

Conrad 30 Waivers for Physicians on J-1 Visas: State Policies, Practices, and Perspectives

EXECUTIVE SUMMARY

BACKGROUND AND PURPOSE

Non-U.S. citizen international medical graduates (IMGs) are a vital component of the physician workforce providing care to rural and underserved populations. The Conrad 30 Waiver Program, through sponsorship of waivers that allow IMGs on J-1 visas to remain in the U.S. after residency training, supplies a significant proportion of health care providers in rural and underserved communities. States collectively recruit approximately 800 to 1,000 IMGs annually through the Conrad 30 program to practice in underserved communities. This study examined state Conrad 30 programs' goals, policies, and practices for recruiting and retaining waived physicians.

STUDY METHODS AND DATA SOURCES

We used mostly qualitative methods to analyze multiple data sources, including (1) a review of available online information on Conrad 30 program websites, documents collected from program staff, and published reports on program outcomes; (2) in-depth interviews with staff in 32 states about Conrad 30 program policies, strategies, trends in recruitment of waived physicians, and efforts to track retention after service obligations; and (3) interviews with 6 experts on physician immigration and the Conrad 30 program.

FINDINGS

The 32 states studied varied considerably in their goals for the Conrad 30 program, program requirements, resources devoted to the program, waiver usage, and information available on physician retention:

- Many program staff wished to recruit more physicians to primary care or rural placements, favoring facilities in Health Professional Shortage Areas over other eligible practice sites. In practice, however, most states did not fill all of the 30 slots available annually, and staff were often willing to sponsor any qualified applicant without regard to specialty or practice location rather than leave a slot unfilled.
- Strategies to improve recruitment included better marketing and customer service; cultivating relationships with physicians, employers, and attorneys; eliminating state program requirements that were not essential for compliance with the federal Conrad 30 program statute; and working with communities to enhance their appeal to J-1 physicians.
- Retention strategies included support of physicians' pursuit of permanent residency through the National Interest Waiver program, building long-term relationships with physicians, and monitoring the employer-employee relationship.

- Other than staffing and state population, we found no clear associations between state characteristics, policies, or practices and number of physicians recruited. A majority of state program staff thought the Conrad 30 program was at least as important as other programs to recruit physicians to underserved areas, with some describing it as “critical.”

Thirteen states collected data on physician retention in shortage areas beyond the initial 3-year obligation period, mostly via exit surveys, finding approximately 55-80% of physicians intending to remain in their communities. Studies tracking actual retention in a few states after obligated service used varied measures and found rates of retention ranging from 40% of physicians with their original employer five years post-obligation to 4% at five to ten years post-obligation. Studies often relied on reports from the original employer, but less information was available on retention in any underserved community regardless of whether or not a physician stayed with that employer.

CONCLUSIONS AND POLICY IMPLICATIONS

Findings from this qualitative study lead to several overarching conclusions and policy implications.

- Conrad 30 program staff generally valued the J-1 visa waiver as one of several important tools for recruitment of physicians to rural and underserved communities.
- The decentralized nature of Conrad 30 programs, with a basic federal legislative framework but limited federal oversight and guidance, allowed staff in each of the 50 states great flexibility in designing and administering the program.
- State staff were frequently both cooperative, in sharing knowledge and lessons learned, and competitive with other states to recruit a limited pool of waived physicians that may decrease gradually as U.S. medical school graduates increasingly fill residency slots currently occupied by IMGs on J-1 waivers.
- Some interviewees expressed mixed feelings about the program related to the difficulty recruiting physicians to placements of highest need, such as rural areas and primary care, and ethical concerns about recruiting physicians from countries with even greater need. Without other comparable solutions to physician shortages, however, no one suggested changes to the program to address these concerns.
- Conrad 30 program staff in many states were engaged in monitoring waived physicians and their employers, collecting data, and assessing impact. Some staff wanted more resources and technical assistance to support more rigorous evaluation of their efforts to alleviate provider shortages.
- Data are needed to support an objective, systematic, national assessment of the outcomes of the Conrad 30 program. Such an evaluation could begin with states that have more robust program records and outcome data and expand as feasible to include other states. This information could help shape state and federal policy regarding waived physicians’ roles in rural and underserved health care delivery.

INTRODUCTION

International medical graduates (IMGs) are approximately one quarter of the nation’s practicing physicians.^{1,2} Top source countries where IMGs attended medical school include India, the Philippines, Mexico, and Pakistan.² IMGs provide a quarter of U.S. physician office visits and serve a disproportionate number of low-income patients in communities with shortages of health professionals, including rural areas.³ The Conrad 30 Waiver Program (Conrad 30 program) is one avenue that enables non-U.S. citizen and non-permanent resident IMGs to practice in the U.S. by providing health care to rural and underserved populations (see boxed information on “Conrad 30 Program Basics”). IMGs in residency training on a J-1 visa must return to their home

countries for at least two years after completing a residency but can remain in the U.S. on a J-1 visa waiver if they serve for three years' providing care in designated Health Professional Shortage Areas (HPSAs), in Medically Underserved Areas (MUAs), or in facilities located outside of those shortage areas if they serve populations who reside in HPSAs or MUAs.⁴

Federal agencies can request waivers, but collectively, states sponsor the majority of J-1 visa waivers via Conrad 30 programs.⁵ Federal legislation governs basic requirements of the Conrad 30 program, but each state has wide latitude in deciding the level of resources to devote to the program, setting policies regarding types of placements desired (e.g., rural or urban facilities and primary care or specialist providers), processing applications, monitoring physician and employer fulfillment of requirements, and supporting retention after the three-year obligated service period is complete. As demonstrated in a companion report, states vary widely in their usage of J-1 visa waivers.⁶

National data suggest that IMGs play an increasingly important role in providing care to disadvantaged communities,^{7,8} and (J-1) waived physicians are a significant component of that workforce, accounting for approximately 800 to 1,000 physicians entering practice per year through the Conrad 30 program.⁶ Thus states can affect the recruitment and retention of waived physicians and their patterns of providing health care services to rural and urban underserved populations. No systematic effort has been made to compare and contrast state policies and practices for recruiting physicians through the Conrad 30 program. Understanding states' approaches to recruitment, placement of waived physicians, monitoring, and retention can offer lessons for maximizing the benefit of service programs that address rural and urban underserved physician shortages.

CONRAD 30 PROGRAM BASICS

- When a non-U.S. citizen or non-permanent resident IMG enters the U.S. on a J-1 exchange visitor visa for U.S. residency training, the expectation is that they do not have the intention to immigrate permanently to the U.S. They must return home for two years upon completion of the residency program, unless the physician finds an offer of full-time employment for at least three years to provide care to underserved populations in the U.S. Once an offer is obtained, the employer and physician apply to a state's Conrad 30 program.⁹
- If the application satisfies the state's requirements, the state recommends to the U.S. Department of State (DOS) that the physician receive a waiver of the J-1 visa requirement to return to his or her home country. The DOS may then recommend a waiver to U.S. Citizenship and Immigration Services (USCIS), which grants the waiver.
- The IMG physician remains in the U.S. by converting to an H-1B visa, another type of non-immigrant visa. Unlike the J-1 visa, the H-1B offers the option to pursue permanent residency after successfully completing obligated service.
- States are allowed to recommend waivers for up to 10 of their 30 Conrad 30 slots to facilities located outside of shortage areas but that serve populations from underserved areas (such as a facility in a community adjacent to a geographic HPSA that serves patients from the HPSA), typically referred to as "flex" (flexible) waivers.

STUDY QUESTIONS AND METHODS

This study (reviewed and approved by the University of Washington Human Subjects Division) aimed to understand how state policies and practices affected their use of J-1 visa waivers and shaped waived physicians' practice patterns.

STUDY QUESTIONS

Study questions examined the following topics:

- What are states' goals for recruiting waived physicians through the Conrad 30 program?

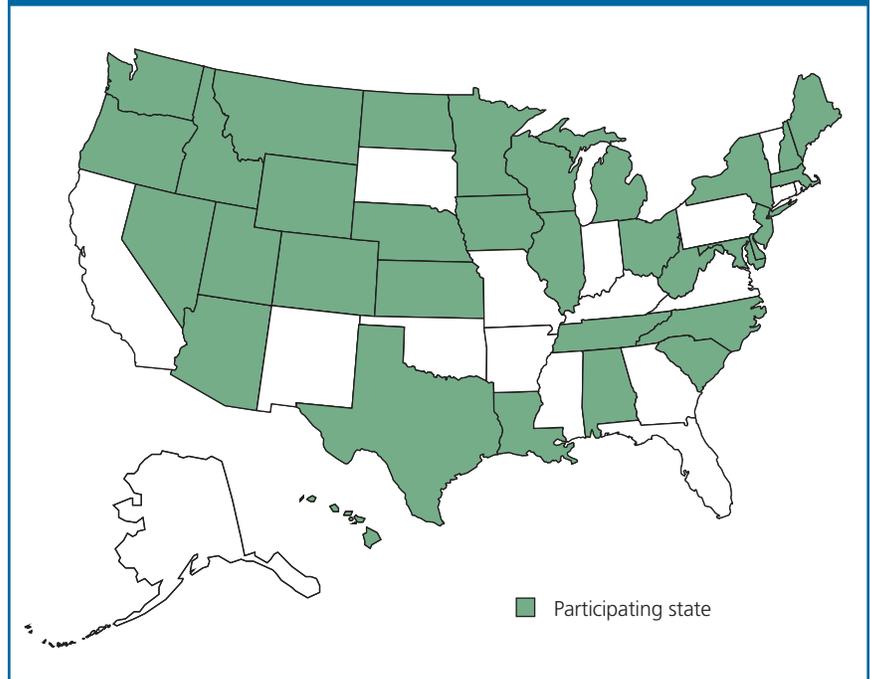
- What are states' requirements for Conrad 30 applications, employer-employee contract terms, and eligibility for waiver sponsorship?
- What strategies do Conrad 30 program staff use for recruiting waived physicians and retaining them during and after their service obligation?
- How do program staff judge the success of the Conrad 30 program in alleviating provider shortages?

METHODS

Study data sources included Conrad 30 program websites and policy documents, interviews of state program staff, interviews with experts on the use of J-1 visa waivers, and available information on retention of waived physicians, as follows:

- (1) We reviewed state Conrad 30 program websites, policy documents, and other online resources with information on J-1 visa waiver requirements by state.^A We created a database organizing the information retrieved into categories, including waiver request requirements, placement policies, and compliance monitoring policies.
- (2) We identified all 50^B state Conrad 30 program officials from program websites and other publicly available sources (3RNet.org, directories on attorneys' websites) and contacted them up to four times by email and telephone to request interviews. We also introduced the study through an existing Yahoo! listserv for Conrad 30 program officials. Program officials from 32 states, representing all regions of the U.S., participated in telephone interviews of one half to two hours in length in 2011 (see Figure 1). Interview topics included further clarification of the information obtained in (1) above and the key study questions about program goals, requirements, and strategies for waived physician recruitment and retention; perceptions of the program's importance in alleviating shortages; and perceptions of program success. For states that engaged in tracking of physician retention, we collected any outcome data that state staff were willing to provide.
- (3) We interviewed six key informants in 2011 and 2012, five by telephone and one by email, known for their expertise on the use of J-1 visa waivers, including one official from 3RNet (formerly Rural Recruitment and Retention Network, an organization that assists states with recruiting rural health professionals), two immigration law attorneys, one physician recruiter, and two officials from Department of Homeland Security involved with immigration.

Figure 1. States of Conrad 30 Program Staff Interviewees



A. For example, the Ranchod Law Group: <http://j1visa waiver.net/j-1-waivers/j1-conrad-30-states-information/>

B. Our focus was primarily on the use of the program to support the physician workforce for rural communities in U.S. states, and therefore we excluded the District of Columbia, Guam, and Puerto Rico.

We conducted a qualitative analysis of the content of interviews, supplemented with information from program materials, to categorize interviewee responses and summarize the resulting findings. In addition, we reviewed available statistics from program staff and published reports on waived physician retention.

FINDINGS

WHO SETS CONRAD 30 PROGRAM POLICY?

Conrad 30 programs are governed by federal guidelines, but within those guidelines states have considerable flexibility to set their own policies. States set policies for Conrad 30 programs at a variety of levels of government:

- In most states, Conrad 30 program policies were established within the state's department of health, in some cases by the top official in the department (e.g., secretary or commissioner), but more often by the official directly in charge of the program, typically the state Primary Care Office (PCO) director or a subordinate with delegated authority.
- In some states, the governor's office played an active role in policymaking for the program.
- In other states, the program's overall framework or specific policies were established by legislative statute. Where the governor or legislature set policy, program staff typically worked closely with higher officials in the department or the legislature to inform the policy.
- In one state, a non-profit organization operated the program.

Program changes, particularly policies involving setting or changing applicant fees, were more difficult to enact when they required state legislative action. It was clear that program staff with more discretion to set their own policies appreciated the flexibility to shape and modify the program over time to meet evolving health care needs identified by staff, often in consultation with other stakeholders, such as state health care associations.

PROGRAM POLICY GOALS AND REQUIREMENTS

"Because we haven't filled every slot, ever...there is no control or restriction on where physicians are placed. We don't restrict placements because we don't fill all positions."

Program policies were frequently formally codified and publicly available on state programs' websites. There was significant variability among states in the general policy areas addressed and specific rules adopted, though some states had adopted identical or similar policies and language from other states. Many states reserved the right to evaluate each waiver request on a case-by-case basis using more informal criteria, relying on their knowledge of communities and employers to determine whether the program should sponsor the waiver. Program policies, where they existed, typically addressed the following topics:

Restrictive clauses. Less than half of states reported that they allowed any kind of restrictive contract clause, such as non-compete, non-solicitation, and liquidated damages clauses. Most states disallowed non-compete clauses that would prevent a physician from practicing in the same area, such as for a competing health system after completion of service, and non-solicitation clauses that would prevent a physician from recruiting a former employer's patients or employees. About half of program staff expressly disallowed liquidated damages clauses that would require a physician to compensate a former employer if the contract was violated in any way. Several staff persons commented that they were not concerned about the inclusion of restrictive clauses because they were frequently difficult to enforce; others were adamant that those kinds of restrictions be removed from employment contracts before they would process a waiver.

Fees. The vast majority of programs did not charge employers application fees, but staff from programs that did reported that the fees helped ensure that the program could operate. Interviewees noted that the fees, ranging from \$500 to \$3,571, were small in comparison with attorney fees or the amount that an employer might spend on recruitment.

Goals for waiver placements. Beyond the federal J-1 visa waiver requirements of providing care to underserved areas or populations, state Conrad 30 program staff and policy documents articulated a variety of goals for placements of waived physicians. Most of the 32 state program staff interviewed had specific goals for alleviating provider shortages, such as in rural areas, particular facility types, or particular specialties.

Though program staff frequently wanted to fulfill specific recruitment goals, in practice they did not deny waivers to qualified applicants, even those not matching the state's priorities, if it allowed more slots to be filled: "It's better to place them where they will do some good rather than say 'no.'" Thus many programs were willing to sponsor as many of the 30 annual waivers as possible, as long as they met federal requirements. The minority of states that tended to fill all 30 annual waivers were more likely to sponsor waivers that aligned with their recruitment goals. In some states, staff only sponsored waivers that met the state's specific requirements regardless of whether or not all slots could be filled. A few reported that the program's goal was not to fill as many slots as possible. Staff from these programs preferred to sponsor only physicians that fulfilled state recruitment priorities or viewed the program as a last resort in favor of other recruitment options. States' placement policies and preferences frequently addressed the following areas:

- **Rural and urban placements.**^c Staff in a small number of states indicated a clear preference for rural placements, while others informally prioritized rural placements. Most states, however, sought to use waivers to alleviate provider shortages in underserved areas without regard to rural or urban location. A few states had a goal of "equitable" or "balanced" distribution around the state in both rural and urban areas. Some program staff noted that because other programs were available for states to recruit providers to rural areas, such as the National Health Service Corps (NHSC), this was not a priority for the Conrad 30 program.
- **Primary care and specialist placements.** Increasing the supply of primary care physicians was a priority for a large majority of states, while some states prioritized recruiting certain types of specialists for specific communities with need, such as psychiatrists. Nevertheless, most states were willing to accept most or all types of specialists through their Conrad 30 programs, even those preferring to reserve some slots for primary care. One attorney reported the perception, in line with the shift in waivers over time away from primary care and toward specialists,⁶ that states had become "much friendlier to specialists."
- **Types of shortage areas or facilities targeted.** A substantial minority of states did not allow regular (non-flex) placements in MUAs, even though this is a type of shortage area permitted by the federal legislation. They favored placements in HPSAs over MUAs because HPSAs were considered to be much more up to date. A small number of states allowed both HPSA and MUA placements, and some used state-derived measures of shortage areas to target placements. Others targeted safety net facilities, such as Federally Qualified Health Centers, Rural Health Clinics, or Critical Access Hospitals. And still others talked about "knowing your own territory," using the accumulated knowledge of working with providers around the state for many years to decide which waivers the program would support.
- **Proof of care to the underserved.** Most states required employers to substantiate that waived physicians would provide care to underserved populations, such as through documentation of the proportion of Medicaid patients served in the past year. Program staff in some other states, however, did not mention requesting this kind of proof.
- **Flex waivers.** Nearly all states allowed for the use of "flex" waivers (positions outside of an underserved area where physicians serve patients from underserved areas). Not all states that allowed flex waivers actually used them, particularly

C. Each state used its own definitions of rural and urban as well as primary and specialist care, as described in further detail in the companion study to this report.⁶

states that were able to fill all 30 slots in designated shortage areas. Federal regulations allow up to 10 flex waivers per year, and some states set additional restrictions on flex waivers, such as:

- allowing only 5 flex waivers annually instead of 10
- specifying minimum percentages of patients from underserved areas or on Medicaid that a facility must serve
- designating specific types of facilities that could employ a waived physician
- requiring that flex waivers only be used when fewer than 30 waivers had been sponsored in shortage areas (HPSAs, MUAs).

RECRUITMENT STRATEGIES

“Physicians have a lot of choices. It’s very competitive. We want to make it easy for them.”

“Be friendly and open. Give them a positive experience with a government agency.”

“We have the luxury of being fairly strict with type of shortage areas that qualify, because we fill all 30 every year. If that weren’t the case, we would open up shortage designation criteria.”

“We have a much more hands-on approach. I do a lot of work with doctors and employers before the waiver is granted.”

“If we find the community or site hasn’t been welcoming, we won’t recommend a waiver there again.”

“I think success in the volume of utilization is almost driven by personality and vision of the state waiver officer.”

Most state program staff wanted to adopt strategies that they thought would help recruit more physicians. A small minority saw their role as limited to responding to and processing waiver requests that met state and federal requirements, relying on employers, attorneys, and physicians to determine if the physician was an appropriate match for the position, negotiate terms, and then complete the waiver application. Most program staff looked for ways to streamline their programs as much as possible; however, one program official said that more stringent state requirements for waivers would result in recruitment of higher quality physicians. Strategies states used to improve recruitment included better marketing and customer service; cultivating relationships with physicians, employers, and attorneys; reducing application or placement requirements that would create barriers; and working with communities to enhance their recruitment appeal (see Table 1).

Some of the strategies cited were generic to provider recruitment in general, but many were specific to recruitment of J-1 physicians, such as working closely with all parties involved in the waiver application process, maintaining relationships with immigration attorneys, and socializing foreign physicians on appropriate work expectations and employer-employee relations.

Table 1. Strategies used by Conrad 30 program staff to recruit physicians for J-1 visa waivers

Strategy	Examples
Market to and educate employers and others involved in recruitment.	<ul style="list-style-type: none"> Target recruiters, hospital associations, primary care associations, recruiting associations, and residencies. Use workshops, fairs, newsletters, and presentations.
Recruit IMGs in training.	<ul style="list-style-type: none"> Target residency programs in the state that have more IMGs.
Reach out to attorneys.	<ul style="list-style-type: none"> Maintain good relationship with attorneys, focusing on those that process more waivers.
Maintain a recruitment database to facilitate matching between open positions and physicians.	<ul style="list-style-type: none"> Use a national networking database, such as www.3RNet.org, or an in-house database.
Recruit physicians to communities with other physicians, friends, family, or patients from similar backgrounds.	<ul style="list-style-type: none"> Enlist the help of physicians from a particular country to recruit others from that country. Match physicians with patients who speak the same language.
Work closely with physicians and employers to ensure a good match.	<ul style="list-style-type: none"> Ensure employers understand contractual obligations. Encourage employers to accommodate physicians' special needs (e.g., dietary preferences, a long enough vacation to visit the home country).
Provide excellent customer service.	<ul style="list-style-type: none"> Ensure that policies are clear and process transparent. Respond quickly to inquiries. Make the application as easy as possible for employers, attorneys, and physicians.
Educate physicians early about work rights, responsibilities, and lifestyle.	<ul style="list-style-type: none"> Provide information about reasonable workload expectations and important amenities (e.g., access to faith community, climate).
Lower barriers to program entry.	<ul style="list-style-type: none"> Follow federal guidelines without adding extra requirements (e.g., not requiring extra years of service or specific patient population targets).
Enforce employer compliance with program rules and obligations.	<ul style="list-style-type: none"> Deny future participation in the program to employers who do not follow the rules or who mistreat physicians.
Work with communities and facilities to improve appeal.	<ul style="list-style-type: none"> Conduct assessments of positive and negative recruitment factors (e.g., using the Community Apgar process¹⁰). Demonstrate community support (e.g., require community letters of support).

RETENTION STRATEGIES

“You have three years to convince this doctor to stay. And with the National Interest Waiver, you’ve got 5 years. It’s just the next step for us.”

“If you know the family is from India, can you [the employer] let them have a month off to go home every few years and bring in a locum for that time?”

“We can’t do a lot, but it’s always the personal needs that affect retention, so we can have a continuous conversation about building the relationship with their providers, whether they’re a J-1 or not.”

“Once communities get to know these physicians, they [communities] tend to really fall in love.”

Program staff in all but a few states said it was a goal for the state to promote long-term retention of waived physicians in their practice sites or communities and saw a role for themselves to do so. A small number of states did not share this goal, saying that

retention was the responsibility of the community or employer. One person thought that encouraging retention of a physician on a J-1 visa waiver was not an appropriate role for the state to play.

Retention of rural providers can be challenging for a variety of reasons, including lack of access to urban amenities, professional isolation, and high workload. Interviewees described retention challenges with waived physicians in rural and underserved communities as the same as for physicians completing obligated service in other types of programs, except with potentially greater cultural differences between the physician and the community.

Program staff were mindful of ways to encourage retention at each stage of the relationship with the physician, pre-service, during service, and post-service (see Table 2). The most frequently mentioned retention strategy was to support physicians' pursuit of permanent residency by writing letters of attestation in support of a federal National Interest Waiver. The National Interest Waiver leads to permanent residency after five years of service in a shortage area and requires a letter from a federal agency or state department of health documenting the physician's service.¹¹ The three years of the J-1 visa waiver service count toward the five-year requirement.

Other common retention strategies included building relationships with physicians over time and monitoring the employer-employee relationship. Both of these objectives could be achieved through site visits, phone calls, and surveys. The option to visit physicians in person was only available to programs with adequate staffing, and several staff commented that they wished they had the time. A number of programs also required that a clear retention plan be submitted with the waiver application to ensure that employers approached recruitment with long-term retention in mind. The notion that good recruitment practices lead to positive retention was further reflected in the fact that several of the other retention strategies mentioned, such as ensuring a good match between physician and employer from the beginning, were also cited as important recruitment strategies.

Table 2. Strategies used by Conrad 30 program staff to retain physicians during and after obligated service on J-1 visa waivers

Strategy	Examples
Pre-service	
Require employers to provide a retention plan with the application.	<ul style="list-style-type: none"> Require a description of plans to support long-term cultural adjustment. Require the employer to provide a history of retaining providers.
Educate employers about retention strategies.	<ul style="list-style-type: none"> Conduct retention workshops.
Establish stringent requirements to ensure high commitment of both physician and employer.	<ul style="list-style-type: none"> Require a four- or five-year contract as a condition for state waiver sponsorship.
Recruit physicians to communities that have other physicians, friends, family, or patients from similar backgrounds.*	<ul style="list-style-type: none"> Enlist the help of physicians from a particular country to recruit others from that country. Recruit couples instead of single physicians.
Work closely with physicians and employers to ensure a good match.*	<ul style="list-style-type: none"> Ensure employers understand contractual obligations. Encourage employers to accommodate physicians' needs (e.g., dietary preferences, a long enough vacation to visit the home country).
Educate physicians early about work rights, responsibilities, and lifestyle amenities.*	<ul style="list-style-type: none"> Provide information about reasonable workload expectations and important amenities (e.g., access to faith community, climate). Encourage physicians to visit the community, talk with other physicians, and ask questions of employers.
Enforce employer compliance with program rules and obligations.*	<ul style="list-style-type: none"> Verify through the license that the physician is practicing at the correct site. Deny future participation in the program to employers who do not follow the rules or who mistreat physicians.
Work with communities and facilities to improve appeal.*	<ul style="list-style-type: none"> Conduct assessments of positive and negative recruitment factors (e.g., using the Community Apgar process¹⁰). Demonstrate community support (e.g., require community letters of support).
During service	
Monitor program compliance and employer-physician relations.	<ul style="list-style-type: none"> Use regular phone calls, site visits, or questionnaires.
Build relationships with physicians, and between physicians and their communities.	<ul style="list-style-type: none"> Sponsor community networking activities to create camaraderie among young professionals. Visit physicians or be otherwise available for assistance.
Provide technical assistance to employers.	<ul style="list-style-type: none"> Strategize with employers about how to meet physicians' needs. Educate employers about the National Interest Waiver, allowing the physician to stay at least two more years.
Post-service	
Disallow restrictive contract clauses.	<ul style="list-style-type: none"> Ensure that the physician is permitted to work elsewhere in the same community if she or he leaves the employer after three years.
Support physician's pursuit of a National Interest Waiver.	<ul style="list-style-type: none"> Provide the physician with a letter of attestation documenting shortage area service.
Evaluate the program.	<ul style="list-style-type: none"> Conduct exit or post-exit surveys of both employers and physicians.

* Also cited as a recruitment strategy.

MEASURING CONRAD 30 PROGRAM SUCCESS

“I’d say it’s one of the necessary things in our toolbox. You might not use this tool all the time, but when you need it, it’s really, really valuable.”

“Where some of these people are going, they’re filling a huge need, because there are no others for miles and miles around.”

“Adding a few physicians to some small towns makes a big difference.”

“It’s important really only in those areas that are looking to hire outside of primary care—an interesting, creative avenue for them to get a J-1 physician specialist...There are some bright spots here and there that really fit with our program philosophy, but I’m not sure on the whole.”

“The J-1 program is really critical in addressing primary care and specialist shortages. We’d be in a bigger mess than we’re in without it.”

“It’s not a permanent fix to our rural communities. There’s not a cultural match. I think it’s unrealistic to think that someone from India is going to be happy in rural [state].”

“In some isolated rural areas, this program is very important.”

“The fact that obligated physicians may move after three or four years may reflect broader societal trends of mobility, a more migratory workforce than in prior decades. I was talking with an employer who said three years was a long time for physicians to be on staff, especially if just out of training. That’s better than average for physicians as a whole.”

“It’s a brain drain on developing countries, and a back door to immigration.”

In the interviews, program staff wrestled with the question of what they considered success for the Conrad 30 program in their states, based on multiple considerations: which factors were within their control, which factors were outside their control, the roles that they considered appropriate for state government to play in recruitment and retention, comparison of waived physicians with physicians recruited by other means, and the ethics of foreign physician recruitment. State program staff reported varied perceptions of the Conrad 30 program’s importance and their perspectives on the numbers of waiver physicians recruited and retained where quantitative data were available.

Importance of the Conrad 30 program in addressing shortages. Program staff were asked how important a role the Conrad 30 program played in obtaining providers to address provider shortages, and whether the program was the leading program, an equal player among many, or having less of an impact than other programs. Most program staff said it was one of many equal players, or gave it a mixed assessment—important in some communities, not in others, playing neither major nor minor role. A substantial minority reported that the program was “absolutely needed,” “critical,” “essential,” or extremely important,” and a few said it was the “leading program.” A smaller number of staff judged that the program was not having as much effect as other programs (e.g., NHSC or state loan repayment programs), even “a last resort.”

Reported advantages of the program cited included that it allowed recruitment of specialists and that it cost no money except for staffing. Most viewed it as complementary to other programs in their state and reported a high degree of coordination with those other programs. A disadvantage noted by several state staff and other key informants interviewed was that the J-1 visa was intended for educational exchange that would benefit the physician’s country of origin as well as the U.S., but the waiver

circumvented this purpose. By allowing physicians to stay in the U.S. rather than return home, it deprived poorer countries of a physician workforce that they desperately needed.

Recruitment success. In the companion report to this study, we found that waivers had shifted somewhat over time from rural primary care placements toward urban specialist placements.⁶ A few interviewees offered possible reasons for this trend, but none of these views were widely held. We also found that states with larger populations or with more program staff time devoted to the program used more waivers. Larger states' shares of waivers increased over the decade of the 2000s, particularly in the transition from 20 waivers allowed (before fiscal year 2001-02) to 30 (from 2001-02 to the present). We examined the program practices thought to affect numbers of physicians sponsored and found no other clear patterns. Examples of the numerous cases that ran counter to the conventional wisdom about recruitment included the following:

- A state with a high fee filled all 30 slots.
- A state with no additional requirements beyond federal legislation had low usage.
- A state with significant staff FTEs and a welcoming, user-friendly approach did not fill all slots.
- A state that conducted regular site visits and surveyed physicians on satisfaction had modest numbers of placements.

The sample size of 32 was insufficient to identify a reliable constellation of policies or practices that were associated with high recruitment, save for the importance of staffing. Indeed, several states' program staff wanted to increase activities to promote the program among employers and J-1 physicians but often did not have the time. Programs with more staff that recruited more physicians included states with both small and large populations. Higher program staffing levels may have reflected greater demand for waivers in some states. We also speculate that higher staffing may have indicated a strong commitment to sponsoring waived physicians by providing the necessary resources to support a variety of practices that, taken as a whole, were more favorable to recruitment.

Assessing retention. Some staff considered completion of the three-year service obligation a successful retention outcome. Not all programs monitored physicians after waivers had been processed. Others were clearly focused on retention of physicians after fulfilling their waiver obligation. No national data exist on retention of waived physicians, but there have been some efforts to document where waived physicians practice after completion of the service obligation, whom they serve, and how long they stay.¹²⁻¹⁵

In the early 2000s, 85% of states reported tracking waived physicians during or after service.¹⁶ Half of program staff interviewed for this study had tracked physician retention in some way, and a few others expressed a desire or had plans to do so. Much of this information, however, was not publicly available. This summary of findings on retention does not identify states whose program staff provided estimates in confidential interviews. Findings for Nebraska, Wisconsin, and Washington state were publicly available in published reports or articles.

The measures of retention used were determined by the resources and capabilities available to track physicians in each state, typically according to one of three definitions: completion of the three-year service obligation; intent to remain in the community or practice upon completion of service; and remaining in the community, practice, or the state for a specified period of time after completion of service. States with sophisticated health workforce information systems could follow physicians as long as they remained in the state, but most states did not have these resources available and instead relied on surveys of physicians or employers or both during, at completion of, or after completion of service. The variations in approaches used, data quality, and results obtained prevent drawing any general conclusions about the success of the Conrad 30 program in solving provider shortages.

Not all programs tracked successful completion of the three-year service obligation, but estimates from those that did ranged from 70% in Wisconsin¹² to more than 90% in other states. Thirteen states had collected data on physician retention in shortage areas beyond the initial 3-year obligation period. Most of the programs' retention data consisted of exit surveys on physicians' intent to remain in the community. Estimates from a handful of states providing statistics were that 55-80% of physicians intended to remain in their communities upon completion of obligated service.

In some states, staff were able to track providers from a few months to ten years after service and, in one state, until providers left the state. Findings on retention after obligated service were as follows:

- In one state, 76% of physicians were in the same community for at least a few months post obligation.
- In another state, 40% of physicians remained at their original location 1 to 5 years post-obligation, dropping to 4% 5 to 10 years post-obligation.
- A study in Nebraska, looking back over a 10-year period from 2001 through 2010, found that 39% of physicians remained at their original location.¹⁵
- In Wisconsin, a survey of rural employers that had hired waived physicians from 1996 through 2002 found that just over 40% of physicians remained with the same employer after five years, and just over 30% after seven years.¹² It was not known, however, if physicians who left their original employer were still in the community or not.
- In Washington state, physicians with J-1 visa waivers from 1995 through 2003 had remained with their employers for a median time of 23 months post-obligation, for up to 10 years afterward, and in underserved communities (whether with the original employer or not) a median of 26 months post-obligation.¹³ Of those whose original placements were in rural areas and who had moved, 74% went to urban areas.

Did the Conrad 30 program meet staff expectations? Staff were asked if the program had exceeded, met, or fallen short of their expectations for providing physicians for underserved areas. Though a few reported no specific expectations for the program, most said that the program had met or exceeded their expectations. A minority thought the program was not meeting the greatest needs in their states for rural or primary care physicians.

CHALLENGES TO USING CONRAD 30 WAIVERS

**“The lack of guidance and no coordinating entity make it difficult.
It’s hard to know what is federal statute and what’s left to the states.”**

“Some communities aren’t always accepting of someone who doesn’t look like them.”

“There may be a—I don’t know how to put this—a cultural readiness factor.”

“For the PCOs [Primary Care Offices] in almost every state, this is one more job on top of five others.”

In some states, the Conrad 30 program was not seen as an important source of physician supply for underserved communities because those states had other solutions at their disposal, including “growing their own,” that is, educating and placing physicians from within the state in shortage areas. But most program staff, particularly those in states that did not typically fill all 30 waiver slots, reported at least one challenge that prevented them from using Conrad 30 waivers to the full extent desired. Challenges fell into five broad categories reflecting community characteristics, program administration, the waiver process, federal requirements, and the state’s physician pipeline through training and licensure. No single challenge was mentioned by more than a small minority of interviewees.

Community characteristics. A number of staff pointed to the difficulty recruiting to small, remote, and frequently mostly white communities that were a racial, cultural, or geographical mismatch for a racially diverse group of physicians that mostly came from urban backgrounds. Unsurprisingly, difficulty recruiting was particularly pronounced in high-poverty communities with few cultural, educational, or career opportunities for a physician or the physician’s family.

Program administration and oversight. Administrative challenges included a lack of funding for staff to operate the program and track participants to collect retention data. Perhaps because of limited staff funding, a couple of program interviewees mentioned that they had not promoted the program sufficiently. Related to these operational challenges, the lack of federal guidance or coordination of the program made it difficult for staff to know what authorities the federal law permitted the states in terms of establishing program policies and regulations. In addition, as one attorney commented, though the flexibility states have in program design has been “liberalizing,” the decentralized nature of the program had resulted in a fragmented national workforce policy that pits states against each other.

Waiver process. The waiver application was cited as a burden to employers and J-1 physicians, including both the legal fees and time required for processing.

Federal requirements. Two program staff persons expressed opposing viewpoints about flex waivers. One wanted complete flexibility for states to determine where to place all physicians (“change all slots to flex slots”). Another thought that 10 flex waivers annually were too many and that larger population states with fewer shortage areas were able to attract more physicians than they had when there were fewer flex waivers permitted.

Physician pipeline through training and licensure. Some staff point to challenges in their state’s physician pipeline, including few IMGs in residency training in the state, and onerous licensure rules that prevented J-1 physicians from getting waivers in a timely way, such as the requirement to complete residency before obtaining a license.

DESIRED TECHNICAL ASSISTANCE

“If we had an annual reporting form, that someone collects, we could have robust data.”

In addition to obvious solutions to the operational challenges of the Conrad 30 program, like increased staffing, a number of staff desired various types of technical assistance in the areas of best program practices as well as monitoring and evaluation.

Several staff wanted information on practices that worked in other states, and to some extent, this information has been available through an active Yahoo! online community with an email listserv where states post requests for technical assistance and share experiences with other states. Much of this content, while archived, has not been synthesized or updated, though there are efforts to organize some information, such as the data used in this study’s companion report on annual waivers processed in each state.⁶

In reviewing state documents for this study, it was clear that several staff persons had modeled their states’ programs on the policies and application materials of other states. Nevertheless, program staff wanted more federal or state policy guidance, such as guidelines for employers. Another content area of interest was physician retention tools and best practices, such as a simple pre-/post-obligation assessment tool, a “do-it-yourself” retention kit, webinars about retention, and a mentoring program for physicians in isolated underserved areas.

In addition to a learning community, some staff called for robust data collection over time, via surveys of physicians and employers as well as a centralized national repository of waiver data that could be used to evaluate program outcomes and best practices.

LIMITATIONS

This study has some limitations. Not all states participated in interviews, though the sample included a majority of states and covered all U.S. Census regions. Key informant responses were subject to potential biases in recall, selective disclosure of information, and interpretation, which we attempted to limit through the use of a structured interview instrument. Data on retention of waived physicians were limited and measures of retention were not consistent across states.

CONCLUSIONS AND POLICY IMPLICATIONS

“It’s such a strange program because we administer it but have zero enforcement over what happens.”

**“That’s the one thing that makes me kind of sad about the program.
We don’t like to feel that we’re poaching doctors from countries that really need them.”**

**“Every state is customized, there are reasons each state does it the way they do.
Congress has allowed each area to plug in local knowledge.”**

**“We don’t decide to make them move, and if they don’t come to the U.S.,
they’re going to go to Canada, the U.K., Australia, New Zealand, or a country that has more
reasonable immigration than we do. They’re going to go where they want to go.”**

**“I think the states are great for understanding community needs, but then
you have 50 fiefdoms. But physician workforce issues are a national concern.”**

**“Not everyone is an advocate of the Conrad 30 program. Not everyone believes they should stay on....
It’s not in the [federal] government’s best interest to have a policy about how to recruit an IMG.
Some say those physicians are needed in their home countries, and they should fulfill the
conditions under which they came here [to return home on completion of training].”**

Conrad 30 program staff in most states expressed positive views about the impact of the waivers as a recruitment tool even as they expressed mixed feelings about certain aspects. These concerns included the limited federal oversight and assistance, competition for a J-1 physician supply that might be dwindling, ethical dilemmas about foreign physician employment to address U.S. workforce needs, and insufficient data to gauge program success.

FEDERAL VS. STATE PROGRAM GUIDELINES AND OVERSIGHT

Several interviewee comments suggest that the combination of a relatively small number of federal requirements, limited federal technical assistance and oversight, and no federal funding had both advantages and disadvantages. Staff interviewed in most states viewed the Conrad 30 program as one of several important recruitment and retention tools, noting that this program’s flexibility helped staff in each state customize the program to strike a balance between program resources, patient needs, employer demand, and physician interest. While state government officials likely had a better knowledge of the needs of communities within their states than federal agencies, Conrad 30 program budgets in many states did not allow staff to make maximum use

of the program or to provide sufficient oversight. Some interviewees were also concerned that the competitive nature of physician recruitment through the Conrad 30 program resulted in an incoherent national strategy for addressing workforce shortages.

THE COMPETITION FOR J-1 PHYSICIAN SUPPLY

The findings from this study support the conclusions of a companion study⁶ that program staff in many states saw themselves competing with other states for J-1 physicians to sponsor for Conrad 30 waivers, even as they cooperated by sharing information and lessons learned amongst themselves. Most states reported that there were not enough interested physicians and employers to use the 30 slots available each year, forcing program staff to choose between accepting any qualified applicant versus imposing requirements that reflected state recruitment preferences for facility types, shortage areas, and specialties.

Some have expressed concern about whether residency positions will be available for foreign-trained physicians as U.S. medical graduates increase in number,¹⁷⁻¹⁹ potentially leading to a declining supply of J-1 physicians. It appears unlikely that residency positions for IMGs will disappear completely in the foreseeable future, but one recent analysis projects that available positions—those not filled by U.S. medical graduates—may decline by about one third by 2023.²⁰ J-1 physicians were 42% of all IMGs in 2015,²⁰ and the projected downward trend in total IMGs suggests that the competition may increase between states for a smaller pool of J-1 physicians.

ETHICAL CONCERNS

Several state interviewees and expert key informants mentioned ethical concerns about reliance on foreign physicians “from countries that probably need them more than we do” to address U.S. health care professional shortages. If U.S. graduates fill an increasing share of available residency positions over time, this shift will be more in line with the World Health Organization’s ethical recruitment guidelines aimed at reducing the health care professional “brain drain,”²¹ but it will not likely solve the problem of U.S. physician maldistribution. Despite having concerns, most program staff sought to maximize the recruitment of J-1 physicians, and no one suggested that the program be changed to address these issues in the absence of another comparable recruitment tool.

IMPROVING DATA AND PROGRAM EVALUATION

A lack of national statistics and a lack of oversight, potentially leading to employer abuse of physicians, were the two biggest concerns for one attorney interviewed, echoing the findings of a U.S. Government Accountability Office study in 2006.¹⁶ With limited resources and no national reporting requirement for the Conrad 30 program, many states are nevertheless monitoring program participants as well as collecting and analyzing data in an effort to exercise appropriate oversight, measure impact, and improve the program. These efforts have undoubtedly helped staff to demonstrate the value of the program within their own states, but many called for technical assistance to improve data collection and evaluation. Inconsistent approaches among the states to monitoring program participants and assessing the program’s impact, without standard measures of physician practice patterns or definitions of retention, complicate oversight and evaluation of a decentralized J-1 program. Collection of comprehensive data on physician practice patterns during and after waived service would be needed for a rigorous evaluation of the outcomes of Conrad 30 J-1 visa waiver programs across the country. A rigorous national evaluation of the outcomes of Conrad 30 J-1 visa waiver programs could be undertaken by collecting comprehensive data on physician practice patterns during and after waived service. The results of such an evaluation to understand waived physicians’ practice patterns and related state workforce strategies can inform future state and federal health workforce and immigration policies aimed at ensuring access to care for rural and underserved populations both in the U.S. and in other countries.

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