

Federal AIDS Policy Partnership Ryan White Work Group

HIV/AIDS Community Consensus on the Future of the Ryan White HIV/AIDS Treatment Modernization Act (Public Law 109-415)

The Ryan White Work Group is a coalition of national, local and community-based service providers and HIV/AIDS organizations that represent HIV medical providers, public health, advocates and people living with HIV/AIDS committed to ensuring that the Ryan White Program continues to ensure appropriate primary care and treatment and support services to uninsured and underinsured individuals living with HIV/AIDS.

In December of 2006, the Ryan White Program was reauthorized for a three year period and contained a sunset clause. Without action, the Program will expire on September 30, 2009. The reauthorization included many significant changes including changing the distribution formulas from estimated living AIDS cases to actual living HIV and AIDS cases, a core services requirement, and provisions regarding unobligated funds. The impact of these changes has not yet been fully or sufficiently analyzed as the changes are ongoing and sufficient data are currently unavailable.

The HIV/AIDS community has come together over the past several months to examine the possibilities for the future of the Ryan White Program. During a series of meetings and teleconferences, a broad range of participating organizations considered a number of factors including available data, information on how changes from the last reauthorization have affected services provided to Ryan White clients and the effects of these changes on their lives and health status/access to services. The Ryan White Work Group has carefully considered the time necessary to work through complicated program mechanics in order to make recommendations for change with the time available prior to sunset of the current legislation. After discussion the undersigned HIV/AIDS organizations have agreed to recommend the course of action as described in this *Community Consensus*.

The *Community Consensus* is largely cohesive; however, with such a large number of organizations involved and a large number of issues discussed there is some divergence on a few provisions. Those minority views are noted below. In addition to this *Community Consensus*, *participating* organizations submitted a document to Congress in the fall of 2008 recommending four technical fixes to the current legislation. These technical fixes are included at the end of the recommendations.

Additionally, the HIV/AIDS community is involved in a variety of additional policy discussions that potentially impact the Ryan White Program such as the development of a National AIDS Strategy, as well as broader health care reform. In order to maintain health stability for persons living with HIV/AIDS, it is necessary to secure an extension of the Ryan White Program while the larger issues of our nation's health care system and a national strategic plan for HIV prevention, care and treatment are developed, assessed and analyzed.

Recommendations on the Legislative Future of the Ryan White Program

The undersigned organizations unanimously agree that the Ryan White Program must be extended for a period of at least three years. We believe an extension is the most prudent course of action given the many concurrent factors impacting the legislative future of the Program. Additionally, the HIV/AIDS community believes that the Ryan White Program must be reexamined in a comprehensive manner after the implementation of much-anticipated health care reform proposals and/or a national HIV/AIDS strategy. It would be premature to alter the Ryan White Program without waiting for specific proposals and programs.

During an extension process the dates in the legislation must be carefully examined and changed to reflect the new authorization period of FY2010 through FY2012. It is important that the dates be changed consistently and language no longer applicable to the Ryan White legislation be eliminated so as not to cause unintended consequences. This process can be looked at as “restarting the clock” on the current three-year authorization. The remainder of our recommendations honors this “restarting” concept and keeps alterations to the legislation at a minimum.

Authorization Levels

The current legislation includes authorization levels for each of the three fiscal years that are inadequate to address program need. Included in the current legislation is a 3.7 percent increase for the majority of the Parts, an increase which is significantly less than what is seen in other health authorization legislation such as for the Community Health Centers. For this reason, the community asks that for fiscal years 2010, 2011 and 2012 (the years included in a three year extension of the Program) the section of *Authorization of Appropriations* be altered to include language allowing for such sums as necessary.

Proposal: We ask that the extension bill include *Such Sums Necessary* language. This allows appropriators to respond to current economic conditions and provide adequate funding levels. Each Part of the legislation includes a section on *Authorization of Appropriations*. Each section be altered to state: “For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2012.

Continued Protection for States with Maturing HIV Case Data

Currently all states are collecting name-based HIV data. However, some states have only recently made this transition and do not yet have mature named-based HIV surveillance systems. In the last reauthorization, states with maturing systems were allowed to submit their HIV data directly to HRSA and incur a five percent penalty. If at any time during the three-year authorization period, the state’s name-based HIV data is certified by the Secretary as accurate and reliable, the state has the ability to have CDC directly report the cases and avoid the five percent penalty. CDC has estimated that the earliest that all states may have mature HIV systems is in FY2012. As the new authorization period goes on, fewer and fewer states will submit their data directly to HRSA and will use the CDC system.

Proposal: We recommend that states continue to have the option of submitting name-based data to HRSA until their state's name-based reporting system is deemed accurate and reliable by the HHS Secretary. Under this scenario, the five percent penalty would stay the same. In Parts A and B of the legislation, the section on *Requirement of Names-Based Reporting* must be updated for fiscal years 2010 through 2012 so that the provision remains the same.

Extension of TGA Eligibility

The last reauthorization created two separate tiers of Part A jurisdictions – Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs). It also created a prevalence test that had been intended to apply after three years of the bill. HRSA has notified six current TGAs that they are in jeopardy of losing their eligibility in FY2010. The community believes it is premature to discontinue funding to these (and any other jurisdictions) before client level data is fully realized and an analysis can be done of the services provided to individuals. In addition, because HIV data is not currently mature, eligibility is based only on AIDS cases. Once HIV case data becomes available it is assumed that EMA and TGA eligibility will be updated to include HIV and AIDS cases. Continuity of care is vitally important for persons receiving Ryan White-funded services.

Proposal: We recommend that all TGAs retain their status and continue to receive Ryan White funding. *Sec. 2609 (c) Certain Eligibility Rules* under Title I of the current legislation should be updated to ensure that transitional grant areas retain their status. Language referencing subpart I should specifically be made to refer to transitional grant areas and the years should be updated as follows: References to fiscal year 2006 should be changed to fiscal year 2009 and references to fiscal year 2007 should be changed to fiscal year 2010.

Extension of Hold Harmless Provisions

Over the years, The HIV/AIDS community has wrestled with the issue of “hold harmless” provisions which, as of the last reauthorization, are now applied to the Part A Eligible Metropolitan Area (EMA) to eligible cities and Part B formula grants to states. Many organizations within the community maintain that the formulas should operate without adjustment in an effort to allow funds to follow the epidemic as closely as possible. At the same time, many (often the same) organizations have expressed concern that programs serving Ryan White clients need consistent levels of funding to make investment in infrastructure and build comprehensive programs. Large shifts, particularly drops in funding, can be destabilizing and lead to gaps in the provision of primary care and support services. As the numbers of reported HIV cases have changed relative to other jurisdictions and as the formulas for both Parts A and B have changed over the years to emphasize different factors, Congress has created a hold harmless clause to ensure that jurisdictions do not lose levels of funding that jeopardize the provision of HIV/AIDS services. Thus, “hold harmless” provisions were instituted to attempt to control the rate at which jurisdictions felt the full impact of new formulas. It should be noted that while a jurisdiction's proportion of HIV/AIDS cases relative to other jurisdictions might decrease, the number of persons living with HIV/AIDS in need of Ryan White services continues to increase in every jurisdiction. Many organizations have expressed concern that the discussion over hold harmless has at times overshadowed the real issue facing all funded jurisdictions which is that current funding levels are inadequate to meet demands in all areas of our country.

The current legislation instituted new “hold harmless” provisions for Part A Eligible Metropolitan Areas (EMAs) and Part B formula awards by authorizing funding for grants in FY 2007 at not less than 95% of funding for FY 2006 and funding in FY 2008 and FY 2009 at not less than 100% of 2007. The formulas for Parts A and B continue to be in a period of adjustment due to several factors including the switch in formulas to living HIV/AIDS cases from estimated living AIDS cases and the fact that some states’ new name-based HIV reporting systems have not yet matured. The CDC has estimated that the earliest a nationwide mature HIV system would be available is 2012. Further, the number of living HIV and AIDS cases continue to fluctuate and additional cases from maturing name-based HIV reporting systems will be added to overall case counts. Due to a convergence of all the above factors, eliminating hold harmless provisions in this transitional period would likely result in a loss of funding in some jurisdictions that would lead to destabilized HIV/AIDS care and support services.

Proposal: In keeping with other proposals in this document, the HIV/AIDS community recommends that the hold harmless provisions for Parts A and B should be restarted by simply adjusting the dates on current legislation as follows: formula grants in FY 2010 should be no less than 95% of funding for FY 2009 and funding for FY 2011 and FY 2012 should be no less than 100% of FY 2010.

Minority View: AIDS Alabama, Community Access National Network, Connecticut AIDS Resource Coalition and The AIDS Institute agree with the majority viewpoint that FY 2010 should be set at no less than 95% of funding for FY 2009. For FY 2011 and FY 2012 this group would like to see the formula funding for Parts A and B better match the number of HIV/AIDS cases in each jurisdiction without destabilizing existing systems of care. Additionally, these organizations believe the same hold harmless measures should be adopted for Transitional Grant Areas as for EMAs.

Allow the Provision of Food Pursuant to a Doctor’s Prescription as a Core Medical Service

Under the 2006 reauthorization, Medical Nutrition Therapy (MNT) is an allowable core service. MNT involves the assessment of the nutritional status of a person with a condition, illness or injury that puts them at risk, by a registered dietitian. It is a comprehensive examination of each individual that includes the review and analysis of medical and diet history, anthropometric measurements and laboratory values, after which the registered dietitian provides nutritional counseling and education about a specific disease state. In the case of HIV, a therapeutic nutrition plan that is most appropriate to manage or treat HIV/AIDS is chosen.

Access to adequate and appropriate food is fundamental, as it is the foundation of any medical therapy and has numerous benefits. For people living with HIV/AIDS, a well-balanced diet can help strengthen the immune system, prevent infections and reduce hospitalizations. The majority of the HIV/AIDS community supports the inclusion of food and nutrition services provided pursuant to medical nutrition therapy as a core medical service. Such a provision has no impact on any pre-existing definition of medical nutrition therapy and has many positive medical outcomes: it connects clients with primary care services, increases adherence to drug regimens and requires maintenance in primary care services for Ryan White Program eligible clients. The Association of Nutrition Services Agencies states that based on an estimate of meal provision throughout their membership only about 20% of meals provided through their membership

would qualify for eligibility under this standard, assuming a local planning council prioritized the service in a particular EMA or TGA. Most meals provided would not be affected by this proposal and would continue to be regarded as a support service within the current guidelines of the Ryan White Program.

Proposal: Under Parts A and B, core medical services provisions, amend item (H) “Medical nutrition therapy” to state “Medical Nutrition Therapy, and food and nutrition services when provided pursuant to such therapy as advised by a physician” as part of the package of services that can be considered core medical services. Under this proposed approach, the definition of medical nutrition therapy is unaltered, and food and nutrition services not provided pursuant to MNT would continue to be treated as support services.

Minority Viewpoint: The American Academy of HIV Medicine (AAHIVM), the HIV Medicine Association (HIVMA) and the Ryan White Medical Providers Coalition (Coalition) define medical nutrition therapy as nutritional supplements prescribed by a licensed dietitian or medical provider. The Academy, Coalition, and HIVMA support the current HRSA interpretation of “medical nutrition therapy” as it applies to core medical services for Ryan White. These organizations do not support an expansion of the definition of medical therapy to include food or other nutrition services. These groups maintain that such an expansion would be a substantive change and goes beyond the scope of technical fixes that are currently under consideration for an extension of the current Ryan White Program through 2012.

Alter the Definition of Medical Transportation and Allow it as a Core Medical Service

As a result of the most recent reauthorization, “medical transportation” has been classified as a support service. Medical transportation has been narrowly defined to mean transportation solely to and from Ryan White-funded medical-related services. This interpretation of the term medical transportation fails to accommodate areas that do not have strong public transportation infrastructure or that are comprised of large rural areas. For example the narrow modification may disallow rural gas vouchers, affecting the ability of clients to obtain food or other necessities. In areas with public transportation, it may prevent providers from purchasing the least expensive forms of tickets such as monthly vouchers, instead forcing clients to make multiple trips to service providers for individual bus passes or using more expensive forms of transportation such as taxis. Consequently local authorities are precluded from making common sense decisions about providing transportation in the service of treatment and care. For this reason, we recommend that transportation services within support services be broadened by removing the qualifier “medical.”

The HIV/AIDS community has long pointed out the need for a constellation of services to ensure that people living with HIV/AIDS receive the best possible care. The inability of a person living with HIV to access needed medical treatment, including physician services, due to a lack of transportation is itself a lack of medical care. For this reason we additionally recommend that “medical transportation” specifically should be included as a core medical service.

Proposal: The HIV/AIDS community recommends removing the qualifier “medical” from transportation in the support services category and including “medical transportation” specifically in the definition of core medical services.

Minority Viewpoint: The American Academy of HIV Medicine, the HIV Medicine Association and the Ryan White Medical Providers Coalition support the current HRSA interpretation of transportation and do not support changes to the definition of transportation or the addition of medical transportation to the core medical service definition. These groups agree that medical transportation is important but many HIV programs are facing serious challenges covering the current list of core medical services, including critical components of the standard for HIV care, such as laboratory monitoring. They also feel that such an expansion would be a substantive change in the opinion of these groups and goes beyond the scope of technical fixes that are currently under consideration for an extension of the current Ryan White Program through 2012.

Technical Fixes

These technical fixes were submitted to Congress in the fall of 2008 and remain a high priority for the HIV/AIDS community.

ADAP Rebate Dollars

Rebate model ADAPs (those that purchase via a pharmacy network and then request rebates from pharmaceutical companies to obtain the 340B program drug prices), which make up over half of the states, have been instructed by HRSA that they must spend rebate dollars first (considered “program income” by HRSA) before using their federal ADAP grant award. With new carryover rules and penalties in the Ryan White HIV/AIDS Treatment Modernization Act, this will lead to some states losing future ADAP funding should they have more than two percent of their federal ADAP grant unobligated. Regardless of how rebate income is classified, the Ryan White Program requires rebates to be put back into the Part B program with preference given to ADAP services. Rebate income should not be considered program income or result in a reduction of expenditures and therefore should be allowed to accrue after a grant year has ended and spent after federal funds are expended.

Proposed Language: “In keeping with Congressional intent and Section 2622 (d) of Public Law 109-415, rebate funds associated with Section 2616 of Public Health Service Act (42 U.S.C. 300ff-26) are exempt from 45CFR92.21. HRSA will consult with state grantees to develop a process that certifies and describes that such funds are in compliance with Section 2616 (g) of Public Law 109-415.”

Unobligated Funds

The current legislation contains a provision that penalizes Part A and B grantees if they have more than two percent of their award unobligated at the end of a grant year by making them ineligible for the supplemental components of their awards. This provision presents an undue burden on grantees, who must comply with basic grants management such as working with subgrantees, but also deal with state budget factors such as hiring freezes, spending caps, etc. that make obligating grant dollars down to a very small amount difficult. Due to these uncertain economic times, it is not appropriate to penalize HIV/AIDS programs for circumstances beyond their programmatic control. We support an increase in the penalty threshold from two to five percent. Additionally, we ask that the penalties for having more than five percent of grants unobligated be suspended, allowing grantees access to subsequent years supplemental funding and eliminating reductions in future grant awards.

Proposed Language: For Parts A and B, strike or suspend “Corresponding Reduction in Future Grant” section under Section 104 and Section. 207 – “Timeframe for Obligation and Expenditure of Grant Funds.” Additionally, in all Parts providing a penalty for failure to obligate funds, change the language of the exception to the penalty from 2 percent to 5 percent. For example, for language reading, “except that this clause does not apply to the eligible area if the amount of the unobligated balance was 2 percent or less”, strike “2” and replace with “5”.

Minority Viewpoint: The AIDS Institute does not support this proposal in total. It supports expanding the amount of unobligated balances allowed to up to 5 percent, and striking one penalty, specifically the one that makes jurisdictions ineligible for future supplemental funding.

Part D Medical Expenses

For FY2007 and FY2008 budgets, Part D grantees have been instructed by HRSA to include medical expenses in their program budget. Unlike other parts of the Ryan White Program, Part D is not required to allocate a proportion of funds to medical expenses, as Part D grantees are able to access Medicaid, SCHIP and other public programs to pay for most primary medical care for their clients. In fact, Part D was exempted from the core medical services set aside in the 2006 reauthorization legislation. Part D must, however, provide access to these services either directly or through contract. This has been a requirement of Part D since its inception, and HRSA has historically allowed Part D grantees to enter into memoranda of understanding (MOUs) with medical providers to ensure access to primary care, even when financial reimbursement was not involved. The Ryan White Program is required to be the payer of last resort, and asking Part D dollars to go toward medical expenses that can be paid for through other sources is in direct conflict with this requirement.

Proposed Language: Section 2671 (h) definitions (3) Services add the following "(C) Nothing in this part shall be construed as requiring funds to be used for primary medical care when other payers are available for such care."

Add (4) Contracts.-The term "contracts" includes memoranda of understanding when outpatient or ambulatory care is provided outside of this part.

Severity of Need Index and Client Level Data

The current legislation allows for the development of both Client Level Data (CLD) and a Severity of Need Index (SONI), but intentionally does not include provisions for implementing the CLD or the SONI as components of the funding allocation process. CLD will commence on January 1, 2009 with a portion of grantees and will run parallel with the current HRSA data systems for one to two years. A version of SONI has been developed, but not tested. Since HIV data will not be mature for all states until at least 2012, we believe that Part A and Part B resources should continue to be distributed by existing formula and supplemental mechanisms through 2012. Additionally, HRSA issued a competitive grant notice to Part A and B for funds to assist in the development of their CLD system. The grant announcement was issued so early in the process that many states and cities did not apply for the funds but are now realizing they need them. SPNS funds should be made available on a continuing basis to cities and states that need them to support activities to develop, maintain, and train on use of a CLD systems.

Proposed Language: “It is the intent of Congress that Part A and Part B resources continue to be distributed by existing formula and supplemental mechanisms.” Amend Section 2691 Special Projects of National Significance, Subparagraph (b) by inserting after “The Secretary shall award grants under subsection (a) to entities eligible for funding under parts A, B, C, and D” the following “to support them in implementing the new client level data system and make funds available to each Part in the same percentage as each Part’s contribution to the SPNS budget.”

Note: This document has been created by the Ryan White Work Group of the Federal AIDS Policy Partnership. For additional information, please contact Interim Co-Chair Laura Hanen (NASTAD) at 202-434-8091 or at lhane@nastad.org or Co-Chair William McColl (AIDS Action), at 202-530-8030 ext. 3096 or at wmccoll@aidsaction.org.

The following organizations endorse the recommendations in the *HIV/AIDS Community Consensus on the Future of the Ryan White HIV/AIDS Treatment Modernization Act:*
(Note: 134 organizations have signed on as of March 9, 2009)

ActionAIDS, Inc, Philadelphia, PA
African Services Committee, New York, NY
AID Atlanta, Atlanta, GA
AID Gwinnett, Duluth, GA
AIDS Action Baltimore
AIDS Action Committee of Massachusetts, Boston, MA
AIDS Action Council, Washington, DC
AIDS Alabama, Birmingham, AL
AIDS Alliance for Children, Youth & Families, Washington, DC
AIDS Care Group, Chester, PA
AIDS Foundation of Chicago, Chicago, IL
AIDS Institute, New York State Department of Health, Albany, NY
AIDS Legal Referral Panel of the San Francisco Bay Area, San Francisco, CA
AIDS Project Los Angeles, Los Angeles, CA
AIDS Service Center NYC, New York, NY
AIDS Services of Austin, Austin, TX
AIDSNET, Bethlehem, PA
Alameda and Contra Costa Counties Collaborative Community Planning Council Transitional Grant Area Oakland, CA
Albany Damien Center, Albany, NY
American Academy of HIV Medicine, Washington, DC
American Dental Education Association, Washington, DC
Asian & Pacific Islander American Health Forum, San Francisco, CA
Asian & Pacific Islander Wellness Center, San Francisco, CA
Association of Nurses in AIDS Care, Akron, OH
Association of Nutrition Services Agencies (ANSA), Washington DC
Bedford Stuyvesant Family Health Center, Inc. - Wellness Center, Brooklyn, NY
Bexar County Department of Community Investment, San Antonio, TX
Buddies of New Jersey, Inc., Hackensack, NJ
CAEAR Coalition, Washington, DC

CAEAR Foundation, Washington, DC
Cascade AIDS Project, Portland, OR
Catholic Charitable Bureau of the Archdiocese of Boston, Inc., Boston, MA
Catholic Charities CYO, San Francisco, CA
Center for Community Alternatives, Syracuse, NY/New York, NY
Center of H.O.P.E., Jackson, MS
City of Passaic/ Passaic Alliance, Passaic, NJ
City of Paterson, NJ
Community Access National Network, Washington, DC
Community HIV/AIDS Mobilization Project (CHAMP), New York, NY /Providence, RI
Community Servings, Boston, MA
Connecticut AIDS Resource Coalition, Hartford, CT
County of Los Angeles Department of Public Health, Office of AIDS Programs and Policy, Los Angeles, CA
Dab the AIDS Bear Project, Jacksonville, FL
Desert AIDS Project, Palm Springs, CA
Face to Face/Sonoma County AIDS Network, Santa Rosa, CA
Family and Community Service of Delaware County, Media, PA
Family Service of Chester County, West Chester, PA
Food Bank of Contra Costa and Solano, Concord, CA
Food Outreach, Inc. St. Louis, MO
Frannie Peabody Center, Portland, ME
Friends for Life, Fort Lee, NJ
GAAMHA, Inc., Gardner, MA
Gaudenzia, Inc., Philadelphia, PA
Gay Men's Health Crisis, New York, NY
George Santana Citiwide Harm Reduction, Bronx NY
Georgia Equality, Atlanta, GA
Georgia Ryan White Working Group, Atlanta, GA
God's Love We Deliver, New York, NY
Grady Health System Infectious Disease Program, Atlanta, GA
Harlem United, New York, NY
Health and Home Support Services, Inc., Newport News, VA
Health Care of Southeastern Mass., Inc., Brockton, MA
Hispanic Federation, Washington, DC
HIV ACCESS, Alameda County, CA
HIV Medicine Association (HIVMA), Arlington, VA
HIV/AIDS Law Project, Phoenix, AZ
HIV/AIDS Volunteer Enrichment Network, Inc. (HAVEN), Annapolis, MD
HIVictorious, Inc., Madison, WI
HOPE: Hispanic Office of Planning and Evaluation, Inc., Boston, MA
Human Rights Campaign, Washington, DC
International AIDS Empowerment, El Paso, TX
JRI Health, Boston, MA
Lansing Area AIDS Network, Lansing, MI
Latin American Health Institute, Boston, MA

Legacy Community Health Services, Inc. Houston, TX
Lifelong AIDS Alliance, Seattle, WA
Lower East Side Harm Reduction Center, New York, NY
Malama Pono Kauai AIDS Project, Lihue, Kauai, HI
Manna House Inc, Baltimore, MD
Maui AIDS Foundation, Wailuku, HI
Metro Atlanta Ryan White Planning Council, Atlanta, GA
Mid-Hudson Valley AIDS Task Force, Inc., Hawthorne, NY
Minnesota AIDS Project, Minneapolis, MN
Moveable Feast, Inc., Baltimore, MD
Nashville CARES, Nashville TN
National Alliance of State and Territorial AIDS Directors, Washington, DC
National Association of AIDS Education and Training Centers, Detroit, MI
National Association of Counties, Washington, DC
National Association of People With AIDS, Washington DC
National Black Gay Men's Advocacy Coalition, Washington, DC
National Center for Transgender Equality, Washington, DC
National Coalition for LGBT Health, Washington, DC
National Gay and Lesbian Task Force Action Fund, Washington, DC
National Minority AIDS Council, Washington, DC
New Mexico AIDS Services Albuquerque, NM
NJSHAC (New Jersey Statewide HIV/AIDS Coalition), East Brunswick, NJ
Northeast Regional HIV Planning Coalition United Way of Wyoming Valley, Wilkes Barre, PA
NY HIV Health & Human Services Planning Council, New York, NY
Office of Health Policy & AIDS Funding, New Orleans, LA
Ohio AIDS Coalition, Columbus, OH
OHSU/Partnership Project, Portland, OR
Okaloosa AIDS Support and Informational Services, Inc., Ft. Walton Beach, FL
Open Hand, Atlanta, GA
OUTREACH New Mexico HIV Consumer Advocacy Network, Albuquerque, NM
Parents, Families, and Friends of Lesbians and Gays (PFLAG) National, Washington, DC
Park West Health System, Inc., Hidden Garden Program, Baltimore, MD
Paterson Counseling Center, Inc., Paterson, NJ
Pennsylvania School for the Deaf/Center for Community and Professional Services, Philadelphia, PA
Philadelphia FIGHT, Philadelphia, PA
Pittsburgh AIDS Task Force, Pittsburgh, PA
Project Inform, San Francisco, CA
Project Open Hand, San Francisco, CA
Public Health Management Corporation, Philadelphia, PA
Ryan White Medical Providers Coalition, Arlington, VA
Sacramento HIV Health Services Planning Council, Sacramento, CA
San Antonio AIDS Foundation, San Antonio, TX
San Francisco AIDS Foundation, San Francisco, CA
Sexuality Information and Education Council of the United States (SIECUS), Washington, DC
Sonoma County Commission on AIDS, Santa Rosa, CA

South Texas Development Council, Laredo, TX
Southwest CARE Center - Santa Fe, NM
State of Wisconsin AIDS/HIV Program, Madison, WI
Temple Comprehensive HIV Program, Temple University School of Medicine, Philadelphia, PA
The AIDS Institute, Washington DC
The COLOURS Organization, Inc., Philadelphia, PA
The Family Center, New York, NY
The Phoenix Group Foundation, Inc., Atlanta, GA
The Recovery Center (HIV/AIDS Services Dept) Monticello, NY
The Sharing Community, Yonkers, NY
Travelers Aid of Metropolitan Atlanta, Atlanta, GA
Triangle AIDS Network, Beaumont, TX
Us Helping Us, Washington, DC
Village Care of New York, New York NY
Vital Bridges NFP, Inc., Chicago, IL