PHI QUALITY CARE THROUGH QUALITY JOBS

December 19, 2025

Re: PHI Comments on NPRM: Public Charge Ground of Inadmissibility (DHS Docket No. USCIS-2025-0304)

Thank you for the opportunity to respond to the Notice of Proposed Rulemaking (NPRM) from the Department of Homeland Security (DHS) regarding the Public Charge Ground of Inadmissibility. We strongly urge DHS to withdraw this proposal, as it would have devastating consequences for the nation's direct care workforce and for the older adults and people with disabilities who rely on direct care workers for daily care and support.

About Us. PHI is a national organization committed to strengthening the direct care workforce by producing robust research and analysis, leading federal and state advocacy initiatives, and designing groundbreaking workforce interventions and models. For more than 30 years, we have brought a 360-degree perspective on the long-term care sector to our evidence-informed strategies. **As the nation's leading authority on the direct care workforce, PHI promotes quality direct care jobs as the foundation for quality care.**

PHI respectfully urges the DHS to withdraw this NPRM. The rule would rescind the 2022 public charge regulation that narrowly defined and limited how the government assesses whether a person is allowed to enter the U.S. or obtain a green card. The current proposal discards the clear, administrable, and evidence-informed framework adopted in 2022 and replaces it with an expansive, vague, and punitive approach that treats the use of legally available safety-net programs as strong evidence against an immigrant's admissibility and future status.

This rule would have a devastating impact on the nation's largest and most in-demand occupation—direct care—and force many immigrants, now and in the future, to forego necessary food, shelter, and health care. Immigrants constitute at least 29 percent of the direct care workforce—with much higher proportions in some regions (both metropolitan and rural) where they are indispensable to

maintaining access to care.[1] In addition, many direct care workers who are not immigrants themselves live in mixed-status households that would be affected by this rule. Due to the low wages that characterize direct care occupations, nearly half of direct care workers rely on some form of public assistance to meet their basic survival needs.[2]

Because this proposed rule would broaden the public charge standard, expand the range of benefits and circumstances that can be weighed against immigrants and their families, and tighten public charge bond rules, it will have severe and foreseeable negative consequences for direct care workers, millions of Americans who depend on these services, the long-term services and supports (LTSS) system as a whole, and the nation's economy. PHI therefore urges DHS to withdraw this proposed rule in its entirety and retain the current 2022 public charge rule.

Background on the direct care workforce. Nearly 5.4 million home care workers, residential care aides, and nursing assistants comprise the direct care workforce in the U.S.[3] These workers provide vital daily care and support to more than 9.8 million older adults and people with disabilities across the spectrum of long-term care settings[4], as well as in hospitals and other settings. Their labor ensures that many family caregivers—who are predominantly women—do not have to partially or fully exit the labor force (and disrupt or end their careers) in order to ensure their family members and friends receive care.[5]

Immigrants are an essential and significant portion of the direct care workforce.[6] While at least 29 percent of direct care workers are immigrants, the actual proportion is likely much higher, since these data do not sufficiently account for the "gray market," which includes direct care workers hired directly by individuals and families using private funds.[7] Research shows that restrictions and deportations hurt the quality of direct care, while local increases in immigration lead to higher quality and more person-centered care.[8] Immigrant workers tend to remain in direct care positions longer than U.S.-born workers, providing stability and improved quality of care over time.[9] Conversely, harsher restrictions on immigrant workers correlate with reduced staffing levels in care settings.[10] PHI's research has consistently demonstrated that direct care workers—regardless of immigration status—are dedicated professionals who provide essential services that enable millions of Americans to maintain optimal health, wellbeing, and independence. Policies that destabilize this workforce directly harm care recipients and their families.

Increasing longevity and the growing U.S. population of older adults will continue to drive demand for direct care workers. As a result, direct care jobs are our nation's largest occupation with the most anticipated growth in the years ahead. It is estimated that this sector will add more than 772,000 new jobs to the economy between 2024 and 2034.[11] Yet even now, providers across the LTSS sector—including home care agencies, nursing homes, and assisted living communities—report chronic vacancies, high turnover, and reduced capacity. These shortages already limit access to services that are fundamental to the health and safety of older adults and people with disabilities.

Despite their importance, direct care jobs are characterized by low wages, insufficient training, and limited advancement opportunities. In particular, low wages combined with a high rate of part-time work make it challenging for direct care workers to financially support themselves and their families. Median annual earnings for direct care workers are just under $26,000.[12] As a result, 36 percent of direct care workers live in low-income households and 49 percent rely on the public benefits at issue in this NPRM, such as Medicaid, SNAP, and cash assistance.[13] Since immigrants (and people living in immigrant families) make up such a large portion of the direct care workforce and so many direct care workers must rely on public benefits to make ends meet, any policy that chills benefit use by immigrant workers or makes it riskier for immigrants to enter or remain in this workforce will directly undermine the stability and capacity of our LTSS system and drag down our economy.[14]

Medicaid is the primary payer for LTSS in the U.S.,[15] since Medicare and private health insurance do not for the most part provide long-term care coverage.[16] As the largest payers, federal and state governments hold significant leverage over the quality of direct care jobs. Yet historically and today, federal and state governments have undervalued the contributions of direct care workers. The fact that so many direct care workers need public benefits, in other words, is due to state and federal policy decisions and budget limitations.

The NPRM will exacerbate direct care workforce shortages. This proposal will discourage immigrants from entering and remaining in direct care jobs. By substantially broadening what may be considered in public charge determinations, the rule injects immigration risk into any decision by a low-wage worker or their family to use benefits for which they are lawfully eligible.

This dynamic will deter potential immigrants with caregiving skills from coming to the U.S. or accepting low-paid yet essential jobs if they fear that temporary reliance on safety-net programs will jeopardize their status. It will also push current immigrants out of the direct care workforce when continuing in their job becomes incompatible with maintaining or adjusting their immigration status. In addition, it will deepen geographic inequities in both metropolitan and rural areas that rely heavily on immigrant direct care workers.[17]

As already noted, most direct care workers, including many who are primary earners for their families, already struggle to cover housing, food, transportation, and childcare costs.[18] The proposed rule effectively tells these workers and their families: if you access programs that help you survive on low wages you will be labeled a public charge, face bond consequences, or be denied adjustment of status in the future.

The predictable result is a chilling effect. Workers and their families will disenroll from or forego benefits, including health coverage for themselves and their children, food assistance, and housing support. Economic insecurity for these workers will worsen, leading to higher stress, more instability in housing and transportation, and increased difficulty meeting basic needs. These stressors will translate into higher absenteeism, turnover, and burnout, precisely in roles where stability and continuity of relationships are crucial to quality care.[19]

These impacts are not speculative. DHS's own analysis anticipates large declines in benefit participation and acknowledges reductions in Medicaid payments to providers and reduced revenues for businesses in SNAP and housing markets. Those "indirect" effects translate directly into harmful labor-market conditions for the direct care workforce. Given the existing fragility of direct care workforce supply, even modest reductions in immigrant participation will have major consequences for access to LTSS.

The NPRM will undermine access to LTSS, harming older Americans and people with disabilities. Access to a stable direct care workforce is vital for millions of older Americans and people with disabilities and chronic illnesses. Without reliable direct care workers, individuals must go without essential care, leading to preventable hospitalizations, early nursing home admission, and other serious harms. Family caregivers are forced to cut back or leave paid employment to fill gaps in care.[20] Community integration goals under the Americans with

Disabilities Act (ADA) and the *Olmstead* decision are undermined as community-based supports become less available or less reliable.[21]

As well as driving these consequences for individuals, the proposed rule will also harm LTSS employers who rely on Medicaid funding. By creating significant reductions in Medicaid and other program enrollment, the rule will reduce revenue for Medicaid providers such as home care agencies and nursing homes. Providers already operating on thin margins will have fewer resources to recruit direct care workers, offer competitive wages and benefits, and invest in the training, supervision, and career advancement programs that promote retention. In a field already confronting vacancy rates so high that providers routinely decline referrals or reduce operations entirely, this rule pushes the system in the wrong direction.[22]

By making it harder for immigrant workers to remain in or join direct care jobs and by reducing Medicaid revenue for LTSS providers, the proposed rule directly threatens the health, independence, and civil rights of people who depend on these services.

The negative effects of this NPRM would amplify the harm caused by recent Medicaid, labor law, and other immigration policy changes. In the context of the largest-ever cuts to Medicaid, the proposed stripping of minimum wage and overtime protections from home care workers, changes to immigration enforcement, and restrictions on immigration, this NPRM would serve an untenable blow to the direct care workforce.

On July 4, 2025, President Trump signed a budget reconciliation bill that cuts nearly $1 trillion from Medicaid over the next decade.[23] As well as threatening direct care workers' wages and economic stability, these Medicaid cuts will also directly impact many direct care workers who rely on Medicaid coverage for themselves and their families.[24]

Also this summer, the U.S. Department of Labor (DOL) moved to strip minimum wage and overtime protections from home care workers (who comprise the largest segment of the direct care workforce). The rule would reinstate a Fair Labor Standards Act (FLSA) exemption for home care workers, reversing nearly a decade of progress and perpetuating historically rooted views about whose labor deserves to be valued and protected and whose does not. Stripping these protections will undermine professional recognition of home care workers, erode

job quality, and make it even harder to recruit and retain the workforce our country desperately needs.

The federal Administration has already made significant changes to immigration enforcement while simultaneously restricting new immigration. These changes fall disproportionately on direct care workers.[25] As noted, federal data estimates that 29 percent of direct care workers are immigrants, including 11 percent who are non-citizens.[26] The restrictions on immigration included in the public charge proposal will cause further harm to our nation's direct care workforce while eroding our nation's long-term care infrastructure.

The NPRM is inconsistent with statutory intent and sound public policy. Congress did not intend public charge policy to penalize lawful use of safety-net programs. The Immigration and Nationality Act (INA) authorizes consideration of whether an individual is "likely at any time to become a public charge," but it does not require DHS to treat use of modern safety-net benefits as presumptive evidence of inadmissibility.[27] For decades, including under the 2022 DHS rule, federal policy rightly distinguished between (1) short-term, supplemental, non-cash benefits that help low-income workers and families meet basic needs, and (2) primary dependence on public cash assistance or long-term institutionalization at government expense, which truly indicate long-term reliance.[28]

The proposed rule collapses this distinction, effectively turning routine participation in modern safety-net programs by gainfully employed people doing essential work into a negative factor for immigration consideration, despite the fact that these programs were explicitly designed to support work and promote health and stability. In the NPRM, DHS recognizes that this proposal extends to U.S. citizens in mixed-status households, which means U.S. citizens will be denied benefits to which they are legally entitled because their family members fear immigration consequences. This approach is completely inconsistent with Congress' creation and expansion of Medicaid, SNAP, and other public benefits as work-supportive policies.

The NPRM also conflicts with longstanding, broader federal goals for health, equity, and workforce stability. The federal government has repeatedly recognized the urgent need to strengthen the direct care workforce, improve access to home and community-based services, advance health equity, and

support family caregivers. Yet, this proposal would increase uninsurance and underinsurance among low-wage workers and their families, exacerbate direct care workforce shortages and weaken support for family caregivers, and disproportionately harm immigrants and people of color that are already overrepresented in both the direct care workforce and public benefits recipients.

This proposed rule trades speculative, unlikely, and ideologically driven notions of "self-sufficiency" for concrete harms to the caregiving infrastructure upon which the entire country depends in direct contradiction of Congressional intent and long-standing federal goals.

The NPRM's economic analysis gravely underestimates workforce and system-wide costs. The NPRM's economic impact analysis acknowledges significant reductions in benefit use and Medicaid provider revenues but fails to fully account for other major economic effects on the workforce, LTSS system, and larger economy. For example, DHS is failing to account for:

- The cost of increased workforce turnover and vacancies in direct care, including recruitment, training, onboarding, and overtime costs when positions cannot be filled.
- The cost of lost LTSS capacity, including delayed or forgone home care, increased nursing home placements, and higher rates of hospitalization and emergency department use due to unmet care needs.
- The cost to family caregivers and employers, in the form of lost wages, reduced labor-force participation, and compromised productivity when family members must forego paid employment to fill care gaps.
- The long-term economic and health impacts of increased uninsurance and unmet basic needs among low-wage direct care workers and their children.

By focusing narrowly on short-term reductions in public benefits spending, the analysis ignores the reality that public charge-induced disenrollment will shift costs, not eliminate them, and that many of those costs will be borne by the health care and LTSS systems, employers, and state and local governments. An effective economic analysis must grapple with the real-world conditions of the direct care labor market. The proposed rule fails to do that.

In conclusion, PHI strongly urges DHS to withdraw this rule. The direct care workforce is essential to our nation's LTSS system and immigrant workers are essential to the direct care workforce. Any policy that drives these workers out of

the field or creates barriers to their success harms not only the workers themselves but the older adults and people with disabilities who depend on them. PHI urges DHS to prioritize policies that strengthen, rather than undermine, this critical workforce.

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