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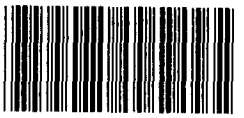

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MENTAL HEALTH GRANTS:

Funding Not Distributed in Accordance With State Needs

Statement of
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Before the
Subcommittee on Health and the
Environment
Committee on Energy and Commerce
House of Representatives

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Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss how the $1.3 billion in federal funds are distributed under the Alcohol, Drug Abuse and Mental Health block grant program.[1] As you know, the Congress recently made several changes in the formula used to allocate funding among states.

We were asked to (1) review the allocation of block grant funds, (2) comment on how well the current formula targets funds to states in relation to their mental health needs, and (3) provide our views on a proposed formula being considered by the Subcommittee for allocating mental health funds.[2] Briefly, our analysis shows that:

-- The recent formula changes have improved the targeting of the block grant to states in relation to their population at risk of drug abuse.

-- Populations at risk of mental health disorders and alcohol abuse, however, will have little influence on the distribution of block grant funding when the hold harmless is eliminated.

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[1]Of this total, block grant funding for mental health services was $244 million for fiscal year 1991.

[2]See H.R. 2311.

-- Within states, the current formula's allocation of funding between mental health and substance abuse is unrelated to state differences in mental health needs.

-- Allocating mental health funds through a separate apportionment formula, as proposed in the Subcommittee bill, would significantly improve the targeting of mental health funds in accordance with state needs. It would, however, redistribute mental health funds across states; some would gain funds and others lose funds.

Before discussing these results, Mr. Chairman, I will briefly review the allocation of funds under the block grant.

ALLOCATION OF BLOCK GRANT FUNDS

Before fiscal year 1989 most of the funding was allocated on a hold harmless basis, that is,

-- funding allocated among states was based on the aid each had received under categorical programs that were consolidated into the block grant in 1981 and

-- within each state, funds were allocated between mental health and substance abuse based on funding for these two areas under the earlier categorical programs.

We and others reported that the hold harmless did not allocate funding in accordance with available indicators of state needs.[3] The Congress adopted a new formula beginning in fiscal year 1989 with a gradual phaseout of the interstate hold harmless between 1989 and 1992.

The current formula uses three factors:

1. Population age groups with high incidence rates of alcohol, drug, and mental health problems. These groups reflect the at-risk population intended to be served by the program.

2. An urban population factor to reflect a higher incidence of drug abuse in urban than in rural areas.

3. An income factor to direct more aid to poorer states to compensate for their more limited ability to fund services from state resources.

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[3]Hold Harmless Provisions Prevent More Equitable Distribution of Federal Assistance Among States (GAO/T-HRD-90-3, Oct. 30, 1989) and University of California at San Francisco, Institute for Health and Aging, Review and Evaluation of Alcohol, Drug Abuse and Mental Health Services Block Grant Allotment Formulas, Final Report, 1986.

In addition, the current formula includes a minimum grant to prevent reductions in funding for states whose allotments would otherwise be less than $7 million.

The current formula did not change the within-state allocation of funds. The within-state hold harmless remains.[4]

ALLOCATING MENTAL HEALTH FUNDS ACROSS STATES

We considered three dimensions of need in analyzing the interstate apportionment of both total funding and mental health funding:

1. People at risk.
2. The cost of labor and office space used to provide services.
3. The ability of states to fund services from state resources.

We used the same high-risk age groups as in the current formula. That is, 25-64 year olds represented the population at high risk for alcohol abuse; 18-24 year olds, for drugs; and 25-44 year olds, for mental health disorders.

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[4]However, as funding for drug abuse has increased in recent years, the within-state hold harmless percentage for substance abuse has been increased. The percentage for mental health has been correspondingly reduced.

In developing our proxy for the population at risk of drug abuse, we double counted urban 18-24 year olds. This procedure assumes an urban prevalence of drug abuse twice that of rural areas. In a November 1990 report on the apportionment formula,[5] we reported that the weight given urban population in the current formula implicitly assumes that drug abuse is 15 times more prevalent among urban residents than among their rural counterparts. However, data on drug incidence indicate urban-rural differences in the range of no more than 1 to 3 times more prevalent in urban areas.

Although costs are not included in the current formula, the high weight placed on urban population may also serve as a proxy for the higher cost of providing services in urban states. However, urbanization is a relatively poor proxy for costs. Instead, we used a cost index to reflect interstate differences in the cost of labor and office space. This is intended to take into account the fact that a dollar of federal aid purchases fewer services in states that must pay more for labor and office space. Adjusting for cost differences enables us to compare grant dollars of comparable purchasing power.

To reflect states' ability to fund services from state resources, we used the same income measure used in current law: Total

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[5]Drug Treatment: Targeting Aid to States Using Urban Population as Indicator of Drug Abuse (GAO/HRD-91-17, Nov. 27, 1990).

Taxable Resources, as reported by the Treasury Department.[6] We believe this to be a reliable indicator of states' funding capacity.

To isolate the effects of the interstate apportionment formula, we analyzed the per capita distribution of funding that would result without any hold harmless funding. We did not include states that benefit from the minimum grant provision.

We performed a series of correlations and regression analyses. All yielded two basic findings: (1) the at-risk drug population and the cost of services best explain the current distribution of block grant funding, and (2) the at-risk mental health and alcohol populations have little influence on the distribution of funds. When controlling for at-risk populations and the cost of services, these analyses also show that poorer states do not receive more aid than states with greater funding capacity. The lack of targeting to states with high at-risk mental health and alcohol populations and low funding capacity occurs because of the high weight placed on urban population in the current formula.

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[6]Total Taxable Resources, as defined and compiled by Treasury, is an average of per capita personal income (PCPI) and gross state product (GSP). PCPI measures the income received by state residents; GSP measures all income produced within a state, whether received by residents or nonresidents, or retained by business corporations.

ALLOCATING MENTAL HEALTH FUNDS WITHIN STATES

As I indicated earlier, each state's allotment is divided between substance abuse and mental health services based on historical funding patterns under the earlier categorical programs. This within-state hold harmless policy has led to what can now probably be best described as a random allocation of federal mental health funds among states.

I will illustrate this point using four states--Vermont, Indiana, Wisconsin, and Iowa. These states have comparable concentrations of the high-risk age groups and are comparable in terms of the cost of providing services. Taking both factors into account, they are between 84 and 87 percent of the national average. Figure 1 shows each state's funding per person at risk after being adjusted for cost differences. Vermont and Indiana receive $43.81 and $26.77, respectively, per person at risk when expressed in dollars of comparable purchasing power. This compares with a national average grant of $10.48 per person at risk. At the other extreme Wisconsin and Iowa receive just $0.84 and $0.22, respectively, per person at risk.

The explanation for these tremendous funding differences is the hold harmless percentage, which allocates each state's grant between mental health and substance abuse. For Vermont and Indiana these hold harmless percentages allocate 51 and 49 percent

of their block grant for mental health services as compared to a national average allocation of 20 percent. In contrast, Wisconsin and Iowa, which received comparatively little mental health funding in 1981, have just 2 percent and 1 percent of their respective allotments earmarked for mental health services, even though their needs are comparable to those of Indiana and Vermont. The wide differences in hold harmless percentages produce the wide differences in funding per person at risk shown in the figure.

PROPOSED FORMULA FOR ALLOCATING MENTAL HEALTH WOULD IMPROVE EQUITY IN FUNDING MENTAL HEALTH NEEDS

The Subcommittee is considering separating mental health from substance abuse and allocating mental health funds among states under a separate formula. The formula under consideration would continue to use age cohorts to reflect people at high risk of mental health disorders and would direct additional aid to states with a lesser capacity to fund program services from state resources. It would improve on the current law in two respects. First, it would better reflect people in need of mental health services, and second, it would allow for the intended targeting of additional aid to states with lesser financing capacity. It would, however, redistribute mental health funds across states; some states would gain funds and others lose funds.

Rather than relying only on the high risk 25-44 age group, the formula being considered would reflect other age groups as well. In other words, 18-24 year olds and people over 44 would also be included in the count of people at risk in the formula but with lesser weights. This will reflect both the needs of these age groups and the fact that they have a lower reported incidence of mental health disorders.

In addition, because an urban population factor is not included in the formula, more funding would be directed to states with less capacity to fund services from state resources. However, the relatively low weight placed on this factor means that the fiscal disadvantage of low capacity states is only partially offset. To fully offset state differences in fiscal resources would require targeting a greater percentage of available resources to low-capacity states.

Finally, Mr. Chairman, I note that the proposed formula does not take into account the cost of labor and office space used to provide services. Consequently, other things being equal, high-cost states will not be able to purchase services comparable to what can be purchased in states with lower costs. The approximate 40-percent cost differential between California and South Carolina, for example, would not be reflected.

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Mr. Chairman, that concludes my statement. I hope the information I've presented will assist the Subcommittee in the difficult task of finding an equitable basis for effectively allocating federal resources for mental health and substance abuse services. I would be happy to answer any questions you may have. Thank you.

Figure 1: Mental Health Funding Per Person At Risk