AAPCHO
ASSOCIATION OF ASIAN PACIFIC COMMUNITY HEALTH ORGANIZATIONS

April 25, 2022

Samantha Deshommes, Chief
Regulatory Coordination Division, Office of Policy and Strategy
U.S. Citizenship and Immigration Services
Department of Homeland Security

Re: DHS Docket No. USCIS-2021-0013, Comments in Response to Proposed Rulemaking, Public Charge Ground of Inadmissibility

Dear Chief Deshommes,

On behalf of the Association of Asian Pacific Community Health Organizations and our member community health centers and organizations, thank you for the opportunity to comment on the Department of Homeland Security's proposed rule on the public charge ground of inadmissibility. We support the department's efforts to enact new rulemaking on public charge and encourage it to act quickly to improve and finalize this rule to protect and enhance the wellbeing of immigrants and their families.

AAPCHO is a national nonprofit association of community-based health care providers, primarily federally qualified health centers, that advocate to improve health care access and outcomes of Asian Americans (AAs), Native Hawaiians, and Pacific Islanders (NH/PIs). AAPCHO members are critical health access providers to nearly three quarters of a million vulnerable and low-income patients, providing linguistically accessible, culturally appropriate, and financially affordable health care services. Among AAPCHO members, nearly half of patients served are limited English proficient (LEP) and 9 in 10 have incomes falling below 200 percent of the poverty line. Further, AAPCHO member health centers employ multilingual staff and may serve as high as 99% LEP patients with some health centers providing services in up to 70 languages.

Impact of Racism, Xenophobia, and Immigration Policy on AA and NH/PI Communities

Immigrants make extraordinary contributions to our economy, our communities and to American life. At some point, some individuals may need to access certain benefits in order to support their health and wellbeing. Receipt of health care, nutrition, or housing assistance is not an indication that they are or will become primarily or permanently reliant on the government–rather it is an investment in our families and communities.

Yet immigrants and their families face barriers to health care that are rooted in xenophobic and structural racism--and health outcomes can not be separated from social health. We have seen the chilling effects of anti-immigration policies on our patients, who are foregoing essential services, disenrolling from benefits for which they are eligible, or just not showing up to receive necessary

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health care. This is true despite the Biden administration's rollback of some harmful proposals over the past year.

AA communities are especially impacted by anti-immigrant fears given that more than half (57%) of Asians living in the U.S. were born in another country. A recent KFF survey conducted at AAPCHO member health centers found that one quarter (25%) of Asian health center patients did not apply for or stopped participating in a government program to help them pay for health care, food, or housing in the past year due to immigration-related fears. Additionally more than 4 in 10 (44%) say that they worry a lot or some that they or a family member could be detained or deported. These fears have been compounded by the rise in anti-Asian hate and discrimionation during the COVID-19 pandemic and leads to increased likelihood that immigrants will not seek or will delay care at a time when doing so is of paramount importance. Immigration laws should not discourage immigrants and their family members from seeking physical or mental health care, nutrition, or housing benefits for which they are eligible.

Several AAPCHO members report that because the Trump Administration's public charge policy went into effect at about the same time as the COVID-19 pandemic began, patients stopped mentioning public charge specifically and now talk about immigration policy more explicitly–even though the Trump-era public charge rule was subsequently rescinded. Some members have reported that patients have just incorporated the fear of public charge into their lives and that immigration is now a barrier to their health care. AAPCHO health centers experienced this as patients were afraid to take advantage of supports like cash and food assistance during the pandemic because of their fear that it could put their future immigration status at risk. For example, AAPCHO members report a significant drop in participants in the WIC program, with one AAPCHO member reporting that it had to close its WIC program because of the lack of enrollment. This downturn is highly correlated with fear and confusion around public charge and immigration policy.

Moreover, 45% of health center patients have Medicaid and CHIP coverage. Over 1,300 community health centers nationwide hire enrollment assisters and conduct outreach and enrollment activities throughout the year to educate vulnerable and underserved communities on the benefits of health insurance coverage. CHCs have a statutory obligation to provide care to all patients, regardless of their ability to pay. The vacated Trump-era rule created fear and hesitation that led to immigrants disenrolling or not enrolling in public benefits, like Medicaid. In order for CHCs to serve uninsured and underinsured patients, it is imperative that patients enroll in health care coverage when they are eligible. On the front lines of the COVID-19 pandemic, there are multiple factors contributing to the loss of health center revenue since 2020. The pandemic has likely contributed to the increased health and financial needs and declines in health coverage among immigrant families. Anti-Asian hate, and anti-immigrant policies generally, have exacerbated fear and anxieties seeking the health and mental health care they may need. And statutory restrictions limited immigrants' access to COVID-19 relief and made families reluctant to access services at facilities like community health centers.

Recommendations to Improve the Proposed Rule:

Given the strong and negative impact that public charge has on immigrants' use of benefits, AAPCHO strongly opposes the use of a public charge determination altogether. The policy is an outdated construct based on racist and classist immigration policies. It continues to discriminate against low income AA and NH/PI immigrants and perpetuates a cycle of confusion and fear in immigraiton policy. That said, we understand that DHS must enforce the law, and we support the Biden administration's efforts to enact new rulemaking on public charge. This proposed rule recognizes that use of core health, nutrition, and housing assistance programs should in no way be linked to the public charge provision. Immigrants and their family members should not be discouraged from seeking physical or mental health care, nutrition, or housing benefits for which they are eligible. Overall, the proposed rule is an important step in the right direction.

There are, however, key provisions of this proposal that need to be strengthened and improved in order to ensure equitable access to benefits and to provide clear guidance on the public charge policy.

1) *DHS should NOT include any Medicaid benefit—including for long-term institutionalization—in a public charge determination.*

AAPCHO opposes the inclusion of long-term institutionalization at government expense and recommends it be removed from the public charge determination. Medicaid is the primary payer of long-term care in the U.S. and covers 6 in 10 nursing home residents. Community health centers provide care to 1 in 5 Medicaid beneficiaries and 1 in 3 people living in poverty nationwide. Among AAPCHO members, 48% of patients are enrolled in Medicaid and 23% are uninsured. AAPCHO members and CHCs broadly have experienced significant declines in Medicaid enrollment and patient numbers as a result of the fear (aks "chilling effect") caused by the inclusion of Medicaid in the 2018 public charge rule. In a KFF study conducted among AAPCHO member health centers last year (2021), one quarter (25%) of Asian health center patients did not apply for or stopped participating in a government program to help them pay for health care, food, or housing due to immigration-related fears. It is our members' experience that linking any Medicaid coverage to public charge causes confusion, contributes to the chilling effect, and ultimately leads patients to forego the health care they need, even if they are Medicaid eligible or will not be subject to a public charge test.

The best way to mitigate the chilling effect is to exclude Medicaid full stop. It is difficult to provide clear messages and will place additional burdens on CHC staff to explain to patients who need Medicaid that their enrollment for non-institutionalization purposes now will not be used to indicate that they will rely on Medicaid for long-term care in the future. In fact, some AAPCHO members have reported that patients have incorporated the fear of public charge into their lives and that immigration is now a barrier to their health care. Given this precedent, and the trauma immigrant communities experienced because of the 2018 public charge rule, any mention that any

part of Medicaid will be considered in a final rule could lead to patients not enrolling or choosing to disenroll from health benefits, and ultimately not seeking the care they need.

2) *DHS should NOT include any state, tribal, territorial or local benefit—including programs that provide cash for income maintenance—in a public charge determination.*

AAPCHO opposes the inclusion of state, tribal, territorial or local benefits and recommends that they be removed from the public charge determination. These assistance programs are exercises of authority reserved to states, tribes, territories, or localities who may choose to support their residents that should not be considered in federal immigration policies. Failure to exclude non-federal programs, including cash assistance programs, would undermine states' efforts to mitigate social problems and inequity, as well as complicating messages about the policy, undermining nationwide efforts to combat the persistent chilling effect.

For CHCs, including these benefits would negatively impact health center services and their outreach to patients. It would add additional administrative and financial barriers on CHCs that are already stretched thin and operate at the margins, and it would force them to navigate the complex web of federal and non-federal programs. When the 2018 public charge rule went into effect, CHCs were forced to dedicate limited resources, staff time, and at times seek legal assistance to help patients navigate whether their use of benefits could hinder their ability to adjust or change their status in the future. This was complicated by the fact that many state-run programs share a federal match. CHC patients and staff were fearful that enrolling immigrant patients into any assistance programs could lead to deportation if that patient or their family member were to adjust status in the near future. In the KFF survey of AAPCHO member health center patients, 44% of respondents say that they worry that they or a family member could be detained or deported.

In fact, one AAPCHO member reported cases of patients declining pandemic-related cash assistance provided by their county government to offset the loss income for those who were forced to isolate but did not have jobs that would cover their income while they were out. For many county residents who did access this program, the funding meant they would not lose their homes because they couldn't make rent for that month. However the patient refused, stating that they did not want to face any consequences for accepting the government's aid, especially since the individual's mother was on a visiting visa. Despite numerous outreach efforts, as well as explicit confirmation from the county government that accepting this assistance would not negatively impact them, the patient would not accept the help they needed. The CHC reported that this situation occurred because of the fear instilled in the immigration population due to the public charge rule

Excluding state, tribal, territorial, or local government programs would ensure that CHC patients are not discriminated against for accessing programs their state or local governments have prioritized for the benefit of their residents. Rather, it would result in a single, uniform, federal standard and assist CHCs in providing accurate and consistent assurances to patients.

3) *DHS should explicitly exclude certain programs from a public charge determination and provide a non-exclusive list of examples of excluded programs in the final rule text.*

As discussed, previous changes to the public charge policies have caused significant fear and confusion among immigrants, their families, and the CHCs and other service providers who serve them. In the KFF survey conducted among AAPCHO member health center patients, 54% of patients said they do not have enough information about recent changes to U.S. immigration policy. AAPCHO encourages DHS to explicitly exclude the following programs and provide a non-exclusive list of examples in the regulatory text.

- State, tribal, territorial, or local cash benefit programs for income maintenance ("General Assistance")
- Special purpose cash (e.g. child care assistance, energy assistance such as LIHEAP, rental assistance, crime victim compensation/restitution)
- Financial assistance targeted to aid specific populations such as survivors of human trafficking or crime
- Disaster assistance such as Individual Assistance Under the Federal Emergency Management Agency's (FEMA) Individuals and Households Program and other disaster assistance provided by state, Tribal, territorial, or local governments
- Pandemic cash assistance such as federal, state, local, tribal or territorial cash assistance. Economic Impact Payments, state Pandemic Emergency Assistance Funds, Paycheck Protection Act assistance, or other types of public health relief payments
- Non-cash services under TANF and short-term non-recurring benefits under TANF as defined at 45 CFR 260.31(b)(1)
- Earned cash benefits (e.g. state unemployment insurance or similar programs, veterans benefits, social security payments, Title II Social Security disability payments; government pensions)
- Tax-related benefits (e.g. child tax credit, earned income tax credit, economic impact payments, any other tax credit or reduction, and similar state or local programs)
- Programs that provide temporary, universal or "guaranteed" income to a targeted or selected group of people. The very nature of these programs is to raise the income of the community across the board and not to address individual needs or personal circumstances
- Programs that provide non-means tested payments such as the Alaska Permanent Fund Dividend or a broad stimulus payment provided outside of the tax system
- Loans or benefits provided to businesses rather than individuals, such as small business loans or assistance through the Paycheck Protection Program (PPP).

Providing this non-exhaustive list of excluded programs would ease administrative burdens on CHCs and enable CHC staff to provide accurate information on specific programs that will never be used in a public charge determination to their patients.

Recommendations for DHS to communicate the new public charge rule when finalized:

1) *DHS, in partnership with benefits granting agencies, should create materials clearly communicating the new public charge rule in multiple languages.*

Language is the second largest barrier to care, following insurance status, for community health center patients in our nation. Our experience demonstrates that patients who know they will have difficulty explaining their medical needs or problems to a doctor or nurse are less willing to seek care. According to UDS 2019 data, 24% of all community health center patients, and 47% of AAPCHO's members' patients, are best served in a language other than English. Research demonstrates that language is a significant factor in a patient's decision to seek and obtain care. Non-English speakers are 26% more likely than English speakers to not have a routine checkup with a doctor in the past year. Individuals that spoke a language other than English at home were 73% more likely to have no usual provider and 71% more likely to not have had a primary care visit in the past year than individuals who spoke English at home.

DHS should update its current Frequently Asked Questions (FAQ) explaining the new public charge rule, particularly where the new rule differs from the 1999 Field Guidance, which is current policy. DHS should work with HHS, USDA, HUD, DOL, ED, DOJ (victim services, and crime victims compensation) and other relevant agencies to create public charge resource pages in multiple languages on the agency websites, similar to the public charge webpage that DHS currently has, explaining the new rule and its limited applicability to benefits programs.

Further, DHS and benefits granting agencies should create materials in multiple languages and on agency letterhead that can be used by CHCs and other service providers. CHC's are trusted sources of information for their communities, including immigrant families. It is imperative that CHCs and other community groups who work directly with families are given outreach materials suited to their populations and their ways of interacting with their clients. These materials should use language that is accessible to immigrant communities and should be available in multiple languages for communities with limited English proficiency. These materials must communicate key messages about the public charge rule and be available in multiple forms.

2) *DHS should partner with and provide funding to CHCs and other community-based organizations for outreach and education to immigrants and their families.*

CHC's are trusted sources of information for their communities, including immigrant families. DHS should financially support CHCs, and other community-based organizations who are trusted messengers in sharing information about the new public charge rule directly to immigrant families and patients. We are fearful that with the public charge rule again being changed, even if the changes are for the better, will cause confusion and potentially lead to another chilling effect that could keep patients from feeling safe in accessing public benefits, such as Medicaid.

Despite the Biden administration's reversal of the 2018 public charge rule, the chilling effect continues to be a significant deterrent for immigrants and their families seeking the care they need. A study conducted by the California Health Care Foundation showed how misinformation and advice from the media, family, and community members increased the chilling effects. The study found that messaging is key to combating the chilling effects and respondents identified sources of incorrect information on public charge from media channels, social media like Facebook and WeChat, newspapers, and word of mouth. It is imperative that the Biden administration provides funding for community outreach programs to provide trusted and reliable public charge information in key community locations and through channels that immigrants and their families can rely on.

Funding from DHS can help cover costs so that more CHCs, and other CBOs, can have support in managing disenrollment and re-enrollment processes (aka "churn") that adds unnecessary costs to CHCs. Some CHCs have set up a public charge multilingual "helplines," organized newsletters and instituted other ways to disseminate immigration-related information to patients, all managed by health center staff. These activities required additional staff training and the development of new workflows, while siphoning off of time and resources from the actual provision of health care. As a result, these health-care providers have diverted resources from their core missions to address community and individual patient concerns about the public charge determination. Some CHCs have diverted as much as $1 million as a result of the 2019 public charge rule.

Support for Specific Provisions of the Proposed Rule:

1) *DHS should maintain "primarily dependent" as the appropriate standard for a public charge determination.*

AAPCHO supports DHS's proposal that "primarily dependent" rather than a lesser level of dependence is the appropriate standard for adjudicating officers to apply a public charge determination. While we oppose the use of long-term institutionalization at government expense or the use of state, territorial, tribal, or local programs in a public charge determination, as we detailed above, we do support the proposal that if the benefits were used to overcome hardships caused by a temporary situation that no longer applies, it does not predict whether the individual is likely to rely on that assistance in the future. We agree that individuals who received benefits in the past and no longer receive them have experienced a change in circumstances that may make them unlikely to need benefits in the future.

2) *DHS should maintain the narrow definition of "receipt" of countable benefits.*

AAPCHO supports DHS's proposal to narrowly define what constitutes "receipt" of a benefit in a public charge determination. While we disagree with certain programs that DHS proposes to include as a countable benefit, as detailed above, we do agree that what qualifies as receipt is the intending immigrant themselves being "listed as a beneficiary." Applying for benefits; being approved for benefits in the future; or assisting another to apply for benefits does not count as

receipt of benefits. This is crucial to mitigate the "chilling effect," especially on children in mixed-status households. CHC staff, like community health workers and medical providers, have shared that patients have come into appointments in tears for fear that their visit may hinder the ability for a family member to adjust or change their immigration status. For example, a California CHC reported that a youth in California who had recently been diagnosed with leukemia attempted to commit suicide because they believed that their use of benefits could lead to the deportation of their parents. Misinformation combined with confusion almost led to the untimely death of a teenager. In cases like this, it is very important that the rule clearly excludes family members' use of benefits.

To provide further clarification, we do recommend that DHS make small changes that will help with the administrability of the rule. The definition should state specifically that issuance of the actual benefit or provision of the service is essential to the definition of receipt. We further recommend that the definition include some additional clarification as to what does not count as receipt of benefit and that it include an explicit, non-exclusive list of examples of what does not count as receipt against the intending immigrant.

3) *DHS should maintain the provision that favorably considers the affidavit of support.*

We support that this proposal does not define the five factors (age, health, family status, assets, resources and financial status, and education and skills) to consider in a public charge determination and instead more strongly weights the affidavit of support. In addition to their relatively low importance compared with the affidavit of support, defining the five factors could lead to adjudicator bias based on an applicant's characteristics. If an intending immigrant has someone willing to support them financially, as evidenced by an Affidavit of Support, this fact should be considered favorably to overcome a public charge test.

4) *DHS should maintain the requirement that adjudicating officers provide justification for all denial decisions in writing.*

AAPCHO supports the requirement that every denial decision be in writing, reflect consideration of each of the five statutory factors, as well as the affidavit of support, and articulate a reason for the determination. This practice will reduce the risk that the adjudicator is applying the wrong standard and will require the adjudicator to justify the decision. It will also be helpful to the applicant seeking any reopening or reconsideration of the denial.

5) *DHS should maintain the provision that receipt of benefits while in an exempt immigration category does not count in a public charge determination.*

AAPCHO supports the provision of the proposed rule that clarified that benefits received while in an exempt status will not be considered as part of a public charge test. This protects immigrants from public charge consequences for any benefits received at any time in the past if the immigrant is eligible for resettlement assistance, entitlement programs, and other benefits typically reserved for

refugees, without regard to whether the immigrant has been granted refugee/asylum status. CHCs are often relied on to provide care to such individuals. This provision will provide these vulnerable populations with safer access to the benefits they may need to recover from the conditions that qualify them for humanitarian protection.

We also support the enumeration of 29 categories of immigrants to whom the public charge ground of inadmissibility does not apply. We encourage DHS to quickly and regularly update the USCIS policy manual to reflect any additional exempt groups.

Conclusion

The public charge policy has been detrimental to our member community health centers and the patients they serve. It has enormous negative consequences on the ability for immigrant patients and their families to seek the care they need and use the services for which they are entitled. It has also burdened CHCs making it more difficult for them to provide affordable, quality, and patient-focused care. It is imperative that the Administration act with urgency and move through rulemaking that ends in a strong and clear final rule as soon as possible. Clear regulations will set parameters so that immigrants, their families, and service providers can understand how a public charge assessment will be determined and reduce the fear and anxiety felt by many immigrants and their families.

Thank you for the opportunity to submit comments on the proposed rule.

Sincerely,

Association of Asian Pacific Community Health Organizations
Asian American Health Coalition dba HOPE Clinic
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International Community Health Services
Lana'i Community Health Center
North East Medical Services
South Cove Community Health Center
Waimanalo Health Center
Wests Hawaii Community Health Clinic