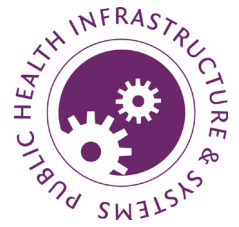


CASE STUDIES IN COOPERATIVE AGREEMENT REQUIREMENTS

CASE STUDY #1



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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 other 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 #1

Introduction

The present case site is a multi-county health department in the Southeast region of the United States, serving a largely rural population greater than 200,000. The department 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, prenatal and post-birth support, and child health services. Services are generally provided by the health department with few subcontractor agreements.

Activities are funded through a mix of local, state, and federal funding streams. Grant awards constitute greater than one-half of revenues with more than one-tenth of revenues as federal cooperative agreement funds. County taxes are a modest source of flexible funding, near one-fifth of revenues, and allow expenditures toward locally important priorities. There has been a decreased interest over time in pursuing 'optional' grants passed through the state as it is perceived that administering those awards is more costly than benefits received, with respect to level of funding.

General Circumstances of Requirements

Within this case study, a primary focus was placed on general experiences of the case site regarding agreement requirements. Interview questions and desk review of agreement documentation also focused on several specific cooperative agreements 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) *Tuberculosis Elimination and Laboratory Control* (TB), CDC-RFA-PS20-2001.

Each are regularly occurring federally funded programs. 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 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 while the TB cooperative agreement requires community disease control and treatment performance. Deliverable requirements often involve monthly, annual, or mid-point reporting, with some programs reporting on multiple funding streams according to differing schedules. This reporting tracks data elements from the same program but by different perspectives, such as general performance versus policy systems and environmental change.

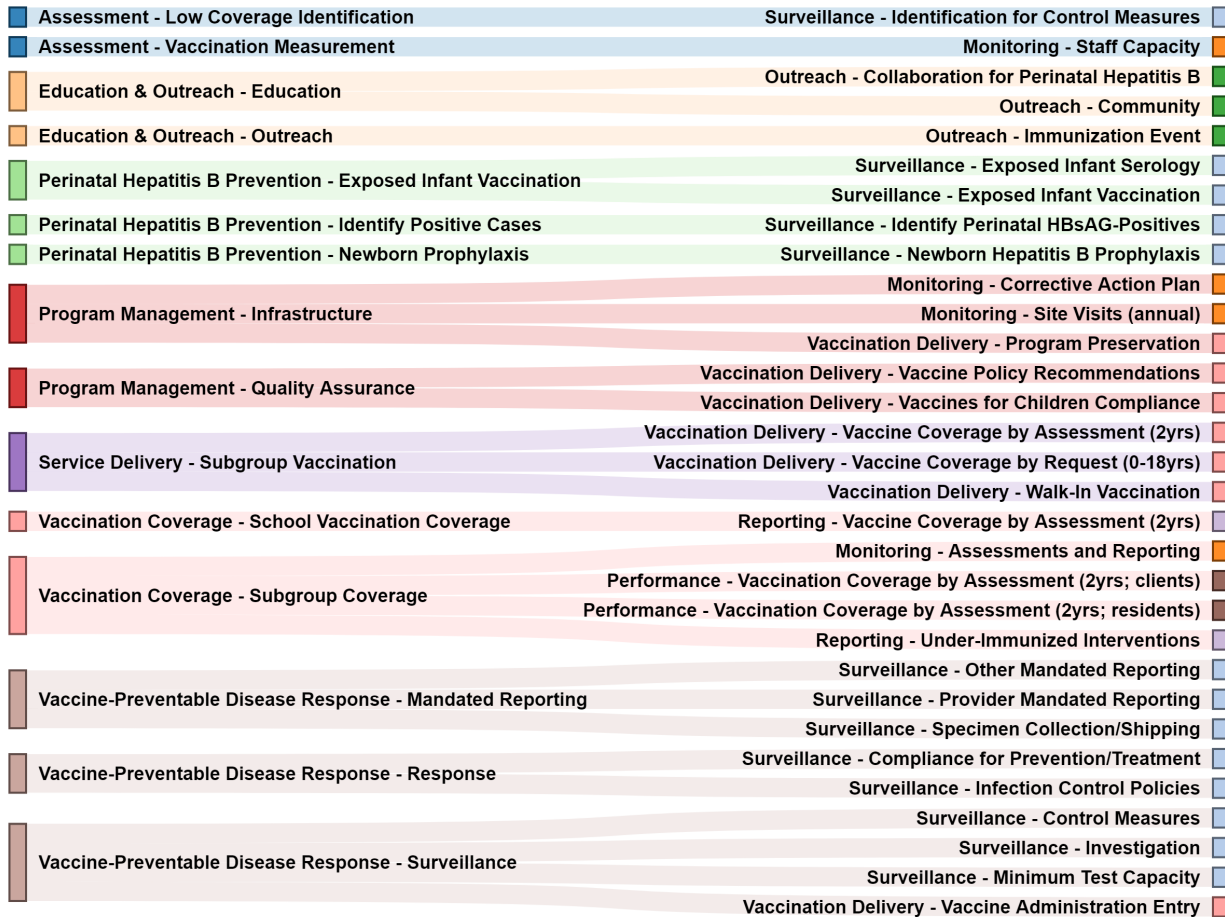
Cooperative Agreement Requirements

Immunization and Vaccines for Children

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 200,000 for less than \$40,000 annually, supporting less than 1 full-time equivalent (FTE). Some expected activities are time- and resource-intensive, such as hosting reoccurring site visits or facilitating jurisdiction-wide vaccine coverage assessments for children and adolescents. The IMM-VFC program possesses a variety of challenging elements such as coordination across multiple public health programs — including encouragement of recommended vaccinations during maternal health visits — engagement with local physicians to increase the administration of vaccinations, and the need to provide for and maintain equipment for drugs procured as a part of Section 340B of the federal Public Health Service Act.

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 2019.

Public Health Emergency Preparedness

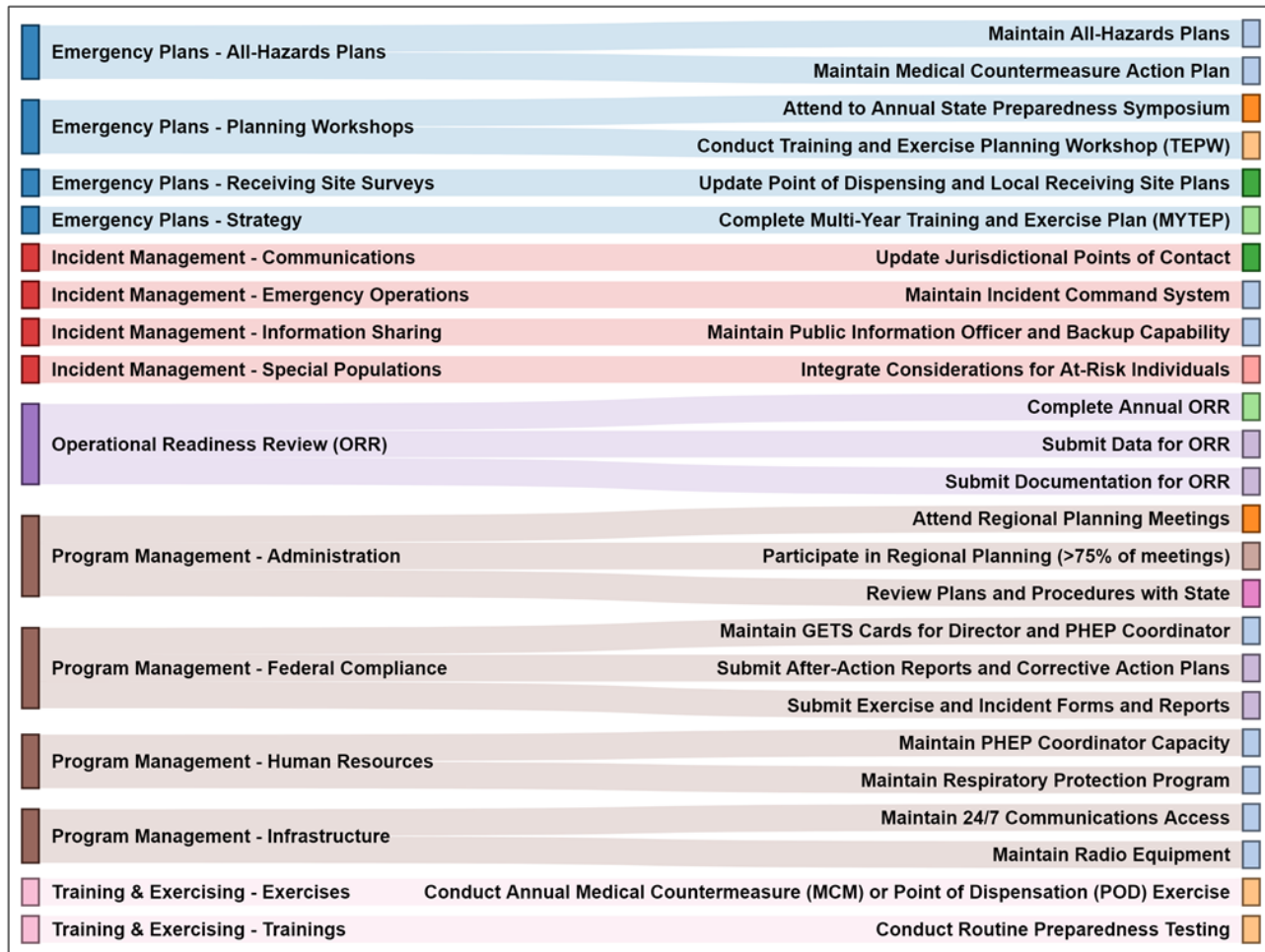
The PHEP cooperative agreement, similarly, was perceived as underfunded versus contractual obligations. The terms and conditions passed through the state to the local jurisdiction for the PHEP agreement (right of Figure 2) were to be delivered across the same population but for less than \$40,000 annually, also less than 1 FTE. Obligations for this agreement ranged from routine administrative and planning activities to annual exercise requirements and operational readiness reviews (ORRs), that may likely be of considerable expense beyond that reimbursable through the grant. A population health program such as PHEP has expansive requirements for planning and preparedness as well as demonstration of those activities, each of which are challenging to accomplish with less than 1 FTE of time over a year.

Tuberculosis Elimination and Laboratory Control

The TB cooperative agreement services (right of Figure 3) were to be delivered across the same population but for approximately \$20,000 annually with some significant variations. Obligations for this agreement were viewed to be minimal, ranging from population-based infection control. Of interest, the federal funds associated with the pass-through funding from the state were observed to be less than \$100 in some budget periods while the contractual obligation retains the same provisions for periods with higher performance requirements.

Figure 2.

Sankey diagram of Public Health Emergency Preparedness cooperative agreement (CDC-RFA-TP17-1701) 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 200,000 residents.*



Note: Funding total included in figure label is approximation from federal awards pass-through reporting for fiscal year 2019.

Perceptions on Requirements

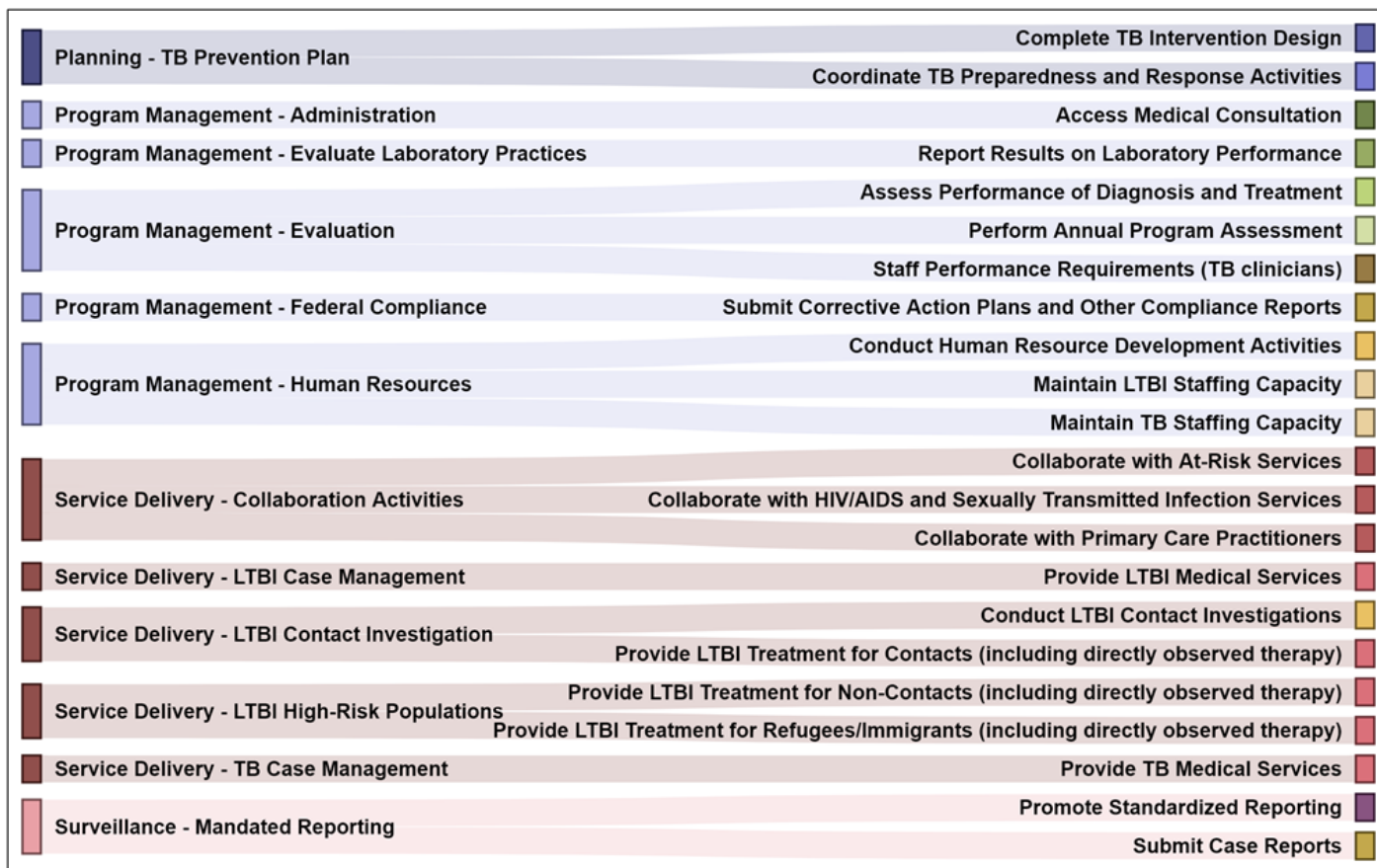
How Achievement May Be Facilitated

Interviewees acknowledged beneficial requirements or those believed to facilitate achievement of objectives of subawards passed through the State. Though few examples were successfully elicited within interviews, some requirements were perceived by interviewees to facilitate successful achievement of the initial cooperative agreement goals or objectives were benefits, such as alignment to state fiscal year (versus the federal fiscal year) or performance metrics serving the “big picture” which were less prescriptive or onerous. Interviewees felt that particularly effective arrangements were those

in which adequate funding was available for specific metrics that also included an attainable timeline. There was a general agreement that it is reasonable to have stipulations for how services such as family planning, child, and maternal health are delivered.

Figure 3.

Next page, Sankey diagram of Tuberculosis Elimination and Laboratory Control cooperative agreement (CDC-RFA-PS20-2001) requirements (left) and state-local agreement requirements (right); *approximately \$20,000 in annual pass-through funding for a program serving a combined population greater than 200,000 residents.*



Note: Funding total included in figure label is approximation from federal awards pass-through reporting for fiscal year 2019.

Additionally, grants such as the TB cooperative agreement appeared to be received favorably due to the long-term receipt of grants for tuberculosis control and consistency of obligations over time.

Adding Layers of Complexity

Interviewees acknowledged the necessity of requirements and how they may arise from each different funding source but that the intertwining of funding strings adds complexity; so much so that one interviewee noted the perception that there is: “more complexity” in public health than in their previous employment sector in the banking system.

Duplication of Efforts

An additional challenge with the IMM-VFC program is duplicative data entry into different systems for client health records, immunization registry, surveillance systems, and other program-specific systems as required by the state. To make matters worse for the agency, at the

time of interview, the respondent noted that they had become aware of an additional state-sponsored tracking system for entering electronic disease surveillance information that may be relevant for COVID-19, described as:

“another system as yet to be rolled out...to be trained on...so, it literally is double-entry...”

How Achievement May Be Impeded

Micromanagement of fund activities was held as a primary factor to impeding achievement of cooperative agreement goals or objectives. Further complication ensued when funding was bundled from multiple State administrative units which contained different managers with their own, and often competing, priorities. One respondent summarized the issue in the following way:

“I think micro-managing any of the programs and their dollars is very unhelpful. I think very often we lose sight of why we're doing a program.”

Interviewees reported obligations that were overly onerous or impeding to the objectives of subawards passed through the State. Elevated reporting burdens and human resource allocations were frequently cited as a key barrier to achievement — a common theme across case studies. This issue was noted by multiple respondents in a variety of forms. A key example is in double entry of data, either being requested by separate administrative units at the State or required to be entered into separate State-stewarded information systems. Several respondents also noted resource intensive and burdensome requirements of budgeting “at the person level.” This is further complicated for reimbursement-based grants that require accounting at the person level and often lead to budget revisions in which one person cost slightly less than anticipated while another may have cost slightly more.

Other Findings

Other notable findings were obtained beyond those described above. First, multiple concerns were raised that there was little transparency regarding the origins of agreement provisions and staff are generally unable to distinguish which requirements flowed down from the NOA to the State and which were additional requirements devised by the State, itself. Similarly, there was little transparency in how federal funding received by the state is equitably distributed, prompting one interviewee to speculate:

“I don't know whether we're getting everything we should or whether it's being siphoned off as its coming downstream.”

Next, the type and number of administrative requirements present within agreements caused pass-through funds to be viewed less favorably. Local funding, however, was viewed most favorably because there were fewer “strings attached.” There was a strong perception at the agency that certain grants are underfunded versus the contractual obligations, such as the IMM-VFC grant.

Of note, this case site had extensive experience with non-State, third-party organizations serving as intermediaries in grant management. These arrangements typically presented in the form of the third party as the subrecipient of federal funds and acting as the fiscal and contractual agent with the local health department while data reporting was to the State. Interviewees

Tuberculosis Elimination and Laboratory Control

The local health department typically receives approximately \$20,000 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 active and latent tuberculosis infections with activities such as (but not limited to):

- Perform disease surveillance and case reporting functions across the service area.
- Directly observe the treatment of patients with active and latent TB infections (refugees/immigrants, high-risk contacts, other persons).
- Administration of immunizations and facilitate quarterly immunization events.
- Engage with area providers to enhance surveillance operations and adherence to treatment.
- Coordinate preparedness and response activities across jurisdictions.

described, at best, a confusing communication pathway and, at worst, a substantial administrative burden in meeting the third party's reporting requirements that often conflicted with the State's reporting requirements. Financial reimbursement was also described as unnecessarily lengthy and fraught with challenges, especially given that in some contracts the third party can request payments be returned at any time. The experiences by the local health department suggest that these third-party intermediaries may be more likely to create barriers to achievement of the original cooperative agreement due to the additional bureaucracy and competing priorities by the third-party organization.

Finally, it was notable that the health department's experiences with direct fund agreements (versus those passed through the State) were positive. Though the health department did not possess a direct federal agreement at the time of interviews, interviewees described prior arrangements. Direct federal arrangements were viewed more favorably due to the perception that a higher amount of funding would be available and, more importantly, that indirect costs could be covered (typically lacking in State aid-to-local agreements). In

cases of both local tax and direct federal funding, the funding streams offered more transparency and there were more clear linkages between intent of funding provided and the requirements associated with those funds.

Lessons Learned and Recommendations

Lessons Learned

Multiple themes were observed across the different interviews. The most prominent theme from the interviews was the perceived inflexibility of funding uses and requirements from cooperative agreement pass-through funds. This was widely held as a clear barrier to achieving the goals of the original cooperative agreement as well as local population health goals. As an example, one interviewee described a requirement to use standardized assessment form in certain situations. The strict adherence to the form and narrow set of questions did not provide an opportunity for the use of “clinical judgment to determine what needs to be asked and evaluation and dug deeper on.” The inflexibility posed by the requirement impedes an individualized approach to patient care.

A second prominent theme from the interviews was a perception that the level of funding awarded may often be insufficient to deliver or subcontract delivery of the obligated activities. Even more troublesome is when small dollars are also accompanied by overly prescriptive spending conditions, such as restricting from spending on staff time (often a critical expense).

Because of the perceptions of inflexibility and insufficient funding, some “optional” grants — non-mandatory State or pass-through grants — are not considered for application by the local health department. An example of the thought process for this consequence is summed up by one interviewee:

“Could we provide better care cheaper by not following the requirements and not accepting the money? But we’re, I think, so afraid because our budget is so small, of taking that risk, that we just kind of stick with the status quo.”

Interviewee Recommendations

Interviewees generally believed that the intent of the funding was to enable achievement of individual or population health outcomes. Regarding the latter, interviewees desired to have outputs from grants to illustrate “the story” of big picture outcomes, exemplified by one interviewee:

“...I value very much the work that our incredibly dedicated, underpaid workforce accomplishes...it would be nice to find a way to tell the story of costs to do public health well and Public Health 3.0 in particular without making it sound like frivolous government.”

Multiple interviewees indicated that the original cooperative agreement is not often shared with the pass-through application or agreement and suggested that there would be a benefit to knowing the original goal of the cooperative agreement and obligations of the state receiving the award. Some discussion suggested that improving reporting relationships would be beneficial and that a more direct relationship with the funder (fewer intermediaries and bureaucracy) would be preferable, if possible. Though one interviewee acknowledged the reality that the federal government “has to go through somebody” and that the federal government cannot directly grant all local awards, a strong preference exists to prevent there being “a different (intermediary) for every pot of money.”

One interviewee felt strongly that primary intents of many administrative requirements — prevention of waste, fraud, and abuse — could be streamlined through mechanisms such as requiring and acknowledging staff credentialing, requiring independent financial audits, reduced oversight of accredited health departments, etc.

Future Research

Additional investigations should be directed toward the amount of funding versus obligations or deliverables at each level for cooperative agreements. Questions remain unanswered regarding the how achievement of agreement goals may be associated with types of activities or level of effort versus the amount of funding awarded.

Additionally, the future case studies would benefit from having a better perspective on behalf of the state or any third parties, including how funds are subawarded or retained. 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. 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.

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