

CHARLES D. BAKER
GOVERNOR

KARYN POLITO
LT. GOVERNOR



MARYLOU SUDDERS
SECRETARY

MARGRET R. COOKE
COMMISSIONER

**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
Representative Jon Santiago, MD	Speaker of the House of Representatives, Designee
Noemi Custodia Lora, PhD	Senate Minority Leader, Designee
Lisa Bennington, RN	House Minority Leader, Designee
Representative Marjorie Decker	House Chair of Joint Committee on Public Health
Laurie Millman, Director, Center for New Americans	Senate Chair of Joint Committee on Public Health, Designee
Kerby Roberson, Esq.	Governor’s Advisory Council for Refugees and Immigrants
Julian Robinson, MD	Board of Registration in Medicine
Seema Jacob, DDS	Board of Registration in Dentistry
Lori Keough, PhD, CNP	Board of Registration in Nursing
Dipu Patel, PA	Board of Registration of Physician Assistants
Randy Jean, PT	Board of Allied Health Professionals
Deeb N. Salem, MD	Massachusetts Medical Society
Hafez Alsmaan, MD	Massachusetts Health and Hospital Association, Inc.
Man Wai Ng, DDS, MPH	Conference of Boston Teaching Hospitals, Inc.
Deborah DeMarco, MD	UMass Chan Medical School
Allison B. Cohn, MPH	Boston Welcome Back Center at Bunker Hill Community College
Amy M. Grunder, Esq.	Massachusetts Immigrant and Refugee Advocacy Coalition, Inc.
Robert P. Marlin, MD, PhD, MPH (Licensed Physician)	Massachusetts Immigrant and Refugee Advocacy Coalition, Inc.
Elisa Tristan-Cheever, MD, MPH (Internationally Trained Medical Professional)	Massachusetts Immigrant and Refugee Advocacy Coalition, Inc.
Damian K. L. Archer, MD	Massachusetts League of Community Health Centers, Inc.

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

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://bhwh.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

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

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

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

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/departments-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.

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/1rUqKQLwtYIImWzL3r22wDMillR7ZTxap/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 states⁴² 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 Missouri⁴⁴ 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/bridge>

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

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=&paperId=1&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.

James G. Lavery, Esq., Director

Bureau of Health Professions Licensure

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.*~~