

August 13, 2025

Robert F. Kennedy, Jr.
Secretary
Department of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C., 20201

**RE: Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA);
Interpretation of “Federal Public Benefit” (AHRQ-2025-0002)**

Dear Secretary Kennedy:

The National Association of Community Health Centers (NACHC) is the leading national membership organization dedicated to promoting Community Health Centers (CHCs) (also known as Federally Qualified Health Centers or health centers) as the Employer, Provider, and Partner of choice for primary and preventive care in all communities, as well as the foundation of the primary health care system in America.

As you know, CHCs are the best, most innovative, and resilient part of our nation’s health system. For sixty years, CHCs have provided high-quality, comprehensive, affordable primary and preventive care. In addition to medical services, CHCs provide integrated dental, behavioral health, pharmacy, vision, and other health services to America’s most vulnerable, medically underserved communities in rural, urban, suburban, frontier, mountain, and island communities. Today, the health center workforce of 326,000 serves nearly 34 million people at over 17,000 locations, ensuring patients receive the care they need and pay what they can based on a sliding fee scale.

NACHC maintains its role as the national voice for CHCs and believes high-quality primary health care is essential in creating healthy communities and preventing chronic conditions. The collective mission and mandate of NACHC and the 1,512 CHCs nationwide are to close the primary care gap and provide high-quality, cost-effective primary and preventive medical care to communities across this country. When we improve patients’ health, we help people to go back to work, we lower health care costs,¹ and we support local economies.²

We appreciate the opportunity to respond to this interpretation of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

I. NACHC supports the administration’s commitment to honoring the statutory exemption of nonprofit charitable organizations from PRWORA’s verification requirements.

The Department’s approach to distinguish between the definition of a “Federal public benefit” and the separate issue of verification requirements is a crucial point that we fully support. While the prohibition set forth in § 1611(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) is a matter of statutory interpretation, the mechanism for verifying eligibility, as detailed

¹ https://www.nachc.org/wp-content/uploads/2025/01/PolicyPapers_NationalValueImpact_FINAL_Jan2025.pdf

² Ibid.

in the 1998 Notice, is “conceptually distinct.”³ We appreciate the Department’s decision not to formally revise the existing guidance on verification requirements at this time. This approach correctly recognizes and maintains the statutory intent of a 1996 amendment to PRWORA.

The 1996 statutory amendment to PRWORA explicitly clarifies that a charitable nonprofit organization providing a federal public benefit is, “not required under this chapter to determine, verify, or otherwise require proof of eligibility of any applicant for such benefits.”⁴ This provision is critical for CHCs, which are predominantly nonprofit charitable organizations by their very nature and legal structure.

By maintaining the existing guidance, the Department honors the original congressional intent behind the Health Center Program (Section 330 of the Public Health Service Act). As established by Congress, CHCs’ core mission is to serve all individuals in their communities.⁵ Imposing a verification requirement would conflict with federal law and impose a new burden to CHCs. The statutory exemption for nonprofit charitable organizations provides the necessary legal framework for CHCs to continue fulfilling their mission without fear of penalty.

Furthermore, the 1997 guidance issued by the Department of Justice provides essential protections, stating that a, “nonprofit charitable organization that chooses not to verify cannot be penalized (e.g., through cancellation of its grant or denial of reimbursement for benefit expenditures) for providing federal public benefits to an individual who is not a U.S. citizen, U.S. noncitizen national, or qualified alien.”⁶ This protection is essential for the operational viability of CHCs. The burden and cost of implementing and administering an immigration status verification system would divert scarce resources away from direct patient care, undermining the very purpose of the health center program.

We strongly support the Department’s position that the verification requirements are separate from the definition of a federal public benefit. We urge the Department to uphold the existing statutory exemption for nonprofit charitable organizations, which allows CHCs to continue providing essential healthcare to all residents of their communities, consistent with both the letter and spirit of the law and congressional intent.

II. NACHC Urges the Administration to Preserve the “Community Benefit” Interpretation for All Health Centers - Private Nonprofit and Public Community Health Centers

The Department’s proposed change to abandon the 1998 “community benefit” interpretation of a “Federal public benefit” represents a fundamental departure from a longstanding and effective policy. We strongly urge the Department to retain the 1998 framework, which correctly recognized programs designed to provide benefits to communities as a whole are distinct from those that provide direct payments or assistance to an “individual, household, or family eligibility unit.” The Health Center Program is a quintessential example of a community-based program and, as such, should not be redefined as a “Federal public benefit” under PRWORA.

³ Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA); Interpretation of “Federal Public Benefit”, 90 Fed. Reg. 31,232 (July 14, 2025)

⁴ 8 U.S.C. § 1642(d)

⁵ 42 U.S.C. § 254b

⁶ Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA); Interpretation of “Federal Public Benefit”, 63 Fed. Reg. 41,658 (Aug. 4, 1998).

The Health Center Program, authorized by Section 330 of the Public Health Service Act, is not a program that provides benefits directly to individuals in the manner of welfare, housing, or other similar benefits. Rather, the Health Center Program provides grant funding to both private, nonprofit organizations and public agencies that operate health centers consistent with the requirements of the authorizing statute and related regulations and policies. This grant funding enables all CHCs, private nonprofit and public, to serve entire medically underserved communities, or “catchment areas,” as defined in the statute. A health center’s grant application is based on a demonstration of the unmet health needs of a specific geographic area or population group, not on the individual eligibility of potential patients. The statutory mandate requires CHCs to provide services to “all residents of the area served by the center,” regardless of their ability to pay or insurance status.

The 1998 interpretation, which stated that a preponderance of a program’s services must be provided to individual, household, or family eligibility units to be considered a “Federal Public Benefit,” correctly applied the principles of statutory construction.⁷ It recognized that a program’s primary purpose, whether it is to provide a community-wide benefit or a direct individual benefit, is central to its proper classification under PRWORA. The Health Center Program’s focus on improving the overall health of a community by ensuring access to primary and preventive care for all residents is a community benefit, not an individual one. This includes providing services to underserved populations such as migratory and seasonal agricultural workers, homeless individuals, and residents of public housing within that catchment area, all of whom contribute to the health and well-being of the community at large. The underlying statute recognizes that the amount of a CHC grant is not determined by any individual’s need for benefits but sets forth a formula that takes into account the overall community’s needs by relying on the CHC’s total costs and total revenues associated with serving the broader community.⁸

The new interpretation, which appears to abandon this community-focused distinction, fails to acknowledge the core mission and statutory requirements of the Health Center Program. Redefining the program as a “Federal Public Benefit” would inappropriately conflate a grant for the operational costs of a community-based health provider with a direct cash or in-kind payment to an individual. This would not only contradict the clear congressional intent of the Health Center Program but would also create significant administrative burdens and potential confusion for both CHCs and the patients they serve, ultimately hindering their ability to fulfill their mission.

We believe it is essential to ensure that health programs created to provide overall benefits to a community, such as the Health Center Program with its designated service area requirement, are not improperly classified. We urge the Department to reaffirm the 1998 interpretation, which more accurately and appropriately reflects the nature of these vital community-focused programs.

III. Redefining Community Health Centers as a “Federal Public Benefit” Would Create an Unfunded Mandate and Divert Resources

The proposed redefinition of the Health Center Program as a “Federal Public Benefit” and any new requirements to verify eligibility would create an unworkable and unfunded mandate for CHCs. Imposing new administrative burdens and eligibility restrictions on these essential safety-net providers

⁷ Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA); Interpretation of “Federal Public Benefit”, 63 Fed. Reg. 41,658 (Aug. 4, 1998).

⁸ 42 USC 254b(e)(5)

conflicts directly with their foundational mission, congressional intent, and nearly three decades of established policy.


As discussed throughout this letter, Congress expressly exempted charitable nonprofit organizations from PRWORA’s verification requirements to ensure they could perform important community-facing services. Congress recognized CHCs as a critical component of the nation’s public health infrastructure, tasked with improving health outcomes, reducing system-wide costs, and mitigating disparities in care. Reversing this exemption would not only undermine these objectives but would also put access to care at risk for millions of patients annually.

Adding new requirements would create substantial administrative and operational burdens. Such mandates would divert scarce resources—including staff time, technology, and funds—from clinical services to compliance infrastructure. This would strain already under-resourced CHCs and impair their ability to fulfill their statutory mission. Forcing CHCs to develop new policies, technology, and training procedures for eligibility verification would be an unfunded mandate, taking away from their primary purpose of providing high-quality, low-cost, comprehensive care. The federal paperwork burden is already substantial, and adding more “red tape” would only further limit the effectiveness of federally funded programs for those they are intended to serve.

For decades, CHCs have been a lifeline for millions who would otherwise have no access to comprehensive, affordable, quality healthcare. In 2024 alone, nearly 34 million individuals, including 638,000 pregnant women, more than 428,000 veterans, 4.2 million seniors, and 9.8 million children, accessed care at a CHC. Limiting access and creating new barriers would compromise the well-being of entire communities.⁹ The Health Center Program should not be defined as a “Federal Public Benefit” and must remain statutorily exempt to ensure it can continue to serve as a beacon of hope and health for millions of people across the country.

NACHC appreciates the opportunity to respond to this public benefit notice and looks forward to continuing to engage with HHS on this prominent issue. If you have any questions, please contact Vacheria Keys, Vice President of Policy and Regulatory Affairs, at vkeys@nachc.org.

Sincerely,



Joe Dunn
Chief Policy Officer

⁹ Health Resources and Services Administration (HRSA), Bureau of Primary Health Care (BPHC), *Health Center Program Uniform Data System (UDS) Data, 2023*