December 10, 2018

The Honorable Kirstjen Nielsen
Secretary
U.S. Department of Homeland Security
3801 Nebraska Avenue, NW
Washington, DC 20016


Dear Secretary Nielsen:

Thank you for the opportunity to submit comments on the above-captioned proposed rule. America’s Essential Hospitals is deeply concerned about the Department of Homeland Security’s (DHS) proposed broadening of the definition of public charge and the consequences it would have for the nation’s health care system, vulnerable patients, and state and local economies. The changes would be costly for federal, state, and local governments and detrimental to public health, and they would reverse the substantial progress providers have made in delivering care to patients in the most appropriate and cost-effective settings.

America’s Essential Hospitals is the leading champion for hospitals and health systems dedicated to providing high-quality care to all. Filling a vital role in their communities, our more than 320 member hospitals provide a disproportionate share of the nation’s uncompensated care—that is, services the hospital provides but for which it receives no reimbursement. The average essential hospital provides $71 million in uncompensated care annually, about nine times more than other hospitals. Essential hospitals devote nearly 70 percent of their inpatient care and 60 percent of their outpatient care to patients receiving insurance through public programs, including Medicaid. Our members provide state-of-the-art, patient-centered care while operating on financial margins half that of other hospitals—4 percent on average compared with 7.8 percent for all hospitals nationwide.¹

Through their integrated health systems, members of America’s Essential Hospitals deliver services across the continuum of care, from primary through quaternary care, including level I trauma care, outpatient care in their ambulatory clinics, public health

services, mental health care, substance abuse treatment, and wraparound services. Essential hospitals’ involvement in their communities goes beyond the direct provision of health care—they are leaders in:

- training the next generation of doctors and other health care professionals;
- improving population health and reducing disparities in health;
- responding to natural disasters, terrorist attacks, and other crises; and
- addressing the nation’s deadly opioid crisis through innovative approaches aimed at treating substance abuse and reducing dependence on opioids.

Beyond their vital role in providing access to lifesaving care, essential hospitals also are economic pillars in their communities. They bolster their state and local economies and, in many instances, are the largest employers in their state. They promote economic diversity and business revitalization in struggling cities and sponsor job training programs to help residents in their communities find employment. The proposed rule would have a profound impact on these hospitals, which would have downstream effects for state and local economies. The impact would reach far beyond immigration, into health care, housing, nutrition, employment, and other sectors of the economy.

We are extremely concerned that DHS’ proposed rule to change the public charge definition will spread fear and confusion among immigrant communities, including for those who are lawfully residing in the country and are legally eligible for benefits under Medicaid, Medicare Part D, or other public benefit programs. Patients forgoing public insurance programs and seeking care at hospitals without insurance would strain the tight budgets of essential hospitals. Policies that would reduce the number of individuals receiving Medicaid and, in turn, cut into Medicaid reimbursement for providers would disrupt beneficiaries’ access to care. The detrimental effects of the rule would not end there—it would be harmful to the health care system at large, resulting in increased health care costs systemwide and worse health outcomes among the most vulnerable. **For the reasons we outline in our comments below, we urge DHS to withdraw its public charge proposed rule.**

1. **DHS’ proposal to expand the scope of the public charge definition will deter millions of vulnerable people from seeking health care.**

DHS’ proposal to revise the definition of “public charge” as it is used by immigration officials would cause irreversible harm to the efforts of health care providers on the front lines of caring for the nation’s vulnerable patients. Under current policy, DHS only considers cash benefit programs and institutionalization for long-term care in the public charge determination. In the rule, DHS proposes to expand the list of benefits to include multiple public programs spanning various government agencies. These benefit programs include non-emergency Medicaid benefits and low-income subsidies for prescription drugs under Medicare Part D. Both public benefit programs are indispensable to ensuring access to affordable, high-quality health care for Americans.
Medicaid covered 67 million people in 2018, while more than 12 million people received subsidies through Medicare Part D in 2017. The Medicaid program is an integral part of the American health care system. Medicaid is a vital source of coverage, providing primary care, prenatal care, mental health and substance abuse services, specialty care, prescription drug coverage, and a range of wraparound services. Medicaid also is a critical source of coverage for children, paying for routine check-ups, oral and vision care, and treatment for chronic conditions. Care reimbursed by Medicaid drives improved outcomes; reduces emergency department (ED) use and unnecessary hospitalizations; and helps decrease infant and child mortality rates. The benefits of Medicaid go beyond health care—individuals who receive Medicaid go on to become productive members of the workforce and realize better employment and educational attainment, thus strengthening the economy. The program also lifts millions of individuals out of poverty, making them self-sufficient and less dependent on government programs in the long run. Discouraging people from receiving Medicaid benefits would roll back more than a half century of progress. Ultimately it would damage not just health outcomes, but also the ability of individuals to lift themselves out of poverty because of its link to general well-being, to the economy, educational attainment.

Including Medicaid benefits in the public charge definition would deter otherwise-eligible individuals from enrolling in Medicaid and cause many of those currently receiving Medicaid to disenroll from the program. This trend is not unprecedented or surprising. In fact, historical data confirms that this type of behavioral response is inevitable. Even more concerning is that these changes would cause even citizens to reconsider whether to continue receiving public benefits. In the mid-1990s, immigration and welfare legislation stoked similar fear in immigrant communities, causing millions to drop coverage. A large portion of the coverage losses were attributable to those who remained eligible for the benefit programs but nonetheless disenrolled out of fear or confusion. Across public programs, benefit use among noncitizen households dropped 35 percent from 1994 to 1997. In Los Angeles County alone, disenrollment during this period reached 71 percent. The coverage losses were not limited to noncitizens—the chilling effect of welfare reform led to double-digit decreases in the number of citizens, as well as refugees and asylees (who were exempt from the changes) who were receiving welfare and Medicaid benefits. For example,

Evidence already has begun to emerge of patients forgoing care or disenrolling from benefit programs in anticipation of the public charge proposed rule. Even before DHS issued the proposed rule, state agencies administering the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) reported disenrollment rates up to 20 percent earlier this year.\footnote{Evich HB. Immigrants, Fearing Trump Crackdown, Drop out of Nutrition Programs. \textit{POLITICO}. September 3, 2018. \url{https://www.politico.com/story/2018/09/03/immigrants-nutrition-food-trump-crackdown-806292}. Accessed November 18, 2018.} Other research shows that for the first time since 2007, enrollment in the Supplemental Nutrition Assistance Program (SNAP) dropped—by 20 percent.\footnote{American Public Health Association. Study: Following 10-year gains, SNAP participation among immigrant families dropped in 2018. November 12, 2018. \url{https://www.apha.org/news-and-media/news-releases/apha-news-releases/2018/annual-meeting-snap-participation}. Accessed November 18, 2018.} In California, health care providers in one survey noticed a 42 percent increase in missed health care appointments among children in immigrant families and a 67 percent increase in concerns expressed about enrollment in Medicaid and nutritional programs. Forty percent of their patients considered disenrolling from these programs.\footnote{The Children’s Partnership. California Children in Immigrant Families: The Health Provider Perspective. March 2018. \url{https://www.childrenspartnership.org/wp-content/uploads/2018/03/Provider-Survey-Infographic.pdf}. Accessed November 18, 2018.} We have heard similar accounts from essential hospitals across the country who say their patients are hesitant to seek care and have inquired about whether to disenroll themselves or family members from insurance programs.

These trends will continue and further accelerate if DHS finalizes its proposal. America’s Essential Hospitals commissioned Manatt Health to conduct a comprehensive analysis of American Community Survey data and Medicaid administrative and payment data to gauge the potential impact of the proposal. The results of this analysis underscore the far-reaching effect of the proposed rule.\footnote{Manatt Health. Medicaid Payments at Risk for Hospitals Under the Public Charge Proposed Rule. November 2018. \url{https://www.manatt.com/Manatt/media/Documents/Articles/Medicaid-Payments-at-Risk-for-Hospitals-Under-the-Public-Charge-Proposed-Rule_Manatt-Health_Nov-2018.PDF}. Accessed November 18, 2018.} The inclusion of Medicaid in the list of public benefits would cause insurance losses, resulting in higher uninsurance rates and worse health outcomes. As illustrated in the table below (Table 1), our analysis revealed that more than 13 million Medicaid and Children’s Health Insurance Program (CHIP) enrollees would be subject to the chilling effect of the rule. These individuals are here lawfully, either as citizens or with some form of legal immigration status, but could possibly reconsider the value of remaining covered under Medicaid or CHIP out of fear of immigration-related consequences for themselves or a family member. The analysis does not account for individuals who are eligible but not currently enrolled in Medicaid or CHIP and might choose not to enroll...
out of fear, and therefore actually understates the potential population at risk of forgoing health benefits due to DHS’ proposal.

**TABLE 1: MEDICAID AND CHIP ENROLLEES SUBJECT TO CHILLING EFFECT, BY AGE AND CITIZENSHIP STATUS (OVER ONE YEAR; BY MILLIONS)**

<table>
<thead>
<tr>
<th>AGE</th>
<th>NONCITIZENS</th>
<th>CITIZEN FAMILY MEMBERS OF A NONCITIZEN</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>3.6</td>
<td>2.1</td>
<td>5.7</td>
</tr>
<tr>
<td>Children</td>
<td>0.9</td>
<td>6.7</td>
<td>7.6</td>
</tr>
<tr>
<td>Total</td>
<td>4.4</td>
<td>8.8</td>
<td>13.2</td>
</tr>
</tbody>
</table>

*Note: Estimates reflect 2016 data from the American Community Survey Public Use Microdata Sample (ACS/PUMS). Sums of components may not equal totals due to rounding.*

Our analysis found that half of those subject to the chilling effect are children. The health consequences of children forgoing care during their formative childhood years would be severe, depriving them of a benefit vital to their mental and physical development. For millions of families, Medicaid and CHIP are lifelines that keep them healthy and, ultimately, productive members of society. This proposal puts children’s healthy development and education at risk by destabilizing their families. Forcing parents to choose between their ability to remain with or reunite their family and accessing critical benefits is short-sighted and would harm these families and their communities.

In the preamble to the rule, DHS estimates the number of individuals who might disenroll due to the public charge proposals. However, DHS’ methodology for calculating the impact grossly underestimates the group of individuals who could experience the chilling effect of the rule. DHS limits its analysis to the number of noncitizens who are likely to apply for adjustment of status every year, which DHS estimates at about 2.5 percent of the foreign-born, noncitizen population. In DHS’ estimation, approximately 142,000 Medicaid recipients might disenroll in a given year, which is an extreme underrepresentation of the actual affected population. In fact, DHS cites evidence of disenrollment rates after welfare reform by legal immigrants up to 54 percent, and acknowledges that its methodology “may result in an underestimate” if noncitizens choose to disenroll years before they apply for adjustment of status. As our analysis and citation of historical evidence indicates, the population exposed to the chilling effect of these changes likely would be much larger than DHS anticipated.

2. **DHS’ proposal would strain hospital budgets and local and state economies.**

Including Medicaid, Medicare Part D, and other public health benefits in the public charge definition would deprive essential hospitals of vital resources that allow them to advance their missions while providing high-quality care and responding to pressing public health crises. Essential hospitals play a unique and vital role in the Medicaid delivery system. Given our largely low-income, vulnerable patient populations, we are

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distinctly positioned to make a real and lasting impact on the lives and well-being of the most disadvantaged among us. Members of America’s Essential Hospitals consistently find innovative and efficient strategies for providing high-quality, complex care to their patients, all while facing high costs and limited resources. Clinical and support staff at essential hospitals are adept at providing the culturally and linguistically competent care appropriate for their diverse patient populations. The reality is that with their patient mix and narrow margins, our members depend on Medicaid funding to carry out their missions and remain viable.

In addition to their role as health care providers, hospitals are drivers of economic activity in their community and are some of the largest employers in their communities. Nationally, essential hospitals contribute 1.5 million jobs to their economies and more than $115 billion in economic activity.13 Lost Medicaid revenue would translate to higher costs and strained budgets for hospitals. Essential hospitals, which treat disproportionate numbers of low-income patients who are either uninsured or on public insurance programs, take on an unequal share of the financial burden of caring for the vulnerable. As part of their commitment to serve all patients, essential hospitals have generous charity care policies, through which they provide free or discounted care to patients with limited financial means. This results in high levels of uncompensated care.

Losses in Medicaid coverage would translate to lower or no reimbursement for hospitals. Ultimately, if individuals walking through hospitals doors no longer are covered by Medicaid, they could delay seeking vital primary and preventive care and instead seek care in the ED when their condition has worsened. If the proposal is finalized, essential hospitals will continue to provide these services but will not be reimbursed, further weakening their already tenuous financial position.

As part of our analysis, we calculated the hospital Medicaid payments at risk for the 13 million beneficiaries, cited in Table 1, likely to experience a chilling effect from this proposal. Based on Medicaid and CHIP payment data from 2016, hospitals could lose up to $17 billion annually in payments from these programs. This impact would be especially pronounced for essential hospitals. The $4.5 billion at-risk Medicaid and CHIP payments at essential hospitals make up 26 percent of the total at-risk amount, while essential hospitals constitute only 4 percent of all hospitals in the analysis. This disproportionate impact would be unsustainable for essential hospitals, which operate on margins narrower than the average hospital and provide nine times more uncompensated care—$71 million per hospital on average in 2016.14 If the proposal goes into effect, the chilling effect and the associated decline in Medicaid revenues would result in a further increase in uncompensated care.

The vital link between adequate reimbursement for Medicaid providers and access to care for beneficiaries cannot be overstated. When Medicaid payment falls, many providers either cannot afford or choose not to treat Medicaid patients. Those that do often are forced to shift the unreimbursed Medicaid costs onto other payers. While we

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14 Ibid.
can rely on the commitment of essential hospitals to serve all patients, their ability to meet that commitment becomes severely compromised when reimbursements fall far below costs. This would force hospitals in already precarious positions to make difficult operational and financial decisions, including whether it is sustainable to continue operating. Whether they must limit certain services, close clinics, or entirely shut down, the resulting reduced access would have a downstream effect on patient access.

The cost of caring for Medicaid patients who disenroll would not disappear—it would fall on other entities, including state and local governments. If DHS’ goal is to reduce the financial burden on the federal government, it is shifting that burden to hospitals and local and state governments instead. As hospitals incur higher uncompensated care costs, local and state governments would have to fill the void to cover these costs through other financing sources. Ultimately, the health care system as a whole would experience rising costs with increased ED visits.

State and local governments spend about $265 billion annually on hospitals, excluding Medicaid payments. In addition to providing base Medicaid payments, Medicaid provides states with funds for disproportionate share hospital (DSH) payments to partially offset uncompensated care costs associated with Medicaid and uninsured patients. The federal government’s matching contribution to each state for DSH payments is capped at a statutorily-determined amount, known as a state-specific allotment. As the amount of uncompensated care increases in states due to patients losing insurance coverage, states with unspent DSH allotments may increase DSH payments to hospitals with higher uncompensated care costs. Due to the way in which Medicaid is financed, not only would states be on the hook for increased Medicaid DSH spending, but the federal government’s matching payments for this DSH spending would result in increased costs to the federal government. Decreased Medicaid enrollment and the associated decrease in Medicaid revenues for hospitals are therefore a losing proposition for all parties involved in the provision of health care.

Given their role as large employers in their communities, the closure or scaling back of hospital operations would have a ripple effect on local and state economies. One study looked at the potential economic loss to the United States resulting from disenrollment from health and nutritional benefit programs related to DHS’ proposal and found that the economic ripple effects of lost jobs could exceed $30 billion. For hospitals, loss of important Medicaid payments would affect operations. A shutdown or scaling back of hospital operations would reduce employment and the hospital’s economic contribution from spending on goods and services.

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3. The inclusion of health care benefits in the public charge definition would undermine public health efforts.

In addition to worse health outcomes for the individuals directly affected by the loss of insurance, the effects of the expanded public charge policy would be felt by others in their communities and across the country. As people put off receiving necessary preventive and primary care, including immunizations, they will be at higher risk for acquiring communicable diseases that they might transmit to others in their communities, whether at their homes or in their workplaces. In this way, the rule would lead to a higher likelihood of outbreaks of transmissible diseases. As people forgo insurance and avoid prenatal and postnatal visits, this could result in higher rates of low birth weight, infant mortality, and maternal morbidity.17

Disincentivizing access to critical health programs, coupled with a loss in payments, would hinder essential hospitals’ innovative efforts to address some of the nation’s most pressing health care crises. To cite one example, hospitals have been leading the way in providing care for people experiencing opioid-related health problems, like infection or overdose, associated with substance misuse. Addressing the opioid crisis has been a top priority of this administration, as evidenced by the Department of Health and Human Services (HHS) declaring it a public health emergency last year. According to HHS data, 64,000 Americans died from drug overdoses in 2016.18 As a result of the gravity of this issue and their direct contact with patients, hospitals have an enormous role to play in the prevention and treatment of this problem.

Essential hospitals are uniquely situated to address the opioid crisis. They partner with pharmacies, public health departments, law enforcement, emergency medical services, and other community providers to combat the crisis. One essential hospital, in Massachusetts, has been a national leader in fighting the opioid crisis. The hospital runs the largest primary care office–based opioid treatment program in New England and has served as the model for similar programs in 35 states. Another essential hospital, in New Jersey, was the first hospital to develop an alternatives-to-opioids program in its ED that prioritizes the use of non-opioid treatments to manage acute pain. This has served as a model for similar programs across the country. These interventions require resources, and if hospitals see steep cuts to their finances due to the rule, they may not be able to keep investing in these innovative programs.

The rule undermines the work of other government agencies, such as HHS, to increase access to affordable coverage and attain better health and health outcomes. HHS has made tremendous strides in its goals to achieve high-quality health care. Some of HHS’ main priorities have been to reduce excess readmissions, avoidable hospitalizations, and ED overuse. HHS and providers have worked toward these common goals and made

substantial progress in these areas. In its latest strategic plan, HHS includes the objectives of promoting affordable health care, improving Americans’ access to health care, and preventing, treating, and controlling communicable diseases and chronic conditions.\textsuperscript{19} The proposed rule would directly contradict and frustrate efforts to meet these objectives.

Further, because it includes housing and nutritional benefits, the public charge rule would counteract the progress that policymakers, health care providers, and other community partners have made in addressing factors beyond clinical care that influence a person’s health, including their social, economic, and environmental circumstances—commonly referred to as social determinants of health. The rule likely would drive up poverty rates, homelessness, and malnutrition, all of which lead to adverse health outcomes.

4. **By discouraging eligible individuals from enrolling in public benefit programs, the proposed rule undercuts existing laws that determine eligibility for public benefits.**

In justifying the addition of Medicaid and other public benefit programs to the public charge regulations, DHS cites the amount of federal expenditures on these benefit programs, as well as high participation rates in these programs. However, none of the data DHS cites indicates that these benefit programs are used by individuals who are unlawfully in the United States or who are not legally eligible for these programs. Neither does the evidence indicate that noncitizens are more reliant on these programs than citizens. In fact, the data DHS provides shows that the rate of participation in these benefit programs, including Medicaid, is lower for noncitizens than it is for citizens.\textsuperscript{20} Other than to discourage individuals who are legally eligible for Medicaid and other benefits from using these benefits, there is no clear rationale for why DHS finds it necessary to include these benefits in the public charge definition.

There are already strict laws in place that limit the types of noncitizens who are eligible for public benefit programs. The vast majority of federal benefit programs are limited to citizens and very specifically defined groups of noncitizens, while precluding undocumented immigrants from receiving benefits. Under the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, most federal public benefits were limited to “qualified immigrants” who must satisfy a five-year waiting period before receiving any benefits. Undocumented immigrants are not eligible for most benefits, which are limited to lawful permanent residents, refugees, asylees, and other categories of humanitarian immigrants. PRWORA already clearly delineates the categories of noncitizens who are eligible for benefits and prohibits those who have not satisfied the waiting period. Therefore, DHS’ proposed changes undermine existing eligibility rules by deterring populations who are legally entitled to Medicaid and other benefits from enrolling in these programs.

\textsuperscript{20} 83 Fed. Reg. 51114, 51161 (October 10, 2018).
5. DHS should not add CHIP to the list of benefits considered in a public charge determination.

In the preamble of the proposed rule, DHS seeks comments on including CHIP as one of the benefits included in the public charge definition and states that it will consider including it in the final rule. America’s Essential Hospitals strongly urges DHS not to include CHIP in the list of public benefits included in the public charge determination. Providing coverage for more than 9 million children, CHIP is an important program that has received bipartisan support since its initial passage in 1997.\textsuperscript{21} Funding for CHIP has been reauthorized in both Republican and Democratic congresses. One of the original cosponsors of CHIP legislation in 1997, Sen. Orrin Hatch (R-UT), stressed the “moral responsibility” of providing coverage to uninsured children.\textsuperscript{22} Putting CHIP on the list of benefits would undermine this critical program for children and undercut decades of gains that the program has made in insuring children.

CHIP has significantly expanded coverage for children, leading to a remarkable decrease in the uninsured rate for children from 14 percent in 1997 to about 5 percent in 2016.\textsuperscript{23} Similar to Medicaid, CHIP provides children with access to primary care, preventive care, dental care, and specialty care. DHS cites as a rationale for including CHIP the fact that “total Federal expenditure for the program remains significant.” However, the benefits of healthier children insured through CHIP lead to increased educational attainment and productivity in adulthood, thus benefiting the economy in the long-term.\textsuperscript{24} The long-term costs of an increase in the rate of uninsured children and the associated worsening of health outcomes far outweigh the costs associated with maintaining the CHIP program. CHIP does not keep children or families in poverty or cause them to be dependent on the government. On the contrary, it provides families with the ability to lift themselves out of poverty and for children to lead healthy and productive lives. Adding CHIP to public charge grounds would only deprive those who are legally entitled to receiving coverage under CHIP from the benefits of the program. The consequences of this would be the same as Medicaid disenrollment—it would lead to an even greater burden on hospital budgets and higher ED use, which would lead to higher health care costs for all involved stakeholders, including federal, state, and local governments.


6. The rule would be administratively burdensome for providers and state and local agencies, and it runs counter to HHS’ efforts to reduce regulatory burden on providers.

The financial implications of the rule would be compounded by the operational complexities associated with training staff and updating hospital systems and processes to comply with the rule. The regulatory burden the rule would impose on providers conflicts with HHS’ work to reduce excessive administrative burden. This administration has emphasized the importance of reducing provider burden and emphasizing patient care, as exemplified in HHS “Patients Over Paperwork” initiative.25 However, due to the complexity of the rule, it is bound to increase regulatory burden and strain hospital systems and staff resources, thereby impeding HHS’ progress so far in reducing unnecessary burden on providers.

Hospitals are large, complex organizations with thousands of administrative and clinical staff who are placed across multiple units and physical locations of the hospital. For large hospital systems, their reach expands outside the four walls of the main building into the community, through networks of hospital-based clinics and mobile units that efficiently bring health care to patients where they need it. Staff placed throughout these ambulatory networks interact with patients and receive questions from patients on the appropriateness of applying for benefits and receiving health care services.

Although the rule has not been finalized, providers already are fielding questions from patients on the implications of changes in immigration policy. If the rule is finalized, providers (who are not immigration experts) would have to invest significant staff time to understanding the nuances of the rule. Their analysis of the rule’s implications for their patients would include determining which groups of individuals are affected by the changes, which benefits are covered by the rule, and which other factors are considered in the public charge determination. Once hospitals gain an understanding of the rule, they would have to determine how to update their internal processes and policies, including intake policies, enrollment and eligibility activities, or charity care policies. Providers would have to train their front-line staff, including educating them about the rule and how it could affect patient eligibility and access to health care.

One of the first points of contact between hospitals and patients is during the intake process, when hospitals collect information from patients on their insurance status. Understandably, patients who are insured might have questions for hospital intake staff about whether their receipt of benefits will imperil their current or future immigration status, although these staff are not necessarily the best equipped to answer such questions. In addition to intake staff, hospitals and other health care providers employ eligibility and enrollment counselors who assist patients with determining eligibility for benefits and with processing their applications for insurance or other health-related programs. These staff are placed at multiple points of contact, including in hospitals’ vast networks of clinics and in their main hospital.

After the expansion of Medicaid through the Affordable Care Act, states are required to allow hospitals to determine whether individuals are presumptively eligible for Medicaid and the hospital can receive payment for services pending a complete eligibility determination. While an individual interacting with one of these enrollment staff might be eligible for Medicaid based on all eligibility requirements, the policies in the proposed rule raise many questions. Is enrollment staff now required to inform them of the immigration consequences of enrolling in Medicaid? How do hospitals reconcile their responsibility to inform patients about their eligibility for benefits, such as Medicaid, with the prospect that receiving these benefits could result in an adverse outcome for the patient’s future application for permanent resident status? Moreover, what if a patient who is eligible for Medicaid refuses to enroll because of confusion or misunderstanding of the consequences of the rule, even if they are not at risk or not subject to a public charge determination? Hospital staff would have to take on additional responsibilities and understand how to deal with these types of scenarios, which are beyond their current scope and responsibilities. Most of these questions are legal in nature and are not necessarily the most appropriate questions for hospital staff to answer. However, given the complex interplay between eligibility and immigration status, providers undoubtedly would be put in a position to have to advise patients on these difficult questions.

State agencies administering Medicaid and other public benefit programs also would experience increased administrative burden if the proposed rule is finalized. States have made substantial progress in recent years to streamline eligibility determinations, enrollment, and renewal of coverage for Medicaid and CHIP patients. This progress includes having implemented systems to allow for real-time eligibility determinations, providing online applications, and automatic renewal of coverage without requiring the enrollee to submit additional documentation or applications. States have invested time and resources into bringing their eligibility and enrollment systems up to this level. If DHS finalizes the rule, these processes could implicate populations subject to the public charge determination, such as if they are automatically enrolled into Medicaid. Beneficiaries would have to proactively disenroll from Medicaid, CHIP, and other public programs, and they are likely to do so even if they are not directly affected by the public charge changes.

Similar to the challenges faced by hospital staff, state and local agencies would have to respond to inquiries from beneficiaries and applicants about the repercussions of the public charge rule on their eligibility. This would require staff to answer technical and legal questions and would result in increased burden in the form of higher call volumes and visits from consumers. State and local agencies would see an influx of requests from DHS and from noncitizens applying for immigration status to verify their receipt of public benefits. To collect information that can be used in the public charge determination, DHS proposes to use a new form (I-944, Declaration of Self-Sufficiency) with detailed information about applicants for immigration benefits, including their

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receipt of public benefits such as Medicaid. In the draft form, DHS directs the applicant to provide documentation from the respective agency about any applications for or receipt of public benefits. This would require not just proof of actual receipt of benefits, but even proof of a past application for receipt of benefits. The draft form specifies the types of appropriate documentation as “a letter, notice, certification or other agency documents” with specific information about the benefits received. If the rule is finalized, agencies can anticipate significant increases in workload associated with requests for documentation as well as follow-up requests from DHS for verification of documentation.

The proposed rule also would lead to increased churn, or turnover, in populations enrolled in Medicaid, CHIP, Part D subsidies, and other public benefits. Individuals who receive these benefits could disenroll out of fear of immigration consequences. If they later learn that they were not, in fact, subject to a public charge determination or are in desperate need of health care due to a new health condition, they might choose to re-enroll. As individuals fluctuate between disenrolling and re-enrolling in Medicaid, agency caseload would increase as they have to process terminations and applications for benefits with greater frequency.

In addition, state and local agencies already have established consumer-facing communications in the form of applications, application instructions, training for staff, and forms and posters displayed to applicants in public areas. These messages are based on the existing public charge definition, which has been consistent since 1999. If this definition were to change in the extremely complicated manner proposed, states and localities would have to recreate their communications materials to accurately capture these changes.

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America’s Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Senior Director of Policy Erin O’Malley at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,

Bruce Siegel, MD, MPH
President & CEO
APPENDIX
Manatt Health Report and Methodology of Analysis
Conducted for America’s Essential Hospitals