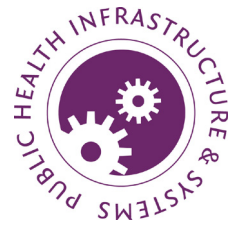


CASE STUDIES IN COOPERATIVE AGREEMENT REQUIREMENTS

CASE STUDY #2



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Introduction

National public health funding is a complex network of funding streams that arise from all levels of government and public sources. Funding from the federal government comes in many forms, but a common funding instrument is the cooperative agreement. Cooperative agreements are awarded to state, local, tribal, and territorial governments, or private organizations, with 'substantial involvement' of the federal awarding agency in recipient activities toward the purpose of the agreement.¹ These federal awards are formalized through a notice of award (NoA), which includes pertinent information about the award such as federal fund amounts authorized, applicable cost-sharing or matching, and any terms and conditions of the award; terms and conditions generally arise from the Notice of Funding Opportunity (NOFO).²

Defining Requirements

Terms and conditions outline general, program-specific, and award-specific obligations or requirements accountable by the recipient in exchange for awarded funds.² General administrative and public policy requirements outline specific administrative and financial processes to be adhered to as well as necessary acknowledgments or restrictions set forth within federal law such as the Civil Rights Act of 1964 or protection of human subjects.² Program- and award-specific requirements often specify personnel or resources to be acquired, activities or assessments to be performed, collaborative efforts, necessary performance, and other processes or outcomes expected to achieve the purpose and goals of the cooperative agreement. General-

ly, requirements included within the NoA also apply to any subrecipients or contractors unless specified.² Award recipients as "pass-through entities" (via subawarding or contracting out funds), may modify or add to those requirements and may even bundle multiple federal awards or funds from other sources which may involve additional requirements.

CDC Cooperative Agreements

The Centers for Disease Control and Prevention (CDC) coordinates funding opportunities that provide capacity-building assistance for the US public health system. The CDC offers a variety of cooperative agreements to strengthen and support the public health system, ranging from broad programmatic funding (e.g., public health emergency preparedness) to research or outcomes for specific health conditions. Each cooperative agreement NoA contains an expansive list of requirements to ensure efficient and effective uses of public money.

Strings Attached

The potential exists, however, with such a complex network of funding sources and layers of requirements, that competing interests of funding sources and overly prescriptive or restrictive requirements may impede achievement of the purpose or goals of the cooperative agreement. The resulting infrastructure or environment for recipients may lead to tradeoffs between achieving one objective over another, duplication of efforts, increased administrative burden, and other barriers to achieving goals. In some cases, the time and expense to perform award activities may exceed the value of the award. Due to this, potential applicants may choose not to apply for the funding opportunity.

Aims of This Project

This case study has several aims. First, we aim to discuss the importance of characterizing requirements and distinguish federal flow-down requirements versus requirements added by pass-through entities. Next, we offer context of the case site to provide depth to the study. Finally, we leverage key informant feedback from public health practice to synthesize learnings on delivering upon agreements and the impacts of facilitating and impeding requirements.

Case Site #2

Introduction

The case site is a county health department in the Midwest region of the United States, serving a semi-urban population greater than 200,000. The department is accredited by the Public Health Accreditation Board (PHAB) and offers a variety of clinical and population-based services to their local community. Provided services include infectious and communicable disease investigations, vaccination services, public health inspections, clinical nursing services, and public health licensing and permitting. Select services are also provided through shared service contracts to counties within the region.

Funding for activities arises through different governmental and private funds as well as fees and fines. County taxes are a substantial source of flexible funding, typically greater than one-third of revenues, and allow expenditures toward locally important priorities. Federal cooperative agreement funds passed through the state department of health are sizeable, typically comprising one-fifth of total revenues. There has been a reluctance to submitting applications for funding opportunities related to 'optional' grants due to the perception that the costs and restrictions may outweigh the benefits of the funding.

General Circumstances of Requirements

A primary focus of interviews with the case site was to gather impressions on general experiences with federal pass-through funds but to also contrast those experiences with other experiences with direct federal funding. Interview questions and desk review of agreement documentation also focused on several specific

cooperative agreements and grants for a more in-depth investigation:

- 1) *Immunization and Vaccines for Children* (IMM-VFC), CDC-RFA-IP19-1901
- 2) *Public Health Emergency Preparedness* (PHEP), CDC-RFA-TP17-1701
- 3) *Carol M. White Physical Education Program* (PEP) grant, CDFA 84.215F

Each of the first two are regularly occurring federally funded cooperative agreement programs while the final grant relates to a prior federal program that was directly funded. Requirements for the reviewed cooperative agreements, through their respective NOAs, were generally directed to the state ("recipient") and obligated administrative processes, programmatic activities, and expected performance. The direct grant from state to locals allowed for a closer relationship with federal program officers with similar obligations as the pass-through grants.

Interviewees characterized the requirements of both pass-through and direct grant awards as standard terms and conditions, considered "deliverables" by the State. The subaward agreements between the local health department and the state obligated specific activities or performance in return for program funding. As an example, both IMM-VFC and PHEP cooperative agreements included emergency planning deliverables, routine reporting processes, and other standard deliverables. Deliverable requirements often involve monthly, annual, or mid-point reporting. This reporting tracks data elements such as persons served, vaccinations provided, hours worked, educational sessions or events delivered, mileage and expenses, and other similar deliverable data.

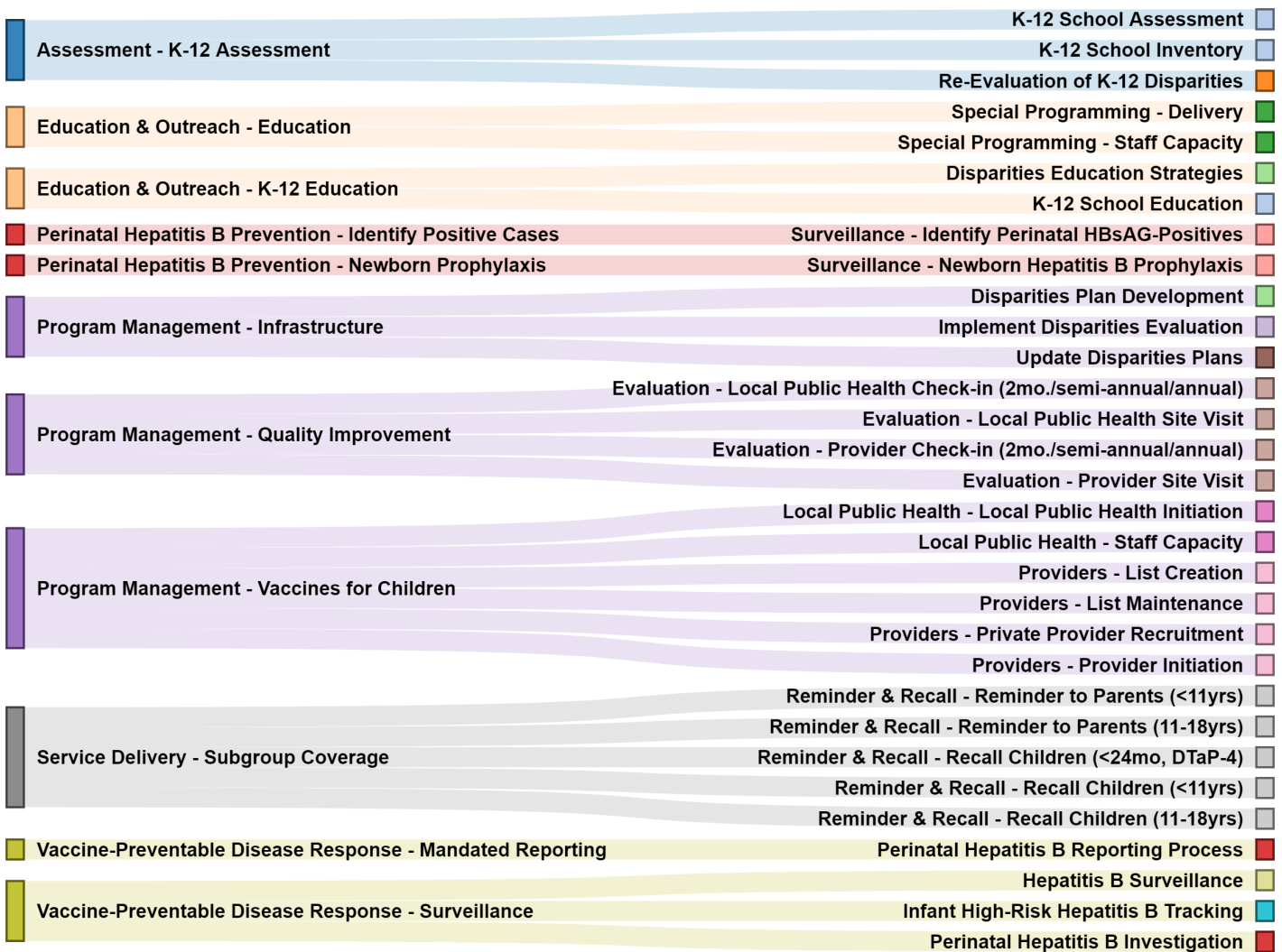
Cooperative Agreement Requirements

Immunization and Vaccines for Children

The IMM-VFC state-local agreement was viewed to be underfunded versus the contractual obligations. The summarized terms and conditions of the IMM-VFC agreement from the state (right of [Figure 1](#)) were to be delivered across a population greater than 230,000 for less than \$100,000 annually. As such, the obligations are perceived to be onerous while spending restrictions may be overly equipment is not available for other electronic means.

Figure 1.

Sankey diagram of Immunization and Vaccines for Children cooperative agreement (IMM-VFC) requirements (left) and state-local agreement requirements (right); approximately \$40,000 in annual pass-through funding for a program serving a combined population greater than 100,000 residents.



Note: Funding total included in figure label is approximation from federal awards pass-through reporting for fiscal year 2021.

Agreement obligations may not align with local priorities or initiatives but may rely upon standardized processes like for vaccine education to providers, following a core curriculum with options to utilize additional curricula. Of note, one interviewee stated that the vaccination curriculum has historically been an annual requirement and that the same providers often receive the same education over the years and that providers:

“...could teach this, they have this stuff memorized and they’ve heard it before.”

Public Health Emergency Preparedness

The PHEP cooperative agreement, on the other hand, was perceived as having a higher level of funding with enhanced flexibility. The summarized terms and conditions of the PHEP agreement from the state (right of [Figure 2](#)) were to be delivered across the same population but for just over \$300,000 annually. Obligations for this agreement ranged from routine administrative and planning activities to annual exercise requirements and a variety of drills, potentially at substantial expense for health department staff and external participants.

Figure 2.

Sankey diagram of Public Health Emergency Preparedness cooperative agreement (CDC-RFA-TP17-1701) requirements (left) and state-local agreement requirements (right); approximately \$300,000 in annual pass-through funding for a program serving a population greater than 200,000 residents.



Note: Funding total included in figure label is approximation from federal awards pass-through reporting for fiscal year 2021.

A primary challenge with the PHEP program, as a reimbursement-based agreement, is the need to encumber costs for longer durations due to delays in payment or insufficient progress on deliverables or performance.

Perceptions on Requirements

Productive Requirements

Interviewees acknowledged beneficial requirements or those believed to facilitate achievement of objectives of subawards passed through the State. Though few examples were able to be elicited within interviews, interviewees believed there was a role for a reasonable set of requirements. Other favorable requirements paradigms were described regarding deliverables-based arrangements — *funding with fewer restrictions in exchange for*

specific achievements — rather than traditional expense reimbursement grant agreements were favored by the case site. Besides the enhanced flexibility in local decision-making on expenditures, deliverable-based grants offer less risk in performing activities deemed later to be non-reimbursable and avoid instances of encumbering expenses over long periods while awaiting reimbursement. Deliverable-based awards were perceived to possess enhanced clarity on terms and conditions with less granular cost accounting, and more readily available funding.

Burden of Administration

For awards passed through the State, interviewees acknowledged the role of state personnel within different state programs or divisions when creating subaward

agreements that may be bundled together. One interviewee observed for most deliverables that they:

“aren’t necessarily programmatically driven as much as they are administratively and... a lot of that comes down from the State.”

As such, these deliverable-based grants are often funded through reimbursement mechanisms in which expenses may be encumbered for an extended duration due to timeframes needed to review submitted deliverables. This may be further exacerbated with reimbursement-based grants in which it is believed that money is lost when recipients may only claim exactly what is spent. There may be substantial investment of time to plan for and track person-level accounting of time and to distinguish acceptable deliverables or forms of activity. In addition, there are categories of expenditures that the case site incurs that is not eligible for coverage by the reimbursement model (e.g., certain marketing expenditures). Certain requirements and allowable expenses are not always completely clear upfront, leading to situations where a reimbursement request may take multiple months to process only to find out that certain expenses such as staff time or travel were not approved. Meanwhile, those activities or staff allocations continued during processing and were not reimbursed.

Duplication of Efforts

Interviewees described instances of duplicated efforts such as when prior work needed to be revised after continuation guidance from the State has retroactively modified specific processes. For example, one interviewee described how a change to terminology for PHEP reporting, such as changing from using “handicap person” to...“functionally disabled,” led to “shuffling paper” and spending “tons of time wordsmithing large documents rather than” completing more impactful deliverables like “building relationships and resiliency against our communities with our partners.” Such shifts in scope and requirements within multi-year grants may render long-term planning ineffective and sometimes wasteful of past efforts.

Impeding Requirements

Interviewees reported obligations that were overly onerous may impede achievement of the primary

Immunizations and VFC

The local health department typically receives under \$100,000 in federal pass-through dollars (<1% of total budget) to provide population-based services for a population greater than 200,000 and to provide some clinical services for client immunizations and case investigation of infectious diseases with activities not limited to:

- Administration of immunizations (including VFC program duties and vaccine preservation).
- Provider inventory and quality improvement activities, including immunization provider recruitment, facilitation of site visits, periodic check-ins.
- Planning and activities to reduce immunization coverage disparities.
- Perform inventory and assessment for all K-12 schools (plus offer education events).
- Identify perinatal Hepatitis B cases, investigate those cases, follow-up on testing and treatment, and track infant high-risk Hepatitis B.
- Create and manage a county-wide immunization reminder and recall system for children (including reminders to parents).
- Deliver education events across the county to immunization providers.

objectives passed through the State. There was a consensus among interviewees that the quantity and scope of obligations, deliverables, and required performance associated with cooperative agreements passed through the state seemed to be hardly attainable for funding, especially considering restrictions placed on spending. Grant agreements are formalized with many pages of terms and conditions and often not tied to specific funding amounts, though some exceptions are present for deliverable-based grants. Though there are often

myriad required activities or performance thresholds within agreements, there are sometimes restrictions against funding staff time or certain materials critical to achieving the objectives; indirect costs are often not reimbursable through these agreements. This is not all-too palatable at the local level, summed up by one interviewee:

“If I had to guess, the total amount of that grant that the CDC gave out, it’s probably very large; only \$9,500 makes it to you...what can you do for \$9,500?”

Elevated reporting burdens and human resource allocations were frequently cited as a key barrier to achievement — a common theme across case studies. This was of particular concern when multiple funding streams were managed differentially by separate state programmatic units that sometimes have vastly different administrative requirements. One interviewee characterized such impeding processes by the state not as maligned but more of a complexity realized downstream as issues which “diffuse down locally that become time consuming.” An example of this offered by an interviewee was the challenge related to accounting practices were adjusting or correcting reporting often results in even greater expense than the initial discrepancy, with one interviewee offering a strong description of the challenge:

“If you’re off a penny, it takes you three hours to correct that single penny.”

A prominent theme from the interviews is the perceived inflexibility of funding uses and requirements — another common theme across case studies. This was widely held as a clear barrier to achieving the goals of the original cooperative agreement as well as local population health goals. One interviewee reported that the use of promotional items like gift cards, considered to potentially be a strong incentive to community engagement, was not allowable according to pass-through grant restrictions which limited options for community health improvement.

Because of the perceptions of inflexibility and insufficient funding, multiple interviewees noted that their health department and others have considered refrain-

ing from applying for certain future grants. This situation was summed up as:

“...eventually, you know, that dog doesn’t hunt.”

Challenges with Managing Cooperative Agreements

- Perceptions that deliverables were devised to meet the State’s administrative needs, rather than programmatic goals.
- For reimbursement-based grants, necessary expenditures may be encumbered for an extended duration or deemed ineligible for reimbursement, causing unanticipated budget deficits or losses.
- Shifting scope, requirements, or administrative guidance from the State has led to duplication of efforts, wasted time, and ineffective planning.
- Perception that site received insufficient funding to deliver on agreement terms and conditions.
- State funding sources, such as those included in aid-to-local agreements, disallowed budgeting for indirect costs—unlike in the federal agreements.
- Elevated administrative burdens constrained human resources, such as when time spent making State-required accounting corrections cost more than would be received via the correction.
- Strict terms and conditions, such as restrictions on activities or spending, impeded professional judgment—to the detriment of program plans.
- State funding sources, such as those included in aid-to-local agreements, disallowed budgeting for indirect costs—unlike in the federal agreements.

Other Findings

Of note, the case site had a prior directly funded federal grant, the Carol M. White Physical Education Program (PEP) grant, which they contrasted with cooperative agreements passed through the state. Their experience with direct federal grants was positive and was favorably referenced by multiple interviewees. One interviewee noted the ease in managing a direct grant such as the PEP, a non-deliverable grant, in which

“... [federal program officers] told you what to do and we just did it.”

Another interviewee greatly favored direct grants, stating that working with those grants offered “...more flexibility and efficiency...” than with pass-through grants and may offer more money with less layers of bureaucracy. A substantial component of this is the ability to apply funds toward indirect costs, often not allowable in pass-through arrangements. An example from one interviewee described the impact as

“[an indirect rate of] ten percent of \$3 million over that time would give \$300 thousand to inject into our infrastructure to help support advancement.”

So, there was a general perception among interviewees that more funding was available with the PEP grant relative to the expense of deliverables and other requirements. The funding was also viewed to be readily available, in contrast to the reimbursable grants which run the risk of delayed payments and instances of encumbering expenses for extended durations.

Lessons Learned and Recommendations

Lessons Learned

Multiple interviewees indicated that the original cooperative agreement is not often shared with the pass-through application or agreement but described favorable arrangements in which having clarifications on the intent of requirements led to a more positive attitude toward belaboring them. This suggests that there would

be a benefit to knowing the original goals of a given cooperative agreement and obligations of the state receiving the award.

It appears that federal-to-state agreements with less administrative requirements or restrictions which may flow down to subawardees, such as containing provisions which prohibit certain instances of layering add-on requirements by the state, are favorable toward achieving program goals. Similarly, benefits may be achieved when the state may have a consistent, coordinated strategy for grant management among programmatic units within the state that each manage federal pass-through grants.

Interviewee Recommendations

Interviewees shared many different recommendations to improve current paradigms and systems. In general, each of the interviewees held a similar vision for successful grant awarding and requirements, suggesting that a flexible funding paradigm, supportive of local priorities and strategies, and possessing a simpler or uniform administrative reporting structure may allow for improved efficiency and effectiveness. This vision may necessitate federal and state coordination and enhancements to local flexibility and delivery.

Several interviewees recommended that grant-makers consider rewarding recipients or subrecipients for innovative practices that enhance impact as an additional aim to incentivize and maximize achievement. An ideal paradigm would be one described by an interviewee in which flexibility would allow for opportunities such as for:

“health educators that are not tied to a grant, but are general-funded and can do tobacco one day (and) can do [vaccination] education another day...”

Multiple interviewees had recommendations for states to offer additional flexibility with pass-through and other state funding. A purpose for this would be to allow funding to be allocated toward local priorities such as strategies for community health improvement plans, to bolster core public health services, or to improve social determinants of health. Further, when states may bundle together funding streams within award packages to

localities, local input should help to guide development of deliverables or performance against the goals of the package. Such processes may be suggested to:

“...start somewhere where that money can go to address the community health improvement plan, which may be different or completely separated from the core of the grants.”

In addition to recommendations for federal or state grants to have enhanced flexibility, one interviewee also suggested that unspent award funding remaining after deliverables have been successfully completed early be able to be allocated toward local priorities; consideration of bonuses like those offered in private sector agreements would also be beneficial. This may necessitate local policymaker support and refraining from “sweeping funds” into the local general fund.

Future Research

The present study offered a brief investigation of funding and requirements paradigms for a county health department in the Midwest region of the United States, serving a semi-urban population greater than 200,000. The narrow scope of the investigation allows future research opportunities regarding additional cooperative agreements and jurisdictions. Additional investigations should be directed toward the amount of funding versus obligations or deliverables at each level for cooperative agreements. For instance, multiple interviewees described an interest in understanding the original cooperative agreements and amount of funding received by the state from federal sources in contrast with the subawarded funding and associated obligations.

Appendix — Methodology

Research Questions

The research for this case study was guided by three questions:

1. What typical facilitating and impeding requirements exist for subrecipients of federal pass-through funding?

2. How may facilitating and impeding requirements influence achievement of cooperative agreement goals?
3. How may added requirements affect achievement of cooperative agreement goals?

Research Design

These research questions guided our selection of a mixed-methods research design in which we solicited feedback from public health practitioners and regarded cooperative agreement and contractual documentation. We selected four case sites representing different geographic areas of the United States and different size and demographics of local public health jurisdiction, though one of the sites was unable to fully participate and three case studies were completed. In lieu of a structured interview protocol, we utilized an informal interview format that allowed participants flexibility in their responses. With consent, interviews were recorded by the Zoom communications platform for research purposes.

Data Collection Methods

We conducted semi-structured interviews with available staff, including top executives, financial officers, and program supervisors. Each interview was approximately one hour in length with the opportunity for a shorter follow-up interview. Case sites also agreed to provide different documents which contained agreement terms and conditions, continuing guidance, and other requirements. Documentation included award agreements and addenda, local applications for state funding, and audit statements. We also obtained federal cooperative agreement notices of funding opportunity (NOFOs) that described recipient requirements incorporated into NoAs.

Data Analysis Methods

Recorded interviews were transcribed, and original media and transcriptions were loaded into NVivo 12 Plus. A coding infrastructure was developed to classify interviewee statements related to experience with different funding sources, contractual requirements, grant management activities, interviewee recommendations to change funding or requirement paradigms, and other topics. Key themes from these qualitative data were used for discussion.

Contractual requirements were extracted from submitted documents and summarized for up to three cooperative agreements per case site. Requirements were classified uniquely according to type of requirement, entity(ies) requirement applied to, and source of requirement. Additional information was extracted for each requirement, such as specific text of the requirement and the location of the requirement within the document. Flow-down and add-on requirements were analyzed to determine the relationship between cooperative agreement terms and conditions and resultant local requirements (see [Figure 1](#), [Figure 2](#), and [Figure 3](#)). Sankey diagrams were created to illustrate the flow of requirements from federal to local levels.

References

1. 31 U.S.C. 6305 - Using cooperative agreements. In. 31 - *Money and Finance*. 2010 ed: U.S. Government Publishing Office; 2010.
2. Office of the Assistant Secretary for Resources and Technology. *HHS Grants Policy Statement*. Rev. Jan. 1, 2007. ed. Washington, D.C.: U.S. Dept. of Health and Human Services; 2007.

July 2021

This project was supported by the Center for State, Tribal, Local, and Territorial Support and (CSTLTS) within the Centers for Disease Control and Prevention (CDC) under grant number 6 NU38OT000306-03-01, Strengthening Public Health Systems and Services through National Partnerships to Improve and Protect the Nation's Health. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by CDC or the U.S. Government.

Thank you to the following individuals who contributed to the development of this report:

Steve Reynolds, Deputy Director, CSTLTS, CDC

Chelsea Payne, Associate Director for Management, CSTLTS, CDC

Liza Corso, Senior Public Health Advisor, CSTLTS, CDC

Doha Medani, Public Health Advisor, CSTLTS, CDC



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