, and USDA from 1994 to 1995. We counted those physicians who were working on January 1, 1996, for the facility listed in agency data as in compliance. At a 95-percent confidence level, the rate of compliance among the 1994 to 1995 requests (those practicing on January 1) is at least 93 percent.

We also used the survey results of the 1994 to 1995 samples to estimate the practice specialties and practice settings of physicians who were practicing on January 1, 1996. For this analysis, we included those 150 physicians who were practicing on January 1, 1996, for the facilities listed by the agency. The estimates at the 95-percent confidence intervals are shown in tables VI.2 and VI.3.

We also obtained comments on the use of waivers for physicians from the survey respondents.

Survey of States Regarding Waivers for Physicians With J-1 Visas

To identify the states' participation in requesting waivers for physicians, we used a questionnaire for information on (1) whether or not the state had requested or planned to request waivers for physicians with J-1 visas in fiscal years 1995 and 1996, and (2) the state's involvement in waivers for these physicians. We sent a questionnaire to the contact person provided by USIA or the official responsible for public health issues in all 54 eligible jurisdictions, including the 50 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands. Each state reported on the number of waivers requested by the state, if any; factors considered in state requests; monitoring activities; and state involvement in requests for waivers made by federal agencies. The respondents also commented on the use of waivers for physicians to address medical underservice and provided a copy of their state's written policies, if any, regarding these waivers.

In addition, to obtain information on the number of waivers for physicians requested by the states in 1995, we telephoned officials at those states that indicated they had requested waivers in fiscal years 1995 or 1996.

Coordination

To determine the conditions attached to the waivers, we interviewed state and federal agency officials, reviewed their written waiver policies, and analyzed the results of our state survey.

To look at coordination of physician placements, we cross-tabulated the agency data on waiver requests received by the agencies between 1994 and 1995 by state and selected those physicians whose waiver requests were sent to USIA between 1994 and 1995. We obtained the number of physicians who were NHSC scholarship or federal loan repayment recipients who were practicing in each state as of December 31, 1995, from HHS' Bureau of Primary Health Care.[26] We added the number of waiver physicians and NHSC physicians and compared them with the number of full-time-equivalent physicians needed to remove primary care Health Professional Shortage Area designations in that state as of December 31, 1995. We used the shortage area dedesignation level because it is the primary measurement used by HHS and the requesting agencies to establish the need for physicians.[27]

We used USIA's data file to identify those locations for which more than one agency requested waivers for physicians and checked the requesting agencies' data to see if they showed a request for that practice location.

Compliance

We identified instances where physicians did not comply with the terms of the waiver through (1) discussions with the ARC Inspector General and a review of reports from that office, (2) our survey of facilities where requesting agencies believed that the physicians were practicing, (3) site visits to facilities where the physicians were supposed to be practicing, and (4) discussions with USIA and other agency officials. If a facility indicated that the physician never worked there, we contacted the facility, INS, or both to obtain information on the reason the physician never worked there and to confirm that a waiver had been granted. We also reviewed case files at the requesting agencies and USIA to check for documentation, if any, of the physician's departure from the facility or noncompliance. For physicians that did not work at or left the facilities, we tried to locate the physician through AMA data; the unique provider identification number database, which is maintained by the Medicare program; telephone listings; state licensing boards; and other sources.

[26]For this analysis, we did not include physicians practicing under the NHSC state loan repayment program or the community scholar program, because data on the number of these physicians practicing in each state on December 31, 1995, were not readily available from HHS. If these physicians were included, the number of NHSC physicians in practice on December 31, 1995, would increase.

[27]We used the Health Professional Shortage Area designation as a measure of need for this reason. However, our prior work found problems with HHS' shortage area designations. Our report, GAO/HEHS-95-200, Sept. 8, 1995, discusses these problems in detail.

Exchange Visitors in Graduate Medical Education in the United States

Exchange visitors are only a portion of physicians in graduate medical education programs. As shown in table II.1, about 1 in 10 physicians in programs accredited by ACGME was an exchange visitor in August 1995. Of those who were international medical graduates—physicians who did not graduate from U.S. or Canadian medical schools—about 1 in 3 was an exchange visitor. Only these exchange visitor physicians are subject to the J-visa 2-year foreign residence requirement. Hence, while policy changes regarding waivers for exchange visitors will affect more than one-third of the international medical graduates in graduate medical education or training, most international medical graduates will not be affected.

Table II.1: Immigration Status of Physicians in ACGME-Accredited and Combined Specialty Programs, August 1, 1995

	All physicians		International medical graduate physicians[a, b]	
Immigration status	**Number**	**Percent**	**Number**	**Percent**
Exchange visitor (J-visa)	9,573	9.8	9,183	36.8
Nonimmigrant (H-visa)	2,618	2.7	2,363	9.4
Permanent U.S. resident	8,937	9.1	6,985	28.0
Naturalized U.S. citizen	8,730	8.9	1,973	7.9
Native U.S. citizen	61,886	63.1	2,057	8.2
Refugee	963	1.0	862	3.4
Unknown	4,501	4.6	980	3.9
Miscellaneous[c]	827	0.8	579	2.3
Total	**98,035**		**24,982**	

Note: Percent columns may not total 100 because of rounding.

[a]Does not include graduates of Canadian medical schools.

[b]Medical school type was not indicated for 454 residents (0.5 percent of all residents).

[c]Includes temporary visitors on B-2 visas and students on F-1 visas.

Source: AMA.

Waiver of the Foreign Residence Requirement for Exchange Visitors

Under the Mutual Educational and Cultural Exchange Act of 1961,[28] the Director of USIA establishes programs intended to promote mutual understanding between the people of the United States and other countries by means of educational and cultural exchanges. Under these exchange visitor (J-1 visa) programs, designated organizations sponsor nonimmigrant aliens' temporary visits to the United States for the purposes of teaching, instructing or lecturing, studying, observing, conducting research, consulting, demonstrating special skills, or receiving training. ECFMG is the designated sponsor for exchange visitors participating in graduate medical education.[29] After completing this program, it is expected that participants will return to their home countries and impart what they have learned and experienced to the people of their country.

Section 212(e) of the Immigration and Nationality Act[30] requires that certain J-1 visa program participants, including participants in graduate medical education, reside at least 2 years in the countries of their nationalities or last residences after leaving the United States. They must meet this requirement before they are eligible to apply for nonimmigrant visas (H and L) as temporary workers, for permanent residencies in the United States, or as immigrants.

History of the 2-Year Foreign Residence Requirement

There was no 2-year foreign residence requirement or waiver provision in the exchange visitor program authorized with the passage of the U.S. Information and Educational Exchange Act of 1948.[31] The act required participants to depart the United States after completing their programs. The 2-year foreign residence requirement and its related waiver provision evolved through a number of legislative changes after the exchange visitor program was authorized in 1948.

In 1956, the Congress amended the 1948 act to require that participants reside in and be physically present in their home countries or cooperating countries for at least 2 years before applying for immigrant visas, nonimmigrant H visas, or adjustments of status to permanent resident. In

[28]P.L. 87-256 (1961).

[29]To be eligible for ECFMG sponsorship, foreign physicians must pass a medical science examination and meet English-language requirements, fulfill minimum medical education requirements, and have a contract for a position in a program accredited by ACGME.

[30]8 U.S.C. 1182(e) (1994).

[31]P.L. 80-402 (1948).

recommending this amendment, the Senate Committee on Foreign Relations stated that it was needed to counteract situations in which some participants were departing the United States as required, going to Canada or Mexico, and immediately returning to the United States on immigrant visas. The Committee stated that this defeated the primary objective of the exchange program; that is, to impart participants' experiences in the United States to the people of their country. It further stated,

"the amendment would make perfectly clear to all concerned...and, above all, the foreign nationals themselves—that the exchange program is not an immigration program and should not be used to circumvent the operation of the immigration laws."[32]

The 1956 amendment also provided for a waiver of the foreign residence requirement on the basis of a request from an interested U.S. government agency showing the waiver to be in the public interest.[33]

The Mutual Educational and Cultural Exchange Act of 1961, under which the exchange visitor program now operates, contains a provision amending the Immigration and Nationality Act, which established the foreign residence requirement. Under that provision, a participant could reside for 2 years in a foreign country other than his or her home country. The act also provided for a waiver of the foreign residence requirement (1) upon a determination that departure from the United States would impose exceptional hardship on the participant's spouse or child (who must be a U.S. citizen or a lawful resident alien) or (2) at the request of an interested U.S. government agency (after a favorable recommendation). The conference report states

"To make available the services of exchangees who possess talents desired by our universities, foundations and other institutions, the language of the House bill was modified to permit the waiver of the foreign residence requirement on the request of an interested U.S. Government agency."[34]

An amendment to the foreign residence provision in 1970 removed the blanket application of the foreign residence requirement for exchange visitors and imposed it only on participants (1) whose participation was financed in some way by the United States or their home countries or

[32]S. Rep. No. 1608, 84th Cong., 2d Sess. 2, 3 (1956).

[33]P.L. 84-555 (1956).

[34]H. Conf. Rep. No. 1197, 87th Cong., 1st Sess. 17 (1961).

(2) whose home countries clearly needed their services.[35] Also, participants could no longer meet the 2-year foreign residence requirement by residing in other foreign countries but had to reside in the countries of their nationalities or their last foreign residences before coming to the United States. This requirement still applies. The 1970 act also established two additional bases for waivers: persecution because of race, religion, or political opinion and statements by the participant's home countries that they had no objections to the waivers. These bases still apply except that the statement of no-objection waiver is no longer available to participants in graduate medical education or training.

Participants in Graduate Medical Education or Training Face More Stringent Conditions

After 1970, changes to the foreign residence and waiver provisions primarily strengthened restrictions on participants coming to the United States for graduate medical education or training. In 1976, the Congress imposed restrictions on medical graduates' participation in the exchange visitor program. In the 1976 act, the Congress noted

> "that there is no longer an insufficient number of physicians and surgeons in the United States such that there is no further need for affording preference to alien physicians in admission to the United States under the Immigration and Nationality Act."[36]

In light of this finding, the Congress tightened immigration laws for foreign doctors and strengthened requirements affecting J-1 visa program participants who were coming to the United States for graduate medical education or training. The latter were

- made subject to the 2-year foreign residence requirement whether or not their programs were financed by a government,
- made ineligible to apply for waivers on the basis of no-objection statements from their home countries,
- limited to 3-year stays in the United States,
- required to make a commitment to return to their home countries after completing their training, and
- required to provide written assurance by their home countries that after completing their training and returning home, they would be appointed to positions in which they would fully use the skills acquired in their education or training.[37]

[35]P.L. 91-225 (1970).

[36]P.L. 94-484 (1976).

[37]P.L. 94-484.

In 1981, USIA asked the Congress to extend the limit up to 7 years for medical doctors to encourage them to study in the United States rather than in a Communist country. The House Committee on the Judiciary questioned USIA officials regarding the likelihood that physicians would be willing to return home after 7 years, during which time they may have raised families in the United States. The Congress increased the usual permissible duration of stay to 7 years, but it imposed additional requirements:[38]

- Graduate medical education or training participants were required, as a continuing reminder, to furnish annual affidavits to INS attesting that they would return to their home countries upon completion of the education or training for which they came to the United States.
- U.S. officials were required to issue an annual report to the Congress on participants who had submitted affidavits, including their names and addresses, the programs in which they are participating, and their status in the programs.

In reporting on this legislation, the House Committee on the Judiciary "notes the flagrant abuse of the exchange program during the past decade and seeks to alleviate possible 'brain drain' from various countries." It said that the affidavits were to ensure that the physicians comply with the terms of their agreement.[39]

State Requests for Waivers

Amendment of the Immigration and Nationality Act in 1994[40] established another basis for physicians to obtain waivers of the J-1 visa foreign residence requirement. Under the amendment, up to 20 waivers for physicians with J-1 visas may be granted at the request of a state[41] department of public health or its equivalent each fiscal year. The law imposed several conditions for state-requested waivers:

- The alien physician must (1) demonstrate a bona fide offer of full-time employment at a health facility, (2) agree to begin employment at that facility within 90 days of receiving the waiver, and (3) agree to work there

[38]P.L. 97-116 (1981).

[39]H.R. Rep. No. 264, 97th Cong., 1st Sess. 16 (1981)

[40]P.L. 103-416 (1994).

[41]"The term state includes the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands. 8 U.S.C. 1101(a)(36)(1994).

for at least 3 years while maintaining a nonimmigrant work status (H-1B visa).[42] (The physician's status as a nonimmigrant may not be changed until the employment contract is fulfilled.)

- The alien physician must agree to practice medicine for at least 3 years in a geographic area or areas designated by the Secretary of HHS as having a shortage of health care professionals.
- If the alien physician is otherwise contractually obligated to return to a foreign country, that country's government must furnish a statement to the Director of USIA that it has no objection to a waiver.
- If the physician fails to fulfill the contract, he or she must reside and be physically present in the country of his or her nationality or last residence for at least 2 years after departing the United States before becoming eligible to apply for an immigrant visa, for permanent residence, or for any other change of nonimmigrant status

The 1994 amendments apply only to exchange visitors who were admitted to the United States under a J-visa or acquired J-visa status before June 1, 1996.

1996 Amendments

Other amendments to the Immigration and Nationality Act regarding waivers for physicians with J-1 visas were passed in the 104th Congress. The amendments were included in the Omnibus Consolidated Appropriations Act, 1997,[43] and (1) impose additional requirements for waivers requested by interested U.S. government agencies, and (2) extend authorization for waivers for aliens entering the United States with a J-visa or acquiring such status through May 31, 2002.

The amendments subject physicians seeking waivers through interested U.S. government agencies to some of the same requirements as those sponsored by state agencies. For example, the amendments require such physicians to (1) agree to work for at least 3 years for the health facility named in the application, (2) work in an area designated by the Secretary of HHS as having a shortage of health care professionals, (3) begin work within 90 days of receipt of the waiver, and (4) maintain a nonimmigrant status until their 3-year commitment is completed. Physicians who do not fulfill this commitment become subject to the 2-year foreign residence requirement.

[42]The Attorney General may determine that extenuating circumstances, such as the closure of the facility or hardship to the alien, would justify a period of less than 3 years.

[43]P.L. 104-208 (1996).

Results of GAO Questionnaire for States Regarding J-1 Visa Waivers for Physicians

United States General Accounting Office

GAO

Questionnaire

April 1996

Survey of States Regarding J-1 Visa Waivers for Physicians

INTRODUCTION

The U.S. General Accounting Office is conducting a review of J-1 visa waivers for physicians to practice in medically underserved communities. As part of this study, we are collecting information on state J-1 visa waiver programs as well as on states' roles in requests for J-1 visa waivers made by U.S. government agencies. We are sending this questionnaire to all 50 states, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands of the United States.

INSTRUCTIONS

Please complete the questionnaire and return it, along with a copy of your state's policies on J-1 visa waivers for physicians, if any, within ONE WEEK of receipt. You can use the enclosed pre-addressed envelope or send it via FAX on (206) 287-4872. The questionnaire should take about 15 minutes to complete.

Please provide the name, title, and telephone number of the individual who completed this questionnaire so that we may consult him or her, if necessary, for clarification of your responses or additional information.

name:_____

title:_____

phone #:(_____)_____

STATE J-1 VISA WAIVER PROGRAM

1. Did your state request any state J-1 visa waivers for physicians in federal fiscal year 1995 (10/1/94 - 9/30/95)?

   37% yes--> **82(total)**# of waivers requested

   63% no

2. Has your state requested or will it be requesting any state J-1 visa waivers for physicians in federal fiscal year 1996 (10/1/95 -9/30/96)?

   63% yes
   28% no -->*skip to question 8*
   9% undecided-->*skip to question 8*

3. How many state J-1 visa waivers has your state requested from October 1, 1995 through March 31, 1996? *(enter 0 if none were requested during that time)*

   102 (total) waivers requested

4. How many applications for state J-1 visa waivers did your state receive from employers between October 1, 1995 and March 31, 1996? *(enter 0 if no applications were received during that time)*

   112 (total) applications

please continue on next page-->

5. Based on your current situation, how adequate is the annual limit of 20 state J-1 visa waivers to meet your state's needs for physicians under this program? *(check one)*

   18% much more than adequate
   29% more than adequate
   27% adequate
   6% less than adequate
   0% much less than adequate
   18% too early to tell
   3% no response

6. Listed below are some of the factors you might consider when reviewing state J-1 visa waiver applications. Which of the following factors, if any, does your state consider in deciding whether to request state J-1 visa waivers? *(check all that apply)*

   97% Whether the practice location is in a health professional shortage area (HPSA)
   65% Whether the practice location is in a medically underserved area/population (MUA/MUP)
   29% Whether other state J-1 visa waiver physicians are practicing in the area
   24% Whether other J-1 visa waiver physicians who received waivers through U.S. government agencies are practicing in the area
   27% Whether physicians under National Health Service Corps (NHSC) obligations are practicing in the area
   85% Whether the facility has tried recruiting in the past without success
   0% None of the above factors

7. We are also interested in any activities your state conducts to monitor compliance with the conditions of the J-1 visa waiver. Which of the following activities, if any, does your state conduct or intend to conduct this year for state J-1 visa waiver physicians? *(check all that apply)*

   35% We require periodic reports by the physician
   50% We require periodic reports by the facility
   21% We conduct periodic site visits
   82% We rely on the employers to enforce employment contracts
   15% We rely on other federal or state agencies to monitor compliance
   38% We act in response to reports from other federal or state agencies
   32% other *(please specify)* _____
   3% No activities

please continue on next page-->

J-1 VISA WAIVERS REQUESTED BY U.S. GOVERNMENT AGENCIES

8. J-1 visa waivers may also be requested by interested U.S. government agencies (e.g., Dept. of Agriculture, Appalachian Regional Commission, Dept. of Housing and Urban Development). Which of the following activities does your state conduct for interested government agencies' requests for J-1 visa waivers for physicians in your state? *(check all that apply)*

   72% Prepare a letter from a state official when supporting the waiver
   78% Verify that the request is for a needy area
   37% Track practice locations of the agencies' J-1 visa waiver physicians
   15% Monitor physician compliance with the conditions of the waiver
   48% Provide assistance to facilities applying for U.S. government agencies' J-1 visa waivers
   7% Other *(please explain)*
   _____
   _____

   9% No involvement

9. If you have any comments on the J-1 visa waiver program, such as the reasons for participation or nonparticipation, please enter them in the space below. *(Attach separately if additional space is needed)*

36 states provided comments

10. Please include a copy of your state's written policies, if any, regarding J-1 visa waivers for physicians, with your completed questionnaire.

33 states provided written policies

Thank you for your assistance. When our study is complete, we will send you a copy of our report.

Waiver Requests for Physicians With J-1 Visas, by States and Federal Agency, 1990-95

Year	Waivers requested by states[a]	Waivers requested by federal agencies				Total
		DOT	ARC	HUD	USDA	
1990			70			**70**
1991			121			**121**
1992			164			**164**
1993		2	266		6	**274**
1994		1	217	9	268	**495**
1995	89	1	157	375	752	**1,374**
Total	**89**	**4**	**995**	**384**	**1,026**	**2,498**

Note: Determined on the basis of the date the agency sent the request to USIA. USIA officials said that they recommend virtually all waiver requests and INS officials said that they approve virtually all waiver requests that have a favorable USIA recommendation.

[a]States were first authorized to request waivers in October 1994.

Results of GAO Survey of Health Care Facilities Regarding Waivers for Physicians With J-1 Visas, 1994-95 Requests

This appendix contains the responses to questions we asked facilities that requested waivers of the J-1 visa foreign residence requirement for physicians. We sent the questionnaire to the facilities for 211 physicians who had their waivers requested through ARC, DOT, HUD, and USDA from 1994 to 1995 (determined on the basis of the date the agency received the waiver request). We analyzed the practice specialties and practice settings for the 150 physicians who were practicing on January 1, 1996, for the facilities listed on agency data.

Table VI.1: Waiver Physician Employment Status

	DOT		ARC		HUD		USDA		Population estimate
Status	Percent	Number of responses	Percent	Number of responses	Percent	Number of responses	Percent	Number of responses	percent
Practicing at the facility on January 1, 1996	100	2	100	38	59	29	73	81	75
Left before January 1, 1996	0	0	0	0	0	0	3	3	2
Never practiced/not planning to practice there	0	0	0	0	2	1	2	2	2
Planning to start after January 1, 1996	0	0	0	0	39	19	23	25	22
Total		**2**		**38**		**49**		**111**	

Note: Physicians whose waivers were requested in 1994-95. Percent columns may not total 100 because of rounding.

Table VI.2: Practice Settings of Waiver Physicians Practicing on January 1, 1996

Figures are percent

Practice setting	DOT (n=2)	ARC (n=38)	HUD (n=29)	USDA (n=81)	Population estimate	Sampling error for all agencies[a]
Nonprofit community or migrant health center that receives federal funding	0	29	21	24	24	+/- 7
Nonprofit community health center with no federal funding	0	16	28	10	15	+/- 5
For-profit health center	0	0	3	4	3	+/- 3
Hospital	0	3	24	25	19	+/- 6
Private or group practice	100	32	21	22	24	+/- 7
Other[b]	0	21	3	16	15	+/- 5

Note: Physicians whose waivers were requested in 1994-95 who were practicing on January 1, 1996, at the facilitity that requested the waiver. Percent columns may not total 100 because of rounding; n = number of responses.

[a]At a 95-percent confidence level, the sampling error associated with the population estimate.

[b]Includes rural health clinics, mental health clinics, health department clinics, and other practice settings.

Table VI.3: Practice Specialties of Waiver Physicians Practicing on January 1, 1996

Figures are percent

Practice specialty	DOT (n=2)	ARC (n=38)	HUD (n=29)	USDA (n=81)	Population estimate	Sampling error for all agencies[a]
Internal medicine	100	53	48	59	55	+/- 8
Pediatrics	0	16	41	21	24	+/- 6
Family practice	0	21	3	9	11	+/- 5
Obstetrics/gynecology	0	3	0	0	1	+/- 1
General practice	0	0	0	2	1	+/- 2
General surgery	0	0	0	1	1	+/- 1
Psychiatry	0	8	0	2	3	+/- 3
Other	0	0	7	5	4	+/- 3

Note: Physicians whose waivers were requested in 1994-95 who were practicing on January 1, 1996. Percent columns may not total 100 because of rounding; n = number of responses.

[a]At a 95-percent confidence level, the sampling error associated with the population estimate.

Physician Need and Number of Waiver and National Health Service Corps Physicians, by State, 1995

This appendix contains information for each state showing (1) the identified physician need in the state (2) the number of physicians with waivers granted or in process, and (3) the number of physicians who received NHSC scholarships or federal loan repayment who were practicing in the state. We used the number of full-time-equivalent physicians identified by HHS as needed to remove primary care Health Professional Shortage Area designations in the state on December 31, 1995, because it is the primary measurement used by HHS and the requesting agencies to establish the need for physicians.[44] Although physicians with waivers may also practice in designated Medically Underserved Areas, HHS does not remove this designation and, as a result, there is no dedesignation level to measure the need for physicians in the Medically Underserved Area. To measure the number of waiver physicians who would be practicing on December 31, 1995, or shortly thereafter, we used data from the requesting agencies and states on the number of waiver applications sent to USIA from 1994 to 1995. For the number of NHSC physicians in a state, we used the number of NHSC scholarship and loan repayment recipients who were practicing on December 31, 1995. This is a conservative number of NHSC physicians; however, because it does not include the number of physicians who were NHSC state loan repayment recipients practicing in shortage areas, which was not available by state from NHSC at the time of our review.

As shown in table VII.1, the degree to which the identified physician shortage can be offset by the waiver physicians practicing in a state varied between the states. In addition, when combined with the NHSC physicians practicing there, the number exceeded the number of physicians needed to remove some states' primary care Health Professional Shortage Area designations, while other states' identified physician needs were not met by these two physician sources.

[44]As noted in our report, GAO/HEHS-95-200, Sept. 8, 1995, HHS' measure of full-time providers needed to dedesignate a Health Professional Shortage Area does not take into account the number of waiver physicians or NHSC providers practicing in the area. As a result, the number of waiver physicians or NHSC providers practicing in an area would not change the number of physicians that HHS identified as needed to remove a shortage area designation.

Table VII.1: Physician Need and Number of Waiver and NHSC Physicians, by State, 1995

State	Physicians needed[b]	NHSC[c]	Agency requesting waiver for physician[a]						Waiver physicians as a percent of identified need	NHSC physicians as a percent of identified need
			USDA	DOT	HUD	ARC	States	Total		
Alaska	18.7	1							0	5
Alabama	123.7	29	29		3	75		107	86	23
Arizona	58.5	28	15		4		5	24	41	48
Arkansas	61.4	8	39				1	40	65	13
California	511.3	46	33		11			44	9	9
Colorado	74.2	22	5		3			8	11	30
Connecticut	56.6	8			11			11	19	14
Delaware	4.4	5	1					1	23	114
District of Columbia	30.1	3			1		2	3	10	10
Florida	206.4	32	33		12		3	48	23	16
Georgia	196.5	26	15		2	11	1	29	15	13
Guam	3.1								0	0
Hawaii	6.0	2							0	33
Idaho	36.0	10	1					1	3	28
Illinois	165.0	40	81		37		1	119	72	24
Indiana	85.7	7	18		7		4	29	34	8
Iowa	34.4	25	12					12	35	73
Kansas	35.8	18	26		3			29	81	50
Kentucky	103.1	12	19		8	64	18	109	106	12
Louisiana	217.6	8	112		6			118	54	4
Maine	19.9	8	9					9	45	40
Maryland	36.9	16	2		5	1		8	22	43
Massachusetts	64.0	20			9		6	15	23	31
Michigan	243.6	34	56		44		2	102	42	14
Minnesota	31.8	12	19		1		2	22	69	38
Mississippi	136.0	15	71			17	1	89	65	11
Missouri	95.6	34	51		8		7	66	69	36
Montana	16.1	8	3					3	19	50
Nebraska	18.2	8	6				1	7	38	44
Nevada	41.1	4							0	10
New Mexico	65.0	4	5					5	8	6
New Jersey	53.8	11	4		20			24	45	20
New Hampshire	12.4		3					3	24	0
New York	387.9	78	63		89	21		173	45	20

(continued)

State	Physicians needed[b]	NHSC[c]	Agency requesting waiver for physician[a]						Waiver physicians as a percent of identified need	NHSC physicians as a percent of identified need
			USDA	DOT	HUD	ARC	States	Total		
North Carolina	121.9	26	23		2	10	6	41	34	21
North Dakota	19.1	2	16	2			2	20	105	10
Ohio	160.8	30	8		21	22	3	54	34	19
Oklahoma	63.3	4	23				4	27	43	6
Oregon	80.1	12	1					1	1	15
Pennsylvania	123.2	35	3		6	48		57	46	28
Puerto Rico	334.6	8							0	2
Rhode Island	20.0	5			2		3	5	25	25
South Carolina	127.3	22	19			17	5	41	32	17
South Dakota	31.2	5	6					6	19	16
Tennessee	85.8	12	18		8	25		51	59	14
Texas	386.3	18	130		52			182	47	5
Utah	28.6	21	1					1	3	73
Vermont	7.0	2	1					1	14	29
Virgin Islands	5.7	1							0	18
Virginia	80.2	15	5			18		23	29	19
Washington	102.2	33	6				7	13	13	32
West Virginia	55.2	5	1			45	1	47	85	9
Wisconsin	87.6	7	25		9		4	38	43	8
Wyoming	7.7	3	3					3	39	39
Total	**5,178.6**	**848**	**1,020**	**2**	**384**	**374**	**89**	**1,869**	**36**	**16**

[a]Number of waiver requests for physicians submitted to USIA in 1994 and 1995.

[b]Number of full-time-equivalent physicians needed to remove all primary care Health Professional Shortage Area designations in the state, as of December 31, 1995.

[c]Number of physicians who were NHSC scholarship and loan repayment recipients practicing in the state, as of December 31, 1995.

Comments From the Appalachian Regional Commission

APPALACHIAN REGIONAL COMMISSION

A Proud Past, A New Vision

Office of the Federal Co-Chairman

November 12, 1996

Sarah F. Jaggar, Director Health Services
Quality Public Health Issues
United States General Accounting Office
701 Fifth Avenue, Suite 2700
Seattle, Washington 98104

Dear Ms. Jaggar:

I am writing in response to your letter of October 22, 1996 requesting the Commission's comments on the draft report on J-1 waivers for physicians to practice in underserved areas. We appreciate your report, which contains many valuable suggestions for effective operations of J-1 Waiver programs, and we support your recommendations.

I have asked Commission staff to convey several points of clarification and other minor suggestions to the GAO evaluator-in-charge by separate memorandum. In this response, I will only briefly touch on certain issues raised in the report which appear to be especially significant.

In particular, I would like to emphasize the Commission's agreement with your conclusion that continued cooperation and coordination among the Federal entities involved in processing waivers is of paramount importance to these programs. The Commission has been involved since late last year with the interagency J-1 workgroup to which you refer several times in the draft report. As you note, this work group has now produced a proposed regulation which should go far to ensuring consistency in the administration of the various J-1 waiver programs. Moreover, staff interaction to resolve particular placement problems has increased significantly as a result of the group's efforts and jurisdictional concerns, especially regarding placements in the Appalachian Region, have largely been resolved. The spirit of interagency cooperation evidenced thus far by the work group should result in more tightly administered and effective J-1 programs government-wide.

In addition to agreeing with your emphasis on cooperation among the Federal entities in J-1 matters, the Commission especially supports your recommendations regarding the need for a state to be involved, and concur with J-1 placements by Federal entities in underserved areas within that state's boundaries. The Commission's decision to operate its J-1 program in close

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Alabama Georgia Kentucky Maryland Mississippi New York North Carolina Ohio Pennsylvania South Carolina Tennessee Virginia West Virginia

cooperation with the health officials of its member states has contributed, I believe, greatly to the effectiveness of the program.

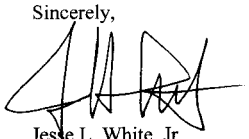
The Commission's J-1 program is completely need-based and is operated solely to address the acute problem of physician recruitment and retention facing many Appalachian communities. We are committed to ensuring that each ARC J-1 placement fulfills a genuine need for a physician in a particular community. In our experience the greatest single danger to the integrity of this program is the placement of additional J-1 doctors in communities which already enjoy adequate physician to population ratios. It is the state health officials with whom we work who can give us true assessments of need and supplement Federal underservice data, which may not be current, with invaluable information "from the field."

I would like to comment further only on the elements of your draft report concerning enforcement and monitoring. I agree that the recent J-1 waiver amendments to the Immigration and Nationality Act contained in the Omnibus Consolidated Appropriations Act, 1997 are a welcome strengthening of the penalty provisions for federally sponsored waiver physicians. I am equally encouraged, however, by the results of the various surveys you conducted during your examination of the J-1 waiver programs. The compliance record of over 90 percent in your surveys coincides with the results of the Commission's own reviews over the past two years. I believe the high levels of compliance can be maintained and even increased as more attention is given to consistent and effective program administration.

I was particularly gratified by the data you report indicating that a significant number of J-1 doctors remain at their practice site even after their commitments have expired. These results are a first indication that the Commission's J-1 program may in fact be providing a long-term solution to the problem of physician shortages in Appalachia.

Thank you for the opportunity you have afforded the Commission to comment on this useful report.

Sincerely,



Jesse L. White, Jr.
Federal Co-Chairman

Comments From the Department of Agriculture

DEPARTMENT OF AGRICULTURE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20250

NOV 2 1 1996

Ms. Patricia (Kim) Yamane
Senior Evaluator
General Accounting Office
701 Fifth Avenue, Suite 2700
Seattle, Washington 98104

Dear Ms. Yamane:

Thank you for the opportunity to comment on the draft report on J-1 visa waivers. It is clear from the number of waiver requests received by the Department of Agriculture (USDA), and corresponding letters of community and Congressional support, that there is a strong need for J-1 physicians.

We have several concerns regarding the program and many suggestions for its improvement as outlined below. One major concern is the lack of coordination between other Interested Government Agencies (IGA) and Health and Human Services (HHS). As a result, physicians granted J-1 visa waivers to work in designated medically underserved areas are not being counted by HHS. Therefore, a rural area may be fully medically served, but it is not being represented as such since J-1 physicians are not being applied against the number of physicians needed. In determining whether to act as an IGA, it is important for USDA to have access to the current number of physicians needed in a particular area so that we know when the limit for physicians assigned to a specific rural area has been reached.

Another major concern is the lack of funding to operate this program. The Agricultural Research Service has absorbed costs in excess of $300,000 annually (from funds appropriated for research programs and activities), and has processed 2,000 waiver petitions since becoming involved in January 1994. It is estimated that $500,000 would be required to adequately conduct and manage the program, and provide the resources necessary to perform oversight and operational support. An alternative to funding the program from appropriated research funds would be to initiate a fee-for-service type application fee to offset operational costs, which would require legislative authority to collect and utilize the fees.

USDA is in the process of drafting regulations which will strengthen its visa waiver program and address concerns brought out in the GAO report. The purpose of the proposed regulations is to establish requirements and procedures for submitting waiver requests to USDA, and to ensure that we do not merely rubber stamp requests to act as an IGA. It is important when making a determination to act as an IGA on waiver requests that USDA not be misled by factual circumstances. The proposed regulations attempt to secure evidence that is corroborated so as to prevent misrepresentation and fraud. In addition, the proposed rules will set out requirements that will assist us in monitoring the program.

AN EQUAL OPPORTUNITY EMPLOYER

Though the following is not a complete reflection, the proposed regulations will at a minimum require:

a. A local or state health department (or both) verify the need for the physician and the rural nature of the medically underserved area.

b. Proof that the medical facility is set up to serve those that need the services by accepting all patients regardless of ability to pay or the source of the payment.

c. Evidence that the designated area, population group or facility will be served.

d. The employer and J-1 physician verify annually that the terms of the contract are being met. Failure to comport with this requirement could result in USDA refusing to accept future J-1 visa waiver petitions.

e. The type of facility be limited to general hospitals and primary care clinics and practices to ensure that primary medical care is the reason the patients are visiting the facility.

f. There be no noncompetition clauses in the contract between the medical facility and the J-1 physician if such would force the physician to be unable to serve the medically underserved area at the end of the 3-year term.

g. There be no contract termination clauses for reasons other than loss of subsidies, forced closure of the facility, or the physician's failure or inability to perform his/her duties.

It should be noted that the type and amount of evidence needed to ensure that USDA is making an informed decision will vary from case to case.

USDA must define the term rural. USDA'S involvement in the J-1 visa waiver program furthers its mission to improve underdeveloped rural areas. Therefore, it is very important that the definition of rural be elastic enough and sensible enough so as not to frustrate that policy. It goes without saying that what USDA deems to be rural for these purposes would be only those areas not yet covered by other agencies. In this regard, it is important that USDA continue its discussions with officials of the Department of Housing and Urban Development (HUD) begun prior to HUD's moratorium. These discussions identified the need to define urban and rural so that no overlap exists and, likewise, no gaps are created.

Again, we appreciate the opportunity to comment on the draft, and hope our comments will be helpful. We look forward to the final report submitted to Congress.

Sincerely,

Catherine E Woteki

CATHERINE E. WOTEKI, Ph.D., R.D.
Acting Under Secretary
Research, Education, and Economics

Comments From the United States Information Agency

United States Information Agency

Washington, D.C. 20547

Office of the Director

USIA

November 14, 1996

Ms. Sarah F. Jaggar, Director
Health Services Quality and Public Health Issues
Health, Education, and Human Services Division
United States General Accounting Office
Washington, D.C. 20548

Dear Ms. Jaggar:

Thank you for the draft copy of your excellent report on J-1 visa foreign physicians and your penetrating look at all implications of their role in providing medical care in health professional shortage areas in the United States.

For some time USIA has been concerned about the mushroom growth of foreign physician waiver applications, as well as the conflicting regulations governing the state and federal agency process. As you mention in your report, after months of meeting with other federal agencies, USIA recently published preliminary regulations to eliminate many of these differences. While helpful, you are correct that neither these regulations nor the requirements included in the amendments to the Omnibus Consolidated Appropriations Act, 1997, will resolve all of the issues.

USIA agrees there is a demonstrated need for one entity (or entities) to accept responsibility for assuring greater coordination among those seeking to place foreign physicians in health professional shortage areas. A foreign physician should be placed in a community only after all efforts to recruit an American physician have failed; monitoring procedures should be in place to assure the physicians are fulfilling the needs for which they were employed; and penalties should be in place for the employer and/or the physician when there is failure on either part to fulfill the contract. USIA does require evidence of efforts to recruit an American physician, but the recommendation you make to have the requesting agency coordinate with federal and state programs such as the NHSC is an excellent one.

We will be interested in guidance which may be provided by Congress as a result of your efforts. To the extent possible, this Agency will continue to work closely with all participants in an effort to find solutions to the unresolved issues.

Sincerely,

Joseph Duffey
Director

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Acknowledgments

In addition to those named above, the following individuals made important contributions to this report: Sarah F. Jaggar, Issue Area Director; Susan Lawes, Senior Evaluator; Susie Anschell, Evaluator; Julie Rachiele, Technical Information Specialist; Evan Stoll, Computer Specialist; Jerry Aiken, Computer Specialist; Julian Klazkin, Senior Attorney; Stan Stenersen, Evaluator; Lisa DeCora, Intern; Kathleen Belfi, Support Services Technician; and William J. Carter-Woodbridge, Communications Analyst.

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