National
MLTSS
Health Plan Association

Samantha Deshommes
Chief, Regulatory Coordination Division
Office of Policy and Strategy
U.S. Citizenship and Immigration Services
Department of Homeland Security
20 Massachusetts Avenue NW
Washington, D.C. 20528

Re: Notice of Proposed Rulemaking Inadmissibility on Public Charge Grounds (DHS Docket No. USCIS–2010–0012)

Dear Chief Deshommes,

Thank you for this opportunity to provide comment on the Department of Homeland Security (DHS), U.S. Citizenship and Immigration Services' proposed rule *Inadmissibility on Public Charge Grounds*.

On behalf of the National Managed Long-term Services and Supports (MLTSS) Health Plan Association, we would like to express our concern with the proposal to allow the receipt of a broader set of public benefits (including all Medicaid benefits) to factor into determinations of whether an individual is or might become a 'public charge,' as it may have the unintended consequence of reducing an already strained long-term care workforce. Based on the most recent estimates, approximately one in four direct long-term care workers are immigrants[1] and may be subject to this new determination standard that may eventually lead to their emigration. As the demand for long-term care continues to increase alongside the portion of the population above the age of 65, the workforce serving these individuals will need to expand rather than contract.

The Association represents health plans which contract with states to provide long-term services and supports (LTSS) to beneficiaries through the Medicaid program. Our members currently cover about 75 percent of all enrollees in MLTSS plans and assist States in delivering high quality long-term care services at the same or lower cost as the fee for service system with a focus on ensuring beneficiaries' quality of life and ability to live in the community instead of an institution. Member organizations include Aetna Inc., AmeriHealth Caritas, Anthem Inc., CareSource, Centene Corp., Commonwealth Care Alliance, Health Plan of San Mateo, L.A. Care Health Plan, Molina Health Care Inc., Tufts Health Plan, UPMC Health Plan, and WellCare Health Plans Inc.

Given the number of baby boomers who will transition into the age 65+ population, the need for long-term care is expected to precipitously grow. The United States Census Bureau projects that by 2035 one in five individuals in the U.S. (78 million) will be above the age of 65 and approximately two percent of the population (9 million) will be above the age of 85.[2] As this population continues to age, they are likely to need help with various activities of daily living (ADLs), such as bathing, dressing, and eating. Recruiting a

[1] Espinoza, Robert. "Immigrants and the Direct Care Workforce". PHI. June 2017. Available at <https://phinational.org/resource/immigrants-and-the-direct-care-workforce/>
[2] THE NEXT FOUR DECADES: The Older Population in the United States: 2010 to 2050. United States Census Bureau. Available at <https://www.census.gov/prod/2010pubs/p25-1138.pdf>

large enough workforce (e.g. personal care aides and home health aides) to support these individuals will be a challenge. A direct care workforce shortage currently exists, with one in five caregiving positions unfilled in some parts of the country,[3] and an additional 1.1 million direct care workers will be needed by 2030 to meet growing LTSS needs. This challenge also extends to health plans, who need to meet certain requirements to contract with an adequate number of providers within their networks to meet the needs of their enrollees.

The DHS currently considers an individual to be a "public charge" if they "[have] become (for deportation purposes) or [are] likely to become (for admission or adjustment purposes) primarily dependent on the Government for subsistence, as demonstrated by either the receipt of public cash assistance for income maintenance or institutionalization for long-term care at Government expense." Government assistance, under this definition, includes Temporary Assistance for Needy Families (TANF), General Assistance programs, and institutional long-term care (e.g. nursing home services provided under Medicaid). Under the proposed rule, the DHS suggests to more broadly include monetizable benefits such as Supplemental Security Income (SSI), TANF, Supplemental Nutrition Assistance Program (SNAP), and public housing alongside non-cash benefits such as benefits paid for by Medicaid and low-income subsidies for Medicare Part D.

Given that most home health aides and personal care aides fall close to or below the federal poverty level (FPL),[4] they are more likely to utilize one or more of the public programs that would factor into public charge determinations under the proposed rule. We are concerned this would lead to a certain portion of the approximately one in four long-term care providers who are immigrants to be deemed public charges and would eventually need to leave the country. As outlined above, there already exists a shortage of caregivers, compounded by several factors such as competition with retail job positions, the need to establish positive career trajectories, and the difficulty of caring for people with complex needs. As such, we are concerned that any additional pressure on the workforce would further exacerbate the issue at hand.

Additionally, some individuals may choose to forgo LTSS services for chronic conditions in response to this proposed rule, eventually leading them to seek care via emergency departments. This would shift spending onto local hospitals and may increase overall healthcare spending relative to current spending on home- and community-based LTSS. As mandated by the Emergency Medical Treatment and Labor Act (EMTALA), emergency departments are required to stabilize and treat any individual who seeks care, regardless of their insurance status or ability to pay. If a beneficiary no longer has access to the services that help maintain their independence and quality of life, their condition may deteriorate to the point where they would need emergency treatment. Therefore, hospitals may be forced to accept a new population of individuals who do not have access to public benefit programs to pay for the emergency services rendered. This represents a transfer of covered costs for long-term care services to non-covered medical costs.

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[3] The Long-Term Care Workforce Crisis: A 2018 Report. Wisconsin Health Care Association. May 2018. Available at <http://files.constantcontact.com/10709df6001/8d407825-0d49-42af-9ae2-5f0aaddfd468.pdf?ver=1524683264000>

[4] Based on data from the Bureau of Labor Statistics (BLS), the median salary for home health aides and personal care aides was approximately $23,000 in 2017. Comparatively, in 2017, federal poverty guidelines defined 100% of FPL for household sizes of 2 and 3 individuals as $16,240 and $20,420, respectively.

As the DHS considers changes to public charge determinations, we encourage the Department to consider the unintended consequences of incorporating a broad definition of public benefits in public charge determinations on the long-term care workforce. As the health care system works to accommodate an increasingly aging population, long-term care providers will be an essential component of any strategy to care for individuals in the setting of their choice.

Thank you for your consideration of our comments. If you have any questions, please contact me at latkins@mltss.org.

Sincerely,

G. Lawrence Atkins
Executive Director