CHARLES WINTERSTEEN & ASSOCIATES
ATTORNEYS AT LAW

CHARLES H. WINTERSTEEN
KRYSTAL A. BICKFORD

RUTH DUNNING, OF COUNSEL

53 W. JACKSON BLVD., SUITE 809
CHICAGO, ILLINOIS 60604
TEL: (312) 566-0301
FAX: (312) 588-0437

VIA FEDERAL EXPRESS

January 8, 2016

Chief, USCIS Administrative Appeals Office
20 Massachusetts Ave. NW, MS 2090
Washington, D.C. 20529

Re: Form I-140, Immigrant petition, physician national interest waiver
Self-petitioner: [redacted] **59048**

Dear Sir/Madam:

This firm represents the self-petitioner, [redacted] in the above referenced matter. On October 27, 2015 the Texas Service Center denied [redacted] immigrant self-petition, which requested that [redacted] be classified as eligible to immigrate to the U.S. as a physician whose immigration is in the national interest, pursuant to INA § 203(b)(2)(B)(ii). The Director of the Texas Service Center also certified this matter directly to the USCIS Administrative Appeals Office. On November 25, 2015 [redacted] through his undersigned counsel, submitted a brief in support of the petition (via UPS Next Day Air service) to the Administrative Appeals Office.

On December 17, 2015 the self-petitioner, through his undersigned counsel, requested leave to submit an *amicus curiae* brief in support of the petition, no later than January 11, 2016. On January 4, 2016 the self-petitioner's counsel contacted the Administrative Appeals Office by telephone at 703-224-4501 to inquire whether the Administrative Appeals Office would be sending a written notice in response to the request for leave to submit an amicus brief. Self-petitioner's counsel was advised by the Administrative Appeals Office employee who answered the telephone, that the self-petitioner had leave to submit the *amicus curiae* brief, as requested.

Pursuant to the leave granted by the Administrative Appeals Office in the above-referenced telephone conversation, we are submitting the enclosed brief in support of the self-petition, prepared by jointly by the American Immigration Lawyers Association and the American Immigration Council. Thank you for your careful consideration of the enclosed brief, and please advise this frim if you need any additional documentation in support of [redacted] Form I-140 national interest waiver immigrant self-petition.

Respectfully yours,

Charles H. Wintersteen

CHARLES WINTERSTEEN DIRECT NUMBER: 312-588-0372 E-MAIL: CHW@ CHARLESWINTERSTEEN.COM

U.S. DEPARTMENT OF HOMELAND SECURITY
U.S. CITIZENSHIP AND IMMIGRATION SERVICES
ADMINISTRATIVE APPEALS OFFICE
WASHINGTON, D.C.

In the matter of:	
[redacted]	[redacted]
Self-Petitioner	[redacted]59048
Form I-140 Immigrant Petition Physician National Interest Waiver INA § 203(b)(2)(B)(ii)	

BRIEF OF AMICI CURIAE AMERICAN IMMIGRATION COUNCIL, AMERICAN IMMIGRATION LAWYERS ASSOCIATION, AND THE INTERNATIONAL MEDICAL GROUP TASKFORCE ON CERTIFICATION FROM A DECISION OF THE TEXAS SERVICE CENTER

I. Introduction

There is a critical and growing shortage of physicians in the United States, both within primary care and within medical specialties. According to the Association of American Medical Colleges (AAMC), on a national level, "projected shortfalls in primary care will range between 12,500 and 31,100 physicians by 2025 while demand for non-primary care physicians will exceed supply by 28,200 to 63,700 physicians."[1] The study further explains that due to the aging of the U.S. population, there will be increased demand for "specialty care at a faster rate than the demand for primary care services."[2] To address the longstanding shortage of general and specialty care physicians in certain geographic areas, Congress established the national interest waiver (NIW) for physicians in 1999. 145 Cong. Rec. H11,321-22 (1999).

Under the plain language of the statute, all physicians are eligible for a NIW if they meet two requirements. First, they must work full-time in an area the Secretary of Health and Human Services (HHS) has designated "as having a shortage of health care professionals" or at a health care facility under the Secretary of Veterans Affairs' (VA) jurisdiction. INA § 203(b)(2)(B)(ii). Second, a federal agency or a state public health department must determine that the

---

[1] Ass'n of American Medical Colleges, *The Complexities of Physician Supply and Demand: Projections from 2013 to 2025*, at vi (March 2015), *available at* http://bit.ly/1OUvrli.

[2] *Id.* at 13. Between 2013 and 2025, the number of individuals under age 18 will increase by only 5%, while those over 65 will increase by 46%. *Id.*

physician's work in a designated shortage area or VA facility is in the public interest.[3] HHS has several shortage designations, including the Health Professional Shortage Area (HPSA), Medically Underserved Area (MUA) and Medically Underserved Population (MUP).[4] The agency maintains a database – the federal shortage database - which may be accessed to determine whether a community or facility is in a shortage area.[5]

In this case, the Texas Service Center (TSC) erred when it disregarded agency policy and practice and relied exclusively on the Physician Scarcity Area (PSA) database to deny petitioner's NIW.[6] It improperly concluded that because petitioner was a specialty physician – namely, a physician specializing in hematology-oncology – he must practice in a designated PSA, not a MUA or HPSA, to qualify for a NIW. In keeping with longstanding practice, the TSC should have looked to the designations of the HPSA and MUA/P,[7] instead of relying on PSA, a database that was developed after the enactment of INA § 203(b)(2)(B)(ii), is no longer in use, and has not been updated in years.

---

[3] *Id.*

[4] U.S. Dept. of Health and Human Services, Health Professional Shortage Areas, http://www.hrsa.gov/shortage/find.html (last visited Jan. 8, 2016).

[5] *Id.*

[6] *In the Matter of* [redacted], [redacted]59048 ([redacted]).

[7] Because the MUA and MUP designations are usually referred to together, they are identified as MUA/P herein.

It would be inappropriate for USCIS to use a denial in an individual case to carry out what would be a dramatic policy change instead of providing advance notice and an opportunity for public comment. In addition, the TSC's approach is improper because it is contrary to the plain language of the statute and Congress's intent to address the growing need for access to health care. Moreover, the TSC's new approach to adjudicating the physician NIW is impermissible because USCIS does not have the statutory authority or expertise to decide which shortage area designations apply to which physicians.

II. Interests of the Amici Curiae.

The American Immigration Lawyers Association (AILA) is a national organization comprised of more than 14,000 lawyers and law professors practicing, researching, and teaching in the field of immigration and nationality law. AILA seeks to advance the administration of law pertaining to immigration, nationality, and naturalization; to promote reforms in the laws; to facilitate the administration of justice; and to elevate the standard of integrity, honor, and courtesy of those appearing in a representative capacity in immigration, nationality and naturalization matters. AILA's participation as amicus in this case is a continuation of its advice to USCIS concerning the eligibility of

specialty physicians for NIWs as provided by INA § 203(b)(2)(B)(ii)(I).[8] AILA's membership includes lawyers who represent employers who have sponsored specialist physicians and self-petitioning specialist physicians who will be significantly affected by this case.

The American Immigration Council is a non-profit organization established to increase public understanding of immigration law and policy, advocate for the fair and just administration of our immigration laws, protect the legal rights of noncitizens, and educate the public about the enduring contributions of America's immigrants. The Council frequently appears before federal courts and administrative tribunals on issues relating to the interpretation of the Immigration and Nationality Act and related regulations.

The International Medical Group Taskforce (IMGT) is an independent bar organization that is comprised of attorneys dedicated to helping Americans in rural and other physician-shortage areas obtain urgently needed basic medical services. Among other goals, IMGT strives to educate national and state policy makers, administrative officials, and the American public on the need for fair and reasonable laws that permit international medical graduates to become

[8] For example, in November 2000, AILA submitted comments to the interim rule promulgated by the legacy Immigration and Naturalization Service to implement this law. *See* Comments to the Interim Rule Implementing the §203(B)(ii) Provisions of the Immigration and Nationality Act as Relating to Immigrant Visa Petitions Filed Under the Job Offer Waiver/National Interest Waiver provisions for Alien Physicians, AILA Doc. No. 00061159 (Nov. 6, 2000).

licensed as physicians and to begin or continue their medical careers in the United States. IMGT works on behalf of universities, teaching hospitals, medical centers, and clinics of all sizes, and on behalf of international medical graduates seeking necessary immigration-related authorizations. IMGT attorneys represent a large number of employers and J-1 physicians who require immigration counsel in the U.S. The group is therefore inherently interested in the outcome of litigation that will impact the ability of J-1 physicians and their employers to seek legal counsel, and in any constraints placed upon the apportionment of legal costs for that representation.

III. The Legal Background and Agency Policy and Practice

A. The Statute

In passing the Nursing Relief for Disadvantaged Areas Act (Nursing Relief Act) of 1999, Congress recognized that foreign physicians were an important part of the solution to the shortage and maldistribution of physicians in the United States. Accordingly, in Section 5 of the Nursing Relief Act, Congress amended INA § 203(b)(2)(B) to provide for the mandatory approval of NIWs for qualified physicians, removing the Service's discretion to make the NIW determination. Pub. L. No. 106-95, § 5, 113 Stat. 1312 (1999). Specifically, Congress amended the statute to provide that "the Attorney General *shall* grant a national interest waiver ... on behalf of any alien physician... [who] agrees to work full time as a physician in an area designated by the Secretary of Health

and Human Services as having a shortage of health care professionals or at a health care facility under the jurisdiction of the Secretary of Veterans Affairs." INA § 203(b)(2)(B)(ii)(I)(aa)(emphasis added). In addition to requiring the physician to work in an HHS- designated area or a facility under VA jurisdiction, the Nursing Relief Act provided that a Federal agency or state public health department must have determined that the physician's work is in the public interest. INA § 203(b)(2)(B)(ii)(I)(bb).

B. Interim Regulations

The legacy Immigration and Naturalization Service (INS) issued interim regulations that restricted NIW eligibility to primary care physicians despite clear and generous statutory language that any physician would be eligible for this avenue to permanent residence. 65 Fed. Reg. 53,889 (Sept. 6, 2000) (codified at 8 C.F.R. § 204.12(a)(2)(i) and effective Oct. 6, 2000). The agency further deviated from the statute by requiring physicians to prove that they were employed in a federally designated shortage area specific to their medical specialty to qualify for a NIW. 8 C.F.R. §§ 204.12(a)(2)(i) and (c)(2)(i). Following litigation challenging these regulations, the Ninth Circuit concluded that several sections of the interim regulations were in conflict with and *ultra vires* to the Nursing Relief Act. *Schneider v. Chertoff*, 450 F.3d 944, 961 (9th Cir. 2006) ("Schneider decision").

The Service never finalized or amended the invalid regulations, but instead issued a memorandum in response to the *Schneider* decision ("*Schneider* Memo") providing revised instructions and corresponding revisions to the Adjudicator's Field Manual (AFM) regarding how to process physician NIW petitions consistent with the plain language of the statute.[9] These revisions state unequivocally that specialist physicians are eligible for NIWs:

> (C) Primary or Specialty Care: As of the [sic] January 23, 2007, NIW petitions may be submitted on behalf of primary and specialty care physicians who agree to work full-time in areas designated by HHS as having a shortage of specialty care health professionals, i.e. Health Professional Shortage Area (HPSA), Medically Underserved Area (MUA), Medically Underserved Population (MUP), and Physician Scarcity Areas (PSA).[10]

The USCIS explained why it included specialists in the NIW program through a comparison to the Conrad waiver program, a Federal program for J-1 physicians.

> Since 2000, INS, and now USCIS, has given state departments of health more flexibility to sponsor waivers for physicians willing to work in medically underserved areas. For instance, under the

---

[9] Memorandum from Michael Aytes, then-Associate Director, Domestic Operations, USCIS to Regional Directors, Service Center Directors, District Directors, National Benefits Center Director, Chief, Service Center Operations and Chief, Field Operations, "Interim guidance for adjudicating national interest waiver (NIW) petitions and related adjustment applications for physicians serving in medically underserved areas in light of Schneider v. Chertoff, 450 F.2d 944 (9th Cir. 2006)("Schneider Decision")," HQ 70/6.2, AD06 46 (Jan. 23, 2007), *available at* http://www.uscis.gov/sites/default/files/USCIS/Laws/Memoranda/Static_Files_Memoranda/schneiderintrm012307.pdf.

[10] *Id.* at 11.

> Conrad waiver program, state departments of health may sponsor waivers for *J-I specialist physicians* who will provide service to medically underserved populations (MUP). The Conrad program is similar to the national interest waiver program as they both have a medical service requirement under which the physician must work in a medically underserved area.[11]

The AFM revision added the PSA to the list of existing underserved designations, including the HPSA, MUA and MUP:

> In 2004, HHS considered specialists in its listing of specialist care scarcity areas under the Physician Scarcity Area (PSA) bonus payment program. While HHS did not make a declaration of an absolute shortage area, it did define geographic areas as scarcity areas based on the ratio of physicians to the population of Medicare beneficiaries. The Nursing Relief Act requires USCIS to recognize HHS designations of health professionals without limitation to primary care. In following HHS' designations of MUP and PSA, USCIS will now recognize physicians in primary care and specialty care.[12]

This revision, however, did not replace the shortage area designations with the PSA for purposes of determining specialty physicians' eligibility for NIWs. Since issuance of the *Schneider* Memo with accompanying revisions of the AFM, USCIS has consistently approved NIWs for specialists working in *any* HHS designated shortage area.[13]

---

[11] *Id.* at 11-12 (emphasis added).
[12] *Id.* at 12.
[13] *See* Exh. A at 2 (Minear Decl. ¶ 5) ("To date, no physician [NIW] I have filed has been denied because the specialist physician petitioner was not employed in a PSA."); Exh. B at 1 (Walker Decl. ¶¶ 3-4)(Approvals obtained for "many sub-specialty physicians" who work in counties not designated as PSAs.).

C. HPSA and MUA/P

The designation of health care professional shortage areas is a dynamic process involving state health departments[14] and the federal government. It takes into consideration the ratio of the population to primary care physicians in "rational areas" for the delivery of primary care services and whether primary care is available within 30 minutes travel time. 42 C.F.R. Part 5, Appendix A, I B.1, II A.1(a) (2005).[15] The state and federal agencies also take into account factors such as poverty levels and the percentage of a population over 65. 42 C.F.R. Part 5, Appendix A, I B.2, 4. The methodology used to designate shortage areas is intended to be a manageable, statistically-based method to determine whether an area has a shortage of health care professionals.

Limiting the count of physicians to those providing primary care in order to designate a health care professional shortage area is a data-gathering convenience for the state and federal government and does not mean only primary care physicians are in short supply in the area.[16] There is no data

---

[14] State health departments generally delegate the work of shortage designations to Primary Care Offices (PCO).

[15] Rational areas include areas such as counties, groups of counties, portions of counties, established neighborhoods and communities within metropolitan areas. *Id.* at Appendix A, I B.1.

[16] Statement of Connie Berry, Manager, Texas Primary Care Office, Texas Department of State Health Services (Berry Statement), Exh. C; *see also* Statement of Donald Jones, Manager-Health Procession Resources Section,

point provided for measuring the number of specialists required to serve a particular geographic area in part because there are over 140 types of specialists.[17] The federal shortage database[18] is the best basic resource available for determining whether an area has a shortage of primary and specialty care physicians and other healthcare professionals.[19] Though the HPSA and MUA/P designations consider only lack of access to primary care physicians, they serve as proxies for lack of access to specialty care because factors relevant to determining shortages—distance, poverty and percentage population over 65—pertain equally to access to primary care and access to specialty care.[20]

D. PSA Designation

The PSA database, as acknowledged in the *Schneider* Memo, has never been an independent shortage designation. The PSA database was created in 2004, well after the Nursing Relief Act, in the Medicare Modernization Act of

---

Illinois Department of Public Health-Center for Rural Health (Jones Statement). Petitioner's Brief Exh. B.

[17] Ass'n of American Medical Colleges, Center for Workforce Studies, 2012 Physician Specialty Data Book (Nov. 2012), bit.ly/22NHOdh; Exh. C (Berry Statement).

[18] U.S. Dept. of Health and Human Services, Health Professional Shortage Areas, http://www.hrsa.gov/shortage/find.html (last visited Jan. 8, 2016).

[19] Exh. C (Berry Statement).

[20] *Id.* ("As such, these designations serve to identify areas that lack access to healthcare in general, not just access to primary care."); Pet. Br. Exh. B (Jones Statement) ("The input for the HPSA shortage designation system is not just the number of primary care physicians in a particular area, but includes extensive and diverse demographic data on the community...").

2003 (MMA) to implement a bonus payment system for services provided between January 1, 2005 and June 30, 2008. Pub. L. No. 108-173, § 413, 117 Stat. 2066 (2003). The implementing regulations provide the following definition of PSA:

> § 414.66 Incentive payments for physician scarcity areas.
> **(a) *Definition.*** As used in this section, the following definitions apply. *Physician scarcity area* is defined as an area with a shortage of primary care physicians or specialty physicians to the Medicare population in that area. 42 C.F.R. 414.66(a).

As the definition clearly states, the physician scarcity area is a limited designation based on ratio of physicians to Medicare recipients in a specific area. It was a narrow designation designed only to ensure that physicians were incentivized by bonus payments for services rendered between January 1, 2005 and June 30, 2008 to Medicare recipients. This designation simply did not address other elements of limited health care access for low income residents or other factors considered in HHS shortage designations. The PSA designation may have provided an additional basis to for specialty physicians to seek a NIW, but to limit specialty physicians to PSAs contravenes the Nursing Relief Act, which requires USCIS to approve NIW petitions for physicians working in areas having a shortage of health care professionals—areas far more numerous than PSAs.

Significantly, the PSA designation is no longer in effect (since services had to be rendered by June 30, 2008 to receive those bonus payments).[21] Affirmance of the TSC's decision to limit NIWs to specialists providing services in PSAs will eliminate specialists from qualifying for NIWs for working in an HHS-designated shortage area and will limit NIWs to those serving in Veterans Administration facilities.[22]

IV. The Denial Must Be Overturned To Avoid Conflict With The Statute

The TSC's sudden conclusion that a specialist physician must be working in a PSA to qualify for a NIW is not supported by the statute and must be reversed. The TSC cites to the *Schneider* Memo as the authority for its conclusion that a specialist physician cannot qualify for a NIW unless he or she will be employed "in a PSA designated for that area." *See* Denial at 7-8.

Nowhere in the statute, however, does Congress restrict either the type of medical practice or the methodology by which a shortage area is identified. Instead, Congress "created a *non-discretionary* national interest waiver of the labor certification requirements for doctors who agreed to work in federally-

---

[21] Centers for Medicare & Medicaid Services, PSA, *at* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses/PSA.html.

[22] Exh. B at 1-2 (Walker Decl. ¶ 5)("If the USCIS limits the [NIW] for Sub-specialists to [PSAs], then the procedure will essentially be unavailable to these physicians. This is so because most sub-specialty physicians work in tertiary medical centers which are not typically in [PSAs], even though many of these hospitals are in primary care Health Professional Shortage Areas (especially in rural states like Mississippi.")

designated health professional shortage areas." *Schneider*, 450 F.3d at 948 (emphasis in original). For NIW eligibility, Congress specified the following conditions:

- The physician agrees to work full-time in an area that has been federally-designated as having a shortage of health care professionals or at a health care facility under the Secretary of Veterans Affairs' jurisdiction; and
- The physician's work in the area or facility was previously found to be in the public interest by a federal agency or state public health department.

INA § 203(b)(2)(B)(ii)(I).

Congressional intent is clear from the text of the statute. In the first clause, Congress identifies where an eligible physician must work, and in the second clause, requires a determination that work in "such an area" is in the public interest. An interpretation that limits specialist physicians to employment in a PSA conflicts with the plain meaning of INA § 203(b)(2)(B)(ii).

A. TSC's Interpretation is Impermissible as USCIS Lacks Statutory Authority and Expertise to Determine Which Shortage Area Designations Apply to Which Physicians

Section 203(b)(2)(B)(ii) is clear and unambiguous. Assuming, however, that USCIS believes that there is ambiguity as to how to determine whether a specialist physician is working in an area having a shortage of health care professionals, Congress delegated that determination to HHS because that agency has the expertise to make that determination. Accordingly, the TSC's

break from longstanding USCIS policies and practice and attempt to stray into the province of the state and federal healthcare agencies would receive no deference in federal court.

For any level of deference to be given, an agency must be acting within the scope of its authority as delegated by Congress. USCIS lacks the authority to determine under which type of shortage area a specialty physician is eligible for a NIW.

Congress requires USCIS to approve a physician NIW petition if the conditions Congress specified—including the HHS Secretary's designation of a shortage area—are met. INA § 203(b)(2)(B)(ii)(I) ("The Attorney General [now USCIS, as delegated by the DHS Secretary] shall grant a national interest waiver...") Congress did not leave shortage area designations for USCIS to interpret, as the statute makes conferral of the benefit—the grant of the NIW—mandatory when the physician meets the specified criteria. *See White v. United States,* 543 F.3d 1330, 1338 (Fed. Cir. 2008) (agency was "not free to contradict the precise requirement Congress has already spoken to" regarding survivor benefits under the Public Safety Officers' Benefit Act); *American Forest & Paper Ass'n v. EPA,* 137 F.3d 291, 297 (5th Cir. 1998) (agency cannot add criteria when Congress required agency to approve program if statutory criteria were met).

Here, Congress has delegated authority to another agency, HHS, to determine whether a physician can satisfy one of the preconditions for the NIW by agreeing to work full-time in a health care professional shortage area. INA § 203(b)(2)(B)(ii)(I)(aa). Thus, USCIS' opinion about such a designation is not entitled to any weight. *See, e.g., Patel v. Holder,* 707 F.3d 77, 79 (1st Cir. 2013) (no deference to BIA interpretation of the underlying criminal statute as to which it has no expertise); *Francis v. Reno,* 269 F.3d 162, 168 (3d Cir. 2001) (BIA not entitled to deference in its interpretation of a federal criminal statute it is not charged with administering).

B. TSC's Interpretation Frustrates the Strong Public Policy Interests Congress Intended to Achieve and the Administration's Stated Goals of Improving both Access to Healthcare and Employment-Based Immigration

Health care and access to it is of paramount importance in this country. Demographic trends indicate that the need for adequate access to medical care will continue to increase nationwide. A policy that limits specialist physician NIW petitions to employment in a PSA ignores this reality by preventing physicians from providing badly needed health care services to some of the most underserved areas in the country.[23] Denying foreign physicians like the

[23] Exh. B at 1 (Walker Decl. ¶¶ 2-3)("Mississippi is one of the most severely medically underserved states in the United States ...[O]ur state relies heavily on U.S. trained foreign medical graduates for provision of primary care, as well as critically needed sub-specialty medical care. *** We have in the past obtained approval of PNIW's for many sub-specialty physicians, who work in

petitioner the opportunity to serve these areas exacerbates the very problem Congress attempted to address with the physician NIW.

As described in the *Schneider* decision:

> Congress created the [Nursing Relief] Act "to assist the under-served communities of this Nation by providing adequate health care for their residents." 144 Cong. Rec. H6931, H6933 (1998). Congress reasoned that, "[b]y allowing alien physicians and the medical facilities that employ them to avoid the labor certification process, this provision ensures that residents of areas with a shortage of health care professionals will have access to quality health care." 145 Cong. Rec. H11,321, H11,322 (1999).

450 F.3d at 955 n.15.

The determination that a community has a shortage of medical professionals is complex and requires the most up-to-date data available. As Congress recognized, HHS, not USCIS, is equipped to make these important determinations. Here, the TSC's decision has improperly redrawn the lines to exclude medical specialists who could provide much needed medical care in areas that suffer from a lack of health care professionals. If the TSC's interpretation becomes USCIS policy, the purpose of the NIW would be seriously undermined.

The plain language of the statute does not in any way exclude specialty physicians from eligibility for NIWs, though it does limit the pool of physicians

---

counties that are designated as HPSA's, but not [PSAs]."); Exh. D at 1 (Crawford Decl. ¶ 3)("[Specialists] often choose to stay indefinitely, thus providing valuable medical expertise in remote, rural or urban areas that would otherwise not attract American born medical expertise of the same caliber.").

eligible for the program—whether specialists or not. And yet, under the longstanding adjudication scheme, the HPSA and MUA/P designations do limit the pool of eligible specialist physicians to those working in HHS-designated shortage areas. This is reasonable. It is not reasonable, however, to rely on the PSA designation to limit the pool of eligible specialists. The database for HPSA and MUA/P designations is updated and more accurate than the PSA database, and is the database used by the state healthcare agencies charged with determining whether a community is underserved.[24]

Why in this case does the TSC choose an interpretation that will have a negative impact on communities with shortages of health care professionals by depriving them of access to much needed specialist physicians? State healthcare agencies and healthcare facilities have long relied on longstanding USCIS practice which places specialist physicians in underserved areas designated as HPSA or MUA/P. Moreover, the physicians themselves have relied on USCIS practice by committing to working in these underserved areas. The sudden and unexplained change in policy by the TSC has disrupted these settled expectations and reliance interests.[25]

---

[24] Exh. C (Berry Statement).

[25] Exh. A at 1-2 (Minear Decl. ¶¶ 3, 5) ("These are physicians who would otherwise have been unable to remain in the United States without a gap in employment. *** [F]our ...specialist petitions are still pending."); Exh. B at 1 (Walker Decl. ¶ 4 concerning pending NIW petitions). *See also* Exh. D at 1 (Crawford Decl. ¶ 3 ("Often the [NIW] petition affords the only method by which

Amici urge USCIS to promulgate regulations consistent with its longstanding policies regarding specialty physician NIWs. Legacy INS did not go through the notice and comment process for the interim physician NIW regulations and never issued final rules. Instead, it issued the *Schneider* Memo in 2007 and began approving otherwise qualified specialist physicians who worked in a shortage area as designated in the HPSA or MUA/P.[26] Issuing regulations would provide clarity around this critical issue.

Prior to promulgating regulations, USCIS should affirm its longstanding practice and policy of relying on HPSA or MUA/P designations to determine whether a specialist physician is eligible for a NIW. Contrary to the TSC's decision, a PSA designation is not a rational method for assessing specialist physicians' eligibility. *See Schneider* Memo at 11-12. Worse, it is a highly ineffective and problematic approach that relies upon outdated data to assess whether an area has a shortage of medical professionals. It is a nonsensical limitation that will weaken access to healthcare for vulnerable communities. Here, USCIS has the opportunity to provide much needed clarification for talented specialist physicians who are committed to practicing in areas with shortages of health care professionals and in communities that desperately need them.

---

a physician can obtain work authorization ... This encourages physicians to commit to employment in areas with a shortage of health care professionals.")

[26] See n.13 *supra.*

Respectfully submitted this 8th day of January, 2016.

Leslie K. Dellon

Leslie K. Dellon, DC Bar No. 250316

Leslie K. Dellon
Emily Creighton
American Immigration Council
1331 G Street, NW, Suite 200
Washington, DC 20005
Tel: (202) 507-7530
Fax: (202) 742-5619

Russell R. Abrutyn
American Immigration Lawyers Association
3250 W. Big Beaver, Suite 529 Troy, MI 48084
Tel: (248) 643-0642
Fax: (248) 643-0798

Ian David Wagreich, on behalf of
International Medical Group Task Force
Hughes Socol Piers Resnick Dym, Ltd
70 W. Madison Street
Suite 4000
Chicago, IL 60602
Tel: (312) 604-2726
Fax: (312) 604-2727

Exhibit A

SWORN DECLARATION OF JENNIFER MINEAR

I, Jennifer Minear declare under penalty of perjury and in accord with 28 U.S.C. §1746 as follows:

1. I am an attorney admitted to practice law in Virginia. I am admitted to practice before all Virginia state courts, the U.S. District Court for the Eastern District of Virginia and the U.S. Fourth Circuit Court of Appeals. I graduated from Cornell Law School in 2001. My business address is: McCandlish Holton, PC, PO Box 796, Richmond, Virginia 23218.

2. I have been practicing immigration law for over 10 years and am currently employed as a Director in the Immigration Practice Group of McCandlish Holton, PC where I practice exclusively U.S. immigration law with a particular emphasis on physician immigration cases. Approximately 90% of the cases I represent are physician immigration matters. I am past chair of the Healthcare/Physician Committee of the American Immigration Lawyers Association and immediate past Chair of the Government Liaison Committee of the International Medical Graduate Taskforce, the physician immigration bar organization. I speak and publish frequently on physician immigration matters. Among the articles I have written is "*Getting a Green Card on the Five-Year Plan: National Interest Waivers for Clinical Physicians*" published by the American Immigration Lawyers Association in their book, "Immigration Options for Physicians (3d ed. 2009)."

3. I frequently represent foreign physicians who file physician National Interest Waiver petitions pursuant to INA §203(b)(2)(B)(ii), including both primary care physicians and medical specialists. In some cases, a physician client reaching the end of his 6 year maximum stay in H-1B status has been able to obtain extended work authorization by committing to work for five years in a healthcare shortage area and then filing a concurrent physician National Interest Waiver and I-485 application for Adjustment of Status. These are physicians who would otherwise have been unable to remain in the United States without a gap in employment. The physician National Interest Waiver thus provides a "win-win" scenario for all involved – the physicians who derive an immigration benefit they would not otherwise have, and American residents who obtain access to healthcare they would otherwise not receive.

4. In January 2007, USCIS clarified through policy guidance that it would accept physician National Interest Waiver petitions filed by either primary care or specialist physicians working in a Health Professional Shortage Area (HPSA), Medically Underserved Area (MUA) ***or*** Physician Scarcity Area (PSA). Since that time, all of the physician National Interest Waiver petitions I have filed have been submitted on behalf of physicians employed in HPSAs or MUAs. To the best of my knowledge, I have never had a client employed in a PSA.

5. According to a search of my firm's client database, since 2007 I have filed approximately 46 physician National Interest Waiver petitions. Of these, 17 were filed on behalf of primary care physicians and 29 were filed on behalf of specialists. Of the primary care

physician petitions, 14 have been approved and of the specialist physician petitions, 25 have been approved. Seven petitions, four of which are specialist petitions, are still pending. To date, no physician National Interest Waiver I have filed has been denied because the specialist physician petitioner was not employed in a PSA.

Executed on January 6, 2016

Jennifer Minear

Exhibit B

SWORN DECLARATION OF BARRY J. WALKER
IMMIGRATION ATTORNEY
TUPELO, MISSISSIPPI

I, Barry J. Walker declare under penalty of perjury and in accord with 28 U.S.C. §1746 as follows:

1. I am an attorney admitted to practice law in Mississippi. I am admitted to practice before the Supreme Court of Mississippi, the Northern District Court of Mississippi and the U.S. Court of Appeals for the Fifth Circuit. I graduated from the University of Mississippi School of Law in August of 1975, and I hold a Master of Laws from Tulane University School of Law (1988). My business address is 212 N. Madison Street, Tupelo, Mississippi 38804.

2. I have been practicing immigration law for 25 years. I am the Senior Partner of Walker and Ungo Immigration Law Firm. Our firm practices predominately in the area of employment based immigration, with some family based practice. Since 1994, my individual practice has been concentrated in the area of physician immigration. I represent numerous health care employers in Mississippi and other states. My clients include several hospital systems, the University of Mississippi Medical Center, as well as several non-profit Federal Qualified Health Centers. Mississippi is one of the most severely medically underserved states in the United States, with 76 of our 82 counties designated as Single County Health Professional Shortage Areas. Simply put, our state relies heavily on U.S. trained foreign medical graduates, for provision of primary care, as well as critically needed sub-specialty medical care.

3. The Physician National Interest Waiver (PNIW) case has, in my practice, served as one of the most useful, expeditious and cost-effective procedures for permanent residence for foreign national, sub-specialty physicians. We have in the past obtained approval of PNIW's for many sub-specialty physicians, who work in counties that are designated as HPSA's, but not Physician Scarcity Areas (PSA's).

4. Within the last year, we have obtained two (2) USCIS approvals of Physician National Interest Waiver I-140's, emanating from Hinds County, Mississippi. Hinds County is a Single County HPSA, but it is not a PSA. One of these physicians is an Interventional Cardiologist and the other is an Oncologist. We currently have a PNIW pending for a Neurologist from Hinds County, Mississippi. I have a client who is a Neonatologist who will work in Lee County, Mississippi, (a HPSA, not a PSA) for whom we are planning to file a Physician National Interest Waiver. We have another client who is a rheumatologist working in Lee County, Mississippi for whom we are planning to file a Physician National Interest Waiver.

5. If the USCIS limits the Physician National Interest Waiver for Sub-specialists, to Physician Scarcity Areas, then the procedure will essentially be unavailable to these physicians. This is so because most sub-specialty physicians work in tertiary medical centers which are not typically in Physician Scarcity Areas (PSAs), even though many of

these hospitals are in primary care Health Professional Shortage Areas (especially in rural states like Mississippi).

6. The Physician National Interest Waiver is a very useful and beneficial procedure for primary care and sub-specialty physicians. The procedure permits physicians to very quickly establish a priority date. This is especially important for Indian and Chinese physicians, who experience long backlogs in visa availability. The procedure also allows physicians other than Indian or Chinese, to very quickly submit an application for adjustment of status. The adjustment of status provisions of the PNIW law provide for employment authorization for the principal immigrant and his/her spouse, which can be enormously supportive of the quality of life for those physician families that live in rural areas of the United States.

Executed on January 6, 2016

Barry J. Walker

Personally appeared before me, Barry J. Walker, who being by me first duly sworn, stated on his oath that the things, matters and circumstances set out above are true and correct.

This 6th day of January, 2016.

Danane Lynch
Notary Public

Exhibit C

Connie Berry

1101 Coopers Hawk Path Pflugerville TX 78660 | 512-585-2395 | BerryConnie@hotmail.com

January 7, 2016

Chief, Administrative Appeals Office
U.S. Citizenship and Immigration Services
20 Massachusetts Avenue, NW, MS 2090
Washington, D.C. 20529-2090

Dear Sir/Madam:

For the last 20 years, I have been the manager of the Texas Primary Care Office at the Texas Department of State Health Services. The office is funded by Health Resources and Services Administration (HRSA) to measure and improve access the health care services. My counterparts are the other 53 Primary Care Offices (PCOs) across the country. In addition to measuring access, the PCOs are also the location of the Conrad State 30, J-1 Visa Waiver Programs. While at the Texas PCO, I coordinated and assisted the Conrad 30 programs in how to effectively grow, manage and expand their Conrad 30 programs. As you may know, there is no central office or federal home for the Conrad 30. States have relied and supported each other in this work. I retired in August of this year, but I continue to consult and provide technical assistance to the Conrad 30 programs.

This fall I learned that the USCIS Texas Service Center departed from the long standing practice of approving National Interest Waiver petitions for specialists and stated that specialists must be working in a Physician Scarcity Area (PSA) to qualify for the immigration benefit. The Physician Scarcity Area designations are no longer used or identified by the Centers for Medicare and Medicaid Services. Moreover, the PSAs were relevant only with respect to Medicare bonuses paid to physicians, not as a shortage designation. There are two federal shortage designations managed by HRSA, the Health Professional Shortage Area (HPSA) designation and Medically Underserved Area/Population (MUA/P) designations. These areas are identified and analyzed by the state PCO, and if the federal criteria are met they are recommended for designation by HRSA. While it is true that these designations only count the primary care physicians located in a specific area, the designations are also based on extensive data on the community such as poverty levels and the Medicare population. As such, these designations serve to identify areas that lack access to healthcare in general, not just access to primary care. The reason that only primary care physicians are counted is that there is no agreed upon data point for access to specialists as a group of physicians as there are over 140 types of specialists. These two designations are the basis not only for National Interest Waiver petitions, but also for J-1 visa waiver recommendations, whether for primary care or sub specialist physicians.

The HPSA and MUA/P are the two designations used by PCOs at the State Health Departments to determine whether a physician's work, whether in primary care or a specialty, has been in the public interest, for the National Interest Waiver.

I hope this information is helpful to you. If you have any questions or need any further information or assistance, please let me know. I will be happy to assist you. My contact information is below.

Sincerely,

Connie Berry
Phone: 512-585-2395
E-Mail: BerryConnie@hotmail.com

Exhibit D

SWORN DECLARATION OF Kristi L. Crawford

I, Kristi L. Crawford, declare under penalty of perjury and in accord with 28 U.S.C. §1746 as follows:

1. I am an attorney admitted to practice law in Tennessee. I am admitted to practice before the Supreme Court of Tennessee and the U.S. District Court for the Western District of Tennessee. I graduated from the University of Memphis, Cecil C. Humpreys School of Law in 1999. My business address is: 108 North Center Street, Suite 201, Northville, Michigan, 48167.

2. I have been practicing immigration law for fifteen years. I am a solo practitioner specializing in employment-based immigration matters, specifically in the health care industry. More than 95% of my practice is directed towards the immigration needs of physicians practicing in the United States. Most of my clients are small and mid-size multispecialty practice groups. I also represent a number of regional hospitals. I have repeatedly been an invited speaker on the Physician National Interest Waiver program for professional groups and have authored essays on the topic.

3. In the past five years specifically, I have submitted approximately fifty (50) Physician National Interest Waiver (PNIW) cases. Ten (10) of these I-140 immigrant visa petitions were for specialists; eight (8) were filed at the Texas Service Center. We have not received one denial during that time. Clinics and hospitals rely on the PNIW to provide physician coverage during a five-year term. Often the petition affords the only method by which a physician can obtain work authorization (under an adjustment application based on the approved petition) or extend their H1B non-immigrant status. This encourages physicians to commit to employment in areas with a shortage of health care professionals. During the course of service these physicians develop community ties, purchase homes, have children enrolled in school, and become invested members of the local community. In short, they often choose to stay indefinitely, thus providing valuable medical expertise in remote, rural, or urban areas that would otherwise not attract American born medical expertise of the same caliber.

4. A brief review of our client records reveals that between 2014-2015 we received four (4) I-140 approvals for specialists. The group consisted of an endocrinologist, two critical care/pulmonologists, and a pediatric neurologist. Areas included: Charleston County, South Carolina (low-income HPSA), Madison County, Nebraska (MUA), and Ector County, Texas (FQHC look alike). The Charleston County and Ector County cases were not located in areas that qualified as PSA. The Madison County, Nebraska case happens to be PSA. designated, but no information regarding this designation was included at the time of case submission and none was requested by the examiner. Since USCIS policy guidance was provided in January 2007 stating that HPSA, MUA, or PSA qualified, I do not believe that I have provided any evidence of PSA status in any PNIW based I-140 petition and none has been requested.

Executed on January 7, 2016

[Name]