REPORT TO THE CONGRESS

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

How States Plan For And Use Federal Formula Grant Funds To Provide Health Services

Department of Health, Education, and Welfare

GAO found that States had neither set up adequate planning procedures to provide for health services nor gathered sufficient information to establish priorities in areas to be funded with Federal money and with the States' own resources.

Recommendations are directed at the need to set up better program management on a continuous basis, to review the use of grant funds, and to measure program results through adoption of evaluation procedures.

MWD-75-85

DEC. 9, 1975

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164031(5)

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

This is our report on how States plan for and use Federal grant funds to provide--public health services, maternal and child health services, and crippled children services.

We made our review pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

We are sending copies of this report to the Director, Office of Management and Budget, and the Secretary, Department of Health, Education, and Welfare.

Comptroller General
of the United States

Contents

ABBREVIATIONS

GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
MCH	maternal and child health

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

HOW STATES PLAN FOR AND USE FEDERAL FORMULA GRANT FUNDS TO PROVIDE HEALTH SERVICES

Department of Health, Education, and Welfare

D I G E S T

The idea behind Federal formula grant programs that promote the highest attainable level of health is that State and local governments

--are more aware of their needs than the Federal Government and

--should be permitted to decide, broadly, how to spend the Federal funds.

Federal formula grants are funds distributed to States according to a formula generally based on population and per capita income.

Although Federal health grants are used to provide numerous and beneficial health services, State health agencies need to establish an adequate planning process to identify local needs, if the formula grant programs are to be used as intended.

States GAO visited had not established adequate plans to provide for health services nor accumulated data needed to establish priority funding areas and to measure program results. (See p. 9.)

As a result, the extent to which the grants were used to accomplish the following formula grant program objectives was not known:

--To provide public health services where needs are greatest and benefits most attainable.

--To reduce infant mortality and promote the health of mothers and children in rural areas or areas with severe economic distress.

--To identify early those children needing, but not receiving, crippled children's services. (See p. 10.)

For the most part, States had allocated funds to specific health programs based primarily on tradition and administrative convenience. The same programs were continued yearly with little management review. As a result, health services programs were fragmented and poorly managed. (See p. 22.)

HEW regards formula grant funds as State entitlements and is reluctant to assume any management responsibility for the program. HEW management activities and reporting requirements did not assure that States are using Federal funds effectively and are complying with certain Federal legal requirements. (See p. 35.)

GAO recommends that the Secretary:

--Assist States in developing a systematic and continuous planning process. (See p. 20.)

--Determine whether Federal objectives for the formula grant programs are being met in States' use of grant funds and identify management practices which require improvement to assist in meeting Federal objectives. (See p. 34.)

--Replace reports now required from the States with a report enabling Health, Education, and Welfare regional offices to review use of grant funds and to assess compliance with legal requirements. (See p. 38.)

HEW said positive actions are being or will be taken in response to GAO's recommendations. (See app. VII.) HEW, however, expressed some reservations on the reporting requirements for the public health services program. (See p. 39.) Comments received from State agencies were considered by GAO in finalizing the report. (See apps. VIII, IX, and X.)

CHAPTER 1

INTRODUCTION

Our report is about the use of Federal funds provided by three formula grant programs--general public health, authorized by section 314(d) of the Public Health Service Act (42 U.S.C. 246) and maternal and child health (MCH), and crippled children's services, authorized by title V of the Social Security Act (42 U.S.C. 701).

The idea behind Federal formula grant programs (Federal funds distributed to States according to a formula based on population and per capita income) is that State and local governments are more aware of their needs than the Federal Government and should be permitted to decide, within broad program categories, how to spend the Federal funds.

ROLE OF THE FEDERAL GOVERNMENT

The formula grant programs are administered jointly by the Department of Health, Education, and Welfare (HEW) headquarters offices and by HEW regional offices. Headquarters responsibilities include establishing policy, issuing program regulations and guidelines, and distributing the funds. Basic policy and program guidelines are given to the regional offices and the States in a series of policy and procedure manuals. HEW headquarters is also responsible for program evaluations, and a percentage of each appropriation is available to cover this cost.

Grant program administration has been decentralized by assigning HEW regional offices responsibility for

--providing technical advice to the States on administrative problems and program content,

--conducting site visits to review State programs,

--making financial audits of the grants, and

--reviewing and approving State plans required by the three grant programs.

ROLE OF THE STATES

The States are responsible for managing the formula grant programs day-to-day, which includes monitoring program activities and evaluating results. Each State must submit management reports to HEW regional offices. (See p. 36.)

The States must also prepare a State plan for each of the three programs. Although Federal law and regulations specify areas which must be addressed in a State plan (see ch. 3), the States are free to determine how the funds will be used within the broad program categories. The States decide which health programs will receive grant support and the extent of that support. The States also fully control how the funds will be used to provide community services.

SCOPE OF REVIEW

We reviewed the formula grant programs to find out how States plan for and use formula grant funds. We wanted to know the extent to which States are aware of their health needs and whether or not they have established programs to meet their citizens' priority needs. We considered how selected States plan for and use formula grant funds and the extent of HEW's assistance and monitoring of State programs. We worked principally at State health and welfare departments in Indiana, Kentucky, and West Virginia; HEW headquarters in Rockville, Maryland; and HEW regional offices in Philadelphia (region III); Atlanta (region IV); and Chicago (region V).

Our field work in Kentucky and Indiana was completed in August 1974 and in West Virginia in June 1974.

CHAPTER 2

PROGRAM PURPOSES AND HOW FUNDS ARE DISTRIBUTED

The purposes of the formula grant programs and how the funds are distributed to the States are prescribed by Federal law. The States use Federal funds according to each program's general purpose statement. Each State's share of the annual Federal appropriations is generally based on population and per capita income.

GENERAL HEALTH PROGRAMS

Purpose

In 1966, the Congress amended the Public Health Service Act to provide grants to States to support, develop, and expand public health services according to their established priorities and goals. States could thus use Federal funds flexibly.

Before 1966, the Federal Government supported State public health programs through 16 different categorical health programs. Funds appropriated for one category could not be transferred to another, nor could they be used for any other public health problem.

The formula grant program purpose is to:

> "* * * provide grants to the States for support, development, and expansion of public health services to meet the needs of their citizens in accordance with priorities and goals established by the States."

This program was intended to become the principal source of Federal assistance for most ongoing State and local public health programs. Federal assistance authorized and the amounts subsequently appropriated are shown below.

FY	Authorized	Appropriated
	(thousands)	
1968	$ 70,000	$60,200
1969	90,000	66,032
1970	100,000	90,000
1971	130,000	90,000
1972	145,000	90,000
1973	165,000	90,000
1974	90,000	90,000

Federal law placed only two restrictions on a State's authority to distribute general health grants. First, because mental health programs in many States are administered by State agencies other than the State health agency, the act required that at least 15 percent of a State's allotment be made available to the State mental health authority. Funds allocated for mental health purposes were not included in our review. Second, effective in fiscal year 1969, at least 70 percent of a State's allotment was made available for public health services at the community level. This assured that Federal funds were used primarily to directly provide services.

Distribution of funds

In accordance with section 314(d) of the Public Health Service Act, HEW adopted regulations providing that Federal funds be alloted to the States based on (1) $3 per person up to a maximum of $300,000 and (2) population and per capita income. Section 314(d) provides that the Federal funds supplement, not supplant, State and local efforts. An HEW policy statement further defined the requirement--the States must maintain their level of funding at an amount no lower for any fiscal year than for the preceding fiscal year. HEW is allowed to furnish States with equipment, supplies, or personnel in lieu of funds. When equipment or supplies are furnished or HEW employees are sent to a State, the fair market value of the equipment or supplies or the pay and allowances for personnel are subtracted from the State's allotment. The State must request HEW to provide these services.

In fiscal year 1974, the three States in our review were alloted:

--Indiana, $1,786,800.
--Kentucky, $1,313,300.
--West Virginia, $829,000.

MCH PROGRAM

Purpose

The Social Security Act, enacted in 1935, authorizes MCH grants. The grants are intended to enable the States to expand and improve services to reduce infant mortality and otherwise promote the health of mothers and children--especially in rural areas and economically distressed areas.

Distribution of funds

Before July 1, 1974, title V of the Social Security Act provided for allocating Federal funds to three kinds of programs. Of the funds appropriated annually:

--50 percent was available for distribution on a formula basis, as authorized by sections 503 and 504, to States to be used for MCH services and for services for crippled children. The act specified that the Secretary of HEW determine, for each fiscal year, the division of funds between MCH services and crippled children's services. Historically, the funds have been divided almost equally between these two services.

--40 percent was available for special project grants for (1) maternity and infant care services, including family planning and intensive infant care projects, as authorized by section 508, (2) health services for children and youth care, as authorized by section 509, and (3) dental health services for children and youth, as authorized by section 510.

--10 percent was available for supporting training and research projects, as authorized by sections 511 and 512, respectively.

Federal funds available for distribution in fiscal year 1974 totaled $265,868,000.

The act authorized the Secretary of HEW to (1) transfer up to 5 percent of the annual appropriations among authorized programs and (2) use up to 25 percent of 50 percent of the funds authorized for programs under sections 503 and 504 for projects which the Secretary determined to be of regional or national significance. In addition, a part of the funds authorized each year under sections 503 and 504 was set aside for mental retardation projects.

Funds to be used for MCH services under section 503 were distributed to States according to the following formulas:

--One-half of the funds available for MCH services was divided among the States by allocating $70,000 to each and dividing the remaining funds among them, according to each State's percentage of total live births in the United States, during the latest

calendar year for which statistics were available. State matching of these funds on a one-for-one basis was required.

--The other half of the funds, after setting aside certain amounts for mental retardation projects and for other projects which the Secretary of HEW determined to be of regional or national significance, was divided among the States according to each State's financial needs. The formula used to distribute these funds favored rural States having low per capita incomes and State matching was not required.

The distribution of funds for crippled children services under section 504 is discussed on page 7.

HEW could distribute the remaining funds appropriated under title V through direct project grants to State agencies and to public or other nonprofit institutions. Grants were made for

--projects for maternity and infant care services, health services for children and youth care, and dental health services for children and youth, authorized by sections 508, 509, and 510, and

--training and research authorized by sections 511 and 512 (could include contracts or other agreements, in addition to grants).

When title V was amended in 1967 to authorize special project grants (sections 508, 509, and 510), provision was made to transfer such projects to the States on July 1, 1972. After that date the funds were to be distributed to the States under the formula provisions. Transferring the special project grants, however, was extended to June 30, 1974, primarily because neither the States nor HEW had made adequate preparation for the transfer.

On July 1, 1974, funding for the special projects was discontinued. Ninety percent of the appropriation became available for distribution under sections 503 and 504. As a result, the funds available to the States increased from $60,778,000 to $179,051,000.

Project grant funds were not distributed evenly throughout the country; therefore, shifting funds from project to formula grants would have resulted in some States getting less funds and others getting more. In order to

lessen the impact on the States receiving less funds and to "hold harmless" the population served by the project grants, the Congress amended title V to provide that no State receive less than its 1973 allotment plus the amount of special project funds or the allotment calculated under the July 1, 1974, method. For the States we reviewed, this increased formula grant funds to be managed by the States as follows:

	FY 1974	FY 1975	Increase
Indiana	$1,345,800	$3,911,700	$2,565,900
Kentucky	1,172,400	3,430,800	2,258,400
West Virginia	603,100	1,760,900	1,157,800

CRIPPLED CHILDREN'S PROGRAM

Purpose

The crippled children's program, started in 1935 under title V of the Social Security Act, is intended to enable each State to extend and improve services for crippled children, including diagnostic, medical, and surgical services and hospitalization.

Title V requires the States to try more vigorously to screen and treat children with disabilities, or conditions leading to disability, through intensified identification and periodic screening of children. The act defined a crippled child as one below the age of 21 who has an organic disease, defect, or condition which may hinder normal growth and development.

Distribution of funds

Under section 504 of the act, funds to be used for crippled children are distributed to the States according to the following formulas:

--One-half of the funds available to the States for crippled children's services must be divided among the States by allocating $70,000 to each and dividing the remaining funds among them based on each State's need, as determined by the Secretary, after considering the number of crippled children in the State needing services and the cost of furnishing such services to them. (The number of crippled children in each State is not known, and, in practice, the funds are divided among the States according to each State's percentage of the total people under 21 in

all States.) State matching on a dollar-for-dollar basis is required.

--The other half of the funds, after setting aside certain amounts for mental retardation projects and for other projects which the Secretary of HEW determines to be of regional or national significance, is divided among the States according to each State's financial needs. The formula used to distribute these funds favored rural States having low per capita incomes, and State matching is not required.

In fiscal year 1974, a total of $64,900,000 was available for distribution to the States to support crippled children's programs.

The three States we reviewed received the following Federal funds for fiscal year 1974:

--Indiana, $1,436,900.
--Kentucky, $1,288,500.
--West Virginia, $740,900.

CHAPTER 3

HOW STATE HEALTH PROGRAMS ARE PLANNED

The idea behind the Federal formula grant program is that State and local governments are more aware of their citizens' health needs than the Federal Government and should be permitted to decide, within broad program categories, how to spend the Federal funds. The three States we reviewed did not have a systematic or continuous planning process to identify health needs, and little data existed on which to base management decisions or measure the effectiveness of health programs.

In order to receive formula grants, Federal laws require the States to have a State plan, approved by HEW, providing for health services.

Section 314(d) of the Public Health Service Act requires that State plans for general health services contain

--policies and procedures to be followed in spending grant funds,

--assurances that the grants will be used to provide and strengthen health services,

--provisions that the scope and quality of services provided under the plan will be in accordance with HEW prescribed standards,

--provisions for reviewing and evaluating the State plan from time to time, but not less often than annually, and

--provisions for fiscal control, fund accounting, and submitting reports to HEW.

Title V of the Social Security Act requires that State plans for MCH and crippled children's services provide for

--trying to reduce infant mortality; promoting the health of mothers and children; and identifying, diagnosing, and treating crippled children;

--early identification of crippled children;

--coordination with other medical, health, nursing, educational, and welfare groups and vocational rehabilitation for crippled children;

--demonstration programs, especially for dental care, for children and family planning; and

--a program of projects to include maternal and infant care, intensive infant care, care for children and youth, dental care, and family planning.

Title V of the Social Security Act also provides that the States work toward providing MCH and crippled children's services in all parts of a State by July 1, 1975.

Our review in the three States showed that the State health plans were deficient; they did not provide a logical basis and directions for using formula grant funds. Officials in all three States said that they consider the plans to be administrative exercises necessary to comply with Federal requirements and that the plans are seldom used by personnel responsible for program implementation. Weaknesses in the plans and the related planning process were:

--The plans, for the most part, described ongoing programs rather than blueprints for future growth and services. Measurable program goals and priority funding areas had not been established.

--The State health departments had not established a systematic and continuous planning process. Data on program needs and results generally was not being gathered for planning and assessment purposes.

--The State plans were prepared and programs administered without input from State comprehensive health planning agencies.

--Adequate plans for the program of MCH projects were not developed as required.

As a result, the extent to which the grants were used to accomplish the following formula grant program objectives is not known.

--Provide public health services where the needs are greatest and the benefits most attainable.

--Reduce infant mortality and promote the health of mothers and children in rural areas or areas of severe economic distress.

--Identify early those children needing, but not receiving, crippled children's services.

STATE PLANS NOT BLUEPRINTS FOR FUTURE GROWTH AND SERVICES

The States are required, by Federal laws, to prepare a State plan for the formula grant program and to review and update the plan periodically. HEW must review the plans and, before approving them, be assured that the grants will be used to make a significant contribution to providing health services.

Health officials in the States we visited said that (1) they consider the plans to be administrative exercises necessary to comply with Federal requirements and (2) the plans are not used by State personnel for program management and evaluation purposes.

For example, Indiana uses over 50 percent of Federal general health funds for grants to local health agencies, such as county health departments; but, the State plan gives the local agencies no guidance on the priority funding areas for such grants--funding areas are selected by the local agencies.

According to the State health commissioner, although guidelines were not in the plan, each funded project is reviewed and approved by either a regional or State planning agency and by an intradepartmental committee using established policies to determine need and impact of the proposed program.

The State plans we reviewed generally described ongoing programs compiled by individual program managers. Any program goals or objectives were stated in general terms and were not sufficient for use in measuring the progress of specific programs.

For example, the goal of the crippled children's program in Indiana was to raise the health of crippled children to the highest possible level. Indiana, however, did not have an estimate of the number of crippled children in the State or know what their medical problems were likely to be.

Since they were initially prepared, little revision had been made to the State plans we reviewed. For example, in Kentucky the annual updating, for most years, consisted of changing the date on the plan's cover. Also, programs were continued each year without substantial change, apparently

because of tradition and administrative convenience. Little or no effort was made to compare the merits of programs and eliminate or redirect those which were unproductive or inefficient.

Kentucky's Secretary for Human Resources told us that an HEW change in annual report format (that is, from a narrative report to a checklist) discourages States from formulating conclusive narrative program plans and caused poor communications between management and program operations.

STATE HEALTH DEPARTMENTS: NO SYSTEMATIC PLANNING PROCESS

The States we reviewed did not have within the State health departments a systematic and continuous planning process for using formula grant funds.

Health planning was generally the responsibility of individual program managers who continued the previous year's programs. The State plans were basically compilations of individual program descriptions, prepared by the program managers, which received little management review by top level officials. For example, a Kentucky State official said the individual program plans were reviewed only to check prescribed format and to verify statistical data. He said that the content of the individual program plans was not discussed with the program-level managers.

In Kentucky a substantial amount of Federal funds intended for general health programs was allocated to specific programs by the accounting department, for administrative convenience. Some program managers, however, were not aware that Federal funds were allocated to their programs.

None of the States we reviewed had a current inventory of health services available at the community level. Indiana's State health commissioner told us that such information would be highly desirable but most difficult and costly to obtain.

Little was known about the total people needing specific program services or the geographic distribution of potential program recipients. As an example, West Virginia operated a token program for needy cancer victims which provided 2 days hospitalization for diagnosis, an additional 5 days for treatment, and a limited number of radiation treatments as long as funds were available. We noted that the program generally used all available funds before the end of the

year and that some eligible people had to be denied service. The program's funding generally continued based on the prior year's funding and services.

We also found that the health services provided were fragmented and poorly managed. The same programs were continued each year, with little management review, while major unmet needs existed in many areas. (see ch. 4.)

West Virginia's Director of Health said his department could develop more effective solutions to public health needs and a way to measure effectiveness with more funds and additional proficient manpower. He also said a statistics system unit is being planned within the Division of Vital Statistics and that with increased funds a more sophisticated system could be developed to provide a systematic and continuous planning process. The director pointed out that the State's 55 county health departments present to the State Health Department an annual plan and progress report.

In commenting on our draft report, the Kentucky Secretary for Human Resources told us that a recent reorganization (health activities were consolidated into a Department of Human Resources) eliminated most of the problem areas disclosed by our review.

Kentucky's Secretary for Human Resources also informed us that the department implemented a management-by-objectives planning system under which careful attention is given to program priorities and efforts are made to build in factors which would later enable program measurement and evaluation to take place.

At the time we completed our field work in Kentucky (Aug. 1974) the department had under consideration a planning system called "POME." This system called for problem identification, development of objectives and related accomplishment methods, and program evaluation.

In view of the secretary's comments on our draft report (see app. IX.), we returned to Frankfort to update our information on the planning efforts being made by the department.

Interviews with department officials disclosed that program managers were being required to provide top management with a statement of program objectives and that progress being made toward accomplishing stated objectives was being reported to the State Legislature twice a year. At the time of our visit in August 1975, two reports had been

prepared and use of the system had resulted in program objectives being changed or more clearly and accurately stated by program managers.

We were told, however, that organized data gathering methods to support and direct the management-by-objectives system have not been fully implemented. Without supporting data the program objectives could be lacking in soundness and objectivity. The department's management system should be improved when data gathering methods have been developed and fully implemented.

COORDINATION WITH COMPREHENSIVE HEALTH PLANNING AGENCIES[1] NOT ACHIEVED

The Public Health Service Act requires that spending general health funds be consistent with State comprehensive health planning agencies plans for manpower, facilities, and services in the physical, mental, and environmental health areas. The Social Security Act does not require this for the title V programs. Except for Indiana, State health agency officals do not generally work with the comprehensive health planning personnel to develop programs, and there is little concern about whether general health spending is consistent with plans being developed by such agencies.

For example, the director of West Virginia's Department of Health said that the department's only working relationship with the State planning agency entails giving copies of department reports to the planning agency for their files.

PLANS NOT WRITTEN FOR MCH PROJECTS REQUIRED BY JULY 1, 1972

The Social Security Act, as amended in 1967, required that responsibility for special project grants funded directly by HEW under sections 508, 509, and 510 of the act be transferred to the States on July 1, 1972. Funds formerly used by HEW for these projects were to be available

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[1]At the State level, comprehensive health planning is now the responsibility of a State health planning and development agency and a statewide health coordinating council. The local level agency is the health systems agency.

to the States on that date. The amendment required that the States establish a program to provide for projects in the following areas by July 1, 1972:

--Maternal and infant care.

--Intensive infant care.

--Care for children and youth.

--Dental services.

--Family planning.

The date was extended twice because neither the States nor HEW had completed the planning required to transfer the responsibility; however, the responsibility was transferred to the States on July 1, 1974.

According to HEW, the maternal and infant care program's objective is to serve women early in pregnancy and provide comprehensive health care. Many women in low-income families receive poor or no prenatal care, have a high incidence of complications of pregnancy, have high maternal and infant mortality rates, and deliver prematurely two or three times as frequently as the national average. Infants born of such pregnancies are vulnerable to brain damage, neurologic disability, and mental retardation.

The purpose of the intensive infant care program is to reduce infant mortality and disease by providing specialized care for infants. Studies in the United States and in other countries show that the infant mortality rate may be effectively reduced among infants by using special intensive care centers. Such centers provide improved medical and nursing supervision for infants born prematurely or with conditions detrimental to their normal growth and development.

The major objective of the children and youth program is to provide comprehensive health services for children in low-income families by offering care such as identifying those needing care, preventive health services, diagnosis, and treatment.

The dental health program's major objective is to develop programs which will provide comprehensive dental services for children who would not otherwise receive care, because they are from low-income families or for reasons otherwise beyond their control.

The goals of family planning services are to provide families the freedom to choose the number and spacing of their children, to promote the health of mothers and children, and to help reduce maternal and infant deaths.

HEW and State health officials said that it is impossible to implement the comprehensive program outlined by the legislation because

--available funding will support only a token effort to provide the required services,

--medical personnel and facilities available to State and local health departments are not adequate for current operations, and

--neither the States nor HEW have conducted the necessary planning for the expanded services.

Before July 1, 1974, the three States reviewed had no projects which provided the required five services. The existing projects funded under section 508 or 509 of title V were:

--Indiana: maternal and infant care and family planning.

--Kentucky: maternal and infant care and comprehensive care for children and youth.

--West Virginia: maternal and infant care.

The above projects were token efforts which served only a small part of the State's eligible population. For example, the maternal and infant care project in Kentucky was restricted to four eastern counties. The program served about 850 women and costs about $450,000 annually. The four counties contain only 4 percent of the State's population.

The three States intended to continue the above programs at about the same level as previously funded by HEW.

Plans for the required services

Only West Virginia had a firm plan to establish programs to provide the required five services. The other States were still trying to decide how to meet the requirement. Officials in the two States said that they (1) were reluctant to finalize plans until the Congress actually

transfered the responsibility and (2) had no final HEW guidelines for States to implement the program of projects. All three States were considering only minimal efforts to provide the required services.

Indiana

For Indiana, the legislative change increased the Federal grant funds available for fiscal year 1975 to $3,911,700--an increase of $2,565,900 to be managed by the State.

Indiana had not finalized plans for using the extra funds to provide the required services, but the following tentative allocation had been made when we completed our field work.

	Amount (thousands)
Continued support of State and local programs	$2,000
Continued support of maternity and infant care project (note a)	550
Continued support of a family planning project (note a)	400
New intensive infant care project	50
New comprehensive dental care project	24
New children and youth project	876

[a]Previously funded by HEW.

The funds allocated for family planning will enable Indiana to assume responsibility for an existing project in one county. According to the MCH program director, he selected this county over 38 counties without organized family planning programs, because he wanted to expand the existing program which had a solid foundation.

Plans for the intensive infant care project were incomplete. Personnel training at a university medical center was being considered along with a proposal, being studied by the State's medical association, to establish eight or nine intensive infant care centers to be located throughout the State.

The dental project was to be established in a county which did not have a dentist. The county health department would be responsible for the program. A dental hygienist would provide preventive measures and refer

children needing treatment to nearby dentists on a fee-for-service basis. No analysis had been made to determine if these dentists could handle the additional caseload.

Children and youth services were to be added to an existing county MCH program.

In commenting on our draft report the State health commissioner said, without adequate guidelines from HEW, the State chose to begin using the additional funds on existing State and local programs rather than to delay implementing services. The commissioner also said the State's MCH plan now contains objectives which focus on improving the health of mothers and children.

Kentucky

The legislative change increased Kentucky's grant funds for fiscal year 1975 from $1,172,400 to $3,430,800--an increase of $2,258,400.

Plans for providing the required five services had not been finalized, but Kentucky will continue the three special projects previously funded by HEW--a maternal and infant care project which operated in four eastern counties, a children and youth project which operated in an economically deprived area of Louisville, and a child evaluation center in Louisville, supported by funds set aside by the Secretary, HEW, for mental retardation. (See p. 5.) Plans were being prepared for new programs providing dental, intensive infant care, and family planning services.

The proposed dental program will operate in only one county, selected on the basis of the large percentage of people not receiving dental care. Only one dentist practiced in this county, for a dentist to population ratio of 1 to 7,800. This compared with the State ratio of 1 to 3,199 and the national ratio of 1 to 2,150. The program will employ, through the local health department, a full-time clinical dentist, two dental assistants, and a dental hygienist. The estimated annual budget is $73,000.

The University of Kentucky will operate the proposed intensive infant care program to serve the residents in eastern Kentucky. The program will expand the intensive care nursery for newborn babies at the university's medical center. The estimated first-year cost is over $213,000, including about $60,000 for equipment.

A family planning program will be established by funding 1 of the 15 existing regional family planning projects. This project previously was funded by HEW under title X of the Public Health Service Act. It serves about 4,000 women from 7 counties and costs about $200,000 annually.

West Virginia

For West Virginia, the legislative change increased the State's formula grant allotment by $1,157,800, from $603,100 to $1,760,900, for fiscal year 1975. The additional funds will be used to continue existing projects providing maternal and infant care services and to establish new projects for intensive infant care, dental health, and children and youth services. Tentative funding for the three new projects is:

--Intensive infant care, $150,000.
--Dental Health, $85,000.
--Children and youth, $300,000.

The intensive infant care program will be limited to purchasing services for babies from medically indigent families. Two hospitals which recently opened intensive care units will provide the services.

The dental services will be provided under a contract with the Southern West Virginia Regional Health Council, Inc. The program will operate in 2 counties with a target population of 1,263 children, age 3 to 12 years. A major consideration in selecting this area was the availability of three dental facilities.

The children and youth services will also be provided under a contract with the Southern West Virginia Regional Health Council, Inc. The program will operate in three counties and serve children through 12 years of age. About 2,644 eligible children live within the project boundaries. The main consideration in selecting the location for the program was the availability of medical specialists.

The existing family planning program in West Virginia is almost entirely supported under title X of the Public Health Service Act. Funding is about $1 million a year. West Virginia plans to continue operating this program with title X funds and will not allocate MCH funds for this purpose.

CONCLUSIONS

State health plans prepared for the formula grant programs are generally descriptions of ongoing programs rather than blueprints for future growth and service. State personnel consider the planning requirement an administrative exercise necessary to receive Federal grants. State management officials made little use of, or gave little attention to, the plans, and the plans served no useful purpose for program direction or evaluation purposes.

The three States did not have adequate data to identify their health needs and lack a systematic planning process to establish needs or develop health programs on a priority basis.

State health agency personnel generally do not work with comprehensive health planning agencies, and there is little concern as to whether health expenditures are coordinated with such planning agencies.

Adequate plans for starting a program of MCH projects had not been developed as of July 1974, and such programs probably could not be adequately implemented, in the three States included in our review, without substantial additional Federal support.

RECOMMENDATIONS

We recommend that the Secretary of HEW:

--Help the States to develop a systematic and continuous planning process to provide a logical basis and direction for using Federal formula grant funds. Such a planning process should provide for establishing, by the States, priority funding areas and measurable program objectives to be used by HEW and the States to evaluate the effectiveness of using Federal formula grant funds.

--Develop regulations requiring that the use of MCH funds be coordinated with State comprehensive health planning agencies and stressing that State health agencies establish ongoing working relationships with such planning agencies in providing the health services authorized by the formula grant programs.

AGENCY COMMENTS AND OUR EVALUATION

HEW agrees that improved planning by State health agencies is needed but believes this cannot be achieved with

the leverage of relatively small Federal programs such as formula grants.

HEW pointed out that this need was addressed by the newly enacted National Health Planning and Resources Development Act of 1974 (Public Law 93-641) and that, once this legislation is fully implemented, local agencies in coordination with State agencies will be responsible for developing a systematic and continuous planning process, which will provide a logical basis and direction for the use of certain Federal formula grant funds.

HEW is optimistic that, although title V formula grant programs are not covered by this legislation, in due course it will effect a significant improvement in the planning and management of these programs.

Specifically, HEW said the MCH work plan for fiscal year 1976 provides for developing guidance material that will encourage States to assess their needs and to establish priorities and goals designed to help them meet their stated objectives.

Regarding State plans for the public health services program, HEW maintains that the plans are reviewed, evaluated, and changed as appropriate at least annually. HEW pointed out that the plans need only pertain to those services supported by the Federal funds allotted to the States under section 314(d) of the Public Health Services Act and the required matching funds. The shortcomings of these plans, as disclosed by our review, are discussed on pages 11 and 12. Also, as pointed out by HEW, the planning for this program is now subject to the requirements of Public Law 93-641.

HEW is now drafting an amendment to title V regulations to insure that States include MCH and crippled children services in their comprehensive health planning systems.

CHAPTER 4

HOW FORMULA GRANTS ARE USED BY THE STATES

The States generally allocated the funds to programs based primarily on tradition and administrative convenience. Funds were used for the same programs each year, with little management review. As a result, health service programs were fragmented and poorly managed, and Federal funds were not used flexibly, as intended, in areas of greatest need and most attainable benefits.

USE OF GENERAL HEALTH FUNDS

Indiana

Indiana allocated funds to over 30 separate general health programs during fiscal year 1973 (see p. 40), including health education, nutrition, nursing, and sanitation. Despite the apparent large number of programs, important chronic disease programs such as heart or cancer were not funded. In fiscal year 1973, about $4,371,300 was spent for general health programs. The State provided $2,702,700, the Federal general health grant provided $1,630,000, and other Federal grants provided $38,600. Information on local spending for these programs was not available at the State.

About $342,000 of the Federal grant was used to support 16 State-operated programs. The State accounting department determined the amount of Federal support for each program and designated certain employees to be paid with Federal funds. The employees were selected because they worked or consulted with local health units and included nurses, dairy and food inspectors, and sanitary engineers. State officials said that these types of employees, rather than supervisory or administrative personnel, were paid with Federal funds in order to help meet the 70-percent legal requirement that section 314(d) funds be spent on community services.

The remainder of the 70-percent requirement was met by making grants, totaling $879,270 in 1973, to local health agencies. A formal, grant-application process was established to allow local health units to apply for Federal funds to support a variety of programs. The State program directors told local agencies that funds were available and assisted local agencies in completing applications and processing the requests through a formal, grant-review mechanism. An interdepartmental committee reviewed the grant applications, and the State health commissioner approved them.

The county had to initiate a grant application. A State official said that applications being continued were accepted first because, in part, they were received on time and complied with the required format. In 1973, the State awarded 72 grants to local agencies. The grants supported a variety of projects, including regional tuberculosis clinics, county sanitation programs, home health services, and health education. Usually, once a grant was awarded, funding was continued each year with little change.

Indiana generally had not spent all the Federal grant funds. For the 6-year period ending with fiscal year 1973, the State failed to use about $1,348,000 of available Federal funds, although unmet needs existed in many areas. For example, 11 county health departments did not have a nurse on the staff in 1973, and many counties did not have sanitarians. Screening programs for hypertension, diabetes, or glaucoma had not been established in many counties. Even the State's highest priority program, tuberculosis control, did not cover the entire State. In commenting on our draft report, the State health commissioner stated that programing Federal funds has been difficult at times due to large amounts becoming available late in the fiscal year. The commissioner also said the high tuberculosis risk areas are covered by programs. He also pointed out that local authorities must make funds available for programs in their areas and that the State board of health cannot legally force establishment of programs.

The State health commissioner said that (1) he allocated funds based on his professional judgment, (2) little data on which to base decisions was available, and (3) while available data would indicate an area most needing financial support, local community attitude often prevented State assistance. As a result, individual programs funded by the State health department were not organized to provide or expand services in areas of greatest need. A local program existed because of local initiative, rather than a structured State effort.

Kentucky

Kentucky allocated funds to around 20 separate general health programs during fiscal year 1973 (see p. 41), including communicable disease, radiological health, and central laboratory services. General health spending for the year was about $3,789,300. The State provided $2,505,700; the Federal grant provided $1,283,600. In addition, the

counties spent about $3,136,600 for general health programs during the same period.

About $347,000 of the Federal grant was used to support nine State-operated programs, which were essentially the same as the categorical grant programs operated before the formula grant program. Each program received about the same amount of Federal funds as provided by the categorical program in 1966. Allocating Federal grant funds was primarily an accounting function, and several program managers were unaware of Federal support for their programs.

To meet the 70-percent requirement for community services, Kentucky distributed $936,691 of general health funds to county health departments. A formula used to determine each county's allocation considered the county's complete general health plans. The lowest county allotment was $612, the highest $108,353, and the average $8,074. According to a health department official, no attempt was made to allocate general health funds on a priority basis.

West Virginia

West Virginia allocated funds to over 20 general health programs during fiscal year 1973 (see p. 42), including emergency medical services, laboratory services, nutrition, and public health nursing. During the year the State provided about $1,823,300 and received a Federal grant of about $785,000. The State also appropriated $1 million for distribution to county health departments on the basis of population, weighted by per capita income.

West Virginia did not distribute any Federal grant funds to local health agencies, because personnel in the State divisions who worked with, or in, the counties were considered to provide community services. Costs related to personnel were considered to meet the 70-percent requirement, and in 1973 over 75 percent of the Federal grant was used for such personnel costs.

Federal funds were used in essentially the same manner and amount as under the categorical grant system. No major change in health department operations occurred as a result of the formula grant program. According to the State director of health, since Federal funding has not increased substantially, it is necessary to fund new or expanded programs with State funds. For fiscal year 1975 more than one-half of the Federal funds were used to continue supporting basic ongoing programs, such as environmental health and public health nursing, according to the director.

SHORTCOMINGS IN STATE GENERAL HEALTH PROGRAMS

The major shortcomings in general health programs the three States operated were

--most programs covered only a small percentage of the State's total eligible population,

--many programs were inefficient and ineffective, and

--few programs were evaluated in order to identify weaknesses, determine benefits achieved, or make necessary changes.

Examples of these shortcomings follow.

For the heart disease program, Kentucky entered into contracts with its two medical schools to conduct cardiac clinics around the State. The clinics operated for 45 days during fiscal year 1974 and provided services for about 1,200 patients. Each clinic patient was referred, in writing, by a physician who stated the patient was indigent. The clinics then gave physical examinations, diagnoses, and evaluations and recommended treatment to the private physician. Although each patient was considered indigent when referred to the clinic, the State did not follow up to determine if the patient actually received treatment. The State did not evaluate the program to determine its effectiveness.

In Indiana, the largest single expenditure was for tuberculosis control; however, the program was active in only 58 of the 92 counties. This program was started in 1966, by one county, with financial assistance from HEW. Other counties sought Federal financial support for local clinics, and the State coordinated the establishment of 10 regional clinics. The clinics were designed to serve the surrounding counties; however, some counties refused to contribute toward the cost of operating the clinics and, therefore, were not included in the program. In the counties served, 87 percent of the known cases were reported to be under treatment. Little was known about cases of tuberculosis in the other counties.

In Kentucky, glaucoma was the second leading cause of blindness. The State had a screening program, but only 35 of the 120 counties participated in it. Although only 10,394 tests were made during fiscal year 1973, Kentucky had a high-risk population estimated to be about 1.3 million. The program director recognized the importance of

identifying glaucoma early, because no cure exists and damage is irreparable. He stated that more counties should participate; however, he believed that the counties should initiate program participation, and the State made no effort to expand the program.

Every county participated, to some extent, in Kentucky's diabetes program. Over 20,000 tests were given annually, but the program director did not believe that high-risk target groups[1] were being reached. He said that the national average for finding diabetes was 8.2 cases per 1,000 tests, yet the rate in Kentucky was only 3.1 per 1,000. Also, 31 percent of those tested were under 24 years old, and 59 percent were under 40 years old.

The diabetes program did not provide medication. Further, no followup was made to determine if a diabetic identified by the screening program received proper medication.

The cancer control program in West Virginia emphasized early diagnosis and treatment of needy patients suspected to have cancer. State officials considered this program to be the last resort for needy cancer victims. The program authorized 2 days hospitalization for diagnostic study and an additional 5 days for treatment, if cancer were found. A limited number of radiation treatments were provided, as long as funds were available.

During fiscal year 1973, the program authorized assistance to 465 patients. Because of the high hospitalization costs, available funds were spent before the end of the year. One hundred forty-seven patients with cancer, advanced beyond early diagnosis and treatment, requesting assistance had to be refused.

USE OF MCH FUNDS

MCH formula grants support various programs in the States we reviewed, but few programs were available statewide and most served only a limited number of patients, mostly children. Most programs were continued each year with little change.

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[1]Defined by Kentucky's diabetes program director as (1) overweight, (2) over 40 years of age, (3) relative of a known diabetic, or (4) mother of a baby weighing over 9 pounds at birth.

Indiana

The Division of Maternal and Child Health of the Indiana State Board of Health did not directly provide services to mothers or children. Rather, it planned, promoted, and coordinated MCH activities carried out by other State board of health divisions or units. The program had only three employees: a medical director and two clerks.

The Federal MCH grant to Indiana for fiscal year 1973 was about $1,291,100 (see p. 43). The State contributed $356,000; however, this amount was less than the minimum matching requirement for the Federal grant. In order to qualify for the Federal funds, Indiana included a county health department's MCH spending to meet the minimum matching requirement.

The largest MCH program in Indiana was dental health. The program involved fluoridating water supplies, providing topical fluoride applications to school children, and training dentists to treat handicapped children. The fiscal year 1973 total costs were $127,495.

Program officials said that (1) about 60 percent of Indiana's population had the optimum levels (0.8 parts per million) of fluoride in their drinking water and (2) 77 percent of the participants in the topical fluoride program were from communities having fluoridated water. No attempt was made to concentrate the topical fluoride program in communities with low fluoride levels in their water. The State health commissioner said Indiana has developed a new program which, when implemented, will reach these communities.

The State used about $927,230 of the Federal funds to award 39 grants to public or nonprofit health agencies. The grants supported such activities as family planning, well baby clinics, and visiting nurse programs. The grants were awarded as discussed on page 22 for the general health program.

Of the $900,000 available for distribution to local health agencies, about $260,000 was granted to State universities; many counties did not receive funds for basic MCH programs. For example, 38 of the 92 counties had no organized family planning services for low-income families. Forty-two counties, containing 20 percent of the population, received no funds for immunization programs, and 79 counties did not provide well child clinics. Only seven counties provided organized prenatal services.

The State health commissioner said the grants to State universities benefit mothers and children throughout the State and that 54 counties now have organized family planning programs.

Kentucky

The Division of Maternal and Child Health of the Kentucky Health Department operated programs in fiscal year 1973, including (1) pediatric services, (2) nutrition, (3) family planning, and (4) communication disorders. In addition, the division provided four separately funded projects with technical and administrative direction. These projects were

--a maternal and infant care project funded under section 508 of the Social Security Act,

--a child evaluation center funded directly by HEW (set-aside funds for mental retardation), and

--two family planning projects funded under title X of the Public Health Service Act.

Fiscal year 1973 MCH program spending was about $2,283,400--made up of a $1,185,800 Federal grant and State contributions of $1,097,600. (See p. 44.) Local health agencies also contributed $1,640,888. The majority of the Federal grant was spent at the State level. Only $143,862 was distributed to local health agencies.

None of the MCH programs were statewide. For example, the nutrition program was active in 34 of the 120 counties. The largest program, family planning, funded under title X and section 503 of title V, operated in 115 counties. MCH programs, other than family planning, concentrated primarily on services for children.

West Virginia

West Virginia MCH programs are supported by Federal funds from several different sources, including title X of the Public Health Service Act which provides funding for a statewide family planning program. The Appalachian Regional Commission also provides funding for an eight-county, early-childhood development program.

The title V MCH program consists primarily of four programs operated by the Maternal and Child Health Division of the West Virginia Department of Health and three programs

operated by other divisions of the health department. The MCH program also contributes funds to the State's Hygienic Laboratory and to the Division of Vital Statistics. The programs operated by MCH are (1) prenatal and delivery assistance, (2) child hospitalization, (3) child health conferences, and (4) mental retardation. A dental health program, a public health nursing program, and a nutrition program receive MCH funds but not direct supervision. In addition, the MCH program used three mobile health units to provide health services in remote areas.

The Federal grant to support title V MCH activities during fiscal year 1973 was about $618,400. (See app. VI.) The State contributed about $113,400, and the Appalachian Regional Commission provided about $900,000, which was spent in an eight-county target area.

According to West Virginia officials, in addition to the lack of funds, a major problem in attempting to expand programs was the lack of full-time county medical officers. Only 5 of 55 counties had full-time medical officers, and only 180 nurses work at the county level. Also, the age and condition of the county health department facilities and equipment were inadequate to conduct all necessary programs.

The MCH director considered the prenatal and delivery assistance program and the child health conferences to be the most important programs supported by MCH funds. The prenatal and delivery assistance program cared for only 355 of the estimated 9,145 women eligible for the program. The director estimated the cost to properly fund this program statewide to be about $3 million annually, or about 4 times the total MCH budget for fiscal year 1973. The child health conferences were available in only 30 of the 55 counties.

In commenting on our draft report, the MCH director pointed out that he does not have adequate funds or enough personnel to expand programs. He also stated that long-range planning has not been possible due to the uncertainty of Federal funding but that Federal funds from a variety of sources have provided valuable services and accomplishments although the funds are restricted to certain areas and people.

USE OF FUNDS FOR CRIPPLED CHILDREN

Nationwide, over 400,000 children are treated annually under State crippled children's programs assisted by Federal formula grants. The three States we reviewed treated the following number of children during fiscal year 1973.

	Indiana	Kentucky	West Virginia
Federal grant	$1,478,000	$1,338,678	$ 742,200
State and local contributions	3,531,327	2,111,342	1,525,754
Total	$5,009,327	$3,450,020	$2,267,954
Number of children treated	7,757	12,522	8,657

The three States did not actively identify children needing program services, but relied on informal referrals from family, friends, doctors, local public health personnel, or others. The States were generally reluctant to look for children needing treatment, because the caseload generated by the informal referrals used available funds. We noted, however, that two of the States could have gotten more reimbursements from the Medicaid program for eligible children who were receiving services from the crippled children's program.

The services provided varied in all three States. Two States accepted only those children considered treatable. The other State (Indiana) accepted all children, including those hopelessly physically or mentally incapacitated.

Indiana

The crippled children's program in Indiana was located within the State welfare department, which supervised the 92 county welfare departments responsible for the program at the county level. Federal and county funds supported the program.

Indiana welfare officials believed that they were meeting the State's needs even though only 7,757 children were provided services during 1973. Although the caseload was low compared to the State's population, they credited other welfare programs and voluntary organizations with providing the needed care. The welfare department did not have data to show the extent of treatment by such organizations.

The crippled children programs in Indiana did not actively seek new cases. Only seven 1-day clinics were held in 1973 to locate children needing, but not receiving, treatment. Only one such clinic was held in 1974; program offi-

cials said it was held strictly to meet the Federal legal requirement that children needing care be identified. The officials also said that anyone in the State could refer a child needing help to the crippled children's program. Efforts to inform the public about the program, however, were limited to contacts with physicians and nurses and an information booklet placed in county welfare offices.

A child is considered financially ineligible for crippled children's services if he is eligible for Medicaid coverage. The State did not know how many children in the program were covered by Medicaid and had been able to obtain such information from only two counties. This information showed that some children eligible for Medicaid were being provided services by the crippled children's program, without seeking reimbursement from the Medicaid program. The medical director of the crippled children's program was trying to transfer these children to the Medicaid program.

Kentucky

In Kentucky, the Commission for Handicapped Children administered the crippled children program. Under State law the commission locates, diagnoses, treats, and rehabilitates handicapped children. Program officials estimated that 45,500 children need the program's services, at an annual cost of more than $8.2 million.

The Kentucky program did not actively try to locate children needing, but not receiving, their services. Rather, the program relied on other agencies, including local health departments and private physicians, to refer handicapped children to it.

The program operated diagnostic and treatment clinics for 1,035 clinic days during fiscal year 1973. Almost 90 percent of these days were held in Louisville and Lexington, Kentucky. Generally, the patients paid their own transportation costs to one of the program's major service areas. The program did assist with transportation costs after the patient had been accepted into the program.

The Secretary for Human Resources, in commenting on our draft report, considered finding cases a minor problem, as all available funding is devoted to the current caseload. He pointed out that the major clinics are concentrated in Louisville and Lexington because of the availability of excellent medical facilities and medical specialists.

About 20 percent of the crippled children in Kentucky's program are eligible for Medicaid. Generally, hospitals

must bill Medicaid for costs eligible under that program, and the crippled children's program paid the remainder of the bills. The program did not keep a list of patients eligible for Medicaid and knows only in the case of one hospital the costs billed to Medicaid, if any.

To determine the impact of not seeking reimbursements under the Medicaid program, we reviewed 30 cases eligible for Medicaid assistance. The records showed these cases cost $6,469 in 1973. Our review showed that $4,222 of this amount should have been but was not billed to the Medicaid program. According to program personnel, administrative error was the primary reason why the bills were not submitted to Medicaid.

Kentucky's Secretary for Human Resources said all third-party reimbursement programs are now being used as effectively as possible and that the problem of identifying patients eligible for Medicaid has been solved.

West Virginia

The West Virginia program was administered by the State welfare department. Welfare officials think the program was treating most of the eligible children, because HEW statistics show that 3.2 percent of the national population under 21 has some physical limitation and that 1 percent has a major problem. With a total West Virginia population under 21 of 675,204, they estimated that 6,752 children in West Virginia had severe handicaps. The active caseload was about 6,000.

The West Virginia program did not try to identify the number of children needing treatment. Instead, the program relied on others such as State health department personnel, county health staffs, or private physicians to identify and refer children in need of the service. This informal referral system had not been evaluated to determine its effectiveness.

The State health department had a system that used birth certificates to identify children born with defects. In 1973 this system identified 407 children, of which 219 were found medically eligible for the crippled children's program. However, 165 of the 219 children, or 75 percent, were not visited by county health department personnel to determine what care was needed or to counsel the parents on available help. After we discussed this situation with program officials, they took corrective action.

Computer listings which identified the patients awaiting authorization for treatment and those who had not completed applications contained 757 and 1,344 names, respectively. Some children's names were listed for over 2 years, because the staff did not periodically review the lists and take action to assure that children needing treatment received medical care.

One thousand and forty-seven children were dropped from the program in 1973 for one of the following reasons.

1. The patient missed two consecutive clinic appointments.

2. The new patient missed the first clinic appointment.

3. The family failed to return the annual financial eligibility report.

We reviewed 46 of these cases--31 missed 2 consecutive appointments and 15 missed their first appointment. Of these 46 patients, 20 returned to the program within 5 months after being dropped. The other cases were closed without further followup, under the assumption that the parents were not interested.

CONCLUSIONS

The States were using Federal formula grant funds to provide numerous and beneficial health services. The States we visited, however, had not structured their programs flexibly as intended--spent Federal funds in areas of greatest need and most attainable benefits. For the most part, the States allocated the funds to specific health programs based primarily on tradition and administrative convenience. The same programs were continued each year, with little management review. As a result, health services programs were fragmented and poorly managed.

Basic program weaknesses include:

--Ongoing programs are not evaluated to identify operational problems or to measure program benefits.

--Only a few people receive services from many programs.

--Little direction or guidance is provided to local health agencies.

--Available third-party reimbursement programs, particularly Medicaid, are not being used effectively.

RECOMMENDATIONS

We recommend that the Secretary of HEW initiate reviews of the States' use of Federal formula grant funds to (1) determine whether Federal objectives for the formula grant program are being met and (2) identify program management practices which require improvement to assist in meeting Federal objectives. We also recommend that the Secretary of HEW encourage and assist the States to establish procedures to insure using the Medicaid program for eligible patients.

AGENCY COMMENTS

HEW stated that it is acting to implement our first recommendation within the constraints of existing resources. A program directive to be issued during the first quarter of fiscal year 1976 will require the establishment of a system for reviewing State plans and for obtaining performance reports on formula grant programs. HEW believes reviews of the contemplated program performance reports will enable it to implement our recommendation.

HEW also said title V formula grants will be monitored by a new reporting system, which will provide program performance data that will enable MCH program personnel to fully implement our recommendation.

HEW told us it has acted to implement our recommendation on the use of the Medicaid program.

CHAPTER 5

HEW ADMINISTRATION

Our review in three States showed that HEW management shortcomings were:

--No uniform guidelines establish minimum acceptable standards for State health plans.

--Meaningful periodic reports from State health agencies are not required, and those received are not adequately reviewed.

--Few program evaluations or analyses identify the need for program improvement and methods or approaches to health problems which show success.

HEW headquarters involvement in the formula grant programs was limited primarily to issuing general policy statements and regulations and to distributing the Federal funds. Providing technical assistance to the States and approving State health plans had been delegated to the 10 HEW regions.

PLANNING ASSISTANCE

HEW issued a "Health Grants Manual" containing administrative instructions to the States, including some suggested planning methods, such as cataloging existing health programs in the State. HEW did not maintain the manual on a current basis, and, as a result, State personnel often were not sure of correct administrative procedures. For example, a draft change to the HEW manual, dated April 1, 1968, containing the steps required to obtain Federal approval of State health plans for MCH services and services for crippled children, was distributed to the States; but, the draft change was never finalized. The States we visited were unsure of the planning process necessary to satisfy Federal requirements. No two State plans were in the same format.

HEW also issued draft guidelines in 1973 to assist the States to plan for assuming the special MCH project grants being funded by HEW and to develop projects to provide the five required MCH services. (See p. 15) The draft guidelines, marked for discussion only, were never finalized.

State plans were generally approved if the basic legal requirements were addressed. If HEW regional offices were dissatisfied with program content, the plans were still approved and regional office personnel attempted to persuade

the State to make changes. HEW regional office officials said they considered formula grants as State entitlements; and, therefore, they had to use persuasion to obtain program improvements.

MONITORING STATE PROGRAMS

HEW headquarters personnel did limited monitoring of the formula grant programs. Routine management data such as State health plans, progress reports, or expenditure reports were not forwarded to headquarters personnel. These officials said (1) the HEW regional office was responsible for knowing State activities and (2) they were not responsible for how State health agencies spent formula grant funds.

To monitor formula grant programs, the HEW regional offices organized MCH divisions staffed by specialists. Administration of the general health program was divided among specialists appointed to manage such programs as disease control, environmental health, and occupational health and safety. No manager had overall responsibility for general health formula grants. Monitoring activities generally consist of infrequent site visits and telephone discussions. A record of these contacts to show the agreements reached or action required was not always kept.

Required State reports

Each State must submit three types of annual reports to HEW regional offices.

1. Expenditure report. Beginning with fiscal year 1972, expenditure reports showed only the total funds the State spent.

2. Statistical report. This report provided data on the number of patients receiving specific services. The reports, however, did not compare costs to the number of patients. In addition, the reports could not be compared to the expenditure reports, because the items reported varied.

3. Progress report. This report described in general terms the services a State provided. The reports did not follow a uniform format and did not compare funds to health services provided.

Since the reports, except the statistical report, were not consistently prepared from State to State and did not compare services to the number of patients treated, specific uses of formula funds by most States could not be determined. Further, the expenditure reports were inaccurate. For

example, Indiana's expenditure reports for MCH programs included only one county health department's activity. This county's spending was included to meet minimum matching requirements. Other county expenditures were not shown.

In Kentucky, the 1973 financial report for the general health program showed only the State funds spent in the counties. State health department headquarters spending was not included. As a result, the report indicated that Kentucky did not meet the program's required State level of effort. As of August 1974, a State official said HEW had not questioned the inaccurate report. We also noted that a Social Security Act requirement that 6 percent of the MCH appropriation be made available for family planning services cannot be monitored from the required HEW reports.

HEW EVALUATIONS

HEW headquarters is responsible for evaluating formula grant programs. The Public Health Service Act provides up to 1 percent and the Social Security Act provides up to 0.5 percent of the respective appropriations for use by the Secretary, HEW, to evaluate formula grant programs.

In its report on the Partnership for Health Amendments of 1967, the House Committee on Interstate and Foreign Commerce stated that these programs must be continually evaluated to guarantee that the public's interests and needs were being met. The report also stated:

> "The Secretary should insure that the goals and objectives of these programs are kept sharply in focus and that the best means for accomplishing objectives are employed. Once these programs are in operation, follow-up on their progress should be made. Evaluation studies and analyses should be conducted to identify and extend the application of those program methods and approaches which show high success and to spot program weaknesses in time to permit steps to be taken to improve program performance.
>
> "Assessment and comparison of different ways of accomplishing program objectives should be made and the most effective approaches should be emphasized. The Secretary should develop appropriate measures of the progress of programs to insure that quality is maintained and that program achievements are made in an economical way. The bill provides that the Secretary may perform evaluation either directly or through grants or contracts. Although the funds available for evaluation will be a small fraction of those available

for the programs which are authorized, no more than 1 percent, the committee feels that making these funds available for evaluation will contribute substantially to the success of the programs proposed in the bill."

In fiscal year 1973, about $900,000 of general health funds was available for program evaluations. Most of these funds were used to develop data systems. For example, about $400,000 was used during the year to further develop a uniform health program reporting system. As of June 30, 1974, HEW had allocated about $1.8 million of evaluation funds, over several years, for this system. Other efforts during the year included evaluating Federal, State, and local computer statistical systems. Little was done to evaluate State-controlled formula grant programs.

About $1.25 million of MCH and crippled children's funds was also available for evaluations. Most of these funds were used to develop data systems for special project grants awarded to State agencies and to public and other nonprofit institutions.

HEW officials said (1) program evaluations are a State responsibility and (2) HEW regional office personnel, through daily working relations with State agencies, can determine State programs' adequacy and work toward necessary improvements.

CONCLUSIONS

HEW regards formula funds as State entitlements and is reluctant to assume any management responsibility for the programs. HEW management activities and reporting requirements do not assure that States effectively and efficiently use Federal funds. Management shortcomings are:

--No uniform guidelines establish minimum acceptable standards for State health plans.

--Meaningful periodic reports from State health agencies are not required and those received are not adequately reviewed.

--Few program evaluations or analyses identify the need for program improvement and methods or approaches to health problems which show success.

RECOMMENDATION

We recommend that the Secretary of HEW replace the reports now required from the States with a report enabling

HEW regional offices to monitor the use of formula grant funds and to assess compliance with legal requirements. Such a report should show the type and volume of services being provided and should compare costs to services, with administrative and support costs shown separately.

AGENCY COMMENTS AND OUR EVALUATION

HEW said the new reporting requirements for formula grant programs (see p. 34) will enable its regional offices to fully implement our recommendation. HEW pointed out that the new reporting requirements will gather program performance data and that a recently prepared cost finding manual will help States determine costs in a uniform manner and accumulate cost data of the type we recommended.

HEW believes the reports required for the public health service program enable the regional offices to adequately monitor the use of program funds and to assess compliance with all legal requirements.

We agree that the reports being received by HEW were adequate to assess compliance with legal requirements for the public health service program and that performance reporting on the three programs will be improved by actions being taken by HEW (see p. 34).

APPENDIX I

FUNDING OF GENERAL HEALTH SERVICES

IN INDIANA (note a)

FOR FISCAL YEAR 1973

Program	General health	MCH	Total Federal	State	Total program
Handicapped	$ -	$ -	$ -	$ 36,225	$ 36,225
Health education	26,096	5,545	31,641	75,514	107,155
Information section	-	4,256	4,256	16,764	21,020
Illustrations	-	-	-	11,082	11,082
Nutrition	15,007	-	15,007	4,507	19,514
Public health records	-	1,748	1,748	22,477	24,225
Public health statistics	-	-	-	33,361	33,361
Systems and data processing	-	9,783	9,783	50,911	60,694
Chronic disease and gerontology	-	-	-	14,085	14,085
Communicable disease	5,314	-	5,314	70,820	76,134
Health facilities	5,567	-	5,567	162,728	168,295
Tuberculosis	5,965	-	5,965	44,122	50,087
Nursing	20,948	16,031	36,979	27,119	64,098
Bureau of laboratories	19,511	-	19,511	69,337	88,848
Food, drug, and dairy	21,892	-	21,892	115,986	137,878
Microbiology	21,786	-	21,786	96,912	118,698
Serology	-	-	-	72,361	72,361
Water and sewage (note b)	-	-	496	70,036	70,532
Dairy products	39,597	-	39,597	227,449	267,046
Milk inspection	-	-	-	202,054	202,054
Drug control	-	-	-	50,408	50,408
Retail and manufactured food	38,259	-	38,259	155,530	193,789
Weights and measures	-	-	-	107,061	107,061
Grain testing	-	-	-	13,282	13,282
Industrial hygiene	24,599	-	24,599	31,251	55,850
Radiological health	40,793	-	40,793	215	41,008
Sanitary engineer	-	-	-	25,230	25,230
Branch personnel	-	-	-	138,636	138,636
Public water supply	13,501	-	13,501	45,584	59,085
Housing and schools	-	-	-	20,297	20,297
General sanitation	25,726	-	25,726	75,723	101,449
Migrant labor	17,921	-	17,921	-	17,921
Miscellaneous programs	-	768	768	3,685	4,453
Virology	-	-	-	28,282	28,282
MCH program support	49,233	-	49,233	-	49,233
Local agency grants	[c]879,270	-	879,270	-	879,270
Operating expense	359,062	-	359,062	583,689	942,751
Total	$1,630,047	$38,131	[d]$1,668,674	$2,702,723	$4,371,397

[a]Funds provided by local governments not included.

[b]Federal support provided by other grant programs.

[c]Includes $324,288 for tuberculosis control.

[d]The general health and MCH totals do not equal the total Federal amount because of footnote b.

FUNDING OF GENERAL HEALTH SERVICES IN KENTUCKY (note a) FOR FISCAL YEAR 1973

Program	Federal	State	Total Program
Communicable disease	$ 25,994	$ 25,098	$ 51,092
Chronic disease Heart Cancer Diabetes Glaucoma Rheumatic fever Kidney	99,079	251,077	350,156
Sanitary engineering Water supplies Swimming pools Plumbing	25,533	99,115	124,648
Radiological health	43,140	64,607	107,747
Occupational environment	567	34,168	34,735
Laboratory central services (note b)	98,758	141,921	240,679
Occupational health (note b)	39,299	42,335	81,634
Duplicating services (note b)	14,104	5,287	19,391
Multiphasic screening (note b)	441	-	441
Total	$346,915	$663,608	$1,010,523
County programs Tuberculosis Cancer Heart Chronic ill Sanitation Home health service General health	936,691	1,842,134	2,778,825
Total	$1,283,606	$2,505,742	$3,789,348

[a]Funds provided by local governments not included.

[b]Additional Federal support provided by other grant programs.

APPENDIX III

FUNDING OF GENERAL HEALTH SERVICES IN WEST VIRGINIA (note a) FOR FISCAL YEAR 1973

Program	Federal	State	Total Program
County dental clinics	$ 31,564	$106,883	$138,447
Central administration	104,997	244,450	349,447
Division of vital statistics	13,469	97,183	110,652
Emergency health services	13,129	45,148	58,277
Disease control	22,296	7,020	29,316
Public health nursing	39,468	41,371	80,839
Sanitary engineering	113,221	188,179	301,400
Bureau of nutrition	15,507	27,512	43,019
Civil service	6,325	11,108	17,433
Histopathology services	7,475	16,675	24,150
Cancer control	29,627	4,038	33,665
State hygienic laboratory	128,908	273,005	401,913
Public health education	15,480	16,186	31,666
Local health units	58,552	2,118	60,670
Welfare screening	12,653	-	12,653
Heart disease control	42,118	93,925	136,043
Mercer regional heart, cancer, and stroke project	23,857 -	8,076 -	31,933 -
Radiological health	9,870	25,949	35,819
Tuberculosis control	88,186	314,504	402,690
Regional heart programs	8,030	13,216	21,246
Dental health programs	-	46,146	46,146
Regional environmental health	-	27,154	27,154
Industrial hygiene program	-	30,137	30,137
Care of needy cancer patients	-	183,320	183,320
State funds appropriated to local health department by legislature	-	1,000,000	1,000,000
Total	$784,732	$2,823,303	$3,608,035

[a]Funds provided by local government not included.

APPENDIX IV

FUNDING OF MCH

IN INDIANA (note a)

FOR FISCAL YEAR 1973

Program	General Health	MCH	Total Federal	State	Total Program
Health education	$13,556	$ 19,099	$ 32,655	$ 27,235	$ 59,890
Information section	-	6,025	6,025	3,594	9,619
Illustrations	-	-	-	7,339	7,339
Nutrition section	14,239	-	14,239	653	14,892
Public health records	-	4,419	4,419	69,391	73,810
Systems and data processing	-	523	523	7,753	8,276
Communicable disease	1,667	-	1,667	48,228	49,895
Dental health	-	110,426	110,426	17,069	127,495
Health facilities	54	-	54	430	484
Hospital and institutional services (note a)	-	-	54	19,251	19,305
MCH	-	39,071	39,071	-	39,071
Medical care administration (note b)	-	-	223	-	223
Nursing	13,672	11,222	24,894	19,802	44,696
Drug control	-	-	-	2,181	2,181
Retail and manufactured food	6,045	-	6,045	5,378	11,423
Branch personnel	-	-	-	2,121	2,121
Local agency grants	-	927,230	927,230	-	927,230
General health program support	-	38,131	38,131	-	38,131
Other operating expense	-	134,962	134,962	125,607	260,569
Total	$49,233	$1,291,108	[c]$1,340,618	$356,032	$1,696,650

[a]Funds provided by local governments not included.

[b]Federal support provided by other grant programs.

[c]The general health and MCH totals do not equal the total Federal amount because of footnote b.

APPENDIX V

FUNDING OF MCH IN KENTUCKY (note a) FOR FISCAL YEAR 1973

Program	Federal	State	Total Program
Division staff and administration	$ 140,215	$ 491	$ 140,706
Family planning	245,493	-	245,493
Communication disorders	89,027	-	89,027
Nutrition	53,713	51,232	104,945
Pediatric services	272,971	34,525	307,496
RH testing and lab services	51,895	-	51,895
Public health nursing	25,895	60,670	86,565
Dental health maintenance and clinics	73,956	-	73,956
Duplicating and mailing	51,470	9,000	60,470
Personnel and training	37,328	37,746	75,074
Grants to counties	143,862	903,913	1,047,775
Total	$1,185,825	$1,097,577	$2,283,402

[a]Funds provided by local governments not included.

APPENDIX VI

FUNDING OF MCH IN WEST VIRGINIA (note a) FOR FISCAL YEAR 1973

Program	Federal	State	Total program
MCH staff and administration	$273,563	$ 23,265	$296,828
Central administration	35,710	-	35,710
Pediatric hospitalization and child health conferences	118,609	-	118,609
Prenatal and delivery service	54,406	34,835	89,241
Cardiac clinic	6,173	-	6,173
Mobile unit	-	55,284	55,284
Civil service	1,540	-	1,540
Support of other divisions:			
Public health nursing	25,815	-	25,815
Hygienic lab	38,429	-	38,429
Vital statistics	14,779	-	14,779
Dental health	14,760	-	14,760
Nutrition	18,228	-	18,228
Mental retardation program (note b)	16,376	-	16,376
Total	$618,388	$113,384	$731,772

[a]Funds provided by local governments not included.

[b]Special mental retardation grant provided $191,150 additional Federal support.

APPENDIX VII

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C. 20201

OFFICE OF THE SECRETARY

JUL 2 4 1975

Mr. Gregory J. Ahart
Director, Manpower and
Welfare Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report to the Congress entitled, "How States Plan for and Use Federal Grant Funds to Provide Public Health Services, Maternal and Child Health Services, and Crippled Children Services." They are enclosed.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

John D. Young
Assistant Secretary, Comptroller

Enclosure

COMMENTS

Comments of the Department of Health, Education, and Welfare on the Comptroller General's Draft Entitled "How States Plan for and Use Federal Grant Funds to Provide--Public Health Services--Maternal and Child Health Services--Crippled Children Services" of April 28, 1975.

General Comments

The basic premise of a formula grant program as intended and established by the Congress is that such a program is block support, an entitlement where the funds become a part of a State's total program. Therefore, formula grants cannot be administered as project grants.

Although we agree that there is a need for improved planning by State health agencies, we believe that this cannot be achieved through the leverage of relatively small Federal programs such as the formula grants. Good planning must relate total health needs to total resources available--Federal, State, and local funds.

The Congress has recognized this need in the newly enacted National Health Planning and Resources Development Act of 1974 (P.L. 93-641). A key element in this legislation is the establishment of coordinated State and local health planning bodies responsible for review and approval of proposed expenditures of formula grants awarded under the Public Health Service Act. Once the legislation is fully implemented, local agencies in coordination with State Health Planning and Development agencies will have responsibility for developing a systematic and continous planning process which will provide a logical basis and direction for the use of certain Federal formula grant funds. Although this law does not include Title V formula grants programs, we are optimistic that in due course it will effect a significant improvement in the planning and management of State Maternal and Child Health and Crippled Children services health programs.

Our comments on the specific recommendation made in the draft report follow.

GAO Recommendation

That the Secretary of HEW assist States in developing a systematic and continous planning process which will provide a logical basis and direction for the use of Federal formula grant funds. Such a planning process should provide for the establishment by the States of priority funding areas and measurable program objectives for use by HEW and the States in evaluating the effectiveness of the use of Federal formula grant funds.

Department Comment

We concur with this recommendation as it relates to the MCH Program. The MCH work plan for fiscal year 1976 already includes an activity focused on developing guidance documents designed to assist States in organizing their formula grant programs in a logical coherent fashion. The guidance material encourages States to assess their needs and to establish priorities and goals designed to assist them in meeting their stated objectives.

In keeping with the statutory statement that the grant is "to assist the States in establishing and maintaining adequate public health services," State plans under section 314(d) submitted to and approved by the Secretary are reviewed, evaluated, and modified as appropriate at least annually. The State plans are developed specifically to meet the requirements contained in the statute and the regulations. Consequently, the plans need only pertain to those services supported by Federal funds allotted to the States under section 314(d) and the required matching funds.

GAO Recommendation

That the Secretary of HEW develop regulations requiring that the utilization of MCH funds be coordinated with State comprehensive health planning agencies and stressing that State health agencies establish on-going working relationships with such planning agencies in the provision of health services authorized by the formula grant programs.

Department Comment

We concur. The Public Health Service is now in the process of drafting an amendment to Title V regulations to ensure that States include Maternal and Child Health and Crippled Children services in their comprehensive health planning systems.

As in the case of PHS grants which are covered by the newly enacted National Health Planning and Resources Development Act, it is expected that the contemplated amendment to Title V regulations will emphasize close coordination in the development and application of the MCH plans between the Statewide Health Coordinating Councils and the local Health Systems Agencies.

GAO Recommendation

That the Secretary of HEW initiate reviews of the States' use of Federal formula grant funds to (1) determine whether Federal objectives for the formula grant programs are being met and (2) identify program management practices which require improvement to assist in meeting Federal objectives.

Department Comment

We concur. As it relates to section 314(d) formula grants, PHS is already acting to implement this recommendation within the constraints of existing resources. PHS is incorporating a requirement in the departmental Grants Administration Manual that headquarters agencies develop specific program performance requirements. The proposed directive to be issued during the first quarter of fiscal year 1976 will apply to all PHS formula programs, including those under section 314(d). Its purpose will be to establish a system for reviewing State plans and for obtaining performance reports relating to the award and administration of PHS formula grants programs. Examples of information which may be required by program performance reports are as follows:

a. Goals established for program during the reporting period.

b. Actual accomplishments during that period.

c. Brief discussion of other aspects of the program's impact; i.e., unanticipated beneficial effects, innovation, et al.

d. Estimated cost of the program

1) by major program, function, or activity,

2) per population reached, and

3) by more definitive units of cost where appropriate.

e. Discussions of reasons for slippages or failures to meet goals, etc.

Reviews of the contemplated program performance reports will enable us to implement GAO's recommendation.

Section 314(d) formula grants will observe and follow the new requirements to the extent that such requirements are compatible with their statutory history.

Monitoring of Title V formula grants is currently in the process of entering a new phase. We are confident that the new Programs of Projects requirement, the revised State plan, plus other initiatives in technical assistance will result in improved monitoring of the programs in the future. The quarterly and statistical reporting systems to become operational by the third quarter of fiscal year 1976 will allow MCH program personnel to review the States' use of Federal formula grants as recommended by the draft report. The Programs of Projects proposed regulations will outline the States' action

plans to provide medical care services in accordance with Title V mandates. The new reporting systems will provide program performance data which will enable MCH program personnel to fully implement GAO's recommendation.

GAO Recommendation

That the Secretary of HEW encourage and assist States in establishing procedures which will ensure use of the Medicaid program for eligible patients.

Department Comment

We concur. The Department has already acted to implement this recommendation. On July 31, 1974, the Social and Rehabilitation Service through its Medical Services Administration issued the program regulation guide entitled "Interrelations with State Health and State Vocational Rehabilitation Agencies and with Title V Grantees." The regulation guide has been distributed to all State agencies administering health assistance programs. The purpose of the regulation guide is to clarify the use of Title XIX funds and to encourage payment for medical care provided by agencies, institutions, or organizations furnishing health services under Title V, to the extent that these services are covered in Medicaid State Plans.

Additionally, MCH is developing information reports which will indicate whether State health agencies have adopted steps to ensure that available third-party reimbursement programs, particularly Medicaid, are being effectively utilized. Failure to follow the program regulation guide will result in States not being in compliance with the MCH statute. In these circumstances, and as part of the review and approval process, MCH Regional Program Consultants (RPCs) will adopt appropriate action.

Finally, MCH already provides guidance to their RPCs to provide assistance to the States in establishing procedures for the use of the Medicaid program for eligible patients. This is accomplished as part of the periodic field visits and conferences to the State health agencies by the RPCs.

GAO Recommendation

That the Secretary of HEW replace the reports now required from the States with a report which will enable HEW regional offices to monitor the use of formula grant funds and to assess compliance with legal requirements. Such a report should disclose the type and volume of services being provided and should relate costs to services with administrative and support costs shown separately.

Department Comment

We concur with this recommendation as it relates to the MCH program. The new reporting requirements (see our comments to the third recommendation) will enable HEW regional offices to fully implement GAO's recommendation. Programmatic achievements will be measured against stated objectives to monitor the use of formula grant funds and to assess compliance with the statute as outlined in the respective programs of projects. The new reporting requirements will gather data concerning clinical visits, patients' screening for medical services, age groups of patients, infant mortality, infant dental care, etc. Finally, a recently prepared cost finding manual will assist States in determining costs in a uniform manner and to accumulate cost data of the type listed by the draft report.

Concerning Federal formula grants authorized by the Public Health Service Act, we believe that our regulations and guidelines already require compliance with this recommendation. The budget reports currently required of State agencies for formula grants under section 314(d) enable the regional offices to administer current legal requirements. The expenditure reports utilized are those required under 45 CFR Part 74 and Federal Management Circular No. 74-7 (formerly OMB Circular No. A-102). These reports enable the regional offices to adequately monitor the use of formula grant funds and to assess compliance with all legal requirements.

Technical Comment

References made in the GAO draft report to coordination with "State comprehensive health planning agencies" should be changed to reflect Public Law 93-641 which replaces the 314(a) agencies with State Health Planning and Development agencies and Statewide Health Coordinating Councils (SHCCs). For purposes of review of allotments and coordination in planning, references should be to the SHCC; for local planning input, the Health Systems Agencies should be cited.

APPENDIX VIII

STATE OF INDIANA

INDIANAPOLIS

STATE BOARD OF HEALTH

Address Reply to:
Indiana State Board of Health
1330 West Michigan Street
Indianapolis, IN 46206

July 1, 1975

Mr. Gregory J. Ahart, Director
Manpower and Welfare Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

Attached are our comments on the Draft of a Report prepared by the Comptroller General entitled, "How States Plan for and Use Grant Funds to Provide Public Health Services, Maternal and Child Health Services, and Crippled Children Services."

Sincerely,

WILLIAM T. PAYNTER, M.D.
STATE HEALTH COMMISSIONER
INDIANA STATE BOARD OF HEALTH

Enc.

GAO note: Page references in this appendix refer to the draft report and do not necessarily agree with the page numbers in the final report.

Comments on the Draft Report
of the
General Accounting Office Review
of the
Use of Federal Formula Grant Funds (314d)
of the
Public Health Service Act and Title V
of the
Social Security Act
by the
Indiana State Board of Health

GENERAL COMMENTS

Such a report is most difficult to respond to since the purpose and intended use of the formula grant funds appears to be interpreted differently by the Indiana State Board of Health; Department of Health, Education, and Welfare; and the General Accounting Office. This probably arises from the underlying concept of federal formula grant programs as stated on Page 8 of the Draft Report: "State and local governments are more aware of their needs than the federal government and should be permitted to decide, within broad program catagories, how the federal funds are to be spent." Further, on Page 12 of the Report, it is stated that Congress intended to "...provide grants to states for the support, development and expansion of public health services to meet the needs of their citizens in accordance with priorities and goals established by the states."

This implies to us that the protection, promotion, and maintenance of the health of the people living in local communities is a responsibility shared by local, state, and federal government and the formula grant is the mechanism through which the federal government fulfills its obligation. We also believe that when the Indiana State Board of Health submitted the plans required under the 314(d) and Title V programs and these were approved by H.E.W., it was proper to proceed accordingly.

We experience great difficulty with the comments beginning on Page 20 of the Draft Report and continuing through Page 29. We are not sure that these comments relate to both formula grants programs or only to Title V of the Social Security Act. Further, the comments, for the most part, refer to three states as a group, thus making it difficult to determine those that apply to Indiana. However, we react to some of the comments made in this portion of the Report.

SPECIFIC COMMENTS

- Page 21: "Officials in all three states informed us that the plans were written in order to receive the federal grants and that little use was made of the plans by personnel responsible for program implementation." We would question that a responsible official of the Indiana State Board of Health offered a comment of this nature.

- Page 21: The comments dealing with data on program needs and results, as well as those on establishment of measurable program goals and priority for funding areas, are reasonably accurate. Even though we recognize our deficiencies in this area, we doubt that any branch of government has in place, at the moment, a health data system capable of achieving the degree of sophistication implied by the comments in the report.

- Page 21: "Adequate plans for the program of Maternal and Child Health projects had not been developed." We would add that adequate guidelines were not available from H.E.W., and, in order not to delay the implementation of services, it appeared advisable to begin with existing state and local programs. Our Maternal and Child Health Plan now contains objectives which focus on improvement of the health of mothers and children in terms of measurable outcomes.

- Page 21: "State Plans were prepared and programs were administered without input from State or Regional Comprehensive Health Planning Agencies." State plans, as required, were reviewed and approved by the State Agency and grants for local programs were allowed only after review and approval by the appropriate Regional Agency. In those instances where project requests originated in a community not included in an approved region, the review and approval function was performed by the State Comprehensive Health Planning Agency.

- Page 22: "Indiana used over 50 percent of federal general health funds for grants to local agencies, such as local health departments, but the state plan provided no guidance on priority funding areas for such grants--funding areas were selected by local agencies." Admittedly, specific and detailed guidelines were not in the plan, but every project funded was reviewed and approved by either a Regional Comprehensive Health Planning Agency or the State Agency and by an intra-staff committee that worked with preestablished policies to determine need and impact of the proposed program.

- Page 23: We have no comments concerning Indiana's crippled children's program since it is not administered by the State Board of Health.

- Page 23: We have no comments to offer concerning the statements as to plan revision and planning processes in effect in the states since they appear to be opinions and subjective in nature.

- Page 24: We do not believe that the statement that "...a substantial amount of federal funds...were allocated to specific programs by the accounting department for administrative convenience," properly reflects the information conveyed. Certainly there were more significant reasons than "administrative convenience."

- Page 24: "None of the states in our review had a current inventory of health services available at the community level." This is highly desirable, but most difficult and costly to achieve. We do have such information on local health departments. Full knowledge and information of the type alluded to in the report will result when a system is put in place that has the full cooperation of all providers--both public and private plus the fiscal intermediaries.

- Page 25: "We found that the state health agency officials do not generally work with the comprehensive health planning personnel in developing programs...." This certainly is not the case in Indiana. Early in these comments we described our relationship with the "A" and "B" Comprehensive Health Planning Agencies.

COMMENTS ON CHAPTER IV

GENERAL COMMENTS

It appears to us that the introduction to this Chapter is merely an opinion and totally subjective in nature. The statement "...expenditures of formula grant funds have been fragmented, poorly managed and not used to implement the intended flexibility to spend the federal funds in areas where the need is the greatest and benefits most attainable." It fails to take into consideration the concept of the formula grant programs stated earlier in the Report that state and local governments are more aware of their needs than the federal government and should be permitted to, within broad categories, determine how the federal funds are to be spent. Further, it seems inconsistent with early criticism leveled at the states for failure to serve all communities with a large variety of programs.

SPECIFIC COMMENTS

- Page 37: "Indiana allocated funds to over 30 separate general health programs....Despite the apparent multiplicity of programs, important chronic diseases such as heart or cancer were not funded." It was our opinion that the Regional Medical Program was funded for and charged with the responsibility for dealing with these disease entitites and that we should direct our attention elsewhere.

- Page 38: "The amount of federal support for each program was determined by the accounting department which designated certain employees to be paid with federal funds....we were told by State Officials that these types of employees, rather than supervisory or

administrative personnel, were paid with federal funds in order to meet the 70 percent legal requirement that section 314(d) funds be spent on direct community services." Since this statement fails to describe the procedures by which such assignment of funds was made, it implies that the accounting department arbitrarily and on its own assigned personnel to be paid out of federal funds. This is an inadequate description of the method utilized to make such assignments.

- Page 38: "The initiative to apply for the grants had to originate with the county and the state gave priority to continuation applications.... Generally, once a grant was awarded for a local program, funding was continued year after year with little change." Local agencies were encouraged by general announcements, meetings, and conferences and direct contact by State Board of Health personnel to submit project requests. Priority was given to continuation applications if the program expanded services not otherwise provided. Policy also provided for a gradual phasing out of the funding of projects.

- Page 39: "The State of Indiana has generally not spent all the federal grant funds....although unmet needs existed in many areas. For example, 11 county health departments did not have a nurse on the staff in 1973 and many counties did not have sanitarians...." We are faced by two problems in this situation. Local authorities must appropriate funds regardless of the source, local authorities must employ local personnel, and the State Board of Health does not have the legal power to force them to do either.

- Page 39: "...Even the state's highest priority program, tuberculosis control, did not cover the entire state." With the resources, manpower and local interest available (all of which were limited) the high tuberculosis risk areas were covered.

- Page 39: We have indicated earlier in these comments that, as other states and other agencies both private and public, including the federal government, the health data available leaves much to be desired. In the absence of the necessary data it is necessary to depend upon the best professional judgment possible for determining wise allocation of funds. We have previously replied to the allegation that "A local program existed because of local initiative rather than a structured state effort."

- Page 43: "Indiana's largest single expenditure was for tuberculosis control; however, the program was active in only 58 of 92 counties....The state coordinated the establishment of 10 regional clinics. The clinics were responsible for serving surrounding counties; however, some counties refused to contribute to the cost of operating the clinics and, therefore, were not included in the program." Based

upon cost benefits, it appeared wise to cover the high risk counties and this was done. No county was excluded from the program for failure to contribute to the cost of operating the clinics. The counties only had to agree to pay clinic charges for indigent residents participating in the program.

- Page 45: Even though the Division of Maternal and Child Health had a small staff at the time that the program was reviewed by the General Accounting Office, it should be pointed out that many elements of the Maternal and Child Health program are implemented by personnel from the Division of Dental Health, Division of Nursing, Division of Health Education and the Nutrition Section.

- Page 46: "In order to qualify for the federal funds, Indiana counted the MCH expenditures of a county health department to meet the minimum matching requirement." This is permissible under federal law and is quite proper since a large share of the MCH dollars goes for the support of local programs.

- Page 46: Indiana does have an outstanding dental health program and is so recognized by leaders in public health dentistry throughout the country. We have now developed a program which will be implemented and has as its objective to reach those communities with water containing less than the optimum fluoride level.

- Page 47: "Of the $900,000 available for distribution to local health agencies about $260,000 was granted to state universities and many counties did not receive assistance for basic MCH programs...." We would point out again that in Indiana the State Board of Health is limited in the degree to which it can force health programs on local communities. In our opinion the funds alloted to state universities will achieve results from which mothers and children throughout the state will benefit. In addition immunizing biologicals are available to all low income children in the State, AntiRho (D) immune globulin is provided for low income mothers. There are 54 counties out of 92 with organized family planning services for low income individuals. Approximately 80 percent of the State's population is located in the counties served. There are 13 counties with organized well-child services and an additional 37 provide immunization services. Approximately 80 percent of the State's population reside in these counties. Diagnostic and evaluation services for individuals with mental retardation or other developmental disabilities are available to all children at the Indiana University Medical Center. In addition. facilities in Gary, South Bend, Fort Wayne, Lafayette, Jeffersonville and Evansville provide services on an areawide basis.

APPENDIX VIII

Programming the use of federal funds has been difficult at times. During the period covered by this Report, it has not been uncommon for Congress to appropriate funds as late as the third quarter of the fiscal year in which we were operating. Substantial increases in funds coming late in the fiscal year are most difficult to use wisely and effectively. It is pointed out in the report that Indiana has generally not spent all of the federal grant funds. It is stated further that for a six-year period ending in fiscal year 1973, Indiana failed to use about $1,348,000 of such funds. This would average out at approximately $225,000 per year which would not be surprising since departments of government are prevented from committing money which is not in hand.

APPENDIX IX

THE SECRETARY FOR HUMAN RESOURCES
COMMONWEALTH OF KENTUCKY
FRANKFORT 40601

June 4, 1975

Mr. Gregory J. Ahart, Director
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

In response to your letter of April 28, 1975, I would like to express my thanks for being contacted to comment upon your findings. In the following statements I shall indicate why many of the General Accounting Office's conclusions regarding the use of Federal formula grant funds (314d and Title V of the Social Security Act) in the state of Kentucky are unfounded and erroneous.

First, my principal objection is that this report was for the period ending June 30, 1973. The state reorganization of semiautonomous agencies had not yet occurred. During the time covered by the report, the appropriate departments of state government were organized separately as the Department of Health, Department of Mental Health, the Commission on Handicapped Children, and the Kentucky Commission on Aging. Currently, all of these former agencies are now a part of the Kentucky Department of Human Resources. Programmatically, the Bureau for Health Services includes three of the former departments--Health, Mental Health, and Handicapped Children--while Budgets and Accounts and Grants Management are a part of the Bureau for Administration and Operations. Thus, the organizational and administrative frames of reference are completely different now as compared to when the GAO report was written.

Second, our initial reactions to the overall GAO report were that it does not seem to follow the usual format for a professional audit report. The informal and often repetitious nature of the language, the unsupported allegations and the attribution of remarks to such unidentified personnel as "a Kentucky State Official" or "State Health Agency Personnel" do not reflect what one would generally expect in the way of the professional quality of a General Accounting Office Audit Report. Indeed, it might appear that the charge given to the investigators had set the tone of the report before it was ascertained whether or not the facts of the matter were correct.

Third, in 1972 the Department of Health, Education, and Welfare changed its format for reporting on 314d. The agency moved to a checklist type report and plan from its earlier format which required a narrative program description and delineation of priorities. Even so, our fund allocations continued to be representative of program priorities. This checklist served to discourage the states from formulating conclusive narrative program plans and would undoubtedly result in some poor communications between management and program operation.

GAO note: Page references in this appendix refer to the draft report and do not necessarily agree with the page numbers in the final report.

Fourth, with respect to the comments on page 24, the Mental Health Department did exercise review of prior year operations and restructuring of priorities before new year funds were programmed. We are not aware that any funds were allocated by the Budgets and Accounts people for administrative convenience. Further, the Mental Health Department had a complete inventory of most social services and mental health services available at the community level.

Fifth, it is interesting to note that for a year or so prior to the completion of this report, the Health Department had engaged in an intensive exercise with all its mid-level and top-level management in the initiation and implementation of a complete system of Management by Objectives (MBO). This took the better part of a year and included training throughout the central office of the Department as well as within each local health department and district health department throughout the state. Careful attention was given to program priorities and every effort was made to build in factors which would later enable program measurement and evaluation to take place. Since part of this exercise was concurrent with the last stages of report preparation by GAO, it is interesting that no mention of this occurs in the GAO report.

Sixth, page 52 makes allegations concerning the lack of case findings with respect to the Handicapped Childrens Program. For the past two years, this program has exceeded estimated budgetary levels by an average of $500,000 per year; however, it still served over 14,000 children in 1974. The tremendous expense of many elements of service within the program structure (burn surgery, scoliosis, orthopedic surgery for birth defects and the like), limitations of funds, and inflation point up the fact that our roles of children needing service almost always exceed the availability of the service so that case finding is indeed a minor problem. While it is true that major clinics are either in Louisville or Lexington because of their availability to the State's medical centers together with the specialists in practice and their excellently equipped hospital facilities including expensive and sophisticated medical equipment, we are constantly attempting to establish more outreach clinics in communities as our medical specialty population decentralizes. The problem of eligible patients (for Medicaid) in the Handicapped Children's Program has been alleviated with the advent of the central Bureau for Administration and Operations. The ascertainment of eligibility upon referral is almost a routine matter.

Seventh, page 44 offers a very good example of the use of erroneous figures. GAO states that to identify a new case of diabetes, the costs were $19,701 for people under 24; $2,800 for people under 40; and $365 for those over 40; whereas, our figures indicate that the cost is $3,600, $2,900, and $150 respectively.

Eighth, with respect to the conclusions reached on page 55 of the GAO report, almost without exception the so-called basic program weaknesses were either exaggerated before or have been dealt with in the new organizational structure of the Department for Human Resources. We currently have a formal division in the Bureau for Administration and Operations which concerns

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itself not only with the statistical data base of the Department, but also with the monitoring of program administration. The Department operates a complex program budgeting system, including the allocation of resources to the program and sub-program levels, as well as accountability by cost center for the expenditure of these resources. All third party reimbursement sources are utilized as effectively as possible even to the extent that we currently are experiencing cash flow problems because Federal agencies have not allocated funds in sufficient quantities to permit us to draw down in sufficient levels to meet current obligations.

Ninth, it would appear that the draft is weak and unconclusive. We would be happy to meet with any members of the GAO staff in order to realign the facts or to demonstrate such remedial actions as may have been initiated in those areas of deficiency. We would further request that at such time as this report is brought to the attention of the appropriate committee of Congress that we be allowed the courtesy of either an appearance in person to deal with the allegations and alleged abuses noted herein or that a copy of our response be made a matter of record in addition to its possible inclusion by means of modification or revision to the final GAO report.

It is imperative to remember that when the GAO audit was conducted for FY '73, Kentucky had not undergone its state reorganization. The Federal monies were being utilized by diverse, semiautonomous agencies that had neither uniform, standardized procedures nor programs. Most of the problem areas have been eliminated since the Department for Human Resources was created by the reorganization effort.

In order to offer a balanced view of how the problems are perceived differently at the Federal and State levels, it would be desirable to attach a copy of the three sample states' responses to the GAO final report. As per a telephone conversation with Mr. Willis Elmore, he stated to one of my staff members that this would be done. This should be quite helpful in clarifying the report.

I believe you will find that the following responses deal with the major criticisms in the report. If any further clarification is needed, please feel free to contact me.

Sincerely,

C. Leslie Dawson

CLD:wam

APPENDIX X

N. H. DYER, M.D., M.P.H.
STATE DIRECTOR OF HEALTH

State of West Virginia
DEPARTMENT OF HEALTH
CHARLESTON 25305

May 27, 1975

Mr. Gregory J. Ahart, Director
Manpower and Welfare Division
United States General Accounting Office
Washington, D. C. 20548

Dear Mr. Ahart:

With your letter of April 28, 1975, you sent me segments of a draft report to the Congress of a review of the use of Federal formula grants by selected states.

I have reviewed this report and also made it available to the program directors in the West Virginia State Department of Health responsible for utilization of Title V and 314(d) funds. Following their review, I received from them written reports relative to their reactions to the general and specific program comments. From this broad review I wish to present the following comments:

(1) It was the consensus that the West Virginia State Department of Health could develop more effective solutions to citizens' needs for public health services and develop means for measuring effectiveness of existing public health programs if more adequate appropriations were made available plus the availability of proficient manpower. A positive step in this direction has already been taken with the recent development of a Cooperative Health Statistics System Unit within the Division of Vital Statistics. This system is part of a new national program launched by the National Center for Health Statistics within the Federal Department of Health, Education, and Welfare. We recently reported to the Advisory Commission on Intergovernmental Relations, to one question in their detailed questionnaire relating to 314(d), that if the funding level for the grant were greatly increased, a more sophisticated section of planning, evaluation, and research would be developed to provide a systematic and continuous planning process.

GAO note: Page references in this appendix refer to the draft report and do not necessarily agree with the page numbers in the final report.

(2) There was unanimous group reaction to the GAO report that the broad statements of criticism relating to the lack of a systematic or continuing planning process were, for the most part, unwarranted. All of the State's fifty-five county health departments present to the State Department of Health an annual plan and annual progress report. This is one criteria as to eligibility for State aid. While 314(d) provides 70% ($576,000) for local health services, the West Virginia State Legislature provides an annual appropriation of $1,500,000 for distribution to county health departments by formula. This is an approximate ratio of 3 to 1.

It is from the local reports and the State level plan that we present our annual budget and plan to the State Legislature (see Exhibit A attached). This is a copy of the Department's budget summary and justification for fiscal year 1976. We are required to show the State Legislature how Federal funds are used as well as the matching requirements. On page four of Exhibit A are specific public health needs as reflected by the total planning process. This is a realistic request represented in dollars as 26.6%. Copies of this report were furnished the State Comprehensive Health Planning Agency for their review and comments. They were given an opportunity for input. (Draft reference--Page 21.)

(3) The Nation-wide public health program received a great stimulus in 1935 with the passage of Titles V and VI of the Social Security Act. Under this Act general health grants, which support basic State and local public health services were inaugurated in fiscal year 1936. A Federal-State partnership developed and in 1950 eight PHS categorical grants were made available to West Virginia totaling $747,419. In that same year State funds amounted to $796,994. (See Exhibit B attached.) During the next twenty-five years (1950-1975) State appropriations for public health increased 551%, an average of 22% a year. The categorical grants, merged into a block grant in 1966, increased ten percent, or an annual average increase of .04%.

The GAO review stated that funds were used for the same programs year after year. Since funding for the proposed "Partnership for

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Health" was never realized, it has been necessary to turn to State funds for new and expanded programs with a continuation of the 314(d) to support these services. In fiscal year 1975 more than one-half of the block grant supports such basic ongoing programs as Environmental Health; Hygienic Laboratory; Public Health Nursing; and, Tuberculosis Control.

(4) Funds for MCH Programs represent 81.7% of the total of the two sources of funds involved in fiscal year 1975. The following sources of Federal funds were available:

FISCAL YEAR 1975

Maternal and Child Health

Fund A	$ 667,800	
Fund B	1,222,400	
Mental Retardation	190,244	
Family Planning	1,056,356	
Maternity & Infant Care	548,660	
Sub Total	$3,685,460	(81.7%)
Public Health Service		
Block Grant	823,100	(18.3%)
GRAND TOTAL	$4,508,560	

There is a table in the GAO draft report identified as APPENDIX VI, titled "Funding of Maternal and Child Health--Fiscal Year 1973." The total of the column captioned "Federal" is shown as $618,388. The only reference to this table is the first sentence on page 49 of the report which states "The Federal grant to support MCH activities in West Virginia during fiscal year 1973 was about $618,400. Federal funds for "MCH activities" have never been this small in years. Is the reference to Fund A or Fund B? This needs clarification.

We find the need for further clarification in other MCH comments. On page 21 of the report is this statement:

"Adequate plans for the program of maternal and child health projects had not been developed."

On page 29 is the following statement:

"At the time of our review only one State, West Virginia, had a firm plan to establish programs to provide the required five services."

Due to the diverse nature of the many programs within the Department's Division of Maternal and Child Health, we do not feel that the report adequately reflects the many services the citizens of West Virginia are receiving. For that reason I have selected the reaction report prepared by Dr. Jack Basman, Director, Division of Maternal and Child Health, to be made a part of this report. It is attached and identified as Exhibit C.

We appreciate having the opportunity to review your draft report and furnish our comments. If you should desire additional information, please let us know.

Sincerely yours,

N. H. Dyer, M. D., M. P. H.
State Director of Health

NHD:jh

GAO note: Due to their length, the exhibits attached to this letter were not included in this report. They were

--fiscal year 1976 State Health Department budget request,

--historical comparison of State health appropriation increases and the Federal contribution, and

--detailed MCH division comments on our draft report.

PRINCIPAL HEW OFFICIALS RESPONSIBLE FOR ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
David Mathews	Aug. 1975	Present
Caspar W. Weinberger	Feb. 1973	Aug. 1975
Frank C. Carlucci (acting)	Jan. 1973	Feb. 1973
Elliot L. Richardson	June 1970	Jan. 1973
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
John W. Gardner	Aug. 1965	Mar. 1968
ASSISTANT SECRETARY FOR HEALTH:		
Theodore Cooper	May 1975	Present
Theodore Cooper (acting)	Feb. 1975	Apr. 1975
Charles C. Edwards	Mar. 1973	Jan. 1975
Richard L. Seggel (acting)	Dec. 1972	Mar. 1973
Merlin K. DuVal, Jr.	July 1971	Dec. 1972
Roger O. Egeberg	July 1969	June 1971
Philip R. Lee	Nov. 1965	Jan. 1969
ADMINISTRATOR, HEALTH SERVICE AND MENTAL HEALTH ADMINISTRATION (note a):		
Harold O. Buzzell	May 1973	June 1973
David J. Sencer (acting)	Jan. 1973	May 1973
Vernon E. Wilson	May 1970	Dec. 1972
Joseph T. English	Jan. 1969	May 1970
Irving Lewis (acting)	Sept. 1968	Jan. 1969
Robert Q. Marston	Apr. 1968	Sept. 1968
ADMINISTRATOR, HEALTH SERVICES ADMINISTRATION:		
Robert Van Hoek (acting)	Feb. 1975	Present
Harold O. Buzzell	July 1973	Jan. 1975

[a]Effective July 1, 1973, the Health Services and Mental Health Administration was abolished and the Public Health Service was reorganized into six health agencies under the direction and control of the Assistant Secretary for Health. Most Health Services and Mental Health Administration functions were transferred to four new agencies: the Center for Disease Control; the Health Resources Administration; the Health Services Administration; and the Alcohol, Drug Abuse, and Mental Health Administration.

	Tenure of office	
	From	To
REGIONAL HEALTH ADMINISTRATORS:		
REGION III:		
George C. Gardiner	Apr. 1974	Present
George C. Gardiner (acting)	Apr. 1973	Mar. 1974
Eric Farig (interim)	Sept. 1971	Mar. 1973
REGION IV:		
George A. Reich	Mar. 1974	Present
Eddie J. Sessions (acting)	Sept. 1972	Mar. 1974
Emil E. Palmquist	Apr. 1970	Aug. 1972
REGION V:		
E. Frank Ellis	Dec. 1971	Present

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