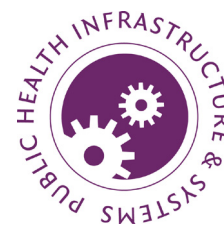


CASE STUDIES IN COOPERATIVE AGREEMENT REQUIREMENTS

PROJECT OVERVIEW

CASE STUDY #1



National public health funding is a complex network of funding streams and associated terms and conditions (“requirements”) that arise from government at all levels as well as private sources. Cooperative agreements are common in the federal government and may be directly awarded to local public health or “passed through” states and other entities. Notices of award (NOAs) and pass-through agreements often contain expansive lists of requirements to ensure efficient and effective uses of public money; these requirements are the focus of the project.

Researchers first reviewed NOAs and state-local (“aid-to-local”) agreements to identify specific requirements placed on the local health department through funding arrangements. Then, researchers distinguished those devised by the pass-through entity (“add-on requirements”) from those that originated in NOAs (“flow-down requirements”). Finally, selected key informants were interviewed to offer additional context for each case site.

Background on Case Site

The present case site is a multi-county health department in the Southeast region of the United States, serving a combined, largely rural population of greater than 100,000. 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 sub-contractor agreements.

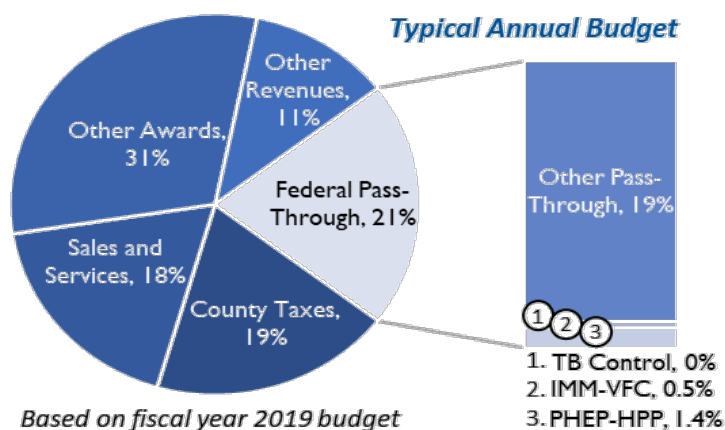
Activities are funded through a mix of local, state, and federal funding streams. Grant awards constitute greater than one-half of revenues with more than one-tenth

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 determined priorities. There has been a decreased interest over time in pursuing ‘optional’ grants passed through the State as it has been perceived that those awards may be more costly than funding may support. This may lead to less activity toward state or federal objectives.

Cooperative Agreements Reviewed

- Tuberculosis Elimination and Laboratory Control (TB) CDC-RFA-PS20-2001
- Immunization and Vaccines for Children (IMM-VFC) CDC-RFA-IP19-1901
- Public Health Emergency Preparedness (PHEP) CDC-RFA-TP17-1701

Local Context – Budget and Population



Population Estimate: >100,000 persons

Budget Estimate: \$6–7 million

Per Capita Estimated Funding Allocation of Reviewed:

1. TB Control: *negligible (insufficient to run program)*
2. IMM-VFC: < \$40,000 (<\$0.40 per capita)
3. PHEP-PHEP: < \$40,000 (<\$0.40 per capita)

General Circumstances of Agreements

Requirements of the federal cooperative agreements (i.e., NOAs) were generally directed to the recipient; the recipient of reviewed cooperative agreements was the State. The health department, though, was not involved with the State's initial award and had not seen those State-federal agreements. State aid-to-local agreements ("subawards") generally included requirements devised specifically for the local health department with few retaining the term or condition language from the State-federal agreement; NOAs were not attached to aid-to-local agreements. Further, aid-to-local agreements bundled together multiple federal awards in addition to being a vehicle for providing State funds to locals. Together, these factors presented a challenge for the health department in distinguishing flow-down requirements from State add-on requirements. This may have further exacerbated the health departments decreased interest in pursuing "optional" grants.

Perceptions on Requirements

Health department staff were interviewed about their experiences with public health funding and requirements associated with that funding. Conversations elicited perceptions on how federal pass-through awards differed from directly-funded arrangements as well as how different requirements facilitated or impeded achievement of objectives devised by the state and federal grantors.

How Achievement May Have Been Facilitated

Interviewees acknowledged where aid-to-local requirements led to success in objectives such as when reporting timeframes were able to be aligned to state fiscal year versus federal or with performance metrics the seemed less prescriptive or onerous and served the "big picture." There was an agreement among interviewees that it is reasonable to have certain terms and conditions with funding awards and that most have clear benefits.

How Achievement May Have Been Impeded

Interviewees described many instances of where aid-to-local requirements seemed to prevent achievement of goals. Much conversation related to perceived challenges in delivering on contracts. Generally, there

were many ways in which restrictions on funding use, addition of onerous reporting requirements, or other prescriptive terms or conditions presented barriers to achievement of the intended objectives. The following interviewee statements capture key barriers to achievement.

On micromanagement of funds:

"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."

On administrative burden of requirements:

[A new State-developed information system was] "another system as yet to be rolled out...to be trained on...so, it literally is double-entry..."

On level of funding versus required activities:

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

"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."

Other Findings from Interviews

Interviews with staff led to other findings related to funding and requirements that were notable.

Pass-Through Funds Were Viewed Least Favorably

Pass-through funds were poorly regarded due to the type and number of administrative requirements and were believed to be underfunded versus the contractual obligations. As an example, the IMM-VFC funds require population-based activities (for a population above 100,000), clinical vaccine administrations, and collaborations with local providers for less than one full-time equivalent of funding. In contrast, local funds were viewed most favorably due to fewer "strings attached."

Third-Party Intermediaries Present Additional Barriers

The case site had extensive experience with non-State, third-party intermediaries that acted as fiscal and contractual agents on behalf of the state. Concerns were

raised that the arrangement added confusion to the reporting pathways and fund objectives. It was noted that there were also instances of third-party reporting requirements conflicting with state reporting requirements. Lastly, financial reimbursement was also described as unnecessarily lengthy and complex, such that the intermediary could “claw back” funds with little rationale.

Lessons Learned

- Inflexibility of pass-through arrangements or overly prescriptive terms and conditions may prevent achievement and impede use of clinical judgment.
- The level of funding may often be insufficient to deliver services or to subcontract based on the load of terms and conditions; “optional” grants may receive less interest.

Recommendations

- Funders should provide recipients and sub-recipients with outputs or analyses from data submitted.
- Pass-through agencies should provide subawardees with the state-federal agreements and, ideally, identify the sources of terms and conditions contained within aid-to-local agreements.
- Administrative requirements should be streamlined (e.g., honor staff credentialing, reduced oversight of accredited health departments), especially with bundled funds by different state administrative units.

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, Pubic Health Advisor, CSTLTS, CDC



www.naccho.org



The mission of the National Association of County and City Health Officials (NACCHO) is to improve the health of communities by strengthening and advocating for local health departments.

1201 Eye Street, NW 4th Floor Washington, DC 20005

P 202.783.5550 F 202.783.1583

© 2021. National Association of County and City Health Officials