BOSTON MEDICAL CENTER

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July 9, 2019

Electronically filed: https://www.regulations.gov/comment?D=HUD-2019-0044-0001

Office of the General Counsel, Rules Docket Clerk
U.S. Department of Housing and Urban Development
451 Seventh Street SW, Room 10276
Washington, DC 20410-0001

Re: FR-6124-P-01: Housing and Community Development Act of 1980: Verification of Eligible Status. 84 Fed. Reg. 20589 (proposed May 10, 2019) (to be codified at 24 CFR 5).

Dear Secretary Carson:

Thank you for the opportunity to submit comments on the proposed rule entitled, "Housing and Community Development Act of 1980: Verification of Eligible Status," docket number FR-6124-P-01.

I am writing on behalf of Boston Medical Center (BMC), a private, not-for-profit academic medical center located in Boston, Massachusetts. As the largest safety-net provider and busiest trauma and emergency services center in New England, BMC's mission is to provide exceptional care, without exception to all patients. Our patient population has the highest public payer mix of any acute care hospital in Massachusetts at 77% – with over half of our patients receiving care funded through MassHealth (the state's combined program for Medicaid and the Children's Health Insurance Program) or free care (i.e. uninsured). Of our Medicare patients, who make up roughly a quarter of our patients, fully 80% are dually eligible for Medicaid. As the primary teaching affiliate of the Boston University School of Medicine, BMC providers are leaders in their respective fields, bringing the most advanced technologies and techniques to bear for their patients across our more than 70 medical specialties and subspecialties.

The patients BMC serves are incredibly diverse, representing many different races, ethnicities, and countries of origin. Nearly a third of our patients (32%) do not speak English as a primary language. The Interpreter Services Department at BMC is one of the most extensive in New England, providing face-to-face interpreters on-site in 13 spoken languages, in addition to 24/7 telephonic and video interpreting in over 250 languages. Last year, our interpreters assisted in over 300,000 interactions with patients and visitors. BMC also provides a host of specialized

clinical services tailored specifically to meet the medical and psychosocial needs of our foreign-born patients through our Immigrant and Refugee Health Clinic and the Boston Center for Refugee Health and Human Rights (BCRHHR).

BMC is a leader in accountable care for low-income patients. Through our health plan, BMC HealthNet Plan, BMC is managing the largest Medicaid Accountable Care Organization (ACO) population in Massachusetts, with 1 in 5 MassHealth ACO members enrolled in our ACOs across the state – in communities including Greater Boston, Brockton, New Bedford, and Springfield. Under this new model, BMC receives a capitated payment to care for patients. Therefore, we must remain committed to ensuring people not only receive high-quality medical care when they need it, but also have the resources needed to stay healthy. These factors include housing, food, and economic stability – known as the social determinants of health. We are well positioned to succeed in the MassHealth ACO program, which began March 2018, because of our long history of addressing the social determinants of health impacting our patients.

At BMC, we have an ambitious goal – to make Boston the healthiest urban population in the world by 2030. Long at the forefront of health systems addressing social determinants of health, BMC continues to make strategic investments in this area to alleviate broader social burdens in service of our goal. In December 2017, BMC made a $6.5 million investment over five years in affordable housing and related community-based programs – including $1 million for a stabilization fund that will provide grants to community-based organizations to help families avoid eviction in and around Boston, and $1 million for community partners to create a housing stabilization program for individuals with complex medical problems. At BMC, we are proud of our long-term commitment to address the root causes of what make our patients sick. Through this investment, we acknowledge the importance of having safe, stable, and affordable housing available in the places where people live.

In my role as President and CEO of Boston Medical Center, I appreciate and support the work of the U.S. Department of Housing and Urban Development (HUD) in providing housing and housing assistance programs for low-income individuals and families across the country. I am deeply concerned, however, about the potential wide-ranging impacts the proposed changes to **HUD's housing assistance eligibility requirements** would have on the health of our patients and community, if finalized. For the reasons detailed below, I strongly urge HUD to not finalize the proposed rule.

Loss of Federal housing assistance will result in greater housing insecurity and poorer health for thousands of low-income individuals

The proposed rule would require all individuals under the age of 62 living in federally subsidized housing (including the Section 8 housing program) to have their immigration status verified through the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) program. In addition, the proposed rule would mandate that only individuals that have verified eligible immigration status can serve as the head of household or spouse, i.e. the leaseholder. Further, the proposed rule states that "a family shall not be eligible for assistance unless ***every*** member of the family residing in the unit is determined to have eligible status,"

while outlining certain exceptions that would allow a household to receive continued assistance or temporary deferral of termination of assistance for up to a maximum of 18 months.

If enacted, this proposal would mark a significant change in policy since currently HUD does not require verified immigration status for leaseholders or household members. Presently, households with at least one eligible member receive prorated assistance based on only the number of individuals with verified eligible immigration status, i.e. individuals with non-verified or ineligible immigration status do not add to a household's level of assistance.

A HUD regulatory impact analysis of the proposed rule identified over 25,000 "mixed status" households – which include both members who are eligible and others who are ineligible for housing assistance based on their immigration status – would be affected, jeopardizing housing for over 108,000 individuals. Of this total, 71% have eligible status (e.g. U.S. citizens, legal residents, refugees or asylees), including 56,000 children.[1]

The rule, in effect, would evict thousands of families from federally subsidized housing on account of at least one member of the household having ineligible immigration status. In certain instances, the proposal may incentivize family separation by compelling mixed status families to split in order for eligible members to continue to receive housing assistance. Though, in its analysis, HUD notes that it "expects that fear of the family being separated would lead to prompt evacuation by most mixed households, whether [or not] that fear is justified." Acute and sustained fear is itself detrimental to physical and mental health – while eviction and loss of stable housing, the most likely result of the proposed rule, is one of the strongest, documented contributors to poor health.[2,3,4]

In Boston and Cambridge, the local housing authorities estimate that the proposed rule could impact over 1,000 individuals in 300 households across the two municipalities. Similar to the national HUD estimates, fully two-thirds of these individuals are U.S. citizens or have eligible immigration status, a majority of which are children.[5,6] While local municipalities working in partnership with non-profit organizations, like BMC, shelters, and others, have made great strides in getting homeless and housing unstable individuals and families into stable housing, this proposal would, almost overnight, erase years of hard work, spent resources, and progress. HUD should be working in line with its mission to alleviate homelessness, not exacerbate it.

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[1] U.S. Department of Housing and Urban Development. Proposed Rule Docket No. FR-6124-P-01 "Housing and Community Development of 1980 Verification of Eligible Status" Regulatory Impact Analysis. April 15, 2019. https://www.regulations.gov/document?D=HUD-2019-0044-0002.

[2] Dong M, Anda RF, Felitti VJ, et al. "Childhood residential mobility and multiple health risks during adolescence and adulthood; the hidden role of adverse childhood experiences. *Archives of Pediatrics and Adolescent Medicine.* 2005; 159(12):1104-1110.

[3] Cutts D, Wellington C, Ettinger de Cuba S, Bovell-Ammon A, Coleman S, Sandel M. "Household history of eviction associated with increased hardships and adverse caregiver and child health outcomes." Presented at Pediatric Academic Societies. April 28, 2019; Baltimore, MD.

[4] Desmond M & Tolbert Kimbro R. "Evictions fallout: housing, hardship, and health." *Social Forces*. 2015; 94(1):295-324.

[5] Reinert S. "Nearly 60 city families in public housing units threatened by Trump administration proposal." *Cambridge Day*. May 20, 2019.

[6] Boston Housing Authority. Unpublished. Received on June 18, 2019.

Additionally, the proposed rule does nothing to address the scarcity of federal housing resources or shorten the existing long waitlists for subsidized housing, while instead it creates additional barriers for individuals – both immigrants and U.S. citizens – to gain or maintain housing and stay healthy.

BMC is in the business of removing barriers and lowering the cost of care for our patients

Under the MassHealth ACO program, BMC is held accountable for both the quality and cost of care we provide. Our system is paid in accordance with our performance against a slate of health outcomes and process-oriented quality measures. We also receive a state prescribed per member per month payment rate to provide treatment and prevention services for our ACO patients, and are financially at risk for any dollars we spend over this capitated budget. These incentives drive our system to further our commitment to addressing the social determinants of health, including housing, and continue to break down all barriers that stand in the way of our patients' health.

We expect that individuals who lose their housing benefits as a consequence of this proposed rule would experience higher rates of homelessness and worse health, and as a result would require more frequent and severe utilization of health care services. In its regulatory impact analysis, HUD cites that studies have found costs associated with homelessness could range from $20,000 to $50,000 per person per year.[1] Taken in the aggregate, this dramatic shift in resources to cover a newly homeless population would increase health care costs overall.

Worse health and higher costs of care are not only bad for our patients, but are also bad for BMC's bottom line – especially in the ACO context, since these factors increase the likelihood that we fall short of achieving our quality and financial benchmarks. Our own internal analyses on the interplay of housing, substance use disorder, and medical comorbidities in our ACO patient population show that unstable housing is the most significant driver of annual total cost of care of any single factor. In addition to the financial implications within our ACO, there are additional costs associated with an anticipated increased demand for our existing housing support services, like intensive case management through our partnerships with Project Hope, Elders Living at Home, and MetroHousing Boston and legal consult provided by Medical Legal Partnership-Boston, which are non-reimbursed at present. In effect, the proposed rule transfers more of the burden of caring for impacted low-income individuals and families from the federal government to states and non-governmental organizations like BMC, without providing any compensatory resources to offset the costs.

While the potential impact to BMC would be significant, the proposed rule would likely have a far greater ripple effect on society. Research by Children's HealthWatch, which is headquartered at BMC, found that unstable housing among all families with children, regardless of immigration status, will cost the United States $111 billion in avoidable health and education expenditures over the next ten years (assuming the current number of families living in unstable homes remains constant).[7] If the proposed rule were to go into effect, these astounding cost figures

[7] Poblacion A, Bovell-Ammon A, Ettinger de Cuba S, Sandel M, Chappelle K, Hidalgo M, Cook J. "Pathways to stable homes: promoting caregiver and child health through housing stability. Children's HealthWatch. May 2019. https://childrenshealthwatch.org/wp-content/uploads/CHW-Pathways-Report.pdf

would likely balloon even further, causing even more harm to families and safety-net providers, and exacerbate the strain on limited federal, state, and local resources.

To make matters worse, by HUD's own admission, the proposed rule is expected to increase its administrative costs (i.e. to enforce evictions) and decrease the quantity and quality of public housing in order to provide subsidies for eligible families that take the place of those evicted.[1] HUD should instead provide greater resources to increase housing security.

For the reasons outlined above, I strongly urge HUD to not finalize the proposed changes and instead focus efforts on expanding housing and housing assistance programs in order to increase housing security and promote healthy living.

I appreciate the opportunity to provide comments on this proposed rule. If you have questions, please contact Vice President for Government Affairs Melissa Shannon at 617-638-6732 or Melissa.Shannon@bmc.org.

Sincerely,

Kate Walsh

Kate Walsh
President & CEO