CASE STUDIES IN COOPERATIVE AGREEMENT REQUIREMENTS

CASE STUDY #3

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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 performed, collaborative efforts, necessary performance, and other processes or outcomes expected to achieve the purpose and goals of the cooperative agreement. Generally, 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 as a means 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.

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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 #3

Introduction

The present case site is a local health department serving an urban population greater than one million. The department is accredited by the Public Health Accreditation Board (PHAB) and offers a multitude of clinical and population-based services to their local communities. The department delivers a wide range of services across domains of infectious disease control, environmental public health, chronic disease and health behaviors, clinical care, and addressing the social determinants of health.

Funding for activities within the jurisdiction arises through many different sources. Local taxes are the most substantial source of funding and offer great flexibility in governmental activities. Grants and other contributions make up nearly one-third of revenues for governmental activities. The remaining one-fifth of revenues arise out of charges for services which contribute primarily to business activities. Most public health services are delivered through shared service contracts with vendors and other contractors in the area, with the health department serving as the pass-through entity for some federal cooperative agreement funds.

General Circumstances of Requirements

A primary focus of interviews with the case site was to understand interviewee perceptions on a primarily direct funding relationship with the federal government, contrasted with services necessarily passed through the state government (e.g., public health preparedness funds). Interviews had aims of discussing contrasts observed between direct and pass-through funding relationships. Interview questions and desk review of agreement documentation also focused on several specific cooperative agreements and grants for a more in-depth investigation:

1) *Integrated Human Immunodeficiency Virus: Surveillance and Prevention* (HIV), CDC-RFA-PS18-1802.
2) *Public Health Emergency Preparedness* (PHEP), CDC-RFA-TP17-1701.
3) *Epidemiology and Laboratory Capacity for Infectious Diseases* (ELC), CDC-RFA-CK19-1904.

Each of the first two are regularly occurring federally funded cooperative agreement programs while the final ELC grant relates an existing federal program with special crisis funding made available to address the SARS-CoV-2 (COVID-19) pandemic. Requirements for the HIV and ELC agreements, through their respective NOAs, were directed to the jurisdiction ("recipient"). Requirements for the PHEP agreement, also through its respective NOA, was directed to the state ("recipient") and passed through to the jurisdiction. All requirements obligated specific administrative processes, programmatic activities, and expected performance.

Cooperative Agreement Requirements

Integrated HIV Surveillance and Prevention

The largest program that passes funds to sub-recipients or subcontractors is the HIV prevention program. Different federal awards are directly received by the jurisdiction, from which multiple service organizations receive funds to deliver services across an expansive region. A main challenge with this paradigm is that, with multiple funding streams arising from different programmatic sources, there may often be a "lost perspective on what the overall objective of" awards received when such a variety of organizations are involved in service delivery. The summarized terms and conditions of the HIV agreement from the CDC (**Table 1**) were to be delivered across a total population greater than one million for greater than $5 million annually.

Table 1.

Summarization of requirements for the Integrated HIV Surveillance and Prevention cooperative agreement (HIV) through the direct federal arrangement for calendar year 2020; *greater than $5 million in annual federal direct funding for a program serving a total population greater than one million residents.*

Surveillance & Case Identification	Programmatic Infrastructure	Community Partnerships
Medical and Laboratory Case Identification	Improve Testing and Treatment Capacity	Provide Community Prevention Campaigns
Data Collection and Integration	Enhance Integrated Information Systems	Support Needle Exchange Programs
Routine Data Quality Review	Maintain Programmatic Compliance	Support Condom Distribution Programs

Prevention Services	Planning & Preparedness	Capacity-Building & Technical Assistance
Viral Suppression for Diagnosed Persons	Maintain Detection and Response Plans	Offer Trainings and Technical Assistance
Preexposure Prophylaxis for HIV-Negative	Enhance Response Capacity	Enhance Geographic Mapping Capabilities
Conduct Targeted Perinatal Testing	Develop Work Plans	Link and Analyze Data Sources

Note: *Table created from Integrated HIV Surveillance and Prevention Programs for Health Departments funding opportunity announcement (CDC-RFA-PS18-1802). Funding total included in table label is approximation from approved funding.*

Public Health Emergency Preparedness

The largest program that passes funds to sub-recipients or subcontractors is the HIV prevention program. Different federal awards are directly received by the jurisdiction, from which multiple service organizations receive funds to deliver services across an expansive region. A main challenge with this paradigm is that, with multiple funding streams arising from different programmatic sources, there may often be a "lost perspective on what the overall objective of" awards received when such a variety of organizations are involved in service delivery. The summarized terms and conditions of the HIV agreement from the CDC (Table 1) were to be delivered across a total population greater than one million for greater than $5 million annually.

ELC for Infectious Diseases: COVID-19

The jurisdiction, due to its population size, has received many different crisis funds over the years. With the 2020 coronavirus pandemic, funding was first made available to the ELC program for COVID-19 through the *Coronavirus Aid, Relief, and Economic Security Act of 2020* (the "CARES Act"). A subsequent and much larger grant made available through the *Paycheck Protection Program and Health Care Enhancement Act of 2020* ("Phase 3.5 appropriation") focused on "enhancing detection." Both grants have been subject to repeated revisions. The funds support a vast array of activities to prevent, track, mitigate, and inform on SARS-CoV-2 infections within the jurisdiction. Substantial reporting requirements are in place with both ELC grants and each funding stream has its own reporting pathway. The summarized terms and conditions of the ELC agreements from the CARES Act (Table 2) and the Phase 3.5 appropriation (Table 3) were each to be delivered across a population greater than one million for greater than $2 million (spent over 24 months) and $50 million (spent over 30 months), respectively.

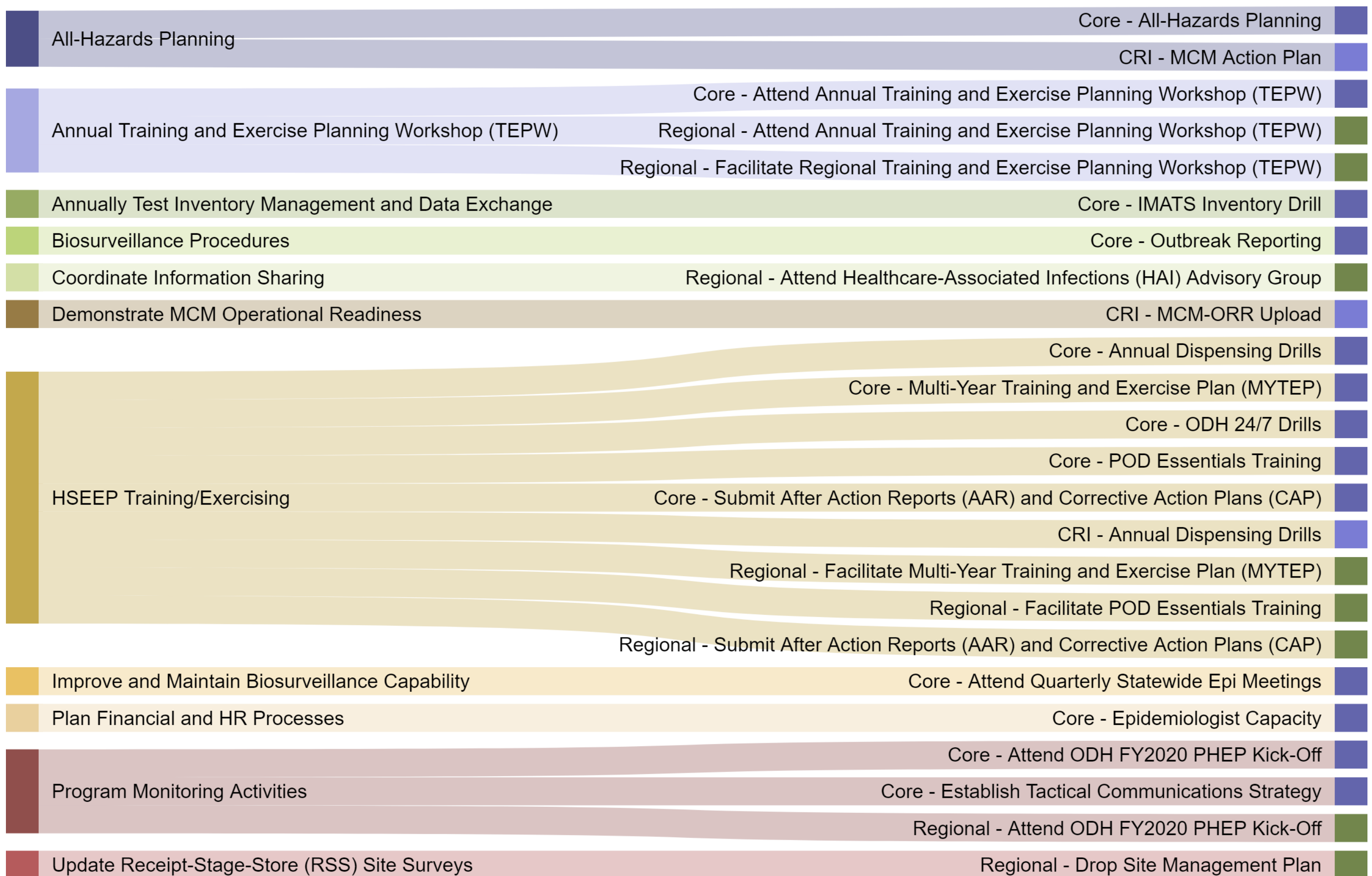
Experience with Direct Funding Arrangements

A clear benefit of direct funding is an enhanced level of funding versus awards from a pass-through entity. One such benefit is that direct federal funding agreements allow the jurisdiction to budget or charge for indirect costs which may not be allowable with other arrangements. Though completely appropriate for an entity to retain a portion of pass-through funds to cover expenses, some conflicts arise with the sub-recipient in believing that too much funding may be withheld. A strong perception was shared by an interviewee that their state may go "overboard" in retaining funds and may use the funds as a means of "backfilling the state's general fund," potentially leading to a dramatic "disinvestment from public health at the state level."

Communicating with different teams or programmatic units often leads to what seems to be different streams of information that do not appear to be "fully aligned." Further, directly funded arrangements are favorable to pass-through arrangements in that activity and reporting timeframes are relaxed and there is a less burdensome clearance process for funding and reporting. Direct awards are generally considered to be bureaucratically simpler and faster in administration, having "cut out a lot of middlemen." For these reasons, the jurisdiction prefers direct federal awards.

Figure 1.

Sankey diagram of Public Health Emergency Preparedness cooperative agreement (CDC-RFA-TP17-1701) requirements (left) and state-local agreement requirements (right); *approximately $1,000,000 in annual pass-through funding for a program serving a population greater than one million residents.*



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

Table 2

Summarization of requirements for the COVID-19 CARES Act supplement; *greater than $2 million in federal direct funding for a program serving a total population greater than one million residents.*

Support Infection Prevention Efforts	Enhance and Expand Laboratory Testing	Maintain Situational Awareness
Assess and Monitor Healthcare Infections	Expand Symptomatic Testing Capacity	Assess and Monitor Availability of Resources
Infection Prevention in High-Risk Healthcare	Expand Serology Screenings *(past infection)*	Leverage Data to Monitor Local Operations
Infection Prevention for High-Risk Employers	Automate Testing and Data Reporting	Monitor At-Risk Populations

Improve Surveillance and Reporting		
Establish / Enhance Community Surveillance	Track and Report COVID-like Illness Cases	Monitor Cases in Connected Jurisdictions
Establish / Enhance Local Case Reporting	Track and Report COVID-19 Deaths	Monitor and Report Daily Incidence Rate

Note: *Table created from the CARES Act supplemental ELC funding opportunity announcement (CDC-RFA-CK19-1904). Funding total included in table label is approximation from approved funding.*

Table 3

Summarization of requirements for the COVID-19 Phase 3.5 supplement; *greater than $50 million in federal direct funding for a program serving a total population greater than one million residents.*

Enhance Local Capacity	Enhance and Expand Laboratory Testing	Collaborate with Local Partners
Train and Hire Critical Staff	Establish / Expand Rapid Testing Capacity	Coordinate with Federally Funded Partners
Enhance Prevention and Response Capacity	Enhance Local Testing Capability	Partner to Enhance Lab Capacity
Enhance Data Management and Reporting	Enhance Analytics and Reporting	Partner to Enhance Infection Control Efforts

Enhance Investigative Capacity	Improve Surveillance and Reporting	
Utilize Laboratory Data for Response	Enhance Local Information Systems	Track and Report COVID-like Illness Cases
Conduct Contact Tracing and Containment	Establish / Enhance Local Case Reporting	Track and Report COVID-19 Deaths
Identify High-Risk Exposures and Cases	Establish Automated Electronic Reporting	Monitor and Report Daily Incidence Rate
Prevent Exposures in High-Risk Settings	Expansion of Data Elements Reported	

Note: *Table created from the Phase 3.5 supplemental ELC funding opportunity announcement (CDC-RFA-CK19-1904). Funding total included in table label is approximation from approved funding.*

Perceptions on Requirements

How Achievement May Be Facilitated

Interviewees appreciated the lack of 'nit-picking' and enhanced flexibility with the directly funded arrangements. The periodicity of reporting may be more beneficial with direct federal grants than pass-through grants in that quarterly or annual reporting may be more likely. The interviewees acknowledged that, generally, terms and conditions associated with funding opportunities tended to facilitate successful completion of program goals.

Burden of Administration

In general, interviewees acknowledged a substantial load of reporting requirements that could become burdensome. As mentioned with the PHEP cooperative agreement, work plans lead to considerable administrative reporting in that there are typically several work plan activities that require planning and procedure development. Other administrative burdens occur with lengthy evaluation planning and tracking, especially frustrating with unclear instructions or templates that are difficult to work with.

A notable barrier to achieving overall goals of a program is when the agreement terms require budgeting and accounting of personnel time and specific materials in reimbursement-based grants. An interviewee explained that, when activities deviate from initial budget, additional time must be spent reconstructing those changes when requesting reimbursement. The federal direct grants, however, were noted as having enhanced flexibility to move funding across line items, providing a better opportunity to use the total amount of funds that were awarded and to use them in a timely manner. This contrasts with state processes that may be much more scrutinized and delayed.

Duplication of Efforts

The case site, like many others, receives multiple different awards, sometimes bundled together. Each different award typically includes evaluative requirements, though, but not in alignment between funding streams. This often leads to duplication of efforts when similar data or different analytical outputs of data must be submitted to separate funders or through separate data systems. Another example of duplication occurs when multiple funding streams contribute to a shared activity and require separate reporting. As one interviewee described it:

> **"Everybody wants to know what their dollars are doing and, in many cases, it becomes a little arbitrary to decide, you know, what someone's dollar is doing or not."**

How Achievement May Be Impeded

A common condition of funding is that there are certain restrictions on what may be purchased with agreement funds. For example, the ELC cooperative agreement allows spending on vaccine operations but does not allow the purchase of the COVID-19 vaccine. A primary barrier to achievement is when the criteria for success change over time. This may occur when work plans are revised without respect to prior plans or when continuing guidance moves efforts in another direction. Frustrations also occur when funder methods are not transparent, such as how funding is distributed, and the amount of share allocated to the jurisdiction.

Subcontractor Arrangements

The site, being a direct recipient of many direct federal funds, serves as a pass-through entity for some of those funds. Multiple subcontractor arrangements have been in place to distribute funds, with some arrangements including multiple different subcontractors on a single contract. Each subaward or subcontract includes terms and conditions, however, these programmatic and financial provisions typically flow down from the funder and have few add-on requirements. This process was described by one interviewee:

> **"…we try to add as little as necessary… we may add some variables, but we really work on the principle here that we want as lean a data collection system as possible…as everything that applies to us applies to whoever we fund."**

A goal is to have few subcontractors but with those subcontracts including multiple aligned funding streams; this enables the added benefit of "being able to move money around within a contract." The jurisdiction provides almost no direct services and contracts out most programs. Examples include HIV/AIDS programming and preparedness and crisis funding. Programs such as Ryan White are subcontracted to providers to perform testing and medical care. PHEP funding has been provided to contractors to coordinate disaster planning and response, while crisis funding has been awarded to subcontractors to facilitate an expanded COVID-19 testing program.

Public Health Emergency Preparedness

The local health department typically receives around $3 million in federal pass-through dollars to provide population-based services for a population greater than one million to prepare for and respond to public health emergencies with activities not limited to:

- Strengthen community resilience in partnership with jurisdictional Health Care Coalitions (HCCs).
- Strengthen incident management processes with standardized incident command structures and response frameworks.
- Strengthen information management processes with enhancements to equipment, software, and partnerships.
- Strengthen surge management processes with community partners and Medical Reserve Corps (MRC) volunteers.
- Development of all-hazards and incident- or event-specific preparedness and response plans.
- Assessment of gaps according to Capability Planning Guides (CPGs) and Operational Readiness Reviews (ORRs).
- Provision of general and incident- or event-specific emergency operations trainings.
- Facilitation of routine testing and decision-making drills and annual exercises (such as countermeasure dispensation).

Other Findings

Data received by the site from subcontractors is analyzed and interpreted prior to being submitted to federal or state funders in reporting requirements. A complaint from interviewees is that data submitted to the state "only goes one direction" and is not provided back to the jurisdiction in a contextual or meaningful way. This is an issue as it not only indicates a lack of transparency but runs the risk of inhibiting evidence-based interventions for the jurisdiction among neighboring jurisdictions.

Lessons Learned and Recommendations

Lessons Learned

AA common theme across different interviews is the benefit of flexible funding, especially that which may be used to respond to emerging issues. The jurisdiction has observed that smaller jurisdictions with less local commitment to public health have weakened capacity to hire skilled professionals, so a stronger local fiscal allocation allows for enhanced public health infrastructure. This was described by one interviewee as:

> **"Things like that sort of core public health infrastructure is really funded by the CDC and if you're not lucky to be in a jurisdiction that has general fund… You're sort of up the creek with some of that core infrastructure."**

Interviewees from the case site seemed to identify less barriers to achievement for federally funded programs than other case sites. Though there are typical challenges associated with funding agreements such as the payment or reporting arrangements, this case site raised less issues related to burden of requirements. This may be due, in part, to the higher proportion of directly funded cooperative agreements which avoids contention associated with adhering to add-on requirements or perceptions of program funding being "shaved off." The case site was an exemplar of how a reduction in intermediaries may be associated with more favorable perceptions of funding arrangements.

Interviewee Recommendations

One interviewee recommended that there be a more coordinated federal or state approach, to "think more globally" about how multiple funding streams are evaluated. This recommendation aimed to reduce the high administrative burden associated with the frequency of reporting but also duplication of efforts when reporting similar data elements to different governmental programmatic subunits. Multiple interviewees described interests in reforming data submission paradigms to reduce administrative complexity but also enhance use of submitted data.

As mentioned previously, several interviewees suggested that flexible funding, primarily from a strong local fiscal allocation, is key to maintaining a capable public health infrastructure. There are clear benefits of flexibility, such as:

> **"… the ability to move funds without always having to do a budget redirection. Being able to, you know, just use reasonable judgment to respond to things as opposed to having to ask for permission first, every time there's something new that needs a response."**

A strong theme of flexibility was communicated by interviewees as it could allow for local decision-making and prioritization of activities to achieve desired population health outcomes.

Lastly, regarding cooperative agreement funds, one interviewee suggested that additional process allowances be available for budgeting or reimbursement, such as no cost extensions for remaining expenditures below a certain threshold or shorter turnaround times for budget adjustments. Each process allowance may serve to enhance achievement of program goals. Similarly, one evaluation recommendation by an interviewee was design sets of performance metrics to be more streamlined, for example with contract tracing where monthly metrics may conflict with quarterly or bi-annual reporting timeframes.

Future Research

The present study offered a brief investigation of funding and requirements paradigms for a local health department serving an urban population greater than one million. The case study offered a strong illustration of how direct funding arrangements may be perceived and contrasted with pass-through arrangements. 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.

Recommendations for Improvement

- Federal grant-makers and State pass-through administrators should respect and support local priorities and strategies and allow for a more flexible funding paradigm and should consider incentives for innovation and achievement.
- State pass-through administrators should consider unification of sub-award administration to ensure a consistent, coordinated management strategy.
- Federal grant-makers and State pass-through administrators should respect and support local priorities and strategies and allow for a more flexible funding paradigm.
- Federal grant-makers and State pass-through administrators should consider mechanisms to streamline requirements, such as performance metric reporting and associated timelines.

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**). Sankey diagrams were created to illustrate the flow of requirements from federal to local levels.

References

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