Commission Regarding Foreign-trained Physicians Living in Maine
Resolve 2023, chapter 93
Tuesday, October 18 – 10 AM
Room 202 (Labor and Housing Committee Room)
Cross State Office Building, Augusta, ME

DRAFT

Agenda: Meeting #1

10:00 Welcome
Chairs, Senator Donna Bailey and Representative Kristi Mathieson

Commission member introductions

Review of Resolve 2023, chapter 93 (authorizing legislation for the study)
OPLA staff

10:30 Healthcare workforce issues
Maine Hospital Association – Sally Weiss
Maine Medical Association – Dr. James Jarvis

11:00 Challenges for foreign-trained health professionals
Maine Immigrants' Rights Coalition – Mufalo Chitam
New Mainers Resource Center – Sally Sutton

11:30 Pathway to licensure in medicine in Maine
Board of Licensure in Medicine – Tim Terranova

11:45 Other states' approaches to licensure in medicine
OPLA staff

12:00 Information requests and next steps
OPLA staff

Commission Regarding Foreign-trained Physicians Living in Maine

Resolve 2023, c. 93

Membership List

Name	Representation
Senator Donna Bailey, Chair	Member of the Senate, appointed by the President of the Senate, at least one of whom must be a member of HCIFS
Representative Kristi Mathieson, Chair	Member of the House of Representatives, appointed by the Speaker of the House of Representatives, at least one of whom must be a member of HHS
Senator Chip Curry	Member of the Senate, appointed by the President of the Senate, at least one of whom must be a member of HCIFS
Representative Samuel Zager	Member of the House of Representatives, appointed by the Speaker of the House of Representatives, at least one of whom must be a member of HHS
David Ngandu	Member who is a physician who is a refugee or immigrant, appointed by the President of the Senate
Sally Sutton	Member who is a representative of the New Mainers Resource Center, appointed by the President of the Senate
Tim Terranova	Member who is a member or staff member of the Board of Licensure in Medicine, appointed by the President of the Senate
Sally Weiss	Member who is a representative of the Maine Hospital Association, appointed by the President of the Senate
Mufalo Chitam	Member who is a representative of the Maine Immigrants' Rights Coalition, appointed by the Speaker of the House of Representatives
Imad Durra	Members who are physicians who are refugees or immigrants, at least one of whom must be licensed to practice in the state, appointed by the Speaker of the House of Representatives
Bruno Salazar-Perea, MD	Members who are physicians who are refugees or immigrants, at least one of whom must be licensed to practice in the state, appointed by the Speaker of the House of Representatives
James W. Jarvis	Member who is a Representative of the Maine Medical Association
Anne L. Head	Member from the staff of the Office of the Governor

APPROVED
JULY 7, 2023
BY GOVERNOR

CHAPTER
93
RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND TWENTY-THREE

H.P. 584 - L.D. 937

Resolve, to Establish the Commission Regarding Foreign-trained Physicians Living in Maine

Emergency preamble. Whereas, acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, this legislation establishes the Commission Regarding Foreign-trained Physicians Living in Maine to study integrating foreign-trained physicians into the health care workforce; and

Whereas, this legislation must take effect before the expiration of the 90-day period so that the commission may timely meet and make its report to the Legislature; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Sec. 1. Commission established. Resolved: That the Commission Regarding Foreign-trained Physicians Living in Maine, referred to in this resolve as "the commission," is established.

Sec. 2. Commission membership. Resolved: That, notwithstanding Joint Rule 353, the commission consists of 13 members appointed as follows:

1. Two members of the Senate, appointed by the President of the Senate, at least one of whom must be a member of the Joint Standing Committee on Health Coverage, Insurance and Financial Services;

2. Two members of the House of Representatives, appointed by the Speaker of the House of Representatives, at least one of whom must be a member of the Joint Standing Committee on Health and Human Services;

3. One member who is a member or staff member of the Board of Licensure in Medicine, appointed by the President of the Senate;

4. One member who is a representative of the Maine Hospital Association, appointed by the President of the Senate;

5. One member who is a representative of the New Mainers Resource Center, appointed by the President of the Senate;

6. Three members who are physicians who are refugees or immigrants, 2 of whom are appointed by the Speaker of the House of Representatives, at least one of whom must be licensed to practice in the State, and one of whom is appointed by the President of the Senate;

7. One member who is a representative of the Maine Medical Association, appointed by the Speaker of the House of Representatives;

8. One member who is a representative of the Maine Immigrants' Rights Coalition, appointed by the Speaker of the House of Representatives; and

9. One member from the staff of the Office of the Governor, appointed by the Governor.

Sec. 3. Chairs. Resolved: That the first-named Senate member is the Senate chair and the first-named House of Representatives member is the House chair of the commission.

Sec. 4. Appointments; convening of commission. Resolved: That all appointments must be made no later than 30 days following the effective date of this resolve. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. After appointment of all members, the chairs shall call and convene the first meeting of the commission. If 30 days or more after the effective date of this resolve a majority of but not all appointments have been made, the chairs may request authority and the Legislative Council may grant authority for the commission to meet and conduct its business.

Sec. 5. Duties. Resolved: That the commission shall study integrating foreign-trained physicians, including surgeons, living in the State into the health care workforce to best reflect their level of skills and training, with a focus on those who are here as refugees and asylum seekers, and reducing barriers to licensing for foreign-trained physicians and physicians from other states. The commission shall explore a wide range of options for how to help enable foreign-trained physicians who wish to live and practice in the State to best use their skills and talents, increase health care workforce cultural competency and address potential workforce shortages. The commission shall make recommendations on:

1. Strategies to integrate foreign-trained physicians into the health care workforce;

2. Other ways, outside of being licensed as a physician, that foreign-trained physicians can be supported to best use their skills and training;

3. Changes for regulations that may pose unnecessary barriers to practice for foreign-trained physicians and physicians from other states;

4. Necessary supports for foreign-trained physicians moving through the different steps in the licensing process prior to involvement with the Board of Licensure in Medicine;

5. Opportunities to advocate for corresponding changes to national licensing requirements; and

6. Any other matters pertaining to foreign-trained physicians and physicians from other states considered necessary by the commission.

The commission shall review and identify best practices learned from similar efforts in other states. The commission may hold hearings and invite testimony from experts and the public to gather information. The commission may develop guidelines for full licensure and conditional licensure of foreign-trained physicians and physicians from other states and recommendations for the types of strategies, programs and support that would benefit foreign-trained physicians and physicians from other states to use the fullest extent of their training and experience.

Sec. 6. Staff assistance. Resolved: That the Legislative Council shall provide necessary staffing services to the commission, except that Legislative Council staff support is not authorized when the Legislature is in regular or special session.

Sec. 7. Stakeholder participation. Resolved: That the commission may invite the participation of stakeholders to participate in meetings or subcommittee meetings of the commission to ensure the commission has the information and expertise necessary to fulfill its duties, including, but not limited to, representatives of health insurance carriers, the University of New England College of Osteopathic Medicine, medical graduate residency programs in the State, the Maine Public Health Association, the Maine Osteopathic Association and the Maine Association of Physician Assistants.

Sec. 8. Report. Resolved: That, notwithstanding Joint Rule 353, no later than January 15, 2024, the commission shall submit a report that includes its findings and recommendations, including suggested legislation, to the Joint Standing Committee on Health Coverage, Insurance and Financial Services. The joint standing committee may report out legislation to the Second Regular Session of the 131st Legislature based on the report.

Emergency clause. In view of the emergency cited in the preamble, this legislation takes effect when approved.

Maine's Freedom of Access Act and the Conduct of the Business of the Legislature

Prepared for the Right to Know Advisory Committee
by the Office of Policy and Legal Analysis and the Office of the Attorney General
Updated January 2023

The Maine Freedom of Access Act requires governmental entities to conduct public business in the open and to provide access to public records. Legislative meetings and records are subject to the law and must be open to the public, with some limited exceptions set forth in the law.

Intent of the Freedom of Access Law
The Maine Freedom of Access Act provides that it is the intent of the Legislature that "actions [involving the conduct of the people's business] be taken openly and that the records of their actions be open to public inspection and their deliberations be conducted openly." The Freedom of Access Act, found in Title 1 of the Maine Revised Statutes, chapter 13, applies to all governmental entities, including the Legislature.

Public Proceedings
Under state law, all meetings of the Legislature, its joint standing committees and legislative subcommittees are public proceedings. A legislative subcommittee is a group of 3 or more committee members appointed for the purpose of conducting legislative business on behalf of the committee.

The public must be given notice of public proceedings and must be allowed to attend. Notice must be given in ample time to allow the public to attend and in a manner reasonably calculated to notify the general public. The public is also allowed to record the proceedings as long as the activity does not interfere with the orderly conduct of the proceedings.

Party caucuses are not committees or subcommittees of the Legislature, so their meetings do not appear to be public proceedings. Similarly, informal meetings of the members of a committee who are affiliated with the same party are not public proceedings as these members are not designated by the committee as a whole to conduct business of the committee. However, committee members should be careful when they caucus not to make decisions or otherwise use the caucus to circumvent the public proceeding requirements.

Limited Exception to Public Proceedings (Executive Sessions)
In very limited situations, joint standing committees may hold executive sessions to discuss certain matters. State law is quite specific as to those matters that may be deliberated in executive sessions. The executive session must not be used to defeat the purpose of the Act, which is to ensure that the people's business is conducted in the open.

The permitted reasons for executive session are set forth in the law, Title 1, section 405 and Title 3, section 156. The reasons most relevant to legislative work are discussion of confidential records and pre-hearing conferences on confirmations.

An executive session may be called only by a public, recorded vote of 3/5 of the members, present and voting, of the committee. The motion to go into executive session must indicate the precise nature of the business to be discussed and no other matters may be discussed. A committee may not take any votes or other official action in executive sessions.

If a committee wants to hold an executive session, the committee should discuss the circumstances with an attorney from the Office of Policy and Legal Analysis or the Office of Fiscal and Program Review who can provide the committee with guidance about whether an executive session is permitted and, if so, how to proceed.

Public Records
The Freedom of Access Act defines "public records" broadly, to include all material in possession of public agencies, staff and officials if the materials were received or prepared for use in, or relate to, the transaction of public or governmental business. The scope of the definition means that most, if not all, papers and electronic records relating to legislative business are public records. This includes records that may be stored on an individual legislator's personal computer, tablet or smartphone if they relate to or were prepared for use in the transaction of public business, *e.g.*, constituent inquiries, emails, text messages or other correspondence about legislative matters. Information contained in a communication between a constituent and a legislator may be confidential if it meets certain narrow requirements.

Time-limited Exception from Public Disclosure for Certain Legislative Records
The Freedom of Access Act contains exceptions to the general rule that public records must be made available for public inspection and copying. One exception that is relevant to legislative work allows certain legislative papers to be withheld from public disclosure until the end of the legislative session in which they are being used. The exceptions are as follows:

- Legislative papers and reports (e.g. bill drafts, committee amendments and the like) are not public records until signed and publicly distributed; and
- Working papers, drafts, records, and memoranda used to prepare proposed legislative papers or reports are not public records until the end of the legislative session in which the papers or reports are prepared or considered or to which they are carried over.

The Legislative Council's Confidentiality Policy and the Joint Rules provide guidance to legislative staff about how such records are to be treated before they become public records.

Confidential Records in the Possession of Committees
Committees may also need to be prepared to deal with other types of non-public records, such as individual medical or financial records that are classified as confidential under state or federal law.

If the committee comes into possession of records that are declared confidential by law, the Freedom of Access Act allows the committee to withhold those records from the public and to go into executive session to consider them (see discussion above for the proper process).

In addition, the committee should also find out whether there are laws that set specific limitations on, and penalties for, dissemination of those records. The Office of the Attorney General or an attorney from the Office of Policy and Legal Analysis or the Office of Fiscal and Program Review can help the committee with these records.

Joint Rule 313 also sets forth procedures to be followed by a committee that possesses confidential records.

Legislative Review of Public Record Exceptions
All exceptions to the public records law are subject to a review process. A legislative committee that considers a legislative measure proposing a new statutory exception must refer the measure to the Judiciary Committee if a majority of the committee supports the proposed exception. The Judiciary Committee will review and evaluate the proposal according to statutory standards, then report findings and recommendations to the committee of jurisdiction. The Judiciary Committee regularly seeks input from the Right to Know Advisory Committee on public records, confidentiality and other freedom of access issues.

Public Access Ombudsman
The Public Access Ombudsman, an attorney located in the Department of the Attorney General, is available to provide information about public meetings and public records, to help resolve complaints about accessing proceedings and records and to help educate the public as well as public agencies and officials. Legislators may contact the Public Access Ombudsman, Brenda Kielty, at Brenda.Kielty@maine.gov, or (207) 626-8577 for assistance.

Physician Workforce in Maine

A Brief Overview

October 2023

Maine Hospital Association and Maine Medical Association

MHA

Maine Hospital Association

Maine Medical Association

Maine Healthcare Workforce Data (2020/21)

- Maine continues to deal with a significant workforce shortage across the state, much of which is driven by an aging workforce.
- The 2020 census found that the Northeast has highest percentage in the country of people older than 50 and the lowest percentage of the people ages 18-50.
- The share of workers in the 55-64 age range has nearly doubled in Maine over the last 20 years from 11 percent in 2001 to 20 percent in 2021. The share of workers aged 35-44, 29 percent, and 45-54, 26 percent, has dropped to 21 and 20 percent over the same timeframe, respectively.
- With an estimated 74,860 healthcare workers in Maine, 20,961 are 55 years or older; thus, 30% of Maine's healthcare workforce will retire within 10 years, if not sooner based on current trends.

Maine Physician Workforce Data (2020)

- Total Active Physicians in Maine (2020): 4,459
    - MD: 2,993
    - DO: 768
    - IMG: 608
- Maine ranks #1 in nation for number of physicians aged 60 or older, with 39.3%, or 1,746.
- Maine has 525 physicians, or 11.8%, that are aged 39 or younger.
- Maine will need 120 PCPs by 2030, a 9% increase, to maintain the status quo adjusting for population and care demands. This increase does not account for backfilling those leaving workforce due to age.

Physician Need and Distribution

- While Maine has a higher-than-average ratio of physicians to population, those data do not reflect the maldistribution across the state.
- Most providers live and provide care where 40% of Maine's population lives, which are counties designated as metropolitan, while the remaining 60% live in Maine's most rural 11 counties, where there are fewer providers.
- In 2022, Maine Rural Health Research Center noted "most counties in Maine face shortages of primary care, mental health, and/or dental health professionals, with 15 Maine counties designated as partial health professional shortage areas in all three domains: primary care, mental health and dental health."
- While primary care is needed, Maine hospitals are also experiencing significant difficulties hiring those who can provide specialty care, such as OB/Gyn, ENT, Gastroenterology, Orthopedics and Psychiatry.

Current Openings across Maine Hospitals

- Currently, Maine hospitals are **actively recruiting for 385 physicians**.
- On average, it takes **277 days to recruit one physician in Maine**, with some taking as little as two months and others taking two or more years.
- Maine Hospitals use many strategies to recruit, including offering loan forgiveness, sign on bonuses, and schedule flexibility.

What do physician shortages mean for patients?

- “We have 300+ referrals in a backlog for obstetric/gyn care. It’s a 1 year wait for first appointment.”
- “After over three years of searching, we just hired one gastroenterology(GI) physician who is a J1 candidate. The GI practice still needs 3 more doctors.”
- “Our Ears, Nose & Throat (ENT) practice currently seeking 4 FTEs with only 1.6 FTE remaining. We are currently scheduling new “operative” referrals 9 months out, with a backlog of 167 referrals.”
- “Positions filled with Locums come at an extreme cost and lower quality of care.”
- “We see more people delaying needed care due to access or seeking care in the emergency department.”

Barriers to hiring new physicians

- Geography – Rurality
- Lack of physician leaders & mentors to attract new physicians
- Limited training opportunities in the areas where we need doctors and more UME grads than GME slots.
- Limited to 30 Conrad Visas and 10 Flex for non-HPSA hospitals.
- Call burden can be onerous for small hospitals with fewer providers covering a specialty service.
- Fewer family doctors trained to do obstetrics, which is a model more rural small hospitals have depended on in the past.

Physician Training in Maine

Medical Education in Maine

- University of New England is the sole medical school in Maine
- Tufts University through a partnership with Maine Health has the Maine Rural Track Program, which places medical students in Maine clinical sites for the last two years of their medical school.
- Non-Maine Medical Schools that place medical students in Maine for clinical education: Boston University, University of Vermont, Tufts University.

Maine Teaching Hospitals

- Central Maine Medical Center
- Eastern Maine Medical Center
- Maine General Medical Center
- Maine Medical Center

Physician Training Programs in Maine (“Residency”)

- 308 resident/fellow physicians training in Maine
- Training Programs, or Graduate Medical Education (GME) programs, are 3 to 5 years of training.
- Specialists, such as critical care physicians that work in an ICU, need to complete additional training after residency, called a Fellowship.
- Upon graduation from residency, a physician can become board certified in their field of training.

- Resident Training Programs in Maine:
  - Family Medicine
  - Internal Medicine
  - Pediatrics
  - General Surgery
  - Anesthesiology
  - Radiology
  - Emergency Medicine
  - Internal Medicine Geriatrics
  - Internal Medicine Pediatrics
  - Neurology
  - Obstetrics-Gynecology
  - Pharmacy
  - Psychiatry
  - Urology
  - Vascular Surgery

Fellowships In Maine

- Following the completion of residency training, physicians can choose to complete a fellowship, which consists of another 1-3+ years of training, in a specialized field of medicine.
- Following completion of Fellowship, a physician can become board certified in that specialty.

- Addiction Medicine
- Adult Cardiac Anesthesiology
- Cardiovascular Disease
- Child & Adolescent Psychiatry
- Critical Care Medicine
- Emergency Medicine
- Geriatrics
- Hospice and Palliative Medicine
- Hematology & Oncology
- Integrative Family Medicine
- Nephrology
- Neuromusculoskeletal Medicine (Osteopathic)
- Preventive Medicine
- Pulmonary Critical Care
- Sports Medicine
- Surgical Critical Care

How does Maine do with Graduate Medical Education (GME)?

- Maine ranks 13th in the nation, with 49.8%, for the number of active physicians who completed GME in state and are actively practicing in the state. We do a good job of retaining those that choose to come here to train.
- Maine ranks 45th in the nation with the total number of residents and fellows in ACGME programs per 100,000 pop. In 2020, Maine had 308 residents/fellows, or 22.9/100K.
- Maine ranks 46th in the nation on ratio of GME residents and fellows to Undergraduate Medical Education (UME) students, with 699 UME students attending DO school and 308 residents/fellows. GME to UME ratio is .4.
- Maine and Hawaii are the only two states in the country that have had a 0% change in number of residents/fellows in ACGME accredited programs between 2010 and 2020. Median for nation is a 24.4% increase. Maine actually had a decrease between 2010 and 2020 (311 to 308). Nevada and Montana had 200%+ increase during same time frame.

Challenges International Medical Graduates (IMG) Physicians Face

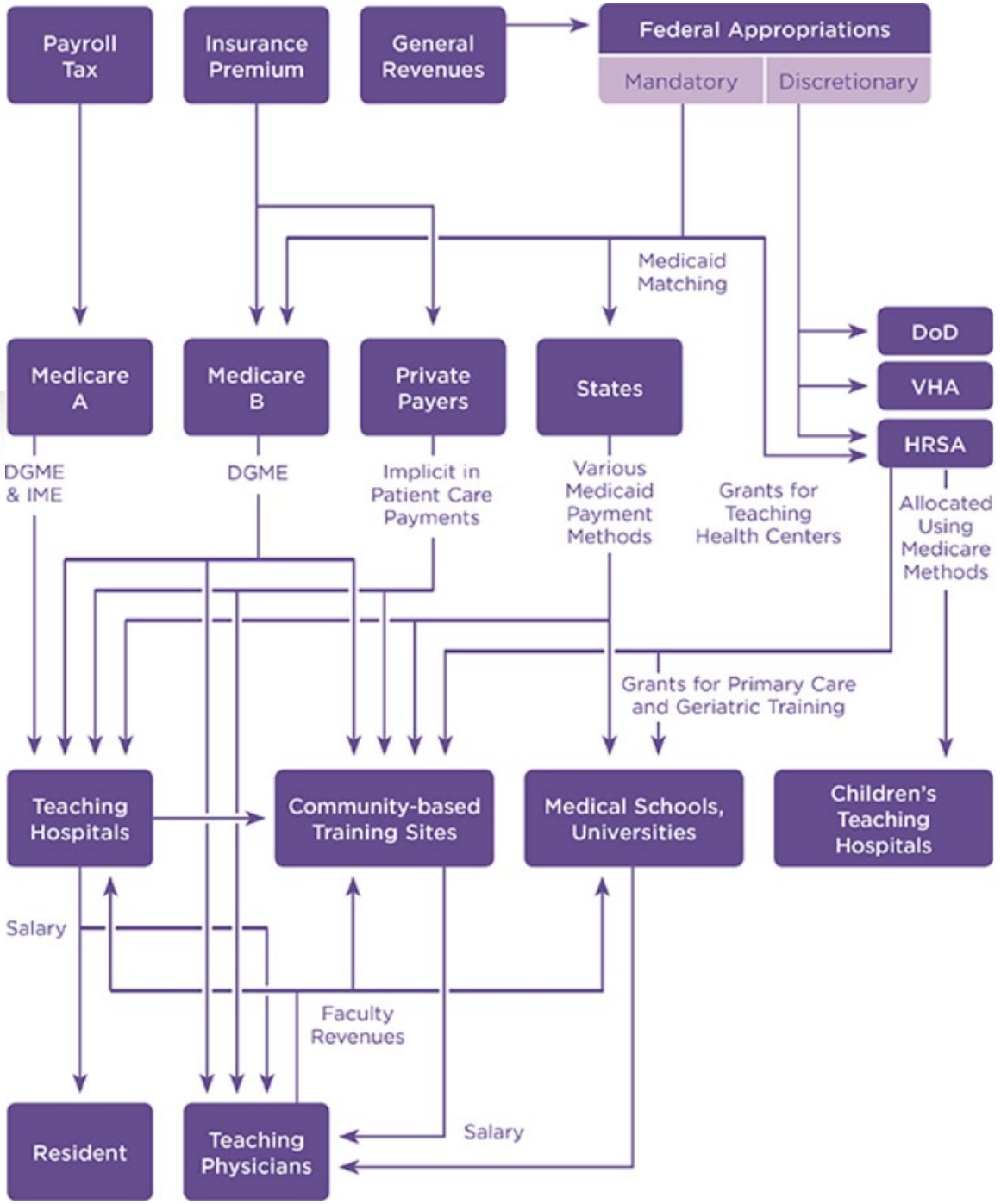
- Most GME Programs require some clinical experience within the United States to be considered as an applicant.
  - This must be a hands-on experience, which may be difficult to find
  - It may be costly to access clinical training (fees, travel, housing)
  - Clinical training, of any type, typically requires an affiliation agreement between a medical school and the healthcare setting where the clinical training is taking place.
  - Clinical training requires malpractice/liability insurance
  - Observerships (aka Shadowing) are not equivalent to hands-on clinical experience.

- Even with GME training, if there has been a gap in practice, licensure may require similar supervised clinical experience.

Additional Information

Overview of Funding

- Direct GME payments include monies for directly training residents, like their stipends/benefits. DME totals about $3B/yr.
- Indirect GME payments are related to supplementing patient care in a teaching environment. IME totals about $7B/yr.
- The Centers for Medicare and Medicaid Services makes the rules about GME payments. These can be found in the Social Security Act of 1965 and in the Code of Federal Regulations.
- [GME Financing - Graduate Medical Education That Meets the Nation's Health Needs - NCBI Bookshelf (nih.gov)]



Direct GME Funding (DGME)

- DGME provides funds for **Medicare's share** of the cost directly related to educating residents. Specifically: resident stipends and benefits, salaries/benefits of resident faculty, accreditation fees, GME office support, etc.
- For Non-Medicare related costs, funds may be acquired from teaching hospital revenue, private payers, Medicaid, Children's GME, VA GME, … (these are all minor contributors in comparison to Medicare).
- Payments are only provided for residents who are in "approved" programs, essentially those accredited by the ACGME. There are programs that are not approved (un-accredited) and do not receive Medicare GME funds, like transplant surgery fellowships, for which there is no official ABMS board exam.
- The payment system was started and is based on 1984 numbers. It uses the amount of money that hospitals claim to have spent per resident (the Per Resident Amount – PRA) on that base year. There are adjustments for inflation, for the number of full-time equivalent (FTE) residents, and for the number of Medicare inpatient days (Medicare's share of total inpatients).
- For example, a hospital's **PRA** is $100K x 100 **FTEs** x 35% Medicare patients **share** of beds = $3.5M DGME payment to the teaching hospital

Indirect (IME)

- IME covers costs of caring for Medicare patients in teaching hospitals to offset teaching inefficiencies and the expenses of higher acuity services and patients.
- Medicare pays for the basic health care services of its patients (per the Medicare Severity Diagnosis Related Group: **MS-DRG**). IME is an added payment to hospitals and varies as a percentage of the MS-DRG service provided to a patient.
- The IME adjustment is based on the Intern and Resident to Bed ratio (IRB – usually 0.25 or greater for a teaching hospital) and a multiplier set by Congress (currently 1.35).
- **Adjusted ratio** = IME multiplier x ((1 + IRB) ^0.405 – 1). The **IME adjustment** = Adjusted ratio x (%Medicare pts)(DRG payment) (Case mix ratio)
- An IME adjustment might be 13%. As an example, a patient having a pacer/defibrillator implanted would elicit the MS-DRG 227 payment of $29,748 to the hospital, Because it is a teaching hospital with residents, the IME adjustment of 13% would be added on to that payment, for an additional payment of $3,867 to the hospital.

The Balanced Budget Act and "The Cap"

- The Balanced Budget Act of 1997 capped the number of residents for which a hospital can receive GME funding. "The Cap."
- About 2/3 of hospitals are currently training MORE residents than those for which they receive Medicare GME funding. They are ABOVE CAP. There are approximately 11,000 FTEs above cap nationally.
- **Currently, 11 residents not supported by Medicare DGME in Maine**.

GME Funding to Maine Hospitals (2018)

Fiscal Year	Provider Number	Hospital Name	ST	Fiscal Year Begin Date	Fiscal Year End Date	Report Status Code	DME	IME	TOTAL GME
2018	200009	MAINE MEDICAL CENTER	ME	10/1/2017	9/30/2018	Amended	$ 8,598,617.00	$ 26,178,740.00	$ 34,777,356.00
2018	200019	SOUTHERN MAINE HEALTH CARE	ME	10/1/2017	9/30/2018	Amended	$ 92,198.00	$ 99,022.00	$ 191,220.00
2018	200024	CENTRAL MAINE MEDICAL CENTER	ME	7/1/2018	6/30/2019	As Submitted	$ 1,022,977.00	$ 2,248,107.00	$ 3,271,084.00
2018	200033	EASTERN MAINE MEDICAL CENTER	ME	10/1/2017	9/30/2018	Amended	$ 1,277,471.00	$ 4,798,995.00	$ 6,076,466.00
2018	200039	MAINEGENERAL MEDICAL CENTER	ME	7/1/2018	6/30/2019	As Submitted	$ 2,574,941.00	$ 3,687,947.00	$ 6,262,888.00
TOTAL							$ 13,566,204.00	$ 37,012,811.00	$ 50,579,014.00

Resources

- Maine Department of Labor's Center for Workforce Information and Research, "2022 Maine Healthcare Occupations Report," Prepared by Andrew Dawson, Senior Economic Analyst, September 15, 2022. https://www.maine.gov/labor/cwri/publications/pdf/2022MEHealthOccupationsReport.pdf
- Association of American Medical Colleges (AAMC), 2021 State Physician Workforce Data Report, January 2022. https://store.aamc.org/downloadable/download/sample/sample_id/506/
- Robert Graham Center, "Maine: Projecting Primary Care Physician Workforce." https://www.graham-center.org/content/dam/rgc/documents/maps-data-tools/state-collections/workforce-projections/Maine.pdf
- Maine's Rural Health Research Center, "Maine: A Health Focused Landscape Analysis," April 28, 2022. Retrieved from: https://digitalcommons.usm.maine.edu/cgi/viewcontent.cgi?article=1025&context=population_health
- GME Financing - Graduate Medical Education That Meets the Nation's Health Needs - NCBI Bookshelf (nih.gov)
- Robert Graham Center, "Data Tables: Graduate Medical Education for Teaching Hospitals." https://www.graham-center.org/maps-data-tools/gme-data-tables.html

Medical Licensing of Foreign Trained Physicians in Maine
October 18, 2023

Timothy Terranova
Executive Director
Board of Licensure in Medicine

1

Maine has 2 Medical Licensing Boards

- Board of Licensure in Medicine licenses allopathic physicians (MD) and physician assistants (PA)
- Board of Osteopathic Licensure licenses osteopathic physicians (DO) and physician assistants (PA)
- This presentation is specific to the Board of Licensure in Medicine

2

General Requirements for Licensure

US/Canadian Medical Graduates*

- Graduate from a medical school accredited by the Liaison Committee on Medical Education (LCME)
- Pass all 3 steps of the USMLE (step 3 is normally taken during residency)
- Complete 36 months of post graduate training (PGT) accredited by the Accreditation Council on Graduate Medical Education (ACGME)

*LCME will end its accreditation of Canadian Medical Schools on June 30, 2025. At that time Canadian medical graduates will fall under Foreign Medical Graduates

Foreign Medical Graduates

- Graduate from an unaccredited medical school (non LCME) and Educational Commission for Foreign Medical Graduates (ECFMG) certification or VQE equivalent
- Pass all 3 steps of the USMLE (step 3 is normally taken during residency)
- Complete 36 months of post graduate training (PGT) accredited by the Accreditation Council on Graduate Medical Education (ACGME)

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Current Licensure Statistics

- 1/2/2018
  - 5,786 active MD licenses
    - 3,489 with a Maine address
- 1/2/2023
  - 7,538 active MD licenses
    - 3,743 with a Maine address
- 12/31/22
  - 1,560 foreign medical graduates licensed (1 in 5)

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USMLE Costs

2023 USMLE Fees	Domestic students/grads (must apply via NBME)	IMGs (international students/graduates) (must apply via ECFMG)
Step 1*	$660	$1,000 USD
Step 2 CK*	$660	$1,000 USD
2023 USMLE Fees	ALL (for Step 3, both domestic and internal grads must apply via FSMB)	
Step 3**	$915	

* In terms of taking Step 1 or Step 2 CK, there is an additional International Test Delivery surcharge if they test outside of the US/Canada (set by Prometric)

**Step 3 is only administered in the US. Therefore, there are NO additional test delivery surcharges.

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ECFMG

- International medical graduates (IMGs) comprise one-quarter of the U.S. physician workforce. Certification by ECFMG is the standard for evaluating the qualifications of these physicians before they enter U.S. graduate medical education (GME), where they provide supervised patient care. ECFMG Certification also is a requirement for IMGs to take Step 3 of the three-step United States Medical Licensing Examination (USMLE®).

6

ECFMG Certification Requirements vs. US Graduates Requirements to enter accredited PGT

ECFMG	US Graduate
• Verification of attendance, completion, and graduation from a recognized medical school	• Verification of attendance, completion, and graduation from a recognized medical school
• Successful completion of USMLE Steps 1 and 2.	• Successful completion of USMLE Steps 1 and 2.
• English proficiency	

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ECFMG English Proficiency

- This was completed by passage of USMLE step 2CS until 2020. It now includes obtaining a 350 (Grade B) on three of the four measured components of Occupational English Test (OET) Medicine: Listening, Reading, and Speaking, obtaining a 300 on the measured component of Writing, and completing one of six pathways to show clinical competence. The six pathways include:
  - Already Licensed to Practice Medicine in Another Country
  - Already Passed an Objective Structured Clinical Examination (OSCE) for Medical Licensure Administered by an Acceptable Medical School
  - Medical School Accredited by Agency Recognized by World Federation for Medical Education (WFME)
  - Medical School Accredited by Agency that Has Received a Determination of Comparability by National Committee on Foreign Medical Education and Accreditation (NCFMEA)
  - Medical School Issues Degree Jointly with a U.S. Medical School Accredited by Liaison Committee on Medical Education (LCME)
  - Evaluation of Clinical Patient Encounters by Licensed Physicians

8

Examples of Incidents

- ECFMG Irregular behavior Cases
  - June 2023 Notice
    - Submission of fraudulent evaluation
    - Submission of fraudulently obtained diploma and transcript
    - Submission of fraudulent certification statement
    - Submission of fraudulent ECFMG email to a university
    - Falsified translation of a bachelor's degree
    - Submission of a fraudulent diploma and transcript

9

Example of Incidents

- Federal Trade Commission Returns More Than $830,000 to Students Misled by Saint James Medical School's Deceptive Marketing Claims (Caribbean 2022)
- Dozens of universities have to stop their medical training (Democratic Republic of Congo 2021)
- Why India's medical schools are plagued with fraud (India 2015)

10

Alternatives to US medical education requirements for foreign medical graduates

- Achieve a passing score on the Visa Qualifying Examination (VQE) or another comprehensive examination determined by the Board to be substantially equivalent to the VQE.

11

Alternatives to US National Exam requirements for foreign medical graduates

- A licensing exam administered by any medical board which is a member of the Federation of State Medical Boards
- Licentiate of the Medical Council of Canada (LMCC)
- British Isles Credentialing

12

Alternatives to US PGT requirements for foreign medical graduates

- Physicians who have obtained 36 months of residency training accredited by the Canadian Medical Association, the Royal College of Physicians and Surgeons of Canada, or the Royal Colleges of England, Ireland and Scotland. BOLIM does not track specifically who is licensed using this alternative but it estimates 20 to 30 licenses are granted per year using this exception.

13

Alternatives to US PGT requirements for foreign medical graduates

- Physicians who are graduates of a foreign medical school, not including Canada or Great Britain, who have a license in another US state and have at least 3 years of clinical experience. If the applicant meets those criteria they can request a waiver based on seven additional criteria. BOLIM does not track specifically who is licensed using this alternative, but it estimates there have been 10 to 20 requests since the law was enacted in 2005.

14

Alternatives to US PGT requirements for foreign medical graduates

- Physicians certified by the American Board of Medical Specialties. Those applicants are deemed to meet the postgraduate education requirement.

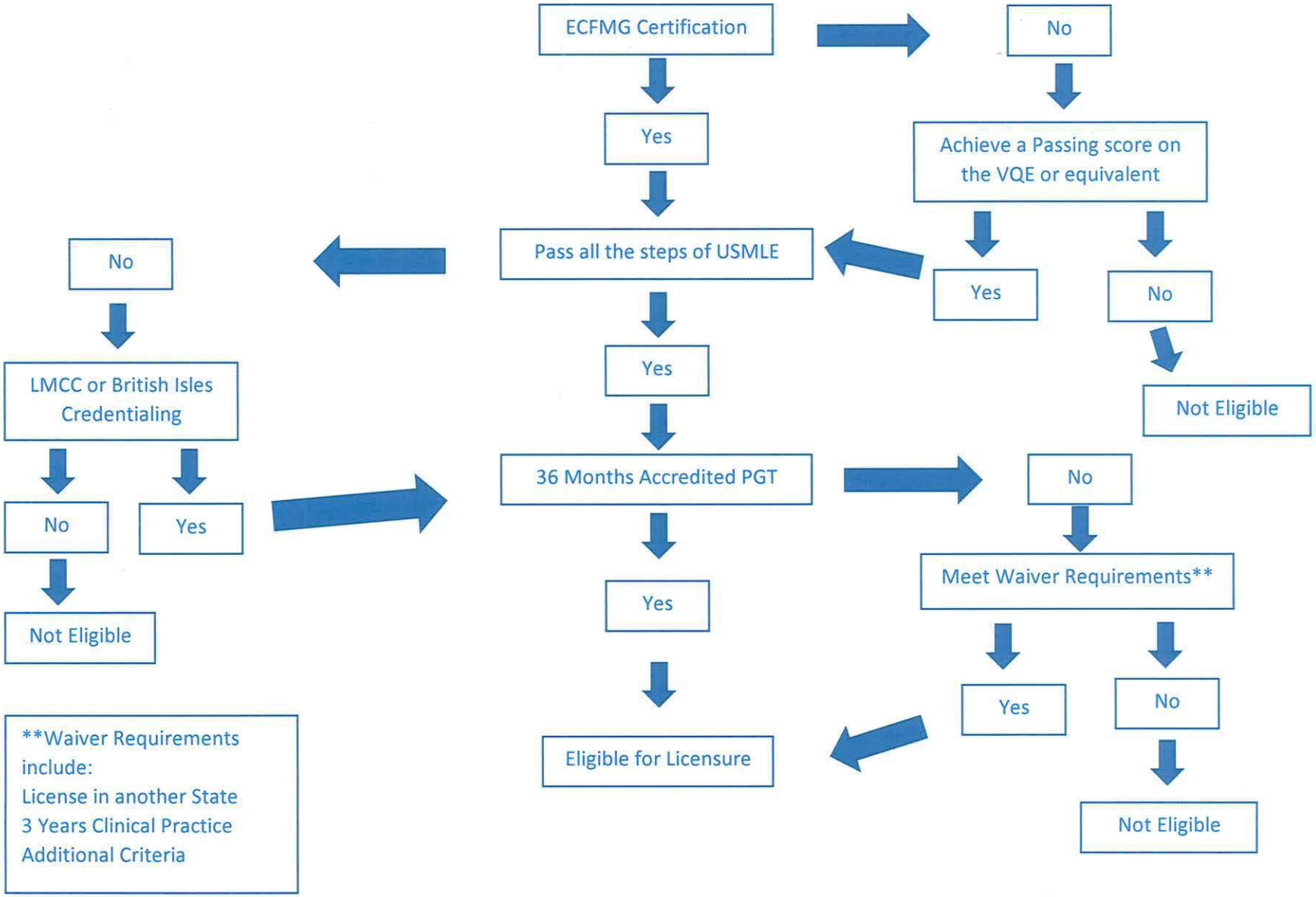
15

Applying for Licensure

- Submit UA ($60)
- Request an FCVS profile be sent to the Board (varying fees)
- Take the Online Jurisprudence Exam
- Complete the Addendum and pay the Maine application fee ($700)
- Submit:
  - Notarized affidavit
  - CV
  - References
  - Answers to any additional questions.

16

Foreign Medical Graduates Pathways to Licensure*



*This is a summary of basic requirements. There may be other issues that affect the granting or denial of a license.

October 18, 2023

Sally Sutton, Policy Specialist
New Mainers Resource Center, Portland Adult Education
suttos@portlandschools.org

Comments Before the Commission Regarding Foreign-Trained Physicians Living in Maine

Since being established in 2013 by the Maine Legislature as a pilot project to serve skilled foreign trained professionals, the New Mainers Resource Center (NMRC) has learned a lot about the barriers new Mainers face and has effectively worked to develop and execute different strategies to help new Mainer professionals better utilize their skills and experience as they start their new lives in our state.

- We have served hundreds of professionals each year, with the vast majority having undergraduate and graduate degrees: New Mainers Resource Center 2021-2022 Annual Report
- Through an affiliation with the Welcome Back Initiative, a national network of 10 centers in 9 states, who are considered to be a national model, we have learned best practices, particularly related to health professionals and physicians
- Through our case management, advising and outreach we have learned from the personal experiences of almost 100 different doctors
- In 2020 we conducted research that was supported with a grant from MeHAF to look at ways to increase diversity and cultural competence of the healthcare workforce, including a special focus on physicians: NMRC/PAE Foreign-Trained Health Professional Licensing Pilot Project Report
- On January 19, 2023 we co-sponsored, with the Daniel Hanley Center for Health Leadership, a Forum to learn how to assist foreign trained doctors' transition back to their profession - Fulfilling Potential: Foreign-Trained Physicians: a Pathway Forward for Maine.
- Maine is not alone in trying to address this problem. As a way to monitor and learn from what is happening in other states regarding legislation for foreign trained doctors, during the past 2 years have participated in national groups such as the Imprint Coalition Advocacy Working Group and the national group, WES Expanding Pathways in Healthcare.

Challenges Faced by Foreign Trained Physicians

As I use the term foreign trained physician I am speaking about: 1. doctors who have gone to medical school, and who are licensed, practicing physicians, including surgeons, who have had years of practice in their home country and who have immigrated to and are now living in Maine or the US. I am not speaking about: 2. US

citizens who have gone to medical school in another country and return to the US to do their residency, or 3. non-US citizens who have completed medical school in another country but have not practiced as a physician or been licensed and are applying for residencies in the US on a J-1 or H-1B visa. I break the first group out because the challenges they face are much different than those of the other two groups.

Additionally, in Maine, one of the most significant factors of most of the new Mainer foreign trained professionals served by NMRC is that they came to the US as refugees or asylum seekers. They did not plan to come to the US but were forced to flee their home country for their safety, threats of violence or imprisonment or because of their political or religious beliefs. This factor must be taken into consideration as it impacts the options people have available to them. People who come as a result of forced migration have not been planning for careers in the US, and consequently face a different set of issues with licensing, some that they have no control over.

For this group, there is also a need to prioritize meeting the basic needs of their families over the investment of time and money it would take to move ahead with their professional careers. This factor keeps many people stuck in positions far below their previous training and profession. From the experience of the NMRC, for health professionals, being re-licensed in their profession is almost impossible to achieve. There are also no quick and cost-effective alternative paths that would get someone close to their former career or a position where they are able to use anything close to the full extent of their skills.

Issues people face include, amongst others:

- Poverty, lack of access to financial resources for licensing-related expenses or schooling and working to meet basic needs keep people from moving forward with their careers. Asylum seekers have the added burdens of being unable to work, having no income, for a period of time until after they have applied for asylum, needing to raise funds to cover the legal costs of their asylum applications, having families back home they also need to support. And now, dealing with housing insecurity that many of the newcomers to the state must face in so many of our communities.
- Need for a survival job to meet basic needs, child care, healthcare, family needs etc. Not having time and financial resources necessary to study English, prep for tests, get clinical experience, etc.
- Limited financial resources available for anything but short term training for entry level healthcare positions.

- Need for accurate information about various options, i.e. time commitment, costs, risks of pursuing medical licensing path (scoring high enough on tests to be competitive, chance of getting into a residency) vs. PA or NP or MPH.
- The years since they graduated from medical school – years of practice are not considered in applying for residencies and can count against them if those years put someone outside the 5 year limit since graduation from medical school requirement of most residency programs.
- The conditions under which refugee and asylum seeking doctors come to the US, fleeing political unrest, trauma, war, and other dangerous conditions puts them at a significant disadvantage. Each year that passes since they graduated from medical school that they spend mastering English and working just to support themselves and family moves them further away from being competitive for a residency. Asylum seekers are also ineligible for most residency programs until they obtain permanent status, which could take 5-10+ years.
- Obtaining a competitive score on the USMLE exams requires a high level of English proficiency and several years of full-time study, which is difficult to do if someone must work to cover living expenses, support family, and cover the costs of taking the USMLE exams. Costs related to being certified to test, obtaining school transcripts and diplomas, test application fees, and test prep materials and courses can range between $10,000 - $15,000.
- Asylum seekers lack of permanent residency, waiting many years to have their cases heard, not eligible for traditional financial aid, impacts not just pursuing medical license but also ability to pursue other professions like PA or NP or MPH because not eligible for sufficient scholarships or loans. Need to work competes with full-time demands/requirements of many programs.
- Challenges getting transcripts and diplomas sent directly from school as required for certification and licensure.
- No recognition for previous education and experience by other health professions or educational programs – even for entry level positions – must re-do training.
- Many people continue to be challenged by the need for a high level of technical English, verbal fluency, and reading comprehension that demonstrates a competency level high enough to meet entrance requirements for specific health profession educational programs, graduate level programs, professional licensing, working at a professional level and passing timed licensing tests.
- Many applying to residency programs have an advantage if they have obtained some US clinical or research experience. Very difficult to get these experiences.

- Maine has a limited and highly competitive number of residency slots with currently no specific program for foreign trained doctors. There are costs associated with applying for residencies including application fees and travel for interviews. The total costs will depend on residency specialty, number of applications and interviews, and location of residency programs.
- **Changes in Certification Requirements Starting in 2024** - ECFMG (Educational Commission for Foreign Medical Graduates) changing process for medical school accreditation. Beginning in 2024, medical schools will need to be accredited by a WFME (World Federation for Medical Education) recognized accrediting agency if they want their students to be eligible for ECFMG certification. Many of the foreign trained doctors coming to Maine as refugees or asylum seekers are coming from countries that do not have this status and will not even be eligible to attempt to apply for a medical license in the US. Maine will need alternative pathways for these physicians to put their skills to use. *(See attached map.)*

<u>Recommendations</u>

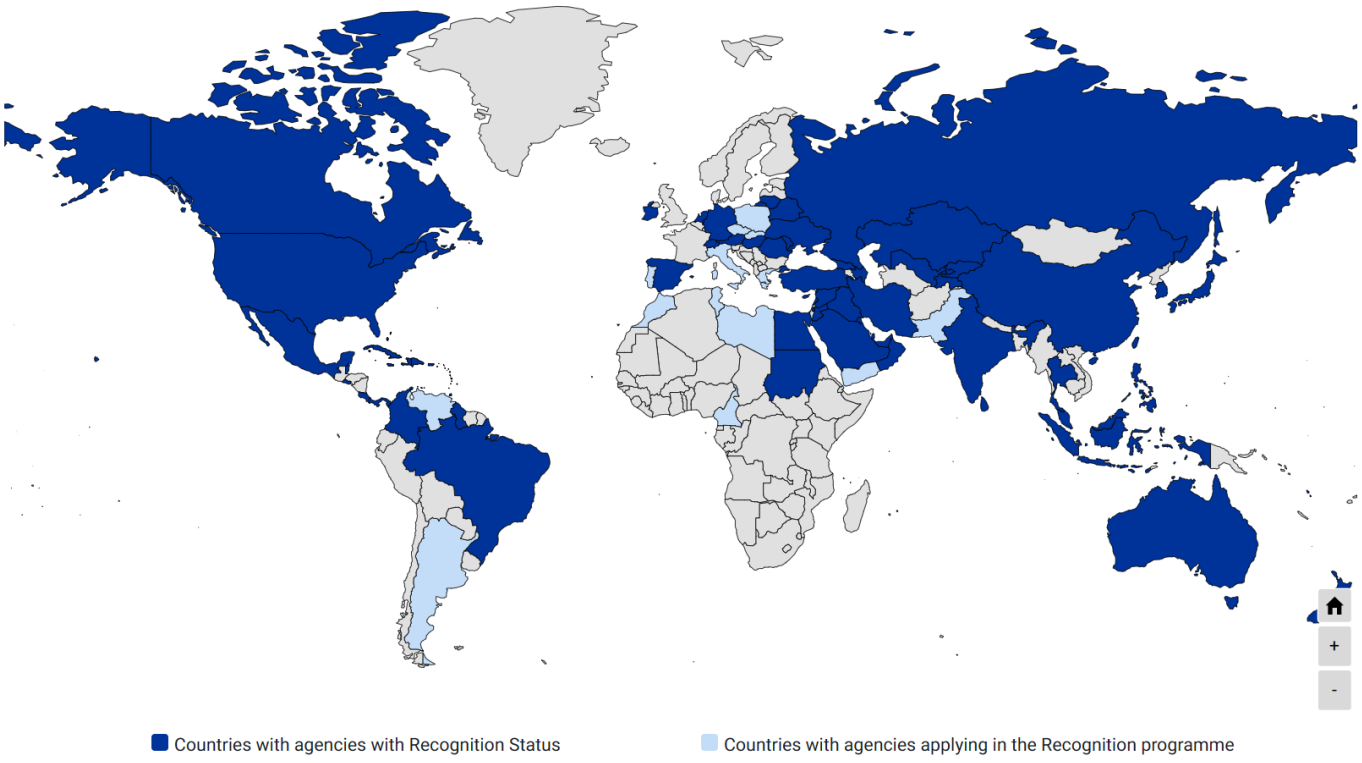
Challenges faced by foreign trained physicians are many. There is much that can be done by employers, colleges and universities, private and state funding programs, etc. to provide the support that would help these health professional move forward on a path that would allow them to use the fullest extent of their skills with the least amount of re-training and each of those entities should be encouraged to examine the barriers that foreign trained health professionals are facing and come up with strategies to address them. Given the limited amount of time available to this Commission, however, it would be my recommendation that we focus our attention in two ways:

1. For those foreign trained doctors for who licensure might be an option, what can be done to identify a licensing pathway, as other states such as Massachusetts have done, with an employer sponsorship and then restricted license followed by full licensure eligibility that would allow them to be licensed as a physician in Maine.
2. For those foreign trained doctors for whom licensure as a doctor is not an option, but who want to pursue other high level health professions, such as PA or nurse or NP or MPH, address the financial barriers that prevent them from entering the educational programs required for those licenses. Providing scholarships or forgivable loans, or loan guarantees in adequate amounts for those who are not eligible for scholarships or to borrow money. For this I would recommend bringing in MeHAF and FAME and other possible funders who can consider the issues and present various options for the Commission to consider.

WFME Recognition of Accreditation programme map:

Welcome to the WFME interactive map featuring countries with accrediting agencies with WFME Recognition Status and countries with accrediting agencies applying in the WFME Recognition of Accreditation programme!

To access information, simply locate the country you are interested in, click on the country and a pop-up window will appear with details about operating accrediting agency/ies with WFME Recognition Status or applying agency/ies in the WFME Recognition programme in that country. To learn more about a particular accrediting agency, click on the link below its name in the pop-up window. This will direct you to the agency's website.



Countries with agencies with Recognition Status

Countries with agencies applying in the Recognition programme

LD 937 Resolve to Establish the Commission Regarding Foreign-trained Physicians Living in Maine

Dear Committee on Health Coverage, Insurance and Financial Services, my name is Abdirahman Hersi. I live in Lewiston and I am writing in support of LD 937, A Resolve to Establish the Commission Regarding Foreign-Trained Physicians Living in Maine.

This legislation would address Maine's health care work force shortage and would help integrate foreign trained physicians living in Maine to contribute their skills and health care knowledge. Foreign trained physicians have been here for many years and some of us have undergone Medical Licensing Exams (USMLE) and have ECFMG Certification. Despite these credentials, we often have had difficulty to integrate into the US and Maine's health care system.

I am originally from Somalia. I have been living in Maine since 2003 and have family and children here in this state. Before coming to the US, I worked as a Physician in Pakistan. Since coming to Maine, I have been able to work and support my family, while studying for the USMLE exams, which was difficult journey. After hard work and dedication, I was able to finish the exams and completing ECFMG Certification as well. After getting the certifications required to get into residency training, I faced enormous barriers to get into the health care system as a physician, such as year of graduation, lack of US clinical experience OR internship, which is only designed for US graduates. I applied to residency many times, four (4) consecutive years, and remained unmatched. My story is not unique. It is one similar to many other IMG doctors all over the US, unfortunately, who are not able to get integrated into the health care system. During my many years of employment in Maine, I have been working in health care as a Research Assistant, Medical Assistant, Pharmacy Technician and, currently, as Core-CHI Certified Medical Interpreter for Covenant Health at St. Mary's Regional Medical Center. It is my hope that this legislation will help provide funding for the integration and formal evaluation, mentorship, or other pathways of foreign trained physicians into health care.

While this legislation has the potential of helping foreign trained physicians integrate into Maine's health care system by seeking and making options available for pathway in which to practice in health care, it also has the possibility of important benefits in filling the some of the needs of the state's health care system.

I thank the committee for considering this important legislation, which will make a big difference for doctors who are of diverse cultural background to serve in the State of Maine's health care work force, and to use their skills without compromising the safety and quality of patient care.

Sincerely,
Abdirahman Hersi
276 Pine ST APT 4
Lewiston, Maine 04240

LD 937 – Resolve to Establish a Special Commission Regarding Foreign-Trained Physicians Living in Maine

Axels Samuntu, MD South
Portland, ME

Dear Committee on Health Coverage, Insurance, and Financial Services, I am writing to support LD 937 a resolve to Establish a Special Commission Regarding Foreign- Trained Physician Living in Maine.

The legislation would address integrating foreign-trained physicians living in Maine into the healthcare workforce that best reflect their high-skill training. Right now, foreign- trained physicians in Maine are not working in the medical field, and they are working far from their full potential. The commission will help us to create a Stakeholder, including healthcare employers, colleges, Universities, immigrant advocacy groups, workforce development, and licensing boards, gather information, issue, and recommendations.

I have been a practicing physician in the Democratic Republic of Congo for two years, and I have been in the United States of America for almost seven years. I never lost my faith until I appeared today in front of the Committee to testify; I wish to practice as a physician in the United States of America, especially in Maine, but it is not accessible due to many barriers. Our work schedules are not flexible, and accessing higher education or processing a license for low-wage jobs is not easy.

I am a student at the University of Southern Maine in the public health program. To be enrolled at the university, my process takes two years. This long waiting time to process your enrollment is one of the barriers I faced before getting enrolled. I never give up. I am still hoping that our future will be better. I work for Maxim Healthcare, a Contactor of the Maine Center for Disease Control, as a Covid Case Investigator. Last year at the Maine Public health Association awards Ceremony, the ME CDC Case Investigator team received the "President Award," the highest award given by MPHA; I and a couple of Foreign- Trained physicians in this room received it too. Previously, I worked for Medical Care Development. Also, I worked for the City of Portland as a Community Health Outreach Worker and volunteered for many organizations. I was the first student representative for PAE at the School Board, Natural Helper for the City of Portland, Alfond Grand Ambassador, and so.

The Maine legislation could help Foreign Trained physicians first realize the dream to practice in Maine or work again as a Physician, second to be hired in a position equivalent to the level or close and third to work in the Healthcare field or Public Health.

Thank you for considering my comments on this critical legislation. It will make a big difference and enhance the life of Foreign Trained physicians who live in the State of Maine to be able to practice again or use their skills to help the people of Maine state in medical or public health fields.

Sincerely,

Axels Samuntu, MD

696 Westbrook Street Apt 2B South Portland, ME

March 1, 2023

Dear Committee on Health Coverage, Insurance, and Financial Services,

My name is ***Cedrick Bisembo***, I live in Auburn. Today, I am here in support of LD 937, a Resolve to Establish a Special Commission Regarding Foreign-Trained Physicians Living in Maine.

The legislation that we are here today in support of would address integrating foreign-trained physicians residing in Maine into the healthcare workforce that best reflects our high level of skills and training. As foreign-trained physicians in Maine, we are working outside our capacity. The commission will consist of stakeholders, including healthcare employers, immigrant advocates, workforce development, and licensing boards, gathering information, and issuing a report of recommendations.

The individuals standing before you today as foreign-trained health professionals may be part of the solution to the workforce shortage that Maine is suffering from today.

I moved to Maine from the Democratic Republic of the Congo in late 2016. Before then, I have been a practicing physician for five years with experience working in Gynecology, obstetrics, and surgery, where I have been the assistant to the supervisor of the Department for two years. I have also been caring for the victims of sexual violence.

In Maine, since 2018, I am working as an Emergency Medical Technician and a Direct Support Professional. Recently during the pandemic, I also started working as a Covid-19 Case Investigator. I have chosen those fields because the access was not so demanding and as a bridge to my long journey in the hope of Practicing one day as a Physician or close to it. After four years, I realized that the problems or barriers I was hoping to solve were still there, such as funding to further my studies due to working in a low-wage job with no flexibility or benefit to further education. I am here in support today for this legislation because the fields I work in demand less education and training than my role as a physician in the Democratic Republic of the Congo.

This legislation will benefit physicians living in Maine like myself because it will help us realize our dream of being able to work as a physician again.

Thank you, Dear Committee, for considering my comments on this critical legislation. It will make a big difference for the doctors who will be able to use their skills to help people and the people they will be able to serve.

To the Committee on Health Coverage,
Insurance and Financial Services

RE: LD 937 - Resolve to Establish a Special Commission
Regarding Foreign-Trained Physicians Living in Maine.

Dear Committee on Health Coverage, Insurance, and Financial Services,
My name is Jean Lenga Lenda. I live in Portland and I humbly came in person to testify in support of LD 937 a Resolve to Establish a Special Commission Regarding Foreign-Trained Physicians Living in Maine.

Currently, foreign-trained doctors in Maine are not working near their capacity. This causes many of them to leave our State, and move where they are allowed to work near full capacity. This legislation would be able to address integrating foreign-trained physicians living in Maine into the healthcare workforce that best reflects their high level of skills and training.

The Commission will consist of stakeholders including healthcare employers, immigrant advocates, workforce development, and licensing boards ..., in order to gather information and issue a report of recommendations.

I was a practicing physician in the Democratic Republic of the Congo since 2006, with a higher training in Trauma-surgery. I worked in American missionary hospitals in the Congo (DRC) as well as in the Republic of Niger.

I had to leave my country in May 2015 to save my life. I landed in the United States on June 12, 2018, and in Maine on July 4, 2018. I did not hesitate to train and work as a CNA, DSP, and CRMA. However, I deeply hope to practice as a doctor again. But many obstacles stand in my way, including funding for training and working full-time in jobs without the possibility of continuing my studies.

This bill would help people like me realize my dream to work again as a doctor or at a level close to that, demonstrating my bravery, my loyalty, and the purity of my heart. It will make a huge and significant difference in the lives of foreign-trained physicians here in Maine, and in the lives of the people of Maine as well.

Thank you for your kind attention and for considering my comments. Maine still has to lead.

Sincerely, Jean Lenga Lenda.
2 Tamarlane, Portland ME 04101.

Most excellent Committee on Health Coverage, Insurance and Financial Services, my name is Jose Aldana and I am from Lewiston. I am writing in support of LD 937 a Resolve to Establish a Special Commission Regarding Foreign-Trained Physicians Living in Maine, due to all benefits that it has for foreign-trained living in Maine. This legislation allows us, to incorporate into the health care workforce and show you: our skills, capacity and experience acquired in our countries.

The Commission will consist of stakeholders including healthcare employers, immigrant advocates, workforce development, and licensing boards, gather information, and issue a report of recommendations.

I'm from Cuba and I have been a practicing physician for 5 years. I came to US 9 months ago and my goal is become a doctor again or working close to that level, but it will be possible when all barriers be delete, this is the way to improve our personal develop and show you our knowledge and skills.

I would glad if this legislation were approved, it help people like me to get our dreams and goals; and benefits the community with more doctors.

Thank you for including my comments on this important legislation, this would be a great opportunity for all foreign physicians living in Maine, to be able to contribute some of our skills to society.

Sincerely, Jose Aldana, Lewiston-Maine

March 21, 2023

Dear Committee on Health Coverage, Insurance and Financial Services.

My name is Vick Mulamba and I live in Lewiston. I am delighted to stress out my entire support to the LD 937 initiative to establish a Special Commission Regarding Foreign-Trained Physicians Living in Maine.

However, my hope will be centered in the strengthening of the healthcare workforce which get affected recently by the pandemic by integrating foreign-trained Physicians living in Maine, in the health system on a comprehensive and performance sound program, through the 131st Legislature's agenda and means. This legislation should capture the neglected and non-utilized intellectual investment, that foreign-trained are representing if being unable to work on full capacity.

Therefore, various stakeholders involvement such as, but not limited to healthcare employers, Immigrant advocates, workforce development, and licensing boards, seems to be incumbent on the achievement of expected milestones.

I have been a medical practitioner for 15 years in DR Congo firstly and lastly in Zambia, before arriving in United States of America where I am living for 1 year and 6 months. I had encountered so many barriers to practicing medicine in United States of America as regards to licensing rules and regulations, and high selectivity for residency program, while I have medical skills which can be detected by an internship program of 2-3 years aside the specialized medical doctor.

Besides, I am still facing serious challenges to get access to the education, even though I had decided against my will to abandon medicine and perhaps focusing in other area like Public Health, but the financing constraints, and the scholarship rigidity criteria, had shut down my intrinsic human development motivation.

It is cannot overemphasized, that the State of Maine is losing my ObGyn skills by being blinded with all traditional rules and regulations set by various institutions as regards to medical practicing, while the underserved community is critically in serious needs.

I had performed more than 5000 ObGyn emergencies, for which I will be happy to demonstrate during the internship program with a supervisor for at least 2 years of supervision and be granted a temporary license with appropriate restrictions if applicable until I provide confidence, than making me passing USMLE's exam which seems to be appropriate for those who are recently graduated.

Looking forward to considering my comments on this important legislation, and it will be a game changer once the neglected doctors are able to use their skills for the underserved community which the majority is Immigrant from our home Africa continent.

Sincerely yours
Dr. Vick Mulamba
Lewiston, ME

Dear Senator,

I am writing to you today to advocate for legislation that would create a pathway forward for foreign-trained physicians seeking licensure in Maine. As a healthcare professional, I strongly believe that Maine can benefit from attracting and retaining talented physicians from around the world to contribute to the state's healthcare system and improve patient outcomes.

I completed my medical education and training and have been a physician for 15 years in one of the top teaching hospitals in China. However, despite my extensive education, training, and practicing, I am currently unable to utilize my skills and knowledge to help patients in the United States. This is due to the complex and time-consuming process of obtaining licensure in this country, which often presents significant barriers for foreign-trained physicians. Despite my passion and dedication to the field of medicine, I am currently unable to contribute to the healthcare system in the way that I am trained and qualified to do so. This is a frustrating and discouraging experience, as I know that I have so much to offer as a healthcare provider but am prevented from doing so by the current system.

Foreign-trained physicians face significant challenges in obtaining licensure in the United States, including passing the United States Medical Licensing Examination (USMLE), completing a medical residency program, and obtaining certification from the Educational Commission for Foreign Medical Graduates (ECFMG). These requirements can be daunting for foreign-trained physicians who are not familiar with the US medical system and may face language and cultural barriers.

However, with the right support and resources, foreign-trained physicians can successfully navigate this complex process and become valuable members of Maine's healthcare workforce. I strongly believe that the legislation would streamline the licensure process and provide support and resources for foreign-trained physicians, making it easier for them to obtain licensure in Maine and contribute to the state's healthcare system.

I urge you to support this legislation and work with your colleagues to make Maine a more welcoming and supportive state for foreign-trained physicians. By doing so, we can improve access to quality healthcare for Maine residents and strengthen our healthcare system overall.

Thank you for your consideration of this important issue.

Sincerely,

Han Hu, Falmouth

19 Mar 2023

Enacted Legislation in Other States Regarding Pathways to Practice for Foreign-Trained Physicians

State-Funded Residency and Career Readiness Programs

State	Program Overview	Eligibility	Service Obligations	Eligibility for Full Licensure

California
 	
UCLA David Geffen School of Medicine International Medical Graduate (IMG) Program; Calif. Bus. and Prof. Code §2066.5
	IMG Program:
	• Assists scholars in completing the following:
	  ○ Passing the U.S. Medical License Examinations (USMLEs).
	  ○ Earning certification by the Educational Commission for Foreign Medical Graduates (ECFMG).
	  ○ Successfully applying to and navigating the National Resident Matching Program.
	• Exam preparation support and financial assistance, including $1,000-$1,500 monthly stipend.
	• English for Health Professionals courses.
	• Supervised, hands-on clinical instruction at UCLA Health and affiliated facilities.
		• U.S. Citizenship, Permanent Resident status, or Permanent Refugee status.
		• Fluency (written and oral) in both Spanish and English.
		• Bi-cultural competency in U.S. American and Latin American cultures.
		• Graduate of a medical school recognized by the Medical Board of California.
		• Graduated from medical school or completed a non-U.S. residency no more than five years prior.
		• Passed U.S. Medical Licensing Examinations (USMLE) Step 1 before applying to the program.
			• Participant contractually agrees upon graduation to enter a three-year Family Medicine residency in California, and then to serve in a medically-underserved community for 24-36 months beyond completion of the residency.	• Application for a Physician's or Surgeon's License is undertaken after the IMG has graduated from the IMG Program and during their Family Medicine residency.
				• A license cannot be issued to an IMG until the applicant has passed USMLE Step 3; applicant must pass Step 3 within not more than 4 attempts.
				• An IMG must complete 24 months of training to be eligible for licensure; the final 12 months used towards eligibility must be continuous and in a single program.
				• An IMG must be licensed by the end of the 36th month of training.

Colorado HB 22-1050 (2022)	IMG Assistance Program: • Established in the Department of Labor and Employment to provide direct services to IMGs through a contract with a third party to administer the program. • Reviews the background, education training and experience of program participants in order to recommend appropriate steps to enable participants to integrate into the state's health care workforce as physicians or to pursue an alternative health career • Provides technical support and guidance to program participants through the credential evaluation process, including preparing for the USMLE and other applicable tests or evaluations.	• IMGs wishing to re-establish their medical careers in the state. • The executive director will determine the eligibility criteria for participation in the program.	None specified	None specified

Enacted Legislation in Other States Regarding Pathways to Practice for Foreign-Trained Physicians

State	Program Overview	Eligibility	Service Obligations	Eligibility for Full Licensure
Colorado (cont'd)	• Provides scholarships or access to scholarships or funds for certain program participants to help cover or offset the cost of the medical licensure process, including the costs of the credential evaluation process, preparing for the USMLE and other applicable tests or evaluations, the residence application process and other costs associated with returning to a career in health care. • In partnership with community organizations working with IMGs, develops voluntary rosters of IMGs interested in entering in the state's health care workforce as physicians and IMGs seeking alternative health care careers. • Provides guidance to IMGs to apply for medical residency programs or other pathways to licensure.			
	<u>Clinical Readiness Program</u>: • Established in the Department of Labor and Employment to assist IMGs with building the skills necessary to become residents in the U.S. medical system. • The Executive Director will contract with a Colorado-based medical school or ACGME-accredited residence program to serve as the program administrator responsible for developing, implementing and administering the clinical program. • Program must be developed and implemented by January 1, 2024. • Program must contain the following elements: o A mechanism for processing and assessing program applications. o Program curriculum, including curriculum pertaining to the practice of one or more primary care specialties and that provides inpatient and outpatient training opportunities combined with community and classroom-based components to	• Must be an IMG whose medical degree qualifications have been evaluated by a credentialing agency approved by the Colorado Medical Board and determined to be equivalent to a medical degree from an accredited medical school in the U.S. or Canada or a state or country with which Colorado has a reciprocal license agreement. • Must have achieved a passing score on the USMLE Step 1 and Step 2 examinations.	None specified	None specified

Enacted Legislation in Other States Regarding Pathways to Practice for Foreign-Trained Physicians

State	Program Overview	Eligibility	Service Obligations	Eligibility for Full Licensure
Colorado (cont'd)	prepare program participants to match into and succeed in a U.S. residency program. ○ An assessment system to assess the clinical readiness of program participants to serve in a U.S. residency program, including clinical readiness for the practice of one or more primary care specialties and additional assessments as resources are available. • After the program participant completes the clinical program curriculum, an assessment of the participant for clinical residence of a residency program. • If the program participant passes the assessment, the program director will issue the participant an industry-recognized credential of clinical readiness, submit a report and recommendation to the administrator of the assistance program who will allow an IMG to interview for a position in the program administrator's residency program.			
Minnesota Minnesota IMG Assistance Program; Minn. Stats. §144.1911	IMG Career Guidance and Support Grant Program: • The commissioner of the Minnesota Department of Health awards grants to eligible nonprofit organizations and eligible postsecondary educational institutions, including the University of Minnesota, to provide career guidance and support services to immigrant international medical graduates seeking to enter the Minnesota health workforce. • Current grantee is the International Institute of Minnesota.	Eligible grant activities include: • Educational and career navigation, including information on training and licensing requirements for physician and nonphysician health care professions, and guidance in determining which pathway is best suited for an IMG based on the graduate's skills, experience, resources, and interests; • Support in becoming proficient in medical English; • Support in becoming proficient in the use of information technology, including computer skills and use of electronic health record technology; • Support for increasing knowledge of and familiarity with the U.S. health care system; • Support for other foundational skills identified by the commissioner;	None specified	None specified

Enacted Legislation in Other States Regarding Pathways to Practice for Foreign-Trained Physicians

State	Program Overview	Eligibility	Service Obligations	Eligibility for Full Licensure
Minnesota (cont'd)		• Support for IMGs in becoming ECFMG certified, including help with preparation for required licensing examinations and financial assistance for fees; and • Assistance to IMGs in registering with the program's Minnesota IMG roster.		
	IMG Clinical Preparation Grant Program: • The commissioner of the Minnesota Department of Health awards grants to support clinical preparation for Minnesota IMGs needing additional clinical preparation or experience to qualify for residency. The grant program must include: o Proposed training curricula; o Associated policies and procedures for clinical training sites, which must be part of existing clinical medical education programs in Minnesota; and o Monthly stipends for IMG participants.	• A Minnesota IMG is defined as an international medical graduate who: o Was born outside the U.S., o Now resides permanently in the U.S. as a citizen or Lawful Permanent Resident, o Has resided in Minnesota for at least two years, and o Did not enter the United States on a J-1 or similar nonimmigrant visa following acceptance into a U.S. medical residency or fellowship program. • Eligible grant applicants are programs and sponsors of clinical medical education or healthcare providers that meet the following criteria: o Are located in Minnesota, o Have a history of providing clinical medical education or clinical preparation, and o Are willing to provide clinical preparation in primary care, including exposure to ambulatory and inpatient medicine in one or more of the following specialties: family medicine, internal medicine, obstetrics, pediatrics, psychiatry and rural medicine.	• Priority given to primary care sites in rural or underserved areas of the state. • IMG participants must commit to serving at least five years in a rural or underserved community of the state.	None specified
	IMG Primary Care Residency Grant Program: • The commissioner of the Minnesota Department of Health awards grants to support primary care residency positions designated for Minnesota	• Participating IMGs must have lived in Minnesota for at least two years and be ECFMG certified.	• Participating IMGs must agree to provide primary care for at least five years in a rural or underserved area of Minnesota after graduating from the	None specified

Enacted Legislation in Other States Regarding Pathways to Practice for Foreign-Trained Physicians

State	Program Overview	Eligibility	Service Obligations	Eligibility for Full Licensure
Minnesota (cont'd)	immigrant physicians who are willing to serve in rural or underserved areas of the state. • Maximum grant of $150,000 per residency position per year.	• Residency programs may also require that participating IMGs hold a Minnesota certificate of clinical readiness for residency. • Eligible primary care residency grant recipients include accredited family medicine, general surgery, internal medicine, obstetrics and gynecology, psychiatry and pediatric residency programs.	residency program and make payments to the revolving international medical graduate residency account for five years beginning in their second year of post-residency employment. • Participants must pay $15,000 or 10% of their annual compensation each year, whichever is less.	
	IMG Residency Preparation Program – BRIIDGE: • The University of Minnesota, in partnership with the Minnesota Department of Health, offers a residency preparatory program for IMGs. • The nine–month program provides inpatient and outpatient training opportunities as well as community and classroom-based components to prepare participants to match into and succeed in residency programs.	• An immigrant now residing permanently in the U.S. as a U.S. citizen or permanent resident; • Did not enter the United States on a J-1 or similar nonimmigrant visa following acceptance into a U.S. medical residency or fellowship program; • M.D. degree or international equivalent; • At least two years of documented Minnesota residency; • ECFMG certification including passing score on USMLE Steps 1 and 2 within 3 attempts; • Demonstrated typing proficiency; and • Personal health insurance coverage throughout the program period.	None specified	None specified
Washington RCW 18.71.475 *Program not yet funded; see Washington IMG Assistance Workgroup below under Studies/ Workgroups/ Commissions*	IMG Grant Program: • Subject to legislative appropriation and donations received from public and private entities, the department of health will award grant funding to: o Approved entities for career guidance and support services to IMGs including, but not limited to, assistance with ECFMG certification application and U.S. medical licensing examination preparation; and o Health care facilities or clinical programs to provide supervised clinical training to IMGs.	Not specified	None specified	None specified

Enacted Legislation in Other States Regarding Pathways to Practice for Foreign-Trained Physicians

Alternative Licensure

State	Program Overview	Eligibility	Restrictions/Service Obligations	Eligibility for Full Licensure
Arkansas Ark. Code §17-95-412; Regulation 28	Educational License to Practice Medicine: • Authorizes the Arkansas State Board of Medicine to issue an academic license to practice medicine to any physician who meets regulatory and statutory requirements.	• Must be of 21 years of age and of good moral character. • Must submit a completed application to the Board, a $400 application fee and a $100 licensure processing fee. • Must appear personally before the Arkansas State Medical Board, together with the sponsoring physician from the University of Arkansas for Medical Sciences Department where the applicant will be practicing medicine. • Must present to the Board information as to what department of the University of Arkansas for Medical Sciences the applicant will be practicing medicine and who will be the applicant's supervisor.	• Must be serving as a faculty member in the State of Arkansas under the supervision of a faculty member licensed by the Board at an academic medical program accredited by ACGME or the American Osteopathic Association operated in the State of Arkansas and established by and under the control of a medical school located in the State of Arkansas and accredited by an accrediting agency recognized by the U.S. Department of Education or approved by the Arkansas Higher Education Coordinating Board to seek accreditation by an accrediting agency recognized by the U.S. Department of Education. • The educational license authorizes the licensee to practice medicine only within the clinical and educational programs established and administered by the University of Arkansas for Medical Sciences. • The educational license is valid for a period of one year from the date of issuance; physician may apply to renew the license for one additional year ($200 renewal fee).	• After two years of consecutive practice under an educational license, a physician is eligible for an active, unrestricted license to practice medicine in the state, without needing to complete a U.S. residency.
Colorado HB 22-1050 (2022)	Re-Entry License: • Allows eligible IMGs to apply to the Colorado Medical Board for a full unrestricted license after meeting certain requirements.	• Must hold a current or expired international license or meet other qualifications specified by the Board by rule • Must satisfy other requirements established by the Board by rule, which may include a recommendation of the IMG from the administrator of the IMG Assistance Program or from the program director of the Clinical Readiness Program or a requirement for specific training.	None specified	• Re-entry license is a full unrestricted license.

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State	Program Overview	Eligibility	Restrictions/Service Obligations	Eligibility for Full Licensure
Colorado (cont'd)		• Must submit to evaluations, assessments and an educational program as required by the Board. • The Board may approve an assessment model to assess the competency of IMGs applying for a re-entry license and must approve criteria, including minimum requirements, standards and competencies for the assessment of applicants.		
Idaho SB 1094 (2023)	Temporary Registration: • Authorizes the Board of Medicine to provide for temporary registration of experienced IMGs who are forcibly displaced persons.	• Must be a graduate of a medical school recognized by the board. • Must be an asylee, a humanitarian parolee or a refugee holding a customs and border protection form I-94 or an equivalent document. • Must have applied for an accredited medical residency training program in Idaho. • Must have at least three years of practice in the person's specialty. • Must have no gap of greater than five years between the person's clinical practice and the person's application for the accredited medical residency training program in Idaho. • Must pass the occupational English test for medicine.	• The IMG must agree to practice in a health professional shortage area, as designated by the federal government, for at least three years following graduation from an accredited medical residency training program in Idaho. • The Board will specify the time period of the temporary registration.	None specified
Illinois SB 1298 (2023) *Effective January 2025*	Limited License: • Allows an IMG physician to apply to the Department of Professional and Financial Regulation for a limited license.	• The Department will adopt rules establishing qualifications and application fees for the limited licensure IMG physicians and may adopt other rules as may be necessary for the implementation of the law.	None specified	• The Department will adopt rules that provide a pathway to full licensure for limited license holders after the licensee successfully completes a supervision period and satisfies other qualifications as established by the Department.

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State	Program Overview	Eligibility	Restrictions/Service Obligations	Eligibility for Full Licensure
Missouri Mo. Rev. Stat. §§334.036, 334.037 and 334.038; 20 CSR 2150.2.200 to 2150.2.260	Assistant Physician License: • Authorizes the Board of Registration for the Healing Arts to issue an assistant physician license to medical school graduates, including IMGs, who have passed Step 2 of the USMLE but have not entered a residency program in the U.S.	• Any graduate of a medical school accredited by the Liaison Committee on Medical Education, the Commission on Osteopathic College Accreditation, or an organization accredited by the ECFMG who: ○ Is a U.S. resident and citizen or is a legal resident alien; ○ Has successfully completed Step 2 of the USMLE or the equivalent of any other board-approved medical licensing examination within the three-year period immediately preceding application for licensure, or within three years after graduation from a medical college or osteopathic medical college, whichever is later; ○ Has not completed an approved postgraduate residency and has successfully completed Step 2 of the USMLE or the equivalent of any other board-approved medical licensing examination within the immediately preceding three-year period unless when the three-year anniversary occurred the applicant was serving as a resident physician in an accredited residency in the U.S. and continued to do so within 30 days prior to application for licensure; and ○ Has proficiency in the English language.	• Must work with a fully licensed physician under a collaborative practice agreement. • The collaborating physician must determine and document the completion of at least a one-month period of time during which the assistant physician will practice with the collaborating physician continuously present before practicing in a setting where the collaborating physician is not continuously present. • Limited to providing primary care services in medically underserved rural or urban areas of Missouri. • A collaborating physician must not enter into a collaborative practice arrangement with more than six full-time equivalent assistant physicians, full-time equivalent physician assistants or full-time equivalent advance practice registered nurses, or any combination thereof. • An assistant physician must complete and attest to completion of at least 50 hours of continuing medical education every two years. • License may be renewed annually.	None specified
New York NY Education Law §6525; S 7002 (2023)	Limited Permit: • Eligible IMGs may apply to the Education Department for a limited permit to practice medicine.	• The following persons are eligible for a limited permit: ○ A person who fulfills all requirements for a standard license as a physician except those relating to the examination	• A permittee is authorized to practice medicine only under the supervision of a licensed physician and only in: ○ A public, voluntary, or proprietary hospital;	None specified

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State	Program Overview	Eligibility	Restrictions/Service Obligations	Eligibility for Full Licensure
New York (cont'd)		and citizenship or permanent residence in the U.S.; ○ A foreign physician who holds a standard certificate from the ECFMG or who has passed an examination satisfactory to the state board for medicine and in accordance with the commissioner's regulations; or ○ A foreign physician or a foreign intern who is in the U.S. on a non-immigration visa for the continuation of medical study, pursuant to the exchange student program of the U.S. department of state.	○ A patient care facility operated by or for any federally recognized American Indian tribe, the Indian health service, the U.S. Veterans' Administration, a prison, a school or a university; ○ A community health center or federally qualified health center; or ○ A private office or clinic where a supervising licensed physician practices and that is not a pain management clinic. • A limited permit is valid for two years and may be renewed biennially; no limitation placed on the number of renewals that may be issued.	
Tennessee SB 1451 (2023) *Effective June 2024*	Temporary License: • Authorizes the Tennessee Board of Medical Examiners to issue a temporary license of limited duration to IMGs who meet specified criteria.	• Must demonstrate competency as determined by the Board. • Must have completed a three-year post-graduate training program in the graduate's licensing country; or have otherwise practiced as a medical professional performing the duties of a physician for at least three of the last five years outside the U.S. • Must submit sufficient evidence that the applicant is an IMG and has an offer for employment as a physician at a healthcare provider that operates in the state and has a post-graduate training program accredited by the ACGME in place.	• An IMG who is granted a temporary license must only provide medical services at a healthcare provider that has in place a post-graduate training program accredited by the ACGME.	• The Board will grant a full and unrestricted license to practice medicine to a temporary licensee who is in good standing two years after the date of temporary licensure. • A temporary licensee who obtains a full and unrestricted license is not subject to the limitation of practicing at a healthcare facility with a post-graduate training program.
Virginia Va. Code §54.1-2936; 18 VAC 85-20-210; 18 VAC 85-20-122	Limited Professorial or Fellow License: • Authorizes the Board of Medicine to issue a limited professorial license or fellow license to certain IMGs upon recommendation from the dean of an approved accredited medical school or college in Virginia.	• Must submit evidence of authorization to practice medicine in a foreign country. • Must submit evidence of a standard ECFMG certificate or its equivalent; may be waived by the Credentials Committee or its designee based on other evidence of medical competency and English proficiency.	• The limited professorial license or limited fellow license applies only to the practice of medicine in hospitals and outpatient clinics where medical students, interns or residents rotate and patient care is provided by the medical school or college recommending the applicant.	• An individual who has practiced with a limited professorial license for five continuous years may have a waiver from the residency requirement when applying

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State	Program Overview	Eligibility	Restrictions/Service Obligations	Eligibility for Full Licensure
Virginia (cont'd)		• Must submit a recommendation from the dean of an accredited medical school in Virginia that the applicant is a person of professorial or of fellow rank whose knowledge and special training meet the following: o For the limited professorial license, the applicant must serve as a full-time or adjunct faculty member and demonstrate knowledge and special training that will benefit the medical school or educational programs sponsored by the medical school in affiliated hospitals. o For the limited fellow license, fellowship must be ranked between the residency level and associate professor levels and applicant must benefit the medical school.	• The limited professorial license is valid for one year and may be renewed annually upon recommendation of the dean of the medical school and upon continued full-time service as a faculty member. • The limited fellow license is valid for one year and may be renewed not more than twice upon the recommendation of the dean of the medical school and upon continued full-time employment as a fellow.	for a full license to practice medicine in Virginia.
Washington RCW 18.71.095	IMG Clinical Experience License: • Authorizes the Washington Medical Commission to issue a limited license to IMGs to gain clinical experience upon nomination by the chief medical officer of any hospital, appropriate medical practice located in the state of Washington, the department of social and health services, the department of children, youth and families, the department of corrections, or a county or city health department.	• Must have been a Washington state resident for at least one year; • Must provide proof the applicant is certified by ECFMG; • Must have passed all steps of the U.S. medical licensing examination; and • Must submit to the commission background check process required of applicants generally.	• A license holder may only practice under the supervision and control of a physician who is licensed in the state and is of the same or substantially similar clinical specialty; and within the nominating facility or organization. • A license holder must file with the commission a practice agreement between the license holder and the supervising physician who is of the same or substantially similar clinical specialty. • A supervising physician may supervise no more than two license holders unless the commission grants a request to increase this limit. • A limited license is valid for two years and may be renewed once by the commission upon application for renewal by the nominating entity.	None specified

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State	Program Overview	Eligibility	Restrictions/Service Obligations	Eligibility for Full Licensure

West Virginia
 	
W. Va. Code §30-3-10; Va. Board of Medicine Legislative and Procedural Rules 11 CSR 2
	Restricted Medical License:
	• Authorizes the Board of Medicine to issue a restricted license in extraordinary circumstances to an applicant who meets the criteria established by rule.
		• After reviewing the application and interviewing the applicant, the Board makes written findings describing:
		  ○ The applicant's exceptional education, training and practice credentials, including but not limited to, academic appointments, length of time in a profession, specialty, scholarly publications and presentations, professional accomplishments, and awards;
		  ○ How the applicant's practice in the state would be beneficial to the public welfare;
		  ○ The applicant's specialty and the need of that specialty;
		  ○ How the applicant's education, training and practice credentials are substantially equivalent to the requirements of licensure for a standard medical license; and
		  ○ That the applicant received post-graduate medical training outside of the U.S. and its territories.
		• The applicant must provide to the Board all additional information requests, and an explanation of the applicant's extraordinary circumstances.
		• A restricted license issued in extraordinary circumstances must be approved by a three-fourths vote of the Board.
			• Restricted license in extraordinary circumstances means a license which contains limitations or conditions including but not limited to the following: practice location; practice setting; specialty area of practice; practice procedures; hours and length of practice; type of patients; sitting for and successful completion of examination(s); evaluations and treatment; education; and monitoring and supervision.
			• The Board may propose rules for legislative approval that establish and regulate a restricted license pursuant to the state's existing standards for medical licensing.
				• The Board may convert the restricted license to a standard license upon application of a restricted licensee who later meets the requirements for a standard license.

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Studies/Workgroups/Commissions

- **Illinois**: HB 5465 (2022)
  Establishes the Task Force on Internationally-Licensed Health Care Professionals within the Department of Financial and Professional Regulation. The duties of the task force are to aim to remove barriers to licensure and practice for health care professionals licensed and practicing in other countries to get licensed and practice in the state; address the health care workforce shortage in the state by increasing the supply of culturally competent physicians, nurses, and other health care professionals; and protect the safety of patients and the broader public. The task force is required to submit an annual report with findings and recommendations to the Governor and General Assembly, beginning one year after the first meeting of the task force.

- **Maryland**: HB 625 (2022)
  Establishes the Commission to Study the Health Care Workforce Crisis in Maryland to examine certain areas related to health care workforce shortages in the State, including examining barriers confronting foreign-born health professionals and identifying career and licensure pathways for refugees and immigrants with education, training and experience from other nations. The commission is required to submit a report with findings and recommendations by December 31, 2023, to the Senate Education, Health, and Environmental Affairs Committee and the House Health and Government Operations Committee.

- **Massachusetts**: FY 2020 Enacted Budget
  Legislation enacted in the FY 2020 budget to establish the Special Commission on Foreign-Trained Medical Professional Licensure to study and make recommendations regarding the licensing of foreign-trained medical professionals with the goal of expanding and improving medical services in rural and underserved areas. The commission submitted a report of its findings and recommendations, including recommended legislation, on July 1, 2022. Legislation (H2224) to implement the commission's recommendations was introduced in February 2023 and is currently pending in the Legislature. The legislation creates a limited license for IMGs with a two-step process – a sponsorship model for one year that is renewable one time, followed by a two-year restricted license followed by full licensure eligibility after two to four years of practicing under the restricted license.

- **Virginia**: International Medical Graduates Work Group
  In 2019, at the request of the Virginia House of Delegate's Committee on Health, Welfare and Institutions, the Department of Health Professions created an International Medical Graduates Work Group to review of barriers to licensure in Virginia as well as initiatives, policies, and programs in other jurisdictions facilitating pathways to medical practice for IMGs in underserved areas. The work group issued its report to the committee in September 2019.

- **Washington**: SB 5846 (2019)
  Established the International Medical Graduate Workgroup to study barriers to practice and make recommendations on how the state can implement an IMG assistance program by January 1, 2022, to assist IMGs in integrating into the Washington health care delivery system. The workgroup issued a report with recommendations to the Legislature in December 2019. In 2020, in response to the recommendations in the report, the Legislature enacted SB 6551, which created the International Medical Graduate Implementation Workgroup and charged the workgroup with determining clinical readiness criteria for IMGs; a grant award process for those who provide career guidance and clinical training for IMGs; and an evaluation process for hardship waivers. The commission issued reports to the Legislature in 2021 and 2022. The workgroup is required to submit an annual report to the Legislature by June 30, 2021, and yearly thereafter until July 1, 2025.

Other Legislation

- **Alabama**: SB 155 (2023)
  Residency equity bill that reduces the residency requirement for licensure for IMGs from three years to two years.

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- **Washington**: RCW 18.71.051
  Waiver from licensure requirements determined by the Washington Medical Commission in rule for IMG applicants who meet specified criteria. Applicants must possess an acceptable body of work related to research, medical excellence or employment, and have the recommendation of other national or international experts in the same specialty or field.

- **Utah**: SB 43 (2022)
  Modifies the Division of Professional Licensing's authority to grant a license by endorsement to foreign-trained individuals by authorizing the Division to issue a license to an individual who:
  - Has been licensed in a jurisdiction outside of the U.S. if after being licensed, the individual has at least one year of experience in the jurisdiction where the license was issued; and the Division determines that the individual's education, experience and skills demonstrate competency in the occupation or profession for which the individual seeks licensure; or the division determines that the licensure requirements of the jurisdiction at the time the license was issued were substantially similar to the current licensure requirements in the state; or
  - Has never been licensed in a jurisdiction outside of the United States, if the individual was educated in or obtained relevant experience in a state, district, or territory of the U.S., or a jurisdiction outside of the U.S.; and the Division determines that the education or experience was substantially similar to the current education or experience requirements for licensure in the state.

- **Vermont**: Office of Professional Regulation Foreign Credentialing Rules
  Legislation enacted in 2019 (H427) directed the Office of Professional Regulation (OPR) to adopt rules that prescribed a process for the Director to assess the equivalence of a license applicant's professional credentials earned outside the U.S. as compared to Vermont license requirements for those OPR professions that do not already have laws addressing the verification and recognition of such credentials. The rules, finally adopted in November 2022, provide a pathway for foreign-trained individuals to become licensed in their field in Vermont. Through the new process, individuals who obtained their professional license or experience outside the U.S. will get a determination of equivalency from an external credential evaluation service. If the evaluation determines the person's foreign work experience, education, training and exams are equivalent to what is required for a Vermont license, a report goes directly to OPR who notifies the applicant to apply for endorsement.

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

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Special Commission on Foreign-Trained Medical Professionals

Report and Recommendations

July 1, 2022

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COMMISSION MEMBERSHIP

James Lavery, Esq., Director, Bureau of Health Professions Licensure (Chair)	Secretary of Health and Human Services, Designee
Senator Rebecca L. Rausch, Esq., LL.M.	Senate President, Designee
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EXECUTIVE SUMMARY

The Special Commission on Foreign-Trained Medical Professionals was established by section 102 of chapter 41 of the acts of 2019 and charged with conducting a study and making recommendations regarding the licensing of internationally trained health professionals with the goal of expanding and improving medical services in rural and underserved areas. The Special Commission was further charged with reporting any recommended legislative changes back to the General Court by July 1, 2021. In light of the COVID-19 Public Health Emergency, the report deadline was extended to April 1, 2022 by section 29 of chapter 29 of the acts of 2021, then further extended to July 1, 2022 by section 14 of chapter 42 of the acts of 2022, to provide the commission additional time to convene and deliberate.

The commission met seven times between September 2021 and May 2022 and consisted of members of the legislature as well as representatives from the Executive Office of Health and Human Service, the Department Public Health, professional licensing boards, medical associations, and groups that advocate for immigrant populations.

The Special Commission recognized that the scope of the study was broad and varied, requiring the members to hear information about physicians, nurses, dentists and physician assistants, in addition to current law and licensing regulations. The commission was staffed by the Bureau of Health Professions Licensure, with presentations from commission members representing the Massachusetts Immigrant and Refugee Advocacy Coalition and the Welcome Back Center, and experts including Jeff Gross of World Education Services Global Talent Bridge and Dr. José Ramón Fernández-Peña, Director of Health Professions Advising at Northwestern University, the immediate past president of the American Public Health Association, and the founder of the Welcome Back Initiative.

Based on the commission's findings, the report outlines the following recommendations for administrative and legislative reforms:

Near Term Recommendations:

1. **Enhanced Online Resources *(Administrative)***
    - Recommends health profession boards revise and reorganize licensing information on websites to better inform internationally trained health professionals of licensing requirements and processes.

2. **Staff Training *(Administrative)***
    - Recommends health profession board staff receive culturally appropriate training to better support internationally trained health professionals.

Medium Term Recommendations:

1. **Licensing Guides *(Administrative)***
    - Recommends health profession boards develop easy-to-follow licensing guides to better inform internationally trained health professionals of licensing requirements and processes.

2. **Stakeholder Training *(Administrative)***
    - Recommends health profession boards develop ongoing professional development training and technical support for state agency staff and stakeholders on the licensing pathways and available career resources.

3. **English Proficiency Testing *(Administrative)***
    - Recommends eliminating redundant English proficiency testing and providing alternative testing and scoring options.

4. **Credential Evaluation Services *(Administrative)***
    - Recommends expanding accepted credential evaluation services for nurses beyond the Commission on Graduates of Foreign Nursing Schools (CGFNS) and allowing out-of-state licensure by endorsement without further credentialing.

5. **Residency Requirements for Licensure *(Legislative)***
    - Recommends re-establishing a minimum of two years of postgraduate training, rather than three, for full licensure eligibility of International Medical Graduates (IMG).

6. **Deadline for Completing USMLE *(Legislative)***
    - Recommends removing or increasing the seven-year time limit for completing all three steps of the USMLE.

Long Term Recommendations:

1. **Pathway to Full Licensure for Limited License Physicians *(Legislative)***
    - Recommends authorizing the Board of Registration in Medicine to develop a pathway to full licensure for physicians previously authorized to practice medicine outside the United States.
    - Recommended pathway would include one to two years of mentored limited licensure, followed by two to four years of geographically restricted licensure that is restricted to practice in an underserved region of the Commonwealth as a primary care physician, psychiatrist, or other shortage specialty, resulting in eligibility for a full, unrestricted license.

2. **Access to Residency for Physicians – State IMG Support Program *(Legislative)***
    - Recommends establishment of a state-supported program to facilitate access to residencies for IMGs, using the Minnesota IMG Assistance Program (IAP) as a model.

3. **Pathway to Full Licensure for Limited License Dentists *(Legislative)***
    - Recommends authorizing the Board of Registration in Dentistry to develop a pathway to full licensure for Limited License Dentists similar to the pathway recommended for IMGs.

4. **Programmatic Supports – Expanded Welcome Back Center *(Legislative)***
    - Recommends expanding the scope of the Boston Welcome Back Center at Bunker Hill Community College to support a wider range of internationally trained health professions, rather than only nurses, in obtaining a license to practice in the U.S.
    - Recommends state funding in addition to grant funding from academic and nonprofit partners to expand the center's focus and geographical reach.

5. **Financial Assistance – Revolving Loan Program *(Legislative)***
    - Recommends creating a revolving loan program for internationally trained health professionals that would provide interest-free loans to help defray the expenses that accompany the licensure process and related costs.

I. Introduction

Despite Massachusetts being recognized as a healthcare leader, the healthcare needs of many areas and populations of the Commonwealth are underserved. Massachusetts has the highest physician to population ratio in the country, yet serious gaps exist across the state in primary care, dental health, and mental health care, affecting hundreds of thousands of state residents. The United States Department of Health and Human Services has designated more than 130 communities in Massachusetts as Health Professional Shortage Areas (HPSAs).[1] Anticipated retirement of physicians and nurses in large numbers over the next several years could exacerbate this issue.

Recognizing that internationally trained health professionals represent a significant resource to address the state's health care provider shortages, now and in the future, the Special Commission on Foreign-Trained Medical Professionals was established by section 102 of chapter 41 of the acts of 2019 (the statute).

The statute named 22 members: the secretary of health and human services or a designee, to serve as chair; an appointee of the senate president; an appointee of the speaker of the house of representatives; an appointee of the minority leader of the senate; an appointee of the minority leader of the house of representatives; the chairs of the joint committee on public health or their designees; a member of the governor's advisory council for refugees and immigrants, a member of each of the boards of registration in medicine, dentistry, nursing, physician assistants, and allied health professionals; a representative of the Massachusetts Medical Society, the Massachusetts Health and Hospital Association, Inc., the Massachusetts League of Community Health Centers, Inc., the Conference of Boston Teaching Hospitals, Inc., the UMass Chan Medical School, the Boston Welcome Back Center at Bunker Hill Community College; and 3 representatives of the Massachusetts Immigrant and Refugee Advocacy Coalition, Inc., including an internationally trained medical professional and a licensed physician.

The statute charged the commission with conducting a study and making recommendations regarding the licensing of internationally trained health professionals with the goal of expanding and improving medical services in rural and underserved areas. Specifically, the commission was tasked with making recommendations on strategies to integrate internationally trained health professionals into rural and underserved areas in need of medical services; identifying state and national licensing regulations that may pose unnecessary barriers to practice for internationally trained health professionals, suggesting changes to the commonwealth's licensing requirements, and identifying opportunities to advocate for corresponding changes to national licensing requirements.

[1] *https://data.hrsa.gov/tools/shortage-area/hpsa-find*

Through informational meetings with invited experts, the commission reviewed and identified best practices learned from similar efforts in other states, identified areas of improvement and developed several recommendations, including pathways to full licensure for internationally trained health professionals willing to work in underserved communities as primary care practitioners, psychiatrists and dentists.

The Special Commission's report was to be filed with the clerks of the House of Representatives and the Senate no later than July 1, 2021. In light of the COVID-19 Public Health Emergency, the report deadline was extended to July 1, 2022. This report reflects the recommendations of the Special Commission.

II. Special Commission Charge

Section 102 of chapter 41 of the acts of 2019,
as amended by section 29 of chapter 29 of the acts of 2021 and
as further amended by section 14 of chapter 42 of the acts of 2022

(a) There shall be a special commission to study and make recommendations regarding the licensing of foreign-trained medical professionals with the goal of expanding and improving medical services in rural and underserved areas.

(b) The commission shall consist of the following members: the secretary of health and human services or a designee, who shall serve as chair; 1 person to be appointed by the senate president; 1 person to be appointed by the speaker of the house of representatives; 1 person to be appointed by the minority leader of the senate; 1 person to be appointed by the minority leader of the house of representatives; the chairs of the joint committee on public health, or their designees; and 15 members to be appointed by the governor, 1 of whom shall be a member of the governor's advisory council for refugees and immigrants, 1 of whom shall be a member of the board of registration in medicine, 1 of whom shall be a member of the board of registration in dentistry, 1 of whom shall be a member of the board of registration in nursing, 1 of whom shall be a member of the board of registration of physician assistants, 1 of whom shall be a member of the board of allied health professionals, 1 of whom shall be a representative of the Massachusetts Medical Society, 1 of whom shall be a representative of the Massachusetts Health and Hospital Association, Inc., 1 of whom shall be a representative of the Massachusetts League of Community Health Centers, Inc., 1 of whom shall be a representative of the Conference of Boston Teaching Hospitals, Inc., 1 of whom shall be a representative of the University of Massachusetts Medical School, 1 of whom shall be a representative of the Boston Welcome Back Center at Bunker Hill Community College; and 3 of whom shall be representatives of the Massachusetts Immigrant and Refugee Advocacy Coalition, Inc., of whom 1 shall be a foreign-trained medical professional and 1 shall be a licensed physician.

(c) The commission shall make recommendations on: (i) the strategies to integrate foreign-trained medical professionals into rural and underserved areas in need of medical services; (ii) state and national licensing regulations that may pose unnecessary barriers to practice for foreign-trained medical professionals; (iii) changes to the commonwealth's licensing requirements; (iv) opportunities to advocate for corresponding changes to national licensing requirements; and (v) any other matters pertaining to licensing foreign-trained medical professionals. The commission may hold hearings and invite testimony from experts and the public to gather information. The commission shall review and identify best practices learned from similar efforts in other states. The report may include guidelines for full licensure and conditional licensing of foreign-trained medical professionals.

(d) The commission shall submit a report containing its recommendations, including drafts of proposed legislation to carry out its recommendations, by filing the same with the clerks of the senate and house of representatives and the joint committee on public health not later than July 1, 2022.

III. Background Information

A. Health Professional Shortages in Rural and Underserved Communities in Massachusetts

1. Primary Care Physicians and Dentists

Nationwide and in Massachusetts, the demand for primary care physicians (PCPs) is growing. The American Association of Medical Colleges projects PCP demand to exceed supply by between 17,800 and 48,000 PCPs in the U.S. by 2034, driven by expansion of health insurance coverage and an aging population.[2] Other projections indicate that by 2030 the demand for PCPs in Massachusetts will grow by 12% (from 5,807 in 2010 to 6,532 in 2030).[3] A study by the U.S. Health Resources and Services Administration projected that physician supply in Massachusetts will also grow significantly, and by 2025 the Commonwealth will be the only U.S. state with a surplus.[4] Despite such trends, however, many Massachusetts residents will continue to face serious challenges in accessing primary care, due the scarcity of providers in underserved areas.

Even with the highest physician to population ratio in the country,[5] data on Health Professional Shortage Areas (HPSAs) point to serious gaps across the state in Primary Care, Dental Health, and Mental Health Care, affecting hundreds of thousands of state residents (see Table).[6]

County-wide data from 2018 indicate that Bristol, Plymouth, Hampden, and Franklin counties have patient:physician ratios respectively of 1890:1, 1590:1, 1490:1 and 1480:1, compared to Middlesex, Norfolk and Suffolk counties, where the ratios are respectively 790:1, 790:1 and 670:1.[7] A 2016 report from the Massachusetts Healthcare Workforce Center (MHWC) showed that some 37.9% of physicians in Massachusetts were practicing in Suffolk County, which contains just 11.4% of the state's population.[8] Same report indicated counties in Western and

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[2] American Association of Medical Colleges (AAMC), *The Complexities of Physician Supply and Demand: Projections From 2019 to 2034* (June 2021) https://www.aamc.org/media/54681/download?attachment

[3] Robert Graham Center, *Massachusetts: Projecting Primary Care Physician Workforce* (2013) https://www.graham-center.org/content/dam/rgc/documents/maps-data-tools/state-collections/workforce-projections/Massachusetts.pdf

[4] U.S. Health Resources and Services Administration, *State-Level Projections of Supply and Demand for Primary Care Practitioners: 2013-2025* (2016), https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/primary-care-state-projections2013-2025.pdf

[5] AAMC, Massachusetts Physician Workforce Profile (2019), https://www.aamc.org/media/37941/download

[6] Health Resources and Services Administration (HRSA) Bureau of Health Workforce, *Designated Health Professional Shortage Areas Statistics. Fourth Quarter of Fiscal Year 2021 Designated HPSA Quarterly Summary As of September 30, 2021* https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport

[7] *County Health Care Rankings & Roadmaps, 2021*, Health Factors: Primary Care Physicians https://www.countyhealthrankings.org/app/massachusetts/2021/measure/factors/4/map. 2018 physician supply data based on Area Health Resource File maintained by Health Resources and Services Administration, Bureau of Health Professions, and American Medical Association's Physician Masterfile.

[8] Massachusetts Health Care Workforce Center, *Data Brief: Health Professions Data Series – Physicians 2014* (2016) https://www.mass.gov/doc/the-massachusetts-health-professions-data-series-physicians-0/download.

Southeastern Massachusetts have lowest concentration of physician practices in state relative to population, including Franklin (0.5% of physicians vs. 1% of the state population), Hampshire (1.4% vs. 2.3%), Barnstable (2.2% vs. 3%), and Plymouth (3.3% vs. 7.5%) counties.[9]

Table: Massachusetts Health Professional Shortage Areas by Profession

Health Profession	Total Designations*	Populations of Designated HPSAs*	Percent of Need Met
Primary Care	65	514,225	38.36%
Dental Health	59	325,211	76.13%
Mental Health Care	56	273,105	32.21%

*HPSA designations may be geographic (a county or service area), population (e.g., low income or Medicaid eligible), or facilities (e.g., a federally qualified health center or a state or federal prison).

Source: Health Resources and Services Administration, Bureau of Health Workforce

The 2016 report also indicated that, compared to Greater Boston, a larger number of municipalities in Western and Central MA and in Northeast and Southeast Massachusetts have few or no PCPs, in some cases with none in adjoining towns/cities.[10] Lower pay, limited opportunities for professional advancement and poor working conditions account in large part for these shortages of providers in HPSAs.[11] Overall, only 20% of physicians in Massachusetts, according to the report, are PCPs and just 6.3% of physicians work in community health centers, which primarily serve underserved populations.[12]

As with PCPs, many towns and cities in Western and Central Massachusetts and in Northeast and Southeast Massachusetts have very limited access to dentists, with 65 municipalities having no dentists at all, in numerous cases with none in adjoining towns/cities, according to a 2016 study from the MHWC.[13] County-wide data from 2019 indicate that in Franklin, Bristol, Plymouth, Hampshire and Worcester counties the ratios of patients:dentists are respectively 1490:1, 1460:1, 1360:1, 1360:1 and 1290:1, compared to Suffolk, Norfolk and Middlesex, where

[9] Population data from UMass Donahue Institute, *Massachusetts Population Estimates by County* (2020) https://donahue.umass.edu/business-groups/economic-public-policy-research/massachusetts-population-estimates-program/population-estimates-by-massachusetts-geography/by-county.
[10] *Massachusetts Health Care Workforce Center, Data Brief: Health Professions Data Series – Physicians 2014* (2016) https://www.mass.gov/doc/the-massachusetts-health-professions-data-series-physicians-0/download
[11] Julie K. Silver et al., Physician Workforce Disparities and Patient Care: A Narrative Review. *Health Equity*. 2019; 3(1): 360–377. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6626972.
[12] *Massachusetts Health Care Workforce Center, Data Brief: Health Professions Data Series – Physicians 2014, op. cit.*
[13] *Massachusetts Health Care Workforce Center, Data Brief: Health Professions Data Series – Dentists 2014* (2016) https://www.mass.gov/doc/the-massachusetts-health-professions-data-series-dentists-2014/download

the ratios are respectively 450:1, 790:1, and 980:1.[14] The 2016 MHWC study also indicated that only 2.6% of dentists in Massachusetts practiced in a community health center setting, where the vast majority of patients with MassHealth receive services.[15] Only 55.1% of the 668,111 individuals under the age of 21 enrolled in MassHealth in 2015 received any dental or oral health services, meaning nearly 300,000 received no oral health care during this time-period.[16]

As other states experience the same shortages, it is expected that healthcare facilities in the Commonwealth will engage in high-cost bidding wars for qualified physicians.

2. Registered Nurses and Licensed Practical Nurses

A recent study points to pandemic-driven shortages of clinical care nurses, due to interrupted exams and clinical placements of new nurses and the accelerating attrition and retirements of Registered Nurses (RNs) of all ages, posing concerns for the long-term RN pipeline.[17] An older study from 2017 predicted that while the supply of RNs in Massachusetts would exceed demand by 2030, the supply of Licensed Practical Nurses (LPNs) in the state will be significantly *below* demand by 2030, due to rising institutional and home health care needs of an aging population.[18] As with RNs, the pandemic has created areas of uncertainty and new challenges with regard to the LPN pipeline.

As with physicians and dentists, data indicate acute shortages of RNs in towns and cities in Western and Central Massachusetts, with many towns having no RNs.[19] Many more locales statewide have only very few RNs relative to population (less than 2.5 per 1,000). Such shortages reflect the smaller presence in these areas of the community hospitals, academic medical centers, and hospital-based ambulatory care centers where most RNs practice, leading these healthcare facilities to rely on hiring "travelers" at great expense to meet staffing needs. Only 2.3% of RNs

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[14] *County Health Care Rankings & Roadmaps, 2021*, Health Factors: Dentists https://www.countyhealthrankings.org/app/massachusetts/2021/measure/factors/88/map. 2019 dentist supply data are based on the Area Health Resource File maintained by Health Resources and Services Administration, Bureau of Health Professions, and the National Provider Identification file maintained by the Centers for Medicare & Medicaid Services.

[15] Only 44.3% of dentists working in group practice and 39.4% in solo practice reported treating patients with MassHealth, compared to 97.5% in community health centers. *Ibid.*

[16] *Ibid.* A more recent analysis of data from Berkshire county indicates that 40% of the county's 25,000 MassHealth recipients have no dentist. See Francesca Paris, "More than a third of Berkshire Medicaid enrollees don't have a dentist. CHP wants to change that," *Berkshire Eagle* (2/5/22) https://www.berkshireeagle.com/news/local/community-health-programs-expands-dental-offerings-in-berkshire-county/article_169cbe00-85bb-11ec-b805-b372ea9dd981.html

[17] Harvard Project on the Workforce, *COVID-19 and the Changing Massachusetts Health Care Workforce* (September 30, 2021) https://www.pw.hks.harvard.edu/post/ma-healthcare-workforce

[18] U.S. Health Resources and Services Administration, *Supply and Demand Projections of the Nursing Workforce: 2014-2030* (July 21, 2017) https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/nchwa-hrsa-nursing-report.pdf

[19] Massachusetts Health Care Workforce Center, *Data Brief: Health Professions Data Series – Registered Nurses 2014* (2016) https://www.mass.gov/doc/the-massachusetts-health-professions-data-series-registered-nurses-2014/download

practice in community health centers that serve primarily low income and other underserved populations. As with RNs, data indicate the most acute shortages of LPNs are in towns and cities in Western and Central Massachusetts; many more locales statewide have only a very small share of LPNs relative to their populations (less than 1 per 1000).[20] Unlike RNs, the majority of LPNs work in skilled nursing, home health, chronic care, or physician office settings.

B. Underemployment of Internationally Trained Health Professionals in U.S. and Massachusetts

Internationally trained health professionals represent a significant potential resource to help address the state's health care provider shortages, now and in the future. More than 600,000 internationally trained health professionals, including physicians, dentists, nurses, allied health professionals, and pharmacists, live in the U.S.,[21] and immigrants represent a large share of the health care workforce.[22] In Massachusetts, immigrants make up 19.2% of health care practitioners and those in technical occupations (i.e., physicians, dentists, allied health professionals, RNs and health care technologists and technicians), including 33.8% of physicians.

Despite high representation in the health care workforce, however, internationally trained health professionals in the U.S. face many barriers to licensure and career advancement (see below, Section IV, for details). Data indicate that 22% of internationally trained immigrant physicians and 17.6% of internationally trained immigrant RNs in the U.S. are underemployed (i.e., either unemployed, employed part time, or out of the labor force), and 14.7% and 14.6% respectively are working in jobs outside their field of training if not outside of health care altogether. This compares to 4.6% of U.S. trained immigrant physicians and 18.1% of U.S. trained immigrant RNs who are underemployed, and 6.7% and 25.3% respectively working in another field.[23]

Internationally educated health professionals in Massachusetts face similar challenges. Almost a quarter (24%) of all internationally educated nurses in the state are either working in low-skilled

[20] Massachusetts Health Care Workforce Center, *Data Brief: Health Professions Data Series – Licensed Practical Nurse 2015* (2018) https://www.mass.gov/doc/the-massachusetts-health-professions-data-series-licensed-practical-nurses-2015/download

[21] Governor's Advisory Council for Refugees and Immigrants (GACRI), *Rx for Strengthening Massachusetts' Economy and Healthcare System* (2014, based on analysis of data from the 2013 National Survey of College Graduates) https://www.immigrationresearch.org/system/files/gac_task_force_report-final-12.18.14.compressed.pdf

[22] Migration Policy Institute (MPI), *Immigrant Healthcare Workers in the United States* (2020, based on MPI analysis of 2018 American Community Survey data) https://www.migrationpolicy.org/article/immigrant-health-care-workers-united-states-2018

[23] Advisory Council for Refugees and Immigrants (GACRI), *Rx for Strengthening Massachusetts' Economy and Healthcare System* (2014, based on analysis of data from the 2013 National Survey of College Graduates) https://www.immigrationresearch.org/system/files/gac_task_force_report-final-12.18.14.compressed.pdf

jobs or unemployed, compared to just 6% of U.S.-educated immigrant nurses.[24] Some 13% of all immigrants in Massachusetts with health-related undergraduate degrees from outside the U.S. are either unemployed or working in lower paying, less-skilled jobs, compared to 9% of immigrants with U.S. health degrees. Of these, 45% have a nursing degree, 10% have a pharmacy degree, 8% have a treatment therapy degree,[25] and 5% have a medical technology technician degree.[26]

[24] Migration Policy Institute, *Brain Waste in the Massachusetts Workforce* (2014, based on analysis of 2010-2012 American Community Survey data) https://www.migrationpolicy.org/sites/default/files/publications/MPI_BrainWaste_MA-FINAL.pdf

[25] Treatment Therapies include physical and occupational therapy and related occupations.

[26] Migration Policy Institute, *As U.S. Health-Care System Buckles under Pandemic, Immigrant & Refugee Professionals Could Represent a Critical Resource* (April 2020, based on analysis of 2017 American Community Survey data) https://www.migrationpolicy.org/news/us-health-care-system-coronavirus-immigrant-professionals-untapped-resource

IV. Barriers to Licensure

Many studies have explored the barriers facing internationally trained health professionals in obtaining licensure and restarting their careers in the U.S.[27] Among the most common "intrinsic" challenges – those that are particular to the situation of internationally trained professionals themselves – are limited English proficiency, a lack of familiarity with the U.S. healthcare system and professional licensing requirements, the paralysis that often comes with the immigrant's loss of professional identity, a lack of U.S.-based professional networks, and the time and financial constraints of having to work "survival" jobs and meet family obligations.

Other more "extrinsic" or structural obstacles facing internationally trained professionals are the complexity and state-by-state variation of licensing requirements; arbitrary and sometimes discriminatory regulations, including required non-clinical coursework, time limits to complete testing, and rigid English proficiency standards; unclear and inconsistent messages from licensing boards, workforce bodies, and higher education institutions on the relicensing process; lack of financial assistance to cover licensing, testing and other fees; and a lack of dedicated support from boards, workforce and adult education bodies, and higher education systems to help internationally trained health professionals navigate these and other barriers.

For each profession and in each state there are a unique set of regulatory, institutional and logistical hurdles that internationally trained professionals must overcome to be relicensed in the U.S. Below we explore the challenges facing physicians, dentists, and nurses, though similar obstacles face internationally trained practitioners in other health professions as well.

A. Internationally Trained Physicians in Massachusetts

1. Must Repeat Residency and Longer Time to Licensure Eligibility

As in most other states, international medical graduates (IMGs) in Massachusetts – even those with years of practice experience outside the U.S. – must complete post-graduate medical training residency in the U.S. to qualify for licensure. A long-standing national cap on residency slots, the complicated application process, the lack of expected U.S. clinical experience, and residency program policies that typically consider only recent medical school graduates (within the prior 3-5 years) all put IMGs at a disadvantage in the residency match process.[28]

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[27] See e.g., Batalova, Fix and Bachmeier, *Untapped Talent: The Costs of Brain Waste among Highly Skilled Immigrants in the United States*, Migration Policy Institute (2016) https://www.migrationpolicy.org/sites/default/files/publications/BrainWaste-FULLREPORT-FINAL.pdf; and Governor's Advisory Council for Refugees and Immigrants (GACRI), *Rx for Strengthening Massachusetts' Economy and Healthcare System* (2014) https://www.immigrationresearch.org/system/files/gac_task_force_report-final-12.18.14.compressed.pdf

[28] In 2021 U.S. citizen IMGs matched at a rate of 54.8% vs. 92.8% for US medical graduates. See National Resident Matching Program, *Results and Data: 2021 Main Residency Match* (2021) https://mk0nrmp3oyqui6wqfm.kinstacdn.com/wp-content/uploads/2021/05/MRM-Results_and-Data_2021.pdf

Additionally, in Massachusetts, IMGs must currently complete three years of postgraduate training before they are eligible to apply for full licensure, while U.S. medical graduates must complete only two. This requirement means that IMGs cannot earn income through outside employment during residency. In addition, IMGs cannot obtain full licensure until well after they have completed residency, as the process typically takes three months. As most physicians completing postgraduate training cannot forgo an income for this length of time and most employers want applicants to start work as soon as possible after finishing residency, IMGs completing residency in Massachusetts often need to take jobs outside of the Commonwealth. This means that the state loses qualified physicians who could provide care in primary care and psychiatry, among other needed specialties.

2. Time Limit for Completing USMLE Exams

Massachusetts also requires applicants for licensure to complete the United States Medical Licensing Examination (USMLE) Steps 1, 2 CK,[29] and 3 within seven years, beginning when an examinee first passes either Step 1 or Step 2 CK.[30] When compared with the 10 years many other states provide, this shortened period can represent a significant obstacle for IMGs, who may require multiple attempts over a number of years to match into a residency after completing Steps 1 or 2 CK, given the challenges they face in the match process.

B. Internationally Trained Nurses in Massachusetts

1. English Proficiency Testing

In Massachusetts, graduates of international nursing programs not conducted in English must pass an English proficiency test in Massachusetts before taking the NCLEX exams required for licensure. Massachusetts accepts four tests, most with an academic orientation: The Test of English as a Foreign Language/TOEFL iBT, the International English Language Testing System/IELTS Academic, the Pearson Test of English/PTE Academic, and the Canadian English Language Benchmark Assessment for Nurses (CELBAN). Test results are also scored on a rigid scale, e.g., for the IELTS Academic the state requires a score of 6.5 overall out of 9, with no individual scores less than 6. For the TOEFL iBT the state requires a total score of 84 out of 120, with 26 of 30 for speaking.[31]

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[29] USMLE Step 2 has two components: clinical knowledge (2 CK) and clinical skills (2 CS). Step 2 CS is meant to demonstrate competence with live patients. Only Step 2 CK is applicable to this analysis.

[30] The USMLE is a three-step examination for medical licensure in the U.S. Step 1, which focuses on the basic science of medical practice, and Step 2, which tests clinical knowledge and skills, are typically completed by U.S. medical graduates during medical school. Step 3, which emphasizes patient management in ambulatory settings, is typically completed at the end of the intern year of residency and allows a physician a license to practice medicine without supervision. See United States Medical Licensing Examination, Step Exams https://www.usmle.org/step-exams

[31] Commonwealth of Massachusetts, Board of Registration in Nursing, *Board-designated Tests of English Proficiency and Required Minimum Cut Scores* https://www.mass.gov/doc/english-proficiency-exams/download

2. Credential Evaluation

Many states use a variety of services to evaluate the credentials of internationally trained candidates for nurse licensure before they are eligible to take the NCLEX. Massachusetts only accepts credential evaluations from CGFNS.[32] Based on the experience of the Boston Welcome Back Center for Internationally Trained Nurses at Bunker Hill Community College,[33] which assists internationally trained nurses in obtaining licensure in Massachusetts, CGFNS can take up to a year to complete credential review, not the 12 weeks mentioned on the CGFNS website.[34] This can significantly delay internationally trained nurses in registering for the NCLEX and applying for licensure by endorsement.

3. Licensure of Internationally Trained Nurses by Endorsement/Reciprocity

Like many states, Massachusetts allows nurses already licensed in another state to be relicensed in the Commonwealth if they have graduated from a board-approved program and passed the NCLEX.[35] However, Massachusetts requires internationally trained nurses licensed in another state to obtain a new CGFNS credential review, even if their credentials have already been evaluated by CGFNS, unless the Board can access the evaluation report. The nurse must also complete an English proficiency test, even if they have tested successfully in another state and been resident and working in that locale.

4. Lack of state support for the Welcome Back Center

The Boston Welcome Back Center at Bunker Hill Community College (BHCC) provides training, coaching, and case management services to internationally trained nurses seeking to attain licensure in Massachusetts. Founded in 2005 with state funding, the Center currently only receives financial support from BHCC,[36] limiting its ability to scale up services and/or operate in other areas of the state.

C. Internationally Trained Dentists in Massachusetts

To be eligible for an unrestricted license, Massachusetts requires candidates to have graduated from a school of dentistry accredited by the American Dental Association's Commission on Dental Accreditation (CODA), which only recognizes U.S. and Canadian dental schools. Individuals with an international degree from an institution not accredited by CODA may be eligible for licensure after completing a U.S. advanced standing dental education program. [37]

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[32] Commonwealth of Massachusetts, Board of Registration in Nursing, Information for nurses educated outside of the United States https://www.mass.gov/service-details/information-for-nurses-educated-outside-of-the-united-states
[33] Bunker Hill Community College, Boston Welcome Back Center https://www.bhcc.edu/welcomeback
[34] CGFNS International, FAQ, https://www.cgfns.org/faq
[35] Commonwealth of Massachusetts, Department of Public Health, Check eligibility for a nursing license by reciprocity https://www.mass.gov/service-details/check-eligibility-for-a-nursing-license-by-reciprocity
[36] Allison Cohn, Educational Case Manager, Boston Welcome Back Center, personal communication
[37] Title 234 CMR 4.00 Board of Registration in Dentistry, Licensure and license renewal applications https://casetext.com/regulation/code-of-massachusetts-regulations/department-234-cmr-board-of-registration-in-

Advanced standing DMD programs for graduates of international dentistry programs are offered at Tufts (2.5 years) and Boston University (2 year) dentistry schools. While Massachusetts offers a one-year, renewable limited practice license that allows internationally trained dentists to practice under the supervision of a fully licensed dentist, there is no pathway to unrestricted licensure in Massachusetts for internationally trained dentists that does not go through a time-consuming and costly U.S. advanced standing degree program. This is not the case in many other states.[38]

dentistry/title-234-cmr-400-licensure-and-license-renewal-applications; American Dental Association, Licensure for International Dentists https://www.ada.org/resources/licensure/licensure-for-the-international-dentists

[38] For example, Wisconsin allows internationally trained dentists to qualify for a license through endorsement, and Ohio and Texas allow internationally trained dentists to obtain licensure by completing a CODA accredited specialty training dental program that is at least two years in length.

V. Special Commission Recommendations

The recommendations below reflect testimony provided to the commission at the October 20, 2021 and December 10, 2021 meetings, and the Massachusetts Immigrant and Refugee Advocacy Coalition's review of relevant policy documents from World Education Services and the Nurse-Physician Advisory Task Force for Colorado Healthcare.[39]

Recommendations are divided into Near Term, Medium Term, and Long Term, based on the level of staff involvement, specialized expertise, program funding, and structural/policy change (legislative or regulatory) required to institute and implement them. Each recommendation includes a designation of "administrative" or "legislative" to indicate which branch of government would be responsible for implementation of each recommendation.

A. Near Term Recommendations

1. Enhanced Online Resources (Administrative)

Executive Agencies responsible for the web pages of each health profession licensure board should provide a dedicated, easily discoverable page with a clear and easily navigable overview of the licensing process for internationally trained professionals, with links to evaluation and testing sites and other relevant internal or third-party sites, as appropriate.[40]

Under the oversight of the Division of Occupational Licensure, within the Office of Consumer Affairs under the executive office of Housing and Community Development, the Bureau of Health Professions Licensure, and the Board of Registration in Medicine, there should be coordination across web pages for different professions to allow health professionals to navigate options for alternative careers.[41]

2. Staff Training (Administrative)

Administrative office staff who support internationally trained health professionals through the licensure process should receive culturally competent training on how to provide those services.

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[39] World Education Services, "Opening Pathways to Practice for Internationally Trained Physicians: State Policy Options" (October 8, 2021) https://knowledge.wes.org/rs/317-CTM-316/images/IMG-Policy-Summary_2021.pdf; Nurse-Physician Advisory Task Force for Colorado Healthcare, "Licensure Recommendations Regarding International Medical Graduates" (August 6, 2021) https://drive.google.com/file/d/1rUqKQLwtYIlmWzL3r22wDMillR7ZTxap/view

[40] See, e.g., the Washington DC Board of Nursing's guidance for internationally trained nurses https://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/Instructions%20International%20Nurses.pdf.

[41] Michigan Department of Licensing and Regulatory Affairs, Resources for Skilled Immigrants https://www.michigan.gov/lara/0,4601,7-154-10573_68301---,00.html

B. *Medium Term Recommendations*

These recommendations involve straightforward regulatory or procedural changes at the discretion of boards, and/or moderate investment in staff time, technical expertise, and external partnerships.

1. Licensing Guides (Administrative)

Detailed licensing/career pathway guides should be developed and provided to internationally trained health professionals to help them understand state licensing requirements, options, costs, and timeline. Models for such guides are available in several other states[42] and can be developed with support from immigrant-serving organizations, workforce development partners, or academic institutions.

2. Stakeholder Training (Administrative)

Provide ongoing professional development training and technical support for state agency staff, health care employers, and immigrant-serving organizations on the licensing pathways and available career resources for internationally trained health professionals.

3. English Proficiency Testing (Administrative)

Test options: Allow for other testing products from providers currently in use, including the IELTS General Training test (which Massachusetts used to offer) or the TOEFL Essentials test, which better assess real-life English competency in reading, writing, listening, and speaking than the academically-oriented tests in current use. The TOEFL Essentials test allows a more affordable and accessible option than presently available. Allow test products from additional providers, including the Michigan English Test (MET) and the Occupational English Test (OET), in use for nurse licensure in other states and Canada.

Scoring strategies: Use "superscoring" strategies that look at an applicant's best scores in each category over a given time frame rather than on just one test (e.g., the TOEFL "My Best Score" option, which looks at best scores in each category over the previous two years).

Redundancy: Allow nurses, who have already passed an English proficiency test for licensure in another state, to apply for licensure in Massachusetts without re-testing English proficiency.

[42] Examples include: for nurses, Maryland https://www.lhiinfo.org/wp-content/uploads/2020/06/Guide-to-Obtain-the-Maryland-Registered-Nurse-RN-License.pdf and Michigan https://www.michigan.gov/documents/lara/2019-career-pathway-RN_667702_7.pdf; for physicians, California https://www.upwardlyglobal.org/california-physician-professional-licensing-guide-updated and Idaho https://glotalent.org/wp-content/uploads/2019/01/Idaho-Medical-Doctor-MD-Licensing-Guide.pdf.

4. Credential Evaluation Services (Administrative)

Expanded service options: To avoid delays in processing and offer flexibility to applicants for licensure, expand accepted credential evaluation services beyond CGFNS, to potentially include Educational Records Evaluation Service (ERES), the International Education Research Foundation (IERF), and Josef Silny & Associates, Inc. All these organizations are members of the National Association of Credential Evaluation Services (NACES) and/or the Association of International Credential Evaluators (AICE).

Redundancy: Allow internationally trained nurses, who are already licensed in another state, to apply for licensure by endorsement in Massachusetts without completing a new credential evaluation.

5. Residency Requirements for Licensure (Legislative)

Require the same minimum number of years (2) of postgraduate training in an ACGME or Canadian accredited program for U.S. medical graduates and IMGs to be eligible to apply for full licensure (as Massachusetts did until 2014), rather than requiring three years for IMGs.

6. Deadline for Completing USMLE (Legislative)

Remove the seven-year time limit for completing all three steps of the USMLE (12 states including California, Florida, Hawaii, Maryland, New York, Pennsylvania have no time limit and 10 states including Indiana, Kansas, Ohio, Virginia, and Wisconsin have a 10 year time limit). Alternatively, consider providing seven years from licensure, rather than from completion of USMLE Step 1, for an IMG to complete all three steps of the USMLE.

C. Long Term Recommendations

These recommendations involve legislation and/or more complex regulatory changes, as well as program development requiring state funding and external partnerships with academic institutions, community-based organizations, or employers.

1. Pathway to Full Licensure for Limited License Physicians (Legislative)

Empower the Board of Registration in Medicine to offer a limited license to an internationally trained physician ("pathway physician") who has been previously licensed or otherwise authorized to practice outside the U.S., has passed USMLE Step 1 and Step 2 CK, and has satisfied other criteria including submitting evidence of Educational Commission for Foreign Medical Graduates (ECFMG) certification. The renewable one-year limited license would allow the pathway physician to practice in a participating health care facility in order to gain familiarity with non-clinical skills and standards appropriate for a Massachusetts medical practice environment, and lead to issuance of a full, unrestricted license after an additional two years of restricted practice in a designated shortage area or specialty.

A candidate physician for this pathway would apply to a federally qualified health center, community health center, hospital or other Board-approved healthcare facility to participate in a mentorship program specifically designed to develop, assess, and evaluate the pathway physician's non-clinical skills, using criteria developed or approved by the Board. Acceptance into the program would be predicated on the Board's grant of a renewable, one-year limited license to practice, for which the facility would apply on the pathway physician's behalf. The limited license would allow the pathway physician to practice only within the program as a full-time employee of the facility. Allowing the facility and/or preceptor to bill for the pathway physician's professional services is a critical, if aspirational, component to this pathway.

After successful completion of the limited licensure program, together with passage of USMLE Step 3 and other prerequisites for licensure as determined by the Board, the pathway physician would be eligible to apply for a restricted license contingent upon committing to at least two years of restricted practice as a primary care physician, psychiatrist or other shortage specialty profession in the same geographic area or another area approved by the Board. This restricted license would be renewable for up to four years. After at least two years of practice under the restricted license, the pathway physician would be eligible for a full, unrestricted license to practice medicine in the specialty and geographic area of their choice.

Both the limited license and the restricted license would allow the pathway physician to practice to the full extent of their scope of practice, but only in a participating facility that serves an underserved population and only in a shortage specialty. Allowing the participating facilities to bill for the pathway physician's professional services in each case is a critical, if aspirational,

component to this pathway. Further input from federal, state and private payers will be necessary to explore recommendations regarding billing practices.

This pathway has similarities to the Canadian Practice Ready Assessment (PRA) model,[43] which operates under a national collaboration in seven provinces. The PRA, however, requires clinical field assessment over just twelve weeks, followed by a period of service in a rural area of the province where the assessment was completed. Unlike IMG pathways in Missouri[44] and Washington State,[45] the commission's recommendation would make Massachusetts the first in the nation for creating a full licensure pathway for internationally trained physicians previously licensed or authorized to practice medicine outside the U.S.

2. Access to Residency for Physicians – State IMG Support Program (Legislative)

We propose state-supported programming to facilitate access to residencies for IMGs, using the Minnesota IMG Assistance Program (IAP)[46] as a model.

Minnesota's state-funded IAP initiative, created by legislation in 2015, facilitates IMG pathways to residency to increase primary care access in rural or under-resourced communities. The program funds 2-3 residency slots in Minnesota yearly and works to place additional residents in partner institutions.

IAP's Career Guidance and Support Program provides grants to non-profit partners to provide career assistance to IMGs in entering residencies. The IAP's IMG Clinical Preparation Grant Program supports programs offering clinical preparation for Minnesota IMGs who agree to practice in underserved areas. IAP's IMG Residency Preparation Program, entitled Bridge to Residency for Immigrant International Doctor Graduates (BRIIDGE),[47] in partnership with the University of Minnesota, offers a nine-month intensive clinical preparation course, helping address residency programs' concerns with recency of graduation from medical school.[48]

[43] Medical Council of Canada, National Assessment Collaboration, Practice Ready Assessment https://mcc.ca/assessments/practice-ready-assessment
[44] Mo. Rev. Stat. § 334.036, https://revisor.mo.gov/main/OneSection.aspx?section=334.036
[45] Revised Code of Washington (RCW) 18.71.095 https://app.leg.wa.gov/RCW/default.aspx?cite=18.71.095
[46] Minnesota International Medical Graduates Assistance Program, https://www.health.state.mn.us/facilities/ruralhealth/img/index.html
[47] *https://med.umn.edu/dom/education/global-medicine/courses-certificates/briidge*
[48] Washington state has also created a grant award process (subject to appropriation) to fund entities offering career guidance and support services to help IMGs meet licensing requirements. Grants can also be awarded to health care facilities or clinical programs that provide supervised clinical training to IMGs. See International medical graduates—Grant funding https://app.leg.wa.gov/RCW/default.aspx?cite=18.71.475

3. Pathway to Full Licensure for Limited License Dentists (Legislative)

Currently the only pathway to full licensure in Massachusetts available to internationally trained dentists is through a costly 2-2.5 year advanced practice dentist graduate program. We propose a pathway that leverages the state's existing limited practice dental license, combined with a one-year period of practice and professional assessment in an underserved area followed by a commitment to practice in an underserved area for a period of 2 years, similar to the Physician Pathway license discussed above.[49]

Massachusetts currently offers a limited practice/intern license that allows internationally trained dentists to practice in a specified location under the supervision of a fully licensed dentist.[50] Applicants must provide suitable documentation of a degree in dentistry as well as meeting other practice and documentation requirements; if the applicant's program was not conducted in English, the applicant must also earn a satisfactory score on a board approved English exam. Limited practice licenses are valid for one year and may be renewed annually.

Similar to the physician pathway process above, we propose that a limited practice dentist could qualify for a full license after at least one year of practice as a limited practice dentist in an underserved area of the state, an assessment of qualifications by a participating facility approved by the Board, and after passage of Parts I and II of the ADA National Board Examination and fulfillment of all other requirements for licensure by examination, except completion of a CODA-approved dental school.[51] This would be followed by two years of practice in the same geographic area or another area approved by the Board.

Alternatively, the Board may adopt programs developed in other states that allow licensing of internationally trained dentists without completing two years of advance standing program at a CODA accredited dental school to receive a DDS or DMD degree. Wisconsin allows qualification by endorsement upon evidence of graduation from a foreign dental school and successful completion of an accredited postgraduate program.[52] Whereas, states such as Ohio and Texas allow internationally trained dentists to obtain a state dental license by completing a two-year CODA accredited specialty training dental program.[53]

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[49] Only two states, Maine https://www.mainelegislature.org/legis/bills/display_ps.asp?paper=HP1231&snum=130&PID=0 and Utah https://le.utah.gov/~2015/bills/static/SB0092.html, currently authorize boards of registration in dentistry to offer full licensure by endorsement to internationally trained dentists who the boards determine have met the equivalent of those states' licensing requirements and meet certain practice criteria.

[50] 234 CMR 4.05, Initial Licensure as Limited License Full-time Faculty or Limited License Dental Intern https://www.mass.gov/doc/234-cmr-4-licensure-and-license-renewal-requirements

[51] 234 CMR 4.03, Initial Dentist Licensure by Examination https://www.mass.gov/doc/234-cmr-4-licensure-and-license-renewal-requirements/download

[52] residency.https://docs.legis.wisconsin.gov/code/misc/chr/lrb_filed/cr_09_007_final_rule_filed_with_lrb

[53] https://dental.ohio.gov/Licensure/Dentist#55637--initial-dental-licensure-for-graduates-of-an-unaccredited-dental-college-outside-the-united-states-application

4. Programmatic Supports – Expanded Welcome Back Center (Legislative)

Expand the scope of the Boston Welcome Back Center at Bunker Hill Community College,[54] which provides orientation, counseling, and case management support to internationally trained nurses in obtaining a license to practice in the U.S., to include support for other internationally trained health professionals.

With state support and grant funding for academic and nonprofit partners, and following the model of WBCs in other states, expand the Center's focus to serve a wider range of health professions, including physicians, dentists, physical therapists, and mental health professionals.

With state seed funding and local institutional and philanthropic support, a WBC could also be launched in Central, Western and other underserved areas of Massachusetts, to help place internationally trained practitioners where the need for health professionals is greatest.

5. Financial Assistance – Revolving Loan Program (Legislative)

The expenses that accompany the licensure process – including the costs of supplemental coursework, test preparation classes, and exam and licensing fees – can be a steep barrier to career advancement for under-employed internationally trained professionals. Building on models in Maine,[55] Kentucky,[56] and Canada,[57] we propose creating a revolving loan program for internationally trained health professionals that would provide interest-free loans to help defray these and related costs. The program would be administered at the state agency level or through a public-private partnership and funded through a combination of state support and corporate and philanthropic contributions.

[54] Boston Welcome Back Center https://www.bhcc.edu/welcomeback
[55] LD 1533, An Act To Amend the Foreign Credentialing and Skills Recognition Revolving Loan Program https://www.mainelegislature.org/legis/bills/display_ps.asp?PID=1456&snum=130&paper=&paperld=l&ld=1533
[56] Louisville Housing Opportunities and Micro-Enterprise (LHOME) Community Development Loan Fund, Inc., JobUp! Loans https://www.lhomeky.org/loans
[57] Windmill Microlending https://windmillmicrolending.org

ACKNOWLEDGEMENTS

I consider it a great honor to have been designated by Marylou Sudders, Secretary of Health and Human Services, to chair this Special Commission. As chair, I thank each appointed member for offering their time, commitment, and expertise, all of whom were integral to the work of the Special Commission and the creation of this final report. My gratitude goes to Jeff Gross, PhD for his presentation to the Special Commission with Amy Grunder, Esq. and Dr. Robert P. Marlin, on Access to Medical Professionals for the Commonwealth's Underserved Populations and Practice Barriers for Foreign-Trained Medical Professionals; Dr. José Ramón Fernández-Peña, for his presentation with Allison Cohn on Barriers to Practice for Foreign-Trained Medical Professionals in Massachusetts: Policy and Program Solutions; and Michael Zimmer for his essential drafting support. Finally, I thank my staff, including Lauren Nelson, Heather Engman, Edmond Taglieri, Joanna Chow, Kelly Poirier, Casey Hall and Elaine Jackson for their diligent work supporting the mission of this Special Commission and for their efforts in marshaling the information and feedback that helped to inform this final report.

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Department of Public Health

APPENDIX

Note: For purposes of proposed statutes as amended, proposed changes are tracked by showing proposed new text in **blue bold**, and proposed deletions are in ~~red strikethrough~~.

A. Limited Registration of Physicians; Pathway to Full Licensure

Proposed legislative language:

SECTION XX. Chapter 112 of the General Laws is hereby amended by inserting in section 9, at the end thereof, the following:-

The board shall promulgate rules and regulations to provide a pathway to full licensure for internationally trained physicians previously licensed or otherwise authorized to practice outside the United States and maintaining limited registration under this section or Board guidance for a period prescribed by the board.

Proposed statute as amended:

M.G.L. c. 112, § 9. Limited registration; fees; qualifications; revocation

An applicant for limited registration under this section may, upon payment of a fee to be determined annually by the commissioner of administration under the provision of section three B of chapter seven, be registered by the board as an intern, fellow or medical officer for such time as it may subscribe if he furnishes the board with satisfactory proof of the following:—

1. He is eighteen or over and of good moral character.

2. (a) He has creditably completed two years of a premedical course of study in a college or university and not less than three and one-half years of study in a legally chartered medical school having the power to grant degrees in medicine; or (b) if he is not enrolled in or a graduate of a legally chartered medical school in the United States or Canada, he is the holder of a standard certificate granted after an examination by the Education Council for Foreign Medical Graduates, unless granted an exemption by the board; or (c) he has completed two years of premedical education in a college or university of the United States, Canada or Puerto Rico and if he has studied medicine in a medical school outside the United States, Canada or Puerto Rico which is recognized by the World Health Organization, has completed all the formal requirements for the degree corresponding to doctor of medicine, except internship and social service, and has completed a year of clinical clerkship approved by the liaison committee on medical education of the American Medical Association.

3. He has been appointed an intern, fellow or medical officer in a hospital or other institution of the commonwealth, or of a county or municipality thereof, or in a hospital or clinic which is

incorporated under the laws of the commonwealth or in a clinic which is affiliated with a hospital licensed by the department of public health under authority of section seventy-one of chapter one hundred and eleven, or in an out-patient clinic operated by the department of mental health, or in the department of public health for duty in clinics or in programs operated or approved by the department of public health, or in programs approved by the board of registration in medicine in the commonwealth and leading toward certification by specialty boards recognized by the American Medical Association.

4. The applicant has applied to participate in the medical assistance program administered by the secretary of health and human services in accordance with chapter 118E and Title XIX of the Social Security Act and any federal demonstration or waiver relating to the medical assistance program for the limited purpose of ordering and referring services covered under the program if regulations governing such limited participation are promulgated under chapter 118E.

Such limited registration shall entitle the said applicant to practice medicine only in the hospital, institution, clinic or program designated on his certificate of limited registration, or outside such hospital, institution, clinic or program for the treatment, under supervision of one of its medical officers who is a duly registered physician, of persons accepted by it as patients, or in any hospital, institution, clinic or program affiliated for training purposes with the hospital, institution, clinic or program designated on such certificate, which affiliation is approved by the board and in any case under regulations established by such hospital, institution, clinic or program. The name of any hospital, institution, clinic or program so affiliated and so approved shall also be indicated on such certificate. Limited registration under this section may be revoked at any time by the board.

The board shall promulgate rules and regulations to provide a pathway to full licensure for internationally trained physicians previously licensed or otherwise authorized to practice outside the United States and maintaining limited registration under this section or Board guidance for a period prescribed by the board.

B. Limited Registration of Dentist; Pathway to Full Licensure

Proposed legislative language:

SECTION XX. Chapter 112 of the General Laws is hereby amended by inserting in section 45A, at the end thereof, the following:-

The board shall promulgate rules and regulations to provide a pathway to full licensure for internationally trained dentists previously licensed or otherwise authorized to practice outside the United States and maintaining limited registration under this section for a period prescribed by the board.

Proposed statute as amended:

M.G.L. c. 112, § 45A. Limited registration of dentists; renewal; revocation

An applicant for limited registration under this section who is eighteen years of age or over and of good moral character who shall furnish the board with satisfactory proof that he has received a diploma from ~~the faculty of~~ a ~~reputable~~ dental college ***approved by the board*** *~~as defined in section forty-six~~ and who shall furnish the board with satisfactory proof that he has been employed as a member of the faculty of a dental college accredited by the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs of the American Dental Association or that he has been appointed a dental intern in a hospital or other institution maintained by the commonwealth or by a county or municipality thereof, or in a hospital or dental infirmary incorporated under the laws of the commonwealth, may upon payment of a fee to be determined annually by the commissioner of administration under the provision of section three B of chapter seven be registered by the board as a limited registrant for one year; provided, however, that practice under any such original or renewal limited registration so issued by the board shall be limited to no longer than five years unless said applicant passes a clinical examination administered by the board or is a full time faculty member. Such limited registration shall entitle said applicant to practice dentistry only in the hospital or other institution designated on his registration and under the direction of a registered dentist employed therein. Limited registration under this section may be revoked at any time by the board and a holder of such a limited registration shall not practice dentistry in a private dental office or private dental clinic; provided, however, that a full time faculty member may participate in, and only in, an intramural group dental practice which is operated, managed and physically located within a nonprofit dental educational or research institution and their affiliated hospitals in which the full time faculty member is employed.*

The board shall promulgate rules and regulations to provide a pathway to full licensure for dentists previously licensed or otherwise authorized to practice outside the United States and maintaining limited registration under this section for a period prescribed by the board.

C. Reputable Dental School

Proposed legislative language:

SECTION XX. Section 45A of said chapter 112, as so appearing, is hereby amended by striking out, in lines 4 and 5, the words "the faculty of a reputable dental college as defined in section forty-six" and inserting place thereof the following words:- a dental college approved by the board.

SECTION XX. Section 46 of said chapter 112 is hereby repealed.

Proposed statute as amended:

See above for proposed changes to M.G.L. c. 112, § 45A.

M.G.L. c. 112, § 46. Reputable Dental College; definition

~~*A dental college shall be considered reputable which possesses the following qualifications:*~~

~~*First, It shall be incorporated and authorized by its charter to confer degrees of doctor of dental medicine, doctor of dental surgery or doctor of dental science.*~~

~~*Second, It shall have a competent faculty and corps of instructors. The teaching staff shall deliver a comprehensive and satisfactory course of lectures supplemented by adequate clinical and laboratory exercises in all subjects pertaining to modern dentistry.*~~

~~*Third, It shall give a course of not less than four separate academic years to matriculants who are graduates of accredited high schools or who present proof of equivalent training, or a course of not less than three separate academic years to matriculants who present satisfactory proof of having successfully completed two years of appropriate pre-dental training in a college or university authorized to grant degrees. Each academic year shall consist of not less than thirty-two weeks.*~~

~~*The administrative policy of the dental college shall be such as to accomplish the requirements of this section.*~~

D. Welcome Back Center

Proposed legislative language:

SECTION X. Section 2 of [the budget bill] is hereby amended in item 7518-0100, by adding the following: ", provided that $500,000 shall be expended to support the Welcome Back Center's collaboration with Healthcare Workforce Partnership of Western Massachusetts to expand services to additional health care license types and additional community college campuses" and in said item by striking out the figure "$32,013,950" and inserting in place thereof the figure " $32,513,950"

Proposed statute as amended:

H. 4700, section 2.

*7518-0100 For Bunker Hill Community College**, provided that $500,000 shall be expended to support the Welcome Back Center's collaboration with Healthcare Workforce Partnership of Western Massachusetts to expand services to additional health care license types and additional community college campuses**.....$32,513,950*

E. Canadian Nurse Reciprocity

Proposed legislative language:

SECTION XX. Chapter 112 of the General Laws is hereby amended by striking section 76B, as so appearing, and inserting in place thereof the following section:

Section 76B. (a) Any person who has taken and passed an examination approved by the board and conducted in the English language, and has been registered by a province of Canada, and meets the eligibility requirements of clinical and theoretical study as determined by the board, and furnishes to the board satisfactory proof of good moral character and having graduated from a school of nursing approved by the board of nursing in the jurisdiction in which the applicant was originally registered shall be deemed to have met standards substantially the same as those of the commonwealth for the licensing of nurses and shall be licensed in the commonwealth without examination.

(b) Any person who has taken and passed an examination approved by the board and conducted in a language other than English, and has taken and passed a test of English Proficiency approved by the Board, and has been registered by a province of Canada, and meets the eligibility requirements of clinical and theoretical study as determined by the board, and furnishes to the board satisfactory proof of good moral character and having graduated from a school of nursing approved by the board of nursing in the jurisdiction in which the applicant was originally registered shall be deemed to have met standards substantially the same as those of the commonwealth for the licensing of nurses and shall be licensed in the commonwealth without examination.

Proposed statute as amended:

M.G.L. c. 112, § 76B. Canadian nurse licensure; reciprocity

*Section 76B. **(a)** Any person who has taken and passed **an examination approved by** ~~the State Board Testing Pool Exam by standards acceptable to~~ the board **and conducted in the English language**, and has been registered by a province of Canada ~~in which an examination was taken before August first, nineteen hundred and seventy~~, and meets the eligibility requirements of clinical and theoretical study as determined by the board, and furnishes to the board satisfactory proof of good moral character and having graduated from a school of nursing approved by the board of nursing in the jurisdiction in which the applicant was originally registered shall be deemed to have met standards substantially the same as those of the commonwealth for the licensing of nurses and shall be licensed in the commonwealth without examination.*

(b)** Any person who has taken **and passed an examination approved by the board** ~~the Canadian Nurses Association Testing Service Exam in English after August first, nineteen hundred and seventy~~ **and conducted in a language other than English**, and has **taken and passed a test of

English Proficiency approved by the Board, ~~*achieved individual scores greater than four hundred in each component of said examination*~~ *and has been registered by a province of Canada* ~~*in which an examination was taken*~~*, and meets the eligibility requirements of clinical and theoretical study as determined by the board, and furnishes to the board satisfactory proof of good moral character and having graduated from a school of nursing approved by the board of nursing in the jurisdiction in which the applicant was originally registered shall be deemed to have met standards substantially the same as those of the commonwealth for the licensing of nurses and shall be licensed in the commonwealth without examination.*

~~*Any person who has taken the Canadian Nurses Association Testing Service Comprehensive Exam in English in August of nineteen hundred and eighty or thereafter and achieved a comprehensive score of greater than four hundred and has been registered by a province of Canada in which an examination was taken and meets the eligibility requirements of clinical and theoretical study as determined by the board, and furnishes to the board satisfactory proof of good moral character and having graduated from a school of nursing approved by the board of nursing in the jurisdiction in which the applicant was originally registered shall be deemed to have met standards substantially the same as those of the commonwealth for the licensing of nurses and shall be licensed in the commonwealth without examination.*~~

~~*Any person who has taken the Canadian Nurses Association Testing Service Exam in French after August first, nineteen hundred and seventy, and has achieved individual scores greater than four hundred in each component of said examination and has been registered by a province of Canada in which an examination was taken, and meets the eligibility requirements of clinical and theoretical study as determined by the board, and has attained a score of at least five hundred and fifty on the English Proficiency Examination and furnishes to the board satisfactory proof of good moral character and having graduated from a school of nursing approved by the board of nursing in the jurisdiction in which the applicant was originally registered shall be deemed to have met standards substantially the same as those of the commonwealth for the licensing of nurses and shall be licensed in the commonwealth without examination.*~~

~~*Any person who has taken the Canadian Nurses Association Testing Service Comprehensive Exam in French in August of nineteen hundred and eighty or thereafter and achieved a comprehensive score of greater than four hundred and has been registered by a province of Canada in which an examination was taken and meets the eligibility requirements of clinical and theoretical study as determined by the board, and has attained a score of at least five hundred and fifty on the English Proficiency Examination and furnishes to the board satisfactory proof of good moral character and having graduated from a school of nursing approved by the board of nursing in the jurisdiction in which the applicant was originally registered shall be deemed to have met standards substantially the same as those of the commonwealth for the licensing of nurses and shall be licensed in the commonwealth without examination.*~~