October 22, 2021

U.S. Citizenship and Immigration Services
Department of Homeland Security
20 Massachusetts Avenue NW
Washington, DC 20529-2140
Submitted via www.regulations.gov

Re: DHS- Docket No. USCIS-2021-0013; Comments on Public Charge Ground of Inadmissibility

To whom it may concern:

The Association of Asian Pacific Community Health Organizations (AAPCHO), California Primary Care Association (CPCA), National Association of Community Health Centers and the XXX undersigned member health centers/organizations submit these comments in response to the ANPRM put forward by USCIS on the public charge ground of inadmissibility. The agency must move quickly to permanently remove the use of all health care benefits from the public charge determination to support the health and wellbeing of immigrants and their families. The receipt of health care, nutrition or housing assistance is not, and should not be treated as, an indication that a person is primarily or permanently reliant on the government.

For the reasons stated in this letter, which includes our responses to questions posted by USCIS, we recommend that the following be addressed and resolved within this ANPRM:

1. In addition to ensuring that the public charge test is narrow and does not amount to a wealth or income test, the public charge regulations must be clear to avoid furthering confusion for immigrant families, which can cause immigrants and their family members to avoid public benefits, known as the chilling effect.
2. The Biden Administration should conduct education and outreach efforts to address the chilling effect. It is imperative the Biden Administration provide financial resources to fund community outreach programs to combat misinformation and stigma among immigrant communities.
3. Include guardrails to prevent a public charge determination from being used as a tool to discriminate against people of color, women, people with disabilities, older adults, or anyone else.
4. Do not consider Medicaid – even for institutional long term care – in a public charge determination
5. Exclude programs funded completely by state, local, tribal and territorial governments
6. Exclude family members' and sponsors' use of benefits
7. Specify that use of benefits as a child or when in an exempt status will not be included in a public charge determination, nor will benefits used when applying for an exempt status, regardless of a person's pathway to that status
8. Exclude any use of benefits by survivors of domestic violence and other serious crimes or exempt status, and by anyone during public emergencies.

I. Community Health Centers (CHCs) and their Patients

CHCs are federally-funded or federally-supported nonprofit, community-directed provider clinics that serve as the health home for over 28 million people, including 1 in 5 Medicaid beneficiaries and 1 in 3 people living in poverty nationwide. It is the collective mission and mandate of over 1,400 CHCs around the country to provide access to high-quality, cost-effective primary and preventative medical care as well as dental, behavioral health, and pharmacy services and other "enabling" or support services that facilitate access to care to individuals and families located in medically underserved areas, regardless of insurance status or ability to pay.

Having been created through the Civil Rights movement, CHCs have, from their inception, been partners in fighting for health equity, expanding health care access, and helping to address social determinants of health. By mission CHCs focus on providing culturally and linguistically diverse services to low income and non-English speaking communities regardless of their ability to pay and immigration status. Health center patients are predominately members of racial/ethnic minority groups, providing care to 10 million Latinx, over 1.6 million Asian Americans (AAs) and Native Hawaiians/Pacific Islanders (NH/PIs), and over 5 million Black patients. CHCs are a medical lifeline, communicating accurate, scientific information and providing holistic, high quality, coordinated services. CHCs provide care to disproportionately more limited English proficient (LEP) patients than the average health facility, recognizing that effective care requires reducing language barriers.

AAPCHO, CPCA, NACHC and our member community CHCs have seen the chilling effects of public charge on our patients, who are foregoing essential services, disenrolling from benefits for which they are eligible, or just not showing up to receive necessary health care. Specifically, under the Trump Administration, community CHCs throughout the country saw a dramatic increase in immigrant families choosing to not enroll in or disenrolling from the Children's Health Insurance Program (CHIP) and Medicaid, as a result of the harmful proposed Public Charge regulations. According to a report from the Urban Institute, more than one in seven adults in immigrant families reported that they or a family member avoided a non-cash government benefit program, such as Medicaid, the Children's Health Insurance Program (CHIP), the Supplemental Nutrition Assistance Program (SNAP), or housing subsidies, in 2019 for fear of risking future green card status. Immigration laws should not discourage immigrants and their family members from seeking physical or mental health care, nutrition, or housing benefits for which they are eligible.

a. Associations Representing CHCs

- The Association of Asian Pacific Community Health Organizations (AAPCHO), is a national voice to advocate for the unique and diverse health needs of AA and NH/PI communities and the community health providers that serve those needs. As health care providers and community based organizations, AAPCHO members work to improve health access and outcomes of medically underserved AA and NH/PIs.

- The California Primary Care Association represents California's 1,370 CHCs who serve 7.4 million patients of which 363,485 are homeless patients and 860,745 are migrant and seasonal farmworkers. CPCA's mission is to lead and position CHCs, and their networks through advocacy, education and services as key players in the health care delivery system to improve the health status of their communities.

- The National Association of Community Health Centers (NACHC) is the national membership organization for federally qualified health centers (also known as FQHCs or health centers).

II. Responses to ANPRM Questions

1. *What costs, if any, has your agency or organization incurred in order to implement changes in public charge policy, such as revising enrollment procedures and public-facing materials? Please provide relevant data*

The Trump-era public charge rule created a huge administrative burden on CHCs and community-based organizations. CHCs have dedicated significant time and resources to train staff to understand policy changes they may not have been familiar with in order to respond to increased numbers of patient inquiries. As a member organization, CPCA helped to create resources like trainings, factsheets (translated into various languages), talking points, social media posts, paid advertisements and much more to help address the chilling effect CHCs saw from patients, while helping to prepare our providers to respond to inquiries and understand the intricacies of the rule. As an organization we have dedicated thousands of dollars (over $100K) to help build these resources and run trainings / meetings / website.

CHCs have had to manage disenrollment and re-enrollment processes (aka "churn") that adds unnecessary costs to CHCs. Some have also set up a public charge multilingual "helplines," organized new newsletters and instituted other ways to disseminate immigration-related information to patients, all managed by health center staff. These activities required additional staff training and the development of new workflows, while siphoning off of time and resources from the actual provision of health care. As a result, these health-care providers have diverted resources from their core missions to address community and individual patient concerns about the public charge determination. At some CHCs its been as much as $1 million.

Until the Biden Administration issues a new Public Charge policy, CHCs and their communities will continue to feel the impact of the chilling effects from the Trump Administration. In this year alone, CPCA has hosted 5 service provider trainings while assisting in material development for 5 or more community trainings.

The cumulative impact of regulatory changes to Medicaid, the Affordable Care Act, and immigration policies has created a culture of fear that will take years of undoing. It is imperative the Biden Administration provides financial resources to fund community outreach programs to combat misinformation and stigma among immigrant communities.

2. *What costs, if any, has your agency or organization incurred as a result of reduction in enrollment, or disenrollment in public benefits programs generally? Please provide relevant data.*

   CHCs do not collect information about patients' immigration status, so it is hard to know if a patient disenrolls because of public charge unless the patient specifically brings it up (and even then, it would not be documented). With that said, CHCs report a significant drop in participants in the WIC program; this is particularly true for programs that served Latinx patients. This downturn is highly correlated with fear and confusion around public charge and immigration policy. Specifically, one AAPCHO member reported that it had to completely close its WIC program due to a lack of enrollment.

   It is also difficult to parse out reductions in enrollment/disenrollment's because of the pandemic. Several CHCs report that because public charge went into effect at about the same time as the COVID-19 pandemic began, it was difficult to discern the reason why patients were hesitant in seeking services. However, we strongly believe that many immigrants and their families continue to have concerns due to large participation rates for community trainings hosted by the CPCA and its immigrant partners regarding public charge, and the questions / comments shared during those trainings. CHCs also witnessed patients being afraid to take advantage of benefits like cash and food assistance during the pandemic because of their fear that it could put their future immigration status at risk. This wasn't identified as public charge, but it was the end result of what the rule had done.

3. *What costs, if any, has your agency or organization incurred as a result of disenrollment or reduction in enrollment in public benefits programs caused by the public charge ground of inadmissibility, the 1999 Interim Field Guidance, or the vacated 2019 Final Rule? Please provide relevant data.*

   Over 45% of health center patients have Medicaid and CHIP coverage. Over 1,300 CHCs nationwide hire enrollment assisters and conduct outreach and enrollment activities throughout the year to educate vulnerable and underserved communities on the benefits of health insurance coverage. CHCs have a statutory obligation to provide care to all patients, regardless of their ability to pay. The vacated 2019 Final Rule created fear and hesitation that led to immigrants disenrolling or not enrolling in public benefits, including Medicaid. In order for CHCs to serve uninsured and underinsured patients, it is imperative that patients enroll in health care coverage when they are eligible. Given this fact, CPCA conducted a financial analysis of its member in 2018 and again in 2019 and determined that CA CHCs could see 101,000 to 305,000 patients disenroll from Medicaid and become uninsured. The growth in the number of uninsured patients and loss of Medicaid reimbursements would have created a financial loss of $56 million to $170 million per year in California's CHCs. If we look at California as a whole, and not just health center patients, we would see 1.5 million patients disenroll from Medicaid, which would cause a projected loss of $7 billion in Medicaid/CHIP

funds for California if we apply the 60% decline of public services use seen in 1996, when the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) was adopted.

On the front lines of the COVID-19 pandemic, there are multiple factors contributing to the loss of health center revenue since 2020. The pandemic has likely contributed to the increased health and financial needs while impacting the decline in health coverage among immigrant families. Unfortunately, restrictions limited immigrants' access to COVID-19 relief and made families reluctant to access services at facilities like CHCs.

Additionally, AAPCHO members report a reduction in enrollment over the past two years since the Trump-era public charge rule started to chill participation in public benefits. In a KFF survey conducted at AAPCHO member CHCs between January to March of 2021, one quarter (25%) of Asian health center patient respondents say that they or a member of their household did not apply for or stopped participating in a government program to help them pay for health care, food, or housing in the past year due to immigration-related fears.

4. *How should DHS define the term ''public charge''?*

DHS should define someone likely to become a public charge for inadmissibility purposes as a person who is "likely to become primarily and permanently reliant on the federal government to avoid destitution." This would be consistent with the congressional intent and historical understanding of public charge as applying to a narrow set of immigrants who are likely to become a "public charge". It is also consistent with case law. In 2020, the Second Circuit Court of Appeals relied on the Board of Immigration Appeals' interpretation of 'public charge' to mean a person who is "unable to support herself, either through work, savings, or family ties."

Under this definition, reliance on the government should not be taken into account unless:

- The government provides the primary source of income. Many people receive modest public benefits that supplement their earnings by improving their access to nutrition, health care, and other services. Using these supplemental benefits will not make someone a public charge.
- The reliance is permanent.
- The reliance is to avoid destitution.

5. *How might DHS define the term "public charge", or otherwise draft its rule, so as to minimize confusion and uncertainty that could lead eligible individuals to forgo the receipt of public benefits?*

The definition "likely to become primarily and permanently reliant on the federal government to avoid destitution" should guide any assessment of an applicant's benefit use. We also hope that government staff reviewing immigration applications, in particular around the public charge means test, are provided training and guidance to remove any personal biases and ensure that there is clear direction as to how these applications should be evaluated. Doing this it will help address the chilling effect since many immigrants' distrust of the evaluation process leads them to question whether or not to access public benefits.

We recommend that the public charge NPRM:

- **Do not consider Medicaid – even for institutional long-term care – in a public charge determination.** According to the Kaiser Family Foundation, in the U.S., one in three people turning 65 will require nursing home care in their lives, and Medicaid is the primary payer for long-term care in the US, covering six in ten nursing home residents. We should not penalize immigrants for the problems in the country's health care system that make it difficult to get care at home and force people into institutional care. In addition, including any type of Medicaid benefit will confuse people and lead them to forego health care.

- **Provide clear guidance on how to predict the likelihood of becoming a public charge based on past or current benefits use no more than two or three year lookback.** Without such guidance, predicting who is likely to become a public charge "at any time in the future" is an act of speculation that could allow

immigration officers to discriminate. The best way to ensure fairness is to ask adjudicators to look back at an applicant's use of certain public benefits for a finite lookback period–such as two or three years—as a way of gauging future likelihood. In addition, adjudicators should take into account any changes in the applicant's circumstances, especially if in the past they were utilizing public benefits but are not using them at the time their application is reviewed. Based on current facts, adjudicators assessment of public charge needs to be reasonably foreseeable.

- **Exclude programs funded completely by state, local, tribal and territorial governments.** Clarify that state or local government funded programs—even if they provide cash assistance—are exercises of the powers traditionally reserved to the states and are not counted as factors in a public charge test. States and localities have a compelling interest in promoting health and safety that includes providing benefits at their own expense without barriers caused by federal policies. Additionally, in California many immigrants and their families decided to forgo using public benefits because there was confusion as to whether or not that program received federal funds, and therefore would be subject to the rule.

- **Exclude family members' and sponsors' use of benefits.** Make clear that benefits used by an applicant's family members or sponsors do not count as factors in the applicant's public charge test. This is critical in minimizing the chilling effect of the public charge rule on access to benefits by people, including citizen children, who are not subject to a public charge determination but whose family members may seek LPR status in the future. CHC staff, like community health workers and medical providers, shared that patient have come into appointments in tears for fear that their visit may hinder the ability for a family member to adjust or change their immigration status. As an example, a youth in CA who had recently been diagnosed with leukemia attempted to commit suicide because they believed that their use of benefits could lead to the deportation of their parents. Misinformation combined with confusion almost led to the untimely death of a teenager. In cases like this, it is very important that the rule clearly excludes family members use of benefits.

- **Exclude any use of benefits by survivors of domestic violence and other serious crimes or exempt status, and by anyone during public emergencies.** Benefits used by survivors of domestic violence or other serious crimes, or used by anyone during natural disasters or other extraordinary circumstances, such as the COVID-19 pandemic or in the aftermath of hurricanes and wildfires, should not be included as factors in a public charge determination. Use of these benefits is due entirely to external events and does not provide any information on the recipient's likelihood of becoming primarily reliant on government assistance at a future date.

- **Specify that use of benefits as a child or when in an exempt status will not be included in a public charge determination, nor will benefits used when applying for an exempt status, regardless of a person's pathway to that status**. DHS should propose that benefits received by children—whose long-term economic contributions are generally *bolstered* by childhood receipt of benefits—be excluded from consideration. In addition, benefits received when in an exempt status, such as cash assistance provided to a refugee, should be excluded regardless of a person's pathway to adjustment of status. Finally, benefits received while an individual is applying for an exempt status should be excluded.

6. *Which factors (whether statutory factors or any other relevant factors identified by the commenter) are most predictive of whether a noncitizen is likely (or is not likely) to become a public charge?*

Immigrants make extraordinary contributions to American life and full use of health, nutrition, and income support programs by immigrant and U.S. citizen members of the community is good economics and good policy. Additionally, within CHCs we have employed immigrants to help address the workforce shortage withing healthcare, including behavioral health. CHCs also work closely with DACA recipients and TPS holders

as they help bring other members of their community into the care fold by being enrollers, health navigators, CHWs, Doulas, etc.

Use of healthcare services, including prevention and chronic disease management, are predictive of better health outcomes. Receipt of health care, nutrition or housing assistance is not an indication that a person is or will become primarily or permanently reliant on the government. These factors should not be used in a public charge determination.

7. *Should DHS consider the receipt of public benefits (past and/or current) in the public charge inadmissibility determination? If yes, how should DHS consider the receipt of public benefits and why?*

   No. Individual's past use of health and other public benefits should not be considered in an inadmissibility determination. With regards to their health, health benefits allow individuals to get the preventive services and chronic care management they need--as well as to treat acute health needs. The COVID-19 pandemic has shown the critical importance of use of benefits as a public health measure to treat, heal and do education about the pandemic. The use of these services should be prioritized--not used against someone during a public charge determination.

   For example, research is clear that Asian and Pacific Islander communities have been dramatically and negatively impacted by COVID-19. Our communities have been hard hit with high rates of infection and mortality. A recent analysis by National Council of Asian Pacific American Physicians and Asian American Research Center on Health found that Asian Americans have a higher case fatality rate that is disproportionately higher—up to five times greater—than the general population, indicating that Asian Americans are not getting access to diagnostic tests, are more likely to die from COVID-19 when they get infected, or both.

   If DHS does choose to consider the receipt of past benefits as part of the public charge determination, it must at a minimum exempt the use of benefits of an individual when they were a child (under age 18).

8. *How should an applicant's age be considered as part of the public charge inadmissibility determination?*

   An applicant's age should not be considered as part of the public charge inadmissibility determination. Being of advanced age and not working in the formal economy should not be viewed as a negative, particularly when an older member of the family is providing care for a spouse, a child, or other family member. In addition, if an older person has a sponsor, family or community that will support them, they will be unlikely to become primarily and permanently dependent on the government. Minors (under 18) should be entirely exempted from public charge inadmissibility determination. Use of benefits as a child or when in an exempt group should not be included in a public charge determination, nor should benefits used when applying for an exempt status, regardless of a person's pathway to legal status.

9. *How should DHS define health for the purposes of a public charge inadmissibility determination? Should DHS consider disabilities and/or chronic health conditions as part of the health factor? If yes, how should DHS consider these conditions and why?*

   The Coronavirus (COVID-19) pandemic has revealed deep-seated inequities in health care for communities of color and has amplified social and economic factors that contribute to poor health outcomes.

   AA and NHPI communities have long faced disparities in their health and health outcomes, which have been exacerbated by COVID-19. Preceding the pandemic, Asian Americans, Native Hawaiians and Pacific Islanders experienced high rates of chronic disease, some of which have been shown to increase risks of serious illness or death if they contact COVID-19. For example, Asian Americans are 50 percent more likely to have diabetes; cancer is the leading cause of death among Asian Americans, and more than half of all Hepatitis B cases in the U.S. are within

the Asian American community. Additionally, when compared to non-Hispanic whites, Pacific Islanders are 2.5 times more likely to have diabetes, and they are 80 percent more likely to be obese, and 30 percent more likely to have asthma.

Latinx communities have also encountered disparities in their health and overall health outcomes. According to the Center for American Progress, Latinos are 1.7 times more likely to contract COVID-19 than their non-Hispanic white counterparts, as well as 4.1 times more likely to be hospitalized from COVID-19 and 2.8 times more likely to die from COVID-19.2 Additionally, one in two Latinos will develop diabetes over their lifetime. Latinos are at a 66% greater risk of developing type 2 diabetes, and once diagnosed, have worse outcomes than non-Hispanic whites. Diabetes often brings mental health problems in its wake: one in five diabetics have depressive symptoms. But Latinos are also less likely to receive treatment for depression, anxiety, and other behavioral issues than their white counterparts. Health, disability and/or chronic conditions should not be considered as part of public charge test. Judging individuals on their health status, chronic health conditions, and disabilities is discriminatory and makes individuals with underlying health conditions "undesirable". Including health as a factor in the public charge determination ignores the reality that a chronic illness is not an accurate indicator of future self-sufficiency and full-time employment capabilities.

The impact of including health, disability and/or chronic conditions as part of the public charge determination would disproportionately impact Latinx, Asian, Pacific Islander, and Black immigrants and their families, furthering health disparities and negatively impacting immigration. What is more, including these factors in the public charge determination may incentivize individuals with chronic conditions to terminate their healthcare and forgo services in order to remain eligible to adjust their status--leading to delayed care and worse health outcomes.

10. *Should DHS account for social determinants of health to avoid unintended disparate impacts on historically disadvantaged groups? If yes, how should DHS consider this limited access and why?*

Yes. Immigrants and their families face barriers to holistic health that are rooted in xenophobic and structural racism--and physical health cannot be separated from social health. CHCs provide enabling services to address a combination of social determinants of health and barriers to access primary care and other important social services. This includes care coordination, health education, transportation, and assistance with obtaining food, shelter, and public benefits. DHS should account for social determinants of health, as Americans experience the same disparate impact, and immigrants should not be penalized for utilizing resources to address societal harms.

The impact of these policies on Asian, Pacific Islander, Latinx, and Black immigrants' ability to access, for example, safe and stable housing or food and nutrition services impacts their health and health care outcomes. For instance, an individual's asthma may be exacerbated by poor housing, lack of air conditioning, and community pollution. Policies must account for these challenges by not including health, health status, chronic conditions or disabilities into the public charge determination.

11. *How should DHS define and consider family status for the purposes of a public charge inadmissibility determination?*

DHS should consider the positives of having a large family, such as more people who can work and bring in income, care for children and elders, and support the family's success and resiliency. DHS should also consider families who are in different stages of being documented and eligible, and the fear of public charge that prevents them from seeking access to these programs. We encourage DHS to provide maximum clarity on how family status will impact public charge determinations to eliminate confusion and hesitation.

12. *How should an applicant's household size be considered as part of the family status factor? What definition of an applicant's household size should DHS use for the public charge inadmissibility determination?*

Household size should not be considered as part of the family status factor. We should not penalize people who are part of a large family, when family members play a role in supporting the whole family, whether in the home caring

for loved ones, or outside the home at work or doing community service.

13. *How should DHS address the challenges faced by those not served by a bank or similar financial institution in demonstrating their assets, resources, and financial status?*

    DHS should ensure that individuals not served by a bank or financial institution have an opportunity to demonstrate their resources. Financial institutions have a long history of practices that de-incentivize equitable participation in traditional banking. For example, redlining policies in housing caused direct and long-lasting harms to the Asian and Pacific Islander communities, and the effects of these harms are still felt today, even after the practice of redlining was outlawed. As recently as 2015, the Seattle Office of Civil Rights uncovered patterns of discrimination in housing rental practices. Entire neighborhoods remain segregated; some are still more than 90 percent white, even 50 years after redlining ended in practice and communities of color were free to move where they pleased.

    Moreover, whether due to fear, uncertainty, discrimination, or any combination of the three, immigrants and their families may not have engaged with traditional financial institutions. DHS, for example, should not require a credit score and/or credit history when they have such negative contexts. Such a requirement is unnecessary and overly burdensome. Credit scoring algorithms are supposedly designed to eliminate bias; they don't take into account factors like age, sex, religion, or race. However, algorithms can get around this restriction by considering the social networks of an applicant, such as their neighborhood. Immigrants of all ethnic backgrounds are equally, if not more likely, than US citizens of any race to live in the lowest income neighborhoods in fast-growing cities. This means an applicant who lives in a low-income community could be considered more of a risk than someone in a white-collar neighborhood. Race has not formally been considered, but ZIP code of residence is often times viewed as a proxy for it. As such, a degree of racial discrimination has still been introduced into the credit system's algorithm regardless of the applicant's individual credit worthiness.

14. *How should DHS consider an applicant's education and skills in making a public charge inadmissibility determination?*

    An applicant's education and skills should not be used in making a public charge inadmissibility determination. Immigrants meaningfully contribute to our communities and societies in a variety of different ways. However, DHS should consider education and skills that are valuable or likely to lead to employment as a potential positive to make up for other circumstances. For example, if an applicant does not currently have a job, but their education and skills indicate that they will find work, they should not be found to likely become a public charge.

15. *Which public benefits, if any, should not be considered as part of a public charge inadmissibility determination?*

    DHS should NOT consider any public benefit programs for the public charge rule determination. In the alternative, DHS should **exclude** from the public charge determination:

    - Medicaid – even for institutional long term care – in a public charge determination
    - Programs funded completely by state, local, tribal and territorial governments.
    - Use of benefits by survivors of domestic violence and other serious crimes or exempt status, and by anyone during public emergencies.

II. CONCLUSION

For the reasons stated in this letter, we urge the Biden Administration to take the recommendations mentioned through out this letter, including making sure the public charge rule does NOT include health programs within the public charge determination. If we want our communities to thrive, everyone in those communities must be able to stay together and get the care, services and support they need to remain healthy and productive.

We also strongly believe that to combat the chilling effect, it is imperative that the Biden administration provides financial resources to fund community outreach programs to combat misinformation and stigma among immigrant communities.

Thank you for the opportunity to submit comments on the ANPRM. Please do not hesitate to contact Adam Carbullido at acarbullido@aapcho.org, Vacheria Tutson at vtutson@nachc.org, or Elizabeth Oseguera loseguera@cpca.org to provide further information or help answer any questions.

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Abrazar, Inc.
Alliance Medical Center
AltaMed Health Services
Asian American Health Coalition dba HOPE Clinic
Asian Pacific Community in Action
Associate Director of Policy
Association for Utah Community Health
Bi-State Primary Care Association
Center for Family Health
Children's Health Fund
Colorado Community Health Network
Community Clinic Association of Los Angeles County
Community Health Alliance

Community Health Association Inland Southern Region
Community Health Center Association of Connecticut
Community Health Network of Washington/Community Health Plan of WASHINGTON
Community Health Partnership
Denver Health's Denver Community Health Services
Edward M. Kennedy Community Health Center
Eisner Health
Gardner Health Services
Golden Valley Health Centers
Harbor Health Services Inc
Health Center Association of Nebraska
Health Center Partners of Southern California
Health Outreach Partners
InterCare Community Health Network
International Community Health Services
Kentucky Mountain Health Alliance, Inc
Marin Community Clinics
Massachusetts League of Community Health Centers
Michigan Primary Care Association
Midtown Community Health Center
Mountain Family Health Centers
Native American Health Center
North East Medical Services (NEMS)
Northeast Valley Health Corporation
OCHIN
Oregon Primary Care Association
Organization's Name
Pennsylvania Association of Community Health Centers
Petaluma Health Center
Primary Health Care, Inc.
Redwood Community Health Coalition
Saban Community Clinic
Salud Family Health
San Francisco Community Clinic Consortium
SDOP
STRIDE Community Health Center
Tri-Cities Community Health
TrueCare
University of Michigan
Valley-Wide Health Center
Venice Family Clinic
WECAN Foundation
Wisconsin Primary Health Care Association
Wyoming Primary Care Association