JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

April 25, 2022

U.S. Citizenship and Immigration Services
Department of Homeland Security
20 Massachusetts Avenue NW
Washington, DC 20529-2140

Submitted via www.regulations.gov

Re: DHS- Docket No. USCIS-2021-0013, 87 Fed. Reg. 37, 10570; Public Charge Ground of Inadmissibility

Justice in Aging appreciates the opportunity to respond to the Department of Homeland Security's (DHS's) notice of proposed rulemaking (NPRM) on the Public Charge Ground of Inadmissibility. Justice in Aging is a nonprofit organization with the mission of improving the lives of low-income older adults living in the United States. For 50 years, we have used the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. Our mission is to secure the opportunity for older adults to live with dignity, regardless of financial circumstances—free from the worry, harm, and injustice caused by lack of health care, food, or a safe place to sleep.

Using our expertise in Social Security, Supplemental Security Income, Medicare, and Medicaid, we work to strengthen the social safety net and remove the barriers low-income seniors face in trying to access the services they need. We also provide technical expertise to thousands of advocates across the country on how to help low-income older adults access the programs and services they need to meet their basic needs. Our advocacy centers on issues that directly address systemic inequities faced by older adults of color, older women, LGBTQ older adults, older adults with disabilities, and older adults who are immigrants or have limited English proficiency.

We thank DHS for its effort to clearly define public charge and limit the types of public benefits considered, since this will reduce confusion and mitigate chilling effects on the use of public benefits in the future. The 2019 rule was accompanied by a far-reaching chilling effect on the use of public benefits by immigrants, including older adults, and their families, which advocates warned would have negative implications on their health, financial stability, and more. We thank DHS for using this opportunity to reverse course and mitigate these chilling effects, and we recommend that this continue to be one of the primary public policy goals of the new rule. In addition, the proposed rule can be strengthened to align with President Biden's direction that DHS and other federal agencies eliminate "barriers that prevent immigrants from accessing government services available to them."[1]

[1] Executive Order 12012 on Restoring Faith in Our Legal Immigration Systems and Strengthening Integration Inclusion Efforts for New Americans (Feb. 2, 2021), https://www.whitehouse.gov/briefing-room/presidential-actions/2021/02/02/executive-order-restoring-faith-in-our-legal-immigration-systems-and-strengthening-integration-and-inclusion-efforts-for-new-americans/.

I. Likely to Become a Public Charge. § 212.21(a)

As discussed in greater detail below, we do not support the (1) the broad definition of cash assistance for income maintenance, which includes non-federal safety net programs and (2) the inclusion of long-term institutionalization. Our proposed definition for public charge is "likely at any time to become primarily dependent on the government for subsistence, as demonstrated by either the receipt of (1) Supplemental Security Income (SSI), 42 U.S.C. 1381 et seq.; or (2) Cash assistance for income maintenance under the Temporary Assistance for Needy Families (TANF), 42 U.S.C. 601 et seq."

The language "primarily dependent" is appropriate in defining public charge. § 212.21(a)

We support DHS's reasoning that "primarily dependent" is the appropriate language when defining public charge. Additionally, we agree that "primarily dependent" does not describe a situation in which a person uses one or more government benefits to meet *some* needs. This higher threshold is especially critical for ensuring that the public charge rule does not discriminate against older adults. Most older Americans will rely on government benefits to meet at least some of their needs at some point in their lives—most typically for long-term services and supports as discussed below. It is important that older immigrants be afforded the same opportunities to meet their basic needs as they age.

The "primarily dependent" language is also more accurate than the alternative of a less- or more-likely language. Public charge determinations are already wrought with subjective determinations and analyses, especially in regards to future projections about whether a person will later become a public charge. We believe that the "primarily dependent" language strikes an appropriate balance between providing a definition in line with the statutory intent without overly confining definitions as the 2019 rule did.

Finally, we agree that DHS should avoid any numerical analysis or threshold because an attempt to find a one-size-fits all threshold is likely to be over-inclusive and not sufficiently nimble to account for the myriad of ways in which older adults access government benefits.

All non-cash benefits should be excluded from the public charge determination. § 212.21(a).

We support DHS's decision to exclude cash assistance for designated purposes, such as child care and utilities. Much like receipt of non-cash assistance benefits, receipt of special-purpose cash assistance does not accurately predict whether a person is likely to be a public charge because individuals who receive these benefits can also independently earn income or have resources. This is also true for disaster assistance, pandemic assistance, and other cash assistance categories that are not intended to maintain income but instead are designed to assist a person in response to a specific circumstance or event. Such assistance is especially important for older adults who are often living on fixed incomes and do not have spare money in their budget in an emergency, especially a prolonged one like the COVID-19 pandemic. By removing non-cash benefits from the public charge determination, we can mitigate subjectivity and structural biases in immigration decisions.

As discussed later in this comment, we urge DHS to exclude all non-cash benefits including those provided by States and localities and institutional long-term care medical services under Medicaid.

Only current use of benefits use should be considered. § 212.21(a)

Consideration of an applicant's use of public benefits should be qualified by only considering the applicant's *current use* of SSI, TANF, or any other benefits that will be part of the public charge determination. A person's past, but not current, use of SSI and TANF is inconsequential to the public

charge determination because the person has had a change in circumstances that may make them unlikely to need safety net programs in the future.[2] For example, over 50% of Americans have enrolled one of the major public benefits programs at some point in their lives according to a 2012 study, and over a third of those who use public benefits use it for under three years.[3] Use of public benefits—including past use—is not a factor required by the public charge statute, and including past use in the determination would send a chilling message to prospective applicants, including older adults, about using public programs to supplement income. Given the high risk of chilling effects and the negligible benefit to determining whether someone will in the future be a public charge, past use of benefits of any kind should not trigger public charge determinations.

II. Cash Assistance for Income Maintenance should only include SSI and TANF and government should not be defined to include non-federal government programs. § 212.21(b), (e)

We recommend that rather than defining "government," DHS clarify in the definition of likely to become a public charge that SSI and TANF are the specific programs that may be considered in a public charge determination, as stated above. We strongly disagree with the inclusion of safety net programs from States, territories, tribes, and localities in the definition of cash assistance for income maintenance for the reasons discussed in comments submitted by the Protecting Immigrant Families coalition.

We support DHS's effort to clearly define which public benefits are considered. As an additional step in mitigating and reversing chilling effects from the 2019 rule, we recommend DHS also provide a non-exclusive list of examples of what does not count as cash assistance.

III. Long-Term institutionalization at government expense should not be included as a category of benefits in the public charge determination. § 212.21(c)

We recommend DHS exclude consideration of long-term institutionalization altogether because of the changed circumstances and nature of long-term care institutions from when public charge was first enacted; because Medicaid-funded institutionalization does not necessarily equate to primary dependence on the government; because making long-term institutionalization a factor discriminates against older adults and people with disabilities; and because not fully excluding Medicaid causes a chilling effect on enrollment in Medicaid and other health assistance programs.

First, including long-term institutionalization as a category of benefits in the public charge determination necessarily includes Medicaid given the landscape of long-term care services in the U.S. today. Medicare does not pay for long-term institutional care and the annual median cost is $94,900 for a semi-private room in a nursing facility.[4] This puts privately funded long-term institutionalization out of reach for most

[2] By virtue of their age, older adults are possibly more likely to have used public benefits in the past as well.
[3] *See* Pew Research Center, A Bipartisan Nation of Beneficiaries (Dec. 18, 2021), https://www.pewresearch.org/social-trends/2012/12/18/a-bipartisan-nation-of-beneficiaries/; Straight Talk on Welfare Statistics (Dec. 9, 2021), https://fortunly.com/statistics/welfare-statistics/#gref. The largest group of public benefits users are children. *Id.*
[4] *See* Genworth, Cost of Care Survey (2021), www.genworth.com/aging-and-you/finances/cost-of-care.html;; *see* Ric Edelmen, *The Sobering Cost of Long-Term Care*, Money Geek (Feb. 14, 2022), https://www.moneygeek.com/seniors/resources/paying-for-long-term-care-guide/ (noting that most individuals over 60 are denied long-term care insurance and recommending reverse mortgages or selling one's home to pay for LTC).

people, including immigrant families with limited income and wealth.[5] Thus, Medicaid is the primary payer of long-term services and supports in the U.S. and pays for more than 60% of nursing facility residents' care.[6]

Institutional long-term care also plays a much larger and different role than publicly-funded almshouses played in the early days of the public charge doctrine.[7] Today, 2.6% of the U.S. population, or 1.4 million people, have their nursing facility care paid for by Medicaid.[8] This is 26 times the number of individuals who relied on almshouses in 1903.[9] The populations who resided in almshouses also vary greatly from those residing in long-term care facilities today. Long term care institutions today serve only people with disabilities--the vast majority (80 percent) are 65 and older and have multiple self-care needs. In contrast, much more varied populations lived in almshouses for all or part of the year, including adults and children of all ages and people with and without disabilities. Given the crucial difference between the almshouses of the last century and long-term care institutions today—particularly their purpose, utilization rates, and the populations who need them—DHS should recognize that this aspect of the public charge doctrine is particularly outdated (and discriminatory as discussed below) and not include long-term institutionalization at all in public charge determinations.

Second, while we agree with DHS's statement in the preamble that "Institutions assume total care of the basic living requirements of individuals who are admitted, including room and board,"[10] thus distinguishing the level of financial support from home- and community-based care (HCBS), we disagree that this equates to primary dependence on the government. First, many people who rely on Medicaid for long-term institutionalization have already contributed significant personal income and assets toward the cost of their care, even before entering an institution, and have been forced to impoverish themselves to qualify for those services.[11] Second, people with Medicaid are also generally required continue to contribute Social Security benefits and other income to the costs of their institutional care on a monthly basis, and are only able to keep a small monthly personal needs allowance ($50 on average) to pay for things like clothing and haircuts.[12] So in this sense, institutionalization itself does not

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[5] On average, a U.S. immigrant earns $31,900 annually. Pew Research Center, Facts on U.S. Immigrants, 2018 (Aug. 20, 2020), www.pewresearch.org/hispanic/2020/08/20/facts-on-u-s-immigrants-current-data/.

[6] Kaiser Family Foundation, Medicaid's Role in Nursing Home Care (2017), https://www.kff.org/infographic/medicaids-role-in-nursing-home-care/

[7] Similarly, SSI is only available to individuals with disabilities and older adults, raising yet another factor that acts as a proxy for age and/or disability in the public charge determinations.

[8] In 2016, 1,347,600 million people lived in nursing homes out of a total population of 323,071,755 people, which is equal to 4 percent of people in the U.S. National Center for Health Statistics, Vital and Health Statistics, Long-term Care Providers and services Users in the United States, 2015-2016, www.cdc.gov/nchs/data/series/sr_03/sr03_43-508.pdf; World Bank, Population total, United States, 2016, https://data.worldbank.org/indicator/SP.POP.TOTL?locations=US; Kaiser Family Foundation, Medicaid's Role In Nursing Home Care (2017) https://files.kff.org/attachment/Infographic-Medicaids-Role-in-Nursing-Home-Care.

[9] United States Census Bureau, Paupers in Almshouses, 104, www.census.gov/library/publications/1904/dec/paupers-1904.html.

[10] 87 F.R. at 10613.

[11] The financial eligibility criteria for Medicaid long-term care often requires middle-income older adults to spend down their savings to qualify because, as of 2022, the income limit for an individual is $2,523 per month (300% of the Federal Benefit Rate) and the asset limit ranges from $2000 to $4000, depending on the state. *See* American Council on Aging, Answers to All of Your Questions About Medicaid Long Term Care (Feb. 28, 2022), www.medicaidplanningassistance.org/medicaid-long-term-care-faq/.

[12] 42 U.S.C. § 1396a (q); *see* Kaiser Family Foundation, Medicaid Financial Eligibility for Seniors and People with Disabilities: Findings from a 50-State Survey (2019). The average monthly Social Security retirement benefit in 2019 $1,461 per month, and the average stay at a residential nursing facility is upwards of $600 per month, and so older

equate to primary dependence on the government as many people have exhausted their household's resources and are paying in to access this benefit.

Third, basing public charge decisions on long-term institutionalization is also in conflict with non-discrimination principles in the Americans with Disabilities Act,[13] Section 1557 of the Affordable Care Act[14] and the Age Discrimination Act of 1975[15] because older adults and people with disabilities are the only groups who experience long-term institutionalization. There is an existing institutional bias in the United States' long-term care system that favors nursing facilities as opposed to home-based support, regardless of the person's needs or desires.[16] As described more fully below, there are many barriers to accessing HCBS that force people into institutions to receive necessary long-term services and supports. In addition, this bias toward institutional settings is also a common perception—adjudicators may inaccurately view older adults and people with significant disabilities as likely candidates for long-term institutionalization in the future, given pervasive stereotypes and lack of understanding of modern disability services. In reality, it is not possible to predict with any reasonable accuracy the likelihood that a person may be institutionalized on a long-term basis in the future.

The inclusion of long-term institutionalization has a racialized impact as well. People with disabilities are overrepresented among communities of color. In fact, disabled people of color experience more and different forms of discrimination in all aspects of life,[17] including institutionalization. Racial disparities in healthcare also result in older adults of color having more disabilities than white older adults and requiring more assistance with activities of daily living, which necessitates long-term care services.[18] Research shows that Black older adults are institutionalized for long-term care services at higher rates than their white counterparts,[19] and are less likely to be moved out of institutional settings.[20] Most

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adults with limited income commonly use all or most of Social Security retirement funds they have paid into for decades towards their long-term care. *See e.g.,* Paying For Senior Care, Social Security & Paying for Senior Housing or Home Care (2019).

[13] 42 U.S.C. § 12132; 28 C.F.R. § 25.130(d) (integration mandate).

[14] 42 U.SC. § 18116. The ACA incorporates the Rehabilitation Act of 1973 and Age Discrimination Act of 1975.

[15] 29 U.S.C. § 6101.

[16] There is only an entitlement to nursing facility care under federal Medicaid law. Leah Smith, Ctrs. for Disability Rights, *The Institutional Bias,* https://cdrnys.org/blog/disability-dialogue/the-disability-dialogue-the-institutional-bias/#:~:text=In%20the%20United%20States%2C%20nursing,community%20based%20services%20are%20optional. (recounting experience of institutionalized patients who were not receiving any special services, such as physical therapy, while in a facility); Council on Quality and Leadership, The Relationship Between Disability Prejudice and Medicaid Home and Community Based Services Spending 11 (2019), https://www.c-q-l.org/wp-content/uploads/2020/02/CQL-2019-Friedman-VanPuymbrouck-Whats-the-relationship-between-ableism-and-community-living-and-why-matter.pdf (finding that the greater a State's implicit ableism, the less the State spent on HCBS).

[17] Ibrahm Kendi & Rebecca Cokley, Podcast, *Ableism & Racism: Roots of the Same Tree (Be Anti-Racism)*, available at https://share.descript.com/view/OhggnmprRFb (discussing bias against disabled students of color).

[18] Shih-Fan Lin et al., *Black-White Disparity in Disability Among U.S. Older Adults: Age, Period, and cohort Trends*, 69 J. of Gerontology 784, 784-797 (2014), available at https://academic.oup.com/psychsocgerontology/article/69/5/784/563587#57309005 (finding that Black older adults had a higher probability of needing assistance with activities of daily living than White older adults).

[19] David B. Smith & Vincent Mor, Racial Disparities in Access to Long-Term Care: The Illusive Pursuit of Equity (20018), https://www.commonwealthfund.org/publications/journal-article/2008/nov/racial-disparities-access-long-term-care-illusive-pursuit.

[20] Meghan J. Morales & Stephanie A. Robert, *Black-White Disparities in Moves to Assisted Living and Nursing Homes Among Older Medicare Beneficiaries*, 75 J. of Gerontology: Social Sciences 1972-1982 (2019), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7566960/.

relevant to the public charge rule, Black older adults are more likely to be in nursing facilities where Medicaid is the primary payer.[21] Therefore, considering long-term institutionalization in the public charge decision would also have a disproportionate negative effect on immigrants of color.

Finally, including any type of Medicaid benefit in public charge determinations will cause confusion and run counter to the public policy goals of the new rule by perpetuating the chilling effect from the 2019 rule. Given that public charge is a forward-looking test, it is difficult to provide clear messages to people who need Medicaid that their enrollment for non-institutional services now will not be used to indicate that they will rely on Medicaid should they need long-term care in the future. It is impractical to communicate that distinction. Just as it is not possible for an adjudicator to predict with any reasonable accuracy the likelihood that a person may be institutionalized on a long-term basis in the future, it is similarly challenging for an individual to know whether they will one day be institutionalized and rely on Medicaid. Including long-term institutionalization unnecessarily complicates the decision for people to enroll in Medicaid even when it would have no public charge implications and would only incentivize disenrollment from the health insurance program. This is particularly dangerous to both public and individual health. The COVID-19 pandemic highlighted the importance of having active health care coverage, and DHS and all federal agencies should take steps like excluding Medicaid completely from the public charge determination to mitigate the long-term impacts of the COVID-19 as well as ensure we are better prepared for future health emergencies.[22]

If long-term institutionalization is included, the definition should be as narrow as possible. § 212.21(c)

If long-term institutionalization is included in the public charge determination, we recommend a definition that is as narrow as possible and accounts for the institutional bias and barriers to accessing home-based care. First, we also strongly support the clarification in the preamble that HCBS are *not* included and recommend that DHS include this clarification in the preamble to the final rule as well as in guidance and training to adjudicators. As DHS notes, HCBS are critical to ensuring people with disabilities, including older adults, can contribute to their communities. For older adults in particular, being supported with daily activities at home allows them to in turn support their families and enables their family members to work outside the home.[23] HCBS are also unlike institutional services in that Medicaid does not pay for room and board. Nor is it as costly for the state--while some people receiving HCBS may need 24-hour support, most individuals receive only a few hours of paid support per week and unpaid caregivers provide the bulk of the care.[24]

We also support DHS's clarification in the regulatory text that institutionalization is, "in the case of Medicaid, limited to institutional services under section 1905(a) of the Social Security Act." Likewise, we

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[21] Lashyra T. Nolen et al., *How Foundational Moments in Medicaid's History Reinforced Rather Than Eliminated Racial Health Disparities* (2020), available at https://www.healthaffairs.org/do/10.1377/forefront.20200828.661111/full/. Additionally, there is documented racial discrimination against older adults of color in private-pay long-term care institutions. Ruqaiijah Yearby, *Striving for Equality, but Settling for the Status Quo in Healthcare: Is Title VI More Illusory Than Real?,* 59 Rutgers L. Rev. 429 (2007).

[22] Kaiser Family Foundation, What Issues Will Uninsured People Face With Testing and Treatment For Covid 19?, https://www.kff.org/coronavirus-covid-19/fact-sheet/what-issues-will-uninsured-people-face-with-testing-and-treatment-for-covid-19/ (reporting that uninsured workers were at a greater risk of exposure); *see generally* The White House, Memorandum on Addressing the Long-Term Effects of Covid-19 (Apr. 5, 2022).

[23] Community Living Policy Center, Reducing Costs for Families and States by Increasing Access to Home- and Community-Based Services (Mar. 2022).

[24] *Id*.

strongly support explicitly excluding imprisonment and short periods of rehabilitation from the definition of long-term institutionalization. We also agree with DHS that sporadic stays where a person may have been institutionalized on multiple occasions, even over a period of years, but is discharged after each stay should be excluded from consideration.

DHS asks whether it should reference a specific length of time in the final rule or associated guidance. We do not support a time-based definition of "long-term" because, much like cash assistance thresholds, it is likely to be over-inclusive. Rather, DHS should define "long-term institutionalization" to refer to someone who is *permanently residing* in an institution. This approach aligns with HHS's recommendation during the 1999 rulemaking. In a letter to DHS, HHS defined "Long-Term Institutionalized Care" as "The limited case of [a noncitizen] who *permanently resides* in a long-term care institution (e.g., nursing facilities) and whose subsistence is supported substantially by public funds (e.g., Medicaid)" (emphasis added).[25] As DHS notes, the length of time, and even seemingly "permanent" institutionalization, must always be considered in the totality of the circumstances.

We further recommend only *current* institutionalization should be considered. The fact that a person was institutionalized in the past does not suggest a likelihood of future institutionalization. As explained below, access to HCBS varies greatly by state and even within states, as well as by disability. Also, states are increasing access to HCBS and the federal government is investing in HCBS, further complicating an adjudicator's ability to predict with any reasonable accuracy the likelihood that a person may be institutionalized on a long-term basis in the future. In addition, past institutionalization may reflect a medical issue that has since been resolved, a lack of access to community services that have since been provided, a lack of accessible housing that has been secured, or any number of other factors that make future institutionalization unlikely.

Consideration of Evidence that Institutionalization Violates Federal Law

We deeply appreciate DHS's recognition that there are some circumstances where an individual may be institutionalized long-term in violation of Federal antidiscrimination laws, including the Americans with Disabilities Act (ADA) and Section 504, and we agree that, "The possibility that an individual will be confined without justification thus should not contribute to the likelihood that the person will be a public charge." Under the totality of the circumstances test, DHS proposes to direct adjudicators who are assessing the probative value of past or current institutionalization to consider any evidence that such institutionalization violates Federal law and asks for comment about what specific types of evidence it should consider for this purpose.

First, we repeat our recommendation that DHS exclude long-term institutionalization altogether as the best, and perhaps only, way to ensure unjustified institutionalization does not contribute to the likelihood that a person will be a public charge. However, if DHS does move forward with including long-term institutionalization as a factor, we recommend that DHS require adjudicators who are reviewing an applicant's past or current institutionalization to examine both (1) whether the individual would have preferred (or acquiesced to) HCBS and (2) the availability and accessibility of HCBS in the particular state and county where they were institutionalized *and* where they are currently residing or intending to reside.[26]

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[25] Inadmissibility and Deportability on Public Charge Grounds, 64 FR 28676 at 28686, May 26, 1999.

[26] Nationwide, more than 820,000 people are on HCBS waitlists. In Florida alone, 50,000 seniors are formally waiting for HCBS. Neither of these figures include many older adults who cannot wait for services nor those who are in institutional long- term care who could have received HCBS if it were available when they needed it. Justice in Aging, Medicaid Home- and Community-Based Services for Older Adults with Disabilities: A Primer (2021);

We urge DHS to provide thorough guidance and training to USCIS officials and adjudicators to consider the totality of circumstances given the two factors above. This guidance and training should expressly include information on the ADA and the *Olmstead* integration mandate, as well as a discussion that HCBS varies from state to state, and even within states, and that federal Medicaid law requires states to cover institutional care but not HCBS. Circumstances that adjudicators should construe as evidence of unjustified institutionalization include, but are not limited to:

- when an individual was part of a hospital-to-institution pipeline—for example, it was recommended they enter an institution for rehabilitative purposes but were either unaware of the ability to return home with support or unable to (e.g., they lost their home while institutionalized because they could not pay the rent or mortgage);
- when there are waiting lists, staffing shortages, or other administrative barriers to accessing HCBS;
- the amount of time it takes for someone in that particular locality to get HCBS after they apply;
- when there are no HCBS options in the individual's locality; and
- when a guardian or other caregiver places the individual in long-term care without the full consent of the individual.

Other relevant circumstances that adjudicators can consider are: the person having previously or currently applied for HCBS; the person is currently or was previously on a waiting list for HCBS; and the individual sought/is seeking assistance to leave an institution, such as by talking to a social worker/case manager or retaining an attorney. In considering the applicant's circumstances, adjudicators should always construe ambiguous evidence or situations where it is difficult to determine the person's conscious preference—for example when a person or their physician was not aware of HCBS options—in favor of the applicant. Finally, the lack of evidence that past or current institutionalization is in violation of Federal law should never be construed against the applicant.

Long-term Institutionalization in the Totality of the Circumstances

Given that the only individuals who require long-term institutionalization are older adults and/or people with disabilities, and the unignorable fact that people of color are more likely to be institutionalized,[27] negatively weighing long-term institutionalization is a proxy for discriminating against these populations and conflicts with the Administration's commitment to health equity.[28] We therefore urge DHS to remove it as a factor completely or minimize its role in the totality of the circumstances test as much as possible.

If long-term institutionalization remains a factor, we support DHS's proposals in § 212.22(a)(3) that current or past institutionalization is not itself alone to be determinative and that the scope and duration of services, proximity of receipt, and evidence that institutionalization violates federal law be

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Community Living Policy Center, Care Can't Wait: How Do Inadequate Home- and Community-Based Services Affect Community Living and Health Outcomes? (2021), https://heller.brandeis.edu/community-living-policy/images/pdfpublications/care-cant-wait.pdf.

[27] Megan J. Morales & Stephanie Robert, *Black-White Disparities in Moves to Assisted Living and Nursing Homes Among Older Medicare Beneficiaries*, 75 J. Gerontology 1973-1974 (2020), available at https://academic.oup.com/psychsocgerontology/article/75/9/1972/5610255?login=false (finding that Black older adults are more likely to be institutionalized than White counterparts).

[28] In DHS's own equity plan, the Department cites public charge rulemaking as an accomplishment. DHS Equity Action Plan Pursuant to Executive Order 13985 (Jan. 25, 2022); *see also* HHS Statements on New Plan to Advance Equity in the Delivery of Health and Human Services (Apr. 14, 2022).

considered. We also urge DHS to take an approach that puts the least burden on the applicant and allows for a presumption that there is a possibility *any* past or current institutionalization was unjustified even absent such affirmative evidence put forward by the applicant. Thus, we recommend removing "submitted by the applicant" and stating instead "evidence that the applicant's institutionalization violates federal law, including the Americans with Disabilities Act or the Rehabilitation Act."

IV. Receipt of countable income should be defined to clearly state that issuance/provision of services is required, clarify what is not receipt, and list examples of what does not count as receipt. § 212.21(d)

We support DHS's narrow definition of "receipt" of countable benefits to mean the intending immigrant themselves being "listed as the beneficiary" by a "public benefit-granting agency." This will be one step in remediating confusion and fear regarding public charge determinations which resulted in a chilling effect. However, we recommend three additions to provide even greater ease of administration and mitigation of the chilling effect.

First, issuance, delivery, and/or provision of services should be added to the first part of the definition. Merely being named as the beneficiary by the applicable benefits-administering agency is insufficient to show receipt of public benefits per the current rule. We recommend clarifying this up front.

Second, rules as to what is not counted as receipt should be added to the second part of the definition. For example, the rule should state that an intending immigrant who is not eligible for a particular countable benefit will not be considered to be in receipt of that benefit, even if another person in their household receives it. The second part of the definition should also include common words that do not necessarily equate to receipt, such as "payee" or "representative payee," "head of household," and receipt "on behalf of." It is not uncommon for older adults to receive assistance with obtaining benefits, and a family member or someone else may serve as a legal guardian, power of attorney, or representative payee. Additionally, if long-term institutionalization is included as a benefit in the public charge determination, the rule should clearly state that approval for such care without also actually residing in an institution long-term does not count. Because of the complicated nature of Medicaid long-term care applications that often take months to get approved, an institution may start a Medicaid application as a matter of course prior to knowing whether that person will remain in the institution and actually receive Medicaid-covered services at all much less on a permanent basis. Thus, it is important to clarify that the application for and approval of Medicaid is not alone does not count.

Lastly, DHS should add a non-exclusive list of examples of what does not count as receipt of benefits by an intending immigrant as part of the regulatory text. For example, the list should include "child only" TANF cases and also "serving as the representative payee" for someone under the SSI program.

V. Under the Totality of circumstances, an affidavit of support should create a presumption in favor of the applicant and age alone, like disability, should not be determinative. § 212.22

We support DHS's proposed language at 212.22(a)(1) that simply acknowledges the statutory language and does not to define the five factors. The previous administration's attempt to define the statutory factors resulted in a complicated web of competing factors, many of which were not listed in or

contemplated by the statute, and that clearly discriminated against older adults.[29] The attempt to define the statutory factors permitted both implicit and explicit biases that made it nearly impossible for older adults to pass the public charge test and was burdensome for applicants, practitioners, and adjudicators to navigate.

We also support the language proposed in 212.22(a)(2) to favorably consider the affidavit of support (AOS). AOSs are more relevant to public charge determinations compared to the statutory factors. Given the importance of AOSs, we recommend that DHS clarify in guidance that if an AOS negates receipt of a public benefit, then the totality of the circumstances test should result in favor of the applicant. We further recommend that DHS provide common-sense guidance to USCIS officials when considering the totality of the circumstances (for example, it is common for older adults to seek mutual support from their families).

We also appreciate that DHS addressed concerns about relying on the disability as a negative factor by including regulatory text at 212.22(a)(4) that a finding that an applicant has a disability is not alone determinative. We recommend that DHS add text that similarly states that age alone should not be a determining factor. We believe this is necessary to prevent discrimination against older adults. First, as mentioned in discussing long-term institutionalization, an adjudicator may incorrectly assume an older adult will need institutionalization simply because of their age. Second, absent specific guidance, adjudicators may also make incorrect assumptions about older adults' assets, resources, and financial status, as well ask their education and skills and unduly disfavor a person who is not working outside the home. In reality, many older adults, especially in immigrant families, contribute greatly to their households by acting as caregivers and helping maintain the home. This allows other individuals to work outside the home.

Conclusion

We appreciate DHS's efforts to promulgate a more humane and clear public charge rule. For the reasons discussed above, we urge DHS to finalize a rule that excludes long-term care altogether and makes the other changes we recommend as soon as possible. We believe these changes will strengthen and better align the public charge policy with the Administration's goals. If any questions arise concerning this submission, please reach out to Natalie Kean, Senior Staff Attorney, at nkean@justiceinaging.org.

Sincerely,

Denny Chan
Director of Equity Advocacy

[29] These factors—ranging from weighted to heavily weighed—took into account, among other factors, an applicant's current and estimated income, job history, job skills, liabilities and debts, health status, health insurance enrollment, assets, credit reports, prior income tax flings, educational level (lack of high school degree was a negative factor), foreign education degree equivalency reports, and proficiency in English.