November 12, 2019

Carl Risch
Assistant Secretary for Consular Affairs
U.S. Department of State
600 19th St, NW
Washington, DC 20006


Dear Assistant Secretary Risch:

Thank you for the opportunity to submit comments on the above-captioned interim final rule. America’s Essential Hospitals is deeply concerned about the Department of State’s (DOS) 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. Moreover, the revised definition is in direct contravention of recent federal court rulings questioning the legality of identical changes to the public charge definition by the Department of Homeland Security (DHS).

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 300 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 $68 million in uncompensated care annually, nearly 10 times more than other hospitals. Three-quarters of essential hospitals’ patients are uninsured or receive insurance through public programs, including Medicaid. Our members provide state-of-the-art, patient-centered care while operating on margins one-fifth that of other hospitals—1.6 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 rule will profoundly impact these hospitals, which would have downstream effects for state and local economies. The effects reach far beyond immigration into health care, housing, nutrition, employment, and other sectors of the economy.

We are extremely concerned that DOS’ interim final rule revising the definition of public charge will exacerbate fear and confusion in immigrant communities, including for those who are lawfully residing in the country and are legally eligible for benefits under Medicaid or other public programs. In their communities, essential hospitals already are witnessing the chilling effect of policies redefining public charge, with patients disenrolling from or forgoing enrollment in public benefit programs. Patients forgoing public insurance programs and seeking care at hospitals without insurance will strain the tight budgets of essential hospitals. Policies that reduce the number of individuals receiving Medicaid and, in turn, cut into Medicaid reimbursement for providers will 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 DOS to withdraw its interim final rule and its January 2018 Foreign Affairs Manual changes and reinstate the longstanding public charge definition from 1999 field guidance.**

1. **DOS’ redefineption of public charge promulgates an unlawful standard and creates two inconsistent definitions for those applying for immigration status.**

DOS adopts the definitions of the terms public charge and public benefit finalized by DHS in its August final rule. Specifically, DOS expands the list of benefits considered in a public charge determination to include non-emergency Medicaid benefits, nutritional benefits, and assistance received through multiple federal housing programs. While the DHS rule applies to individuals applying for immigration status or changing their immigration status from within the United States, the DOS rule applies to those seeking visas at a consulate or embassy of the United States. The DOS rule also applies to a subset of individuals who currently reside in the U.S., apply for a green card, and must
return to their home country to retrieve their visa from the U.S. consulate. As we detail below, we are gravely concerned about the repercussions of these changes for health care, hospitals and health systems, local and state economies, and state and local benefits agencies responsible for updating their policies to comport with the changes.

Five federal courts halted enforcement of the DHS rule, unequivocally stating that the rule violates federal statutes. These courts noted not only that the plaintiffs are likely to succeed on their Administrative Procedure Act claims, but also that the final rule will cause irreparable economic and public health harm. While the DHS rule is on hold, DHS is prohibited from implementing its new public charge standard and will revert to its 1999 definition of public charge, which considers only cash income assistance programs or Medicaid long-term care.

DOS would be ill-advised to move forward with changes that multiple courts barred from enforcement and likely to be invalidated as unlawful. DOS says that its rationale for adopting the DHS definition is to allow for consistent adjudication of immigration applications within the U.S. and from abroad. The agency further notes that having inconsistent public charge definitions would “create a public harm and would significantly disrupt the Department’s interest in issuing visas only to individuals who appear to qualify for admission to the United States.” However, despite the fact that the DHS rule has been enjoined, DOS has indicated its intention to keep the October 15 enforcement date. This will lead to two inconsistent public charge standards, with DHS applying the 1999 standard while the injunction is in place, and DOS applying the revised standard. If DOS’ concern—as expressed in the interim final rule—is about parity with the DHS definition, then it should withdraw its new definition and revert to the 1999 public charge definition.

2. DOS has provided no meaningful opportunity for the public to comment on or prepare for the impact of the changes in the interim final rule.

The department made sweeping changes to well-established policy on public charge in the form of this October 10 interim final rule, while affording the public little opportunity to provide meaningful input on the rule’s impact. The department set an effective date of October 15, a mere three business days after the issuance of the rule, while only providing a 30-day public comment period. The rule took effect while simultaneously opened for comment, depriving stakeholders of time to analyze the impact of the complex rule and provide comments that can be considered in shaping DOS’ policy. As we describe below, the changes to public charge are complex and will require hospitals, state benefits agencies, attorneys, and others time to train their staff and prepare materials to inform the public of these changes. The department should not continue with its plan to revise the public charge definition without giving the public sufficient time to research, prepare for, and respond to the rule.

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3. **DOS’ expansion of the scope of the public charge definition will deter millions of vulnerable people from seeking health care.**

DOS’ revision of the definition of public charge as used by consular officials will cause irreversible harm to the efforts of health care providers on the front lines of caring for the nation’s vulnerable patients. Under the 1999 policy, DOS only considers cash benefit programs and institutionalization for long-term care in the public charge determination. In the interim rule, DOS expands the list of benefits to multiple public programs spanning various government agencies, including non-emergency Medicaid benefits.

The Medicaid program is an integral part of the United States’ health care system. Medicaid is indispensable to ensuring access to affordable, high-quality health care for Americans, covering 65 million people in 2019. 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 variety 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, and to educational attainment.

Including Medicaid benefits in the public charge definition will deter otherwise-eligible individuals from enrolling and cause many of those currently receiving Medicaid to disenroll from the program. This trend is not unprecedented or surprising. In fact, historical data confirm that this type of behavioral response is inevitable. Even more concerning is that these changes would cause citizens to reconsider whether to continue receiving public assistance. 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 but

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nonetheless disenrolled out of fear or confusion. 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, food stamp use among citizen children with a noncitizen parent dropped by 53 percent in the mid-1990s due to welfare reform changes.

Before DHS’ public charge rule was even finalized, evidence already began to emerge of patients forgoing care or disenrolling from benefit programs in response; this trend is certain to continue if DOS adopts the same public charge definition. A Kaiser Family Foundation analysis found that almost half of community health centers reported experience with immigrant patients choosing not to enroll in Medicaid, while about a third of community health centers had patients disenroll or not renew coverage. A 2018 study from Urban Institute, which was conducted before the DHS rule was finalized, found that one in seven adults in immigrant families chose not to apply for noncash benefits because of fear of future immigration consequences. We heard similar accounts from essential hospitals across the country that say patients are hesitant to seek care and have inquired about whether to disenroll themselves or family members from insurance programs.

4. DOS’ policy would strain hospital budgets and local and state economies.

Including Medicaid and other 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 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.

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In addition to their role as health care providers, hospitals are drivers of economic activity and some of the largest employers in their communities. Nationally, essential hospitals contribute nearly 700,000 jobs to their economies and more than $116 billion in economic activity.12 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. Essential hospitals will continue to provide these services but will not be reimbursed, further weakening their already tenuous financial position.

As part of an analysis of the DHS proposed rule, America’s Essential Hospitals calculated that 13 million Medicaid beneficiaries could be at risk of dropping coverage due to that proposal.13 Based on Medicaid and Children’s Health Insurance Program (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—$68 million per hospital on average in 2017.14 If the DOS policy goes into effect, we expect that the resulting confusion and fear in immigrant communities will mirror the impact of the DHS rule and cause beneficiaries to drop coverage, resulting in an 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 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

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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. Hospitals might have to limit certain services, close clinics, or entirely shut down, which 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. 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 $280 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. The loss of important Medicaid payments could result in a shutdown or scaling back of hospital operations, which would reduce employment and the hospital’s economic contribution from spending on goods and services.

5. 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. 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

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visits, this could result in higher rates of low birth weight, infant mortality, and maternal morbidity.\textsuperscript{16}

Disincentivizing access to critical health programs, coupled with a loss in payments, would hinder essential hospitals’ innovative efforts to respond to some of the nation’s most pressing health care crises. To cite one example, hospitals lead the way in providing care for people experiencing opioid-related health problems, like infection or overdose, associated with substance misuse. Responding to 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.\textsuperscript{17} As a result of the gravity of this issue and their direct contact with patients, hospitals play an enormous role in the prevention and treatment of this problem.

Essential hospitals are uniquely situated to respond to 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 epidemic. 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 this rule, they might 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 improve 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{18} DOS’ rule directly contradicts and frustrates efforts to meet these objectives.

Further, because it includes housing and nutritional assistance, the public charge rule counteracts 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.

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

Other than to discourage legally eligible individuals from using public benefits, there is no clear rationale for why DOS finds it necessary to include these benefits in the public charge definition. There already are 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 assistance and prohibits those who have not satisfied the waiting period. Therefore, DOS’ changes undermine existing eligibility rules by deterring populations who are legally entitled to Medicaid and other benefits from enrolling in these programs.

7. **The rule will 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 interim final rule would be compounded by the operational complexities associated with training staff and updating hospital systems and processes to comply with the rule. Hospitals, community organizations, legal organizations, and benefits agencies invested substantial time and resources into training staff and the public, as well as developing materials on public charge in the context of DHS’ rule. They will have to undertake similar initiatives to educate their communities about the DOS 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. 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.

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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 assistance and receiving health care services.

Providers already are fielding questions from patients on the implications of DHS’ final rule changes. If the DOS interim final rule is adopted, providers (who are not immigration experts) would have to invest significant staff time to understanding the nuances of the DOS rule and how it relates to the DHS 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 need 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. In the wake of the DHS proposed and final rules, hospitals have been confronted with many questions. Is enrollment staff now required to inform patients 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 this assistance 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? After the DHS rule, hospital staff had 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 are 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 DOS does not withdraw its rule. States 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 invested time and resources into bringing their eligibility and enrollment systems up to this level. If DOS adopts the updated public charge definition, 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 DOS and from noncitizens applying for immigration status to verify their receipt of public benefits. If the rule is finalized, agencies can anticipate significant increases in workload associated with requests for documentation as well as follow-up requests from DOS for verification of documentation.

The rule also would lead to increased churn, or turnover, in populations enrolled in Medicaid and other public benefits. Individuals who receive this assistance 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, agencies’ caseloads would increase as they process terminations and applications for benefits with greater frequency.

In addition, state and local agencies already 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 were based on the existing public charge definition, which has been consistent since 1999. If this definition were to change in the extremely complicated manner outlined in the interim final rule, 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,

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President and CEO