Howard Brown Health

August 13, 2025

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9888-P
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

**RE: Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA); Interpretation of "Federal Public Benefit" (90 FR 31232)**

Howard Brown Health is one of the largest health centers in the Midwest, serving more than 40,000 patients across seven clinic locations in Chicago. Howard Brown serves adults and youth in its diverse health and social service delivery system focused around seven major programmatic divisions: primary medical care, behavioral health, research, HIV/STI prevention, youth services, elder services, and community initiatives. As a federally qualified health center (FQHC), Howard Brown provides services regardless of a patient's ability to pay or insurance status. Around 20% of Howard Brown's patients are uninsured and we provide healthcare in a state with an increasing number of immigrants and refugees.

Section 330 of the Public Health Service Act (PHSA) requires FQHCs like Howard Brown to provide healthcare services to all individuals. The rule ensures that FQHCs act as a safety net, offering high-quality, affordable healthcare to all members of the community they serve, particularly those facing financial or other barriers to accessing care. This new proposed interpretation of the "Federal Public Benefit" under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) puts access to healthcare for vulnerable populations at risk. This rule will cause non-citizen immigrant patients to avoid seeking healthcare due to fear of detention or deportation. It will also create a financial and administrative burdens for the FQHCs tasked with providing affordable and accessible care to communities who need it the most. **We strongly urge HHS to withdraw the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA); Interpretation of "Federal Public Benefit" rule immediately as it will lead to poorer health outcomes and unduly burdens on safety-net healthcare systems.**

*Poorer Health Outcomes and Worsened Health Disparities for Immigrant Populations*

Immigrant populations, particularly undocumented immigrants, already experience health disparities compared to U.S. born persons. For example, research has shown that

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immigrants utilize preventative care services such as cancer screening less,[1] experience higher rates of some chronic conditions,[2] and experience significant anxiety and depression burden.[3]

Many of these disparities are a result of consistent challenges immigrants face with healthcare access, including stigma and marginalization, difficulties with assimilation, language barriers, and fear of deportation. For example, among immigrant adults who have received care in the U.S., one in four (25%) reports being treated unfairly by a health care provider because of their insurance status or ability to pay (16%); accent or ability to speak English (15%); and/or their race, ethnicity, or skin color (13%).[4] Black immigrant adults are more than twice as likely as White immigrant adults to report being treated unfairly for at least one of these reasons (38% vs. 18%), and the share is also higher among Hispanic immigrant adults (28%).[5]

Due to their citizenship or resident status, many immigrant communities are legally unable to access federal healthcare programs like Medicaid and Medicare. Half of likely undocumented immigrant adults (50%) report being uninsured.[6] This makes accessing any kind of care expensive. As a result, undocumented immigrants are especially dependent on services provided by FQHCs because we serve all patients regardless of insurance coverage, ability to pay, or immigration status. That is why a higher proportion of undocumented immigrants (37%) than of naturalized citizens (26%) and US-born people (23%) reported that their usual place for routine care was a clinic or community health centers. [7] This rule will leave many undocumented immigrants with no place to receive routine care, leading to worsened health outcomes and increased health spending.

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[1] Reynolds MM, Childers TB. Preventive health screening disparities among immigrants: exploring barriers to care. J Immigr Minor Health. 2020;22(2):336-344.
[2] Hummer RA, & Hayward MD (2015). Hispanic older adult health & longevity in the United States: Current patterns & concerns for the future. Daedalus, 144(2), 20–30.
[3] Adzrago, D., Thapa, K., Rajbhandari-Thapa, J. *et al.* Influence of biopsychosocial factors on self-reported anxiety/depression symptoms among first-generation immigrant population in the U.S.. *BMC Public Health* **24**, 819 (2024).
[4] Pillai, Drishti, et al. "Health and Health Care Experiences of Immigrants: The 2023 KFF/LA Times Survey of Immigrants." *KFF*, KFF, 17 Sept. 2023, www.kff.org/racial-equity-and-health-policy/issue-brief/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants/.
[5] *Ibid.*
[6] Pillai, Drishti, et al. "Health and Health Care Experiences of Immigrants: The 2023 KFF/LA Times Survey of Immigrants." *KFF*, KFF, 17 Sept. 2023, www.kff.org/racial-equity-and-health-policy/issue-brief/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants/.
[7] Frost, Jennifer J. "U.S. Women's Use of Sexual and Reproductive Health Services: Trends, Sources of Care and Factors Associated with Use, 1995–2010." *Www.guttmacher.org*, 2 May 2013, www.guttmacher.org/report/us-womens-use-sexual-and-reproductive-health-services-trends-sources-care-and-factors#, https://doi.org/10.1363/2021.33017.

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*Financial and Administrative Burden on FQHCs*

Currently, FQHCs are not required to collect immigration status from patients because services provided by FQHCs have not been considered a federal public benefit under the PRWORA. As such, many FQHCs, including Howard Brown, have not collected such data as doing so could create barriers to care for immigrant patients. This rule will force FQHCs to create new data collection infrastructure and staff training for collecting immigration information without any guidance, research, or funding to support this massive transition. For example, some FQHCs many need to update their electronic health records (EHR) system to collect immigration data, and some may need to migrate to a new EHR system altogether. This is extremely costly, both financially and in administrative burden on staff, and could result in loss of services and worse health outcomes for our patients.

Designating the Health Center Program as a federal public benefit would have devastating consequences for all patients, including U.S. citizens and PRWORA qualified immigrants. Requiring compliance with PRWORA would constitute an unfunded mandate and force health centers to redirect scarce resources from clinical care to compliance and documentation systems. This bureaucratic burden will reduce appointment availability, shrink care teams, and increase wait times—undermining access to care for everyone. Health centers operate under a team-based model designed for cost-efficiency and accountability. Imposing complex eligibility screens runs counter to the Health Center Program's statutory structure and will ultimately cost more—not less—in Medicaid, Medicare, and uncompensated care.

*Conclusion*

For decades, CHCs have been a lifeline for millions who would otherwise have no access to comprehensive, affordable, quality healthcare. In Illinois alone, health centers are the medical home for 1 in 9. Annually we care for more than 1.5 million Illinoisans across more than 400 service sites in medically underserved urban and rural communities.

Section 330 of the Public Health Service Act (PHSA) was established so FQHCs can always act as a safe space to access healthcare for everyone in this country, regardless of immigration or economic status. This rule will only undermine our ability to provide care to all patients, increase health disparities among already vulnerable populations, and cause large economic and administrative burdens on FQHCs that are already facing many obstacles providing healthcare. We urge HHS to immediately withdraw the 2025, "**Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA); Interpretation of "Federal Public Benefit" rule and maintain the 1996 PRWORA interpretation.**

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We greatly appreciate the opportunity to provide comments on this proposed rule. Should you have any questions about our comments, please feel free to contact Timothy Wang, Director of Policy and Advocacy at timothyw@howardbrown.org

Sincerely,
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CEO and President Howard Brown Health

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