PS-24-0047 Frequently Asked Questions
February 26, 2024

Overview

This Frequently Asked Questions (FAQ) document is developed based on the questions received via the mailbox and informational call from potential applicants related to the Notice of Funding Opportunity (NOFO) PS-24-0047: *High-Impact HIV Prevention and Surveillance Programs for Health Departments*.

Frequently Asked Questions (FAQs)

Submission and Due Dates

When are applications due?
Applications are due April 29, 2024, by 11:59 p.m. U.S. Eastern Time, at www.grants.gov. Submit your application to www.grants.gov, not GrantSolutions.

Are we required to submit a Letter of Intent (LOI)? If so, when is it due?
The LOI is strongly recommended. However, it is not required or scored. The LOI is intended to provide CDC with an estimated number of applicants in preparation for the objective review process.

The LOI due date is Friday, February 23, 2024. Please provide a LOI if you plan to or do not plan to apply for funding. LOIs should be emailed to NOFOINFO@cdc.gov. Attn: Erica Dunbar, CDC, NCHHSTP/DHP.

I am having difficulty downloading the application kit.
On www.grants.gov, please download the "full announcement." There are no revised or other supporting documents to download at this juncture.

If technical difficulties are encountered at www.grants.gov, applicants should contact Customer Service at www.grants.gov. The Contact Center is available by phone at 1-800-518-4726 or by e-mail at support@grants.gov.

Funding and Funding Relationships

Is the budget period for the NOFO application the 10-month period starting on August 1, 2024, and then the next 12-month period, or just the first 10-month period? Are we required to submit two budgets (10 and 12 months) for the initial application submission?
For the initial application submission, please submit the first-year budget and budget narrative for the 10-month period starting on August 1, 2024 – May 31, 2025. Please submit one budget that includes surveillance, prevention, and EHE, if applicable. The 12-month funding ranges are provided for reference for the subsequent years.

Should our budget be divided between core and EHE funding?
The budget and budget narrative should delineate and track funding sources separately for reporting. Please submit a budget for surveillance, prevention, and EHE, if applicable.

Is the budget narrative included in the 20-page narrative limit?
The budget and budget narrative are not included in the 20-page narrative.

What about states that have a directly funded city and have overlapping responsibilities? How should we manage HIV surveillance and prevention activities?
Jurisdictions with eligible state and local (city or county) health departments must discuss the proposed program approach implemented by the local health department and how the state and local area will collaborate during the project period to ensure the appropriate provision of services within the referenced area.

Document any agreements reached in a letter of agreement/letter of concurrence (LOA/LOC), which both parties must submit as part of their application.

Why is the data displayed in the table of *Counties per State Representing 30% or Greater of the Cumulative HIV Diagnosis in 2021* different from my local data?
Some of the differences between the NHSS datasets and state HIV surveillance data can be explained by:

- Fulfilment of minimum requirements for data transfer to CDC: Sometimes, cases are missing required information and, as a result, do not get transferred to CDC and are only seen at the state level.
- National level deduplication: Some cases are reported from multiple jurisdictions. CDC merges the duplicate reports as one case for accuracy. The unified case is then assigned to only one of the reporting jurisdictions based on established criteria.

How do we delineate and track funding sources separately for reporting?
Funding flexibility allows jurisdictions to use resources across funding categories (e.g., Surveillance, Prevention, and EHE) to implement comprehensive HIV surveillance and prevention programs.

- Categorical funding must be delineated and tracked separately.
- Therefore, the 424A form should include surveillance, prevention, EHE (if applicable), and total column.

My county is listed as a high prevalence jurisdiction within the state. Previously, our application was submitted by the state department of health. Is my county eligible to apply directly to CDC, or will the state have to apply on our behalf?
Please refer to the funding tables for the list of health departments eligible to apply and directly receive PS-24-0047 funding. EHE jurisdictions with local EHE counties should discuss and partner on the proposed program approach implemented within the local EHE county during the project period to ensure the appropriate provision of services and resources within the referenced area.

Will the NOFO application for PS-24-0047 be submitted through PS18-1802 in Grant Solutions? Is it fair to say that states who apply for the maximum amounts listed in the funding tables would receive it?
Applications must be submitted to www.grants.gov (not Grant Solutions). Applicants can refer to the funding tables for recommended funding amounts for the jurisdiction. Applicants should develop and submit a budget amount to align and support the funded program. All funding is subject to availability.

Floor-level increases have barely covered inflationary costs since 2018. Many states are starting with less money than in 2018 by real dollar value. The funding tables are not realistic for ground-level activities. Are jurisdictions allowed to ask for more than the maximum estimated amount?
CDC anticipates level funding for this NOFO; thus, this funding announcement allows for flexibility in program design. Applicants should develop and submit a budget amount to align and support the funded program. All funding is subject to availability.

NOFO Requirements

There were several activities listed under the six strategies. Are the bulleted activities listed under the six strategies on pp. 17-29 of the NOFO required, recommended, or examples? Are we expected to conduct all activities in the NOFO, or do we pare down to those we intend to prioritize with these funds?
Yes, the six core strategies and the activities listed under each strategy are required.

On p. 58 of the NOFO under Approach, the maximum number of points listed is 45 for the core program and 25 points for EHE. However, #5 of the EHE criteria on p. 59 shows a maximum of 20 points, not 25. Please clarify.
Applicants must respond for the core program. There are 100 points total for the core program (core program only, not inclusive of EHE).

- Approach – 45 points
- Evaluation and Performance Measurement – 25 points
- Applicant's Organizational Capacity to Implement the Approach – 30 points
- Budget (not scored)

If you are an EHE jurisdiction and applying for EHE funding resources, applicants must provide a respond for EHE. An additional 50 points will be provided for EHE.

- Approach – 25 points
- Evaluation and Performance Measurement – 10 points
- Applicant's Organizational Capacity to Implement the Approach – 15 points
- Budget (not scored)

The HIV Perinatal Program Guidance mentioned that my state needs to "participate in activities 4-7," but I only see six activities included. Where can I find the seventh activity?

Please refer to the HIV Perinatal Program Guidance:
https://www.cdc.gov/hiv/pdf/funding/announcements/ps24-0047/CDC_HIV-PS24-0047-HIV-Perinatal-Program-Guidancex.pdf

The activities include:
Required activities in all jurisdictions:

1. Promote routine prenatal HIV and syphilis testing of all pregnant persons, diagnostic HIV testing for HIV-exposed infants, and neonatal syphilis screening per CDC and HHS recommendations.
2. Conduct perinatal, maternal, and infant HIV and syphilis prevention and surveillance activities per CDC recommendations (*TG Pediatric HIV Surveillance* file)
3. Conduct annual matching of persons with diagnosed HIV reported to surveillance with the state birth registry and tribal birth registry, as applicable and report data to CDC (*TG Pediatric HIV Surveillance* file). Collaborate with your local STI program to complete a match between syphilis surveillance and local vital records data.

Expanded activities required in a subset of jurisdictions:

4. Conduct Perinatal HIV Exposure Reporting (PHER), where laws/regulations allow.
5. Develop and implement standard operating procedures for identifying and conducting follow-up of perinatally HIV-exposed infants according to CDC guidance.
6. Support Perinatal HIV Services Coordination (PHSC) to address local issues that lead to missed perinatal HIV surveillance and prevention opportunities.
7. Assess and improve perinatal HIV systems conducting case review and community action using the Fetal Infant Mortality Review (FIMR) Prevention Methodology or a similar process (refer to http:// www.fimrhiv.org/) and incorporate congenital syphilis reviews and systems improvement.

Do we need to use CDC Prevention and Surveillance funding for the required strategies, or can we use another funding source to cover the strategy? For example, Rapid and Ready is supported by HRSA Part A.
Recipients are required to develop and implement a comprehensive HIV prevention and surveillance program within their jurisdiction. Core strategies and associated activities are required for implementation. Funding resources should be used to support the proposed program. Other funding sources may be leveraged to complement your comprehensive HIV prevention and surveillance program.

Why does the NOFO focus on 2021 data for the counties with cumulative HIV cases? In our state, the data has shifted in 2022 and 2023 (preliminary data).
CDC focused on HIV surveillance data through 2021 and reported to CDC's National HIV Surveillance System (NHSS) through December 31, 2022. Data are based on a 12-month reporting delay to allow sufficient time for HIV-related laboratory results and deaths to be reported to CDC and for completion of deduplication and other data quality activities to ensure the most accurate data are used for funding decisions.
https://www.cdc.gov/hiv/library/reports/hiv-surveillance.html

CDC considers data preliminary until a 12-month reporting lag has been reached and should be interpreted with caution.

Previously, CDC had mandated that states perform Data to Care (D2C). Will states still be required to implement D2C in this NOFO time frame? If so, what data elements must be gathered and submitted to CDC? Further guidance on this would be helpful.
CDC is allowing flexibility within this NOFO. Re-engagement efforts are required to be implemented; however, it does not have to be data to care that is implemented. Data-to-care is not required but listed as an example.

However, if a program decides to implement or continue D2C activities, please follow the guidance which describes the data elements and process to report. Data to Care Program Guidance: Using HIV Surveillance Data to Support the HIV Care Continuum (cdc.gov); D2C NIC Monitoring and Evaluation Guidance (cdc.gov)

What time frame should be used for the work plan? For example, what are the dates of Year 1 of funding?
For the workplan time frame, please provide a detailed workplan for Year 1 (10-months, August 1, 2024 – May 31, 2025) and a high-level workplan for Years 2-5.

There were several short-term goals connected with activities. Are we expected also to select goals we intend to prioritize, or are all expected to be met?
The programs supported by this NOFO are expected to demonstrate measurable progress toward addressing the short-term and intermediate outcomes that appear in bold in the NOFO logic model. Please see pages 6 – 8 in the NOFO.

If we are an EHE jurisdiction, can we meet the 25% community mobilization requirement by using the funds to support a prevention community planning council that covers both the Prevention/Surveillance requirements and the EHE requirement?
EHE funding resources can be used to support the establishment of an EHE advisory board. If this board/committee is part of the community planning group (as required under the core program for prevention and surveillance), then EHE resources may be used to support this activity. However, it is important that EHE funding resources reach new partners and new voices.

When will the Principle, Practice, Pathways to Disease Intervention (3PDI) training be available? Will it include training to support D2C and cluster response activities?
The Principles, Practices and Pathways for Disease Intervention (3PDI) is currently under development and will be released in 2025. 3PDI will not go into detail regarding D2C and cluster response activities. However, programs should refer to the following guidance D2C activities, Data to Care Program Guidance: Using HIV Surveillance Data to Support the HIV Care Continuum (cdc.gov). And the following guidance for Cluster Detection and Response (CDR), HIV Cluster and Outbreak Detection and Response | Guidance | HIV Cluster Detection and Response | HIV | CDC.

On p. 15 of the NOFO, it states, "It is recommended that applicants have at least one designated full-time employee (FTE) as HIV surveillance coordinator to lead surveillance activities including data collection and reporting, data systems and management, data analysis, dissemination, and evaluation and uses of surveillance data for public health action." Our HIV Surveillance Coordinator (responsible for all surveillance activities) is currently .5 FTE HIV surveillance and .5 FTE HIV care (linkage to care/HIV DIS). It is

unclear if our program can shift this position to be designated to only surveillance. How will our application be evaluated if we cannot meet 1 FTE for surveillance only?
As stated, this is a recommendation, programs have the flexibility to use the resources to best fit their program needs.

On p. 14 of the NOFO, it states, "In jurisdictions with one or multiple EHE counties, at least 70% of EHE funding should be directed to the local EHE counties supporting local health entities and community organizations; up to 30% of funding resources may be retained by the funded jurisdiction for EHE infrastructure, coordination and oversight of activities and services, to include surveillance and cluster detection and response support, that will be provided by the recipient." I believe this applies to states that subcontract their funding to counties, but I need to ensure it does not apply to San Francisco because that would mean that 70% of the EHE funding must go to CBOs.
For EHE counties receiving direct funding, up to 30% of funding resources may be retained by the funded jurisdiction for EHE infrastructure, coordination and oversight of activities and services, to include surveillance and cluster detection and response support, that will be provided by the recipient.

Referring to p. 71 of the NOFO, are any additional attachments allowed, e.g., resumes, letters of support?
Additional attachments are allowed, not required, unless noted in the NOFO.

On p. 73 of the NOFO, it states that MOAs are allowed. Does this refer only to the MOA with a fiduciary agent as described on p. 13, or can we include MOAs with other program partners?
MOA with a bona fide or fiduciary agent is required if being used for this funded program. MOAs with other program partners are allowed, not required, unless indicated in the NOFO.

On p. 13 of the NOFO, it states, "In addition to core funding, recipients receiving resources for EHE must implement two or more strategies (not implemented under the core funding) to support the stated goal(s)." Is this meant to say "activities?" Based on the Strategies and Activities section of the NOFO, we need two additional activities for some of the strategies, not two additional strategies.
Yes. In addition to core funding, recipients receiving resources for EHE must implement two or more activities under the designated strategy (not implemented under the core funding) to support the stated goal(s).

On p. 43 of the NOFO, it states, "Applicants should provide a detailed work plan for the first year of the project and a high-level work plan for subsequent years. Applicants are to use Specific, Measurable, Achievable, Realistic, and Timely (SMART) objectives or indicators." The NOFO states that the work plan needs to be included in the 20 pages. How much detail is CDC expecting? Usually, the work plan is on top of the 20 pages, and a detailed work plan would probably be at least 10 pages long. Can we instead incorporate the work plan into the narrative? In other words, could we have a short work plan under each strategy? Then, we would not have to use space to repeat all the strategies and activities in a work plan table.

There is no template or format for the workplan. Please briefly incorporate workplan elements in the narrative (within the 20-page limit). A more detailed workplan can be included as an attachment/supporting documentation.

By "flexibility," do you mean funds can be used to address the social determinants of health, e.g., substance use treatment, housing vouchers, or antiracism initiatives?
Funds may be used to address social determinants of health supportive of the funded program. Building partnerships and leveraging resources is highly recommended. Please also see restrictions listed in NOFO.

On p. 30 of the NOFO, it states, "Advances in HIV prevention and new initiatives or priorities may occur during the period of performance. Applicants can enhance their programs by requesting funding to implement a supplemental activity or project to expand, bring to scale, or advance high-impact HIV prevention and surveillance interventions and strategies…. Should additional funding become available to support this optional program of significance, CDC will provide guidance and solicit supplemental or program-initiated funding requests." Does this mean we can request optional funding in the narrative, and our proposal would be considered if they have more money later? Or are they just saying there might be a supplemental funding announcement down the road?
Supplemental funding announcement will be provided, should funding become available. Applicants do not need to submit a proposal at this time for the optional program of significance.

On p. 41 of the NOFO, CDC recommends focused evaluation plans. Is there additional funding for this, or is it expected that funding for a focused evaluation plan would come out of this award?
There is no additional funding for the focused evaluation plans. It is an optional activity under the NOFO. Should additional funding become available, it may be used to support this activity.

Is the 30% to jurisdictions based on overall funding or the funding related to prevention?
30% of EHE funds.

Can the threshold for the different outcomes vary by year and culminate in the final percentage by Year 5?
The NOFO has set performance targets for some program outcomes, including knowledge of HIV status, linkage to HIV medical care, viral suppression, and PrEP coverage. CDC expects jurisdictions to work towards meeting these national targets during each performance year. Jurisdictions are also expected to set reasonable and progressive yearly targets for other program areas.

Will PrEP activities still be limited to 15% of the total budget?
Recipients may provide assistance, no more than 15% of the overall award amount, to support PrEP ancillary support services. Recipients are required to notify CDC, if coverage demands exceed the allotted percentage, to secure permission to redirect additional resources to meet the projected demand.

Strategy 1 requires recipients to "increase knowledge of status to 95% by ensuring all people with HIV receive a diagnosis as early as possible." If all people with HIV have not been identified, jurisdictions do not know how many there are or how many of them have received diagnoses. Without baseline figures, how can jurisdictions achieve or measure an increase to 95%?
CDC publishes estimates of knowledge of status for every state and EHE county in the annual HIV Surveillance Supplemental Report "Estimated HIV Incidence and Prevalence in the United States" (2021 Report: https://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-28-no-3/index.html).

CDC also provides SAS programs to state/local health departments for analyzing state/local HIV surveillance data reported to the Enhanced HIV/AIDS Reporting System (eHARS) to estimate HIV incidence, HIV prevalence (diagnosed and undiagnosed) and knowledge of HIV status in the state/local jurisdiction. Estimates from these analyses can be used to monitor knowledge of status in the jurisdiction.

How does applying for the CDR funding impact this application since funding will likely expand on the activities in Strategy 4?
PS24-0047 funds the strategies and activities that every CDC-funded health department is required to implement related to HIV cluster detection and response (CDR). HIV C-CORE (Centers for Cluster and Outbreak Response Enhancement), which will be administered through the Epidemiology and Laboratory Capacity (ELC) cooperative agreement, CK24-0002 project U, will provide additional funds to competitively selected health departments to pilot and expand CDR innovations, experiences, evaluations, and evidence base. For health departments applying for C-CORE, activities proposed for C-CORE can build on but should not duplicate those funded through PS24-0047.

I am not clear on the expectations concerning the disruption in CDC funding. Is there something jurisdictions need to submit with the application?
If the applicant would like to utilize a bona fide or fiduciary agent to carry out the funding for this program, then a MOU between the intended recipient and bona fide/fiduciary agent must be submitted with the application. If this does not apply to you, then there is nothing additional that needs to be submitted with your application.

Kings and Bronx Counties are identified in New York State as having 30% or greater of HIV diagnoses. Kings and Bronx Counties are also two of the four counties that would be funded under a separate jurisdiction: New York City. Does New York State need to direct higher levels of resources to those two counties as well as the resources directed to them by New York City? Do New York State and New York City need to develop local jurisdictional plans for these two counties, or just New York City?
Jurisdictions with eligible state and local (city or county) health departments must discuss the proposed program approach implemented by the local health department and how the state and local area will collaborate during the project period to ensure the appropriate provision of services and local planning efforts within the referenced area(s). Document any agreements reached in a letter of agreement/letter of concurrence (LOA/LOC), which both parties must submit as part of their application.

Do EHE jurisdictions need to implement two strategies under each pillar or two strategies across the pillars?
EHE jurisdictions need to implement two activities under each of the stated strategies (Diagnose, Treat, Prevent, Respond), and EHE coordination and resource distribution requirements.

Are Los Angeles, San Francisco, Baltimore, Chicago, Philadelphia, New York City, and Houston the only eligible local health departments that can apply on their own? We are in the only county (Mecklenburg County) listed as a recipient of the North Carolina Department of Health, but we must apply through them. Is this correct?
Eligible health department jurisdictions include the 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands. Local (county or city) health departments serving the following metropolitan areas: Baltimore City, Chicago, Houston, Los Angeles County, Philadelphia, New York City, and San Francisco.

The page limit to include the work plan is impossible with all the requirements CDC is requesting for the work plan. Can the work plan be removed from the page limit?
The submitted Project Narrative is a maximum of 20 pages, single spaced, 12-point font, 1-inch margins, number all pages. This includes the work plan. The project narrative must include all the following headings (including subheadings): Background, Approach, Applicant Evaluation and Performance Measurement Plan, Organizational Capacity of Applicants to Implement the Approach, and Work Plan.

Can we reference charts in the narrative in separate attachments and outside the 20-page limit? For example, can we have charts that follow the logic model for the EPMP and work plan? Could these be referenced in the narrative but not count toward the page limit?
The submitted Project Narrative is a maximum of 20 pages and must include all the following headings (including subheadings): Background, Approach, Applicant Evaluation and Performance Measurement Plan, Organizational Capacity of Applicants to Implement the Approach, and Work Plan. A description must be placed in the workplan. Additional details, if warranted, can be provided as an attachment.

For jurisdictions receiving EHE funding, would it be acceptable to include an EHE subheading in each response section?
Yes, this is acceptable.

Is the page limit still 20 pages for EHE eligible jurisdictions? Can that page limit be increased, as this is a competitive application?
The submitted Project Narrative, inclusive of core and EHE, is a maximum of 20 pages, This includes the work plan. The project narrative must include all the following headings (including subheadings): Background, Approach, Applicant Evaluation and Performance Measurement Plan, Organizational Capacity of Applicants to Implement the Approach, and Work Plan. Additional details or supporting documents, if warranted, can be provided as an attachment.

Evaluation

Is the Evaluation Performance Measurement Plan (EPMP) due with the application?
The EPMP is due post-award. A template will be provided at that time. However, applicants should respond to the "Applicant Evaluation and Performance Measurement Plan" section within the submitted narrative. There is no required template for the work plan and initial evaluation responses.

Can you speak to testing reporting? Are jurisdictions still required to use EvaluationWeb (EvalWeb)? Can we update our EvalWeb data to capture better outcome data? Can you clarify if all HIV tests must be entered into EvalWeb or just rapid tests/tests used through NOFO funds?
EvaluationWeb will still be used to submit National HIV Monitoring and Evaluation (NHM&E) data. All HIV tests conducted using PS24-0047 funds must be entered into EvaluationWeb. The final list of process and outcome data expected from HIV testing programs will be shared as part of the EPMP guidance. In addition, jurisdictions are encouraged to capture other outcome data to meet their local monitoring and evaluation needs.

Can you confirm that there will not be aggregate data tables required for EHE funded jurisdictions?
We are working on finalizing the data reporting requirements to meet the monitoring and evaluation needs of PS24-0047. Data collection and reporting requirements will be provided as part of the EPMP guidance. These requirements will apply to all EHE and non-EHE funded jurisdictions.

Will NHM&E variables change for this NOFO?
Many of the NHM&E variables will remain the same but there will be updates to capture data on new or focused activities, strategies, and outcomes of the NOFO.

Is EHE funding only for new and non-traditional partners?
As a part of EHE, there is an emphasis for recipients to partner with new and non-traditional local partners. However, other partners may be included and funded under EHE.