

State Perspectives  
on the  
Use of Fiscal Intermediaries

Association of State and Territorial Health Officials

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# Executive Summary

The CDC Foundation commissioned ASTHO in September 2009 to explore the mechanisms that states use to distribute and use public health funds and states' views about the benefits and challenges of using these various methods. Of particular interest to CDC is the states' use of bona fide agent arrangements as a strategy to expedite the dissemination of federal funds for state health programming.

In a bona fide agent (BFA) or designated agent arrangement, an organization designated by a state or locality as a BFA stands in the place of the health agency to receive the federal grant and implement the project awarded to it. BFA arrangements have been successfully used by some state and local health agencies as a way to more efficiently implement a federal (or state) funded program than may be possible within a state's administrative systems. BFA arrangements are contrasted with traditional contract arrangements in which the state health agency enters into an agreement directly with an organization to implement all or a portion of a public health program. Contracting is commonly and frequently used by the states. Organizations such as state public health institutes (PHIs), universities and non-profits have been used as BFAs and contractors. States have a range of experiences and perspectives on BFAs and contract arrangements. In this report, ASTHO is using the term "fiscal intermediaries" as an umbrella concept to collectively reference a range of financial mechanisms that states may use, including BFAs, contracts, subcontracts, grants and pass-through arrangements.

## Methodology

ASTHO used several methods to gather data for this report. The primary method was an electronic survey distributed to all state and territorial health agencies during October 2009. ASTHO received responses from 29 states and 1 territory. A subset of survey respondents from six states were identified to participate in post-survey key informant interviews. States were chosen for interviews to maximize variation on a number of factors: prior use or non-use of BFA arrangements; state size and geographic location; and the state's views about exploring the use of or expanding use of fiscal intermediary arrangements generally. Finally, ASTHO conducted a review of relevant scholarly literature, government publications and news sources.

## Summary of Findings and Conclusions

ASTHO's review revealed that state health agencies hold a variety of perspectives about BFA and contracting arrangements, and the opportunities for expanding the use of fiscal intermediary arrangements in the states.

***A few state health agencies have used bona fide agent arrangements; most have not.***

States have not widely used BFA arrangements. Yet among states that have used them, they report these relationships as generally beneficial to the state health agency. The primary benefit of BFAs identified was faster administrative processes. The dominant concerns voiced with using BFA arrangements are the lack of direct agency control over the federal funds awarded and the project outcomes by the BFA. A number of states interviewed strongly believed that government is ultimately accountable for the conduct and outcome of the BFA's work on public health issues within its state. Agencies view having more direct control over federal funds and project deliverables through contractual relationships as a preferred way to achieve the same ends as the BFA arrangement. Other states surveyed, however, have had very collaborative and productive relationships with organizations used as BFAs. Any federal efforts to aggressively promote the use of BFAs should be cognizant of these dynamics and consider ways to address states' concerns about control and accountability issues.

***Contracting arrangements are viewed as the preferred fiscal intermediary relationship.***

Contracting was by far the preferred method of state health agencies to distribute federal funds. This clear preference was shown in the number of states using the practice as well as the frequency with which contracts are used. Responding states reported overwhelmingly that contract relationships are beneficial to a health agency's ability to accomplish its public health mission by allowing the agency to retain control over how funds are spent and the outcomes achieved while gaining efficiency and accessing expertise not resident within the agency.

***Some state administrative policies can act as structural barriers to expanding the use of fiscal intermediary arrangements.***

Interviews with key informants revealed that state government policies and administrative practices may act as a barrier to greater use of various fiscal intermediary arrangements. Examples cited by interviewees included state directives to capture the indirect/administrative dollars on federal grants to help support state agency infrastructure. Thus, while it seems there are no apparent significant legal barriers to state health agencies using fiscal intermediaries more broadly, there are some state policies, which are often set outside of the health agency that may hinder a health agency's ability to use the full range of fiscal intermediary options.

***States are uncertain about expanding the use of fiscal intermediary arrangements.***

Respondents and interviewees expressed a mix of opinions about expanding the use of fiscal intermediary arrangements in state health agencies. Some are uncertain because of shifting state needs

and priorities that make it difficult to predict the role of fiscal intermediaries in the future. Others noted prior use of BFAs, but abandoned their use due to insufficient capacity within the BFA organization or changing state government priorities. Still others noted that their state was unlikely to expand its use of fiscal intermediary relationships because of the overriding philosophical and practical concerns about control and accountability for public health programs in the state, as well as the need to preserve federal indirect dollars on grants to support the state health agency and its operations. States willing to consider expanding use of fiscal intermediary arrangements focused on the potential for innovation and enhanced partnerships that such expanded arrangements might bring. Many of the interviewees acknowledged the ever growing balancing act that state health agencies must perform: retaining governmental accountability while dealing with internal governmental pressures to cut agency staff and budgets, and increasing external pressures as currently evidenced with the H1N1 pandemic.

***Other options for expediting the use of federal funds must be fully explored.***

Since all states may not be able to readily adopt alternative or expanded fiscal intermediary arrangements, the key informants identified a number of options to expedite the distribution and use of federal funds within the bounds of current fiscal practices. Practical suggestions included using longer project periods for federal grants and better aligning grant years across CDC and other federal health grants. Other suggestions focused on giving states greater flexibility to direct federal funds to key public health concerns within their states, as well as allowing states more latitude in how they achieve federal deliverables. More fundamentally, state health agency representatives voiced a desire to engage in a productive dialogue with federal health officials and other key state stakeholders to address ongoing issues and problems with current federal funding mechanisms, as well as the pressing need to commit to sustained flexible funding for states' public health infrastructures.

The report concludes that states must balance both practical and policy considerations as they explore new or expanded methods for distributing and using federal grants in their states. It is clear that no one solution will work for all the states. However, states are interested in and committed to effectively and responsibly using federal dollars. States welcome the opportunity to engage in a meaningful dialogue with their federal health partners to optimize current funding mechanisms and to explore the use of other methods.

## Introduction

The Centers for Disease Control and Prevention (CDC) approached ASTHO in summer 2009 to discuss methods the states use to distribute and use CDC and other federal health grants in their jurisdictions. With the shared experiences of administering significant bioterrorism preparedness and pandemic influenza grants—not to mention decades of public health grants—both state and federal agency staffs have many hard-won lessons about what works and what needs improvement in the process of funding state public health programs. Now on the eve of the distribution of American Recovery and Reinvestment Act funding to the states, the CDC Foundation commissioned ASTHO to explore in greater detail the mechanisms that states use to distribute and use public health funds and states' views about the benefits and challenges of using these various methods.

Of particular interest to CDC is the states' use of bona fide agent arrangements as a strategy to expedite the dissemination of federal funds for state health programming. Bona fide agent (BFA) or designated agent arrangements are defined by CDC as instances in which “a foundation, or nonprofit organization, ...serves as the legal agent for applying for federal grants for the state or local health agency.”<sup>1</sup> Organizations designated by a state or locality as a BFA stand in the place of the health agency to receive the federal grant and implement the project awarded to it. BFA arrangements have been successfully used by some state and local health agencies as a way to more efficiently implement a federal (or state) funded program than may be possible within a state's administrative systems.

BFA arrangements are contrasted with traditional contract arrangements in which the state health agency enters into an agreement directly with an organization to implement all or a portion of a public health program. Contracting is commonly and frequently used by the states. Organizations such as state public health institutes (PHIs), universities and non-profits have been used as BFAs and contractors. The CDC Foundation has commissioned a parallel project from the National Network of Public Health Institutes (NNPHI) to assess the experiences of its member organizations when they have served as BFAs and contractors to public health agencies. As will be discussed in detail later in this report, states have a range of experiences and perspectives on BFAs and contract arrangements. ASTHO is using the term “fiscal intermediaries” as an umbrella concept to collectively reference a range of financial mechanisms that states may use, including BFAs, contracts, subcontracts, grants and pass-throughs.

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<sup>1</sup> CDC, Frequently Asked Questions, Communities Putting Prevention to Work-Community Initiative, American Recovery and Reinvestment Act of 2009. From Question 35: “How is a bona fide agent defined...”. Available at [http://www.cdc.gov/nccdphp/DACH/chaps/community\\_initiative/faq.htm](http://www.cdc.gov/nccdphp/DACH/chaps/community_initiative/faq.htm) (last accessed October 24, 2009).

This report explores states' attitudes about expanding the use of fiscal intermediary arrangements, including greater use of BFA arrangements. Contributors to the report addressed facets of their states' administrative systems that would tend to encourage or discourage the adoption of new funding mechanisms or the expansion of other mechanisms. The report highlights both practical and policy considerations that may limit or prevent some states from fully adopting all the funding mechanisms of interest to CDC or implementing them as aggressively as may be desired. These potential inhibiting factors do not mean, however, that states are unable or unwilling to pursue creative options to expedite the use of funds benefiting state public health systems. State health agency senior staff contributing to this report identified a number of options to better facilitate the dissemination of public health funds within the context of current federal and state administrative systems. States recommended further exploration of these and other options in addition to discussing new methods of funding. The report concludes that by using this dual approach state and federal health agencies can work toward the shared goal of efficiently and effectively using federal and state dollars to protect and promote the public's health.

## Project Methodology

ASTHO used several methods to collect the data used in this report. The primary method of gathering information was an electronic survey distributed to all state and territorial health agencies. A copy of the survey instrument is included in Appendix 1. The survey was distributed via email on September 30, 2009 to the health agencies' chief financial or administrative officers, with copies to the State Health Officials and Senior Deputies. The response deadline was October 7, 2009. A reminder message to non-respondents was sent on October 6. As of October 10, 2009, ASTHO received 30 responses (29 states and 1 territory).

| <b>Fiscal Intermediaries Survey Respondents</b> |                          |
|---|--------------------------|
| Alabama   | New Hampshire            |
| Alaska  | New Jersey               |
| Arizona   | New Mexico               |
| Delaware  | North Carolina           |
| Florida   | Oregon                   |
| Hawaii  | Pennsylvania             |
| Illinois  | Rhode Island             |
| Indiana   | South Carolina           |
| Iowa  | South Dakota             |
| Kansas  | Tennessee                |
| Maine   | Vermont                  |
| Maryland  | Virginia                 |
| Massachusetts                                   | Washington               |
| Michigan  | Wyoming                  |
| Minnesota                                       | Northern Mariana Islands |
| Nevada  |                          |

A subset of survey respondents was identified to participate in post-survey key informant interviews. States were chosen for interviews to maximize variation on a number of factors: prior use or non-use of BFA arrangements; state size and geographic location; and the state's views about exploring the use of or expanding use of fiscal intermediary arrangements generally. Interviews were conducted the



#### Key Informant Interview States

Alaska  
Indiana  
Michigan  
Oregon  
Rhode Island  
South Carolina

week of October 19<sup>th</sup> 2009 with 9 health agency staff representatives in 6 states. To preserve the candor of interviewee's responses, their comments will not be attributed to them or their states.

Finally, ASTHO conducted a review of relevant scholarly literature, government publications and news sources. The purpose of the review was to provide background information, as well as to determine if any studies have been conducted to describe or analyze states' experiences using various fiscal intermediary relationships. The results of the survey, interviews and literature review are summarized and discussed in the next section.

## Data Summary and Discussion

ASTHO received responses from 30 jurisdictions (29 states and 1 territory). A detailed summary of the survey results is contained in Appendix 2. ASTHO used membership in the National Network of Public Health Institutes (NNPHI) to loosely categorize states as either having public health institutes (PHIs) or not as one way to compare states' use of bona fide agent (BFA) arrangements.<sup>2</sup> Fifteen (15) of the states that responded to the survey were listed as NNPHI members; 14 states and 1 territory were listed as not having a PHI member of NNPHI.<sup>3</sup> As will be discussed later in this report, whether a state has a PHI is not necessarily determinative of the state using the PHI as a BFA or the use of BFAs generally.

The survey was divided into several major areas of inquiry:

- Use of bona fide agent arrangements
- Use of contract arrangements
- Role of nongovernmental organizations in funding arrangements
- Authority to use fiscal intermediaries
- Expanding states' use of fiscal intermediaries

Key informant interviewees were asked to elaborate on their responses in the above areas of the survey as well as to identify other options for expediting the distribution and use of federal funds by state health

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<sup>2</sup> As noted in the Introduction, organizations that are designated by a state or locality as a BFA stand in the place of the health agency to receive the federal grant and implement to project awarded to it.

<sup>3</sup> National Network of Public Health Institutes member listing at <http://www.nnphi.org/home/section/2/members> (last accessed October 24, 2009).

agencies. The following sections review and discuss the survey results and key informant responses in each of the above areas of inquiry.

## **Use of Bona Fide Agent Arrangements**

The use of BFA or designated agent agreements (collectively “BFA arrangements”) were not widely reported by survey respondents. Twenty-three (23) respondents stated they do not use BFA arrangements, 6 reported using them, and 1 did not know if their state uses BFA arrangements. Of those 6 states that indicated using BFA arrangements, the frequency of use varied greatly. One (1) state estimated their use of BFA arrangements to be 21 or more times over the past five years. Two (2) other states indicated using BFA arrangements 5 to 10 times, while 2 other states reported using BFAs only 1 to 4 times in the last 5 years. One (1) respondent did not identify how frequently it used BFAs.

Respondents and interviewees reported using BFAs for a range of public health programs such as emergency preparedness and response, maternal and child health, and environmental health, to name a few. Some states used the same organization as a BFA for multiple program areas, while other states used different BFAs for different program areas. The tasks and activities collectively performed by BFAs represented a range of functions, including accounting, purchasing, contracting, hiring, research, outreach, education, training and the delivery of health services and screenings. Not all BFAs performed all of these tasks in all of the work they performed as a state’s BFA. The differences seen in the programs and tasks/activities performed by BFAs related to the needs of the state health agency and the capacity of the individual BFA.

States reported using several types of organizations as BFAs, such as public health institutes (PHIs), state and private universities, and other organizations such as non-profits and quasi-governmental entities. There was not a clear link between a state’s use of BFAs and whether or not it had a PHI. Of the 6 states reporting BFA use, 3 had PHIs and 3 did not. Only 1 state reported using its PHI as a BFA. Three (3) states reported using universities as BFAs; 2 used state universities and 1 used a private university. Universities were viewed as an appropriate partner for the health agency and as a convenient funding mechanism for the agency to use. Universities were also viewed as partners with good existing relationships with the agency. One state reported using a quasi-governmental regional EMS provider as a BFA for federal grants. Because of geographic limitations in that state, it made sense to have the EMS provider be the BFA for emergency services in more rural areas of the state. Four (4) states also reported using “other organizations” in BFA arrangements.

States using BFAs reported employing them when either the agency had too much work to do the project itself or the agency did not want to lose out on the funding opportunity for the state (i.e., no other entity in the state might be eligible unless a state agency designated a BFA). One state noted that other state agencies such as the education, corrections, agriculture and the state laboratory have used its PHI as a BFA for projects. In addition to receiving federal funds, BFAs have been used as the designated recipients for grants from private foundations and nongovernmental organizations (NGOs) on behalf of the state. Some BFAs have been used as coordinators and recipients of multi-state grants.

States that reported using BFA arrangements rate their experiences with them as generally beneficial. Five (5) states said the arrangements were “very beneficial.” One (1) state rated their experience as “somewhat beneficial.” Another state provided mixed reviews for the three examples of BFAs they reported; one was “very beneficial,” another was “neither beneficial nor problematic,” while the third was “somewhat problematic.” The states’ ratings according to the type of organization used as the BFA likewise varied: 1 using a PHI as the BFA found it “very beneficial; 2 that used state universities rated them “very beneficial;” and 1 using a private university found it “somewhat problematic.” Ratings for “other organizations” used as BFAs were mixed but generally good; 2 found them “very beneficial;” 1 found it “somewhat beneficial;” and 1 found it “neither beneficial nor problematic.”

### ***Benefits of Using Bona Fide Agents***

A clear benefit to using BFAs identified by respondents and interviewees is the ability of BFAs to generally accomplish things faster and more competitively than state bureaucracies can. Examples provided by states include faster personnel, contracting, and purchasing systems. BFAs were also seen as being able to offer more competitive salaries than state personnel systems. One interviewee noted that a PHI or state public health foundation which is authorized in state law may be eligible for no-bid contacts from the state, thereby further accelerating the use of funds. BFAs were also viewed by some respondents and interviewees as providing a mechanism for state agency staff to travel to required meetings when they may be subject to travel restrictions placed on state-supported travel. However, one person noted that its state has now restricted the health agency’s ability to use alternative mechanisms for accomplishing travel.

Respondents and interviewees identified a variety of other benefits to using BFAs. Geographic limitations may mean that state agencies must decentralize services. BFA arrangements can help to provide public health services in rural areas of a state where local governments may not be able to provide

these. Another interviewee noted that some BFAs may have lower indirect rates than other BFAs or contractors. One person noted that this drives competition among organizations. Finally, one interviewee pointed out that BFAs' actions are not completely devoid of external controls; BFA organizations are subject to reporting requirements and audits by funding agencies. These benefits of BFAs were also generally identified by respondents as the same types of benefits associated with using contractors.

Even though some states acknowledged that BFA arrangements can take federal funds awarded to a BFA out of the direct control of the health agency, some states that reported using BFAs noted that there is still considerable collaboration and coordination between the BFA and the agency. One respondent viewed BFA arrangements as beneficial because they permit the hiring of staff at the BFA organization who can be dedicated to the awarded project and who can concentrate fully on the scope of work. This is contrasted with state health agency staff who have multiple projects to work on and manage. One state noted that in both BFA and contract relationships, the state and organization with the BFA award are listed as co-investigators or co-managers on grants. Additionally, several interviewees recognized that BFAs want to do a good job, believe in the state's public health mission, and have a vested interest in making the agency happy so the BFA will be so designated by the agency again in the future.

### ***Challenges of Using Bona Fide Agents***

Interviewees noted both practical and philosophical challenges that have limited the frequency of states' use of BFA arrangements or prevented their use altogether. A number of state respondents identified the real or perceived lack of control over BFAs by the state health agency as the primary challenge in using BFA arrangements. Because funds are legally going directly to the BFAs, state agencies theoretically do not have control over how the funds are spent or the BFA's activities on the project. One respondent whose state has used BFA arrangements several times noted that one instance was problematic because of the state's limited ability to monitor and oversee the work of the organization acting as the BFA. This challenging situation was further exacerbated by the BFA's lack of knowledge about state limitations in the particular program area and the BFA was unwilling to accept guidance from the state agency to alleviate the problems.

As will be discussed in a later section, some states have developed close partnerships with organizations acting in BFA arrangements that allow the health agency to better coordinate and collaborate on projects despite the grant going to the BFA. Control and coordination, however, bring their own challenges. One state that rated its BFA arrangement as "very beneficial" noted that even if there is productive coordination between the health agency and the BFA organization, it takes time and attention

for the agency staff to engage with the BFA. Thus, there is an opportunity cost for a state health agency in terms of staff time and focus diverted from other projects for which the state agency is receiving funding directly. Under the BFA model, state agencies theoretically are not remunerated for the time spent partnering with the organization that has funding through the BFA arrangement. Such economic considerations are being taken into account more frequently by state agencies given their current budget constraints.

Alternatively, there may simply not be an organization in the state suitable for use as a BFA. This can vary with the program area under consideration; however, states interviewed saw very few, if any organizations, that could service the full range of program areas the health agency is tasked with accomplishing under law. Several persons noted that organizations potentially viewed as BFA candidates can have capacity limitations. This included having adequate numbers of staff members as well as adequately trained staff with expertise to accomplish the administrative and substantive work required.

A few interviewees noted that agencies in their states have been instructed to better capture indirect/administrative dollars from federal funding sources to help fund the state health agency's administrative expenses and leverage the agency's funds to accomplish public health goals that are unfunded or underfunded. Several of those interviewed stated that agencies need every dollar in today's tough economic climate to preserve the core public health functions of the state health agency. If federal funds go directly to the BFA, the much needed administrative dollars go with it. Another state noted that it has to piece together relatively small grant amounts to fund state health agency employees. Therefore, federal indirect dollars are needed to be able to fully cover state employees, as well as leverage funding elsewhere.

Interestingly, some perceived the use of BFAs as a way to avoid legal requirements of the state's bureaucracy as a challenge to using BFAs, while for others this was viewed as a benefit of BFA (and contract) relationships. For some, the wholesale use of BFA arrangements could be viewed as privatizing essential government functions. One interviewee reflected that some public health services can be privatized; other cannot and should not be privatized. Alternatively, one state that uses BFAs wondered how aggressively the agency could continue using BFA arrangements before the broader state government "reins them in."

The extensive use of BFAs in a state also raised concerns among some interviewees about the potential for duplication of infrastructure and services between the health agency and the BFA. Although

BFAs are intended to enhance the agency's capacity to achieve its mission, duplication remains a possibility and a concern. Further, such duplication was seen as impractical and unproductive. This could be especially problematic in smaller states where state and federal funds for public health activities can be scarce.

Some interviewees raised concern that, while expeditious in the short term, extensive long term use of BFAs (and even contracts) could contribute to further dismantling the state's public health infrastructure. More fundamentally, some expressed the need to preserve the state health agency's prominence as the focus of public health capacity in the state, as well as to allow the agency to robustly interact with other government agencies and the state's Executive branch.

### ***Accountability Considerations with Bona Fide Agents***

Significant concerns were raised by respondents and interviewees about accountability considerations in using BFAs and the important role of state health agencies. Some interviewees expressed reservations about using BFAs (or more extensively using BFAs) because of the need to preserve the agency's accountability for the public health outcomes in the state. One person stated this sentiment as the need for the state health agency to preserve the public's trust. When there are public health issues and crises to be addressed, the public expects their government to intervene and take action. If the public health agency is not at the forefront, there is the potential for a loss in the public's confidence. Others voiced a similar hesitancy that BFAs may not be dependable or accountable in a crisis. One interviewee noted other reservations about using BFAs because these organizations may not be as familiar with the political sensitivities around some issue as the health agency staff is.

From a practical perspective, the health agency also needs to protect the image and identity of the agency's "public health brand." Thus, the health agency must be visible. Some expressed fear that extensive use of BFA arrangements would over time ultimately dissipate the state health agency's name, role and mission.

Ultimately, respondents expressed a range of perceptions about what a "BFA" means and how their use is interpreted. For some it equates to privatization, for others it is a partnership, and for yet others it is seen as a way to bring innovation to public health agencies. Additionally, ideas about suitable organizations that could be designated as BFAs also vary. A BFA could be a PHI, a foundation, a non-profit organization, a university; some states have used all of these.

## Use of Contract Arrangements

A clear majority of respondents and interviewees indicated that contracting is their preferred method for funding work with outside organizations and agencies. Typically, states contract out funds from federal agencies, foundations and NGOs. Contracting is generally a competitive process in most states, although states can do no-bid or sole-source contracts but it can take time to get these contracts approved. Generally, the state health agency designs the program goals and deliverables, and then contracts with partner organization to implement all or a part of the program design. States have also used master contracts with some organizations in which new projects can be easily added to the master agreement.

States report using contracts, subcontracts or pass-through arrangements (collectively “contracts”) with much greater frequency than they use BFA arrangements. Twenty-six (26) of 30 survey respondents reported using contracts. Two (2) respondents do not use contracts and two (2) did not know if the agency used contracts.<sup>4</sup> Of the 26 respondents using contract arrangements, 14 reported using contracts over 20 times in the past five years; 2 used them 11 to 20 times; 1 used them 5 to 10 times; and 3 used them fewer than 5 times in the past five years. Six (6) respondents did not indicate a range for their states’ use of contract arrangements, but 2 of these listed several examples of their health agency’s use of contractors.

Respondents provided details on a total of 60 specific instances in which contracts were used by the health agency in the past five years. Of the contracting arrangements identified, most involved the distribution of federal funds in the state. A total of 47 contracts from federal sources were identified; 22 were from CDC and 25 were from other federal agencies. Thirteen (13) contracts were for state funds.

As was the case with BFA arrangements, respondents and interviewees reported issuing contracts to support all program areas within state health agencies (e.g., emergency preparedness, chronic disease prevention, etc.) Some contract organizations were used by multiple program areas, while other organizations contracted to support only one program area. Contractors performed a range of tasks and activities for health agencies, including accounting, purchasing, contracting, hiring, research, outreach, education, health services, and training. Again, not all contractors performed all of these tasks on all of the work they performed for the health agency.

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<sup>4</sup> One state indicated in its initial response that it did not use contracts, subcontracts or pass-through arrangements; however, in a subsequent key informant interview, the state’s respondent revised the response to indicate that the state does use these types of arrangements. The relevant data summaries have been revised by ASTHO to reflect this modified response.

States reported using a variety of organization types as contractors, including PHIs, state public health foundations, state and private universities, and other organizations such as non-profits and for-profit entities. Survey respondents identified “other types of organizations” as the most frequently used type of organization for health agency contracts. Of 56 examples provided, 37 identified using other types of organizations, 11 respondents described using state universities; 2 identified other universities and 6 identified using PHIs as contractors. Interviewees further noted that state legislatures can put in earmarks or set asides for particular organizations that flow through the health agency’s budget. These pass-through dollars may be treated as either a contract or a grant to the designated organization with varying degrees of control/oversight of their activities.

Overwhelmingly, the majority of contract arrangement examples cited were seen as being beneficial to state health agencies. Fifty (50) of 60 examples were identified as “very beneficial.” Another 6 respondents identified the contractual arrangements as “somewhat beneficial.” Three (3) experiences were seen as neutral—“neither beneficial nor problematic.” One (1) respondent did not characterize the relationship with its contractors. None of the respondents identified the contractual arrangements as either “somewhat problematic” or “very problematic.” Overall, states reported having excellent relationships with partner organizations with whom they contract. Many expressed viewing partners as vital to accomplishing the state’s public health mission.

### ***Benefits of Using Contractors***

Both survey respondents and interviewees believed that by using contract arrangements the state health agency retains greater control of the deliverables and actions of the contractor. Because contractors have to report to agency staff, this can mitigate some of the loss of control experienced with BFA arrangements.

As was discussed with BFA arrangements, using contracts can help alleviate some of the challenges of state bureaucracies. Particularly noted were overcoming state personnel system issues. Contractors were viewed as generally being able to hire, fire and reassign persons more efficiently than the state can. This was particularly noted by states experiencing hiring freezes. Contractors can generally offer more competitive salaries than state agencies can. Several interviewees noted that contracting arrangements allow the state to access expertise and services that may not be resident within the agency. It can be more cost effective to contract for expert staff for part-time work as compared to keeping a full-time expert on the agency’s staff.



Another important benefit of contracting identified by an interviewee is that contracting by state agencies can provide economic benefits throughout the state. With a contracting model states can distribute monies into local communities more broadly than if just one or two BFAs are used in a state. In larger states, contracting widely throughout the state can help tailor the services to local needs and resources.

### ***Challenges of Using Contractors***

Respondents and interviewees did acknowledge that state contracting processes can be complicated and time consuming. While contracting was viewed as a way to alleviate some of the issues with the state bureaucracy, it does not necessary eliminate all of them. One state noted that it must seek review of contracts in amounts over \$25,000. This can be time consuming, though it does serve a check-and-balance function. Some respondents noted that their state contracting process may not move fast enough for the agency to take advantage of quick moving funding opportunities (e.g., the use of carryover funds in 90 days) or leave sufficient time after a contract is approved for project work to be accomplished and results fully demonstrated. Failure to complete contracted work, produce results or fully expend funds can ultimately hurt the agency's long-term ability to attract federal, state or foundation dollars.

Viewed practically, one person noted that it can be difficult to effectively coordinate work on a project if there are too many contracts on any one project. The more contractors/partners the state has, the more players potentially at the table, which can delay or hinder consensus around an issue. Another noted that it is incumbent on agency staff to clearly define the statement of work, deliverables required and the expectations with the contractors. If not, the state can get disappointing results. Working with contractors can be slow, even if deliverables are clearly defined. Issues can always arise that slow or require changes to the project scope. Sometimes these issues do not become apparent until they arise during the course of the project.

Another interviewee believed that recent changes to federal contracting rules preserve the "federal" identity of the money as it moves through different organizations resulting in consequences for state agencies. Thus, even if a state health agency receives money as a contractor itself from another state agency, federal rules and limitations on the money still apply. While this may be good for federal tracking purposes, it can limit states' flexibility to use the funds and unnecessarily restrict the money's use within the health agency.

## **Funding Opportunities with Nongovernmental Organizations**

Respondents generally reported being unaware of any instances in which the health agency competitively applied for funding from CDC or other federal agencies, but the funds were awarded to an NGO in the state instead. (An NGO was defined for the purposes of this survey as a public health institute, university, or other non-profit entity.) Only 1 state identified an instance in which the state lost funding to an NGO. The remaining 29 of 30 respondents reported being unaware of instances in which the health agency lost out on funding opportunity to an NGO. Thus, from the cross-section of jurisdictions responding, it would seem that state health agencies are not in competition for federal funds with organizations in their states. The states do not view NGOs that may be designated as BFAs as being in competition in with the state health agency. In fact, the NGO needs a letter or some other proof that the state agency has designated it as the BFA for a particular grant before it can act in that capacity. Key informant interviewees specifically reported that state health agencies are a funding source for NGOs and the agencies view working with NGOs as critical to accomplishing their public health missions.

The survey also inquired about the ability of state health agencies to receive funds directly from an NGO. Twenty-nine (29) respondents reported that their agencies can accept funds directly from an NGO. One (1) state did not respond to the question. Further, 17 of 30 respondents noted that local governments can receive funding directly from an NGO. One (1) respondent indicated that local governments cannot receive funding from NGOs. Three (3) indicated that the local government's ability to accept NGO funds varies by locality. Of these, 1 varies by county and 2 indicated variation based on other unidentified factors. Nine (9) respondents did not know if local governments can accept funding directly from an NGO. These data suggest that it is feasible for NGOs to make grants to state or local health agencies. One state noted that the health agency frequently gets grants from non-profits and foundations to provide services to key constituencies or specific program areas (e.g., cancer screenings). The health agency can also use funding from non-profits and foundations to satisfy the state's funding match required on some federal grants.

Thus it appears there are no real competitive pressures or legal prohibitions that would make it difficult for states to consider new and additional ways to partner with NGOs in their states.

## **Authorities Governing the Use of Fiscal Intermediaries**

Overall, many survey respondents seemed unsure about what approvals would be required and/or whether their laws facilitated or discouraged the use of fiscal intermediaries in their states. Regarding the approvals required to use or expand the use of fiscal intermediaries in their states, 16 of 30 respondents answering the question stated they did not know; 9 indicated that it was a change that could be made within the health agency or secretariat; 1 noted it would require state legislative approval. No respondents said it would require a rulemaking. Four (4) did not respond to the question.

When asked if there are laws, regulations or policies that tend to encourage or facilitate the use of fiscal intermediaries, 18 of 30 respondents said they did not know; 11 indicated there were none; and 1 answered affirmatively. Respondents gave similar responses when they were asked if there are any laws, regulations or policies that tend to discourage or prohibit the use of fiscal intermediaries. Eighteen (18) of 30 respondents said they did not know; 10 indicated there were none; 2 indicated there were laws.

However, when interviewees were probed on this issue, a different interpretation of these data should be considered. Those interviewees, who indicated on the survey that they were uncertain of the laws, etc. either prohibiting or encouraging use of fiscal intermediaries, stated that their uncertainty did not arise from their lack of knowledge of their state laws addressing fiscal intermediaries. Instead, they were uncertain because state policies and administrative mandates or practices may prohibit or make it difficult (e.g., the push to retain indirect costs, the need for competitive bidding, etc.) to use fiscal intermediaries. Therefore, while legal authorities may allow the use of a range of fiscal intermediary arrangements, state government policies and practices, which may be set outside of the health agency, may act as a barrier to their use.

## **Expanding the Use of Fiscal Intermediaries**

Just over half of the respondents (16 of 30) indicated they were unsure about their agency's interest in expanding the use of fiscal intermediaries. Ten (10) respondents reported not being interested in adopting new or expanding their current use of fiscal intermediary mechanisms. Four (4) respondents indicated interest in expanding their use of these mechanisms. Of the 6 states that reported using BFAs, 4 said they were unsure about their interest to expand use of fiscal intermediaries; 2 said they were interested in exploring expanded use. When key informants were asked about their views on this question,

the responses give additional insights into both the practical and policy questions health agency staff must consider in their decisions to use various fiscal intermediary mechanisms.

It was clear that there are different perceptions among state health agencies about the role of fiscal intermediaries. Some interviewees said their state is unlikely to expand use of fiscal intermediaries because the health agency will be held accountable (or will be perceived to be accountable) by the Governor, state legislature or the public for the outcomes and any problems associated with fiscal intermediaries' performance. As noted previously, there was a strong view expressed that contract arrangements give agencies greater control over the outcomes. Others reported that, while there are no legal prohibitions that would act as a barrier to greater use of fiscal intermediary arrangements, their agency is not likely to do it. This was particularly true where interviewees noted that their agency must preserve as much funding as possible to support the agency's operations.

Several interviewees noted larger policy issues in their discussions about expanding the use of fiscal intermediaries. They acknowledged that government rules can be bureaucratic, but the rules provide a check-and-balance function of assuring that public funds—no matter from where derived—are spent responsibly and that there is accountability for their proper use. Others voiced fears of the long term loss of capacity in state health agencies for the relatively short term gain of administrative ease of dispersing federal funds. One interviewee noted that increased use of BFAs and contractors can ultimately cost the state more to run projects.

Expressing a different view, one state enthusiastically noted that it will continue to look for new ways to use BFAs and other innovative funding arrangements. Staff noted that broad collaborations can help government accomplish its goals easier, faster, and for less expense than working alone. This agency sees the use of fiscal intermediaries as a way to drive innovation. If there is a project an agency wants to accomplish and people it wants to work with, staff can find creative ways to accomplish these goals and will deal with state bureaucratic issues as they arise.

Another state noted that it is open to new methods for facilitating and expediting programs. They are operating in an atmosphere where there is increasing pressure to decrease the size of the state government workforce, but still keep pace with growing demands (e.g., H1N1, ARRA grants, etc.). Increasingly, state staff positions are being changed to contract positions. Balancing the accountability required of government with the pressures to outsource work and trim staff from agencies, caused one person interviewed to wonder "how much longer we can keep all the balls in the air."

Still others took a pragmatic view. One person noted that the state's future use and expansion of BFA arrangements would depend on the particulars of specific opportunities or issues that arise. Such an evaluation would be on a case-by-case basis. Interviewees, who were uncertain about their desire to expand the use of fiscal intermediaries generally, noted that their hesitancy did not arise from either negative or positive feelings about fiscal intermediaries *per se*. Their uncertainty stemmed from shifting circumstances within the state (e.g., the project is in a politically sensitive program area or there is a state administrative policy to maximize the recoupment of indirect/administrative dollars on grants) that make it difficult to determine if greater use of fiscal intermediaries is appropriate or possible across the board.

Finally, some states indicated that they have used BFA arrangements in the past, but acknowledged that the state has moved away from them. Several reasons were identified for this shift away from BFA arrangements. First, lack of staff capacity at the organization acting as the BFA contributed to state's ceasing to use a particular BFA. Next, the state's program priorities shifted such that an entity used as a BFA was no longer appropriate for the role. Finally, state funding priorities required the state to retain greater control over the federal funds and fully recoup the federal dollars in ways that might not be as fully realized using a BFA.

Several respondents further noted that they have unsuccessfully tried to create and/or maintain the capacity of organizations that could be used as BFA within their states such as PHIs or public health foundations. Contributing to this lack of success were organizational changes or restructuring in the state's Executive branch or state health agency that changed the agency's priorities, as well as a lack of interest or resources in the broader public health community to maintain it. Another state reported attempting to create a PHI via a Governor's executive order, only to be told by the Attorney General's office that such a move would require legislative approval. In the competing demands before the state legislature, the agency has been unable to get traction with the Governor's office or legislature to support creation of the PHI.

### ***What Would Make It Easier to Work with Bona Fide Agents***

When asked what would make state health agencies more inclined to use BFA arrangements specifically, several interviewees noted that it would be a benefit if the state health agency director or other senior staff would have clear linkages with the boards of the BFAs. It was believed that such an arrangement would permit the state health agency a greater degree of control over the direction of the BFA's work as well as enhancing coordination with the health agency staff. Examples cited of how this

control could be achieved included having the state health officer as the director or the chair of the board of the BFA. In at least one state, the health agency director is the chair of the PHI board. In this state, the state health agency noted that it has a very robust and close relationship with the PHI.

Other states, however, noted prohibitions in their state law that would make such a close relationship or interlocking directorship between the health agency and the BFA impossible. An example cited was one state's limitation on state employees being voting members on board or as a dual employee of organization that receive state funds, especially if the state employee has a say in the decision to award funds to the organization in question. Some voiced concern that overlapping governance structures could give the appearance of impropriety.

One person reported that using an organization as a contractor first allows the agency to achieve a comfort level with the capacity and work product of the organization, as well as its ability to effectively coordinate with the state agency staff. Once a certain level of confidence is attained by the health agency, it may be more inclined to use the organization as a BFA. Some respondents noted that BFAs (and contractors) have a vested interest in being accountable for the deliverables they are tasked with, to actively collaborate with the health agency and other public health partners, and ultimately for the project outcomes. BFA organizations want to continue to be funded. Another interviewee noted that BFAs would work best in larger states that have larger public health budgets, populations, and geographic areas to service.

## **Public Health Fiscal Intermediaries Literature Review**

The states' experiences and observations about the roles of NGOs as fiscal intermediaries reflected in this report are consistent with the published findings addressing the topic. ASTHO specifically reviewed journals, government publications and media accounts for studies and other evaluations regarding state health agencies' use of BFAs or contractors, and the role of NGOs in general in the implementation of public health programs. A list of the articles reviewed is contained in the "Literature Reviewed" section at the end of this report. ASTHO did not find any studies that directly addressed state agencies' use of BFAs. However, a number of studies have discussed the role of PHIs and other NGOs in the provision of public health services, as well as role of NGOs in the analogous area of social service program delivery.

The literature clearly noted similar benefits of using PHIs and other NGOs as those recognized by survey respondents and interviewees. Most frequently recognized was the relative efficiency with which NGOs can administer grant-funded projects.<sup>5</sup> Other benefits that state health agencies can garner by using a PHI include: gaining access to more diverse funding sources; accessing scientific and technical resources at the PHI and its other partner organizations like universities; and enabling the state agency to broaden its “research, development, demonstration, and training capabilities.”<sup>6</sup> Gaining access to expertise outside the state health agency was an important benefit identified by respondents and interviewees with using BFA and contract arrangements.

The literature also revealed lingering concerns about accountability questions when governmental services are outsourced. Saidel noted concerns about the loss of accountability when social services are privatized.<sup>7</sup> These concerns raised in Saidel’s study reported in 1991, were later echoed in Gollust and Jacobson’s 2006 work in which they raised questions about assuring accountability, coordination and quality when public health services are privatized.<sup>8</sup> As noted previously in this report, survey respondents and interviewees continue to raise these same concerns today.

Researchers have analyzed the states’ differing models of PHI organization and governance relative to state health agencies. Taylor examined the Michigan Public Health Institute, in which the state health agency leadership has prominent roles on the institute’s board, thereby allowing for close coordination of efforts.<sup>9</sup> Similarly, Lake and Peterson described Virginia’s decision to establish a PHI outside of the state’s government.<sup>10</sup>

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<sup>5</sup> Taylor JR, Beane GE, Genee CL. The Michigan Public Health Institute: A Model for University, Government and Community Research and Practice Partnerships. *J Research Administration*. 1998;Summer:17-24. Padgett SM, Kinabrew C, Kimbrell J, Nicola RM. Turning Point and public health institutes: vehicles for systems change. *J Public Health Management Pract*. 2005;11(2):116–122. Gollust SE, Jacobson PD, Privatization of public services: organizational reform efforts in public education and public health. *Am J Public Health*. 2006;96:1733-1739.

<sup>6</sup> Taylor JR, Beane GE, Genee CL. The Michigan Public Health Institute: A Model for University, Government and Community Research and Practice Partnerships. *J Research Administration*. 1998;Summer:17-24

<sup>7</sup> Saidel JR. Resource Interdependence: The Relationship Between State Agencies and Nonprofit Organizations. *Public Administration Review*. 1991;51:543-553.

<sup>8</sup> Gollust SE, Jacobson PD, Privatization of public services: organizational reform efforts in public education and public health. *Am J Public Health*. 2006;96:1733-1739.

<sup>9</sup> Taylor JR, Beane GE, Genee CL.

<sup>10</sup> Lake JL, Peterson EA. An alternative structure for improving the public’s health. *Journal of Public Health Management and Practice*. 2002;8(1):75–82.

More broadly, Padgett et al examined, in part, the development of “third sector institutions”—alternative structures outside of government that assist in governmental public health’s mission.<sup>11</sup> The authors were sensitive to the unique setting in each state that can dictate the structure and mission of a “third sector institution”:

The context of action in each state is significantly influenced by the governor and appointed agency heads, the structure and traditions of public health agencies, the legislature, and the overall economic and political climate of the state.<sup>12</sup>

New York State’s Health Research Incorporated is an example of a “third sector institution” that closely supports the New York State Department of Health (DOH) and the Roswell Park Cancer Institute (RPCI) work. HRI’s mission is to “assist DOH and RPCI to effectively evaluate, solicit, and administer external financial support for DOH and RPCI projects, and to disseminate the benefits of DOH expertise through programs such as technology transfer.”<sup>13</sup> Local health departments have also developed public health institutes or similar organizations to support their work. New York City’s Public Health Solutions (PHS) is a non-profit organization that “develops, implements and advocates dynamic solutions to prevent disease and improve community health.”<sup>14</sup> PHS “was founded 50 years ago as Medical and Health Research Association of New York City, Inc, a “research foundation” for the New York City Department of Health and Mental Hygiene (DOHMH).”<sup>15</sup> PHS’s purpose is to “facilitate the creation and administration of research projects and provide greater flexibility to seek new funding resources for research that would inform the work of the DOHMH and other New York City organizations.”<sup>16</sup>

Padgett et al found that non-profit public health organizations worked best when a close relationship with government existed:

Nonprofit public health organizations were described as most effective and influential when the nonprofit organization had a close working relationship with state government—reflected, for example, in the

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<sup>11</sup> Padgett SM, Bekemeier B, Berkowitz B. Building sustainable public health systems changes at the state level. *Journal of Public Health Management and Practice*. 2005;11(2):109–115.

<sup>12</sup> Padgett SM, Bekemeier B, Berkowitz B.

<sup>13</sup> Health Resources, Inc. Available at [www.hrinet.org](http://www.hrinet.org) (last accessed November 3, 2009).

<sup>14</sup> Public Health Solutions. Available at [www.healthsolutions.org](http://www.healthsolutions.org) (last accessed November 3, 2009).

<sup>15</sup> Public Health Solutions. Available at [www.healthsolutions.org](http://www.healthsolutions.org) (last accessed November 3, 2009).

<sup>16</sup> Public Health Solutions. Available at [www.healthsolutions.org](http://www.healthsolutions.org) (last accessed November 3, 2009).



support of specific institute activities with state funds, having the state health officer on the institute board, or working collaboratively on policy issues, conferences, or projects.<sup>17</sup>

The benefit of linked governance between the PHI and the state health agency was similarly expressed by some of the survey respondents and interviewees participating in ASTHO's review.

A number of articles have addressed the important role of non-profits in the delivery of public health and social services at the state and local levels.<sup>18</sup> A 2007 U.S. Government Accountability Office (GAO) report noted, "A complex network of governmental and nongovernmental entities shape the actual outcomes achieved, whether it be through formal partnerships in grant programs or through independent actions of each addressing common problems."<sup>19</sup> This same GAO report echoed ASTHO key informant interviewees' concerns about the capacity of some NGOs to perform the administrative and substantive program tasks required by the agency.

Another area to which researchers suggest attention should be paid is improving the capacity that smaller nonprofit organizations have to address weaknesses in finances, administration, and human capital. Many nonprofits struggling to accomplish their mission on limited budgets lack the resources that could allow them to better manage their finances and strengthen their infrastructure. In addition, particularly in smaller nonprofit organizations, the strengths of board members may be in addressing their organization's mission, and they may lack legal and financial knowledge or the skills necessary to oversee a nonprofit entity.<sup>20</sup>

Health agency representatives interviewed acknowledged the variability in capabilities among non-profits and cautioned that some non-profits are not suitable candidates for BFA or contracting arrangements.

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<sup>17</sup> Padgett SM, Bekemeier B, Berkowitz B.

<sup>18</sup> See for example Saidel JR. Resource Interdependence: The Relationship Between State Agencies and Nonprofit Organizations. *Public Administration Review*. 1991;51:543-553.

<sup>19</sup> U.S. Govt. Accountability Office, GAO-07-1084T Nonprofit Sector: Increasing Numbers and Key Role in Delivering Federal Services, July 24, 2007

<sup>20</sup> GAO-07-1084T Nonprofit Sector: Increasing Numbers and Key Role in Delivering Federal Services.

The implications of the financial relationships between governmental agencies and NGOs have been the subject of a number of publications.<sup>21</sup> A 2009 GAO study analyzed the importance of governmental funding in supporting the continued work of non-profits.<sup>22</sup> In 2002, Van Slyke noted that additional research was needed to consider the “cost implications of contracting for programs in which government has to develop competition and maintain its own capacity because of market demand and elasticity of supply factors.”<sup>23</sup> While Van Slyke was reviewing the impact of privatization on social service programs, an analogy can be made from Van Slyke’s comment to concerns raised by ASTHO interviewees about the ultimate impact BFAs and contractors on state agencies. Interviewees pointed to concerns about preserving funds for agency operations, especially in an uncertain budgetary climate, creating duplicative and potentially competitive public health infrastructures, and maintaining the governmental public health brand.

Finally, Halverson commented that the role of the governmental public health agency is to be the effective facilitator of other actors in achieving system goals.<sup>24</sup> Halverson states:

Accomplishing this task requires the understanding that achieving real public health improvement probably means *moving beyond the statutory minimum mandates of the health department; accepting responsibility for ensuring the actions of a larger set of organizations for which the health department may not provide funding or necessarily regulate*. The public health system is a term that describes the organizations and individual who collectively share the benefits, burdens, and responsibilities of the health of a defined population or community. At the heart of most successful public health systems is a highly effective government public health agency that facilitates the actions of others in accomplishing systemwide goals.<sup>25</sup> [emphasis added]

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<sup>21</sup> See for example Brown LK, Troutt E. Funding relations between nonprofits and government: a positive example. *Nonprofit and Voluntary Sector Quarterly*. 2004;33(1):5–27. Froelich KA. Diversification of revenue strategies: evolving resource dependence in nonprofit organizations. *Nonprofit and Voluntary Sector Quarterly*. 1999;28(3):246–268.

<sup>22</sup> U.S. Govt. Accountability Office, GAO-09-193 Significant Federal Funds Reach the Sector through Various Mechanisms, but More Complete and Reliable Funding Data Are Needed, February 2009.

<sup>23</sup> Van Slyke DM. The public management challenges of contracting with nonprofits for social services. *International Journal of Public Administration*. 2002;25(4):489-517.

<sup>24</sup> Halverson PK. Embracing the strength of the public health system: Why strong government public health agencies are vitally necessary but insufficient. *J Public Health Management Pract*. 2002;8(1):98–100.

<sup>25</sup> Halverson PK.

Collectively these studies support the view expressed by many of the state contributors to this report that collaborative relationships with a variety of nongovernmental public health partners (e.g., PHIs, universities and non-profits) are key to successful program outcomes. These studies also reflect the states' view that governmental public health remains ultimately accountable for the health outcomes in its communities.

## **Other Options for Expediting the Use of Funds**

Because some states either cannot use or cannot quickly use BFA arrangements because of state policies or a lack of suitable candidate organizations in their state, key informant interviewees were asked to identify ways to better expedite the distribution and use of federal funds within the bounds of current state practices. Interviewees provided a number of concrete ideas:

- **Use longer project periods.** Extending the time periods in which to complete projects (e.g., 2 to 3 years instead of 1 year) would serve several important purposes. First, it would reduce the amount of carryover by allowing the funds to be spent over a longer period. Next, it would allow the state more time to accomplish project work as opposed to focusing on administrative activities such as applying for the grant and then having to reapply again so soon. Given the admitted delays in contracting processes, it may take several months for a contract to be put in place, thus delaying the start of project work. Further, longer project periods would permit more time for the agency, contractors and BFAs to demonstrate results.

Agencies could enter into better agreements with contractors and build better relationships with them if there were longer contract periods. One agency person expressed that currently everything is a temporary program; the agency cannot make commitments to staff, local governments or contractors and BFAs beyond one year. Being unable to plan for longer term projects also limits strategic thinking. It can cost the agency more if it cannot negotiate with contractors for longer contract periods.

- **Change the timing of federal grant years.** CDC grants have varying grant years that are not consistent among various CDC grants, the federal fiscal year or state fiscal years. Some CDC grants end during the middle of state pay periods. The recordkeeping needed to account for these projects is time consuming and wasteful. It would be better to have more uniform grant years.

- **Make federal grant requirements less restrictive.** Some saw a distinction between what they termed as “federal micromanagement” versus holding states accountable for outcomes. Examples given of typical restrictive requirements included federal requirements that there be a dedicated full-time agency staff position associated with a particular funding stream. States and locals need the flexibility to use agency positions for multiple roles paid for by multiple funding streams. Given the downward pressure on state agency hiring, hiring freezes, and caps on overall agency staffing levels, agencies need to be able to flex their workforce. Additionally, states can encounter funding constraints when staff working under a particular federal grant run out of funding. Agencies need to be able to flex how that staff is funded so their work can continue. States are cognizant, however, that federal agencies can have limitations imposed through the federal appropriations or authorization processes that restrict how federal funds may be used and the requirements placed on the recipients of those funds. It is acknowledged that there are larger issues to be addressed in this area than just CDC requirements.
- **Give states leeway to target programs to their states’ needs.** State health agencies would have greater flexibility if CDC grants to states could be combined and more flexibility is given to states to direct the funds to particular programs or to address health concerns particular to the state. One interviewee noted that the states should be able to self-assess, supported by data, how broad areas of federal dollars will be directed to address significant public health threats within their states.
- **Look for additional strategies to streamline funding processes.** Several interviewees noted ideas to make federal funding processes more efficient. One suggested consideration of streamlining or abbreviating grant applications and/or reporting requirements for continuation grants. Efficiently combining grant periods and allowing states to report on them at one time was also suggested. Others urged an examination of how specific grant streams have become and identify potential ways to broaden the scope of grants to provide more flexibility in addressing public health issues at the state level.

One state respondent noted that there could be better cooperation/coordination among CDC programs addressing similar goals and populations. An example mentioned was the limitations imposed on state staff working on HIV and TB grants not to overlap their time in these programs even though there are frequent co-infections in the populations served. A siloing effect imposed by funding streams can do a disservice to the agency staff and the people they are trying to help. State staff noted that they value their federal project officers and colleagues, but

the funding constraints imposed on both federal and state personnel can be counterproductive to the shared goals of each.

- **Give more flexibility about how states meet federal deliverables.** A number of interviewees stated that they need more flexibility in how their state goes about achieving federal deliverables. One approach does not work for all states. One interviewee noted that the U. S. Environmental Protection Agency may be an example of how federal dollars are granted to states but the states are given broader discretion about how to achieve the federal goals.
- **Use NGOs as intermediaries to pay for things that the state cannot.** Examples mentioned included funding travel for federal grants. Some states noted that even if travel is required as part of the federal grant, state travel restrictions can make it difficult to travel anyway. Similarly, some federal grants are too prescriptive and can require the acquisition of too specific items (e.g., a given make/model of lab equipment) which may be difficult to pass state purchasing requirements. If federal agencies want to be that specific, they should buy the specified items and provide them directly to the states, or use an intermediary organization to purchase and distribute the required items.
- **Engage the states in a discussion to address funding issues.** Interviewees voiced an appreciation that federal agencies must account for how federal funds are spent. State agency representatives expressed the desire to engage in a productive discussion about how to make the current system more rational and productive for states and the federal agencies. One respondent noted that HHS, the CDC and other federal agencies funding state health agencies need to dialogue with a range of state stakeholders to address the problems with the current system of federal grants to states rather than looking for new ways to bypass the systems at the state level. Such state-level stakeholders should include state budget/finance officers, state health agencies, governors, and state legislators.
- **Recommit to improving the public health system's infrastructure.** All interviewees acknowledged that public health infrastructure development is sorely lacking. One state noted that it was hoping to get federal dollars to start a coronary disease prevention program because there were no state funds available to do so. The state was told that it must build a program before it is eligible for the funds. Thus, the state is left in a vicious cycle with the end result of being unable to address this important prevention activity for its population. One state interviewee

simply identified the overwhelming need to provide sustained funding to build the public health infrastructure as crucial “public health reform.”

## Conclusions

As the foregoing discussion demonstrates, state health agencies hold a variety of views about BFA and contracting arrangements. The collected views of the states reflected in this report are summarized in the following observations and conclusion.

### ***A few state health agencies have used bona fide agent arrangements; most have not.***

States have not widely used BFA arrangements. Yet among those states that have used them, they report these relationships as generally beneficial to the state health agency. The specific benefits of BFAs identified included faster administrative processes and more competitive rates than in state systems, they permit state agencies to extend their reach in larger states or rural areas, and BFAs are generally considered to be good and responsive partners for the health agencies. The dominant concerns voiced with using BFA arrangements are the lack of direct agency control over the federal funds awarded and the project outcomes by the BFA. This directly leads to questions of real or perceived accountability of the state health agency for federal projects awarded to BFAs. A number of states interviewed strongly believe that government is ultimately accountable for the conduct and outcome of the BFA’s work on public health issues within their state. For this reason, state health agencies view having more direct control over federal funds and project deliverables through contractual relationships as a preferred way to achieve the same ends as the BFA arrangement. Other states surveyed, however, have had very collaborative and productive relationships with organizations used as BFAs. Any federal efforts to aggressively promote the use of BFAs should be cognizant of these dynamics and consider ways to address states’ concerns about control and accountability issues.

### ***Contracting arrangements are viewed as the preferred fiscal intermediary relationship.***

Contracting was by far the preferred method of state health agencies to distribute federal funds. This clear preference was shown in the number of states using the practice as well as the frequency with which contracts are used. Responding states reported overwhelmingly that contract relationships are beneficial to the agency’s ability to accomplish its public health mission.

Survey respondents and key informant interviewees identified the primary benefit of contracts as providing the agency with a way to retain control over how funds are spent and the outcomes achieved. Contract arrangements were also seen as beneficial because they can avoid some of the state bureaucratic issues, allow the agency to cost-effectively access expertise not resident in the agency, and provide wider economic benefits throughout the state. Respondents did note, however, that state contracting processes can be time consuming and ultimately result in incomplete use of project dollars and limited results.

***Some state administrative policies can act as structural barriers to expanding the use of fiscal intermediary arrangements.***

While survey responses seemed to indicate that agency staff was unaware of the approvals necessary to change the agency's use of fiscal intermediaries and of the state laws, regulations or policies prohibiting or encouraging the use of fiscal intermediaries, closer discussions revealed an alternate explanation for the survey findings. Interviews with key informants demonstrated their familiarity with applicable state laws and processes. Their comments revealed that state government policies and administrative practices may act as a barrier to greater use of various fiscal intermediary arrangements. Examples cited by interviewees included state directives to capture the indirect/administrative dollars on federal grants to help support state agency infrastructure. Thus, these preliminary results seem to suggest that there are no apparent significant legal barriers to state health agencies using fiscal intermediaries more broadly. Yet there are some state policies, which are often set outside of the health agency, that may hinder a health agency's ability to use the full range of fiscal intermediary options. These administrative policies and practices can in fact act as structural barriers. This review did not specifically address state procurement laws and procedures. A more in-depth review of these legal issues may be required before an initiative to expand the use of fiscal intermediaries is aggressively pursued.

***States are uncertain about expanding the use of fiscal intermediary arrangements.***

Respondents and interviewees expressed a mix of opinions about expanding the use of fiscal intermediary arrangements in state health agencies. Some are uncertain because of shifting state needs and priorities that make it difficult to predict the role of fiscal intermediaries in the future. Others noted prior use of BFAs, but abandoned their use due to insufficient capacity within the BFA organization or changing state government priorities. Still others noted that their state was unlikely to expand its use of fiscal intermediary relationships because of overriding philosophical and practical concerns about control and accountability for public health programs in the state, as well as the need to preserve federal indirect dollars on grants to support the state health agency and its operations. States willing to consider expanding their use of fiscal intermediary arrangements focused on the potential for innovation and enhanced partnerships that such expanded arrangements might bring. Many of the interviewees

acknowledged the ever growing balancing act that state health agencies must perform: retaining governmental accountability while dealing with internal governmental pressures to cut agency staff and budgets, and increasing external pressures as currently evidenced with the H1N1 pandemic.

Interviewees noted that states might be more inclined to use BFA arrangements if state health agency leadership (e.g., State Health Officer, State Medical Officer) has a substantial governance or collaborative role within the organization used as the BFA (e.g., chair of the PHI's board). Yet, other interviewees stated that their state law would prohibit such a relationship. Still other interviewees took a more practical approach; organizations are used as contractors first to assess their performance and ultimate suitability as a BFA.

The survey results and key informant interviews demonstrated no clear consensus among the states about expanding the use of fiscal intermediary arrangements. Each state has practical and philosophical issues to address, which may or may not be a barrier to the state's expanded use of fiscal intermediaries.

***Other options for expediting the use of federal funds must be fully explored.***

Since all states may not be able to readily adopt alternative or expanded fiscal intermediary arrangements, the key informants identified a number of options to expedite the distribution and use of federal funds within the bounds of current fiscal practices. Practical suggestions included using longer project periods for federal grants and better aligning grant years across CDC and other federal health grants. Other suggestions focused on giving states greater flexibility to direct federal funds to key public health concerns in their states, as well as allowing states more latitude in how they achieve federal deliverables. More fundamentally, state health agency representatives voiced a desire to engage in a productive dialogue with federal health officials and other key state stakeholders to address ongoing issues and problems with current federal funding mechanisms, as well as the pressing need to commit to sustained flexible funding for states' public health infrastructures.

**Options Identified by States**

- Use longer project periods.
- Change the timing of federal grant years.
- Make federal grant requirements less restrictive.
- Give states leeway to target programs to their states' needs.
- Look for additional strategies to streamline funding processes.
- Give more flexibility about how states meet federal deliverables.
- Use NGOs as intermediaries to pay for things that the state cannot.
- Engage the states in a discussion to address funding issues.
- Recommit to improving the public health system's infrastructure.



In the final analysis, states must balance both practical and policy considerations as they explore new or expanded methods for distributing and using federal grants in their states. It is clear that no one solution will work for all the states. However, states are interested in and committed to effectively and responsibly using federal dollars. States welcome the opportunity to engage in a meaningful dialogue with their federal health partners to optimize current funding mechanisms and to explore the use of other methods.

# Literature Reviewed

## Commentary – PHIs as Part of the Public Health System

Halverson PK. Embracing the strength of the public health system: Why strong government public health agencies are vitally necessary but insufficient. *J Public Health Management Pract.* 2002;8(1):98–100

## Public Health Institutes

Lake JL, Peterson EA. An alternative structure for improving the public's health. *Journal of Public Health Management and Practice.* 2002;8(1):75–82

Padgett SM, Bekemeier B, Berkowitz B. Building sustainable public health systems changes at the state level. *Journal of Public Health Management and Practice.* 2005;11(2):109–115

Padgett SM, Kinabrew C, Kimbrell J, Nicola RM. Turning Point and public health institutes: vehicles for systems change. *J Public Health Management Pract.* 2005;11(2):116–122

Taylor JR, Beane GE, Genee CL. The Michigan Public Health Institute: A Model for University, Government and Community Research and Practice Partnerships. *J Research Administration.* 1998;Summer:17-24

## Relationships Between Government Agencies and Non-profit Organizations

Brown LK, Troutt E. Funding relations between nonprofits and government: a positive example. *Nonprofit and Voluntary Sector Quarterly.* 2004;33(1):5–27

Froelich KA. Diversification of revenue strategies: evolving resource dependence in nonprofit organizations. *Nonprofit and Voluntary Sector Quarterly.* 1999;28(3):246–268

Gollust SE, Jacobson PD. Privatization of public services: organizational reform efforts in public education and public health. *Am J Public Health.* 2006;96:1733-1739

Jacobson J, Marsh S, Winston P. State and Local Contracting for Social Services Under Charitable Choice. Mathematica Policy Research, Inc. for the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. August 2005

Saidel JR. Resource Interdependence: The Relationship Between State Agencies and Nonprofit Organizations. *Public Administration Review.* 1991;51:543-553

U.S. Govt. Accountability Office, GAO-09-193 Significant Federal Funds Reach the Sector through Various Mechanisms, but More Complete and Reliable Funding Data Are Needed, February 2009

U.S. Govt. Accountability Office, GAO-07-1084T Nonprofit Sector: Increasing Numbers and Key Role in Delivering Federal Services, July 24, 2007

Van Slyke DM. The public management challenges of contracting with nonprofits for social services. *International Journal of Public Administration.* 2002;25(4):489-517

# Appendices

Appendix 1: ASTHO Fiscal Intermediaries Survey Instrument

Appendix 2: Summary of ASTHO Fiscal Intermediaries Survey Responses

# Appendix 1

## ASTHO Fiscal Intermediaries Survey Instrument



Fiscal Intermediaries Survey

This survey is designed to collect information on the use of fiscal intermediaries by state public health agencies. The term “fiscal intermediaries” includes “**bonafide agents**” or “**designated agents**” who receive funding for public health programs directly from the funder, having been so designated by the state public health agency. This survey pertains to funding from the CDC, other federal agencies or state funds. In some instances, non-governmental organizations (such as public health institutes, universities, or other non-profit organizations) receive funding from a state health agency in a **pass-through or sub-contract** arrangement. The state public health agency may be the contracting party with the federal agency, but delegates a substantial portion of the work to the non-governmental organization.

There are also instances where the CDC (or other federal agency) does not require recipients of funding to be governmental entities; **non-governmental organizations can apply for and directly receive funding** from the CDC or other federal agencies without the cooperation or knowledge of a state public health agency.

As noted above, **we are interested in these arrangements whether the funding source is CDC, another federal agency or state funds.**

Name: \_\_\_\_\_ Title: \_\_\_\_\_ State/Territory: \_\_\_\_\_

**Bonafide and Designated Agents**

1. In the last five years, has your state public health agency authorized a “bonafide agent” or “designated agent” to contract with the CDC, another federal agency or receive state funds?

- Yes
  No
  I don't know

2. How many times have you used a bonafide or designated agent in the last five years?

- 0
  1
  2
  3
  4
  5-10
  11-20
  21 or more

3. Please use the following tables to describe up to the three most recent instances of the use of a **bonafide or designated agent**. If you have not used a bonafide or designated agent in the last five years, please skip to the next section.

|  | What was the funding source?   | What type of organization did you select as your bonafide agent?  | How beneficial was the arrangement to the state health agency?   | What, if any, were the main benefits you experienced as a result of this arrangement? | What, if any, were the challenges you experienced as a result of this arrangement? |
|--|--|---|--|---|--|
| Bonafide agent arrangement 1 (most recent) | <input type="radio"/> CDC<br><br><input type="radio"/> Other federal agency<br><br><input type="radio"/> State funds | <input type="radio"/> Public health institute<br><input type="radio"/> State university<br><br><input type="radio"/> Other university<br><input type="radio"/> Other type of organization | <input type="radio"/> Very beneficial<br><br><input type="radio"/> Somewhat beneficial<br><br><input type="radio"/> Neither beneficial nor problematic<br><input type="radio"/> Somewhat problematic<br><input type="radio"/> Very problematic |   |  |

|   | What was the funding source?   | What type of organization did you select as your bonafide agent?  | How beneficial was the arrangement to the state health agency?   | What, if any, were the main benefits you experienced as a result of this arrangement? | What, if any, were the challenges you experienced as a result of this arrangement? |
|---|--|---|--|---|--|
| Bonafide agent arrangement 2 (next most recent) | <input type="radio"/> CDC<br><br><input type="radio"/> Other federal agency<br><br><input type="radio"/> State funds | <input type="radio"/> Public health institute<br><input type="radio"/> State university<br><br><input type="radio"/> Other university<br><input type="radio"/> Other type of organization | <input type="radio"/> Very beneficial<br><br><input type="radio"/> Somewhat beneficial<br><br><input type="radio"/> Neither beneficial nor problematic<br><input type="radio"/> Somewhat problematic<br><input type="radio"/> Very problematic |   |  |

|  | What was the funding source?   | What type of organization did you select as your bonafide agent?  | How beneficial was the arrangement to the state health agency?   | What, if any, were the main benefits you experienced as a result of this arrangement? | What, if any, were the challenges you experienced as a result of this arrangement? |
|--|--|---|--|---|--|
| Bonafide agent arrangement 3 (third most recent) | <input type="radio"/> CDC<br><br><input type="radio"/> Other federal agency<br><br><input type="radio"/> State funds | <input type="radio"/> Public health institute<br><input type="radio"/> State university<br><input type="radio"/> Other university<br><input type="radio"/> Other type of organization | <input type="radio"/> Very beneficial<br><input type="radio"/> Somewhat beneficial<br><input type="radio"/> Neither beneficial nor problematic<br><input type="radio"/> Somewhat problematic<br><input type="radio"/> Very problematic |   |  |

**Pass-through and sub-contract arrangements**

4. In the last five years, has your state public health agency entered into a pass-through or sub-contract arrangement whereby the state agency received funding from the CDC, another federal agency or state funds, but delegated a substantial portion of the work to a non-governmental partner (such as a public health institute, university or other non-profit organization)?

- Yes                     
  No                     
  I don't know

5. How many times have you used a pass-through or sub-contract arrangement in the last five years?

- 0   
  1   
  2   
  3   
  4   
  5-10   
  11-20   
  21 or more

6. Please use the following tables to describe up to the three most recent instances of the use of a **pass-through or sub-contract arrangement**. If you have not used pass-through or sub-contract arrangements in the last five years, please skip to the next section.

|  | What was the funding source?   | What type of organization did you select for the pass-through or sub-contract arrangement?  | How beneficial was the arrangement to the state health agency?   | What, if any, were the main benefits you experienced as a result of this arrangement? | What, if any, were the challenges you experienced as a result of this arrangement? |
|--|--|---|--|---|--|
| Pass-through or sub-contract arrangement 1 (most recent) | <input type="radio"/> CDC<br><br><input type="radio"/> Other federal agency<br><br><input type="radio"/> State funds | <input type="radio"/> Public health institute<br><input type="radio"/> State university<br><input type="radio"/> Other university<br><input type="radio"/> Other type of organization | <input type="radio"/> Very beneficial<br><input type="radio"/> Somewhat beneficial<br><input type="radio"/> Neither beneficial nor problematic<br><input type="radio"/> Somewhat problematic<br><input type="radio"/> Very problematic |   |  |

|   | What was the funding source?   | What type of organization did you select for the pass-through or sub-contract arrangement?  | How beneficial was the arrangement to the state health agency?   | What, if any, were the main benefits you experienced as a result of this arrangement? | What, if any, were the challenges you experienced as a result of this arrangement? |
|---|--|---|--|---|--|
| Pass-through or sub-contract arrangement 2 (next most recent) | <input type="radio"/> CDC<br><br><input type="radio"/> Other federal agency<br><br><input type="radio"/> State funds | <input type="radio"/> Public health institute<br><input type="radio"/> State university<br><input type="radio"/> Other university<br><input type="radio"/> Other type of organization | <input type="radio"/> Very beneficial<br><input type="radio"/> Somewhat beneficial<br><input type="radio"/> Neither beneficial nor problematic<br><input type="radio"/> Somewhat problematic<br><input type="radio"/> Very problematic |   |  |

|  | What was the funding source?   | What type of organization did you select for the pass-through or sub-contract arrangement?   | How beneficial was the arrangement to the state health agency?   | What, if any, were the main benefits you experienced as a result of this arrangement? | What, if any, were the challenges you experienced as a result of this arrangement? |
|--|--|--|--|---|--|
| Pass-through or sub-contract arrangement 3 (third most recent) | <input type="radio"/> CDC<br><input type="radio"/> Other federal agency<br><input type="radio"/> State funds | <input type="checkbox"/> Public health institute<br><input type="radio"/> State university<br><input type="radio"/> Other university<br><input type="radio"/> Other type of organization | <input type="radio"/> Very beneficial<br><input type="radio"/> Somewhat beneficial<br><input type="radio"/> Neither beneficial nor problematic<br><input type="radio"/> Somewhat problematic<br><input type="radio"/> Very problematic |   |  |

**Direct awards to non-governmental organizations**

7. Are you aware of any instances in which the state public health agency applied for funding from the CDC or another federal agency, but a non-governmental organization in your state was awarded the funding instead?

- Yes
  No

If you answered "yes" to question 7, please fill in the following table. If not, please skip to question 9.

| 8. Who was the funder?  | What was the funding opportunity? | Who was the recipient? | In what year did this happen? |
|---|-----------------------------------|------------------------|-------------------------------|
| <input type="radio"/> CDC<br><input type="radio"/> Another federal agency |                                   |                        |                               |

9. In some instances, CDC or other federal agencies contract with non-governmental organizations (like ASTHO) to pass on funding to states for specific projects. Is your state health agency able to accept funding directly from a non-governmental organization?

- Yes, the state health agency can receive direct funding from an NGO
  No, the state health agency cannot receive direct funding from an NGO
  I don't know

If you answered "no" to question 9, please answer the following. Otherwise, skip to question 12.

|  |   |
|--|---|
| 10. In instances where the CDC or other federal agencies contracted with a non-governmental organization to pass on funding to states, has your state used fiscal intermediaries to receive the funding? | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Applicable |
| 11. In such instances, has your state used fiscal intermediaries to do work on the project (contribute to the deliverables)?   | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Applicable |

12. If a federal agency directly funds a non-governmental organization to provide funding for specific projects to local governments in your state, can the locality accept funding directly from the NGO?

- Yes
  No
  It varies by locality
  I don't know

If you answered "It varies by locality" to question 12, please answer the following question. Otherwise, skip to question 14.

13. On what basis does it vary?

- Population size
  County designation
  City designation
  Other
  I don't know

14. Are you interested in adopting or expanding the use of fiscal intermediaries in your state?

- Yes                       No                       Not sure

15. Adopting or expanding the use of fiscal intermediaries in my state would require approval by (select all that apply):

- State legislature       Formal rulemaking       No approval required outside the agency/Secretariat; can be accomplished as part of agency's business process       I don't know

16. Are there laws, regulations or policies in your state that encourage, endorse, or facilitate the use of fiscal intermediaries? If so please identify the laws, regulations or policies and send electronic copies, if possible.

- Yes                       No                       Not sure

17. Are there laws, regulations or policies in your state that discourage or prohibit the use of fiscal intermediaries? If so please identify the laws, regulations or policies and send electronic copies, if possible.

- Yes                       No                       Not sure

18. Please describe any additional thoughts you have about the advantages and disadvantages of using fiscal intermediaries.

**Submit**

## Appendix 2

### Summary of Fiscal Intermediaries Survey Results

ASTHO received 30 responses (29 states and 1 territory).

#### **Bona Fide Agent Arrangements**

1. *In the last five years, has your state public health agency authorized a “bona fide agent” or “designated agent” to contract with the CDC, another federal agency or receive state funds?*

Total Responses: 30

|     |    |            |
|-----|----|------------|
| Yes | No | Don't know |
| 6   | 23 | 1          |

2. *How many times have you used a bona fide or designated agent in the last five years?*

Total Responses: 6

|   |     |      |       |            |             |
|---|-----|------|-------|------------|-------------|
| 0 | 1-4 | 5-10 | 11-20 | 21 or more | No response |
| 0 | 2   | 2    | 0     | 1          | 1           |

3. *Please use the following tables to describe up to the three most recent instances of the use of a bona fide or designated agent. If you have not used a bona fide or designated agent in the last five years, please skip to the next section.*

| Funding       | # of reported arrangements | Organization               | # of reported arrangements | Beneficial or Problematic          | # of reported arrangements |
|---------------|----------------------------|----------------------------|----------------------------|------------------------------------|----------------------------|
| CDC           | 5                          | PHI                        | 1                          | Very beneficial                    | 5                          |
| Other federal | 3                          | State University           | 2                          | Somewhat beneficial                | 1                          |
| State         | 2                          | Other university           | 1                          | Neither beneficial nor problematic | 1                          |
|               |                            | Other type of organization | 4                          | Somewhat problematic               | 1                          |
|               |                            |                            |                            | Very problematic                   |                            |
| <b>Totals</b> | <b>10</b>                  |                            | <b>8</b>                   |                                    | <b>8</b>                   |



**Contract, Subcontract and Pass-through Arrangements**

4. *In the last five years, has your state public health agency entered into a pass-through or sub-contract arrangement whereby the state agency received funding from the CDC, another federal agency or state funds, but delegated a substantial portion of the work to a non-governmental partner (such as a public health institute, university or other non-profit organization)?*

Total Responses: 30

|     |    |            |
|-----|----|------------|
| Yes | No | Don't know |
| 26  | 2  | 2          |

[One state indicated in its initial response that it did not use contracts, subcontracts or pass-through arrangements; however, in a subsequent key informant interview, the state's respondent revised the response to indicate that the state does use these types of arrangements. The relevant data summaries have been revised by ASTHO to reflect this modified response.]

5. *How many times have you used a pass-through or sub-contract arrangement in the last five years?*

Total Responses: 26

|   |     |      |       |            |            |             |
|---|-----|------|-------|------------|------------|-------------|
| 0 | 1-4 | 5-10 | 11-20 | 21 or more | Don't know | No response |
| 0 | 3   | 1    | 2     | 14         | 0          | 6           |

6. *Please use the following tables to describe up to the three most recent instances of the use of a bona fide or designated agent. If you have not used a bona fide or designated agent in the last five years, please skip to the next section.*

| <b>Funding</b> | <b># of reported arrangements</b> | <b>Organization</b>        | <b># of reported arrangements</b> | <b>Beneficial or Problematic</b>   | <b># of reported arrangements</b> |
|----------------|-----------------------------------|----------------------------|-----------------------------------|------------------------------------|-----------------------------------|
| CDC            | 22                                | PHI                        | 6                                 | Very beneficial                    | 50                                |
| Other federal  | 25                                | State University           | 11                                | Somewhat beneficial                | 6                                 |
| State          | 13                                | Other university           | 2                                 | Neither beneficial nor problematic | 3                                 |
|                |                                   | Other type of organization | 37                                | Somewhat problematic               | 0                                 |
|                |                                   |                            |                                   | Very problematic                   | 0                                 |
| Totals         | 60                                |                            | 56                                |                                    | 59                                |

7. *Are you aware of any instances in which the state public health agency applied for funding from the CDC or another federal agency, but a non-governmental organization in your state was awarded the funding instead?*

Total Responses: 30

| Yes | No | Don't know |
|-----|----|------------|
| 1   | 29 | 0          |

8. *If you answered “yes” to question 7, please fill in the following table. If not, please skip to question 9.*

Total Responses: 0

[The one “yes” respondent to question 7 did not complete question 8.]

| Who was the funder?           | What was the funding opportunity? | Who was the recipient? | In what year did this happen? |
|-------------------------------|-----------------------------------|------------------------|-------------------------------|
| CDC<br>Another federal agency |                                   |                        |                               |

9. *In some instances, CDC or other federal agencies contract with non-governmental organizations (like ASTHO) to pass on funding to states for specific projects. Is your state health agency able to accept funding directly from a non-governmental organization?*

Total Responses: 29

| Yes | No | Don't know | No response |
|-----|----|------------|-------------|
| 29  | 0  | 0          | 1           |

If you answered “no” to question 9, please answer the following. Otherwise, skip to question 12.

10. *In instances where the CDC or other federal agencies contracted with a non-governmental organization to pass on funding to states, has your state used fiscal intermediaries to receive the funding?*

Total Responses: 0

| Yes | No | Not applicable |
|-----|----|----------------|
| -   | -  | -              |

11. In such instances, has your state used fiscal intermediaries to do work on the project (contribute to the deliverables)?

Total Responses: 0

| Yes | No | Not applicable |
|-----|----|----------------|
|     |    |                |

12. If a federal agency directly funds a non-governmental organization to provide funding for specific projects to local governments in your state, can the locality accept funding directly from the NGO?

Total Responses: 30

| Yes | No | Varies by locality | Don't know | No response |
|-----|----|--------------------|------------|-------------|
| 17  | 1  | 3                  | 9          | 0           |

If you answered "It varies by locality" to question 12, please answer the following question. Otherwise, skip to question 14.

13. On what basis does it vary?

Total Responses: 3

| Population size | County designation | City designation | Other | Don't know |
|-----------------|--------------------|------------------|-------|------------|
| 0               | 1                  | 0                | 2     | 0          |

14. Are you interested in adopting or expanding the use of fiscal intermediaries in your state?

Total Responses: 30

| Yes | No | Don't know | No response |
|-----|----|------------|-------------|
| 4   | 10 | 16         | 0           |

15. Adopting or expanding the use of fiscal intermediaries in my state would require approval by (select all that apply):

Total Responses: 30

| State legislature | Formal rulemaking | No approval required outside the agency/Secretariat; | Don't know | No response |
|-------------------|-------------------|--|------------|-------------|
| 1                 | 0                 | 9  | 16         | 4           |

16. Are there laws, regulations or policies in your state that encourage, endorse, or facilitate the use of fiscal intermediaries?

Total Responses: 30

| Yes | No | Don't know | No response |
|-----|----|------------|-------------|
| 1   | 11 | 18         | 0           |

If so please identify the laws, regulations or policies and send electronic copies, if possible.

None specifically identified.

17. Are there laws, regulations or policies in your state that discourage or prohibit the use of fiscal intermediaries?

Total Responses: 30

| Yes | No | Don't know | No response |
|-----|----|------------|-------------|
| 2   | 10 | 18         | 0           |

If so please identify the laws, regulations or policies and send electronic copies, if possible.

None specifically identified.

# Notes