ONE SIZE DOES NOT FIT ALL:
What Does High Impact Prevention Funding Mean for Community-Based Organizations in the Deep South?

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I. INTRODUCTION

The Southern HIV/AIDS Strategy Initiative (SASI) applauds CDC's high-impact HIV prevention approach that apportions funding to states, territories and directly funded cities based on the number of people reported to be living with HIV in the jurisdiction rather than on cumulative AIDS cases. SASI also supports funding for the ten cities that account for approximately 37 percent of people living with HIV in the United States and for the 36 jurisdictions with at least 3,000 African American and Hispanic residents living with an HIV diagnosis to support HIV testing for populations disproportionately affected by HIV.[1]

CDC's recent decision to restrict eligibility for prevention funding for community based organizations (CBOs) to those located in designated metropolitan statistical areas (MSAs), however, removes crucial funding for a region that has experienced disproportionately high HIV diagnosis and death rates.[2] CDC's recent funding announcement, PS15-1502, was designed to maximize funding effectiveness by "reach[ing] those areas with the greatest need for HIV prevention services targeting the selected population."[3] When the data is examined on a state level, several Deep South States have a significantly higher percentage of their HIV burden in non-urban areas, as shown by the diagram below. Overwhelmingly, these are areas that are ineligible for direct CBO funding under PS15-1502. In essence, PS15-1502 has a disparate impact on prevention funding in those Deep South States, creating a funding shortfall that is not sufficiently counterbalanced by increased prevention funding to state health departments.

Further, when SASI analyzed the actual funding distribution of PS15-1502 funding to US community-based organizations, we found that funding allocations were not consistent with the geographic distribution of the epidemic.[4]

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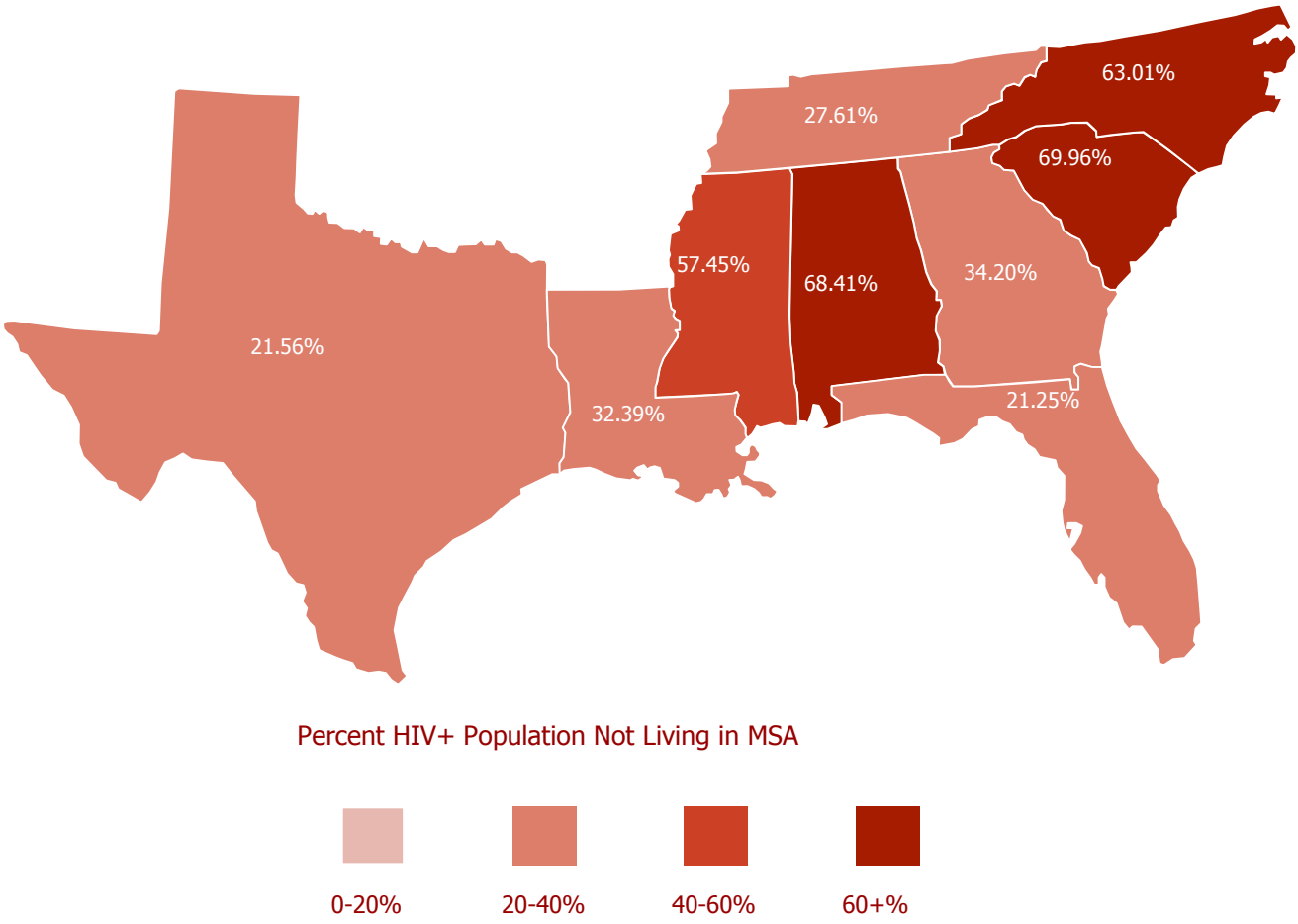
[1] Centers for Disease Control & Prevention, FOA PS12-1201.

[2] Susan Reif, Brian Wells Pence, Irene Hall, Xiaohong Hu, Kathryn Wetten & Elena Wilson, *HIV Diagnoses, Prevalence and Outcomes in Nine Southern States*, 39(6) J. COMM. HEALTH (Dec. 2014).

[3] Centers for Disease Control & Prevention, FOA PS15-1502, at 39.

[4] http://www.cdc.gov/hiv/pdf/funding/announcements/ps15-1502/cdc-hiv-ps15-1502-funding--by-state-and-grantee.pdf.

Percentage of HIV-Positive Individuals in the Deep South States Living Outside an MSA Eligible for CBO Funding.[5]



II. HIV in the Deep South

[5] Based on eligible MSAs in FOA PS15-1502; data taken from Centers for Disease Control and Prevention. HIV Surveillance Report: Diagnoses of HIV Infection in the United States and Dependent Areas, 2013, Table 20; http://www.cdc.gov/hiv/pdf/g-l/hiv_surveillance_report_vol_25.pdf.

The Southeastern United States has the highest HIV diagnosis rate of any US region.[6] In 2013, more than half of national HIV diagnoses reported were located in the Southern United States,[7] which accounted for only 38% of the total US population.[8]

SASI's research has focused on a subgroup of Southern states[9] that are disproportionately affected by HIV and that share certain characteristics such as overall poor health, high poverty rates, and negative health outcomes for those who are HIV positive. In the nine Deep South States, the HIV diagnosis disparity is even more pronounced—although they account for only 28% of the total US population, nearly 40% of national HIV diagnoses were located in the Deep South States.[10]

SASI's research team collaborated recently with CDC researchers to publish new findings about the HIV burden and outcomes in these nine Deep South States, including death rates and 5-year survival among persons living with HIV and AIDS in the targeted states region.[11] Researchers found that HIV positive people in the Deep South States are dying at higher rates than in any other region of the country. Twenty-seven percent of persons diagnosed with AIDS in the 9-state region had died within 5 years of diagnosis. Although survival proportions varied among Deep South States, none had a 5-year AIDS survival proportion "at or above the overall US survival proportion." In Louisiana, one-third of persons diagnosed with AIDS and 19% of those diagnosed with HIV had died within 5 years.

The death rate among persons living with HIV was higher in the Deep South States than in any other US region, even after adjusting for age, sex, transmission category, and area population size. Living outside a large urban area at diagnosis significantly predicted

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[6] Centers for Disease Control and Prevention. HIV Surveillance Report: Diagnoses of HIV Infection in the United States and Dependent Areas, 2013, Table 18; http://www.cdc.gov/hiv/pdf/g-l/hiv_surveillance_report_vol_25.pdf.

[7] The US Census Bureau defines the South as including Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, Oklahoma, North Carolina, South Carolina, Tennessee, Texas, Virginia, West Virginia.

[8] US Census Bureau. United States Population Growth by Region. 2015; https://http://www.census.gov/popclock/data_tables.php?component=growth. Accessed October, 2015.

[9] Alabama, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Texas.

[10] *See* Footnote 6.

[11] Susan Reif, Brian Wells Pence, Irene Hall, Xiaohong Hu, Kathryn Wetten & Elena Wilson, *HIV Diagnoses, Prevalence and Outcomes in Nine Southern States*, 39(6) J. COMM. HEALTH (Dec. 2014).

greater death rates among persons living with HIV in the 9-state region, suggesting ". . . a disconnect between diagnosis and maintenance of HIV care in this region . . ."[12]

Although the death rates among individuals living with HIV provide vital information regarding deaths among persons who have been diagnosed with HIV, these statistics may not clearly reflect deaths due to HIV disease rather than other chronic comorbidities and acute illnesses unrelated to HIV. When CDC data regarding deaths in 2012 due to HIV as an underlying cause are examined, however, the number of HIV related deaths per 100,000 was also higher in the Deep South than in any other US region.[13]

The updated National HIV/AIDS Strategy (NHAS) recognizes that the South is disproportionately affected by HIV and includes a specific target, indicator 9, with the goal of reducing disparities in the rate of new diagnoses by at least 15% among persons living in the Southern United States.[14] Further, under the first goal of the NHAS, "Reducing New HIV Infections," this step is included: "Allocate public funding consistent with the geographic distribution of the epidemic."[15] Indicator 2 provides the specific target of reducing the number of new diagnoses by at least 25 percent.[16] Ensuring that the Southern region obtains its equitable share of prevention funding and that the funding distributions are consistent with the geographic distribution of the epidemic are crucial if we are to reach the goals of the NHAS. To achieve these goals, federal policy makers must focus on the Southern Region of the US including areas outside the large MSAs where the HIV diagnosis rates and HIV-related death rates are high.

III. Past HIV Prevention Funding for Community Based Organizations

Previous CDC direct-funding prevention opportunities for CBOs drew no explicit distinction between CBOs located in an MSA and CBOs outside of MSAs, instead adopting a

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[12] Susan Reif, Brian Wells Pence, Irene Hall, Xiaohong Hu, Kathryn Wetten & Elena Wilson, *HIV Diagnoses, Prevalence and Outcomes in Nine Southern States*, 39(6) J. COMM. HEALTH (Dec. 2014).
[13] http://wonder.cdc.gov.
[14] National HIV/AIDS Strategy for the United States: Updated to 2020, p. 38, July 2015. https://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf.
[15] *See* footnote 14, p. 8.
[16] *See* footnote 14, p.16.

more nuanced approach that considered the local distribution of the HIV epidemic throughout the jurisdiction. CDC PS10-1003, a 2010 funding opportunity and the immediate predecessor to CDC PS15-1502, focused on geographical location only to the extent that HIV prevention should "reflect local prevention priorities and serve persons at high risk for acquiring or transmitting HIV."[17] Applicants were required to describe how their proposed program met the needs of the jurisdiction's comprehensive HIV prevention plan, and the review process also considered the geographical distribution of HIV within each jurisdiction.[18] PS10-1003 did not impose a categorical geographic eligibility requirement. In contrast, the PS10-1003 FOA reflected a preference for funding applicants in proportion to the HIV epidemic geographically.[19] And importantly, PS10-1003 balanced funding opportunities "in terms of the concentration of the available services by geographic area."[20]

Announced in 2014, CDC PS15-1502 represented a sea change in the way that CBOs receive direct funding from the CDC. In contrast with previous CDC direct prevention funding announcements, PS15-1502 explicitly restricted grants in the Deep South States to CBOs located within designated MSAs.[21] Thus, CBOs that were not located within those MSAs were categorically ineligible to apply for *any* direct prevention funding, without regard to the length of time they had been serving the target population, whether they had received direct prevention funding under a previous CBO funding opportunity, or the HIV prevalence in their jurisdiction.

IV. The Impact of PS15-1502 on the Deep South States

The CDC's justification for limiting CBO eligibility for direct prevention funding to those CBOs located in designated MSAs was to target service areas that are

[17] Centers for Disease Control & Prevention, FOA PS10-1003, at 7.
[18] Centers for Disease Control & Prevention, FOA PS10-1003, at 78.
[19] Centers for Disease Control & Prevention, FOA PS10-1003, at 97 (emphasis added).
[20] Centers for Disease Control & Prevention, FOA PS10-1003
[21] Centers for Disease Control & Prevention, FOA PS15-1502, at 37–38. For the nine Deep South States, these MSAs are Atlanta-Sandy Springs (GA), Austin-Round Rock (TX), Baton Rouge (LA), Birmingham-Hoover (AL), Charlotte-Gastonia-Concord (NC-SC), Columbia (SC), Dallas (TX), Houston-Baytown-Sugar Land (TX), Jackson (MS), Jacksonville (FL) Memphis (TN-MS-AR), Miami (FL), Nashville-Davidson-Murfreesboro (TN), New Orleans-Metairie-Kenner (LA), Orlando (FL), Raleigh-Cary (NC), San Antonio (TX), Tampa-St. Petersburg-Clearwater (FL), and Virginia Beach-Norfolk-Newport News (VA-NC).

disproportionately affected by HIV and in greatest need of HIV prevention services.[22] Indeed, the funding announcement states that eligible MSAs were selected based on "having the highest unadjusted number of diagnoses of HIV infection in 2011," and together, they accounted for 71% of the total number of HIV infection diagnoses in 2011.[23]

When the Deep South States are considered in the aggregate, the justification for a categorical exclusion of CBOs not located within an eligible MSA seems valid. As Table 1 shows below, total HIV diagnoses in eligible MSAs in the Deep South States accounted for roughly 65% of all HIV diagnoses in the Deep South States in 2013:[24]

Table 1: Eligible MSA/Non-MSA HIV Diagnoses, 2013

	Eligible MSA* HIV Diagnoses	**% MSA**	**Non-MSA HIV Diagnoses**	**% Non-MSA**	**Total # of HIV Diagnoses**
South Carolina	192**	24.74	584	75.26	776
Alabama	164	26.37	458	73.63	622
North Carolina	621**	39.66	945	60.34	1,566
Mississippi	193**	36.01	343	63.99	536
Louisiana	820	58.66	578	41.34	1,398
Georgia	1,878	62.37	1,133	37.63	3,011
Tennessee	580**	69.13	259	30.87	839
Texas	3,721	76.94	1,115	23.06	4,836
Florida	4,169	77.72	1,195	22.28	5,364
Total	**12,338**	**65.12%**	**6,610**	**34.88%**	**18,948**

*Refers to diagnoses within only PS15-1502–eligible MSAs, not all MSAs, as designated by OMB Bulletin No. 13-01. For MSAs that span more than one state, any state's "share" of that MSA is calculated by determining the number of HIV diagnoses from that state's counties which are included in that MSA.

**Does not include HIV diagnoses in counties for which HIV diagnosis data has been suppressed. Thus, MSA diagnoses may be higher than shown, and non-MSA diagnoses may be lower than shown. However, the effects are expected to be negligible. Specific information on which counties have suppressed data is on file with the authors.

[22] *See* FOA PS15-1502 at 40 ("[I]n the face of increasingly constrained resources and a concentrated, inequitably distributed epidemic, HIV prevention funding must be allocated to those communities and regions that shoulder the greatest share of the national burden.").
[23] FOA PS15-1502 at 39 (citing CDC, *Diagnoses of HIV Infection in the United States and Dependent Areas, 2011*, HIV SURVEILLANCE REP., Feb. 2013, at tbl.15(a)).
[24] *See* Footnote 6.

However, when the HIV diagnosis data is broken down by state, individual variances weaken the robustness of the CDC's justification as applied to certain states. In four out of the nine Deep South States (South Carolina, Alabama, North Carolina, and Mississippi), the number of new HIV diagnoses that occur outside eligible MSAs is greater than the number of HIV diagnoses that occur within eligible MSAs . In other words, the areas of greatest need for HIV prevention services in those states are precisely those areas that are also categorically excluded from PS15-1502 funding.[25] It follows that PS15-1502's new MSA-eligibility requirement dramatically reduces the amount of direct federal prevention funding available for CBOs in those states to address new infections.

The data for HIV prevalence tell a similar story. Table 2 shows that in the Deep South as a whole, 67.14% of the HIV-positive population lived in an eligible MSA at the end of 2012:[26]

Table 2: MSA/Non-MSA HIV-Positive Population, 2012

	MSA* HIV+ Population	**% MSA**	**Non-MSA HIV+ Population**	**% Non-MSA**	**Total # of HIV+ Population**
South Carolina	4,544	30.04	10,581	69.96	15,125
Alabama	3,784	31.59	8,195	68.41	11,979
North Carolina	9,779	36.99	16,658	63.01	26,437
Mississippi	3,724	42.55	5,029	57.45	8,753
Georgia	25,730	65.80	13,372	34.20	39,102
Louisiana	12,460	67.61	5,970	32.39	18,430
Tennessee	11,482	72.39	4,380	27.61	15,862
Texas	56,485	78.44	15,525	21.56	72,010
Florida	77,688	78.75	20,962	21.25	98,650
Total	**205,676**	**67.14%**	**100,672**	**32.86%**	**306,348**

*Refers to the number of individuals living with diagnosed HIV within only PS15-1502–eligible MSAs, not all MSAs as designated by OMB Bulletin No. 13-01. For MSAs that span more than one state, any state's "share" of that MSA is calculated by determining the number of HIV-positive individuals living in that state's counties which are included in that MSA.

[25] For example, the areas of greatest need for HIV prevention services are completely inverted in South Carolina, with roughly 75% of new diagnoses in 2013 falling *outside* of a PS15-1502 eligible MSA.
[26] CDC, *Diagnoses of HIV Infection in the United States and Dependent Areas*, *2013*, HIV SURVEILLANCE REP., Feb. 2015, at tbl. 20.

When considered state-by-state, however, the distribution of those living with HIV closely tracks the distribution of new HIV diagnoses in the states. In the same four Deep South States (South Carolina, Alabama, North Carolina, and Mississippi), the percentage of HIV-positive individuals who do not live in a PS15-1502–eligible MSA is substantially greater than in the other five Deep South States. Furthermore, the percentage of HIV-positive individuals who do not live in an eligible MSA in those four states is significantly greater than the percentage of HIV-positive individuals who do live in an eligible MSA—in all four states, more than 50% of HIV-positive individuals live outside an eligible MSA.[27] The implication is that at least in those states, a significant proportion of HIV-positive individuals and those at risk for HIV are receiving diminished prevention services—if any services at all—because the CBOs that are providing those services are precluded from applying for direct CDC prevention funding.

The stakes are high—in 2010, 132 CBOs nationwide received $41,845,830 in direct prevention funding through PS10-1003.[28] And the stakes are especially high for the Deep South States, with 40 CBOs in the Deep South receiving $13,121,195 in 2010—nearly one-third of the total PS10-1003 funding.[29] These numbers are similar to what Deep South CBOs received in 2004. Under CDC PA-04064, the direct prevention funding opportunity immediately preceding PS10-1003, 43 Deep South CBOs received a total of $15,040,004.[30] Appendices B and C display a list of all Deep South CBOs that received funding under PA-04064 and PS10-1003, the amount of direct prevention funding that each CBO received, and whether that CBO would have been eligible to apply for direct prevention funding under PS15-1502.

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[27] *See also* Appendix A.

[28] CDC, *Awards by State: FY 2010*, *available at* http://www.cdc.gov/hiv/pdf/policies_funding_awards2010.pdf.

[29] *See* Appendix C.

[30] *See* Appendix B. PA-04064 grantee information was calculated by the following method: (1) according to the CDC PA-04064 Quick Facts, awards were announced to the public in May of 2004; (2) all awards in 2004 in all 50 states for CFDC number 93939 (HIV Prevention Activities, Non-Governmental Organization Based) in the U.S. Tracking Accountability in Government Grants System (TAGGS) were searched; (3) only awards titled "HIV Prevention Projects for CBOs" were considered; and (4) only those recipients which were located in a ZIP code corresponding to one of the Deep South States, and their corresponding grant award under PA-04064, were added to the table.

As Appendix B shows, over a quarter of the 43 CBOs that received funding in 2004 were categorically excluded from applying for prevention funds under PS15-1502 solely by virtue of their non-eligible-MSA status. Had the MSA-eligibility requirement applied in 2004, those 12 CBOs would have lost out on a combined $3,838,975, or an average of $319,914 per organization. Nor is the impact of PS15-1502 limited to only a few states. Rather, the MSA-eligibility requirement, if applied in 2004, would have excluded CBOs in eight of the nine Deep South States (Florida, Alabama, South Carolina, Georgia, Mississippi, Texas, Louisiana, and North Carolina) from crucial prevention funds.

Although the effects of the PS15-1502 MSA-eligibility requirement are somewhat diminished when applied to CBOs that applied under PS10-1003, Appendix C shows that PS15-1502 would still have had substantial and appreciable effects on the Deep South States in 2010. Had the MSA-eligibility requirement been applied to PS10-1003, 8 out of 40 CBOs would have been barred from applying for funding and would have lost a combined $2,570,302, or an average of $321,287 per organization. Furthermore, the MSA-eligibility requirement would have excluded funded CBOs in over half of the Deep South States (Georgia, Alabama, Texas, Florida, and Mississippi).

In summary, the HIV diagnosis and prevalence data show that although the PS15-1502's MSA-eligibility requirement is facially neutral, it has the net effect of funneling significant amounts of prevention funding away from the Deep South States, which already bear a disproportionate HIV burden as a region. The MSA-eligibility requirement reduces essential prevention funding in states where HIV is not concentrated in metropolitan centers.

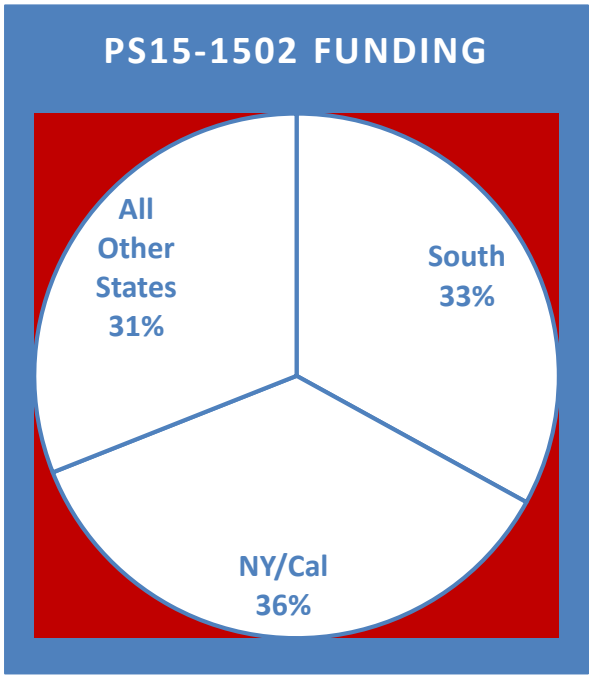
V. CDC Funding Distribution to CBOs in the US pursuant to PS15-1502.[31]

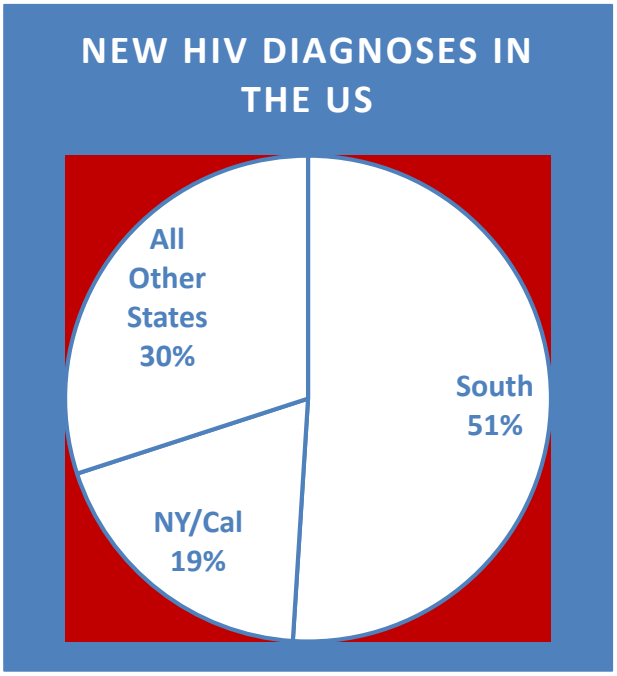
A total of $40,615,001 in CDC funding was recently distributed under PS15-1502 to 83 community-based organizations throughout the United States. SASI examined how the PS15-

[31] http://www.cdc.gov/hiv/pdf/funding/announcements/ps15-1502/cdc-hiv-ps15-1502-funding--by-state-and-grantee.pdf. SASI's analysis excludes funds distributed to organizations in Puerto Rico and the US Virgin Islands.

1502 funding was distributed to the South[32], the Deep South region[33], Florida, and New York/California (combined) and compared the funding distribution to new HIV diagnoses and HIV prevalence percentages.

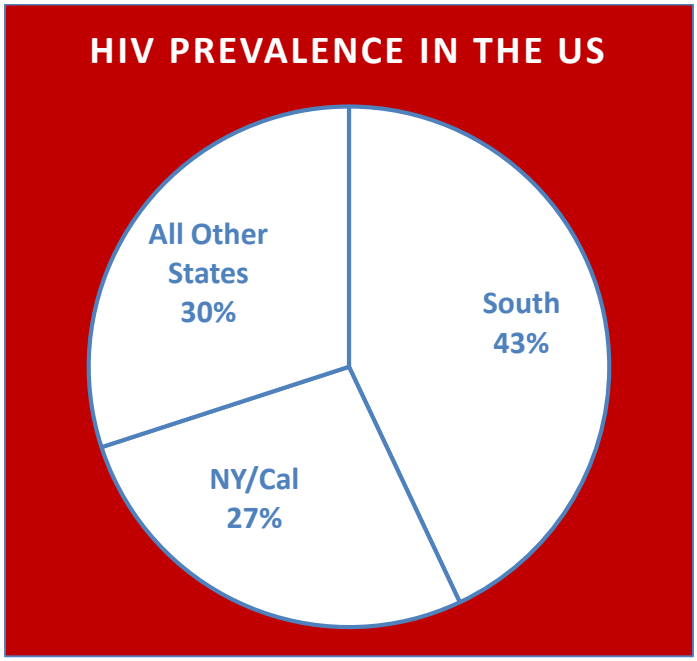
The South received a total of $13,483,383 in PS15-1502 funding which represents 33% of the total funding to US CBOs. In contrast, the South accounted for 51% of all new HIV diagnoses in the US (2013),[34] and 43% of persons living with HIV (year-end 2012,)[35] while accounting for only 38% of the US population.[36] Thirty community-based organizations were funded in the South.





[32] The United States Census Bureau defines the Southern Region as including Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, Oklahoma, North Carolina, South Carolina, Tennessee, Texas, Virginia, and West Virginia.
[33] Alabama, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Texas.
[34] Centers for Disease Control and Prevention. HIV Surveillance Report: Diagnoses of HIV Infection in the United States and Dependent Areas, 2013, Table 18; http://www.cdc.gov/hiv/pdf/g-l/hiv_surveillance_report_vol_25.pdf.
[35] Centers for Disease Control and Prevention. HIV Surveillance Report: Diagnoses of HIV Infection in the United States and Dependent Areas, 2013, Table 20; http://www.cdc.gov/hiv/pdf/g-l/hiv_surveillance_report_vol_25.pdf.
[36] US Census Bureau. United States Population Growth by Region. 2015; https://http://www.census.gov/popclock/data_tables.php?component=growth. Accessed October, 2015.

Two states, New York and California, received a combined $14,794,561 in PS15-1502 funding, which represents 36% of the total PS15-1502 funding and more than the entire South. The two states had a combined 19% of all new HIV diagnoses in the US (2013)[37] and 27% of persons living with HIV (year-end 2012).[38] A total of 28 community-based organizations were funded in New York and California.



The nine Deep South States [39] targeted by SASI received a total of $10,683.383 in PS15-1502 funding representing 26% of the total US funding. The Deep South region is a big driver of the Southern HIV epidemic and had 40% of all new HIV diagnoses in the US [40] and 34% of persons living with HIV [41] while accounting for only 28% of the US population.[42]

One Southern state stands out when examining funding allocation. Florida received $1,050,000 in PS15-1502 funding which represents only 3% of the total funding to US CBOs.

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[37] *See* Footnote 6.
[38] *See* Footnote 5.
[39] Alabama, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Texas.
[40] *See* Footnote 6.
[41] *See* Footnote 5.
[42] US Census Bureau. Annual estimates of the resident population for the United States, regions, states, and Puerto Rico. 2011; http://www.census.gov/popest/data/state/totals/2011/. Accessed March, 2013.

Florida ranked third in the country in HIV prevalence with 11% of the persons living with HIV (year-end 2012).[43] Florida also had 11% of all new HIV diagnoses in the US (2013.)[44]

TABLE 1: Comparison of PS15-1502 Funding Distribution with Percentages of new HIV Diagnoses and People Living with HIV in the United States.

Region/State	Total PS15-1502 Funding Amount Received[45]	Percentage of Total US PS15-1502 Funding Received	Percentage of new HIV diagnoses in US (2013)[46]	Percentage of People Living with HIV in US (year-end 2012)[47]
United States	$40,615,001.	100%	100%	100%
South	$13,483,383.	33%	51%	43%
Deep South Region	$10,683,383.	26%	40%	34%
Florida	$1,050,000	3%	11%	11%
New York & California	$14,794,561	36%	19%	27%

When the numbers of new HIV diagnoses and of people living with HIV are taken into account, it appears that the PS15-1502 funding distribution is inconsistent with the geographic distribution of the epidemic.

[43] *See* Footnote 5.
[44] *See* Footnote 6.
[45] http://www.cdc.gov/hiv/pdf/funding/announcements/ps15-1502/cdc-hiv-ps15-1502-funding--by-state-and-grantee.pdf. SASI's analysis excludes funds distributed to organizations in Puerto Rico and the US Virgin Islands.
[46] Centers for Disease Control and Prevention. HIV Surveillance Report: Diagnoses of HIV Infection in the United States and Dependent Areas, 2013, Table 18; http://www.cdc.gov/hiv/pdf/g-l/hiv_surveillance_report_vol_25.pdf.
[47] Centers for Disease Control and Prevention. HIV Surveillance Report: Diagnoses of HIV Infection in the United States and Dependent Areas, 2013, Table 20; http://www.cdc.gov/hiv/pdf/g-l/hiv_surveillance_report_vol_25.pdf.

VI. CDC Funding to State Health Departments

As we've demonstrated above, the PS15-1502 eligibility restrictions create a significant prevention funding shortfall in several Deep South States. Further, the distribution of PS15-1502 funding is not consistent with the geographic distribution of the epidemic. Because the disease burden in several Deep South States is located outside eligible MSAs, many CBOs that had previously received direct prevention funding are currently barred from applying for funding under PS15-1502. Although those CBOs also have received CDC funding indirectly through their state health departments, this funding does not make up for the shortfall created by PS15-1502.

CDC PS12-1201 is the most recent CDC prevention funding opportunity for health departments in all fifty states, the District of Columbia, U.S. territories, and local health departments that serve ten designated MSAs or Metropolitan Divisions.[48] As would be expected, the CDC directs that for core funding for HIV prevention programs (Category A funding), each health department consider the jurisdiction's distribution of HIV in its funding decisions.[49] Health departments are also required to identify each city or MSA with at least 30% of the epidemic in the jurisdiction and report to the CDC the amount of funding allocated to those areas and how the funding was used.[50] Although in most states, CBOs outside of eligible MSAs do receive some CDC prevention funding through their state health departments, the health departments are not awarded *additional* dollars to supplement the shortfall to those CBOs created by PS15-1502.

PS12-1201 Category B funds, designed for disproportionately affected populations, are directed to testing programs, at least 70% of which must be in healthcare settings. Only 30% of Category B funding can be used for non-healthcare settings (CBOs or other service organizations). As with Category A funds, state health departments are not awarded *additional* funds under Category B to supplement the shortfall created by PS15-1502.

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[48] These ten MSAs and MDs are Atlanta, Baltimore, Chicago, Fort Lauderdale, Houston, Los Angeles, Miami, New York City, Philadelphia, and San Francisco. The MSAs located in the Deep South States are: Atlanta, Fort Lauderdale, Houston, and Miami.

[49] *See* Centers for Disease Control & Prevention, FOA PS12-1201, at 12 ("Applicants are expected to allocate programmatic and financial resources to local areas based on the burden of disease.").

[50] FOA PS12-1201, at 21.

Furthermore, an informal survey of state health departments in the nine Deep South States conducted by SASI reveals that most state health departments distribute their CDC prevention funds based on the geographic breakdown of the epidemic in their states. However, the proportion of funds allocated to CBOs and local health departments appears to vary by state. What is apparent from the survey is that the funding received by CBOs from state health departments does not cover the loss of direct funding that could have been received were it not for PS15-1502's MSA-eligibility requirement.[51]

VII. Conclusion

SASI supports the goals of the CDC's High Impact Prevention policy. We support geographic targeting of resources, which generally means targeting heavily impacted urban jurisdictions. As is clear from the foregoing analysis, however, much of the Deep South HIV epidemic is concentrated outside of MSAs eligible for direct CBO prevention funding. The Deep South region is already experiencing high rates of new HIV diagnoses, high death rates, high HIV-related death rates, and low survival rates. Recent SASI/CDC research also found that living outside a large urban area at the time of diagnosis significantly predicted greater death rates among persons living with HIV in the Deep South region.[52] Reduced prevention funding for CBOs in the Deep South, groups that are uniquely positioned to reach communities at risk for HIV, will only serve to increase the HIV burden in this region. Taking funding away from a region where a substantial proportion of the individuals diagnosed with HIV reside will very likely result in continued growth in HIV infections.

It is also apparent that the CDC distribution of PS15-1502 funds is not consistent with the geographic distribution of the epidemic.

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[51] Relying on state health departments to fill services that would have been provided by CBOs were they able to receive PS15-1502 funding is unsatisfactory because state health departments are not fungible with CBOs. For instance, they serve different purposes, have different stakeholders, and have different relationships with the target communities they are serving.

[52] Susan Reif, Brian Wells Pence, Irene Hall, Xiaohong Hu, Kathryn Wetten & Elena Wilson, *HIV Diagnoses, Prevalence and Outcomes in Nine Southern States*, 39(6) J. COMM. HEALTH (Dec. 2014).

VIII. SASI Call to Action

While SASI supports the targeting of significant resources to the heavily impacted large urban jurisdictions, we also want to ensure that states with more dispersed epidemics, high diagnosis rates, high prevalence of undiagnosed HIV, and high death rates also receive prevention resources targeted to the HIV profile of the state and tailored geographically. In order to accomplish this goal, we ask that the CDC discuss with us the following specific actions that might begin to address the issues we raise in this Report:

1. That the CDC analyze the reasons for the failure to distribute PS15-1502 funding consistent with the geographic distribution of the epidemic.
2. That the CDC create a second tier of HIV prevention grants to directly fund CBOs outside of large urban areas (areas with > 500,000 population) with high HIV diagnosis rates, high prevalence of undiagnosed HIV and high death rates. The funding amount made available for these grants should be proportionate to the HIV incidence outside the large urban areas and should create strategies to address the more dispersed epidemic outside the large urban areas. The funding model for the grants should include:
    - **i.** Smaller grants with streamlined reporting requirements that reflect the level of disease burden in the area, including interventions aimed at reductions in positivity rates and death rates;
    - **ii.** Encourage where possible incentives for collaborations/partnerships to expand the reach and capacity of each grant;
    - **iii.** Discretion to allow the funded CBOs to serve the surrounding rural counties;
    - **iv.** Flexibility to allow CBOs to serve emerging populations while keeping the prevention emphasis on the identified priority populations.
3. That the CDC give state health departments the necessary information and discretion to ensure that areas of the state outside the large urban areas have adequate prevention services by:

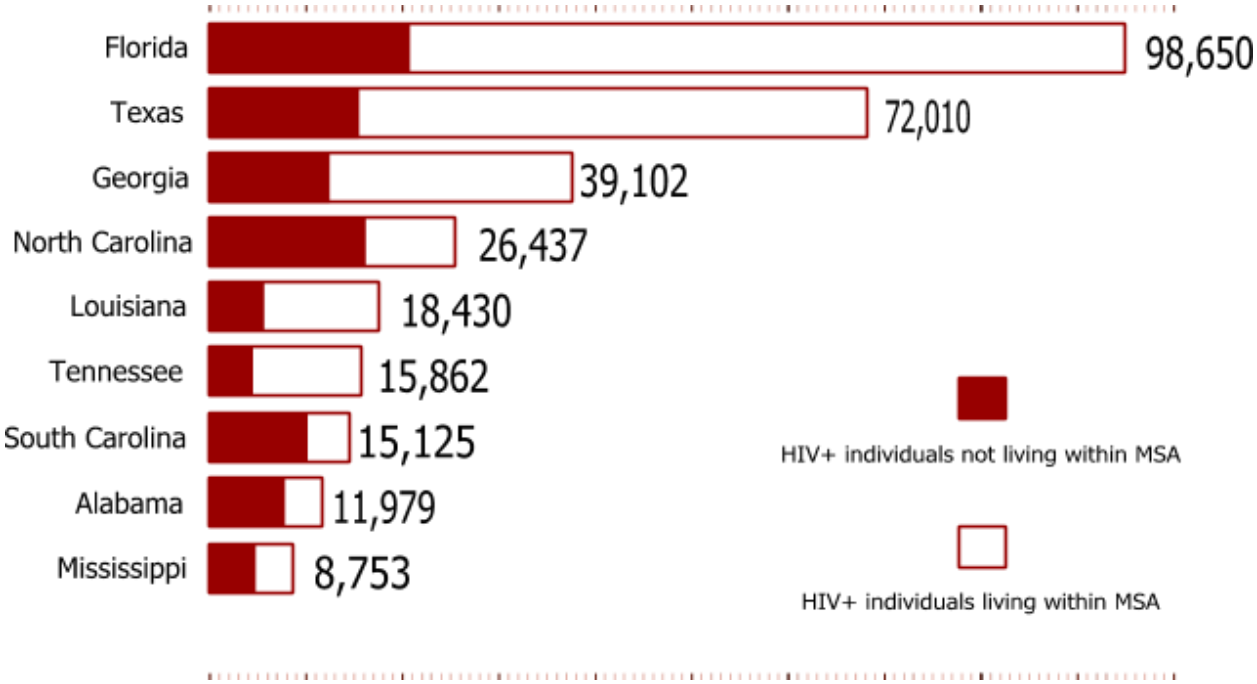
i. providing state health departments with data on the location, catchment areas, and priority populations of CBOs directly funded to provide HIV prevention.

ii. allowing state health departments some discretion to take the resources provided to directly funded CBOs into account when allocating state-based CDC HIV prevention funds in areas of the state with no directly funded CBOs.

iii. Requiring state health departments to make publically available a breakdown of how CDC HIV prevention funds are distributed in each state.

We look forward to discussing our findings with the CDC and to moving forward with solutions.

Appendix A: MSA/Non-MSA Proportion of HIV-Positive Individuals by Population



Appendix B: PA-04064 Deep South CBO Grantees

PA-04064 Grantee	Funding Award	PS15-1502 Eligible?
AID Atlanta (Atlanta, GA)	397,423	Yes
AIDS Education and Services for Minorities, Inc. (Atlanta, GA)	438.455	Yes
AIDS in Minorities, Jefferson County (Birmingham, AL)	285,578	Yes
AIDS Service Association of Pinellas (Pinellas, FL)	413,710	Yes
AIDS Services of Austin (Austin, TX)	362,584	Yes
AIDS Survival Project (Atlanta, GA)	319.483	Yes
Beat-AIDS, Inc. (San Antonio, TX)	435,274	Yes
Basic NWFL, Inc. (Panama City, FL)	309,872	No
Brotherhood, Inc., formerly The Brotherhood (New Orleans, LA)	397,423	Yes
Building Bridges, Inc. (Jackson, MS)	286,862	Yes
Camillus Health Concern, Inc. (Miami, FL)	437,791	Yes
Change Happens! (Houston, TX)	481,754	Yes
Community AIDS Resource, Inc. d/b/a Care Resource (Miami, FL)	265,993	Yes
Comprehensive AIDS Program of Palm Beach County, Inc. (West Palm Beach, FL)	382,216	Yes
Center for Multicultural Wellness Prevention (Orlando, FL)	349,819	Yes
Community Health Care Center One (Fort Lauderdale, FL)	278,387	Yes
Empower U (Miami, FL)	394,338	Yes
Excelth, Inc/Health Care Network (New Orleans, LA)	376,864	Yes
Glades Health, Intl, Inc. (Belle Glade, FL)	325,550	No
Great Expectations Foundation (New Orleans, LA)	259,356	Yes
Health Services Center, Inc. (Anniston, AL)	194,979	No
Healthy Start Coalition of St. Lucie (Fort Pierce, FL)	367,727	No
Houston Area Community Services, Inc. (Houston, TX)	447,447	Yes
HopeHealth, Inc. (Florence, SC)	401,429	No
Institute of Women and Ethnic Studies (New Orleans, LA)	247,989	Yes
Legacy Community Health Services, Inc. (Houston, TX)	459,930	Yes
Miracle of Love, Inc. (Orlando, FL)	393,504	Yes

Minority AIDS Coalition of Jacksonville (Jacksonville, FL)	385,266	Yes
New Orleans/AIDS Task Force, Inc. (New Orleans, LA)	389,631	Yes
Our Common Welfare (Decatur, GA)	361,746	No
Okaloosa AIDS Support & Informational Services (Fort Walton Beach, FL)	230,353	No
Palmetto AIDS Life Support Services (Columbia, SC)	321,398	Yes
Pine Belt Mental Health & Retardation Services (Hattiesburg, MS)	264,338	No
Planned Parenthood Center of El Paso (El Paso, TX)	393,872	No
Renaissance III, Inc. (Dallas, TX)	257,222	Yes
Saint Joseph's Mercy Care Foundation (Atlanta, GA)	349,508	Yes
South Carolina HIV AIDS Council (Columbia, SC)	415,763	Yes
Southwest Louisiana Area Health Education Center (Lafayette, LA)	362,876	No
South Texas Council on Alcohol and Drug Abuse (Laredo, TX)	361,522	No
Tri-County Community Health Center, Inc. (Newton Grove, NC)	264,711	No
Union Positiva, Inc. (Miami, FL)	389,278	Yes
Village South, Inc. (Miami, FL)	269,542	Yes
Wright House Wellness Center (Austin, TX)	311,421	Yes

Appendix C: PS10-1003 Deep South CBO Grantees

PA-04064 Grantee	Funding Award	PS15-1502 Eligible?
AID Atlanta (Atlanta, GA)	389,580	Yes
AID Gwinnett, Inc. (Duluth, GA)	315,836	No
AIDS Action Coalition (Huntsville, AL)	364,830	No
AIDS Arms Network, Inc. (Dallas, TX)	315,836	Yes
AIDS Foundation Houston, Inc. (Houston, TX)	315,836	Yes
AIDS Services of Austin (Austin, TX)	337,248	Yes
Aletheia House, Inc. (Birmingham, AL)	307,612	Yes
Beat-AIDS, Inc. (San Antonio, TX)	389,580	Yes
Brotherhood, Inc., formerly The Brotherhood (New Orleans, LA)	389,580	Yes
Broward House, Inc. (Broward, FL)	240,050	Yes
Building Bridges, Inc. (Jackson, MS)	389,580	Yes
Care Resource (Charlotte, NC)	389,580	Yes
Change Happens! (Houston, TX)	337,248	Yes
Comprehensive AIDS Program of Palm Beach County, Inc. (West Palm Beach, FL)	337,248	Yes
The Coastal Bend AIDS Foundation (Corpus Christi, TX)	364,830	No
Dallas County Hospital District (Dallas, TX)	364,830	Yes
Empower U (Miami, FL)	406,967	Yes
Gay Lesbian Community Center of Greater Ft. Lauderdale (Wilton Manors, FL)	315,836	No
HIV/AIDS Alliance for Region Two, Inc. (Baton Rouge, LA)	240,050	Yes
Hope and Health Center of Central Florida (Winter Park, FL)	315,836	No
Houston Area Community Services, Inc. (Houston, TX)	256,300	Yes
Institute of Women and Ethnic Studies (New Orleans, LA)	256,300	Yes
Jacksonville Area Sexual Minority Youth Network (Jacksonville, FL)	240,050	Yes
Latinos Salud, Inc. (Wilton Manors, FL)	240,050	No
Legacy Community Health Services, Inc. (Houston, TX)	337,248	Yes
Miracle of Love, Inc. (Orlando, FL)	337,248	Yes
My Brother's Keeper, Inc. (Ridgeland, MS)	315,836	No
New Orleans/AIDS Task Force, Inc. (New Orleans, LA)	389,580	Yes
Palmetto AIDS Life Support Services (Columbia, SC)	389,580	Yes
Positive Impact, Inc. (Atlanta, GA)	389,580	Yes

Quality Home Care Services, Inc. (Charlotte, NC)	364,830	Yes
Regional HIV/AIDS Consortium (Charlotte, NC)	240,050	Yes
River Region Human Services, Inc. (Jacksonville, FL)	315,836	Yes
Saint Joseph's Mercy Care Foundation (Atlanta, GA)	337,248	Yes
South Carolina African American HIV/AIDS Council (Columbia, SC)	337,248	Yes
South Texas Council on Alcohol and Drug Abuse (Laredo, TX)	337,248	No
St. Hope Foundation (Houston, TX)	315,836	Yes
Urban League of Greater Dallas (Dallas, TX)	240,050	Yes
Women On Maintaining Education and Nutrition (Nashville, TN)	315,836	Yes
Wright House Wellness Center (Austin, TX)	337,248	Yes

Appendix D: Recent PS15-1502 Funding by State and Grantee[53]

Organization	City	Annual Funding Amount
Alabama (1)		
Birmingham AIDS Outreach	Birmingham	757,793.00
Arizona (2)		
Ebony House	Phoenix	375,003.00
Native American Community Health Center, Inc.	Phoenix	350,000.00
California (14)		
AIDS Project of the East Bay	Oakland	350,000.00
AIDS Services Foundation Orange County	Irvine	350,000.00
AltaMed Health Services Corporation	Los Angeles	350,000.00
APLA Health & Wellness	Los Angeles	350,000.00
Bienestar Human Services	Los Angeles	350,000.00
Black AIDS Institute	Los Angeles	757,793.00
California Prostitutes Education Project (CAL-PEP)	Oakland	702,501.00
Centro de Salud de San Ysidro, Inc. (dba San Ysidro Health Center)	San Diego	350,000.00
Family Health Centers of San Diego	San Diego	757,793.00
JWCH Institute, Inc.	Commerce	702,501.00
Los Angeles LGBT Center	Los Angeles	350,000.00
REACH LA	Los Angeles	350,000.00
San Francisco AIDS Foundation	San Francisco	757,793.00
Special Service for Groups/APAIT	Los Angeles	757,793.00
Colorado (1)		
Empowerment Program	Denver	757,793.00
District of Columbia (5)		
Family and Medical Counseling Service	Washington	350,000.00
La Clinica del Pueblo, Inc.	Washington	350,000.00
Sasha Bruce	Washington	350,000.00
Us Helping Us, People Into Living, Inc.	Washington	350,000.00
Women's Collective	Washington	350,000.00
Florida (3)		
Empower "U", Inc. Community Health Center	Miami	350,000.00
Latinos Salud, Inc.	Wilton Manors	350,000.00
Metropolitan Charities, Inc.	St. Petersburg	350,000.00

[53] http://www.cdc.gov/hiv/pdf/funding/announcements/ps15-1502/cdc-hiv-ps15-1502-funding--by-state-and-grantee.pdf

Organization	City	Annual Funding Amount
Georgia (5)		
AID Atlanta	Atlanta	757,793.00
Empowerment Resource Center	Atlanta	702,501.00
Positive Impact	Atlanta	702,501.00
Recovery Consultants	Atlanta	350,000.00
St. Joseph's Mercy Care Services	Atlanta	350,000.00
Illinois (5)		
Access Community Health Network	Chicago	350,000.00
Association House of Chicago	Chicago	350,000.00
Howard Brown Health Center	Chicago	757,793.00
Chicago House and Social Service Agency	Chicago	757,793.00
Southside Help Center	Chicago	350,000.00
Kentucky (1)		
Volunteers of America of Kentucky, Inc.	Louisville	350,000.00
Louisiana (3)		
Brotherhood, Inc.	New Orleans	350,000.00
Institute of Women and Ethnic Studies	New Orleans	350,000.00
NO/AIDS Task Force d.b.a. Crescent Care Health	New Orleans	350,000.00
Massachusetts (3)		
Fenway Community Health Center, Inc.	Boston	757,793.00
Massachusetts Alliance of Portuguese Speakers (MAPS)	Cambridge	702,501.00
Whittier Street Health Center, Inc.	Boston	350,000.00
Michigan (1)		
Community Health Awareness Group	Detroit	757,793.00
Minnesota (1)		
Indigenous People's Task Force	Minneapolis	350,000.00
Mississippi (1)		
My Brother's Keeper	Jackson	350,000.00
Missouri (2)		
Community Wellness Project (CWP)	St. Louis	350,000.00
Kansas City CARE Clinic	Kansas City	350,000.00

Organization	City	Annual Funding Amount
New Jersey (3)		
Hyacinth AIDS Foundation	New Brunswick	702,501.00
Newark Beth Israel Medical Center	Newark	350,000.00
PROCEED	Elizabeth	350,000.00
New York (14)		
AIDS Center of Queens County, Inc.	Jamaica	702,501.00
AIDS Service Center of Lower Manhattan, Inc.	New York	757,793.00
Community Health Action Staten Island	New York	350,000.00
Exponents	New York	350,000.00
Foundation for Sexually Transmitted Diseases	New York	350,000.00
Iris House A Center for Women Living with HIV, Inc.	New York	702,501.00
Latino Commission on AIDS	New York	757,793.00
Montefiore Women's Center/HIV Prevention Program	Bronx	350,000.00
North Shore University Hospital	Manhasset	757,793.00
Sunset Park Health Council, dba Lutheran Family Health Centers	Brooklyn	702,501.00
William F. Ryan Community Health Center	New York	375,004.00
Women's Prison & Home	New York	350,000.00
Wyckoff Heights Medical Center	Brooklyn	350,000.00
Harlem Hospital Center/NYC Health & Hospitals Corp.	New York	702,501.00
North Carolina (1)		
Quality Home Care Services, Inc.	Charlotte	350,000.00
Ohio (2)		
AIDS Resource Center Ohio, Inc.	Columbus	350,000.00
Recovery Resources	Cleveland	757,793.00
Oklahoma (1)		
Guiding Right, Inc.	Midwest City	350,000.00
Oregon (1)		
Cascade AIDS Project	Portland	350,000.00

Organization	City	Annual Funding Amount
Pennsylvania (3)		
AccessMatters	Philadelphia	757,793.00
Mazzoni Center	Philadelphia	350,000.00
Philadelphia FIGHT	Philadelphia	702,501.00
Puerto Rico (6)		
ASPIRA Inc. de Puerto Rico	San Juan	350,000.00
COAI	San Juan	350,000.00
COSSMA, Inc.	Cidra	350,000.00
Estancia Corazon, Inc.	Mayaguez	350,000.00
Migrant Health Center, Western Region, Inc.	Mayaguez	350,000.00
PR CONCRA	San Juan	350,000.00
South Carolina (1)		
SC HIV/AIDS Council	Columbia	350,000.00
Tennessee (2)		
Le Bonheur Community Health and Well-Being	Memphis	350,000.00
Nashville CARES	Nashville	757,793.00
Texas (6)		
Abounding Prosperity, Inc.	Dallas	350,000.00
AIDS Arms	Dallas	350,000.00
AIDS Foundation Houston, Inc.	Houston	350,000.00
Beat AIDS Coalition	San Antonio	702,501.00
Change Happens	Houston	702,501.00
St. Hope Foundation	Houston	350,000.00
United States Virgin Islands (1)		
Frederiksted Health Care	St. Croix	500,000.00
Virginia (1)		
Candii (dba ACCESS AIDS Care)	Norfolk	350,000.00