October 21, 2021

Via Federal eRulemaking Portal at https://www.regulations.gov

Alejandro N. Mayorkas
Secretary of Homeland Security
United States Department of Homeland Security

RE: DHS Docket No. USCIS-2021-0013, Public Charge Ground of Inadmissibility, 86 Fed. Reg. 47025 (August 23, 2021)

Dear Secretary Mayorkas:

We are writing on behalf of the Washington Association for Community Health ("WACH"), the Community Health Network of Washington ("CHNW"), and their members, all of which are community health centers ("CHCs") in the state of Washington, to respond to the Department of Homeland Security's ("DHS" or "Department") request for comment and feedback on the questions and topics set forth in the Advanced Notice of Proposed Rulemaking ("ANPRM") on the Public Charge Ground of Inadmissibility published in the Federal Register on August 23, 2021. WACH, CHNW, and their member CHCs urge the Department to expeditiously issue clear and non-discriminatory regulations on the public charge ground of inadmissibility that expressly exclude consideration of the receipt of public benefits.

Washington Association for Community Health and Community Health Network of Washington's Interest in the Public Charge Ground of Inadmissibility

The Washington Association for Community Health supports all twenty-seven (27) community health centers in the state of Washington through policy, advocacy, technical assistance, and collaborative learning events and forums. The mission of WACH is to strengthen and advocate for Washington's Community Health Centers as they build healthcare access, innovation and value. In 2020, WACH's members provided health care at over 300 sites across the state of Washington, serving over 1.1 million patients, of which nearly half were enrolled in Medicaid.

Community Health Network of Washington was founded nearly 30 years ago to ensure access to quality health care and coverage for community health center patients and their communities. Today, CHNW represents a diverse network of 21 community health centers with over 250 sites providing physical, behavioral, and dental health care services across Washington State. CHNW also offers Cascade Select qualified health plans on the state's Exchange as part of Washington's innovative public option health plan program. CHNW is also the sole corporate member of Community Health Plan of Washington ("CHPW"), which serves nearly 300,000 enrollees in Washington through its Medicare Advantage and Medicaid health plans and is the only local non-profit Medicaid Managed Care Organization in the state.

Each member of WACH and CHNW is a health center, as defined in Section 330 of the Public Health Service Act, 42 U.S.C. § 254b, established and operating in medically underserved areas ("MUAs") with a patient-led governing board and a mandate to provide high quality, comprehensive primary health care services and supports to patients regardless of their ability to pay. Each health center is a federally qualified health center ("FQHC") as defined in the Medicaid and Medicare programs and the health center's services are required to be covered by those programs.[1] Washington's CHCs provide culturally competent whole-person care and connect patients to a wide range of social and community services. In many Washington health centers, these services are provided by a diverse and multilingual staff in order to meet the needs of their patients and communities; in 2019 and 2020, nearly 30% of patients seen at Washington's CHCs were served in a language other than English.[2]

In addition to providing health care services on a sliding-fee scale to uninsured and underinsured patients, health centers have enrollment counselors and patient navigators dedicated to connecting patients with services and programs to support their health and well-being, including WIC and Medicaid. Given their unique place in their communities, CHCs have seen and continue to see the devastating effects of the fear and confusion created by the changes and challenges to the "public charge rule." Not only have patients refused to apply for public programs and benefits, they have also declined necessary health services, in some cases resulting in increased emergency room use and preventable life-threatening conditions. Of particular consequence, immigration fears have caused an increase in vaccine hesitancy among the communities served by Washington's CHCs, including migrant and seasonal farmworkers. A narrow definition of "public charge" and the express exclusion of public welfare benefits from consideration will be essential to restoring trust and improving the health and wellbeing of the immigrant populations and communities served by Washington's CHCs.

Comments Responding to Specific Questions in the ANPRM

WACH and CHNW have chosen to focus our comments and responses to those areas and questions in which our member CHCs have direct experience and expertise. Washington's CHCs are community-led non-profit organizations that serve as the foundation of the health care safety net and trusted partners of benefit-granting agencies. WACH, CHNW, and our member CHCs are leaders in the provision of culturally and linguistically appropriate whole-person health care and, unfortunately, witnesses to the harm anti-immigrant policies cause their patients, their communities, and the CHCs' ability to provide appropriate and necessary care.

A. Purpose and Definition of Public Charge

[1] 42 U.S.C. § 1396d(*l*)(2)(B) (defining "Federally qualified health center in context of "Federally qualified health center services" as mandatory benefit in Medicaid) and 42 U.S.C. § 1395x(aa)(4) (defining Federally qualified health center" in context of "Federally qualified health center services" as mandatory benefit in Medicare).
[2] Washington Health Center Program Uniform Data System (UDS) Data 2020, *available at* https://data.hrsa.gov/tools/data-reporting/program-data/state/WA (last accessed Oct. 16, 2021).

4. What national policies, including the policies referenced throughout this ANPRM, policies related to controlling paperwork burdens on the public, and policies related to promoting the public health and general well-being, should DHS consider when defining the term "public charge" and administering the statute more generally?

In administering the statute, DHS must take action to ensure that English language proficiency is not a factor in determining whether an individual is inadmissible on public charge grounds. We can find no evidence of a correlation between an individual's English proficiency and the likelihood they will become dependent on the government for subsistence. Indeed, the United States has a long history of welcoming and integrating non-English-speaking immigrants from every country with successful transitions to independence. As participants in federally funded health care programs, CHPW, CHNW, and its member CHCs are all required to provide free oral interpretation and/or written translation services to individuals who request such services. Providing language assistance at no charge to the individual promotes equitable access to services and benefits by ensuring English proficiency is not a *de facto* eligibility requirement. Therefore, consistent with the policies outlined in Executed Order 13985, Advancing Racial Equity and Support for Underserved Communities Through the Federal Government, signed on January 20, 2021, we urge DHS to administer the statute in a way that promotes equitable access to services and benefits and ensures that English proficiency is not a *de facto* eligibility requirement. We further request that DHS propose regulations or issue guidance that plainly states that English language proficiency is not a factor and will not be considered in determining whether an individual is inadmissible on public charge grounds.

C. Statutory Factors

4. Should DHS give any more or less consideration to any one or more of the statutory factors, the Affidavit of Support under Section 213A of the INA, or any additional factors DHS may add through the rulemaking process in a public charge inadmissibility determination?

We agree with other commenters that DHS should consider a properly filed Affidavit of Support as creating a presumption that the applicant will not become a public charge and therefore is not inadmissible on public charge grounds.

With respect to the statutory factors, DHS should take steps to ensure that an applicant's health is not given undue weight in determining whether the individual is likely to become a public charge. An individual's past or current health is not necessarily a reliable indicator of their future status or ability to contribute to their community. Health must be considered in the context of the whole person and their environment and circumstances, including social determinants of health and access to affordable healthcare. Moreover, numerous studies have made clear that institutional racism and unconscious bias contribute to health disparities and worse health outcomes for people of color. Cumulatively, health is much more a reflection of the past than an insight to an individual's future capabilities and, for these reasons, should be given less consideration.

b.2. Should DHS consider disabilities and/or chronic conditions as part of the health factor? If yes, how should DHS consider these conditions and why?

WACH, CHNW, and the CHCs believe that DHS should not consider disabilities or chronic conditions as part of the health factor. An applicant's disability must be excluded from consideration to ensure that the applicant is not discriminated against on the basis of their disability. Most reviewers will not have the clinical background or information to appropriately evaluate the impact of the disability on the individual's overall health, not to mention how it might affect the likelihood that they would become a public charge. In addition, the long history of bias relating to the capabilities of those individuals who have a condition considered a "disability" has led to unnecessary and outsized limitations associated with such a condition and inadequate understanding of individuals' capabilities. To ensure a transparent and objective determination process and to protect applicants from unfair discrimination and biases, DHS should not consider disabilities as part of the health factor.

WACH, CHNW and the CHCs believe that DHS should not consider chronic conditions as part of the health factor because a chronic condition is not indicative of whether an individual is likely to become a public charge. Many individuals diagnosed with a chronic condition do not experience adverse impacts to their functioning and are able to successfully manage their condition. Those individuals who may experience more significant impact may be so affected because they have not had had regular or affordable access to the healthcare and treatments necessary for their condition, either in their country of origin or in the United States. Allowing an individual's chronic conditions to be considered as part of the health factor will amplify the harm caused by a lack of access to affordable and culturally appropriate healthcare. Therefore, DHS should not consider chronic conditions as part of the health factor.

b.3 How should the Rehabilitation Act of 1973's prohibition on discrimination on the basis of disability be considered in DHS's analysis of the health factor?

As federal grantees and participants in federal programs, Section 504 of the Rehabilitation Act prohibits CHNW, CHPW, and the CHCs from discriminating against individuals on the basis of their disability. Section 504 similarly applies to programs and activities conducted by the Department, including determining whether an individual is likely to become a public charge. Therefore, DHS may not determine an individual in the United States is inadmissible on public charge grounds based on or because of their disability. It follows that the Rehabilitation Act of 1973 prohibits DHS from considering an individual's disability in a public charge determination, whether part of the health factor or other statutory factor. Further, an applicant who believes that they have been discriminated against on the basis of their disability in violation of Section 504 of the Rehabilitation Act of 1973 shall be permitted to file a complaint with the DHS Office for Civil Rights and Civil Liberties, consistent with 6 C.F.R. Part 15.

b.5 Should DHS account for social determinants of health to avoid unintended disparate impacts on historically disadvantaged groups? If yes, how should DHS consider this limited access and why?

Yes, DHS must account for social determinants of health and acknowledge the persistent negative effects of systemic racism, institutional bias, and generational trauma on historically disadvantaged and marginalized groups. The failure to do so would be to willfully ignore the influence of implicit bias and would perpetuate current health disparities. Accordingly, DHS must take steps to ensure that it does not exacerbate those harms by accounting for the impact of social determinants of health on an applicant's current health status. In addition, there must be some acknowledgement of the poverty and adverse experiences many immigrants endure in their countries of origin as well as upon arrival in the United States. Many immigrants are seeking to come to the United States to escape poverty and, while they may experience poverty upon arrival, such circumstance is not a reflection of their future potential.

The need to account for the social determinants of health is further warranted due to most immigrants' exclusion from publicly funded programs that address social determinants of health, such as supplemental nutrition assistant program (SNAP) benefits and housing assistance. The denial of such support exacerbates and may even prolong the poverty and hardship new immigrants often experience upon arrival to this country, which in turn negatively affects their health and wellbeing. But these factors do not indicate that the situation is permanent or that the immigrant is likely to become a public charge. We therefore urge DHS to ensure that an individual's health is evaluated through a lens of cultural humility and with appropriate consideration or compensation for social determinants of health.

F. Public Benefits Considered

3. Which public benefits, if any, should not be considered as part of a public charge inadmissibility determination?

WACH, CHNW, and its member CHCs urge DHS to exclude from consideration as part of a public charge inadmissibility determination all public benefits that do not provide long term income maintenance, including all forms of non-cash assistance, as well as all state-funded public benefit programs, including those that provide cash assistance. Programs like Medicaid, CHIP, Section 8 housing vouchers, and SNAP provide necessary support for individuals and families experiencing temporary hardships; they are not a reflection of the individual's future circumstance or potential to become permanently dependent on the government for subsistence. The same is true for disaster relief and other programs that provide temporary cash assistance, which many families received during the Covid-19 pandemic. These benefits are necessary to alleviate the crisis caused by events beyond the individual's control. No one experiencing such a tragedy should have to question whether accepting such assistance will jeopardize their ability to lawfully remain in this country.

4. How should DHS address the possibility that individuals who are eligible for public benefits, including U.S. citizen relatives of noncitizens, would forgo the receipt of those benefits as a result of DHS's consideration of certain public benefits in the public charge inadmissibility determination? What data and information should DHS consider about the direct and indirect effects of past public charge policies in this regard?

As an initial matter, WACH, CHNW, and its member CHCs wish to clarify for DHS that this is not merely a possibility but reality. WACH, CHNW, and its member CHCs know that the fear and confusion created by the 2018-2019 rulemaking has caused parents to unnecessarily disenroll their children from Medicaid and CHIP. For example, a Seattle health center patient who has been a patient at the clinic since 2004 withdrew his two children from Apple Health (Washington's Medicaid/CHIP programs) in 2018 out of fear that their continued enrollment would affect their application for legal permanent resident status. The patient provided the following statement about the decision, "Our goal has always been to be upstanding residents, not a public charge and not having medical insurance for our children was a financial hardship where we had to cut Well Child Checkups and all extracurricular programs for our children's scholarly progress to set them on the best track to being upstanding citizens." We urge DHS to ensure no other family feels forced to make such choices by issuing rules that are clear and easily understood, including specific identification of the benefits that are and are not considered. DHS can also reduce the likelihood that individuals and families will unnecessarily forgo receipt of benefits by limiting the benefits considered in a public charge determination to only federally funded benefits providing cash assistance for income maintenance.

I. Specific Questions for State, Territorial, Local and Tribal Benefit Granting Agencies and Nonprofit Organizations

1. What costs, if any, has your agency or organization incurred in order to implement changes in public charge policy, such as revising enrollment procedures and public-facing materials? Please provide relevant data.

While most of the CHCs are unable to quantify the exact costs incurred as a direct result of changes to public charge policy, several report that between 2018 and 2021, significant staff time has been devoted to working on public charge, taking them away from serving other patient needs and improving health of all patients. Public charge related activities that took staff away from their normal job duties included developing resources for patients and community members, attending trainings on public charge to support patients and community members, providing trainings on public charge rules to health center staff and Board members, tracking and communicating regulatory changes, and tracking and communicating updates on the numerous legal challenges to the 2019 final rule on public charge.[3] One CHC brought in legal aid attorneys to try to ease the burden on staff who did not feel comfortable or confident explaining the changes to the public charge determination to fearful patients and to ensure health center staff could provide health

[3] Inadmissibility on Public Charge Grounds, 84 Fed. Reg. 41292 (Aug. 14, 2019).

center services. To date, hundreds of hours of staff time have been devoted to public charge policy changes rather than patient care and health center services.

5. What, if any, specific concerns does your agency or organization have about how DHS applies the public charge ground of inadmissibility and how should DHS address those concerns?

WACH, CHNW, and its member CHCs are concerned that if DHS applies the public charge ground of inadmissibility in a manner that considers the receipt of *any* public benefits, then patients will continue to forego valuable benefit programs and essential health care services for themselves and their family members, regardless of whether a public charge determination is applicable to them. For example, one health center in Seattle reported that a refugee woman refused to even visit the clinic for an appointment out of fear of public charge, even though she was not subject to a public charge determination due to her refugee status. Another patient, an Eritrean man here legally but without health coverage refused to enroll in any programs because he has heard from others "that the government is unhappy with immigrants receiving benefits." At a health center in Yakima, nearly a dozen patients per week have refused to accept or apply for WIC, MSS, or health insurance, even though both WIC and MSS were excluded from the public benefits that were included in the definition of public charge under the 2019 final rule[4] and, in some cases, occurred before the rules went into effect.

Moreover, the receipt of public benefits by eligible individuals should be encouraged, not penalized. Contrary to the misguided approach of the previous administration's regulations on public charge, the receipt of public benefits indicates the individual is less likely to become dependent on the government for subsistence. The impact of primary care in reducing health care costs is well-documented, as is the ability of programs such as Medicaid, housing assistance, and SNAP to help individuals and families to escape the worst poverty and improve their health and wellbeing. Access to health care and stable housing promote attendance at school for children and employment for adults. Given the widespread benefit of participation in these programs among eligible populations, many of whom belong to historically marginalized and disadvantaged groups, DHS should take action to ensure that immigrant individuals and families are encouraged to access the benefit programs to which they are entitled.

The simplest and easiest way to address the unnecessary and harmful forbearance of public benefits and programs that can improve the health and wellbeing of immigrant patients, their families, and our communities is to exclude all public benefit programs from consideration of whether an applicant is inadmissible on public charge grounds. To the extent DHS determines it cannot exclude all benefit programs, then DHS should limit the benefit programs it will consider to only those federal programs that provide cash payments for income maintenance, consistent with the 1999 Field Guidance.[5] Regardless, the antidote to the pervasive confusion and fear surrounding

[4] *Id.* at 41501.
[5] Field Guidance on Deportability and Inadmissibility on Public Charge Grounds, 64 Fed. Reg. 28689, 28690 (Mar. 26, 1999).

the use of public benefits and programs is for DHS to publish regulations that clearly identify each program that will be considered, how each program will be considered, and expressly state that no other public benefits or programs will be considered. DHS should also revise the application forms to request information only on the specific programs that are considered.

8. How should DHS reduce the possibility that individuals who are eligible for public benefits overseen by your agency would decide to forgo the receipt of those benefits out of concern that receipt of such benefits will make them (or a family member or a household member) inadmissible on public charge grounds, even if receipt of such a benefit would not be considered by DHS in a public charge determination, or would not be a decisive factor in a public charge inadmissibility determination?

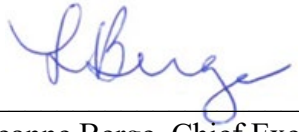
In addition to the actions outlined above, we implore DHS to quickly develop and disseminate communications and resources confirming that the 1999 Interim Field Guidance is the current set of rules used to determine whether an individual is inadmissible on public charge grounds. These materials should simply and clearly identify the standard or test that will be applied and to whom it applies. DHS should also identify who is not subject to a public charge determination and emphasize that they will not be punished or harmed for receiving public benefits or participating in public programs for which they qualify. An official fact sheet or FAQ document published by DHS in multiple languages would be an invaluable resource to our organizations and the individuals we serve. Patients continue to be afraid to accept or enroll in benefits, making the impossible choice to forego health care to protect their immigration status. They cannot wait for a new rule - these individuals and families need to hear directly from DHS now that they will not jeopardize their immigration status or their sponsors by accepting public benefits. Without such clarity from DHS, many immigrants and refugees are likely to continue to self-select out of the physical and mental health services, nutrition assistance, and housing assistance that they are legally eligible to receive.

Conclusion

WACH, CHNW, and its member CHCs appreciate the opportunity to provide comments and feedback in response to the ANPRM. We have witnessed the harm, fear, and confusion in Washington's immigrant communities caused by the prior administration's public charge rule. We encourage DHS to act quickly and conscientiously to issue regulations on the public charge ground of inadmissibility that are unbiased and embrace this nation's history of welcoming immigrants. At the same time, we hope that DHS will develop accessible communications and materials that agencies and non-profit organizations can use to assure our patients and communities that accepting or enrolling in public benefits will not jeopardize their immigration status or that of their families or sponsors.

Sincerely,

Bob Marsalli, Chief Executive Officer
Washington Association for Community Health



Leanne Berge, Chief Executive Officer
Community Health Network of Washington
Community Health Plan of Washington

Washington CHCs:

Columbia Basin Health Association
Country Doctor Community Health Centers
Cowlitz Family Health Center
Community Health Association of Spokane
Community Health Center of Snohomish County
Community Health Care
Community Health of Central Washington
Columbia Valley Community Health
Family Health Centers
HealthPoint
International Community Health Services
Lake Roosevelt Community Health Centers
Mattawa Community Medical Clinic
Moses Lake Community Health Center
The NATIVE Project
NeighborCare Health
NEW Health Programs Association
North Olympic Healthcare Network
Peninsula Community Health Services
Sea Mar Community Health Centers
The Seattle Indian Health Board
Tri-Cities Community Health
Unity Care NW
Valley View Health Center
Yakima Neighborhood Health Services
Yakima Valley Farm Workers Clinic