AMERICA'S ESSENTIAL HOSPITALS

October 26, 2020

The Honorable Chad Wolf
Acting Secretary
Department of Homeland Security
Washington, DC 20528

Ref: DHS Docket No. ICEB-2019-0006, RIN 1653-AA78: Establishing a Fixed Time Period of Admission and an Extension of Stay Procedure for Nonimmigrant Academic Students, Exchange Visitors, and Representatives of Foreign Information Media

Dear Acting Secretary Wolf,

Thank you for the opportunity to submit comments on the above-captioned proposed rule. America's Essential Hospitals is deeply concerned about the Department of Homeland Security's (DHS') proposed changes to the admission period for nonimmigrant exchange visitors pursuing graduate medical education (GME) in the United States. The proposed changes would be detrimental to the nation's health care system, vulnerable patients, and state and local economies. The changes would be costly for federal, state, and local governments and harmful to public health, especially amid a pandemic and declared national public health emergency. **Therefore, we ask DHS to withdraw its proposal to replace the duration of status framework for J-1 physicians.**

America's Essential Hospitals is the leading champion for hospitals and health systems dedicated to providing high-quality care to all. Filling a vital role in their communities, our more than 300 member hospitals provide a disproportionate share of the nation's uncompensated care—that is, services the hospital provides but for which it receives no reimbursement. The average essential hospital provides $80 million in uncompensated care annually, about 10 times more than other hospitals. Essential hospitals also play a critical role in training the next generation of health care professionals. Three-quarters of essential hospitals are teaching institutions, training on average 241 physicians a year—three times as many as other U.S. teaching hospitals. Because of their own diverse workforce and experience treating diverse patients, essential hospitals are uniquely situated to provide the culturally competent care their patients need. Our members provide state-of-the-art, patient-centered care while operating on financial margins one third that of other hospitals—2.5 percent on average compared with 7.6 percent for all hospitals nationwide.[1]

Through their integrated health systems, members of America's Essential Hospitals deliver services across the continuum of care, from primary through quaternary care, including level I

[1] Clark D, Roberson B, Ramiah K. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2018 Annual Member Characteristics Survey*. America's Essential Hospitals. May 2020. https://essentialdata.info/. Accessed October 18, 2020.

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trauma care, outpatient care in their ambulatory clinics, public health services, mental health care, substance abuse treatment, and wraparound services. Their response to the COVID-19 pandemic underscores essential hospitals' central role in the nation's public health infrastructure. Essential hospitals are on the front lines of responding to the COVID-19 pandemic—they are screening, testing, and treating COVID-19 patients in their communities. They continue to respond to the COVID-19 pandemic, including by increasing capacity through alternative care sites, maintaining sufficient quantities of personal protective equipment and other critical supplies, and ensuring staff capacity.

Beyond their vital role in providing access to lifesaving care, essential hospitals also are economic pillars in their communities. They drive economic activity and are some of the largest employers in their communities. Nationally, essential hospitals contribute to more than 1.5 million jobs and nearly $125 billion to their state economies.[2] The proposed rule would have a profound impact on these hospitals' ability to meet the needs of their patients through a robust workforce and train future leaders to fill health care workforce shortages; it also would have downstream effects for state and local economies.

We are extremely concerned DHS' proposal to change the admission period for J visas from duration of status to a fixed period will create uncertainty for teaching hospitals and trainees, potentially forcing residents and fellows to return their country before the completion of their training. This could deter international medical graduates from applying for residency and fellowship opportunities in the future. **For the reasons we outline in our comments below, we urge DHS to withdraw its proposal to replace the duration of status standard with a fixed admission period for J-1 physicians.**

1. DHS' proposal is unnecessary due to the existing rigorous protocols in place for reviewing and extending the stay of physician trainees.

DHS proposes to reverse its longstanding policy—in place since 1985—of admitting individuals on J visas for the duration of status, which is essentially the time during which the exchange visitor is participating in an authorized program. The Department of State grants J-1 exchange visitor visas to 15 categories of professionals seeking to train in specific fields. One of the J-1 categories is physicians who want to pursue GME or training in the United States at accredited medical schools. The duration of status policy allows these physicians to enter the country for the duration of their authorized training program under the sponsorship of the Educational Commission for Foreign Medical Graduates (ECFMG). Under current policy, ECFMG reviews and extends its sponsorship of physicians annually, which also extends the duration of status for these physicians. DHS' proposal would remove the duration of status policy and instead provide a limited four-year admission period for J visas. In some cases, depending on the country of origin of the visa applicant and other circumstances determined by DHS, DHS also could limit the admission period to two years. Upon the expiration of the two- or four-year period, the applicant would have to proactively apply for extension of status, which is a formal application that requires the collection of biometric data, payment of fees, and potentially an interview.

In the proposal, DHS cites the need to combat fraud and abuse and the agency's inability to verify visa holders' status through the existing duration of status policy. However, other than citing a few anecdotal instances of fraud in these visa programs, DHS puts forth no evidence that the existing system—in place for 35 years—is flawed or in need of reform. In fact, there already is a rigorous process in place for first granting a physician a visa and for the physician

[2] Ibid.

subsequently to remain in the country while participating in a GME program. ECFMG works with training program liaisons at teaching hospitals and residency programs to demonstrate that all J-1 physicians are still participating in an authorized program. ECFMG inputs detailed information on J-1 physicians in a DHS database, a process that ensures DHS has access to up-to-date information on these visa holders at any given time. DHS should not seek to overhaul a transparent system that already functions seamlessly and has worked for decades.

2. DHS' proposal would undermine health care delivery and the health care workforce.

DHS' proposal would disrupt the continuity of residency and fellowship programs, many of which last up to seven years. The proposal to limit the admission period to two or four years would, in most instances, hinder the ability of J-1 physicians to complete training through their GME programs. For example, in the case of programs that last for more than two or four years, the onus would be on the physician to submit an extension-of-stay application with the U.S. Citizenship and Immigration Services (USCIS). USCIS estimates processing times of up to 19 months for extension-of-stay applications. Most residency and fellowship contracts are only finalized three to five months before the start of the upcoming program year. The uncertainty about whether a resident or fellow will be granted an extension of stay will severely obfuscate the ability of GME programs to make decisions on the continuation of J-1 physicians' participation in these programs. If these physicians are unable to continue their training, they will have to return to their countries, creating a large void in the health care workforce of teaching hospitals. The uncertainty about residents' ability to remain in the country could translate to increased costs to the health care system, increased workload for other providers, and untreated conditions.

Residents and fellows are a vital part of the provision of care to patients of teaching hospitals. They have taken on increased importance during the COVID-19 pandemic, when hospitals in hotspots experienced exponential surges in cases that strained their already taxed resources and staff. International medical graduates are indispensable to essential hospitals and the broader health care system. Nearly one-third of the physicians in the United States are foreign-born and a disproportionate number of these practice in specialties with physician shortages, such as internal medicine.[3] They also gravitate toward underserved rural and urban areas—places where patients have limited access to health care due to provider shortages. The physician shortage is only expected to worsen over the next decade, with a shortage of up to 122,000 physicians expected by 2032.[4] This new rule will further exacerbate the shortage and the ability of the U.S. health care workforce to remain competitive and prepared for future challenges, pandemics, and an aging population. For teaching hospitals heavily reliant on international medical graduates in their residency and fellowship programs, this would result in a large void in their staff. This proposal will limit the ability of teaching hospitals to recruit the world's most qualified medical graduates and have downstream effects on patient access and patient care.

[3] Iacono R, Ramon C. Immigrants in the Health Care Workforce: An Explainer. April 9, 2020. https://bipartisanpolicy.org/blog/immigrants-in-the-health-care-workforce-an-explainer/. Accessed October 18, 2020.
[4] Association of American Medical Colleges. New Findings Confirm Predictions on Physician Shortage. April 13, 2019. https://www.aamc.org/news-insights/press-releases/new-findings-confirm-predictions-physician-shortage. Accessed October 18, 2020.

3. DHS' proposal would be administratively burdensome for hospitals, physicians, and the federal government.

DHS' proposal would be burdensome for physicians, teaching hospitals, and DHS. For situations in which visa holders' period of admission is expiring and they must proactively apply for an extension of stay, the process would involve the physician's time and resources. DHS notes in the rule that extension-of-stay applications will require an application, with corresponding fees and biometrics requirements (such as fingerprints and photographs, usually done in-person) and, in some cases, interviews.

The proposed policy also would burden hospitals as they adapt to potential resident shortages and have to look elsewhere to staff their residency programs. Teaching hospitals and residency programs will have to closely track resident extension-of-stay applications and their admission periods to anticipate departures. As previously mentioned, the policy also would burden programs making decisions about whether to extend residency placements for additional years. Further, hospitals could be asked to produce additional documentation to support extension-of-stay requests.

Not only would the rule burden hospitals and physicians, but it also would add to the caseload of an already-strained USCIS. There already are months-long—or even yearlong—backlogs in evaluating extension-of-stay requests, and USCIS would face an influx of such applications once visa holders' approved period of stay is close to elapsing. Processing applications and associated materials would be financially costly and would strain current USCIS staff resources and undoubtedly add to processing times.

For the above reasons, DHS should withdraw its proposal as it relates to physicians seeking entry for training with J-1 visas. Maintaining a strong physician training pipeline is critical to allowing the United States to maintain its world-class health care system.

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America's Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Senior Director of Policy Erin O'Malley at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,

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President and CEO