CHCANYS DEFINING NEW DIRECTIONS
Community Health Care Association of New York State www.chcanys.org

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Regulatory Coordination Division
Office of Policy and Strategy
U.S. Citizenship and Immigration Services
Department of Homeland Security
20 Massachusetts Avenue NW
Washington, DC 20529-2140

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RE: Comments on DHS Docket No. USCIS-2010-0012 – Notice of Proposed Rulemaking on "Inadmissibility on Public Charge Grounds"

On behalf of New York State's federally-qualified health centers (FQHCs) and their 2.3 million patients across the State, the Community Health Care Association of New York State (CHCANYS) is writing to express our profound concern about the Administration's Notice of Proposed Rulemaking (NPRM) on public charge determinations.

CHCANYS is New York State's Primary Care Association for FQHCs, also known as community health centers or simply, health centers. We represent more than 800 sites across NY. FQHCs are patient-centered organizations whose shared mission is to provide high-quality, affordable health care to **all** individuals, regardless of immigration status, insurance status or ability to pay. This proposed regulation will deter individuals -- including those seen at FQHCs -- from addressing their own health care needs and those of their families, ultimately leading to worse health outcomes, higher costs, and reduced productivity. As these impacts are in direct contrast to NYS health centers' mission, we ask that the Administration reconsider the proposed changes to public charge determination.

Background of New York State's FQHCs

FQHCs are the backbone of the primary care safety net, and all share three core characteristics:

- Mission-driven to ensure access to care for all: By law and by mission, FQHCs seek to ensure that all individuals have access to high-quality, affordable care, regardless of where they live, whether they have insurance, or their ability to pay.
- Full range of services: Every FQHC offers a full range of primary and preventive services, including dental, behavioral health, and pharmacy services. FQHCs focus on addressing their patients' social determinants of health-- the non-medical factors that influence individuals' health status such as their access to stable housing and adequate nutrition.
- Community-based and managed: Each FQHC is governed by a consumer-majority board of directors who seek to identify and prioritize the services most needed by their

communities. FQHCs cannot be owned or directed by outside organizations; as a result, each FQHC is closely attuned to and aligned with the unique needs of its community.

In New York State, FQHCs serve over 2.3 million patients through more than 800 service delivery locations. 89% of New York State FQHC patients are low income (living at less than or equal to 200% of the federal poverty level, FPL), 28% are limited English speakers, 64% identify as black/Hispanic, 31% are children, and 16% are uninsured. For those patients who experience difficulties paying for services, all FQHCs provide a sliding fee scale to people with incomes below 200% of the federal poverty limit. FQHCs ensure that New York State's most vulnerable populations receive comprehensive, high-quality primary care services.

CHCANYS Comments on the Public Charge NPRM

CHCANYS is deeply concerned about the impacts that this proposal would have on immigrants, their families, and their communities, as well as on the health care safety net – including FQHCs. Specifically:

I. The NPRM will lead to worse health outcomes and decreased productivity for immigrants and their families.

The four categories of benefits specified in the NPRM -- Medicaid, SNAP, public housing supports, and Medicare Part D subsidies – were all designed to keep individuals and families safe and healthy so that they can thrive, contribute to their communities, and reach their full potential. However, this NPRM would create enormous negative consequences for immigrants who qualify for and use these benefits. The fear of triggering these consequences will deter individuals from enrolling or remaining enrolled in these programs. The result will be worse health outcomes and lower productivity, reducing these individuals' ability to achieve self-sufficiency and contribute positively to their communities.

The NPRM's impact will extend far beyond immigrants who plan to seek a Green Card and those enrolled in the four categories of benefits specified. It will result in a significant "chilling effect" – meaning that many individuals will withdraw from benefits for which they are eligible, even though receiving these benefits would have no impact on their immigration status. In a recent CHCANYS survey of NYS health centers, more than half of respondents indicated that they have already begun to see a chilling effect within their health centers. This kind of chilling effect was also widely observed following the passage of the Personal Responsibility and Work Opportunity Act (PRWOA) of 1996.

The chilling effect has potential to manifest itself in several ways:

- Individuals will refrain from enrolling in all benefits, even those that are not considered in public charge determinations, due to concerns that doing so could harm their immigration status.

NYS health centers have reported that since the beginning of 2018, concerns over accessing Medicaid benefits among immigrants and their families has resulted in decreases in early access to prenatal care among expecting mothers and decreased medication adherence rates, including among high need populations, such as individuals with human immunodeficiency virus, or HIV. Fears over deportation associated with accessing public benefits have led to increased behavioral health needs and corresponding difficulties, including poor performance in school among children, food insecurity, and housing instability.

Chilling effects also extend to programs that address individuals' social determinants of health status, such as nutrition and housing. For example, the WIC program is widely agreed to "save lives and improve the health of nutritionally at-risk women, infants and children[1]"; in fact, the US Government website states that "[c]ollective findings of studies, reviews and reports demonstrate that the WIC Program is cost effective in protecting or improving the health/nutritional status of low-income women, infants and children."[2] Despite the fact that the NPRM does not propose to include WIC in public charge determinations, the CHCANYS survey mentioned above found that over half of respondents indicated that they have seen fewer enrollees in WIC due to concerns over deportation.

- Individuals who are not subject to public charge determinations – such as refugees and asylees – will refrain from using benefits due to concerns and confusion about potential impacts on their immigration status. Following the passage of PRWOA, researchers documented extensive "statistical evidence of a withdrawal from benefits among populations whose eligibility was unchanged by the law[3], including refugees and U.S. citizen children."[4] For example, refugees' use of Medicaid dropped by 39%[5], and their use of Food Stamps fell 60%[6], even though the law did not restrict their eligibility for either program.
- Family members of immigrants who are subject to public charge will be negatively impacted, even if they are not subject to public charge themselves. When an individual is afraid to use benefits due to concerns about immigration consequences, their family

[1] https://www.fns.usda.gov/wic/about-wic-how-wic-helps
[2] Ibid.
[3] Francisco I. Pedraza and Ling Zhu, "The 'Chilling Effect' of America's New Immigration Enforcement Regime," Pathways, Spring 2015, https://inequality.stanford.edu/sites/default/files/Pathways Spring 2015 Pedraza Zhu.pdf.
[4] https://www.migrationpolicy.org/research/chilling-effects-expected-public-charge-rule-impact-legal-immigrant-families
[5] Michael E. Fix and Jeffrey S. Passel, Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform: 1994-1997 (Washington, DC: Urban Institute, 1999), www.urban.org/research/publication/trends-noncitizens-and-citizens-use-public-benefits-following-welfare-reform.
[6] Ibid.

members will often be negatively impacted, even if they are not subject to public charge determinations themselves. These impacts will be particularly acute among the approximate 20% of NY Medicaid enrollees living in a household with at least one non-citizen. If one of these parents is afraid to apply for SNAP for fear of the immigration consequences, then their children – who are often US citizens -- will go hungry. If a mother is afraid to apply for WIC, her children will be at increased risk of low birth weight and other health problems. If a parent is concerned about accepting housing support, his US citizen children will lack safe, stable housing.

Children's health and well-being is inextricably linked to that of their parents. Children fare better when their parents are healthy and stable - physically, emotionally, and financially. Parents who are unable to access adequate health care, nutrition, and housing for themselves face increased challenges in caring for their children. As such, any change that results in parents skipping or disenrolling from health, nutrition or housing programs will impact the health of their children throughout their lifespan.

In summary, both the direct and "chilling" effects of this NPRM will lead to worse health outcomes and decreased productivity for immigrants and their families, in both the immediate term and the long term. These impacts are in direct contrast to CHCANYS' mission, which seeks to improve health outcomes by protecting and promoting the health of all underserved children and adults, regardless of their immigration status.

II. The NPRM will discourage parents from seeking health care for their children. Including CHIP in public charge determinations will exacerbate this impact.

Under the NPRM, if an immigrant child is uninsured and eligible for Medicaid, his parent will be faced with an untenable choice: either to enroll the child in coverage, knowing that doing so could prevent him from receiving a Green Card in the future, or to leave the child uninsured, hoping that he will suffer no long-term health consequences. In a recent CHCANYS survey, some New York State health centers have already reported that parents have refused benefits for their citizen children, fearing for their own ability to gain legal permanent status or the ability for other children in the family to gain legal permanent status.

If CHIP were considered in public charge determinations, the number of parents and children who will face this untenable choice would be expanded significantly. CHCANYS strongly opposes including CHIP in public charge determination.

III. The NPRM would increase uncompensated care costs for FQHCs across New York State, putting their financial stability at risk.

In addition to the direct harm to immigrants and their families, this proposal would place significant financial strains on the FQHCs that CHCANYS represents and other safety net providers by increasing uncompensated care costs while decreasing revenues.

- As discussed above, research clearly indicates that this proposal will deter immigrants from enrolling themselves and their children in Medicaid or CHIP. As health centers turn no one away -- regardless of insurance status or ability to pay – FQHCs will continue to care for these individuals, but will no longer receive Medicaid or CHIP reimbursement to help cover the costs.
- A recent analysis by the Geiger Gibson/RCHN Community Health Foundation Research Collaborative estimates that as many as 88,000 patients at NY State's FQHC grantees[7] could lose Medicaid coverage as a result of the proposed rule. [8] When including lookalikes[9] in this sort of analysis, the number of patients potentially affected jumps to 95,000.[10] This could mean New York State Health Centers would lose up to $100,000,000 in Medicaid revenue. [11]
- Uninsured persons tend to delay seeking care longer than insured persons, due to financial concerns. As a result, by the time they finally seek care, they often are sicker and more expensive to treat and therefore more likely to end up in an emergency room or hospital. They are also more likely to develop prolonged, aggravated and even lifelong conditions that early medical intervention could have prevented or ameliorated.
- This proposed rule will impact individuals' and families' ability to keep themselves healthy and productive by impacting their social determinants of health such as access to stable housing and adequate food. This will lead to poorer health status and greater health care needs, and potentially higher costs in the long run.

The factors listed above will result in higher uncompensated costs and lower reimbursement for NYS FQHCs and other safety net providers. Ultimately, the finalization of this proposed rule could put the financial stability of NYS FQHCs at risk, resulting in decreased access to care for all New Yorkers.

IV. The NPRM's cost-benefit analysis significantly underestimates the drops in participation in public benefits that will result from these proposed changes; it also fails to account for many significant costs that will result for safety net health care providers and other community organizations.

[7] This analysis only includes grantees of Section 330 of the Public Health Service Act and does not include "lookalike" sites.
[8] Leighton Ku, Jessica Sharac, Rachel Gunsalus, Peter Shin, and Sara Rosenbaum, How Could the Public Charge Proposed Rule Affect Community Health Centers? (November 2018), https://www.rchnfoundation.org/?p=7294.
[9] Lookalikes are health centers that meet the eligibility requirements to be a federally-qualified health center, but do not receive PHS Section 330 grant funding. CHCANYS membership includes lookalikes.
[10] Per CHCANYS analysis.
[11] Ku et al. *How Could the Public Charge Proposed Rule Affect Community Health Centers?*

In the Regulatory Impact Analysis (RIA), the Administration assumes that the regulation, if implemented as proposed, would lead to a 2.5 percent drop in enrollment in the four programs to be added to public charge determinations. CHCANYS contends that the RIA significantly underestimates the projected declines in participation in public benefits.

- The 2.5% disenrollment rate is far below actual disenrollment rates recorded after the passage of PRWOA. The Administration estimates the number of individuals likely to disenroll from or forego enrollment in a public benefit program as equal to 2.5 percent of the number of foreign-born non-citizens. By the Administration's own account, this estimate is significantly less than actual rates of disenrollment following the passage of PRWORA, which ranged from 21 to 54 percent, depending on the program. It is also significantly below rates of disenrollment that have already been observed in 2018 prior to the release of the NPRM, such as for WIC benefits.
- The RIA estimates consider only the four benefits proposed in the NPRM, while the chilling effect will lead to reduced enrollment in many other types of benefits. As discussed above, chilling effects spread far beyond the programs listed in the NPRM, and significant declines in participation have already been noted in programs such as WIC, immunization campaigns and – most notably for us – primary health care services offered on a sliding-fee scale.

Due to these shortcomings, CHCANYS requests that the Administration reconsider both its estimated rates of disenrollment, and the number of public programs that it considers in its RIA.

In addition, we are concerned that the NPRM's cost-benefit analysis fails to include estimates for the increase in uncompensated care costs for safety net providers, as well as many other indirect costs that would inevitably result if the rule were implemented as written. The NPRM explicitly lists several types of these costs, including reduced revenues for:

> "healthcare providers participating in Medicaid, pharmacies that provide prescriptions to participants in the Medicare Part D Low Income Subsidy (LIS) program, companies that manufacture medical supplies or pharmaceuticals, grocery retailers participating in SNAP, agricultural producers who grow foods that are eligible for purchase using SNAP benefits, or landlords participating in federally funded housing programs."

Despite giving these examples of downstream costs, the NPRM fails to provide any numerical estimates for them. Such costs would be straightforward to estimate, particularly given the data collected following the passage of PRWORA. We therefore request that the Administration estimate and consider these costs when analyzing the costs and benefits of this proposal.

In summary, this proposal would have numerous impacts that are in direct contradiction to NYS FQHCs' mission of providing high-quality, affordable health care to all medically underserved patients, so they can have the opportunity to thrive, contribute to their communities, and reach

their full potential. For this reason, we at CHCANYS ask that the Administration withdraws the proposed changes to public charge determination.