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BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

States Use Added Flexibility Offered By The Preventive Health And Health Services Block Grant

In 1981 the Congress consolidated seven preventive health programs into the preventive health and health services block grant, which gave states broad program and administrative responsibilities Aided by continuing outlays from prior categorical grants, states strived to maintain program continuity between 1981 and 1983, but as those outlays diminished, states reassessed their needs and adjusted the level of support for individual program areas During this period states tended to assign higher priority and make fewer changes in areas where they had considerable involvement before the block grant, such as health incentive programs More changes were made in areas where states previously had less involvement, such as emergency medical services

Established state agencies were carrying out their expanded management responsibilities and reported management improvements They reported increased levels of involvement by certain legislatures, governors' offices, and interest groups and used various methods to obtain public input Overall, state officials rated the block grant as more desirable, while about half the interest groups preferred the prior categorical approach

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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON D C 20548

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To the President of the Senate and the
Speaker of the House of Representatives

Various committees of the Congress requested that the General Accounting Office review the implementation of the block grants created by the Omnibus Budget Reconciliation Act of 1981. The enclosed report provides comprehensive information concerning the progress states are making in implementing the preventive health and health services block grant. It is one of several reports we will issue on block grant implementation.

Copies of this report are being sent to the appropriate House and Senate Committees; the Secretary of Health and Human Services; the Director, Office of Management and Budget; and the Governors and legislatures of the states we visited.

Charles A. Bowsher
Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

STATES USE ADDED FLEXIBILITY OFFERED BY THE PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT

D I G E S T

The Omnibus Budget Reconciliation Act of 1981 substantially changed the administration of various federal domestic assistance programs by consolidating numerous federal categorical programs into several block grants and shifting primary administrative responsibility to states. This report focuses on one of those block grants--preventive health and health services (PHHS)--and is one of a series GAO will issue to give the Congress a status report on block grant implementation.

States GAO visited were aided in implementing the PHHS block grant by outlays from prior categorical grants, which continued to provide substantial support for program operations into 1982. States strived to maintain program continuity under the block grant, but as categorical funds diminished in 1983 and states reassessed their needs, they adjusted the level of support for individual program areas. Where states had considerable involvement in funding and administering the prior categorical programs, they tended to assign those areas higher priority and few service changes were made. Where states previously had limited control, however, more changes emerged in program areas.

As established state agencies implemented their expanded administrative responsibilities, program officials reported management improvements. Various methods were used to obtain public input, and certain state elected officials and interest groups were more involved than they had been under the prior programs. Most state officials rated the block grant more flexible and desirable, whereas about half the interest groups expressed a preference for the prior categorical approach.

GAO did its work in 13 states: California, Colorado, Florida, Iowa, Kentucky, Massachusetts, Michigan, Mississippi, New York, Pennsylvania, Texas, Vermont, and Washington. Together these states receive about 40 percent

of the national PHHS block grant appropriations and account for about half of the nation's population. While these states represent a diverse cross-section, the results of GAO's work cannot be projected to the entire country.

BLOCK GRANT MERGES FEDERAL PROGRAMS AND EXPANDS STATES' AUTHORITY

The federal government has helped fund state preventive health services since the 1930's. Initially federal programs were narrowly focused on specific health problems, but in 1966 the Congress consolidated the programs into a single health incentive grant which gave states greater flexibility. Additionally, between 1966 and 1981, several new preventive health categorical grant programs were created.

In 1981 the Congress consolidated seven preventive health programs into the PHHS block grant: the health incentive grant, health education and risk reduction, hypertension, fluoridation, emergency medical services, urban rat control, and home health services. In addition, the 1981 legislation mandated that rape crisis and prevention services be provided. The legislation also essentially gave broad program and administrative responsibility to the states.

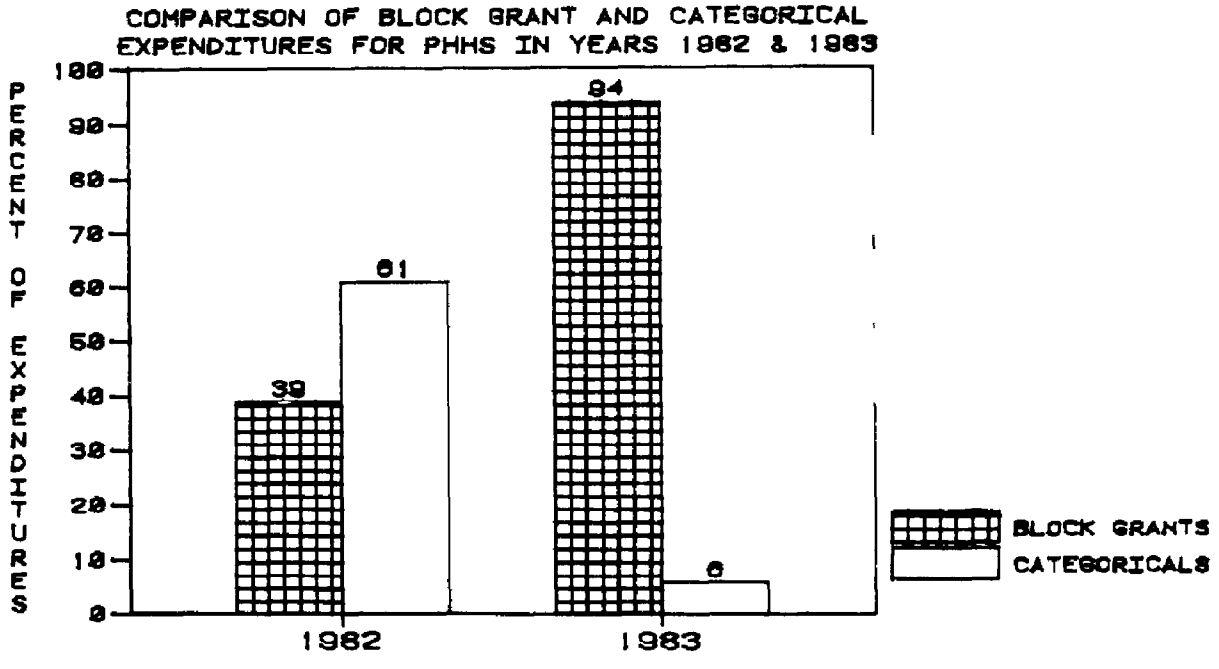
In fiscal year 1982, the Congress appropriated about $82 million for the PHHS block grant, of which about $79 million was distributed to the states. This represented about a 14.5-percent reduction from the $92.5 million distributed to the states in 1981 for programs consolidated into the block grant. In 1983, the amount distributed to the states was increased by about 8 percent to about $85 million. (See p. 3.)

CATEGORICAL OUTLAYS EASE ADJUSTMENTS TO REDUCED FUNDING

Although PHHS funds accounted for less than 3 percent of the states' total health budgets, they generally represented 30 percent or more of financing for broader state preventive health programs funded with block grant moneys as well as state and other funds. Therefore, decisions on how to use PHHS funds are integrated into states' overall health planning and budgeting

processes and are made in the context of the overall availability of funds from all sources. As a result, changes in federal and state funding were important in establishing program priorities and objectives, along with states' desires to assure program continuity and minimize service disruptions. (See pp. 8, 9, 20, 21, and 22.)

Although federal allocations decreased as states began implementing the PHHS block grant, outlays from 1981 categorical awards helped support state and local operations in fiscal years 1982 and 1983. This situation was most evident for the 11 states operating the block grant since 1981. As shown below, such outlays comprised 61 percent of total 1982 expenditures of categorical and block grant funds, or about $15 million, in the 10 states where complete data were available and still accounted for 6 percent, or about $1.5 million, in 1983. (See pp. 12 to 13.)



Tear Sheet

Categorical outlays helped offset the reduced federal appropriations and enabled states to carry forward an average of 43 percent of their 1982 PHHS block grant awards into 1983. As categorical funds decreased, the share of total expenditures from state revenues increased in 9 of the 11 states between 1981 and 1983. (See pp. 14 to 16.)

Because changes in state funding and the availability of categorical outlays varied among states, trends in total expenditures were mixed. Total expenditures increased in 6 of the 11 states operating the block grant between 1981 and 1983 and also increased between 1982 and 1983 in California and New York, which both delayed block grant implementation until 1982. The growth in half these states, however, was modest, ranging from 4 to 6 percent over the 1981-83 period. After adjusting for a national inflation factor for state and local purchases of goods and services of about 7 percent annually over this period, total expenditures increased in 3 of the 13 states. (See pp. 9, 10, 11, 12, and 20.)

STATES STRESS CONTINUITY BUT MOVE TO MODIFY PROGRAM PRIORITIES

The services offered under the PHHS block grant are essentially the same as those funded under the prior categorical programs. However, to better reflect their views, states modified certain program priorities and services. The scope and dimensions of changes varied considerably by program area and were influenced by the degree of involvement states previously had in making funding or administrative decisions. (See pp. 17 to 22 and 24 to 44.)

States had considerable involvement in health incentive, hypertension, fluoridation, and health education and risk reduction categorical programs. Although there were variations across the states, these program areas tended to receive a higher priority, and the percentage of total expenditures for them was generally maintained or increased. The percentage of total expenditures decreased by more than 1 percent in only one state for fluoridation, two states for hypertension, and three states for health incentive and health education and risk reduction. (See pp. 30 to 41.)

States also found little reason to adjust the types of services provided in these four program areas, and changes were linked more to factors independent of expanded flexibility. For example, in the hypertension area six states either shifted from mass screening to more targeted screening efforts or expanded the program's geographical coverage. These actions were attributed primarily to reassessments of recipients' needs or funding restrictions. (See pp. 30 to 33.)

Previously, states had less control over federal emergency medical services and rodent control funds, and under the block grant many assigned these program areas a lower priority. The percentage of total expenditures decreased by more than 1 percent in 8 of the 13 states for emergency medical services and in 4 of the 8 states where rodent control activities were funded in the 1981-83 period. In emergency medical services, officials cited the restriction on equipment purchases as a reason for decreased expenditures because communications equipment was a major prior program expense. Six states did, however, use their new flexibility to broaden the geographical coverage of emergency medical services and to begin funding activities other than those solely supporting the regional coordination systems that were the focus of the prior program. (See pp. 24 to 30.)

In addition to the 13 states, GAO visited 44 service providers to obtain limited examples of the implications for service providers of state block grant implementation. These providers experienced a wide range of changes to their operations. Certain changes were attributed directly to block grant implementation, but providers pointed to an array of factors influencing their operations, particularly escalating costs and changes in other sources of funding.

STATES INVOLVED IN MANAGING PROGRAMS SUPPORTED WITH BLOCK GRANT FUNDS

States typically assigned block grant responsibilities to offices which administered the prior programs and made only minimal changes to their service provider network. Generally, states were carrying out their expanded management role by establishing program requirements, monitoring

grantees, providing technical assistance, auditing funds, and collecting data. These efforts were often integrated with ongoing efforts for state or other federal programs. (See pp. 46 to 56.)

The block grant was intended to enable states to manage programs more efficiently and effectively. According to state officials, the block grant enabled 8 of the 13 states to change or standardize their administrative requirements, 7 to improve planning and budgeting, 3 to better use state personnel, 10 to reduce the time and effort associated with preparing grant applications, and 12 to reduce the time and effort involved in reporting to the federal government. While there were numerous indications of administrative simplification, specific cost savings could not be quantified, and officials offered varying perceptions of changes in administrative costs under the block grant. (See pp. 57 to 63.)

INCREASED PUBLIC PARTICIPATION AND INVOLVEMENT OF STATE ELECTED OFFICIALS

States reported conducting the mandated legislative hearings and preparing required reports on the intended use of funds and making them available for public comment. In addition, 10 states reported holding executive hearings and 8 states reported using one or more advisory groups. Many program officials reported that input from advisory committees, together with informal consultations, had the most influence on decisions. (See pp. 67 to 71.)

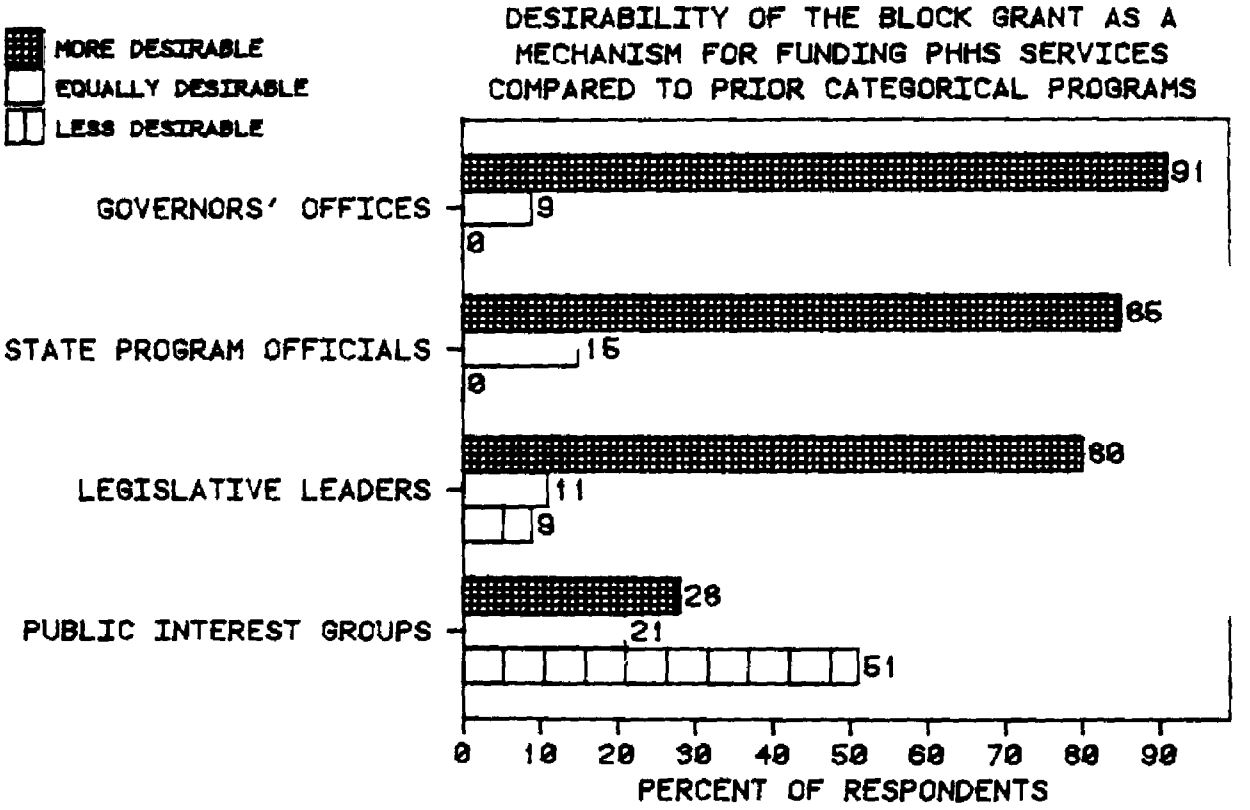
State officials generally believed that levels of public participation were greater under the the block grant than under the prior categorical programs. Also, program officials noted governors and legislatures had become more involved in six and seven states, respectively, usually through the state budget process. (See pp. 64 to 67.)

Under the block grants, interest groups across the 13 states increased their activity with state officials. They were most satisfied with their access to state officials, the time and location of hearings, and the time spent on block grants at hearings. They were least

satisfied with the availability of information prior to hearings, the opportunity to comment on revised plans, and the timing of hearings relative to the states' decisionmaking process. Forty-eight percent believed that changes states have made adversely affected individuals or organizations that they represent, whereas about 27 percent viewed such changes favorably; the rest perceived no impact. (See pp. 71 to 74.)

OVERALL PERCEPTIONS OF BLOCK GRANTS DIFFER

As shown below, state executive and legislative branch officials liked the block grants' increased flexibility and viewed it as more desirable than the prior categorical approach. Conversely, most interest groups tended to view the block grant as a less desirable mechanism. While interest groups and state officials had differing views, both expressed concern about the federal funding reductions that accompanied the block grant, which from their perspective tended to somewhat diminish its advantages. It was often difficult, however, for individuals to separate block grants--the funding mechanism--from block grants--the budget-cutting mechanism. (See p. 75.)



AGENCY COMMENTS

Department of Health and Human Services officials commented that this report was an informative summary of the implementation of the PHHS block grant which would be useful for monitoring the block grant program. They provided oral comments, which were generally limited to technical matters, and these were incorporated, where appropriate, in this report.

Contents

ABBREVIATIONS

CDC	Centers for Disease Control
EMS	emergency medical services
GAO	General Accounting Office
HHS	Department of Health and Human Services
PHHS	preventive health and health services

CHAPTER 1

INTRODUCTION

The Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) substantially changed the administration of various federal domestic assistance programs by consolidating numerous federal categorical programs into block grants and shifting primary administrative responsibility to the states. Of the nine block grants enacted, four relate to health services, one to social services, one to low-income energy assistance, one to education, one to community development, and one to community services.

The 1981 act gives states greater discretion, within certain legislated limitations, to determine programmatic needs, set priorities, allocate funds, and establish oversight mechanisms. Since the act was passed, the Congress, as well as the public and private sectors, has been greatly interested in how the states have exercised their additional discretion and what changes the block grant approach has held for services provided to the people. In August 1982 we provided Congress an initial assessment of the 1981 legislation in our report entitled Early Observations on Block Grant Implementation (GAO/GGD-82-79, Aug. 24, 1982).

Subsequently, we embarked on a program designed to provide the Congress with a series of comprehensive, updated reports on states' implementation of these programs. The first of these reports, entitled States Are Making Good Progress in Implementing the Small Cities Community Development Block Grant Programs, was issued on September 8, 1983 (GAO/RCED-83-186). This report addresses the implementation of the preventive health and health services (PHHS) block grant.

HISTORY OF THE PREVENTIVE HEALTH AND HEALTH SERVICES PROGRAM

The federal government has helped fund state preventive health services on a continuous basis since the mid-1930's. From 1935 to 1965, 16 different categorical grant programs were established to combat specific diseases and public health problems, including cancer, chronic illness, dental disease, heart disease, tuberculosis, venereal disease, and radiological health. As a general rule, the funds for each of these programs could not be transferred to other programs and could not be used to combat other public health problems, even if they were perceived to be more serious.

Officials from states, counties, and cities expressed increasing concern about their lack of flexibility in using these funds--particularly in view of their expanding public health responsibilities, especially those emanating from environmental pollution and population growth. In 1966 the Congress also became concerned with state and local health agencies' abilities to effectively use federal categorical funds and, in response to those concerns, consolidated the then existing categorical programs into a single block grant called the health incentive program.

Between 1966 and 1981 funding for the health incentive grant program continued, while new categorical programs were created to deal with health problems relating to hypertension, health education, water fluoridation, urban rat control, emergency medical services, and home health services. In 1981 the Congress again consolidated these preventive health programs into a single block grant.

THE PHHS BLOCK GRANT

Effective October 1, 1981, section 901 of the Omnibus Budget Reconciliation Act amended the Public Health Service Act to establish the PHHS block grant. Seven existing federal categorical programs were consolidated into this block grant, and rape crisis and prevention were also included as mandated services. By July 1982, all states and territories were administering the PHHS block grant.

The purpose of the PHHS block grant is to enable each state to fund a variety of public health and preventive health services for individuals and families. Generally, funds can be used to provide comprehensive public health services; establish community-based programs for demonstrating and evaluating optimal methods of delivering services; provide health education and risk reduction services, such as deterring smoking and the use of alcohol; establish and maintain programs to detect and prevent hypertension; coordinate emergency medical services; establish rodent control programs and fluoridation programs; demonstrate how to establish home health agencies; and provide services to rape victims and for rape prevention.

The 1981 act requires states to provide the Secretary, Department of Health and Human Services (HHS), information on PHHS block grant activities including (1) a report describing the intended use of payments, (2) a statement which, among other things, assures that the state will identify the populations and areas needing services and will use funds allotted in accordance with the purposes of the act, (3) an annual report on block

grant activities, and (4) annual audit reports of program expenditures. In addition, states applying for funds must also agree to make grants to the following program areas in the amounts shown:

--For hypertension, at least 75 percent of fiscal year 1981 funds in fiscal year 1982, 70 percent in fiscal year 1983, and 60 percent in fiscal year 1984.

--For rape prevention, an allocation determined according to state population from a total national set-aside of at least $3 million for each fiscal year.

The states are generally free to distribute funds across the remaining eligible services as they choose.

The implementation of the PHHS block grant was accompanied by federal funding reductions. The 1982 block grant funds distributed to the states were 14.5 percent below the 1981 levels for all of the categoricals consolidated into the block grant. Funding rose 7.8 percent and 2.1 percent in fiscal years 1983 and 1984, respectively, but the levels were still below the 1981 levels. The following table shows the authorizations, appropriations, and distributions to all of the states for the 1981-84 period.

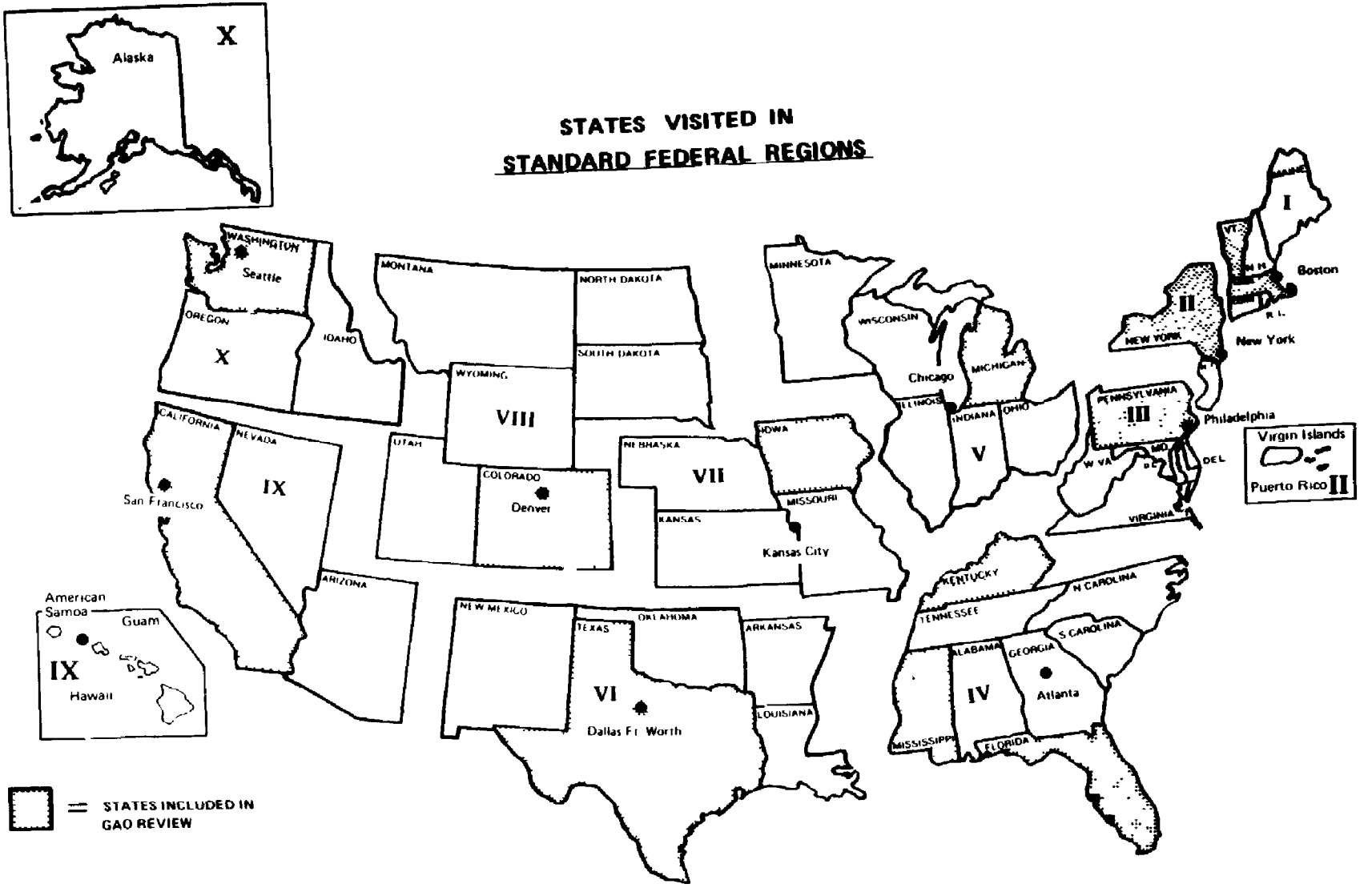
Total PHHS Block Grant Funding

Fiscal year	Authorizations	Appropriations	Distributed within states	Change in funds distributed	
				Dollars	Percent
	(millions)				
1981	$119.5	$93.2	$92.5		
1982	95.0	81.6	79.1	$(13.4)	(14.5)
1983	96.5	86.2	85.3	6.2	7.8
1984	98.5	88.2	87.1	1.8	2.1

Several of the block grants received supplemental funding in 1983 through the Emergency Jobs Appropriations Act of 1983 (Public Law 98-8), commonly referred to as the jobs bill. However, no funds were provided for the PHHS block grant from this source.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our primary objective in work on all block grants is to provide the Congress with comprehensive reports on the states' progress in implementing them. To do that, as shown in the map on the following page, we performed our work in 13 states:


STATES VISITED IN
STANDARD FEDERAL REGIONS
Alaska
X
WASHINGTON
Seattle
OREGON
X
IDAHO
MONTANA
NORTH DAKOTA
SOUTH DAKOTA
WYOMING
VIII
CALIFORNIA
NEVADA
IX
San Francisco
UTAH
COLORADO
Denver
ARIZONA
NEBRASKA
VII
KANSAS
Kansas City
MISSOURI
IOWA
MINNESOTA
WISCONSIN
Chicago
MICHIGAN
ILLINOIS
INDIANA
OHIO
V
NEW YORK
II
PENNSYLVANIA
III
Philadelphia
W VA
MD
DEL
VIRGINIA
Boston
New York
Virgin Islands
Puerto Rico II
KENTUCKY
TENNESSEE
N CAROLINA
S CAROLINA
GEORGIA
Atlanta
ALABAMA
MISSISSIPPI
FLORIDA
IV
NEW MEXICO
TEXAS
OKLAHOMA
ARKANSAS
LOUISIANA
VI
Dallas Ft Worth
American Samoa
Guam
IX
Hawaii
= STATES INCLUDED IN GAO REVIEW

California, Colorado, Florida, Iowa, Kentucky, Massachusetts, Michigan, Mississippi, New York, Pennsylvania, Texas, Vermont, and Washington. These states were selected to attain geographic balance. The states had (1) differing fiscal conditions and varying ranges of per capita incomes, (2) varying degrees of involvement by state executive and legislative branches in overseeing and appropriating federal funds, and (3) a variety of service providers offering preventive health services. At least 1 state was selected in every standard federal region, and in total, the 13 states accounted for approximately 40 percent of the fiscal year 1982 PHHS block grant funds and about half of the nation's population. Our sample of 13 states was a judgmental selection and not intended for projection purposes.

Our review focused on how states are implementing the PHHS block grant and what changes, particularly those related to the block grant, have occurred since the consolidation of the prior categorical programs. Information was obtained at three management levels: the Centers for Disease Control (CDC), the state, and service providers.

At the federal levels, we obtained PHHS fund allocations for fiscal years 1981 through 1984 and certain program information from CDC headquarters in Atlanta, Georgia. Also, we discussed with headquarters officials HHS policies for implementing and monitoring the program.

At the state and local levels, we used a wide variety of data collection instruments and approaches to obtain information from individuals or organizations responsible for or having an interest in (1) a single block grant and (2) multiple block grants. These instruments were designed with the objective of gathering consistent information across states and across block grants where reasonable and practical.

The first set of information sources included state program officials responsible for administering the PHHS block grant and individual service providers. To obtain information from these sources, we used a state program officials questionnaire, financial information schedules, a state audit guide, a service provider data collection guide, and an administrative cost guide.

Almost identical versions of the program officials questionnaire and administrative cost guide were used for all block grants. The other three instruments had to be tailored to each block grant because of differences in the types of programs and services provided under each block grant and the manner in which financial information had to be collected. Our analysis of financial trends focused on changes in total expenditures from federal, state, and other sources, not exclusively on block

grant funds. As a result, we did not make determinations as to whether states had complied with the specific requirements in the block grant legislation governing the use and earmarking of PHHS funds for specific purposes.

The service provider data collection guide was used not to obtain comprehensive data from the service provider level but rather to identify examples of the implications, for service providers, of state policies and practices in block grant implementation. We visited 44 service providers which were judgmentally selected by considering types and size of service providers, location in the state (urban and rural areas), and types of PHHS services provided. These 44 providers are not statistically representative of the total universe of providers, and they represent only a small portion of the total number of service providers in the 13 states. In our selection, we attempted to include where appropriate at least three service providers from each state we visited and at least three service providers for each of the prior categorical programs consolidated into the PHHS block grant. In two states, we expanded our selection to include additional service providers and units of local government that both provided services and passed block grant funds received from the state through to other service providers.

The second set of information sources included representatives from the governor's office, officials from the state legislature, and public interest groups. To obtain information from these sources, we used questionnaires which generally asked about the respondent's specific experience with the block grants and obtained perceptions concerning the block grant concept.

The questionnaires sent to public interest groups solicited their views concerning how the state in which the group is located had implemented and administered block grants. We identified interest groups by contacting about 200 national level organizations, a private organization with extensive knowledge about block grants, and officials in the states we visited and by reviewing mailing lists provided by HHS. Although not a representative sample of all concerned public interest groups, 1,662 questionnaires pertaining to all block grants under review were mailed out and 786 responses were received, of which 234 indicated having at least some knowledge of their state's implementation of the PHHS block grant. These 234 respondents became the basis for our analysis of public interest groups for the PHHS block grant; however, not all 234 responded to each question.

A detailed discussion of the content, source of information, and method of administration for each data collection instrument is included in appendix I. Our work was conducted in accordance with generally accepted government auditing standards.

All questionnaires were pretested and subjected to external review prior to their use. The extent of pretest and review varied, but in each case one or more knowledgeable state officials or other organizations provided their comments concerning the questionnaire or completed the questionnaire and discussed their observations with us. Also, the service provider data collection guide was discussed with various service providers. The design of the financial information schedule was developed in close consultation with the Urban Institute and HHS.

Our field work on the PHHS block grant was done primarily between January and August 1983. At the conclusion of our work, a summary was prepared containing the data developed, using the financial information schedules and the state audit guide. We briefed state officials on the information contained in the summary and gave them an opportunity to comment on its accuracy and completeness. Particular attention was given to the financial information, and state officials were asked to review the data to ensure that it accurately represented trends in the use of categorical and block grant funds over the 1981-83 period. Our summaries were modified, where appropriate, on the basis of comments provided by state officials. The final summaries, together with information received directly from questionnaire respondents, were used to prepare this report.

The information presented in this report was developed for the purpose of assessing the status of PHHS block grant implementation and not intended to evaluate states' effectiveness in devising or managing programs. The following chapters focus on the funding patterns that have emerged under the PHHS block grant and how they differed from the prior categorical programs, changes made at the state and service provider level to the type of PHHS services offered and how they are delivered, state organization and management changes made, and the involvement of citizens, state elected officials, and interest groups in processes which led to decisions on how block grant funds would be used.

CHAPTER 2

STATES USE BLOCK GRANT FLEXIBILITY IN MAKING PROGRAM FUNDING DECISIONS

A major objective of block grants was to provide states more authority to determine their needs and establish funding priorities. States historically have had key roles in administering certain federal preventive health activities, but the block grant expanded opportunities to alter the funding patterns established under the prior categorical programs. Such opportunities, however, were tempered by the reduced federal funding levels associated with the block grant.

Although federal allocations were reduced, trends in total expenditures between 1981 and 1983 for program areas supported with PHHS block grant funds were mixed, with such expenditures increasing in certain states and declining in others. To varying degrees, outlays of categorical funds overlapped with initial block grant allocations, thereby offsetting reduced 1982 federal funding and enabling states to carry forward block grant funds into future years. Additionally, most states increased the expenditure of state funds during the 1981-83 period. Although such increases have prompted a rise in total expenditures in eight states since block grant implementation, the growth in most cases has been modest, and in only three states did total expenditures rise after adjusting for inflation.

While funding has been a central concern, states have used their expanded flexibility in reassessing program priorities and have integrated planning for block grant funds into their overall health planning and budgeting processes. State officials said that they have strived to maintain continuity with the funding patterns established under the prior categorical programs. However, expenditure patterns show that they have modified the level of support provided to individual program areas to better reflect their priorities and the availability of funds.

BROADER STATE PROCESSES DETERMINE USE OF BLOCK GRANT FUNDS

Planning for the PHHS block grant is integrated into states' overall health planning and budgeting processes. Rather than operating as a separate activity, the block grant helps support various state health programs. In this way, decisions on how to use PHHS block grant funds are linked to broader decisions on state health programs and are made in the context of the overall availability of funds from federal, state, and other sources.

Although PHHS block grant funds account for a very small percentage of a state's overall health budget, they do finance a significant portion of certain state programs focusing on preventive health. PHHS block grant funds in each of the states we visited comprised less than 3 percent of the states' total 1983 health budget. However, in 8 of 13 states, PHHS block grant funds represented 30 percent or more of total 1983 expenditures for the preventive health program areas which were funded with PHHS block grant funds, and in no state did they represent less than 13 percent.

The bulk of the remaining program support in these states typically came from state revenues. However, states often supplemented state and block grant moneys with other federal funds, such as Department of Transportation Highway Safety grants and HHS Refugee Health grants. Some states also obtained other funds by requiring a local cash match or by charging fees.

Although block grant planning is integrated with states' overall planning and budgeting processes, the extent of integration varies. In several states, the processes are closely intertwined and PHHS block grant plans are ultimately prepared directly from comprehensive state plans or budgets. For example, Michigan's Department of Public Health develops a budget taking into consideration state health needs, ongoing programs, and expected funding levels from all sources. Once enacted, this budget is used to prepare the block grant intended use report. Likewise, Colorado allocates block grant funds and funds from other sources to specific programs during the state's health planning and budgeting process and prepares its intended use report after the state budget is passed. Similarly, Vermont and Mississippi use state health planning documents in preparing their intended use reports.

In other states, PHHS block grant planning is separate and feeds directly into the budget. For example, in New York, the health department has a separate budget process for federal funds and state funds. For federal funds, a report is submitted to the state legislature reflecting the health department's plans and budget for the PHHS block grant. Subsequently, budget proposals for federal funds are integrated with those for state funds as part of the state's overall budget request to the legislature.

TRENDS IN OVERALL EXPENDITURES MIXED

Trends in total expenditures for program areas supported with PHHS block grant funds varied considerably among the states during the 1981-83 period. As shown in table 2.1, changes in total expenditures ranged from a 19-percent increase in Texas to a 17-percent decrease in Vermont for the 11 states that

administered the block grant since it began in October 1981.[1] Moreover, total expenditures rose in six states and declined in five.

Table 2.1

Total Expenditures for Program Areas Funded With Categorical/Block Grant Funds[a]

State	Total expenditures 1981	1982	1983	Change in expenditures from 1981 to 1983 Amount	Percent
	----------(000 omitted)----------				
Colorado	$ 8,208	$ 9,115	$ 9,522	$1,314	16
Florida	10,476	10,644	10,876	400	4
Iowa[b]	3,726	2,797	3,933	207	6
Kentucky	9,280	10,272	9,633	353	4
Massachusetts	6,394	4,839	5,382	(1,012)	(16)
Michigan[c]	9,224	11,598	8,202	(1,022)	(11)
Mississippi	2,724	2,591	2,879	155	6
Pennsylvania	13,286	12,577	12,615	(671)	(5)
Texas[b]	5,993	6,546	7,146	1,153	19
Vermont	992	637	821	(171)	(17)
Washington[d]	2,751	2,690	2,587	(164)	(6)

[a]Total expenditures include federal PHHS categorical and block grant funds; other federal funds for related programs; state funds; local matching funds; and fees, copayments, and reimbursements (see pp. 80 and 81).

[b]Funding from local sources excluded due to unavailability of consistent data for all years.

[c]For comparison purposes with other states, state expenditures for state/local cost sharing and laboratory services were deleted because those expenditures included costs of activities not directly related to preventive health services as we defined them, e.g., laboratory services include testing specimens for environmental protection purposes.

[d]Based on award rather than expenditure data.

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[1]Because California and New York began block grant administration in July 1982 and only had 1 full year's experience with the program during the 1981-83 period, changes in expenditures in those states are discussed separately on page 20.

The trends in total expenditures varied widely among the states, although each state experienced about a 14.5-percent reduction in its 1982 block grant allocation from the 1981 prior categorical program levels. Although the 1983 block grant allocations to the states increased about 8 percent over 1982 levels, they were still about 8 percent below the 1981 allocations made within the states.

Changes in total expenditures did not parallel changes in block grant allocations primarily due to two key factors--ongoing outlays from prior categorical awards and changes in state funding. To varying degrees, the availability of categorical outlays during block grant years helped offset the reduced block grant allocations and enabled states to carry forward block grant funds into future years. Also, certain states increased expenditure of state funds to help maintain or increase total program expenditures. However, such expenditures declined in other states.

A different picture emerges when total expenditures are adjusted based on a national inflation rate for state and local purchases of goods and services of about 7 percent a year over the 1981-83 period. As shown in table 2.2, nine states had decreases in constant dollar expenditures ranging from 7 percent in Iowa and Mississippi to 27 percent in Vermont. Colorado experienced a 2-percent increase, and Texas experienced a 5-percent increase.

Table 2.2

Total Expenditures Adjusted for Inflation

State	Total expenditures 1981	Total expenditures 1983 adjusted	Change in expenditures Amount	Change in expenditures Percent
	--------(000 omitted)----------			
Colorado	$ 8,208	$ 8,351	$ 143	2
Florida	10,476	9,538	(938)	(9)
Iowa[a]	3,726	3,449	(277)	(7)
Kentucky	9,280	8,448	(832)	(9)
Massachusetts	6,394	4,720	(1,674)	(26)
Michigan[b]	9,224	7,193	(2,031)	(22)
Mississippi	2,724	2,525	(199)	(7)
Pennsylvania	13,286	11,063	(2,223)	(17)
Texas[a]	5,993	6,267	274	5
Vermont	992	720	(272)	(27)
Washington[c]	2,751	2,269	(482)	(18)

[a]Local funding excluded because complete data were not available.

[b]For comparison purposes with other states, state expenditures for state/local cost sharing and laboratory services were deleted because those expenditures included costs of activities not directly related to preventive health services as we defined them, e.g., laboratory services include testing specimens for environmental protection purposes.

[c]Based on award rather than expenditure data.

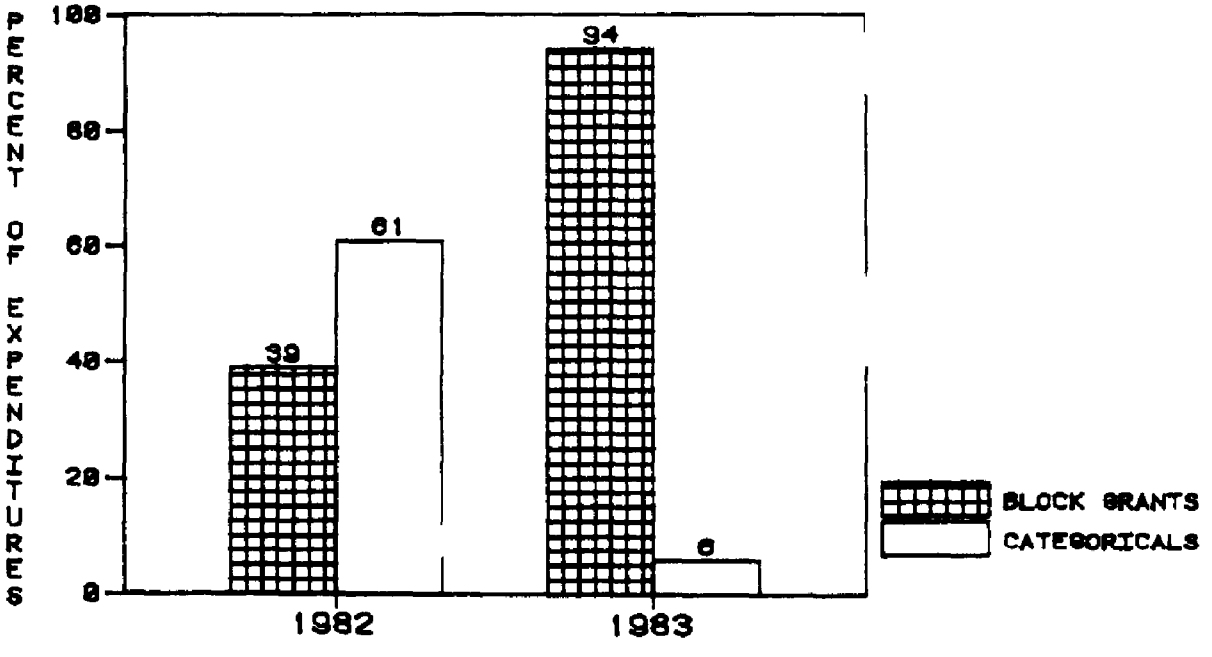
ONGOING CATEGORICAL OUTLAYS LESSEN IMPACT OF BLOCK GRANT REDUCTIONS

Expenditures from prior categorical awards were important because almost all of the categorical programs consolidated into the PHHS block grant were project grants funded for at least a 12-month period. These grants were awarded to states and other entities at various times throughout federal fiscal year 1981, many in the last quarter. In the states we visited, 69 percent of the 1981 awards extended into fiscal year 1982, and some continued into 1983.

As a result, even though states had block grant funding available, many state and local service providers were able to continue operations well into fiscal year 1982 with 1981 categorical funds. As shown in chart 2.1, ongoing categorical

outlays for the 10 states where complete data were available comprised 61 percent of total 1982 expenditures of categorical and block grant funds. Such categorical outlays decreased by 1983 but still accounted for 6 percent of total expenditures of categorical and block grant funds.

CHART 2.1
COMPARISON OF BLOCK GRANT AND CATEGORICAL EXPENDITURES FOR PHHS IN YEARS 1982 & 1983



As shown in table 2.3, ongoing categorical outlays comprised at least 48 percent of 1982 expenditures of categorical and block grant funds in all 10 states where data were available. For example, in Mississippi about 93 percent of federal funds expended in 1982 were from former categorical grants, including 100 percent of emergency medical services funds and 78 percent of hypertension funds. In Pennsylvania, 1981 categorical awards for emergency medical services, fluoridation, and health education and risk reduction extended through 1982, and block grant funds did not have to be expended for those programs until 1983.

Table 2.3

Expenditures of Categorical Funds During Block Grant Years[a]

State	1982 categorical expenditures	Percent of total categorical & block grant expenditures	1983 categorical expenditures	Percent of total categorical & block grant expenditures
	(000 omitted)		(000 omitted)	
Colorado	$1,209	74	$241	15
Florida	1,936	73	235	8
Iowa	366	57	8	1
Kentucky	906	54	207	14
Massachusetts	1,122	68	5	0
Michigan	2,955	51	0	0
Mississippi	1,328	93	260	14
Pennsylvania	3,086	64	518	10
Texas	1,926	48	0	0
Vermont	162	55	18	7

[a]Complete data were not available in Washington.

Although ongoing categorical outlays had diminished by 1983, they mitigated the impact of 1982 block grant funding reductions and delayed the need to expend all block grant funds. The continued expenditure of categorical funds, coupled with the 2-year availability of block grant allocations, allowed states more time to plan for the use of block grant funds and gave them the flexibility to maintain a reserve of funds to buffer the uncertainties of future federal allocations. As a result, states carried forward an average of 43 percent of their federal fiscal 1982 PHHS block grant awards into federal fiscal year 1983, ranging from 14 percent in Vermont to 77 percent in Massachusetts. Several states were projected to carry forward 1983 block grant funds into 1984.

MOST STATES INCREASE THEIR CONTRIBUTIONS TO TOTAL EXPENDITURES

As shown in table 2.4, eight states increased expenditures of state funds for program areas supported by PHHS block grant funds during the 1981-83 period.

Table 2.4

Changes in Expenditures of State Funds for Program Areas Supported With Block Grant Funds

State	State expenditures 1981	State expenditures 1983	Percent change 1981-83
	——(000 omitted)——		
Colorado	$3,820	$5,546	45
Florida	3,842	5,252	37
Iowa	2,245	2,509	12
Kentucky	7,779	8,194	5
Massachusetts	3,443	3,042	(12)
Michigan	3,942	3,775	(4)
Mississippi	147	412	180
Pennsylvania	7,043	6,184	(12)
Texas	2,202	2,577	17
Vermont	349	538	54
Washington	1,611	1,738	8

Increased expenditures of state funds were an important factor influencing changes in total expenditures. Of the eight states where expenditures of state funds increased, six also experienced a growth in total expenditures. Conversely, all three states with decreased expenditures of state funds also had a decline in total expenditures.

Another factor influencing increases in expenditures of state funds was the anticipated reduction in federal block grant funding. For example, Florida officials said that the expenditure of state funds increased by $1.4 million to offset reductions in federal funding and to maintain the level of services in certain high priority programs. In Colorado the increased expenditure of $1.7 million in state funds more than offset reduced federal funds.

As expenditures of state funds increased, state funding accounted for a larger proportion of total expenditures in 1983 than in 1981 in 9 of the 11 states, as shown in table 2.5. While states assumed a greater share of total expenditures as the federal share declined, the extent to which this occurred among the states varied considerably.[2] For example, in Kentucky, the proportion of state contributions increased only

[2]For details on the percentage of expenditures by source of funds, see appendix II.

1 percent, from 84 to 85 percent of total expenditures. However, in Vermont, the state's share grew from 35 to 66 percent of total expenditures.

Table 2.5

Changes in Percentage Share of Total Expenditures Derived From State Funds

State	1981 percent of total expenditures	1983 percent of total expenditures
Colorado	47	58
Florida	37	48
Iowa	60	64
Kentucky	84	85
Massachusetts	54	57
Michigan	43	46
Mississippi	5	14
Pennsylvania	53	49
Texas	37	36
Vermont	35	66
Washington	59	67

CHANGES IN OTHER FUNDING SOURCES VARY

In addition to block grant, categorical grant, and state funds, other sources of funds are available to support state preventive health programs. For instance, states may transfer funds from certain other block grants into the PHHS block grant. While 2 of 11 states exercised this option during the 1982-83 period, the transfers represented a small source of funds. Colorado transferred $146,000 from the alcohol, drug abuse, and mental health block grant in 1983, and Kentucky transferred $239,000 in 1982 and $296,000 in 1983 from the low-income home energy assistance block grant.

Another source of funding in 9 of the 11 states during the 1981-83 period was other federal programs, such as grants from the Environmental Protection Agency for hazardous waste control and the Public Health Service for venereal disease control. In six of the nine states, however, other federal funds accounted for less than 5 percent of total expenditures in 1983, and only in Colorado did they exceed 15 percent. Of the nine states, six experienced decreases in other federal funds expended during the 1981-83 period. For example, expenditures from other federal sources in Colorado declined from $2.8 million in 1981 to $2.3 million in 1983.

In addition to transfers from other block grants and grants from other federal programs, certain states obtained funds from local matching moneys, fees, and third party reimbursements. Eight of the 11 states used such sources during the 1981-83 period, and 6 were able to provide consistent data on such funds during this period. In three states these funds represented less than 1 percent of total expenditures in 1983, whereas in two states, Florida and Mississippi, such funds made up about 20 percent of 1983 total expenditures. From 1981 to 1983, expenditure of these funds declined by 7 percent in Mississippi and increased by 12 percent in Florida. Florida officials said that their increase was a direct result of local matching funds having to keep pace with the rise in state expenditures.

EXPENDITURE TRENDS BEGIN TO REFLECT STATE DECISIONS TO MODIFY PROGRAM PRIORITIES

With few exceptions, categorical program areas funded in 1981 continued to receive support across the 11 states in 1983, as shown in appendix III. Generally, states emphasized maintaining continuity with the patterns established under the categorical programs. Many modifications, however, were made in the level of support for individual program areas to coincide with state priorities and the availability of funds.

As shown in table 2.6, changes in expenditures between 1981 and 1983 by PHHS program area varied considerably. For the 11 states, total expenditures either remained relatively stable or increased for four program areas--health incentive, hypertension, health education and risk reduction, and fluoridation. Under the four prior categorical programs for these areas, states had considerable flexibility to determine the use of funds. With the advent of the block grant, states generally maintained or modestly expanded these program areas which, to a large extent, already had been tailored to meet their needs.

Table 2.6

Changes in Total Expenditures By Program Area[a]

Program area	1981 expenditures	1983 expenditures	Change Amount	Change Percent
	---------(000 omitted)--------			
Health Incentive Grant	$ 35,986	$ 38,544	$ 2,558	7
Hypertension	9,544	9,504	(40)	(0.4)
Health Education and Risk Reduction	4,228	4,621	393	9
Fluoridation	1,685	2,093	408	24
Emergency Medical Services	15,503	12,537	(2,966)	(19)
Urban Rat Control	4,849	3,838	(1,011)	(21)

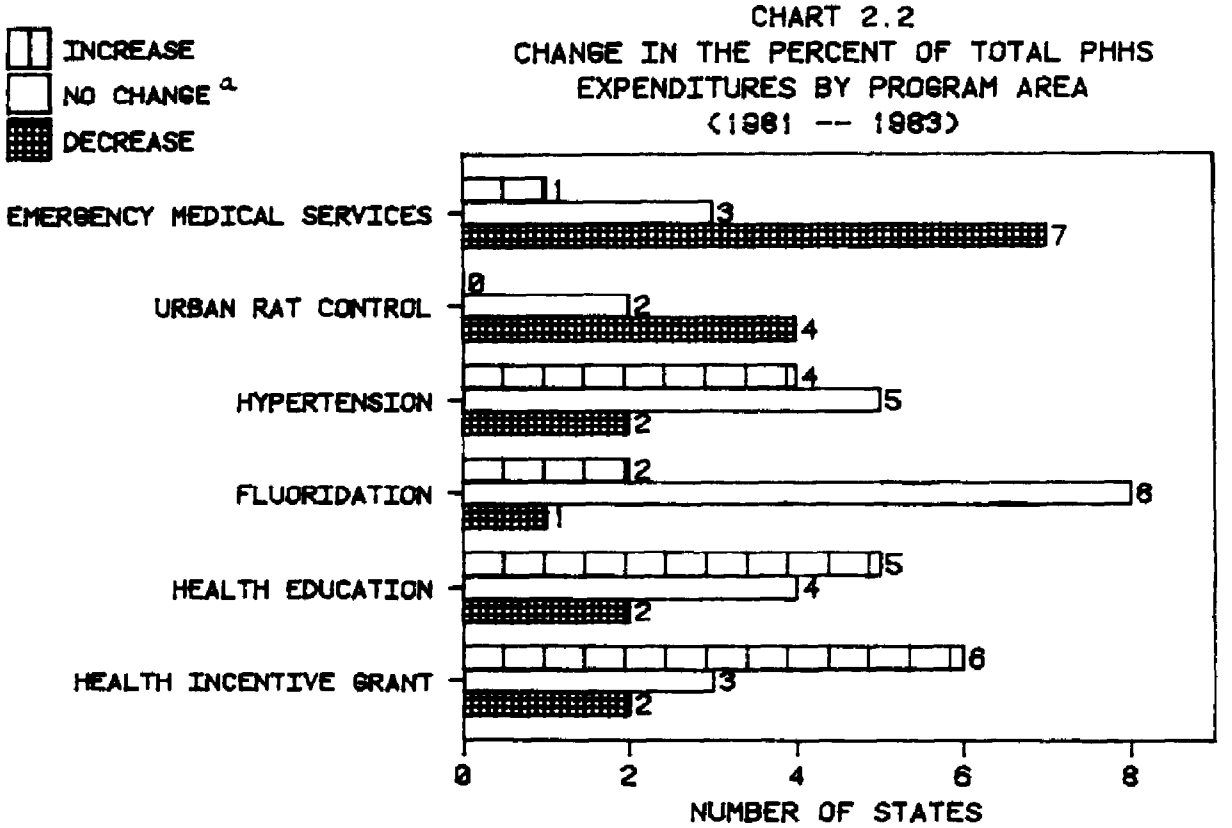
[a]The remaining two program areas, rape crisis and home health services, are omitted because their unique circumstances preclude comparisons between 1981 and 1983. Block grant funds for rape crisis were earmarked in 1982, when states were first required to support these services. Home health services grants under the prior categorical program were isolated 1-year demonstration projects which had no federal appropriations in federal fiscal year 1981.

In contrast, in most states where emergency medical services and urban rat control services were provided in 1981, the services were also provided in 1983; however, expenditures in 1983 for each of these two areas were about 20 percent less than 1981 levels. Grants to states under the categorical programs provided little funding or program discretion, and often categorical grants were made directly to local service providers, bypassing state agencies. Consequently, the block grant offered states much greater authority, although the PHHS legislation prohibits the purchase of equipment, which had been permitted under the prior emergency medical services categorical program.

Although funding decisions varied by state, emergency medical services and urban rat control were often assigned a low priority. Chart 2.2 shows that in 7 of the 11 states, the percentage of total PHHS expenditures dedicated to emergency medical services decreased between 1981 and 1983. Similarly, the percentage of total expenditures devoted to urban rat control declined in four of the six states where such activities were funded during the 1981-83 period. Conversely, the percentage of

total expenditures spent on health incentive grants, hypertension, fluoridation, and health education and risk reduction increased or changed by 1 percent or less in all but one or two states in each program area. Expenditure changes by program area for each state are shown in appendixes IV through IX.

CHART 2.2
CHANGE IN THE PERCENT OF TOTAL PHHS EXPENDITURES BY PROGRAM AREA
(1981 -- 1983)



[a]A change of 1 percent or less.

State officials generally attributed the decline in emergency medical services and urban rat control expenditures to the need to fund higher priority areas in view of limitations on available funds. Additionally, the prohibition on purchasing equipment was another factor cited for decreased emergency medical services funding. Three states did not provide any support in 1983 for emergency medical services or urban rat control services, and others provided less support in 1983 than in 1981 in order to shift funds to other areas. For example, Michigan reduced its support for emergency medical services and rodent control projects to fund other areas considered higher priority, such as licensing and certification of nursing homes and water and food sanitation inspections.

FEW CHANGES IN TRANSITION STATES

At the time of our review, California and New York were only completing their first year of experience with the PHHS block grant because they accepted it in July 1982, whereas the other 11 states began to administer the program in October 1981. Both states adopted initial policies of maintaining program continuity, and few changes were made in the distribution of funds among the program areas. Additionally, total PHHS expenditures rose in both states between 1982 and 1983.

In California, total expenditures increased by 28 percent as expenditures from federal and state funding sources rose by 37 and 11 percent, respectively. In New York, total expenditures increased by 5 percent primarily due to an increase of 7 percent in local funding sources and a 3-percent growth in the expenditure of state funds. After considering the 6.5-percent inflation factor for state and local purchases of goods and services from 1982 to 1983, however, total expenditures increased by 20 percent in California and declined by 1 percent in New York.

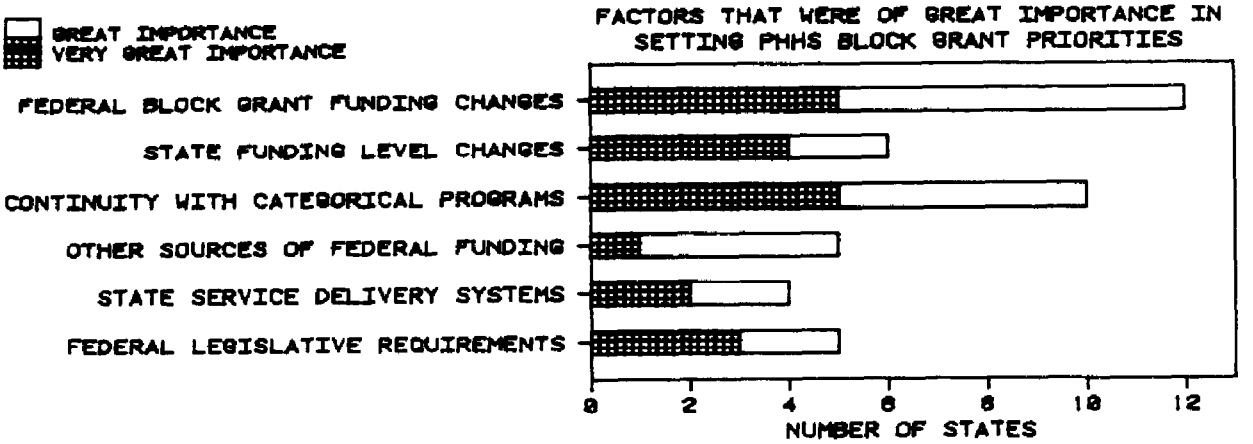
In both states, categorical funds were also available for expenditure during their first block grant year. In 1983, expenditure of categorical funds in California totaled $1.6 million, or 22 percent, of categorical and block grant funds, and expenditure of categorical funds in New York was $2.6 million, or 50 percent, of expenditures from categorical and block grant funds.

In California five of the eight program areas received increased expenditures, and one remained at the same level as the state legislative and executive branches and block grant advisory group expressed a desire to provide a smooth transition by retaining prior categorical program funding patterns and delaying changes until more information could be compiled. The other two program areas, fluoridation and home health services, experienced only small reductions of $20,000 and $66,000, respectively. New York essentially maintained the same proportional distribution of funds among program areas. The state at the time of our visit was reassessing the need to continue or modify most program areas.

FUNDING CHANGES AND PROGRAM CONTINUITY WERE THE DOMINANT FACTORS IN SETTING PROGRAM PRIORITIES

State program officials considered several factors in establishing priorities for programs supported with block grant funds. As shown in chart 2.3, the most important factor was the availability of federal funds.

CHART 2.3
PROGRAM OFFICIALS' OPINIONS ABOUT SELECTED FACTORS THAT WERE OF GREAT IMPORTANCE IN SETTING PHHS BLOCK GRANT PRIORITIES



Coinciding with changes in federal funding accompanying the transition from categorical to block grants, program officials in 12 states said that changes in federal funding were of great importance in establishing program priorities. Because of states' reliance on multiple funding sources, changes in state funding and the ability to use other federal funds also were rated of great importance in six states and five states, respectively. For example:

--Michigan officials explained that they have tried to maintain program levels, but decreases in federal funding and limits on available state funds necessitated reduced funding for the urban rat control and emergency medical services program areas.

--Massachusetts has retained the same pattern of program funding as under the categoricals, but officials point to a narrowing in the scope of services and restrictions on the number and range of persons served as effects of funding reductions.

--Colorado and Kentucky increased state expenditures and opted to supplement PHHS program funding by exercising their new ability to transfer funds from other federal block grant programs.

The next most important factor was the desire to maintain continuity with the prior categorical programs, which prompted states to continue funding the predecessor program areas. Officials in 10 states cited this factor to be of great importance, and it was of some importance in the remaining states. This emphasis emanated from a continued need for the services, a desire to minimize the disruption of ongoing services, and states' basic satisfaction with most existing services because of their role in fashioning the prior programs.

Federal legislative requirements were another important determinant in setting program priorities. For example, each state is allocated an amount which can only be used to fund services for rape victims and for rape prevention. Several state officials also said that the funding priority for emergency medical services was reduced because states were prohibited from purchasing equipment. Additionally, states were also mandated to fund hypertension in fiscal years 1982, 1983, and 1984 at 75, 70, and 60 percent, respectively, on the basis of each state's 1981 hypertension grant award.

Four states also said that the ability to use existing state service delivery systems was of great importance in establishing priorities. Using existing service delivery systems, such as local health departments, can eliminate similar services being provided by other organizations within the same jurisdiction. For example, the Michigan Department of Public Health has made a concerted effort to shift more block grant funds to local health departments in an attempt to maintain program continuity in the face of overall budget constraints.

CONCLUSIONS

Although federal allocations decreased as states began implementing the PHHS block grant in October 1981, ongoing outlays from 1981 categorical awards continued to support many state and local operations well into fiscal year 1982. This allowed states to adjust to the smaller federal allocations over a longer period and offered them the opportunity to carry forward 1982 block grant funds into 1983. As categorical funds decreased, however, the federal share of total expenditures declined from 1981 to 1983 in most states; at the same time expenditure of state funds increased and began assuming a larger portion of overall program costs.

Because changes in the level of state funding and the availability of ongoing categorical outlays varied widely, trends in total expenditures for program areas supported with block grant funds were mixed. Such expenditures from 1981 to 1983 increased in 6 of the 11 states operating the block grant

for 2 years, and total expenditures increased between 1982 and 1983 in California and New York, which delayed block grant implementation until 1982. Although total expenditures increased in eight states since block grant implementation, the growth generally has been limited; and after considering inflation, total expenditures rose only in three states.

In using the expanded flexibility offered by the block grant to establish program priorities, states were motivated by several key factors. Among the most important was the desire to maintain continuity of services, which prompted states to continue supporting most of the same program areas funded under the prior categorical programs. Additionally, federal legislative requirements and changes in the level of federal and state funding frequently influenced the priorities assigned to the various program areas.

Expenditure trends showed states tending to emphasize program areas in which they had significant previous involvement in making funding decisions. Generally, expenditures for health incentive, fluoridation, hypertension, and health education and risk reduction were maintained or increased as a percent of total expenditures from 1981 to 1983. Conversely, the proportion of total funds expended for emergency medical services and urban rat control was down in many states. States often assigned these areas a lower priority, and in the case of emergency medical services officials also cited the restriction on the purchase of equipment as a contributing factor to decreased expenditures.

The following chapter explores the programmatic implications of state funding decisions in each program area. It also describes states' rationales for changes in the types of services provided under the block grant and includes observations of local organizations responsible for delivering services to the public.

CHAPTER 3

FEW CHANGES IN TYPES OF SERVICES BUT SELECTED PROGRAM ASPECTS REFOCUSED

The PHHS block grant gave states greater flexibility to determine what services will be offered and to design programs more in accordance with their perceptions of state and local needs. Because of their considerable prior involvement in most program areas, states generally continued to provide the same types of preventive health services that were being offered under the categorical programs. However, many program areas were modified or refocused to reflect ongoing needs assessments or to take advantage of the block grant's added management authority.

EMERGENCY MEDICAL SERVICES HAVE UNDERGONE MANY CHANGES

Many states have altered the focus of emergency medical services (EMS). As discussed in chapter 2, most states have assigned EMS a low priority and have reduced funding to this area. Moreover, certain states have broadened the program's geographical coverage and the types of services previously supported under the categorical program.

Limited flexibility under categorical program

The prior EMS program strived to develop regional systems to coordinate existing emergency medical services in a specified geographical area. Typically, these systems covered several counties, and coordination activities were provided by private nonprofit entities. Rather than financing direct medical care, funds were used to (1) conduct feasibility studies and plan, (2) establish initial operations and purchase communications equipment, and (3) expand EMS systems. Grants were made over a 5-year period, and ultimately regional systems were to become self-sustaining as federal funds were phased out.

Emergency medical services unit responds to injured victim.

The prior program was very structured and subject to a high degree of federal control. HHS regulations set forth extensive requirements to qualify for funding, such as having adequate medical staff, emergency facilities, and transportation equipment to provide emergency care throughout a system's service area. Moreover, regional systems were required to maintain 15 system components ranging from systemwide communications and providing open access to emergency care to offering public education and developing disaster plans.

Prior funding arrangements for regional systems varied. In some states, funds came directly from HHS bypassing the state government. In other cases, grants were made to the state, which in turn awarded funds to regional systems. States, however, were constrained by the same federal requirements that governed the directly funded grantees.

As reported by GAO in 1976 (GAO/HRD-76-150), establishing regional EMS systems proved to be an ambitious undertaking and many difficulties were encountered. Attempting to superimpose regional entities over city, county, and private service providers prompted jurisdictional disputes and coordination problems. These problems were often compounded where state governments were bypassed. Moreover, when federal support was phased out, some local governments were unwilling or unable to sustain the system.

Block grant flexibility used to refocus EMS activities

Due to the program area's low priority and the restriction on the purchase of equipment, funding for EMS generally declined between 1981 and 1983.[1] As shown in appendix IV, in eight states the proportion of total expenditures dedicated to EMS had decreased by more than 1 percent between 1981 and 1983. Two of these states--Florida and Kentucky--had discontinued or planned to eliminate funding for emergency medical services because state officials believed it to be a local responsibility.

In five states, however, the share of total expenditures devoted to EMS between 1981 and 1983 increased or changed by 1 percent or less. For example, in Washington the proportion of total expenditures slated for EMS had increased from 54 percent in 1981 to 58 percent in 1983. The state's program is predominately supported by state funds and considered a high priority by the state legislature.

In addition to determining the funding priority for EMS, six states have used their new flexibility to broaden the program's geographical coverage or the types of services funded. These states have opted to support more locations throughout the states, as opposed to concentrating funds in a few locations to develop sophisticated systems. In some instances, this is being accomplished by making grants to more regional systems or by channeling funds to local entities for the first time. In other instances, activities are being funded beyond the regional coordination activities that were the focus of the categorical program. A synopsis of state actions to refocus EMS follows:

--After failing to get a waiver to purchase EMS equipment, Iowa expanded its training program into areas with inactive regional systems.

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[1]The Orphan Drug Act, effective January 1983, lifted this restriction for certain existing EMS systems which received funds in 1982.

--Rather than supporting regional coordination activities only, Massachusetts has begun to fund advanced life support training for emergency medical technicians and special projects to provide pediatric training to emergency room nurses.

--While making smaller grants, Michigan has moved from funding three regional systems to 13 local providers.

--While initiating funding for air ambulance and poison center services, Mississippi reduced the amount of funds awarded to existing regional systems to fund new ones.

--Pennsylvania allocates block grant funds to all EMS regional systems, whereas under the categorical program only certain providers were funded.

--Because of the prohibition on purchasing equipment, Texas now offers more planning, consulting, and training services, such as helping cities and counties start or upgrade EMS systems and supporting technician and paramedic certification examinations.

To obtain a local perspective of EMS activities in the above states, we visited six regional systems which also had been funded under the prior categorical program and a hospital that was newly funded under the block grant. The following three examples illustrate the types of adjustments being made by regional systems and states' efforts to fund new EMS locations and types of services.

The Massachusetts Hospital Association operates its EMS program through six regional hospital councils. The association does not provide any direct services to patients but focuses on coordinating existing services, upgrading communications networks, and offering training and technical assistance. The association's total EMS funding over the 1981-83 period has remained relatively stable at about $500,000 annually due in part to the continued outlay of categorical funds for the purchase of equipment.

Funding for their general operations under the block grant, however, has been reduced by about a third. While no staffing or organizational changes have been made, the association reported such changes as reducing data collection, coordination with direct service providers, and public education efforts. The association also noted that the restriction on the purchase of equipment imposed by the block grant has inhibited the growth of EMS services because local entities cannot afford such expensive equipment.

The Gulf Coast Emergency Medical Services in Mississippi serves a tricounty area. The system received about $400,000 in 1981, but $240,000 of the moneys were spent on equipment. Although the system experienced some reduction in operating funds under the block grant, the system director reported that services were not significantly affected. However, some adjustments were made, such as dropping certain first aid and CPR training programs and abolishing a public relations staff position.

In contrast to established regional systems, the Cheboygan Community Memorial Hospital in Michigan was awarded $105,000 in block grant funds to initiate new services in 1983 as part of Michigan's efforts to broaden the geographic coverage of its program. The hospital used EMS funds to coordinate the medical communications and transportation activities of 14 ambulance services and to provide education to EMS volunteers, hospital staff, and law enforcement personnel. The hospital activities cover a six-county area which is predominately rural and poor.

In addition to the providers in states that changed the focus of EMS, we visited providers in California and New York. These states are operating the program essentially in the same manner as under the prior categorical program. Neither of the providers reported any changes as a result of the block grant, and both had experienced funding increases. For example, the New York EMS system continued to provide the full range of services in a six-county area. The increases in funding also allowed it to add staff and several new activities, such as advanced life support, CPR education, and rehabilitation service coordination for critical care patients.

URBAN RAT CONTROL OFTEN YIELDS TO HIGHER STATE PRIORITIES

The urban rat control categorical program was designed to improve the living environment in urban communities by eliminating rat proliferation. Grants were made to states and local entities to support geographically targeted projects which had three phases: (1) preliminary planning and community information efforts, (2) comprehensive operations to rid the area of rats and conditions conducive to rats, and (3) maintaining resources and activities to sustain the condition. As part of the final phase, grantees were to identify local resources to maintain the program.

During the year prior to the block grant, categorical funds were supporting urban rat control projects in 8 of the 13 states. The grants in California, Florida, Michigan, and New York were made through state governments, and those in Kentucky,

Massachusetts, Pennsylvania, and Texas were directly awarded to local entities. No projects were being funded in the remaining five states, and these states have not opted to begin such programs under the block grant.

The eight states which previously funded projects used the flexibility afforded under the block grant to varying degrees. Two states--Kentucky and Texas--did not provide any state support for local urban rat control projects in 1983. Total expenditures in Kentucky decreased from about $267,000 in 1981 to $7,000 in 1983, which continued to come from a prior categorical award. Although the state expended block grant funds in 1982, it did not provide such support in 1983 because program officials believed that rodent control was a low state priority and projects should be funded locally. According to state officials, city and county funding will continue to support one of the two previously federally funded grantees providing urban rat control services.

After accepting the block grant, Texas continued funding a rat control project in Houston for 1 year. However, the state discontinued its support because program officials said that urban rat control is a local responsibility. According to state officials, Houston now supports the project entirely.

In the remaining six states that had projects funded under the predecessor program, the proportion of total expenditures spent on urban rat control decreased from 1981 to 1983 by more than 1 percent in two states and changed by 1 percent or less in four states as shown in appendix V.

Aside from changes related to funding adjustments, only two states, Massachusetts and Pennsylvania, reported changes in the urban rat control program. To achieve broader geographic coverage, Massachusetts reduced funding to the one existing project in Boston and redistributed funds to other urban areas. Pennsylvania continued funding four formerly directly federally funded projects but narrowed their scope from 200 to 50 blocks to accommodate funding reductions.

To obtain some insight into changes in local operations as a result of block grant implementation, we visited rat control projects in Michigan and New York. While both grantees received less funds under the block grant, the degree they depended on block grant funds varied in 1983 from 72 percent in Michigan to only about 9 percent in New York. Accordingly, the grantees' perceptions of the changes emanating from the block grant differed considerably.

In Michigan, we visited the Saginaw County Health Department, which provides urban rat control services in the Saginaw inner-city area. Rat control funding had declined from $188,000 in 1981 to $100,000 in 1983. To compensate, the county reduced its staff from 10 paraprofessionals to 3. As a result, the number of home and neighborhood inspections and information visits declined from 10,686 in 1981 to 3,337 in 1983.

In New York City we visited the Department of Health, Bureau of Pest Control, which has been operating rat control projects for the past 13 years. The Bureau's total funding increased about 22 percent between 1981 and 1982 and declined about 3 percent between 1982 and 1983. In 1983, the Bureau's total funding was about $8 million and only a small part, about $700,000, was block grant funds. Because most of its funding comes from local revenues and federal community development funds, the Bureau director could not attribute any changes in the urban rat control program to the block grant.

TYPES OF HYPERTENSION SERVICES GENERALLY MAINTAINED BUT SOME CHANGES MADE

Predecessor hypertension funds were awarded to state health authorities, which had considerable flexibility in deciding the programs to be funded and services to be offered. Generally, states channeled the funds to local health agencies and nonprofit entities, such as the American Heart Association. The grants supported preventive education efforts as well as screening, diagnosis, and referral services.

Hypertension programs have continued to be a relatively high priority in most states. As shown in appendix VI, the proportion of total expenditures for hypertension activities has increased by more than 1 percent since block grant implementation in 5 of the 13 states and changed by 1 percent or less in another 6 states. In two states, however, hypertension's share of total expenditures decreased by more than 1 percent. For example, in Pennsylvania, hypertension services decreased from $1.9 million, or 14 percent of total expenditures in 1981, to $1.5 million, or 12 percent in 1983. According to state officials, fewer screenings will be conducted along with less education and training activities.

Testing for hypertension

Aside from changes related to funding adjustments, states reported continuing essentially the same types of services that were supported under the categorical program. However, four states shifted the emphasis from mass screening efforts to more narrowly targeted screening of specific population groups or to referral activities.

--According to program officials, Pennsylvania reduced the scope of its hypertension services and focused on certain target populations, primarily blacks between the ages of 18 and 55.

--Massachusetts program officials said that due to limitations on funding, they are focusing on high-risk groups already identified rather than identifying additional groups.

--Florida shifted from screening to referral services to help control hypertension among identified high-risk groups. The state also has emphasized preventive education, such as patient counseling on the role of diet and exercise in controlling hypertension.

--Mississippi program officials said that large scale screening was being phased down. They will continue to target the high-risk population which has been defined as black individuals between the ages of 18 and 55. The state also has added its own funds to strengthen the treatment aspects of the program and has implemented a fee system for hypertension services that is based on recipients' ability to pay.

While these states refocused the types of services offered, two states, California and Iowa, have increased the geographical coverage of their hypertension programs. California moved from concentrating on metropolitan areas to statewide coverage due to indications that service needs were greater in parts of the state receiving little funding. Previously, funds were concentrated in Los Angeles and San Francisco, but a state study showed improved awareness and control of hypertension in these areas. On this basis, the state shifted to multi-county, nonprofit organizations more evenly dispersed throughout the state and targeted funds to Hispanics, Asian-Americans, blacks, and white males over 50 years old.

Iowa increased the geographical coverage of its hypertension program but continued targeting services to specific high-risk groups. Program officials said that in the past, hypertension screening services were primarily provided in Des Moines. The state has now decentralized the program and is encouraging local public health nurses to provide screening services throughout the state. The program emphasizes early intervention so that persons will be reached before the disease causes irreversible health problems.

To gain some insight as to the changes in local operations with the advent of the block grant, we visited 12 hypertension service providers, which included local health agencies and nonprofit organizations. The types of services provided and the level of activity varied widely among the providers. Also, some were newly established, while other were having their funding discontinued. The following examples illustrate the range of these providers' situations.

The Jefferson County Health Department in Colorado operated a hypertension program from 1981 to 1983 in part with categorical and block grant funds. As these funds have been reduced

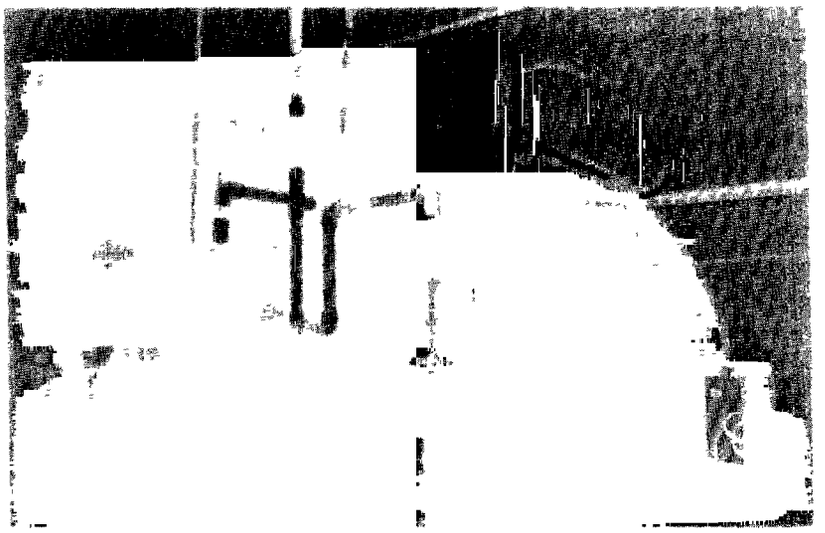
from $12,000 to $6,000 during this period, the county has increased efforts to recruit volunteer nurses. Although funding from the state will be discontinued in 1984 and officials are concerned about the program's future, the county will continue providing hypertension services in 1984 through other programs, such as Adult Wellness, and noted that screening services are available from other providers in the area, such as the American Red Cross.

We also visited the Scott County Iowa Health Department, which began a hypertension program in 1981 with categorical funds and continued it with block grant funds received in 1982 and 1983 of about $18,500 and $28,000, respectively. These funds supported a hypertension program coordinator who planned and managed screening activities. Department officials said the number of persons receiving hypertension services had increased during the 3-year period, particularly among elderly, black, and rural citizens.

In New York City we visited a nonprofit comprehensive health center which began its program in 1981. The center, which serves a predominately Hispanic and black population, provides screening, referral, followup, and patient education. Between 1981 and 1983, the program's operating budget was about $170,000, of which $60,000 came from categorical and block grant funds. Because funding has remained stable, there has been no change in service levels or operations, and client encounters have increased. According to center officials, the state has encouraged them to seek other sources of funding although the state has funded the center through September 1984.

TYPES OF FLUORIDATION SERVICES RELATIVELY UNCHANGED

The fluoridation categorical program was authorized to help promote, implement, and maintain fluoridated water systems. Grants were made to state governments or, in certain cases, directly to local agencies in consultation with state health authorities. Funds supported such activities as purchasing chemicals and equipment, training operators, and educating the public.



Fluoridation equipment.

Under the block grant, the amount of expenditures for fluoridation programs has been maintained or increased in 12 of the 13 states. As shown in appendix VII, since block grant implementation, the proportion of total expenditures dedicated to fluoridation has changed by 1 percent or less in 10 states and increased by more than 1 percent in 2 states. Only in Washington did the share of total expenditures slated for fluoridation decrease by more than 1 percent.

Washington's expenditures for fluoridation had been 5 percent of total expenditures in 1981 but were discontinued in 1983. Categorical funds had been used primarily to purchase fluoridation equipment, and such funds continued to support the program into fiscal year 1982. State officials discontinued fluoridation funding because of higher state priorities but reported that technical assistance is still available through a dental project supported with maternal and child health block grant funds.

Aside from Washington, the remaining states made no major changes in the types of fluoridation services provided since block grant implementation. Except for Pennsylvania, these states previously supported fluoridation services with categorical funds and continued to fund similar activities under the block grant. Categorical fluoridation grants in Pennsylvania were awarded directly to local entities. However, state officials are now funding services that are identical to those supported by prior categorical grants.

While most states made no major changes in the types of fluoridation services provided, California and Michigan made certain changes in their programs. For example, categorical funding in California was used to provide technical assistance, training, and health education to communities interested in using their own resources to fluoridate water supplies. California officials decided to refocus fluoridation block grant funding on replacing equipment in jurisdictions that had already fluoridated their water. Officials said that technical assistance and training to communities were reduced because of state restrictions on travel and a state-imposed 6-percent administrative cost ceiling.

Similarly, Michigan shifted from funding new fluoridation systems to upgrading existing ones. The state had funded communities without fluoridation systems through fiscal year 1982 but received few such requests in 1983. Therefore, funds were redirected to communities with deficient fluoridation systems on the basis of inspections made by state water quality engineers.

We visited two fluoridation service providers to obtain insight into local operations since block grant implementation. Basically, both grants were one-time awards to initiate fluoridation activities and funded only a small portion of the providers' overall operations.

In Florida, we visited the Lakeland Department of Electric and Water Utilities, which received about $68,000 in 1982 block grant funds to cover the costs of purchasing and installing fluoridation equipment and procuring chemicals for the first year. The fluoridation system was installed during the construction of a $10 million water treatment plant as part of a larger $28 million water improvement program. The Department's 1983 operating budget was about $3.3 million. The Department's staffing level and number of clients served had increased from 1981 to 1983, but these changes were attributed to starting a new water treatment plant and the normal growth of the service area as opposed to the block grant award.

Similarly, the Denver Water Board received about $150,000 to purchase and install fluoridation equipment at three water treatment plants. Once installed, the Water Board, which receives about $160 million annually from residential water sales alone, assumed the cost of operating the fluoridation system, including the purchase of chemicals at about $120,000 annually. Because the equipment is automated and only requires monitoring by Water Board personnel, the additional cost of operating the system was considered minimal.

KINDS OF HEALTH EDUCATION AND RISK REDUCTION SERVICES MAINTAINED

Under the former categorical program, health education and risk reduction funds assisted state and local health authorities in planning, coordinating, and evaluating services to encourage preventive health habits and reduce chronic diseases, particularily those relating to smoking and alcohol abuse. Grants were usually awarded to states, which in turn redistributed funds to local health agencies and nonprofit organizations, such as the American Red Cross. States had considerable flexibility in deciding how funds were used and who provided services.

Posters promoting preventive health habits

Most states continued to give health education and risk reduction services high priority under the PHHS block grant. As shown in appendix VIII, the percentage of total PHHS expenditures for health education and risk reduction services increased by more than 1 percent in 5 of the 13 states and changed by only 1 percent or less in another 5 from 1981 to 1983. For example, the increased emphasis placed on health education and risk reduction by the Iowa state legislature prompted the program's share of total expenditures to grow from 4 percent in 1981 to 10 percent in 1983. In addition to continuing a school-based alcohol and smoking program and health awareness activities, the state began a new "mini-grant" program on a statewide competitive basis to enhance the health promotion efforts of local groups and organizations.

In 3 of the 13 states, the funds dedicated to health education and risk reduction services decreased from 1981 to 1983 by more than 1 percent of total expenditures. For example, Washington's funding decreased from $689,000, or 25 percent of total 1981 expenditures, to $212,000, or 8 percent, in 1983. State officials cited the need to fund higher priority areas and said that in 1984 funding for the projects will be referred to the state's Bureau of Alcohol and Substance Abuse because it provides similar services. Similarly, Colorado plans to eliminate support for chronic disease education in 1984 to fund higher priority programs.

Aside from funding decisions, only three states have changed, or planned to change, the type of services offered or the service delivery method.

--Texas added health education and risk reduction consulting services for business and industry in 1983 to help reduce absenteeism, lower insurance costs, and improve employee productivity. Texas officials also explained that although funding for health education and risk reduction was reduced, funding for health incentive services increased and can be used to support any preventive health program, including health education. As discussed on page 41, the San Antonio Metropolitan Health District used its additional health incentive moneys in 1983 to support health education programs.

--Mississippi plans to discontinue support for categorical grant funded projects and establish a centrally state operated program.

--Pennsylvania plans to eliminate support for four demonstration projects originally selected by HHS and establish services in various local health departments.

We visited seven health education and risk reduction service providers in 6 of the 13 states to obtain some insight into changes in local operations since block grant implementation. All providers visited were nonprofit organizations or county agencies, and the primary service provided was chronic disease education. Although PHHS block grant funding for five of the projects was scheduled to be completed in 1984, three providers had applied to state and federal agencies for funding under the maternal and child health and the alcohol, drug abuse, and mental health block grants.

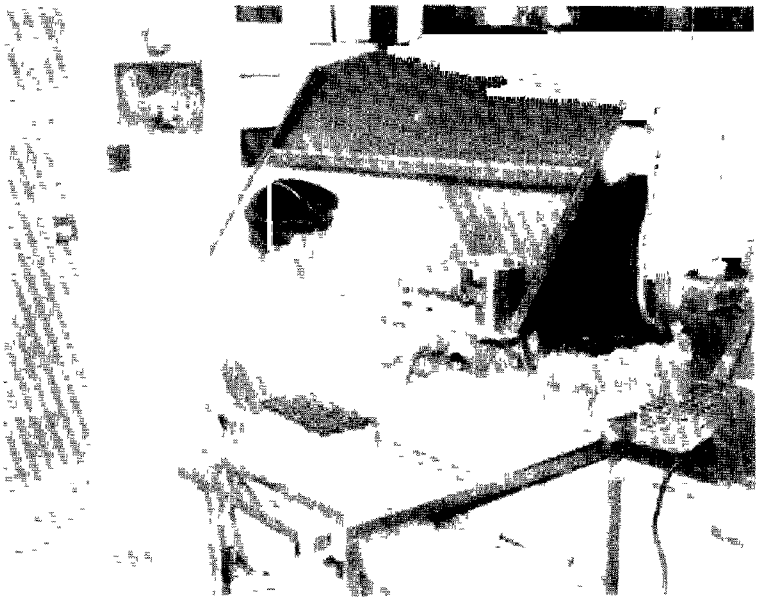
For example, the Colorado Cooperative Extension Service sponsors an alcohol and smoking prevention program for adolescents which had experienced a $36,000 decrease in funding under the PHHS block grant from about $60,000 in 1981 to about $24,000 in 1983. The state plans to discontinue funding health education and risk reduction services in 1984, but the Cooperative Extension Service expects to receive about $19,000 from the federal maternal and child health block grant set-aside fund in 1984 as well as additional funds from the state maternal and child health program. According to the project director, less emphasis is now placed on evaluating the services and the Cooperative Extension Service plans to shift services from rural to urban areas in 1984.

Similarly, Johnson County in Iowa has offered health education services through 1983 but has been notified that future funding will be discontinued. County officials operate a school-based substance abuse program and a "wellness" program, which offer a variety of services, including physical fitness assessments, life style inventories, and stress management. The program is offered to individuals whose ages range from the 20's to 60's. Although state funding will cease in 1984, county officials said that the "wellness" program will be continued for county employees. Also, their level of involvement in the substance abuse program will decrease, but they will still provide consulting services to local schools.

HEALTH INCENTIVE SERVICES REMAIN A HIGH STATE PRIORITY

Since 1966 the federal health incentive grant has been awarded as a block grant to states to assist them in providing comprehensive public health services. It has historically offered states almost unlimited flexibility to determine the programs to be funded and the services to be offered. Although the

specific services offered varied widely from state to state, the types generally funded include laboratory testing, tuberculosis screening, immunization, sexually transmitted disease control, radiation exposure control, hazardous waste control, dental hygiene education, and diabetes education. Health incentive moneys were often combined with state, local, and other federal funds to help support high priority programs, and typically funds were channeled to state public health laboratories or local public health agencies.



Technician performing testing in a public health laboratory.

Under the PHHS block grant, most states have continued to assign health incentive services a relatively high priority. As shown in appendix IX, since PHHS block grant implementation, the percentage of total 1983 PHHS expenditures for health incentive grants has increased in 6 of the 13 states and changed by only 1 percent or less of total expenditures in 4 of the 13 states. Officials in several of these states reported that block grant funding for health incentive services was increased to help restore levels in existence before a 1981 rescission in funding for the prior federal program.

Expenditures for health incentive services as a share of total PHHS expenditures have decreased by more than 1 percent in 3 of 13 states. For example, in Pennsylvania the funds dedicated to the health incentive area, which are used to support a tuberculosis control program, decreased from 34 percent of total expenditures in 1981 to 32 percent in 1983. The state program manager said, however, that services have remained at a constant level as the state adopted cost containment measures and implemented other adjustments to more efficiently use available resources. For example, the state reduced the cost of its laboratory testing, became more selective in distributing drugs, and reduced the average length of stay for hospital care from 21 to 15 days.

Apart from changes related to funding decisions, states reported few changes in the types of services offered, primarily because the prior health incentive program already provided states wide discretion in designing and modifying program services. Program officials in all 13 states reported that the types of services previously offered were essentially continued, and 4 states expanded services. For example, Colorado increased its hazardous waste control activities, and New York expanded such services as poison control and cancer screening.

To obtain some insight into changes in local operations as a result of block grant implementation, we visited seven local health agencies in four states--California, Kentucky, Texas, and Washington. The types of services funded with health incentive grants varied widely among providers. However, block grant funds only represented from about 1 to 10 percent of their total funding. None of the providers reported discontinuing any services, and three established new services or expanded existing activities. The following two examples illustrate how block grant funds are used at the local level. They depict the variety of services funded and provide insight into the relative importance of block grant funds to providers' operations.

Block grant moneys are used to help support tuberculosis control services in Monterey County, California, but the county's program is predominately financed with state and local revenues. The county received $10,668 in block grant funds in 1983, which represented only 2 percent of the 1983 program budget. Although the 1983 block grant funds were 28 percent below 1981 levels, the county's overall funding increased from $307,497 in 1981 to $492,745 in 1983.

County officials said that no major changes in services occurred during this period but believed that increased funding had failed to keep up with increasing costs, particularly personnel expenses. As a result, the county consolidated clinic

locations, established fees for teachers required to obtain skin tests, and computerized data collection and reporting activities. County officials said that these actions have had no major effect on the services provided and noted that any changes due to the block grant would be insignificant because of its low share of total costs. According to these officials, anticipated reductions in state funding pose a greater problem.

Unlike Monterey County, the San Antonio Metropolitan Health District in Texas uses block grant moneys to help fund a variety of services. During the 1981 to 1983 period, these funds, which accounted for about 8 percent of San Antonio's total 1983 operations, supported such services as public health laboratories and epidemiologic surveillance, immunization, sexually transmitted disease control, public health nursing, and diabetes training and education.

From 1981 to 1983 the district's total overall funding increased from about $9.4 million to $12.3 million. Officials said that there were no major changes in the types of services offered but added that increased funding allowed them to expand health education and risk reduction activities. However, program officials expect that an anticipated 7-percent reduction in 1984 local funding may pose a significant problem because local moneys represent 80 percent of their total funding.

PREVENTIVE RAPE SERVICES PROVIDED AS REQUIRED BY LAW

The PHHS block grant legislation earmarks at least $3 million annually for states to provide services to rape victims or for rape prevention. This amount, which is equivalent to about 3 percent of the national block grant appropriation, is distributed on the basis of each state's population. The 13 states used these funds to provide counseling and treatment and/or education activities, and no state planned to make any major changes in the types of services funded during fiscal year 1984. During 1982 and 1983 the 13 states reported expending about $2.1 million of block grant funds on rape prevention.

Rape program facility

Some examples of how states were using the block grant funds to establish or supplement state programs follow.

--On the basis of recommendations from an advisory committee, Florida began one project to provide rape crisis counseling and another to train employees.

--To improve victim counseling and develop standard program criteria for established rape crisis programs, Iowa established the Iowa Coalition Against Sexual Abuse. This umbrella organization provides educational resources and professional consultation to the state's 15 assault centers.

--To complement an existing state victim counseling program, California initiated educational activities, such as classes on self-defense and on how to avoid assault.

--Vermont added about $11,000 in state funds to its $7,000 block grant award to hire a statewide coordinator, who provides information to the public and to rape crisis agencies.

--Pennsylvania expanded its existing counseling services and reported adding educational services, particularly among minorities and school age children.

To obtain a local perspective, we visited rape prevention service providers in three states. The availability of block grant funds enabled each provider to expand its educational, counseling, or training activities for fiscal years 1982 and 1983, although one provider noted such activities will decline in 1984 due to a loss of city funds.

For example, the Boston Area Rape Crisis Center provides counseling services for victims and their families as well as rape prevention education. According to Center officials, the program has historically been funded by private grants and run by volunteers. With the availability of about $14,000 in block grant funds in 1982 and about $18,000 in 1983, the Center hired three part-time employees and increased its hours of operation. As required by its state contract, the Center used block grant funds to provide services to victims and their families. Massachusetts state officials told us that on the basis of public input, services to victims were emphasized over education and training.

HOME HEALTH SERVICES LOW PRIORITY FOR BLOCK GRANT FUNDS

The home health services and training grant program had several peculiarities which distinguished it from the other programs consolidated under the block grant. The program was small, and in 1980 only $5 million was appropriated to fund 83 projects nationwide. There were no federal appropriations in 1981, although several projects received extensions into later years to expend 1980 awards. Because the home health services and training program was not funded in fiscal year 1981, it was not included in the block grant state allotment computation.

Grants were typically awarded for 1 year to home health agencies, which were to become self-supporting in subsequent years. The program was intended to expand and develop home

health agencies and services as defined under the Medicare program and to fund training for professional and paraprofessional personnel. To qualify for an operations grant, home health agencies were required to be certified under Medicare or assure the federal government that the grantee could be certified within 60 days of the grant award. Meanwhile, any public or private nonprofit entity was eligible for a training grant.

Home health services funds were expended by the state or by directly federally funded grantees during 1981 in 8 of the 13 states. After acceptance of the block grant, three of the eight states (California, Colorado, and Washington) decided not to fund home health services and training activities by 1983. In California, a few directly federally funded local entities were operating in 1982 using moneys from prior years, but the state did not make any new grant awards. Colorado officials, which used state funds to provide consultation to home health care agencies, discontinued support for the program in 1983 to support other state priorities. In Washington, state officials awarded a 1-year grant to a home health services project in 1982, after which the grantee was expected to become self-supporting. Washington officials did not award any other grants during 1983.

The remaining five states continued to provide some support for home health services and training in 1983. Kentucky and Texas used block grant funds, whereas Mississippi, New York, and Vermont used state or other revenues only.

We visited two local providers which received block grant funds during 1983. For example, the North Central Texas Home Health Agency received about $48,700 of PHHS funds from the state to provide a home health aide training program in 1983. The agency's total funding in 1983 was about $1,633,000. The home health aide training program was administered by a salaried staff of 1 professional and 1 clerical worker, along with several professional and other volunteers. The program graduated about 164 home health aides from its 80-hour training course during 1983.

CONCLUSIONS

Overall, the types of services states opted to provide under the PHHS block grant were essentially the same as those offered under the prior programs. In response to ongoing needs assessments, the expanded flexibility afforded by the block grant, and limitations on available funds, however, many efforts were made to refocus selected program areas or to alter the emphasis given to certain services and service delivery methods.

The scope and dimensions of changes varied considerably by program area and by state and were influenced by states' degree of involvement and control under the former programs.

Previously, states had limited control over federal emergency medical services and rodent control funds. Under the block grant, three states chose not to fund emergency medical services or rodent control, and in most of the remaining states, the amount of expenditures for these areas in 1983 was down from 1981 levels. Additionally, six states used their new flexibility to broaden the geographical coverage of emergency medical services or to begin funding providers and activities other than those solely supporting the regional coordination systems that were the focus of the prior categorical program.

States had greater control under the former health incentive, hypertension, fluoridation, and health education and risk reduction programs. As a result, states found little reason to adjust the types of services being provided relative to state needs. Moreover, program modifications were linked more to factors independent of expanded block grant flexibility. For example, in the hypertension program area, six states shifted from mass screening to more targeted screening efforts or expanded the program's geographical coverage because of reevaluation of recipients' needs or restrictions on funding.

While states were refocusing certain program components, individual service providers we visited experienced a wide range of changes to their operations. These varied from providers which reported stable or increased funding levels and expansion of program operations to providers for which funding was declining and services provided and clients served had decreased. Certain changes were attributed to block grant implementation, but providers pointed to a diverse array of factors influencing their operations, particularly escalating costs and changes in other sources of funding.

CHAPTER 4

STATES MADE LIMITED CHANGES TO ORGANIZATIONAL STRUCTURES AND PROCEDURES FOR MANAGING PHHS PROGRAMS

A key feature of the block grant was the flexibility it gave states to organize their operations and adjust their management procedures to provide PHHS services more efficiently and effectively. Because the states already controlled most funds awarded under the prior categorical programs, opportunities for organizational change were limited. However, a few states made changes to consolidate programs or enhance service delivery. Also, states made only minimal changes to the structure of the service provider network.

States carried out their expanded grant management role by establishing program requirements, providing technical assistance, monitoring, collecting data, and auditing. These activities were often integrated into ongoing state efforts. The reduced federal requirements, together with the management flexibility provided the states, produced numerous indications of administrative simplification. However, specific administrative cost savings could not be quantified.

ORGANIZATIONAL CHANGES LIMITED AND NOT DIRECTLY ATTRIBUTED TO BLOCK GRANT

The organizational structures and service provider network states used to administer preventive health programs have changed little as a result of the PHHS block grant. States generally assigned PHHS responsibilities to state offices which administered the prior categorical programs or administered related state programs. States have made limited organizational changes to PHHS-supported programs, and when they did, these changes were based on state decisions to consolidate programs or enhance service delivery and not directly related to administering the block grant.

PHHS responsibilities assigned to entities involved in prior categoricals or related state activities

Because nearly 80 percent of the federal funds awarded under the prior categorical programs went through the state government in the 13 states, they already had an established organizational framework in place. Also, when local service providers received categorical funds directly from the federal

government, states also provided their own funds to these grantees or had other ties with them. Accordingly, the introduction of the block grant did not present the states with opportunities for organizational changes that, to a large extent, were not already available.

In 11 of the 13 states, administrative responsibility for PHHS-funded services is assigned to one or more divisions of the state health department. In two states, responsibility has been divided among the health department and other state organizations.

Generally, states assigned administrative responsibility to those state offices which administered the prior preventive health categorical programs or administered related state programs. In six states all prior categorical funds had been awarded to the state government, and for the most part, the same state offices now manage these programs.

In the other seven states, funds for some prior categorical programs had also been awarded directly to local grantees. In these situations, block grant program responsibility was usually given to a state office handling a similar state program. For example, although California, Massachusetts, New York, and Pennsylvania did not receive EMS categorical funds, state offices were delivering similar services. These state offices now administer the block grant funded EMS services.

If a state did not administer a prior categorical program or did not have a similar state program, responsibility was assigned to existing state staff. For example, Pennsylvania officials assigned responsibility for the fluoridation program to the Public Health Consultant for Dentistry, and Massachusetts officials assigned responsibility for the urban rat control program to the Environmental Health Services Office.

Four states had made or plan to make organizational changes to consolidate related programs or enhance service delivery. According to state officials, these changes could not be tied directly to the block grant; however, they were related to improving the operation of PHHS-supported programs.

For example, in 1984, Vermont plans to consolidate its health education programs into one health promotion unit. The administrator said this will improve services to clients and reduce reporting levels. Also, Mississippi did not use block grant funds for the health education and risk reduction program because officials believed the prior categorical program was too

small and isolated to have an impact. However, in 1984, officials plan to allocate $50,000 for a new, centrally managed program, conduct a needs assessment, and develop a health education work plan.

Structure of service provider network minimally affected

Although the types of organizations eligible to provide services vary by program and state, program officials told us that, since implementing the block grant, no major changes have been made in the types of organizations eligible to provide services. Local health departments, other local government agencies, and nonprofit entities remain the predominant eligible providers for all programs. The absence of major changes is consistent with the states' objective of maintaining program continuity which, as discussed in chapter 2 (see pp. 20 to 22), was the driving force behind state decisions to continue funding the prior categorical program areas.

However, four states changed the emphasis placed on the types of organizations used to provide services. For example, Colorado relied less on local health departments to provide hypertension services because state officials believe that other nonstate entities provide the services more effectively. Iowa officials said they are placing greater emphasis on using local health departments to provide hypertension services to obtain greater geographical coverage than had been available using a specific nonprofit entity.

STATES ARE CARRYING OUT GRANT MANAGEMENT RESPONSIBILITIES

With the implementation of block grants, states assumed additional management responsibilities--particularly for those programs which were formerly directly funded by the federal government. These responsibilities include establishing program requirements, monitoring, providing technical assistance, collecting data, and auditing. To some extent, these activities were already being carried out by the state, but the block grant expanded the scope of their involvement. Generally, the 13 states were carrying out these responsibilities although different approaches and emphases were noted.

Requirements imposed on service providers

The block grant increased the states' flexibility to manage program activities in accordance with state priorities and procedures. States no longer had to comply with numerous federally imposed requirements. However, the Congress established certain

prohibitions and restrictions pertaining to PHHS funds. Prohibited activities include providing inpatient services, making cash payments to intended recipients of health services, purchasing or improving land, acquiring or improving a building or other facility, purchasing major medical equipment, obtaining equipment for emergency medical services systems, and providing direct home health services.

The states used the contracting process as the primary means to promote compliance with federal prohibitions. Other methods used included accepting service provider certifications of compliance; including restrictions in state policy guidance, laws, or regulations; reviewing reports submitted by service providers; and investigating complaints about service providers.

Besides federal restrictions, 12 of 13 states placed their own requirements on service providers. The requirements varied by program area; however, most states require providers to report on program activities and populations served. Other common restrictions required service providers to conduct needs assessments, obtain prior state approval before undertaking certain activities such as hiring personnel, and use block grant funds to supplement and not supplant other funds.

Officials in four states changed the requirements imposed on service providers and/or gave local recipients greater discretion in using funds. For example, to receive a one-time grant for special projects in Kentucky, a recipient must have a source of funds to continue the project and can use the funds only for direct services. State officials said that they imposed these requirements so that the projects would become self-supporting and the state could fund different projects in subsequent years. Texas officials said that local health departments were given greater discretion in determining the number of professional staff needed to provide health incentive grant services.

Officials in three states said they planned to make changes in 1984. For example, Vermont program officials plan to include additional reporting requirements and a financial billing format in contracts, request more program information, and impose a 25-percent matching requirement on hypertension providers. Conversely, Washington officials plan to give local agencies greater discretion by testing consolidated contracts. Selected PHHS, maternal and child health, and social services program areas will be included in consolidated contracts, which will be awarded to four local health agencies. According to the state health agency director, this will give the local agencies the same flexibility that states are afforded by block grants.

For the most part, eligibility for PHHS services is linked to need for the service rather than other factors, such as age or economic status. Accordingly, the likelihood of substantial change in this area was small, and generally states have not changed beneficiary eligibility criteria.

Of the 44 service providers visited, 19 said that their relationship with the state had changed since block grant implementation. Eight believed that the state either was more involved with their operations or had increased requirements. Nine believed that the state was less involved or had decreased requirements. Two reported that the change in state involvement varied by type of requirement. For example, a health education and risk reduction service provider in California said that the state exercises more control under the block grant program than it did under the categorical program and the paperwork burden had not changed. In contrast, a service provider in the same program in Iowa reported that there was less paperwork and the state program requirements were less confusing than the prior federal requirements.

In 2 of the 13 states, we asked seven local government organizations which were also service providers to compare the block grant administrative requirements to the categorical program requirements. Five service providers believed the requirements were equally burdensome. One provider believed the requirements were less burdensome because less justification was now needed to approve the budget and expenditures. One provider said they were more burdensome because additional statistical reports and a more detailed evaluation were now required.

In 2 of the 13 states, we also asked local government organizations which were also service providers and passed funds through to other organizations if they imposed restrictions or requirements on these organizations. The two service providers contacted said that they did impose requirements. The first, a hypertension provider, has hiring approval, control over specific staff activities, and discretion over allocation of any funds generated by subrecipients. The provider also requires quarterly reports and approves press releases. The second, an emergency medical services provider, sets regional goals and objectives and requires attendance at meetings.

Monitoring responsibilities are integrated with ongoing state efforts

Generally the block grant has had little effect on the extent of the states' monitoring activities because these activities have been integrated with ongoing state efforts. All

states we visited monitor service provider compliance with federal and state requirements, emphasize different issues, and use various techniques during the process.

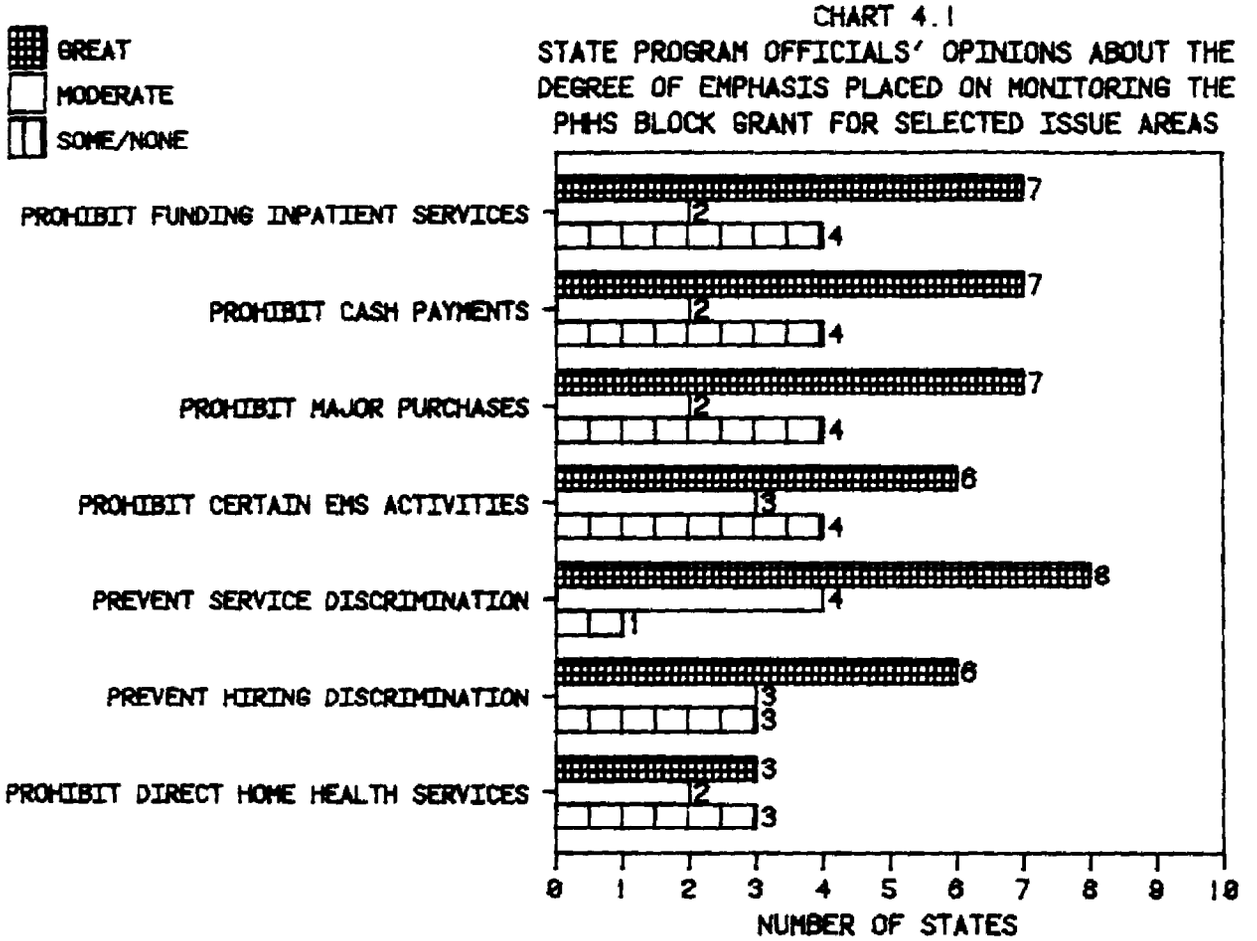
State officials in 9 of the 13 states reported that implementing the block grant had no effect on the extent of monitoring. Most states reviewed block grant fund recipients by monitoring block grants in conjunction with federal categorical programs or with state programs. This approach is used because many service providers receive funds from various federal and state sources, and explains why most states believed the block grant did not affect the level of monitoring. In all 13 states, program offices monitored service provider compliance with federal and state requirements related to the block grant, and in 4 states other state offices or nonstate organizations also monitored service providers.

Two states decreased their monitoring efforts and two increased them. For example, a Colorado official commented that state monitoring decreased due to decreased federal reporting requirements and a lack of funds to support the previous level. Mississippi officials said that they increased monitoring because of the block grant's accountability requirements and the perception that federal entities were skeptical of the state's ability to properly monitor PHHS programs. Officials said that they probably would have increased their monitoring efforts anyway, but the block grant expedited the process.

State officials also told us that they emphasized various issues when monitoring service providers. As shown in chart 4.1, there was considerable consistency in the degree of emphasis states placed on various federal restrictions and issues related to the use of funds. The home health restrictions received relatively less emphasis, probably because few states in our review funded this program area in 1983.

CHART 4.1

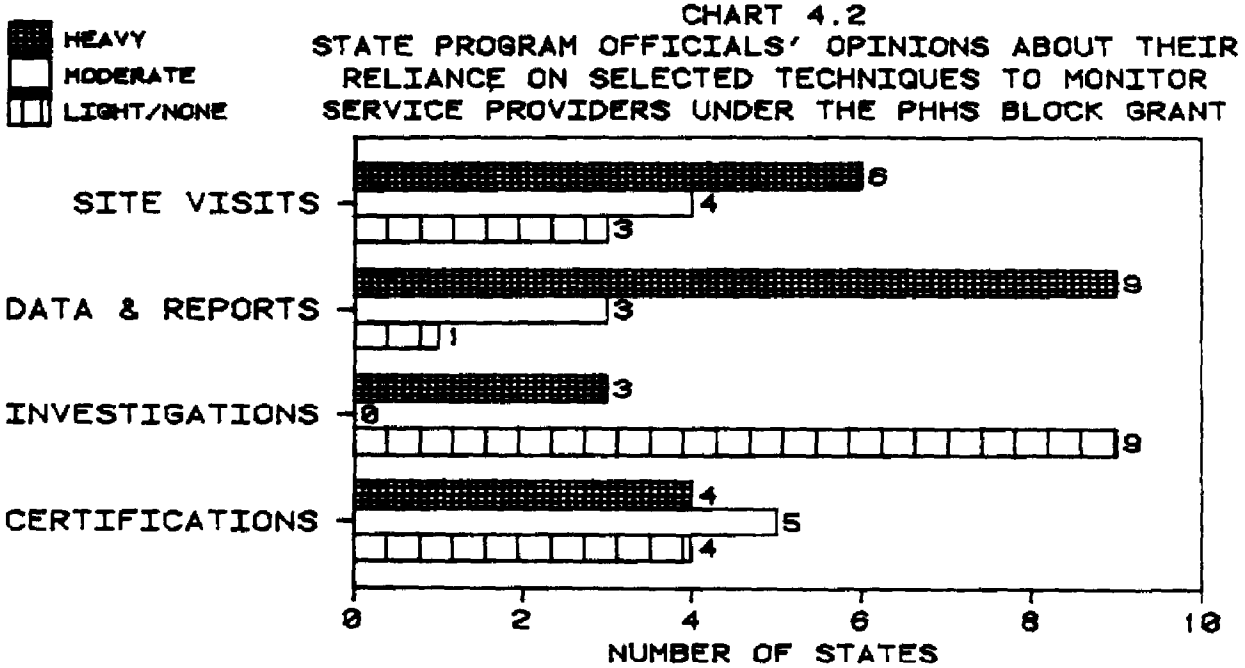
STATE PROGRAM OFFICIALS' OPINIONS ABOUT THE DEGREE OF EMPHASIS PLACED ON MONITORING THE PHHS BLOCK GRANT FOR SELECTED ISSUE AREAS



As shown in chart 4.2, states relied most heavily on reviewing data and reports and site visits to monitor service providers. Program officials in 10 of the 13 states reported that site visits were used for monitoring at least moderately, and in the remaining 3, they were used slightly or not at all. In 6 of the 10 states, the extent to which site visits were used did not vary by type of program or service provider. For example, Vermont officials explained that more site visits are made to non-state entities providing PHHS services primarily due to the turnover in providers and contract changes made under the block grant program.

CHART 4.2

STATE PROGRAM OFFICIALS' OPINIONS ABOUT THEIR RELIANCE ON SELECTED TECHNIQUES TO MONITOR SERVICE PROVIDERS UNDER THE PHHS BLOCK GRANT



Most states provide technical assistance

Officials in 11 of 13 states said they provided technical assistance to local recipients of PHHS block grant funds. The recipients were primarily local governments, hospitals and clinics, and local health departments. States made the greatest use of written guidance, telephone calls, letters, and site visits to provide the assistance which covered federal and state requirements, data issues, and programmatic issues. For the two states that did not provide technical assistance, officials in one said it was not needed because recipients were established contractors which operate under very specific contracts. Officials in the other state said they answered questions from recipients but did not consider that to be technical assistance.

In 2 of the 13 states, we asked service providers that were local government organizations and more likely to have some relationship with state management officials whether they had received any technical assistance or other information from the state. The seven service providers contacted had received assistance primarily about application procedures, reporting and evaluation requirements, and service delivery techniques but had

received little assistance about audits and financial management. Also, of the seven service providers, only two said additional technical assistance would be helpful. One would like information on successful program techniques and an inventory of programs and contacts for minority groups, and the other would like information on audits and what can be purchased under the EMS program.

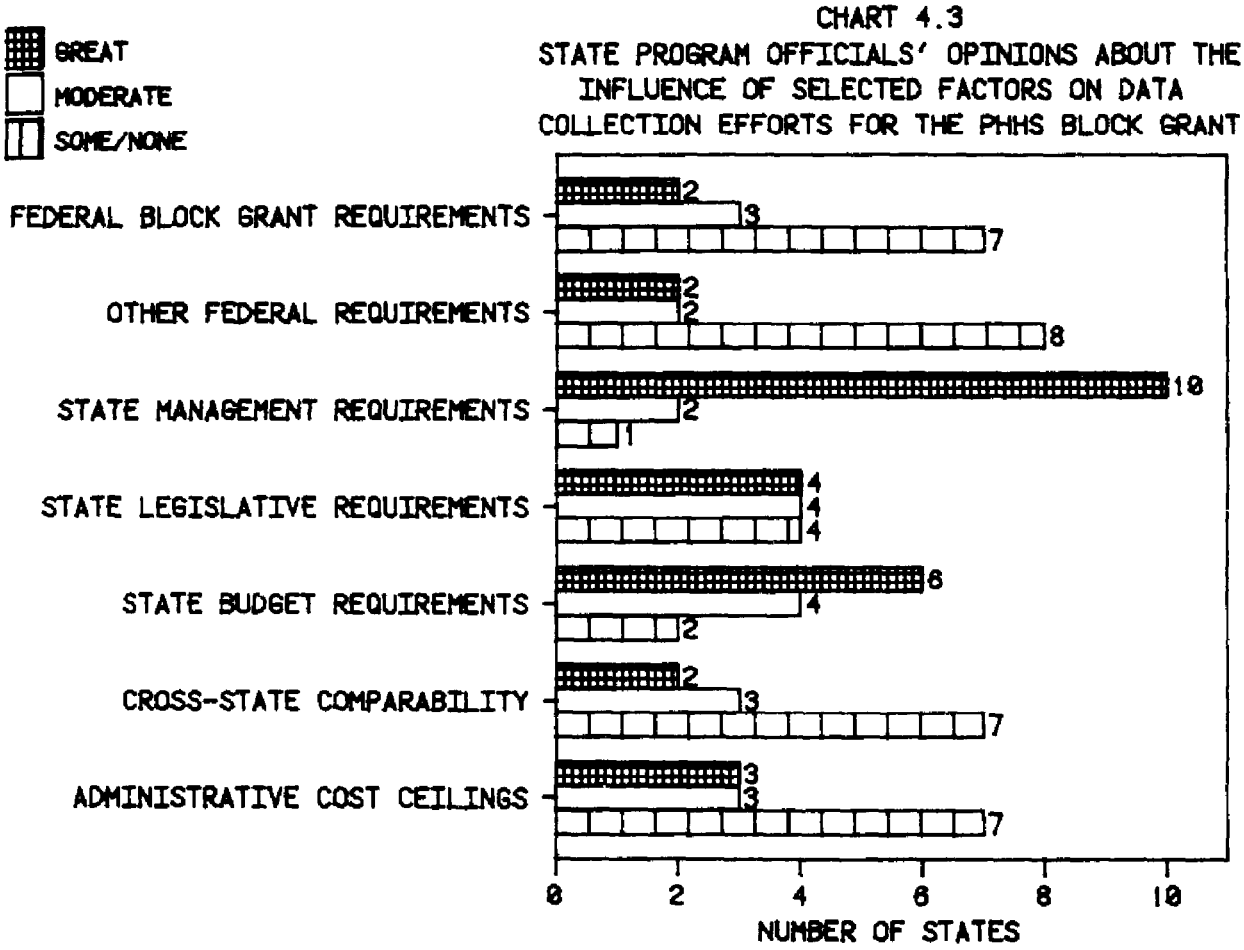
Data collection efforts remain about the same but could increase some

All states collect data on programs supported with block grant funds; however, the types of data and the programs for which information was obtained varied widely. The most common types of data collected include the size of the population eligible for services, measures of service needs, the geographic location of the clients, and the quantity of services delivered. The types least commonly collected were the education and income levels of the clients, handicapped status of the clients, and extent of recidivism.

State officials in nine states told us that the amount of funds dedicated to data collection has remained about the same since block grant implementation. While the reduced federal reporting requirements suggest that data collection efforts would decrease under the block grant, chart 4.3 shows that state management and budget requirements are the driving force behind state data collection efforts.

CHART 4.3

STATE PROGRAM OFFICIALS' OPINIONS ABOUT THE INFLUENCE OF SELECTED FACTORS ON DATA COLLECTION EFFORTS FOR THE PHHS BLOCK GRANT



For example, Vermont officials are placing additional data collection and reporting requirements on service providers because the state legislature is holding the health department more accountable due to the increases in state funds used to provide PHHS services.

Officials in three states said that they would spend more on data collection in 1984. For example, the California Block Grant Advisory Task Force reported that not enough information is available about the categorical programs to determine if wide-ranging funding changes are needed. The California legislature also reported that critical data about block grant programs do not exist and more information is needed before a major redistribution of block grant funds can be made.

State program officials said that additional information would be useful but there were barriers to collecting it. Although officials differed on which types of information would be most useful, many desired additional program evaluation information. Officials in all states said that limited financial resources were a major barrier to collecting more information. Other barriers included the burden placed on local grantees, inadequate staff and/or other resources at the state level, and measurement difficulties in defining or obtaining information.

States now arrange for audits of block grant funds

State audits of PHHS block grant expenditures are a key oversight feature of the block grant legislation. States are required by law and regulations to obtain independent annual audits of the PHHS block grant and make copies of audits available to HHS and the public. Generally, state auditors plan to conduct the state-level PHHS block grant audits as part of single department-wide audits. State officials told us that GAO's Standards for Audit of Governmental Organizations, Programs, Activities, and Functions will be used for these audits, and most states plan annual audits covering their state fiscal year.

Texas was the only state we visited with a completed state-level PHHS audit as of October 31, 1983. According to state officials the audit was performed in accordance with Office of Management and Budget guidance, and it covered the Department of Health, the agency administering the PHHS block grant, and the state fiscal year, September 1981 through August 1982. According to the report, the state auditor tested representative transactions, activities, and records involving PHHS funds and found that the department complied with the terms and conditions of the grant. Also, eight other states had 1982 state-level PHHS audits in process, and audits were planned but not yet started in four other states as of March 1984. In addition, as of January 1984, data developed by the HHS Inspector General for 42 states showed that 21 PHHS audits were complete, 14 were in process, and 7 were planned. These audits covered fiscal year 1982 funds.

State agencies generally plan PHHS service provider audits, and their internal audit staffs and certified public accountants usually conduct them. Some states plan to audit all of their PHHS service providers, and others plan to audit them on a sample basis. According to state officials most will be done annually. Information on audits was available for 6 of the 13 states. State officials said that as of October 31, 1983, 57

PHHS service provider audits were complete, 17 were in process, and 68 were planned.

BLOCK GRANT IMPLEMENTATION ACCOMPANIED BY ADMINISTRATIVE SIMPLIFICATION

Block grant implementation was accompanied by reduced federal administrative requirements in such areas as preparing applications and reports. In addition, the block grant legislation and regulations provided states with the flexibility to establish the procedures they believed were best suited to managing programs efficiently and effectively. Together, these block grant attributes were intended to simplify program administration and produce cost savings.

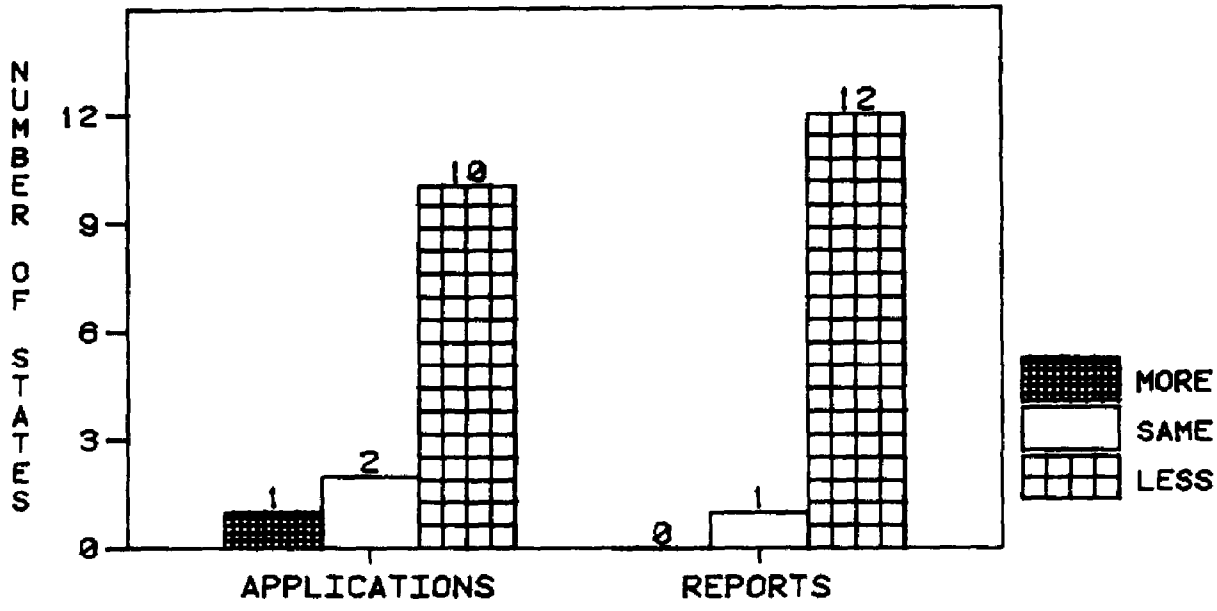
Most states reported that they now spend less time and effort preparing grant applications and reporting to the federal government and that this has enhanced their ability to manage PHHS-supported programs. Also, officials in all 13 states said that the block grant provides more flexibility than the categorical grants in allocating funds and setting program priorities. Over half the states reported that the block grant specifically enabled them to standardize or change administrative requirements and to improve the planning and budgeting for PHHS services or the use of personnel.

States report that reduced federal application and reporting requirements have positive impact

Under the prior categorical programs, management activities, such as application preparation and reporting, had to be done for each categorical program in accordance with specific federal directives. The block grant gave states greater discretion to approach these management activities in accordance with their own priorities and procedures.

As shown by chart 4.4, the vast majority of states reported that, overall, they spent less time and effort preparing federally required applications and reports than they spent preparing similar documents for the prior categorical programs.

CHART 4.4
STATE PROGRAM OFFICIALS' OPINIONS ABOUT THE EFFORT INVOLVED IN APPLYING FOR AND REPORTING ON THE PHHS BLOCK GRANT AS COMPARED TO CATEGORICALS



States must submit an application containing specified assurances and a description of how they intend to use block grant funds. Because the HHS Secretary chose not to prescribe the application form and content, the types of information included varied. Application lengths ranged from about 15 to 75 pages in the 13 states we visited.

Officials in 10 of the 13 states reported spending less time and effort preparing their 1983 PHHS application, and 8 of the 10 said that the application requirements had a positive effect on their ability to manage preventive health services. For example, Vermont, which submitted a consolidated plan for several federal grants, said that this approach will reduce the amount of paperwork and review time at the federal level and will free up time for substantive program planning issues.

Program officials in two states said that they spent the same amount of time and effort preparing block grant applications as they had on the prior programs, and those applications had a neutral effect on program management. Washington staff

explained that the PHHS grant is treated as part of the overall health program and they have not changed the process for developing their state health program since implementing the block grant. New York officials said that the time and effort spent was not reduced because 1983 was the first year they had administered the block grant and considerable effort was required to determine program priorities.

States must submit an annual report to HHS on activities funded under the grant. These reports must include information to determine if funds were spent according to the law and must describe who received the funds and the purposes for which funds were spent, including the progress made toward achieving those purposes. Copies of the reports must be provided, upon request, to interested persons.

Officials in 12 of the 13 states said they spent less time and effort reporting to HHS on block grant activities, and 8 of the 12 reported that the reporting requirements positively affected their ability to manage preventive health services. For example, Texas officials consolidated reports, and Kentucky officials said that the simplified federal reporting requirements facilitated an overview of state prevention programs. Officials in the other five states said that the reporting requirements had a neutral effect on their ability to manage programs.

States report improvements in administrative procedures, planning and budgeting, and use of personnel

Officials in 8 of the 13 states said that the block grant was a factor in their states' efforts to standardize or change administrative requirements. The types of changes reported included standardizing the state's financial reporting system, establishing new procedures for data collection and service provider reporting, and standardizing certain cost reimbursement practices. Officials in three states said that the desire to improve program oversight was a contributing factor to these changes.

For example, California's 1982 Budget Act established a 6-percent administrative cost limit, directed the Department of Health Services to identify state and local administrative costs for the programs included in the block grant, and mandated detailed information and reporting requirements. In addition, state officials are developing a uniform definition of administrative costs for programs included in the block grant. The state also specified new auditing and reporting requirements and improved certain state contracting procedures for all block

grant programs. Also, Pennsylvania officials standardized the application and public hearings requirements across all blocks. Officials in both states said that the block grant was the primary reason the changes were made.

Officials in 7 of the 13 states said that they made specific management improvements in planning and budgeting for PHHS services as a result of the block grant. The types of improvements included discontinuing inefficient programs, prioritizing programs to maximize the use of funds, redirecting funds to direct services, and simplifying the budget process.

For example, the July 1982 comprehensive plan prepared by the Mississippi Bureau of Personal Health Care represented the first steps in developing an agency-wide planning process. To develop future plans the local county units will provide input to their respective health district offices, which in turn will integrate this into a comprehensive agency-wide health care plan. Officials explained that the state was already beginning to move toward a comprehensive planning procedure, but they expedited the process because of the block grant requirement for an intended use report.

Program officials in three states reported improving the use of state personnel directly as a result of the block grant. For example, Texas officials reported that they were able to devote greater effort to program management and less to meeting time-consuming federal paperwork requirements.

Officials in two states said that the use of volunteers had increased since accepting the block grant. Kentucky officials said that they used block grant funds to train volunteers to provide rape crisis and health incentive services. Massachusetts officials said that they relied on volunteers to provide rape crisis counseling and community education services. Also, 24 of the 44 service providers visited said they used volunteers to provide PHHS services. Seven said that they increased their use and one decreased their use. Four of the eight said that the changes were directly related to block grants. In three of these cases, the service provider used volunteers to help provide new services established with block grant funds. In the fourth case, block grant funds increased program visibility, which apparently caused more persons to volunteer their help.

QUANTIFICATION AND COMPARISON OF ADMINISTRATIVE COSTS NOT POSSIBLE

As discussed in the two previous sections, states have experienced a mixture of increased grant management responsibilities and administrative simplifications since implementing the

block grants. Some believed that the administrative savings associated with the block grant approach could offset some federal funding reductions. Others were less optimistic, but many believed that fewer layers of administration, better state and local coordination of services, fewer federal regulations and requirements, and better targeting of services could lead to cost savings.

However, while much was said about the administrative cost savings that might be achieved, little attention was focused on the difficulties associated with quantifying and measuring such savings. Essentially, two types of data must exist to determine specific administrative cost savings:

--uniform administrative cost data at the state level, based on uniform state definitions of administrative costs, and

--comprehensive baseline data on prior programs.

State approaches to defining administrative costs differ widely

Six of the 13 states have written definitions of administrative costs that apply to the PHHS block grant. Officials in three other states provided unwritten definitions, and the remaining four states have no definition. Although the nine states which defined administrative costs did so in a manner essentially consistent with federal guidance, the specific definitions range from very vague and general to precise and detailed. Also, only three states defined administrative cost for subgrantees.

In addition to the differences in administrative cost definitions, states use varying procedures for computing and documenting administrative costs or have no such procedures. Also, none of the 13 states provided subrecipients instructions for computing administrative costs.

At the time of our review, 4 of the 13 states had information on their 1982 administrative costs. Of those, none exceeded the 10-percent limit for the block grant. Another two states which provided information for 1983 were within the limit, and one of these, California, was under the 6-percent state limit it had established. The remaining seven states had not developed information on their administrative costs.

Comprehensive baseline data on prior categorical programs not available

The ability to measure savings is also hampered by the lack of comprehensive baseline data on the cost of administering the prior categorical programs. At the state level, only 5 of the 13 states had specific information on the cost of administering the prior categorical programs. Also, at the federal level, program officials said that it would be extremely difficult to determine the administrative cost of the prior categorical programs because no comprehensive pre-block data exist.

CDC officials said that they could estimate the administrative costs associated with the four categorical programs they had administered. However, an HHS Health Resources and Services Administration official said they were unable to identify costs associated with the three prior categorical programs they had administered which were consolidated into the PHHS block grant.

The inability to specifically determine administrative costs is not something new. In 1978, we reported that despite growing interest in the administrative cost question, there was no information on the cost or staff resources used to administer individual assistance programs. As a result, data to enlighten the debates over the cost of program administration were fragmentary and inconsistent. Essentially, that condition prevails for the PHHS block grant today.

State officials provide varying perceptions about administrative costs

While there are numerous indicators of administrative simplification and management improvement, quantifying any overall administrative savings appears impractical. Therefore, the best indicators of administrative cost savings are probably the perceptions of state officials who have had the greatest contact with administering both the block grant and the prior categorical programs.

These perceptions tend to support the notion that although the block grants have simplified some areas of administration, they have brought added responsibilities in other areas, and the specific impact on administrative costs cannot be quantified. For example:

--A state official from Kentucky said that the PHHS block grant has had an impact on the state's cost of administration, but it cannot be quantified. He noted that the block grant streamlined many federal reporting requirements, and its flexibility allows more funds to go toward direct services.

--A state official from Mississippi believed that administrative costs under the PHHS block grant are greater than those of the former categoricals. He noted that state officials must now interpret regulations, arrange for audits, and manage other aspects formerly handled at the federal regional level. Additionally, because of the broad interest in block grants, state officials have devoted more time to responding to requests for information.

--Massachusetts officials said that PHHS administrative costs have neither increased nor decreased as a result of the change from categorical to block grants.

--In Florida, officials said that most PHHS funds were used for direct client services and administrative costs were charged to state general revenue. Therefore, it is difficult, if not impossible, to track administrative costs.

CONCLUSIONS

States made limited changes in organizational structures for PHHS programs at the state level. Changes that were made related to assigning responsibility for services states had not provided in the past, consolidating programs, or enhancing service delivery in particular program areas. States did make limited changes in the use made of certain types of service providers. However, these changes had little effect on the overall structure of the service provider network.

States carried out their expanded management role under the block grant. They imposed requirements on service providers and monitored them for compliance, provided technical assistance, collected program data, and had program audits underway in most states. Because some of these activities could be integrated into ongoing state efforts, the states' workload did not substantially increase.

The reduced federal requirements and the management flexibility associated with the block grant produced indications of administrative simplification. Most states spent less time preparing grant applications and reporting to the federal government, and many reported specific management improvements related to planning and budgeting and standardizing administrative requirements. However, specific administrative cost savings could not be quantified in a comprehensive manner. Accordingly, the perceptions of state officials remain the best indicators of changes in administrative costs emanating from the block grant.

CHAPTER 5

STATE ELECTED OFFICIALS AND CITIZEN GROUPS HAVE BECOME MORE INVOLVED IN PROGRAM DECISIONS UNDER THE BLOCK GRANT APPROACH

Under the PHHS block grant, governors and legislators in some states became more involved in program decisions than they were under the prior categoricals. This increased involvement usually manifested itself through the state budget and appropriations process. These officials generally considered block grants to be more flexible and believed there was greater public participation than under the prior categorical programs.

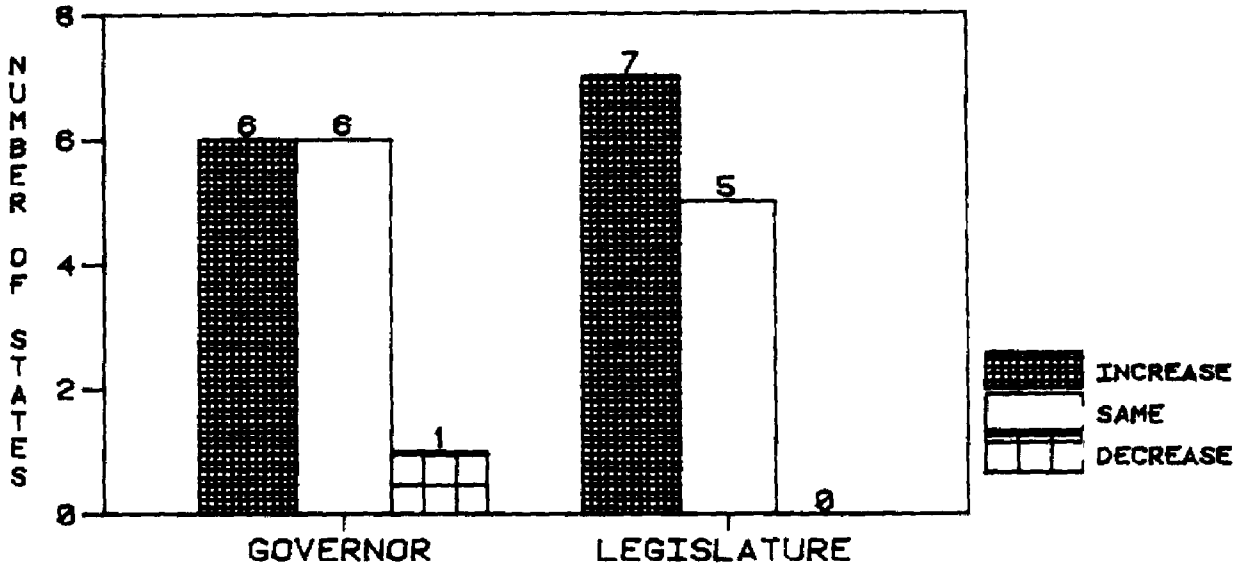
States reported taking steps in addition to the basic federal requirements in obtaining citizen input. In addition to the mandated legislative hearings and circulation of reports on the planned use of PHHS funds, most states reported holding executive branch hearings and establishing advisory committees. Input obtained from advisory committees and informal consultations often influenced PHHS program decisions.

While most of the interest groups we surveyed participated in public hearings, their satisfaction with state efforts to facilitate public input was mixed. Also, while state officials generally believed the block grant approach was a more desirable way to fund PHHS services, interest group respondents generally preferred the prior categoricals.

EXPANDED INVOLVEMENT OF GOVERNORS AND LEGISLATURES

Gubernatorial and legislative involvement in PHHS programs supported with federal funds has increased somewhat under the block grant approach. Chart 5.1 shows that program officials in six states said that their governor's involvement in PHHS block grant program decisions has increased from the levels that existed under the prior categorical programs. Program officials in seven states also said their legislatures were more involved. As a result, governors' and legislatures' involvement in federally funded PHHS programs now equals or exceeds involvement in state-funded programs in 9 of the 13 states.

CHART 5.1
STATE PROGRAM OFFICIALS' OPINIONS ON GOVERNOR AND LEGISLATURE INVOLVEMENT IN PHHS BLOCK GRANT DECISIONS AS COMPARED TO THAT IN PRIOR CATEGORICALS



While governors had several mechanisms available to obtain information on or to exercise control over block grants, most relied on their opportunities to review budget submissions. The widespread use of the budget process as a PHHS oversight mechanism is not unusual since, as discussed in chapter 2, states' decisions on the use of PHHS funds were often made as part of a broader state budget process. Fewer governors relied on public hearings, advisory committees, and the review and approval of federal grant applications. While these latter mechanisms were rated less important by governor's office representatives in many states, they were important to some. For example, Pennsylvania's governor appointed a PHHS advisory council specifically to provide input concerning the use of PHHS funds.

While reliance on the different mechanisms varied among the states, governor's office representatives in 7 of the 13 states said the block grants encouraged them to change their use of these information and control mechanisms. The types of changes included redirecting and rethinking program priorities, becoming more involved in planning and reviewing programs, and increasing interagency cooperation. None of the states planned additional changes to these mechanisms in the near future.

Like the governors, the legislatures strongly relied on the state budget process as an oversight mechanism for block grants. Legislatures in all 13 states appropriate federal PHHS block grant funds, and 10 of them specifically identify funds for certain program areas. Eleven legislatures also require executive branch reports on federal grant operations, including the PHHS block grant.

Legislative staffs in seven states said their legislatures are greatly involved in PHHS block grant decisions. This was a considerable increase over the prior categorical programs, where legislatures in only 2 of the 13 states noted a high degree of involvement. Also, legislative committees in four states made changes to the 1983 block grant plans or proposals submitted by executive agencies. The types of changes involved maintaining or increasing funds for specific services, decreasing funds for specific services, changing methods of service delivery, and changing the amount of funds transferred among blocks. In Iowa, for example, the legislature exercised control over PHHS by transferring 7 percent of PHHS funds to the maternal and child health block grant, by allocating specific percentages of PHHS funds to programs, and by limiting administrative costs.

Governor's office representatives and legislative officials identified four block grant characteristics which encouraged their involvement:

--Consolidation of related categorical programs.

--Greater state authority to set program priorities.

--The ability to transfer funds between blocks.

--Public participation requirements.

Legislative staff in seven states also said that the federal legislative hearing requirement encouraged state legislative oversight. A legislative staff member in Massachusetts noted that the governor has complete control over submitting state applications for funds awarded under categorical programs. However, under the block grant the legislature becomes involved in decisions concerning the use of PHHS funds because of the hearing requirement. Colorado legislative officials also viewed the hearing requirement favorably because in the past the state courts have supported the governor's contention that the legislature may not allocate federal funds through the appropriations process. The governors in seven states also viewed this requirement favorably, some indicating that it served as an impetus to involve the public in these programs.

On the other hand, governor's office representatives said that block grant prohibitions and restrictions on the use of funds tended to negatively affect governors' abilities to oversee block grant planning and implementation. Specifically, governors in nine states reported that federal block grant earmarking requirements, which exist in the PHHS rape crisis and hypertension program areas, had such a negative effect. Similarly, eight legislative officials in seven states agreed that earmarking and other prohibitions also tended to discourage legislative oversight.

INCREASED STATE EFFORTS TO OBTAIN CITIZEN INPUT

States must hold legislative public hearings and prepare and make public reports on their intended and actual uses of PHHS funds. In addition to these mandated sources of citizen input, 10 states reported holding executive agency hearings, and 8 states reported using one or more advisory committees. Program officials reported that advisory committees and informal consultations were the most important sources of information for decisions regarding the use of PHHS funds.

States prepared required reports

Legislation requires a state to prepare a report describing its intended uses of PHHS funds and to make it public in such a manner as to facilitate public comment. Also, states must prepare an annual report on their PHHS activities and make it available on request.

Twelve of the 13 states provided their intended use report to various public and state organizations for comment. Eight of these states distributed the reports on their own initiative rather than on request. In most instances, these reports were sent to either state legislatures or service providers. Also, seven states sent copies to local government officials and organizations representing minorities and women. In Iowa, the the report was not specifically distributed for comment because state officials relied on the legislative hearings to obtain public comment. Four states revised their intended use reports, and each of these states also made the revised reports available for public comment.

A majority of interest groups were generally satisfied with the length of the states' comment periods for the intended use report. However, most tended to be dissatisfied with the availability of copies of the plan, the opportunity to comment on revisions to the plan, and the timing of the comment period relative to the states' decisionmaking process on the use of funds.

Three states plan to make changes to encourage more citizen input on intended use reports. The changes include soliciting comments from more groups and soliciting comments earlier during the planning process.

Also, all states have prepared annual reports on their 1982 PHHS block grant activities. Seven states plan to send copies to state legislators, five plan to send them to service providers, and four plan to send copies to organizations representing minorities, handicapped, and interest groups as well as private citizens, technical experts, and local government officials.

States conducted legislative and executive hearings

Legislation requires the legislatures of the states to conduct public hearings on the proposed use and distribution of PHHS block grant funds. A total of 16 legislative committees in 12 of the 13 states told us they held 45 hearings addressing the block grant. In Mississippi, legislators participated in three regional hearings that were jointly sponsored by the governor and the legislature. Thirty-two committee hearings were held in the state capital, while 13 were held at other locations. Most hearings were conducted by either a budget or appropriations committee. Only four hearings were held separately to address the PHHS block grant, while 23 were held during the states' normal budget an appropriation hearings processes. The remaining 18 PHHS hearings were held as part of separate appropriation hearings, which also included other block grants.

The most widely used method to notify the public of hearings was state mailing lists. In nearly all states the advance notification period generally ranged from 1 to 4 weeks. The average number of individuals or groups that attended the various public hearings for which we were able to obtain data ranged from 112 in Florida to 15 in Pennsylvania.

Legislative officials in three of the four states that held hearings on prior categoricals believed that the level of participation had increased since their state implemented the block grant. Although citizen input received during PHHS legislative hearings increased, it seemed to have little impact on state PHHS decisions. Legislative officials in only one state said that the concerns expressed during legislative hearings led to changes in the state's budget proposal.

While none of the 13 states reported holding executive branch hearings for the 1981 PHHS categorical grants, 10 states reported holding a total of 60 executive branch hearings for the 1983 PHHS block grant. The number of hearings ranged from 12 in Florida and Michigan to 2 in Vermont. All hearings were held to address both PHHS and other block grants and, in some instances, related state programs. No executive hearings were held separately for the PHHS block grant. The amount of advance notification for the executive hearings was 2 to 4 weeks in eight states. The remaining two states gave less than 2 weeks' notice. The average attendance at these hearings ranged from 26 persons in Mississippi to 110 in Vermont. Unlike the legislature, most executive public hearings were held outside the state capital. Most states made special efforts to encourage participation by local governments, service providers, and members of protected groups.

With regard to hearings, most interest groups were satisfied with the number of hearings held, their location, and the amount of time allotted block grants. Conversely, most were dissatisfied with the degree of advance notice, the availability of information prior to hearings, and the timing of hearings relative to the allocation decisionmaking process. Legislative committees in four states plan to make changes in the public hearings process. These changes include holding more hearings outside the state capital, improving the notification process, and holding hearings earlier. Six states plan to make changes in the executive branch hearings, such as scheduling hearings earlier during the allocation process and holding more hearings. Mississippi and Michigan, which held 3 and 12 hearings, respectively, plan to hold fewer hearings.

Considerable use of advisory committees and task forces

Program officials in 8 of the 13 states reported using a total of 20 advisory committees or task forces as part of their PHHS block grant decisionmaking process. Four of these committees addressed the PHHS block grant only, while the remaining 16 committees addressed the PHHS block grant in conjunction with other related block grants and/or state-funded programs.

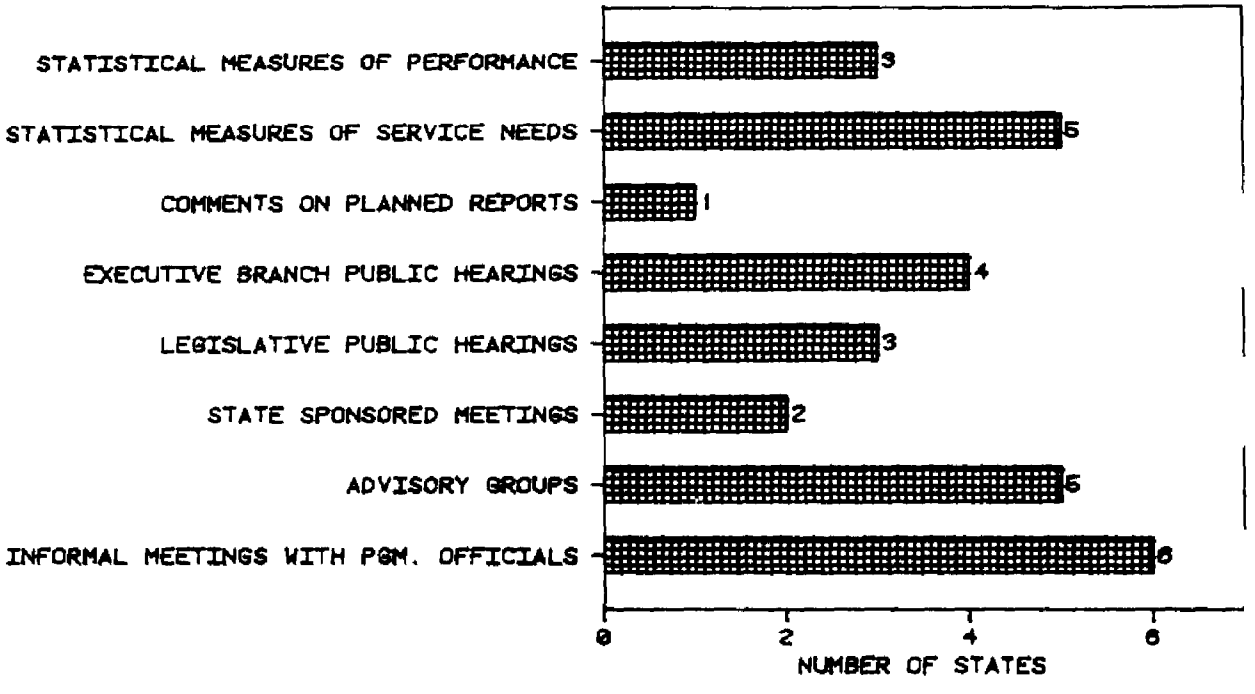
These committees were primarily composed of state program officials, private citizens, service providers, technical experts, minorities, and women. The governor's office appointed members to these groups in all eight states and was directly represented in three states. In California the state legislature also appointed individuals to advisory committees, and in California and Washington, state legislators served on the committees.

A greater share of the interest group respondents was satisfied with both the role and composition of advisory groups focusing on PHHS funds.

Role of citizen input in PHHS decisionmaking

As shown in chart 5.2, PHHS program officials said that measures of service needs, advisory committees, and informal consultations were the sources of information that were most important in making decisions on priorities or objectives for programs supported with PHHS funds. Comments on the planned use report had the least impact.

CHART 5.2
STATE PROGRAM OFFICIALS' OPINIONS ABOUT THE SOURCES OF INFORMATION THAT WERE OF GREAT IMPORTANCE IN PHHS BLOCK GRANT DECISIONS



In 7 of the 13 states, information received from one or more of the citizen input mechanisms led to decisions on the use of PHHS funds. For example:

--In Kentucky, comments received on the planned use report resulted in the state providing local health departments

with funds that are not specifically identified with a program area. This change gave local health departments more discretion in meeting health needs.

--In California, hearings conducted by the Block Grant Advisory Task Force led to decisions to have the state provide hypertension services on a statewide basis rather than to a certain targeted geographical area.

--In Massachusetts, on the basis of recommendations by the Task Force on Prevention, the Preventive Medicine Division established a media resource center to consolidate and enhance the distribution of health information to the public. The center will also train community health providers to use the media for public health education.

PERCEPTIONS OF INTEREST GROUPS AND STATE OFFICIALS ON BLOCK GRANTS

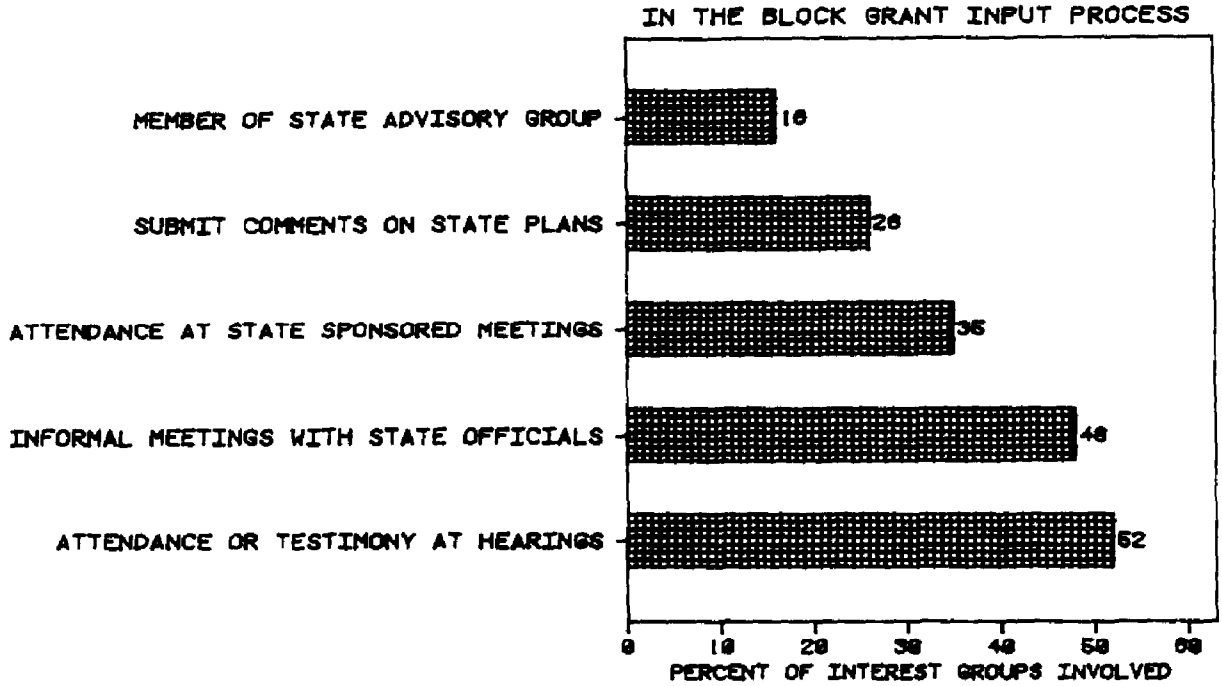
While many interest groups increased their activity with state officials under block grants, their satisfaction with state efforts to facilitate input into PHHS program decisions was mixed. Also, they were divided regarding their satisfaction with state responses to their concerns, but generally they believed state decisions on block grants adversely affected groups they represented. State officials were generally pleased with the block grant approach, whereas interest groups perceived block grants to be a less desirable way of funding PHHS services.

Interest groups give mixed reaction on state input process

Forty percent of the PHHS interest group respondents told us that they increased their levels of activity with state legislatures and/or state executive agencies since block grant implementation. Most of these were statewide organizations involved in a wide range of activities to learn about or influence PHHS programs. As shown in chart 5.3, interest groups participated in various aspects of the state citizen input process. Attending or providing testimony at hearings was the most widely

used input process, with 52 percent of the 234 interest groups responding to our survey participating.[1]

CHART 5.3
PHHS INTEREST GROUP PARTICIPATION
IN THE BLOCK GRANT INPUT PROCESS



[1]234 of the 786 respondents to our survey of interest groups in the 13 states indicated they had some knowledge of PHHS-funded programs. Not all 234, however, answered every question in our survey, and percentages are based on the total number of respondents to each question. The number of respondents to our questions ranged from 46 to 234. The actual number of respondents on a question-by-question basis are detailed in appendix X.

Table 5.1 shows that both attendance and testimony were greater for executive branch than for legislative hearings.

Table 5.1

Percent of Interest Group Participation in Different Aspects of Hearing Process
(234 respondents)

Aspect of process	Percent
Attendance at executive hearings	42
Attendance at legislative hearings	32
Testimony at executive hearings	19
Testimony at legislative hearings	13

Interest group and service provider satisfaction with the state process

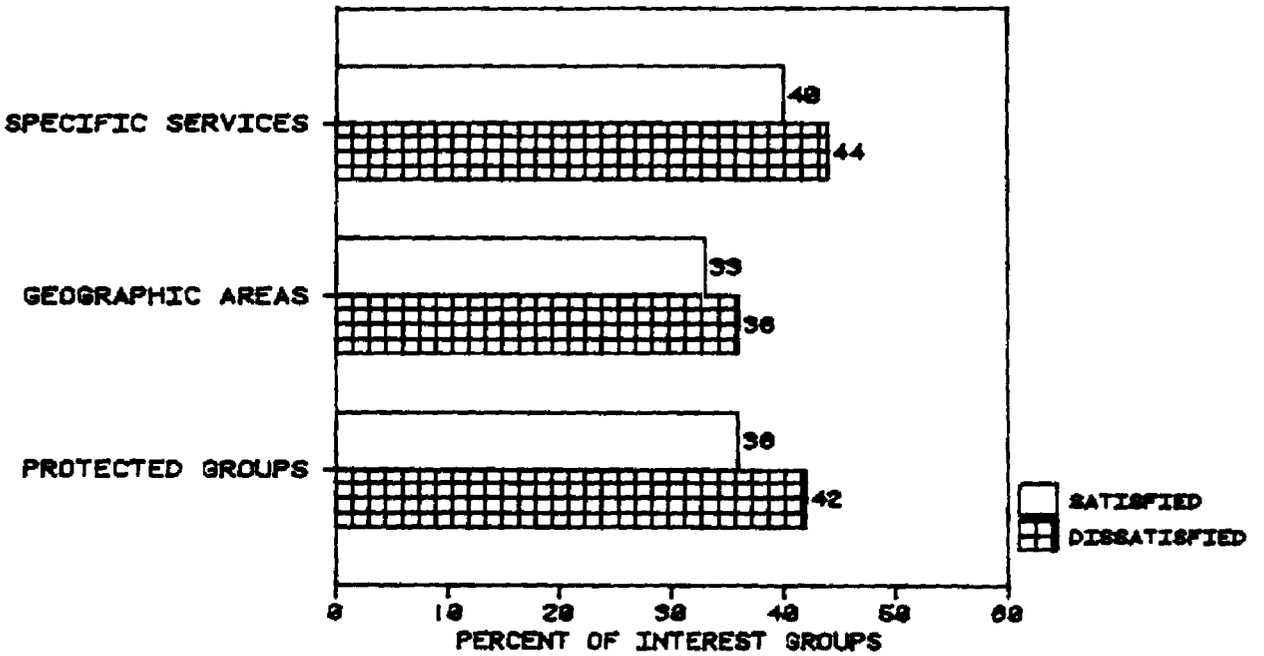
There were no clear trends in satisfaction or dissatisfaction with state methods for facilitating citizen input. The major areas of interest group satisfaction were with the accessibility of state officials for informal consultation (68 percent), the time and location of hearings (57 percent), and the time allotted to block grants at hearings (55 percent). The major areas of dissatisfaction related to the availability of information on the planned use of funds prior to hearings (53 percent), the opportunity to comment on revised plans (51 percent), and the timing of hearings relative to the states' decisionmaking process (50 percent). Interest groups that actively participated in the state processes by testifying, attending hearings, or submitting comments on state plans were more satisfied with state processes than those groups not actively involved.

Three issues of great or very great concern to interest groups were the need to maintain or increase funding for specific services (69 percent), for geographic areas within the state (44 percent), and for services for protected groups, such as minorities and handicapped (52 percent). Program officials told us that they also perceived a considerable concern about the need to maintain or increase funds for specific services during the executive branch hearings.

As shown in chart 5.4, interest groups were divided concerning their satisfaction with state responses to their concerns; however, in all three instances more interest groups were dissatisfied than satisfied. Also, 48 percent of the interest group respondents believed that changes made by the state to

programs supported with PHHS block funds have had an adverse effect on the individuals or groups they represent. Twenty seven percent of the interest group respondents viewed the state changes favorably, and the remainder said there was no impact.

CHART 5.4
DEGREE OF SATISFACTION WITH STATE RESPONSES
TO ISSUES OF GREAT CONCERN TO INTEREST GROUPS



The 44 local service providers we visited said that they relied most heavily on informal consultations with state officials to convey their views. However, most of these providers also attended executive hearings or meetings on the PHHS block grant.

Like the interest groups, the providers had mixed reactions regarding their satisfaction with the states' citizen input process. Fifty percent believed that states provided sufficient advance notice for hearings and that the availability of planned use reports was adequate. The other half believed that this information was insufficient. Overall, most providers believed that the opportunities to provide input into state decisionmaking for PHHS-supported services was greater or about the same under the block grant as it was under the prior categorical programs.

State officials and interest groups have different perceptions of block grant approach

Program officials in all 13 states said the block grant provided them more flexibility than prior categorical programs, and governors in 8 states agreed with that assessment. Most of the legislative leaders in 11 of the 13 states also believed that block grants generally provide more flexibility than prior categorical programs. Also, PHHS program officials, responsible for block grant administration in 11 of the 13 states, believed that federal block grant requirements are less burdensome than the requirements of the prior categorical programs.

State officials generally believed the block grant approach was a more desirable funding mechanism when compared to the categorical approach. Twenty-nine legislative leaders in 12 of the 13 states said block grants were more desirable than categoricals, as did 11 of the 13 PHHS program officials and 10 of the 11 governors responding to our questionnaire. Three legislative leaders in three states believed the block grants were a less desirable approach. The others saw little or no difference between the approaches.

Interest groups, on the other hand, did not generally perceive the block grant approach to be a desirable method of funding PHHS programs. Only 28 percent said the block grant approach was more desirable, while 51 percent saw the approach as a less desirable way of funding PHHS programs. The remaining 21 percent saw little or no difference. The PHHS respondents who saw block grants as less desirable generally were also those who perceived that state block grant decisions had adversely affected those groups or individuals they represented.

While interest groups and state officials had differing views on the desirability of the block grant, both expressed concern about the federal funding reductions that accompanied the block. In our opinion, it was often difficult for individuals to separate block grants--the funding mechanism--from block grants--the budget-cutting mechanism. Accordingly, several state officials commented that the advantages of their expanded flexibility were somewhat diminished by the reduced federal funding, and selected interest groups were concerned about the implications that reduced funding held for the organizations and individuals they represented.

CONCLUSIONS

The increased flexibility of the block grant approach, particularly the opportunity to set priorities for previously directly federally funded programs, has contributed to the increased role of the governors and legislatures in some states in programs previously dominated by federal and state program officials. This increased involvement of state elected officials has been accompanied by increased citizen involvement in the decisionmaking process for PHHS programs. We found states reported taking steps in addition to basic federal requirements to obtain public input, and states made the greatest use of input obtained from informal consultation and advisory committees when making program decisions.

Interest groups provided mixed reactions to the states' citizen input process. They were especially satisfied with their access to state officials. However, many were dissatisfied with the availability of information on planned uses of PHHS funds, the opportunity to comment on revised plans, and the timing of hearings relative to the states' decisionmaking process. Also, interest groups had mixed reactions regarding the adequacy of state responses to their concerns, but more were dissatisfied than satisfied.

In general, state officials found the block grant approach to be more flexible and less burdensome and viewed it as a more desirable method of funding PHHS services. On the other hand, interest groups generally viewed it to be a less desirable method of funding PHHS services and believed that state changes to programs supported with block grant funds negatively affected the groups they represented.

DESCRIPTION OF GAO'S

DATA COLLECTION METHODOLOGY

To obtain information concerning the implementation and administration of block grants in 13 states, we collected data from two sets of sources:

1. Individuals or organizations having an interest in a single block grant, such as the state office that administers the block grant.

2. Individuals or organizations potentially having an interest in more than one block grant, such as groups within the state legislature.

In some instances we obtained data directly from records available at organizations we visited; however, most of the data were provided to us by individuals or organizations. Most data were collected during January to August 1983.

We developed four data collection instruments to obtain information from the first set of sources referred to above and five to obtain information from the second set of sources. The instruments we used to obtain information from sources having an interest in a single block grant were:

--Program Officials Questionnaire.

--Financial Information Schedules.

--State Audit Guide.

--Service Provider Data Collection Guide.

Almost identical versions of the Program Officials Questionnaire were used for all block grants reviewed. The other three instruments were more tailored to the specific block grant.

Questionnaires were used to obtain information from sources with potential interest in more than one block grant. The five respondent groups for these questionnaires were

--governors' offices,

--state legislative leadership,

--state legislative committees,

--state legislative fiscal officer(s), and

--public interest groups.

The approach generally taken with these questionnaires was to ask about the respondent's specific experience with each block grant and then ask some questions about general impressions and views concerning the block grant concept.

The primary focus of our study was at the state level; thus, most of our data collection took place there. Even when collecting data from other than the state level, state implementation and administration remained our major interests. The questions in the Public Interest Groups Questionnaire concerned the group's views on how the state implemented and administered each block grant. The Service Provider Data Collection Guide was used not to obtain comprehensive data from the service provider level but rather to identify some of the implications, for service providers, of state policies and practices in block grant implementation.

The questionnaires were pretested and externally reviewed prior to their use. The extent of pretest and review varied with the questionnaire, but in each case one or more state officials or organizations knowledgeable about block grants provided comments about the questionnaire.

The Financial Information Schedules were discussed with other organizations that had obtained similar information at the state level in the past. The topics to be included in the Service Provider Data Collection Guide were discussed with service providers.

The following sections describe each data collection instrument, including information on the source of the data and the method used to administer the instrument.

PROGRAM OFFICIALS QUESTIONNAIRE

Content

This questionnaire was designed to elicit information about the administration of the block grant. It asked state program officials about

--the ways in which the state established priorities and program objectives,

--the procedures used to obtain the views of citizens and other interested groups,

--the scope of the state's data collection efforts,

--the extent to which technical assistance is provided to state and local providers,

--the state procedures and practices for monitoring service providers, and

--the state's general impressions concerning block grants.

Source of information

The questionnaires were completed by senior level program office officials who had responsibility for administering the block grant in the 13 states included in our study. We specified in the questionnaire that the responses should represent the official position of the program office.

Method of administration

We identified the senior program official in each state and delivered the questionnaire to the office of that official. The state program official was asked to complete the questionnaire with help, if necessary, from other staff and return the questionnaire to our representative. When certain responses were given, follow-up questions were asked to obtain additional information.

FINANCIAL INFORMATION SCHEDULES

Content

The purpose of these schedules was to obtain the best available data on how states were spending block grant funds in addition to other sources of funds on PHHS program areas. These schedules show for state fiscal years 1981-83 the expenditures for each predecessor categorical program area from

--federal categorical funds going through the state government and the amounts received by directly funded grantees,

--block grant funds,

--other PHHS-related federal funds,

--PHHS-related state funds,

--PHHS-related local cash match, and

--other funds, such as fees for services and copayments or reimbursements from third parties, e.g., insurance companies.

In addition, using similar categories, we collected expenditure data at the state level for individual service providers receiving federal funds directly or through the states.

We used expenditure data rather than award data to more accurately reflect the level of activity in each state and program area and to address the effect of categorical outlays during block grant years. In addition, these data generally were collected on a state fiscal year basis because this was the standard accounting period in most states. Washington was the only state in which award, rather than expenditure, data were collected because award data were more readily available. Also, Texas was the only state in which expenditure data were collected on a federal fiscal year basis since this was the format in which data were most readily available. Texas' state fiscal year only varies from the federal fiscal year by 1 month.

Source of information

The expenditure data were obtained from program and budget information available at the state level.

When actual expenditure figures were not available, estimated figures were provided. In these cases, however, state officials agreed that the figures provided represented the best available information at the time we completed our fieldwork.

At times, individual service providers were contacted for expenditure data. We also consulted with officials from the Association of State and Territorial Health Officials, the Urban Institute, and HHS when designing the financial information schedules because of their knowledge and ongoing work in these areas.

Method of administration

Our staff worked with state program and budget officials to complete the expenditure schedules.

STATE AUDIT GUIDE

Content

We used this audit guide to collect information on the state administration and management of the PHHS block grant. The areas covered included

--reviewing the overall state health planning process and determining how planning for PHHS block grant funds and programs fit into this process,

--identifying the administrative structure the state used to deliver PHHS services,

--reviewing program areas supported with PHHS funds to determine and analyze expenditure trends by programs and sources of funding,

--obtaining types of services provided within each PHHS program area and identifying changes made to services provided since the state adopted the block grant,

--identifying changes made to the types of providers eligible to provide services and beneficiaries of services since the state adopted the block grant, and

--obtaining changes made to the methods for distributing federal categorical and block grant funds.

Source of information

The information was obtained from state officials through interviews and state documents.

Method of administration

A detailed audit guide was used by our field staff to obtain this information. Follow-up meetings were held with state officials for further information or clarification of data.

SERVICE PROVIDER DATA COLLECTION GUIDE

Content

This guide was used to collect information concerning services provided with categorical, block grant, and other funds. The areas covered included

--descriptive information about the service provider,

--sources of service provider funding,

--scope of specific services provided,

--methods of service delivery,

--information about clients served by the providers, and

--involvement in public participation.

Source of information

A total of 44 service providers were visited in the 13 states. Those service providers were judgmentally selected to provide some coverage by range of (a) types and size of providers (e.g., state, private, nonprofit), (b) types of PHHS services provided, and (c) location in the state (urban and rural areas). In our selection, we attempted to include where appropriate at least three service providers from each state we visited and at least three service providers for each of the prior categorical programs consolidated into the PHHS block grant.

The service providers were generally selected from a list provided by the state health agencies.

Method of administration

The instrument was completed onsite by our field staff. Interviews with service provider officials and staff and review of documents such as annual reports and internal audits were used to complete the instrument.

GOVERNOR'S OFFICE QUESTIONNAIRE

Content

This questionnaire focused on the role played by the governor and his office in implementing and administering the block grants. Questions asked included

--the extent of the governor's involvement in the decision-making process regarding block grant funding and administration,

--what the governor did to obtain information or exercise control over the setting of state program priorities,

--whether there are any changes anticipated in the way in which the governor will exercise control in the future,

--if additional federal technical assistance would have been useful, and

--what the governor's general impression was about block grants.

Source of information

The questionnaire was completed by the governor or his designated representative.

Method of administration

The questionnaire was mailed directly to the governor, and all governors or their designated representative responded. When completed, the questionnaire was returned to one of our representatives.

STATE LEGISLATIVE LEADERSHIP QUESTIONNAIRE

Content

This questionnaire was used to obtain information about the perceptions of state legislative leaders concerning block grants. The questions asked included

--how block grants affected the way the state legislature set program and funding priorities,

--what the major benefits were of funding programs through block grants,

--how block grants could be improved, and

--what were their general impressions about block grants.

Source of information

We compiled a list of legislative leaders based on a publication by the Council of State Governments, State Legislative Leadership; Committees and Staff, 1983-84. Generally there were four per state: the presiding officer of the senate, the senate minority leader, the speaker of the house, and the house minority leader. A total of 48 questionnaires were administered and 40 were returned, for an 83-percent response rate.

Method of administration

We delivered the questionnaire to the offices of each state's legislative leaders. We asked that they complete the questionnaire and return it to our representative.

STATE LEGISLATIVE COMMITTEES QUESTIONNAIRE

Content

The questionnaire requested information about public hearings concerning block grants held by state legislative committees in the 13 states. Questions included were

--how many hearings were held and where,

--who sponsored the public hearings,

--what mechanisms were used to inform citizens that hearings were being held,

--who testified at the hearings, and

--what concerns were expressed.

Source of information

We attempted to identify those committees in each state that held public hearings for the 1983 block grants. The questionnaires were completed by senior committee staff responsible for organizing public hearings on block grants. Twenty-eight committees received, completed, and returned the questionnaires.

Method of administration

We delivered the questionnaire to each legislative committee that held public hearings for the 1983 block grants. A senior committee staff member was requested to complete the questionnaire and return it to our representative. We followed up on selected questions for additional information.

STATE LEGISLATIVE FISCAL OFFICER QUESTIONNAIRE

Content

The purpose of this questionnaire was to obtain information about the procedures used by the state legislatures to control and monitor block grant programs. Specifically, we asked

--what control or monitoring mechanisms the state legislature has and whether they have changed since block grants were implemented by the state,

--how block grant funds are appropriated,

--whether public hearings led to changes in the use of block grant funds,

--what role the legislature played in changing executive agencies' block grant plans or proposals, and

--what were the fiscal officer's general impressions about block grants.

Source of information

Legislative fiscal officers are generally the directors of the permanent, professional staffs of state legislatures. The National Conference on State Legislatures, the National Association of State Fiscal Officers, and the Council of State Governments provided assistance in identifying the appropriate staff persons to complete our questionnaire.

Method of administration

We delivered 19 questionnaires to fiscal officers in our 13 states. Seventeen were returned, for an 89-percent response rate. We followed up on selected questions for additional information.

PUBLIC INTEREST GROUP QUESTIONNAIRE

Content

This questionnaire asked various public interest groups about

--their involvement with and perceptions of block grants,

--perceptions about the state's efforts to solicit and incorporate citizen input into state program decisions made on block grants,

--their views on the impact of changes made by the state on those persons they represented, and

--their perceptions of changes in civil rights enforcement as a result of block grants.

Source of information

The names and addresses of interest groups were obtained from several sources. Initially we contacted about 200 national level organizations and asked if they had state affiliates that might have dealt with the implementation of the block grants. If so, we requested the names and addresses of those affiliates. The list of 200 national level organizations was compiled from lists developed by GAO staff from mailing lists of organizations interested in specific block grants compiled by HHS and from the staff of a private organization with extensive knowledge about block grants.

This list was supplemented, where possible, by lists of interest groups compiled from public hearing attendance rosters kept by state agencies. The availability of these lists varied by state.

Once an initial list was compiled, we sent it to our staff in the 13 states. They, in turn, showed these lists to state officials involved with the block grants and to a small, diverse group of respondents on the lists. These groups provided corrections and recommended additions of groups that they felt were active in block grant implementation but were not on the list we had initially compiled.

The results of the selection process were not intended to be viewed as either the universe of public interest groups knowledgeable about block grants or a representative sample of public interest groups for any state or block grant. We believe, however, the interest groups we contacted provided a diverse cross-section of organizations knowledgeable about PHHS block grant implementation.

Method of administration

Questionnaires were mailed to the identified public interest groups with an enclosed, stamped, preaddressed envelope. A follow-up letter and questionnaire were sent to those who failed to respond within 3 weeks after the initial mailing.

Of the 1,662 groups on our final list, 786 returned completed questionnaires, for a 47-percent response rate. Of the completed questionnaires, 234 indicated they had at least some knowledge of the implementation of the PHHS block grant in the state in which their organization was located.

PERCENTAGE OF TOTAL PHHS

EXPENDITURES BY SOURCE OF FUNDS

State	1981[a]			1983[a]		
	Federal	State	Other	Federal	State	Other
Colorado	53	47	[b]	41	58	[b]
Florida	41	37	22	28	48	23
Iowa	40	60	[c]	36	64	0
Kentucky	16	84	0	15	85	0
Massachusetts	46	54	0	43	57	0
Michigan	57	43	0	54	46	[b]
Mississippi	73	5	22	66	14	19
Pennsylvania	46	53	1	51	49	0
Texas	62	37	1[c]	64	36	0
Vermont	65	35	0	34	66	0
Washington	41	59	[b]	32	67	[b]

[a]May not add to 100 percent due to rounding.

[b]Less than 1 percent.

[c]Local funding excluded because complete data not available.

APPENDIX III

PERCENTAGE OF TOTAL EXPENDITURES BY PROGRAM

	Colorado	
	FY1981	FY1983
HIG	82	89
EMS	9	4
FLU	3	3
HERR	3	2
HYP	2	1
HHS	1	0

	Florida	
	FY1981	FY1983
HIG	57	56
HYP	22	22
URC	8	8
EMS	7	0
HERR	4	9
FLU	2	4

	Iowa	
	FY1981	FY1983
HIG	70	64
EMS	21	17
HERR	4	10
HYP	3	4
FLU	3	4

	Kentucky	
	FY1981	FY1983
HIG	82	82
HYP	6	7
HERR	4	6
HHS	4	2
URC	3	0
EMS	1	1
FLU	0	0

	Massachusetts	
	FY1981	FY1983
HIG	51	53
EMS	24	23
HERR	9	8
HYP	7	7
URC	6	4
FLU	4	5

	Michigan	
	FY1981	FY1983
HIG	36	38
EMS	25	19
HYP	18	20
URC	12	10
HERR	8	10
FLU	1	2

	Mississippi	
	FY1981	FY1983
HYP	47	54
EMS	30	20
HIG	13	16
HERR	6	5
FLU	3	5
HHS	2	0

	Pennsylvania	
	FY1981	FY1983
HIG	34	32
EMS	27	26
URC	15	15
HYP	14	12
HERR	4	5
FLU	0	0

	Texas	
	FY1981	FY1983
EMS	52	43
HIG	19	33
HYP	12	8
FLU	9	8
HERR	5	3
URC	3	0
HHS	0	1

	Vermont	
	FY1981	FY1983
HIG	36	35
EMS	35	18
HYP	14	23
HERR	7	15
FLU	7	8
HHS	2	0

	Washington	
	FY1981	FY1983
EMS	54	58
HERR	25	8
HYP	11	13
HIG	5	19
FLU	5	0

KEY ON NEXT PAGE

ABBREVIATIONS

EMS	Emergency Medical Services
FLU	Fluoridation
HERR	Health Education and Risk Reduction
HHS	Home Health Services
HIG	Health Incentive Grant
HYP	Hypertension
URC	Urban Rat Control

TOTAL EXPENDITURES FOR EMERGENCY MEDICAL SERVICES

States	1981	1982	1983	Percent of total expenditures 1981	Percent of total expenditures 1983	Change in percent of total expenditures
	------(000 omitted)------					
Colorado	$ 711	$ 918	$ 415	9	4	(5)
Florida	709	542	0	7	0	(7)
Iowa	769	253	654	21	17	(4)
Kentucky	70	214	136	1	1	0
Massachusetts	1,549	688	1,232	24	23	(1)
Michigan	2,332	2,262	1,537	25	19	(6)
Mississippi	815	874	564	30	20	(10)
Pennsylvania	3,578	3,483	3,273	27	26	(1)
Texas[a]	3,139	3,338	3,086	52	43	(9)
Vermont	348	122	145	35	18	(17)
Washington[b]	1,483	1,372	1,495	54	58	4
Subtotal	$15,503	14,066	12,537	1982		
California	-	2,299	2,663	25	23	(2)
New York	-	4,292	3,733	4	3	(1)
Total		$20,657	$18,933			

[a]Funding from local sources excluded due to unavailable complete data for all years.

[b]Based on awards, rather than expenditure, data.

TOTAL EXPENDITURES FOR URBAN RAT CONTROL

States	1981	1982	1983	Percent of total expenditures 1981	Percent of total expenditures 1983	Change in percent of total expenditures
	(000 omitted)					
Colorado	$ -	$ -	$ -	-	-	-
Florida	880	979	920	8	8	0
Iowa	-	-	-	-	-	-
Kentucky	267	329	7	3	0[a]	(3)
Massachusetts	370	243	210	6	4	(2)
Michigan	1,097	1,262	810	12	10	(2)
Mississippi	-	-	-	-	-	-
Pennsylvania	2,053	2,089	1,891	15	15	0
Texas[b]	182	223	0	3	0	(3)
Vermont	-	-	-	-	-	-
Washington[c]	-	-	-	-	-	-
Subtotal	$4,849	5,125	3,838	1982		
California	-	678	744	7	6	(1)
New York	-	1,968	1,201	2	1	(1)
Total		$7,771	$5,783			

[a]Less than 1 percent.

[b]Funding from local sources excluded due to unavailable complete data for all years.

[c]Based on awards, rather than expenditure, data.

TOTAL EXPENDITURES FOR HYPERTENSION

States	1981	1982	1983	Percent of total expenditures 1981	Percent of total expenditures 1983	Change in percent of total expenditures
	------(000 omitted)------					
Colorado	$ 183	$ 133	$ 106	2	1	(1)
Florida	2,279	2,241	2,377	22	22	0
Iowa	104	113	155	3	4	1
Kentucky	588	683	708	6	7	1
Massachusetts	419	247	366	7	7	0
Michigan	1,619	2,102	1,619	18	20	2
Mississippi	1,273	1,312	1,542	47	54	7
Pennsylvania	1,918	1,436	1,519	14	12	(2)
Texas	715	743	599	12	8	(4)
Vermont	134	164	185	14	23	9
Washington[a]	312	293	328	11	13	2
Subtotal	$9,544	9,467	9,504	1982		
California	-	2,005	3,204	22	27	5
New York	-	1,291	1,894	1	2	1
Total		$12,763	$14,602			

[a]Based on awards, rather than expenditure, data.

TOTAL EXPENDITURES FOR FLUORIDATION

States	1981	1982	1983	Percent of total expenditures 1981	Percent of total expenditures 1983	Change in percent of total expenditures
	------(000 omitted)------					
Colorado	$ 282	$ 224	$ 332	3	3	0
Florida	171	261	385	2	4	2
Iowa	116	142	156	3	4	1
Kentucky	20	18	30	0[a]	0[a]	0
Massachusetts	226	260	244	4	5	1
Michigan	66	143	159	1	2	1
Mississippi	95	65	137	3	5	2
Pennsylvania	5	5	20	0[a]	0[a]	0
Texas	511	208	565	9	8	(1)
Vermont	65	34	65	7	8	1
Washington[b]	128	0	0	5	0	(5)
Subtotal	$1,685	1,360	2,093	1982		
California	-	60	60	1	1	0
New York	-	140	796	0	1	1
Total		$1,560	$2,949			

[a]Less than 1 percent.

[b]Based on awards, rather than expenditure, data.

APPENDIX VIII

TOTAL EXPENDITURES FOR HEALTH EDUCATION AND RISK REDUCTION

States	1981	1982	1983	Percent of total expenditures 1981	Percent of total expenditures 1983	Change in percent of total expenditures
	------(000 omitted)------					
Colorado	$ 272	$ 331	$ 161	3	2	(1)
Florida	439	817	977	4	9	5
Iowa	146	283	400	4	10	6
Kentucky	334	469	541	4	6	2
Massachusetts	549	576	423	9	8	(1)
Michigan	749	544	806	8	10	2
Mississippi	158	282	140	6	5	(1)
Pennsylvania	494	938	608	4	5	1
Texas	329	406	231	5	3	(2)
Vermont	69	91	122	7	15	8
Washington[a]	689	108	212	25	8	(17)
Subtotal	$4,228	4,845	4,621	1982		
California	-	1,916	2,179	21	19	(2)
New York	-	457	976	0	1	1
Total		$7,218	$7,776			

[a]Based on awards, rather than expenditure, data.

TOTAL EXPENDITURES FOR HEALTH INCENTIVE[a]

States	1981	1982	1983	Percent of total expenditures 1981	Percent of total expenditures 1983	Change in percent of total expenditures
	(000 omitted)					
Colorado	$ 6,712	$ 7,463	$ 8,448	82	89	7
Florida	5,998	5,804	6,090	57	56	(1)
Iowa[b]	2,591	2,001	2,530	70	64	(6)
Kentucky	7,631	8,221	7,938	82	82	0
Massachusetts	3,281	2,800	2,832	51	53	2
Michigan[c]	3,361	5,166	3,145	36	38	2
Mississippi	342	22	452	13	16	3
Pennsylvania	4,459	3,598	3,995	34	32	(2)
Texas	1,117	1,385	2,330	19	33	14
Vermont	355	226	286	36	35	(1)
Washington[d]	139	442	498	5	19	14
Subtotal	$35,986	37,128	38,544	1982		
California	-	1,290	1,374	14	12	(2)
New York	-	90,904	95,281	79	79	0
Total		$129,322	$135,199			

[a]Since health incentive grants could be used to fund a variety of services, all state expenditures that were not spent in one of the other program areas funded by the PHHS block grant were included in the health incentive expenditures.

[b]Funding from local sources excluded due to unavailable complete data for all years.

[c]For comparison purposes with other states, state expenditures for state/local cost sharing and laboratory services were deleted because those expenditures included costs of activities not directly related to preventive health services as we defined them, e.g., laboratory services include testing specimens for environmental protection services.

[d]Based on awards, rather than expenditure, data.

INTEREST GROUP OPINIONS

ON THE PHHS BLOCK GRANT

Table 1
PHHS Interest Group Satisfaction
With State Methods of Facilitating
Citizen Input Into PHHS Decisions

	Percent satisfied	Percent dissatisfied	Total number of respondents
Hearings			
Time and location of hearings	57	21	140
Time allotted to block grants	55	20	133
Number of hearings	45	36	137
Degree of advance notice	41	45	150
Timing of hearings relative to state's decisionmaking process	34	50	135
Availability of information before hearings	32	53	144
Comments on state plans			
Length of comment period on state intended use plan	44	33	132
Timing of comment period relative to state's decision-making process	36	44	130
Availability of state intended use plan	40	43	144
Opportunity to comment on revised plans	27	51	124
Advisory committees			
Composition of advisory groups	43	38	105
Role of advisory groups	43	38	106
Informal contact			
Accessibility of state officials for informal contact on block grants	68	15	135

Table 2
Desirability of Block Grants Versus Categorical Grants

Percent block grants are more desirable	Percent block grants and categoricals are equally desirable	Percent block grants are less desirable	Total number of respondents
28	21	51	163

Table 3
Level of Activity With State Program Officials and State Legislatures

	Percent increased	Percent remained the same	Percent decreased	Total number of respondents
State program officials	40	52	8	162
State legislatures	39	52	9	155

Table 4
Effects of Program Funding Changes

Percent favorable effect	Percent no effect	Percent adverse effect	Total number of respondents
27	25	48	141

Table 5
Satisfaction With State
Responses to Concerns

Concerns	Percent satisfied	Percent neutral	Percent dissatisfied	Total number of respondents
Increase funds for specific services	40	16	44	129
Decrease funds for specific services	25	32	43	53
Increase funds for geographic areas	33	31	36	89
Decrease funds for geographic areas	20	41	39	46
Increase fund for protected groups	36	22	42	105
Need to change beneficiary eligibility	25	36	39	72
Need to change fund distribution	28	32	40	80
Need to change method of service delivery	29	28	43	82
Need to change program administration procedures	28	27	44	81

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