NATIONAL ASSOCIATION OF Community Health Centers

April 1, 2024

The Honorable John Thune
511 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Debbie Stabenow
731 Hart Senate Office Building
Washington, DC 20510

The Honorable Shelley Moore Capito
172 Russell Senate Office Building
Washington, DC 20510

The Honorable Tammy Baldwin
709 Hart Senate Office Building
Washington, DC 20510

The Honorable Jerry Moran
521 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Benjamin Cardin
509 Hart Senate Office Building
Washington, DC 20510

Re: Senate Request for Information on the SUSTAIN 340B Act

Dear Senator Thune, Senator Stabenow, Senator Moore Capito, Senator Baldwin, Senator Moran, Senate Cardin:

On behalf of the National Association of Community Health Centers (NACHC) and the nearly 400 undersigned organizations, we thank the Senators for the opportunity to provide feedback on the SUSTAIN 340B Act. We appreciate your leadership and efforts to bring lasting bipartisan solutions that will improve the integrity and stability of the 340B program.

NACHC is the preeminent national membership organization for Federally Qualified Health Centers, also known as Community Health Centers (CHCs). Community Health Centers are the best, most diverse, most innovative, and most resilient part of our nation's health system. For nearly sixty years, health centers have provided high-quality primary and preventive care, dental, behavioral health, pharmacy, vision, and other essential health services to America's most vulnerable, medically underserved patients in urban, rural, suburban, frontier, and island communities. Today, health centers serve thousands of communities at over 15,000 locations. Health centers recently reached a historic milestone of serving over 31.5 million patients, including 8.8 million children and nearly 400,000 veterans. They provide care to one in seven rural residents, one in six Medicaid beneficiaries, and one in three people experiencing poverty.

Since its establishment in 1992, the 340B program has been critically important for CHCs. It enables them to purchase outpatient medications at significantly reduced costs, allowing them to provide affordable discounted, or free medications to uninsured and underinsured patients. By law and regulation, health centers must reinvest every penny of 340B savings into activities that expand patient access. This contribution to the operating margin is used to meet the unique needs of their communities, such as dental care, behavioral health, specialty care, translation services, food banks, housing support, and copay assistance programs. When health centers lose 340B resources, patients suffer irreversible consequences.

NACHC helped form the Alliance to Save America's 340B Program (ASAP 340B) to support comprehensive legislative reforms, ensuring the longstanding viability of the 340B program for

true safety-net providers, including CHCs. Through this effort, we have worked diligently to find compromise and solutions that we believe are in the best interest of the 340B program and the patients it is intended to serve. We urge the Senators to incorporate into the SUSTAIN 340B Act the policies discussed in detail below, which we believe appropriately balance vulnerable patients' access to care on the one hand and program integrity and sustainability on the other.

Health centers are the largest primary care network across the country and the safety net for millions of vulnerable patients in underserved communities. Yet, their mission goes beyond health care and extends to services that improve overall quality of life. Central to that mission is the 340B program. It promotes health equity by expanding access to patients in underserved communities by creating savings to address social determinants of health like transportation, food insecurity, life skills training, and social support services. 340B savings fill the gaps to meet community and patient needs better. Ambiguity within the 340B statute has decreased 340B savings through contract pharmacy restrictions and discriminatory actions by Pharmacy Benefit Managers. **These restrictions placed on the 340B program continue to chip away at health centers' financial stability.**

Contract Pharmacies

Many health centers do not have the financial resources to support an entity-owned pharmacy. These health centers rely on contracts with local pharmacies to fill patient prescriptions. In a survey, NACHC found that 43% of health centers rely solely on contract pharmacies, and nearly 90% use contract pharmacies to expand the reach of their 340B program and meet their communities' needs. Contract pharmacies serve as an extension of health centers, increasing patient access by reducing geographic and financial access barriers. Unfortunately, health centers have been losing mission-critical dollars in the 340B program due to discriminatory contracting practices from pharmacy benefit managers and contract pharmacy restrictions by pharmaceutical manufacturers that limit health centers from full participation in the 340B program. Furthermore, over 90% of health center patients are at 200% or below the Federal Poverty Level, making it paramount that they can access affordable medications without additional barriers related to transportation, childcare, or work obligations.

As a member of ASAP 340B, our primary goal has been to protect and strengthen the 340B program. We believe eligibility for contract pharmacies should be determined based on the unique characteristics, patient population, and needs of each type of covered entity. Grantees like health centers, rural hospitals, children's hospitals, and public hospitals who qualify as 340B covered entities should be permitted to utilize unlimited contract pharmacies for eligible prescriptions as part of broader 340B program reforms. We believe directing the benefits of contract pharmacy arrangements to covered entities, like health centers, appropriately assists the providers most reliant on these arrangements. Contract pharmacies can improve eligible patients' access to medicines when used appropriately as one part of a comprehensive set of changes designed to target the 340B program to safety net providers and the patients they serve. However, concerns around duplicate discounts, patient affordability, and the growing involvement of large for-profit PBMs and pharmacies demonstrate the urgent need to proactively find solutions for all stakeholders in the 340B program.

We support the SUSTAIN 340B Act's explicit language that creates a federal statutory obligation

for manufacturers to ship or facilitate delivery of 340B drugs to contract pharmacies. After nearly four years of contract pharmacy restrictions, we encourage this Working Group to consider additional proposals that will create explicit enforcement rights for HRSA if manufacturers refuse to ship or facilitate delivery of 340B drugs to contract pharmacies in the future. These enforcement rights should be included in the Pharmaceutical Pricing Agreement (PPA), which is a binding contract between participating manufacturers in the 340B program and Health and Human Services (HHS). Additionally, we recommend amending the definition of an overcharge in the Alternative Dispute Resolution process to explicitly include the refusal to make drugs available at the 340B price under any scenario. NACHC believes the proper approach to 340B reform includes balanced accountabilities for all stakeholders in the 340B program. It's imperative that HRSA has the proper authority to enforce the 340B statute and protect the integrity of the program.

Contract Pharmacies: Service Areas and Other Related Reforms

Data confirms that grantees, like health centers, utilize contract pharmacies in fundamentally different ways than other covered entities and warrant additional flexibility in the number of permitted arrangements. As previously stated, health centers rely more heavily on contract pharmacies to ensure their eligible patients can access medicines. A 2022 NACHC survey reports that many health centers serve dozens of zip codes through their contract pharmacies, with some reporting providing services to one hundred or more zip codes. Health centers strategically utilize contract pharmacies to reach their patients, partnering with local independent pharmacies and nationally recognized pharmacy groups.[i] Acknowledging these differences between covered entities, we do not think a limit on the number of contract pharmacies is necessary for certain types of covered entities, which include health centers. We do believe there is a need for additional guardrails to address some of the unintended consequences of the existing gray area in the 340B program without jeopardizing patients' access to discounted medicines or the durability of the safety net.

As founding members of ASAP 340B, we have developed a set of compromising solutions that strike the appropriate balance between the intent of the 340B program and additional program integrity measures. Establishing a service area for contract pharmacies is vital to ensure the program is designed to support safety-net providers instead of padding for-profit companies' bottom lines. For instance, contract pharmacies benefit patients living in areas designated as "pharmacy deserts," which are communities without convenient and easy access to local pharmacies. Covered entities should be permitted to contract with pharmacies in areas that increase access for patients who experience barriers to care due to social drivers of health. Eligible covered entities in the 340B program should work with contract pharmacies to implement policies that create patient affordability programs, especially in low- income and underserved communities.

The ASAP 340B policy principles recommend that contract pharmacies should be located within the covered entity's service area to ensure eligible patients can benefit from these arrangements. After consideration of many approaches to define a service area that accounts for the needs of both urban and rural communities, which utilized the Census Bureau's Public Use Microdata Areas (PUMAs) to determine appropriate service areas for each covered entity. A single PUMA includes 100,000 to 200,000 people, and the geographic size of the PUMA varies to meet this population

requirement. Except for hemophilia treatment centers, the service area should be defined by the PUMA where the covered entity is located and may include up to three immediately adjacent PUMAs.

Contract Pharmacies: Mail Order Eligibility

Health centers utilize mail-order pharmacies to provide patients with certain medications that are taken regularly for chronic or long-term conditions; this is especially useful given that health center patients suffer from chronic conditions at higher rates than the general population.[ii] They also improve access to health center patients who oftentimes experience more social drivers of health that can impact their ability to pick up medications in person. Using mail-order pharmacies in specific circumstances will help ensure that 340B resources are received by safety net providers and the patients they serve, and that they are not siphoned off by PBMs and other for-profit companies. Furthermore, health centers utilize specialty pharmacies to help patients access more affordable medications that are generally high-cost, given that they treat rare or complex health conditions. Specialty pharmacies typically do not have physical locations for patients to pick up medications, and they are often shipped to the patient or administered in a clinical setting. Contracting with a specialty pharmacy can help provide health center patients with specific health conditions, personalized care, communication, and condition-specific resources.

As PBMs and chain pharmacies continue to grow their presence in the 340B program, they present a significant threat to independent and community pharmacists' sustainability. Pharmacies' profits per 340B prescription are much higher than their average profit for prescriptions filled on behalf of a third-party payer. Evidence suggests PBMs are using profits generated by the 340B program to undercut independent and community pharmacies, thus pushing those local pharmacies out of their communities.[iii] Using mail order pharmacies as 340B contract pharmacies in targeted circumstances will level the playing field for independent and community pharmacies and direct more safety net funding towards the safety net and away from PBMs' pockets without sacrificing patients' access to discounted medicines.

Pharmacy Benefit Managers' (PBM) and Other For-Profit Companies' Involvement in the 340B Program

Health centers have dealt with the consequences of for-profit companies' unregulated involvement in the 340B program for decades. The five largest contract pharmacy participants and PBMs (Cigna, CVS, Optum, Walgreens, and Walmart) account for nearly three-quarters of total contract pharmacy arrangements. And in 2022, these five companies retained $2.9 billion in 340B discounts as profit.[iv]

Furthermore, for years, pharmacy benefit managers (PBMs) have taken advantage of the lack of federal oversight on their participation in the 340B program, hurting health centers and their patients. PBMs determine which pharmacies will be included in a prescription drug plan's network and how much they will be paid for their services. The 340B statute does not protect health centers from PBMs' discriminatory contracting practices, which transfers 340B savings away from the health center through unpredictable fees, restrictive contracting terms, and aggressive auditing tactics to lower reimbursement.

We strongly believe that 340B discounts should be used to support rural and safety-net providers

and their vulnerable patients, not be diverted for private benefit or other purposes that stray from the health center's mission. To prevent these large corporations from continuing to profit off health center 340B savings, we believe several steps should be taken to reform their involvement in the program:

- PBMs should be prohibited from imposing specified discriminatory contract terms (e.g., fees or chargebacks) due to a covered entity's or pharmacy's participation in 340B.
- Health plans, insurers, and PBMs should be prohibited from interfering with identifying 340B claims or dictating an individual choose to receive a 340B drug from a specific covered entity or contract pharmacy.
- Contract pharmacy fees charged to covered entities as part of participating in 340B should be limited to flat fair-market value fees that should not exceed 125% of the average per-prescription dispense fee paid to pharmacies by all third-party payers.
- Third-party administrator (TPA) fees charged to covered entities should be limited to flat fair market value fees. Covered entities should be required to retain copies of written records with TPAs and contract pharmacies and make copies of those agreements available to the HHS Secretary or a designee upon request.

Taken together, these policies are designed to help ensure that safety net providers like CHCs serve resources intended for low-income and vulnerable patients. To ensure relevant parties comply with these new policies, we support granting authority to the HHS Secretary to impose civil monetary penalties for noncompliance by PBMs, TPAs, and contract pharmacies.

Preventing Duplicate Discounts

We support Congress' and HRSA's goals to increase accountability in the 340B program and appreciate the Senators' acknowledgment of this important issue. Today, HHS has stated it does not have reasonable assurance that states and covered entities are complying with the prohibition on duplicate Medicaid and 340B discounts. As a result, we acknowledge the real risks of duplicate discounts.

It is essential to acknowledge that reforms in discussion would add new requirements on manufacturers, to clearly outline in the statutory language that manufacturers must ship or facilitate the delivery of 340B drugs to contract pharmacies. Given the importance of contract pharmacies to health centers, having this requirement in the statute is monumental to protecting patient access to affordable medications and will clearly state that manufacturers have to ship and facilitate the delivery of 340B medications to contract pharmacies. As part of putting contract pharmacy into law, covered entities should be required to adopt HHS-approved procedures that their contract pharmacies would be contractually obligated to follow to prevent duplicate discounts and diversion of 340B drugs to ineligible patients and to ensure compliance with new patient affordability requirements.

To facilitate the identification of 340B claims, we recommend establishing a neutral, independent Clearinghouse capable of receiving Medicare, Medicaid, and commercial claims data. This Clearinghouse could be used to identify potential Medicaid/340B duplicate discounts, along with potential Maximum Fair Price/340B duplicate discounts prohibited under the Inflation Reduction Act, share identified 340B units reimbursed by Medicare with CMS for exclusion from Part B and

Part D inflation rebates, identify duplicate covered entity claims for 340B discounts on the same units, and provide manufacturers access to a specified list of claims-level data elements for dispensing of their 340B drugs.

To help better identify claims for Medicaid MCO plans, we support utilizing unique BIN/PCN numbers. This is along the same lines proposed in CMS-2434-P, "Medicaid Program; Misclassification of Drugs, Program Administration and Program Integrity Updates under the Medicaid Drug Rebate Program" at § 438.3 (S)(7). NACHC made this recommendation in our comments and thinks this would be useful in helping identify these claims via the Clearinghouse. Additionally, if there are duplicate discounts, repayment could be made possible on the neutral clearinghouse. Apexus, the Prime Vendor for the 340B program, currently has the Covered Entity Refund Service, which helps correct overpayments made to covered entities.[v] A similar process could be incorporated into the clearinghouse to easily make repayments if duplicate discounts were discovered.

This neutral clearinghouse would be a step towards building accountability and coordination for 340B stakeholders without substantially increasing administrative burdens for safety-net providers. The data would be deidentified and subject to safeguards that prohibit use for marketing or other unauthorized purposes. Furthermore, we believe that all stakeholders in the 340B program – covered entities and manufacturers alike – should pay a user fee to contribute to funding this oversight.

Patient Definition

As you acknowledged in the RFI, appropriately defining a 340B covered entity patient and determining which prescriptions are eligible for a 340B discount is paramount to maintaining the integrity of the program. The 340B program, like the rest of the healthcare system, has changed significantly since 1992. As a result, policies originally developed to govern the program are outdated and lack the necessary details to be effective and enforceable in today's health care environment. This has created significant uncertainty for covered entities when undergoing government audits.

ASAP 340B has spent significant time developing a patient definition that reflects the needs of all stakeholders in the 340B program. A fundamental aspect of our policy principles is a different flexibility based on covered entity type, unique circumstances, and patient populations. Health centers are committed to finding compromises and solutions to stabilize the program and believe a strong patient definition will help to resolve covered entities' uncertainty and create more objective and auditable patient definition standards.

Patient Definition: Covered Entity-Patient Relationship

A patient definition should require a meaningful, established, and continuing covered entity-patient relationship and a reasonable connection between the care provided to the patient by the covered entity and the 340B prescription. Health centers serve as primary care health hubs for their patients, providing them with comprehensive, high-quality healthcare services. Patients and health centers should have a continuing and meaningful provider-patient relationship that includes receiving health care services beyond just the administration, infusion, or dispensing of drugs and having regular, in-person visits with a covered entity provider at a registered covered entity site.

Concerning the frequency of in-person visits, we believe it is appropriate to vary this requirement by covered entity type. Under our principles, patients of grantees, like health centers, should be seen in-person at least every 24 months. Patients of all other covered entity types should be seen in-person at least every 12 months to maintain their status as a 340B eligible patient.

Regular in-person visits will allow providers to maintain consistent responsibility for care for eligible patients, which should be demonstrated through improved and auditable record keeping requirements. Auditable records should be able to demonstrate a connection between the patient's eligible prescriptions and the medical condition for which an individual sought care from the covered entity or that the covered entity managed on behalf of the patient and for which the covered entity maintained responsibility in the context of permitted referrals, as discussed in more detail below.

Patient Definition: Referrals

Given the complex medical conditions that health center patients often experience, some health centers may lack the ability to provide specialized or complex care to some patients. In these situations, health centers should be able to collect 340B discounts on otherwise-eligible prescriptions written by non-340B covered entities in cases where the patient sees an outside specialist and the covered entity demonstrates continued responsibility for the care of the individual. Under the health center program, health centers are required to contract for required services if not available at their facility. It is imperative that health centers are able to provide their patients with access to affordable 340B medications through these referral relationships, with appropriate documentation.

We encourage you to implement policies for permitted referrals in the 340B program that take into account the clinical capabilities and the unique ways health centers provide care to their patients, while balancing program integrity that ensures eligible patients can discounted medicines. For example, a patient who visits their usual primary care physician at a local health center presents with concerning symptoms. The physician determines they need to see a specialist and refers them to a non-340B oncologist. If the specialist were to prescribe the individual a new medicine, under these types of referral reforms, this script would be eligible for the CHC to claim a 340B discount on if it is filled at their entity-owned pharmacy or an eligible contract pharmacy, and the CHC receives records of the specialist's services and maintains overall responsibility for the care of the individual. This flexibility is particularly important for patients who must travel farther to access specialty care, including outpatient surgery, cardiac care, trauma care, and obstetrics.[vi]

A strong, auditable, and clear definition of a 340B patient is key to accurately identifying a 340B prescription and preventing unintended consequences that threaten to divert safety net funding away from its intended purpose. As we have seen in recent years, enterprising businesses and individuals will continue to attempt to find new ways to tap into the 340B system for their benefit, creating misaligned incentives that threaten the sustainability of the program. To help prevent further abuse, the Health Resources and Services Administration (HRSA) needs to be able to provide appropriate oversight to the program, including having clear standards to prevent diversion, which is a statutory violation, and effectively enforce the program overall.

Patient Definition: Covered Entity Hierarchy

Given the current lack of clarity in the patient definition, smaller covered entities, like grantees and rural hospitals, have encountered challenges with hospitals and claiming 340B prescriptions. As mentioned previously, smaller providers often refer patients to specialists to ensure they get the appropriate care for their medical needs. Despite the referring physician ultimately being responsible for their patients' overall health by serving as their primary care provider, hospitals often try to claim the 340B discount on medications related to conditions the health center provider manages on behalf of the patient. When these situations arise, the covered entity responsible for the patient's case management or care coordination should claim the 340B discount to be reinvested back into that patient's overall care. Importantly, such a hierarchy must be operationalized via the Clearinghouse to ensure manufacturers only receive one 340B discount claim per script since they are ill-equipped to determine which covered entity should receive the discount.

Without a strong patient definition, creative interpretations and enterprising businesses will continue to find new ways to divert safety net funding away from vulnerable patients and under-resourced providers. As prescriptions are only eligible for one 340B discount, it is not difficult to imagine a world where large, well-resourced institutions take advantage of a lax patient definition and use "referrals" to squeeze out true safety net providers in the system.

Patient Affordability

We strongly believe and are committed to ensuring no low-income or uninsured covered entity patient struggles to afford a 340B medicine. For over 30 years, the 340B program has been helping safety net providers like health centers provide medications for steep discounts to their patients. However, the statute lacks explicit language that patients should benefit from the 340B program. New requirements should be included in any 340B reform legislation to ensure qualifying low-income and uninsured patients benefit directly from 340B through reduced out-of-pocket costs for their medicines, whether they receive their medicine at a health center or contract pharmacy.

Health centers are already required to provide affordability assistance and are willing to be subject to new patient affordability standards that require them to establish a policy that provides discounts on 340B drugs to ensure their low-income and uninsured patients are not denied access to 340B drugs based on their ability to pay. These requirements would extend to grantees' entity-owned and contract pharmacies, where health centers already take significant measures to make medications affordable for their patients. Besides offering discounted medications through the 340B program, health centers creatively employ other affordability measures to help our patients. Health center entity-owned and contract pharmacies offer prescription assistance programs to help patients with lower incomes be able to afford their medications. Another example is copay assistance programs, which lower the copay patients see when acquiring their prescriptions at the pharmacy. Health centers remain dedicated to our mission of providing affordable, quality care and medications to our patients and continue to be good stewards of the 340B program.

Transparency

We thank the Working Group for considering how best to improve transparency in the 340B program. Over the last 30 years, the 340B program has expanded to more than 50,000 covered entity sites and $54 billion in sales at the 340B price. Notably, health centers only make up 5% of

the program.[vii] While the program has grown substantially, requirements regarding the operation of the program have not kept pace. We encourage Congress to adopt accountability measures and reporting requirements for all stakeholders to increase program integrity.

We believe a modified version of the approach taken in Congressman Larry Bucshon's H.R. 3290, introduced in 2023, will bring much-needed transparency to the 340B program. We recommend the language in H.R. 3290 be updated to require covered entities to calculate the 340B margin by comparing the 340B ceiling price to a covered entity's total reimbursement for 340B drugs. Additionally, covered entities should separately report how much they are spending on 340B-related administrative expenses (calculated using an authoritative accounting standard).

Health centers are supportive of ways to increase program integrity among all covered entities. Because of their federal grantee status, health centers already exhibit transparency through reporting myriad data to HRSA and adhering to requirements for Uniform Data System (UDS) reporting. By law and regulation, health centers are already required to put every 340B dollar back into patient care. We support having grantees, like health centers, report how they use the 340B margin they collect using standardized rules established by HHS, consistent with UDS reporting standards.

Program Integrity

We appreciate the members' consideration of program integrity, which we believe is paramount for the long-term sustainability and success of the program. To further strengthen the proposed legislation, we would like to suggest alternative program intent language for the Working Group's consideration.

Program Integrity: Intent

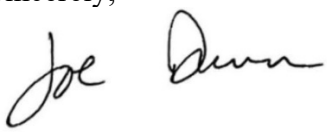
We appreciate the Working Group's proposed intent language for the SUSTAIN 340B Act's sense of Congress. Currently, the 340B statute does not include the intent of the program. Most 340B stakeholders are familiar with the intent statement from a legislative report from the early 1990s, stating that the "340B program enables covered entities to stretch scare federal resources as far as possible, reaching more eligible patients and providing more comprehensive services."

As covered entities, like health centers, have relied on this report language for decades, ASAP 340B recommends the Work Group include proposed intent language directly in the 340B statute to codify the intent of the 340B program permanently. Below is our recommendation:

"The intent of this section is to provide for manufacturer price reductions that enable covered entities, whose mission is to serve underserved or otherwise vulnerable communities, to increase access to affordable drugs and health services for these communities."

We appreciate the opportunity to provide feedback on the SUSTAIN 340B Act. We look forward to continuing to work with you on efforts to modernize the 340B program and stand ready to provide further assistance. We hope that our feedback and ideas help you identify meaningful bipartisan policy solutions. If you have any questions, please contact NACHC's Associate Vice President of Policy & Regulatory Affairs, Vacheria Keys, at vkeys@nachc.org.

Sincerely,



Joe Dunn
Senior Vice President for Public Policy and Advocacy

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[ii] https://www.nachc.org/wp-content/uploads/2023/07/Community-Health-Center-Chartbook-2023-2021UDS.pdf
[iii] Fein A. EXCLUSIVE: For 2023, Five For-Profit Retailers and PBMs Dominate an Evolving 340B Contract Pharmacy Market. Drug Channels Institute, 2023. https://www.drugchannels.net/2023/07/exclusive-for-2023-five-for-profit.html
[iv] Fein A. EXCLUSIVE: For 2023, Five For-Profit Retailers and PBMs Dominate an Evolving 340B Contract Pharmacy Market. Drug Channels Institute, 2023. https://www.drugchannels.net/2023/07/exclusive-for-2023-five-for-profit.html
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Supportive Organizations

National and State Partners

- Association of Asian Pacific Community Health Organizations
- California Primary Care Association
- Colorado Community Health Network
- Community Health Center Association of Connecticut
- Idaho Community Health Center Association
- Indiana Primary Care Association
- Iowa Primary Care Association
- Kentucky Primary Care Association
- Maine Primary Care Association
- Michigan Primary Care Association
- Minnesota Association of Community Health Centers
- Community Health Center Association of Mississippi
- Health Center Association of Nebraska
- Nevada Primary Care Association
- New Jersey Primary Care Association
- North Carolina Community Health Center Association
- Ohio Association of Community Health Centers
- Oklahoma Primary Care Association
- Oregon Primary Care Association
- Pacific Islands Primary Care Association
- Pennsylvania Association of Community Health Centers
- South Carolina Primary Health Care Association
- Texas Association of Community Health Centers
- Virginia Community Healthcare Association
- Washington Association for Community Health
- West Virginia Primary Care Association

Community Health Centers

Alabama	**Arizona**
• Franklin Primary Health Center, Inc. • Health Services, Inc. • Thrive • Alabama Whatley Health Services, Inc. • Alabama Regional Medical Services • AIDS Action Coalition of HSV D/B/A Thrive Alabama	• Ajo Community Health Center • El Rio Health • United Community Health Center - Maria Auxiliadora, Inc • Mountain Park Health Center
California	**Colorado**
• Elica Health Centers • Family Health Centers of San Diego	• Mountain Family Health Centers • Peak Vista Community Health Centers

• Health Access for All Inc • Health and Life Organization, Inc. • Health Center Partners of Southern California • La Clinica de La Raza • La Maestra Community Health Centers • Neighborhood Healthcare • NEMS • Redwood Coast Medical Services • Shasta Community Health Center • The Center For Sexuality & Gender • Diversity • VISTA COMMUNITY CLINIC • Vista Community Clinic • Alliance Medical Center • Chinatown Service Center	• Salud Family Health Inc • Summit Community Care Clinic • Valley-Wide Health Systems
Connecticut • First Choice Health Centers Inc. • Community Health Center, Inc	**Delaware** • Henrietta Johnson Medical Center
Florida • Community Health of South Florida, Inc. • Empower U Inc. • Evara Health • Florida Community Health Center Inc. • Genesis Community Health, Inc. • Gracepoint Health Centers • Health Choice Network • Miami Beach Community Health Center • Project Health, Inc. dba Langley Health Services • THRIVE • Trenton Medical Center, Inc. • Empower U CHC • Community Health Centers of S. Florida • Central Florida Family Health Center, Inc. • Central Florida Health Care	**Georgia** • Curtis V. Cooper Primary Health Care, Inc. • First Choice Primary Care • Georgia Highlands Medical Services • MedCura Health • MedLink Georgia • Neighborhood Improvement Project, Inc. • South Central Primary Care Center • Medical Associates Plus • Community Health Care Systems, Inc. • Georgia Mountains Health Services, Inc.
Hawaii • Hawai'i Island Community Health Center • Kokua Kalihi Valley • Waimanalo Health Center	**Idaho** • Adams County Health Center • Health West, Inc.

Illinois	Indiana
• AHS Family Health Center • Christopher Rural Health Planning Corporation • Esperanza Health Centers • Friend Family Health Center • Greater Family Health • PrimeCare Community Health Centers • Shawnee Health • SIU Center for Family Medicine • TCA Health, Inc. NFP • Promise Healthcare • Family Christian Health Center • Central Counties Health Centers, Inc. • Cass County Health Department	• Centerstone Health Services • Aspire Indiana Health • HealthNet, Inc. • Heart City Health Center, Inc. • Indiana Health Centers, Inc. • Jane Pauley Community Health Center • LifeSpring Health Systems • Windrose Health Network • HealthLinc, Inc. Good Samaritan Family Health Center
Iowa	**Kansas**
• Community Health Care, Inc. • Primary Health Care	• Heartland Community Health Center Mercy and Truth Medical Missions
Kentucky	**Louisiana**
• Family Health Centers • Kentucky Health Center Network • Health First Community Health Care	• Iberia Comprehensive Community Health Center • Southeast Community Health Systems • SWLA Center for Health Services • Winn Community Health Center • Odyssey House Louisiana, Inc.
Maine	**Maryland**
• Health Access Network • Penobscot Community Healthcare	• Choptank Community Health • Family Healthcare of Hagerstown • Maryland Community Health System • Tri-State Community Health Center Preventative Care Health Service Inc
Massachusetts	**Michigan**
• Brockton Neighborhood Health Center • Family Health Center of Worcester, Inc. • Outer Cape Health CHC • South Cove Community Health Center • Stanley Street Treatment and Resources, Inc. • Holyoke Health Center • Duffy Health Center Fenway Health	• Community Health and Social Services Center • Center for Family Health • Cherry Health • Downriver Community Services, Inc. dba Community First Health Centers • East Jordan Family Health Center • Family Health Care

	• Family Medical Center of MI • Grace Health • Hackley Community Care Center • Ingham Community Health Centers • InterCare Community Health Network • MidMichigan Community Health Services • MyCare Health Center • Thunder Bay Community Health Service • Upper Great Lakes Family Health Center • Western Wayne Family Health Centers Advantage Health
Minnesota • Cook Area Health Services, Inc., dba Scenic Rivers Health Services • Minnesota Community Care Open Cities Health Center	**Mississippi** • Aaron E. Henry Community Health Services Center, Inc. • Central Mississippi Health Services, Inc • G. A. Carmichael Family Health Center • Jackson-Hinds Comprehensive Health Center
Missouri • Fordland Clinic	**Montana** • Greater Valley Health Center • Marias Healthcare Services Inc
Nevada • Southern Nevada Community Health Center	**New Hampshire** • Ammonoosuc Community Health Services, Inc.
New Jersey • Ocean Health Initiatives Inc Zufall Health Center, Inc.	**New York** • BronxCare Health Integrated Services System Inc. • Cornerstone Family Healthcare • Family Health Network of Central New York, Inc. • Finger Lakes Community Health • Hudson Headwaters Health Network • Institute for Family Health • Primary Care Development Corporation • Sunset Park Health Council • Syracuse Community Health • Tri-County Family Medicine Program, Inc. • Westchester Community Health Center

	• Charles B. Wang Community Health Center • Bronx Community Health Network
North Carolina • Appalachian Mountain Community Health Centers • Charlotte Community Health Clinic, Inc. • Blue Ridge Health • Rural Health Group, Inc. • The C.W. Williams Community Health Center, Inc • Piedmont Health Services, Inc. CommWell Health	**Ohio** • Community Health & Wellness Partners of Logan County • City of Cincinnati • Circle Health Services • Community Health Centers of Greater Dayton • Center Street Community Health Center • Community Support Services • Compass Community Health • Equitas Health • Fairfield Community Health Center • Family Health Care of Northwest Ohio, Inc. • Family Health Services of Darke County • Family Health Services of Erie County • Five Rivers Health Centers • Health Partners of Western Ohio • HealthSource of Ohio • Knox County Community Health Center • Lorain County Health & Dentistry • Lower Lights Health • Ohio Hills Health Services • Primary Health Solutions • PrimaryOne Health • Signature Health, Inc. • The HealthCare Connection • Third Street Family Health Services • Valley View Health Centers/Community Action Committee of Pike County • Lower Lights Health Center
Oklahoma • Great Salt Plains Health Center, Inc. • Central Oklahoma Family Medical Center • East Central Oklahoma Family Health Center, Inc. • Fairfax Medical Facilities, Inc. • Good Shepherd Community Clinic, Inc. • Health & Wellness Center, Inc.	**Oregon** • Mosaic Community Health • Nehalem Bay Health Center & Pharmacy • Northwest Human Services, Inc • Siskiyou Community Health Center • Cascadia Health Cascade AIDS Project & Prism Health

• Morton Comprehensive Health Services, Inc. • Pushmataha Family Medical Center, Inc • Stigler Health and Wellness Center • Variety Care • Northeastern Oklahoma Community Health Centers, Inc. • Arkansas Verdigris Valley Health Centers, Inc. • Northeastern Oklahoma Community Health Centers, Inc. • Pushmataha Family Medical Center, Inc.	
Pennsylvania • Broad Top Area Medical Center, Inc • Community Health Net • Cornerstone Care • Delaware Valley Community Health • Glendale Area Medical Association, Inc. • Hyndman Area Health Centers • Keystone Health • Keystone Rural Health Consortia, Inc. • Laurel Health • LCH Health & Community Services • NEPA Community Health Care • North Penn Comprehensive Health Centers • Primary Health Network • RHD/Family Practice & Counseling Network • Sadler Health Center Corporation • Scranton Primary Health Care Center, Inc. • Spectrum Health Services, Inc. • Valley Health Partners Community Health Center • Wayne Memorial Community Health Centers • Community Health and Dental Care, Inc. • The Wright Center for Community Health Keystone Rural Health Consortia, Inc.	**Puerto Rico** • Centro De Servicos Primarios De Salud, Inc. • NeoMed Center Inc • Centro de Salud de Lares, Inc. • Morovis Community Health Center
Rhode Island • Thundermist Health Center	**South Carolina** • Careteam Plus, Inc. • Carolina Health Centers • Beaufort Jasper Hampton Comprehensive

	Health Services, Inc. • Foothills Community Health Care, Inc. • Health Care Partners of S.C. Inc. • Little River Medical Center, Inc. • Tandem Health SC • Carolina Health Centers, Inc. • Rural Health Services, Inc.
South Dakota • Horizon Health Care, Inc.	**Tennessee** • Christ Community Health Services • National Health Care for the Homeless Council • Chota Community Health Services
Texas • Community Health Service Agency, Inc. DBA Carevide • Asian American Health Coalition of Greater Houston DBA HOPE Clinic • Community Action Corporation of South Texas • Advanced Pediatric Care Inc • Coastal Bend Wellness Foundation • Carevide • AccessHealth • Avenue 360 Health & Wellness • Community Health Development • Family Circle of Care • Gateway Community Health Center, Inc. • Health Services of North Texas • Lone Star Community Health Center • Nuestra Clinica del Valle, Inc. • Presidio County Health Services • Special Health Resources, Inc. • Su Clinica Familiar • TAN Healthcare • Triangle Area Network, Inc • Valley AIDS Council • Vida Y Salud Health Systems, Inc. Community Health Centers of Central Texas • DBA CommUnityCare	**Utah** • Community Health Centers, Inc.
Virginia • Eastern Shore Rural Health System, Inc.	**Washington** • CHAS Health

• Healthy Community Health Centers • Piedmont Access to Health Services, Inc • Tri-Area Community Health Shenandoah Community Health	• Community Health Care of Tacoma • International Community Health Services • North Olympic Healthcare Network • Sea Mar Community Health Centers • Tri-Cities Community Health • Unity Care NW • Yakima Neighborhood Health Services • NEW Health
West Virginia • WomenCare, Inc. DBA FamilyCare Health Centers	**Wisconsin** • Partnership Community Health Center, Inc.