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STATEMENT OF
GREGORY J. AHART, DIRECTOR, HUMAN RESOURCES DIVISION
BEFORE THE
COMMITTEE ON FINANCE
UNITED STATES SENATE
ON
ADMINISTRATION SPENDING REDUCTION PROPOSALS AND REPEAL
OF TITLE V OF THE SOCIAL SECURITY ACT

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Mr. Chairman and Members of the Committee, we are pleased to be here today to discuss the need to improve the Maternal and Child Health (MCH) program and to consolidate and better coordinate like or similar programs aimed at mothers, infants, and children. Also, we would like to offer our observations on the Administration's proposals to consolidate several categorical health programs, including those related to maternal and child health, into block grants to the States.

Further, on a separate but related matter, we have been asked to present our views on the Administration's proposal to limit or "cap" Federal contributions to State operated Medicaid programs and, at the same time, to modify Federal requirements to provide States with more flexibility in managing programs. Although some of the details of the proposal are vague, our initial analysis indicates that valid arguments have been made on both sides of this issue.

With respect to possible modifications to existing Federal requirements, we are currently developing an inventory of instances over the past 5 years where States have attempted to introduce cost-saving initiatives to their programs but where such efforts have been blocked as being inconsistent with Federal requirements. We plan to provide this material to the Committee.

Getting back to Maternal and Child Health, during the past several years, we have issued several reports on Federal programs providing health and health-related services to mothers, infants, and children. Today, we would like to discuss a number of these reports, but focus on our January 21, 1980, report to the Congress on improving Federal efforts to reduce infant mortality.

Reducing infant mortality, promoting the health of mothers and children, and locating and treating crippled children or children who suffer from conditions leading to crippling are the major objectives of the Maternal and Child Health program authorized by title V of the Social Security Act. With fiscal year 1980 funding of over $375 million, MCH is the major Federal health program aimed specifically at mothers, infants, and children and at reducing infant mortality.

RECOMMENDATIONS FOR IMPROVING FEDERAL AND STATE EFFORTS

Our January report contained several recommendations to the Congress and to the Department of Health and Human Services (HHS) aimed at achieving (1) a more organized and systematic effort at Federal, State, and local levels, (2) greater flexibility at the State and local levels to match resources with needs, (3) better cooperation between public and private health care sectors, (4) more accountability for use of Federal funds, and (5) better program monitoring and evaluation. Many of our recommendations are supportive of the concept of block grants and should be useful to the Congress in considering the Administration's proposals.

For example, our major recommendations to the Congress were:

1. Over the long run consolidate Federal programs funding similar types of activities, directed principally toward health care for women, infants, or children, into one MCH program. We identified the MCH, Family Planning, Adolescent Pregnancy, Sudden Infant Death Syndrome, and genetic disease

screening and counseling programs as candidates for such a consolidation. Our recently completed review of the Sudden Infant Death Syndrome program reaffirmed our view that this program should be consolidated with the MCH program, and our February 6, 1981, report recommended that the Congress direct such a consolidation.

2. In those cases where consolidation is not feasible or might take a long time to accomplish, require the administering agencies at the Federal, State, and local levels to coordinate their activities. We specifically identified the Special Supplemental Food Program for Women, Infants, and Children (WIC) as falling into this category.
3. Revitalize the MCH program by: strengthening the management role and ability of State MCH agencies; giving States more flexibility consistent with national policy, goals, or guidelines in using MCH funds; and directing HHS to monitor more closely MCH activities and use of funds and to take corrective action when State MCH agencies are not complying with requirements or making satisfactory progress toward achieving program goals.

Similarly, our recommendations to HHS for improving its and the States' management of maternal and child health efforts are also generally in-line with the block grant concept. They

do, however, call for somewhat more accountability and Federal oversight than the Administration's proposals envision. Nonetheless, we believe that this is not inconsistent with the notion of giving States more latitude and flexibility in using Federal funds to meet broad national objectives for reducing infant mortality and improving the health of mothers and children.

We recommended, in part, that HHS:

--Designate someone to be responsible for coordinating its various programs related to maternal and child health,

--Formulate national goals in the maternal and child health area,

--More systematically use categorical programs to help States match available Federal resources with unmet need in accordance with State priorities, and

--More closely monitor State progress in meeting national objectives, giving assistance to those States not progressing satisfactorily.

At the State level, we believe a comprehensive, multiyear, statewide maternal and child health plan is needed. The purpose of such a plan would not be to satisfy a Federal requirement, but would be to stimulate the development of a working document that could be used to allocate funds and measure progress. Also, we believe that the States should

be more aggressive in promoting the concept of regionalized perinatal care. This concept is aimed at improving the quality and reducing the cost of medical care by providing the most appropriate level of care to mothers and infants.

Two of our major findings prompted these and other recommendations. First was the fragmented and unwieldly mechanisms of care for mothers, infants, and children that evolved over the years as related but separate Federal programs were established. Second was the inability of the MCH program at the Federal and State levels to deal with this fragmentation.

NEED FOR A BETTER PLANNED, MORE SYSTEMATIC APPROACH

Since establishing the MCH program in 1935, many other programs have been created that provide access to the same or related types of services or activities funded by MCH. These programs include, but are not limited to, Medicaid, including Early and Periodic Screening, Diagnosis, and Treatment; Community Health Centers; National Health Service Corps; Family Planning; and Special Supplemental Food. For the most part, these programs have been administered independently and frequently without coordination with the MCH program at the Federal, State, or local levels.

Some of the consequences of this fragmentation were:

--Persons living in many areas did not have ready access to or had difficulty obtaining health or related services that could help reduce infant mortality, while some areas had a variety of federally funded health care services.

--Pregnant women and infants in some areas received supplemental food under the WIC program but did not receive health care services, and persons in other areas received health care services but not supplemental foods even though WIC's authorizing legislation requires WIC and health care services to be linked.

--Efforts between the public and private health care sectors were often not coordinated or were duplicated.

--Health planning activities affecting mothers and infants were fragmented, not coordinated, or duplicated.

State MCH agencies have generally been unable to overcome the problems resulting from this fragmentation for several reasons, including restrictive Federal requirements and lack of commitment or support at the Federal and State levels.

MCH PROGRAM HAS NOT MET EXPECTATIONS

Historically, MCH funds have enabled States to extend health services to women, infants, and children in urban and rural areas and to improve the management and promotion of MCH activities. However, MCH funds have not been sufficient to enable States to extend services to all those in need or to extend services to the extent envisioned in authorizing legislation or program regulations. In addition, State MCH agencies have had only limited effectiveness in their intended role as a planner, coordinator, overseer, evaluator, or focal point for MCH activities.

Use of MCH funding needs reassessment

MCH authorizing legislation provides that States strive to extend services to improve pregnancy outcome for mothers and infants statewide. However, States have been unable to extend such services to all areas or to all women and infants in need. In addition to limited funding, the factors that have contributed to this situation were (1) the variety of activities that compete for use of MCH funds (such as in-hospital care for mothers, infants, or children, well-baby care, prenatal care, dental care, and family planning) and (2) Federal requirements that States--using MCH funds--continue to fund a series of activities referred to as the "program of projects."

States must have a program of projects in each of five areas--maternity and infant care, infant intensive care, family planning, health services for children and youth, and dental health for children. Although States use a substantial portion--about 54 percent--of their Federal MCH formula grant funds for program of project activities, these projects serve relatively few communities. For example, 30 States reported having only one maternity and infant care project and, in the aggregate, States report that maternity and infant care projects serve only about 240 of the 3,100 counties in the Nation.

We believe that the Congress needs to reassess the way MCH funds are to be used, including the program of projects concept, in view of the other programs that have emerged. We believe that State MCH agencies should develop comprehensive plans for improving pregnancy outcome and using MCH funds. These plans should

--identify and prioritize unmet needs;

--identify available resources, including other Federal project grant programs, and the ability or inability of these resources to meet unmet needs; and

--describe how MCH funds will be used to fill gaps which cannot be met through other programs because of insufficient funds, lack of an area's eligibility for such programs, or other reasons.

MCH management needs improvement

MCH authorizing legislation and/or HHS regulations provide that State MCH agencies are to plan, coordinate, and promote maternal and infant care services and serve as a focal point for developing and implementing comprehensive statewide or regional systems of care for mothers and infants. For the most part, State MCH agencies have not fulfilled their intended role as a focal point for improved management of MCH activities. This has contributed to slow progress in developing and implementing comprehensive statewide or regional systems of care for mothers and infants. For example, none of the States we

visited had current, comprehensive, or action-oriented plans for reducing infant mortality.

State MCH agencies in some cases have not served or have not been able to serve as a focal point for improving pregnancy outcome for several reasons. These include their failure to have assumed or been given this role in their States, their heavy emphasis on service delivery, and the little emphasis given to the MCH program by HHS for several years.

One of the major reasons State agencies have been unable to serve as a focal point is that HHS bypasses State MCH agencies and awards project grants directly to private organizations. State MCH agencies we visited usually had little or no information on or influence over project grants--such as for Community Health Centers--made by HHS directly to local organizations. It is unrealistic to expect State MCH agencies to plan, develop, or promote an integrated system of care for mothers, infants, and children without some input into the planning, placement, and operation of such projects.

An even more fundamental problem, however, has been the lack of commitment and attention by HHS during much of the 1970s to meeting the objectives of the MCH program. The need for better management, including improved planning, of maternal and child health activities at the Federal and State levels was stressed by representatives from several organizations in connection with June 30, 1980, oversight hearings by the Subcommittee on Child and Human Development, Senate Committee on Labor and Human Resources. These organizations included

the American Academy of Pediatrics, the American Association of State and Territorial Health Officers, and the March of Dimes Birth Defects Foundation.

COMMENTS ON BLOCK GRANT PROPOSALS

Our testimony today is based on our quick analysis of the preliminary Administration proposals for repealing title V and creating block grants. We will be pleased to provide the Committee with additional comments after we have had a chance to more fully evaluate the Administration's final proposals.

We endorse the concepts of (1) consolidating separate categorical programs having related objectives and serving similar target populations, (2) placing management responsibility for similar programs in the same agency, (3) giving the States greater flexibility to match resources with needs and priorities, and (4) resolving the problems frequently created when Federal project grants are awarded directly to local organizations, bypassing relevant State agencies. Our recent reports on infant mortality and Sudden Infant Death Syndrome clearly illustrate the need for these actions as do several other GAO reports, such as our January 1977 report on Federal efforts to help mentally disabled persons return to communities from institutions.

While we have not had sufficient time to fully evaluate the Administration's specific proposals for establishing block grants, we have several observations and comments that we believe the Congress needs to consider in its deliberations. These relate primarily to (1) the need to group MCH programs together in the same block grant, (2) the relationship between

programs designated for health block grants and other programs, and (3) lessons that should be learned from previous consolidation efforts, including the need for accountability at the Federal and State levels.

<u>Need to group MCH programs together</u>

The Administration proposes to place several of the programs which generally address the objectives of title V into three block grants to the States rather than one. These are:

--Health Service

MCH

Hemophilia

Sudden Infant Death Syndrome

Supplemental Security Income/Disabled Children

--Preventive Health Service

Family Planning

Genetic Diseases

Lead-Based Paint Poisoning Prevention

Adolescent Health Services

--Social Services

Developmental Disabilities

The Congress and the Administration need to consider whether these HHS programs should be grouped into the same block grant.

These programs generally meet the criteria set forth by the Advisory Commission on Intergovernmental Relations 1/ for identifying the most likely candidates for consolidation. According to the Commission, programs to be merged should be, or be capable of being made:

--Closely related in terms of the functional area covered;

--Similar or identical with regard to their program objectives; and

--Linked to the same type of recipient governmental jurisdictions.

Several arguments can be made for consolidating programs addressing the objectives of title V. These arguments are generally consistent with the Commission's criteria set forth above as well as other criteria, such as strong and continuous congressional support, established by the Commission for the design and use of block grants.

First, these programs are generally aimed at the same target population and at the overall objectives of reducing infant mortality or morbidity, improving the health of mothers, infants, and children, or locating and treating crippled children.

1/A national bipartisan organization representing the executive and legislative branches of Federal, State, and local government and the public. It was created by the Congress to monitor the operation of the Federal system and to recommend improvements.

Separation of these programs has led to fragmentation of effort at Federal and State levels and has seriously impaired the ability of Federal and State agencies to develop and administer well-planned and organized efforts. These problems have been amply demonstrated in our October 1977 report on Federal and State efforts to prevent mental retardation and, again, our January 1980 report on Federal and State efforts to reduce infant mortality.

Second, the Federal Government has had a special interest in and focus on health care for mothers, infants, and children since 1912. This focus and interest developed because of particular problems these groups had, especially in low-income and rural areas, gaining access to health care and because of the variety of needs and organizations involved, including educational, health, nutritional, social services, and welfare. Although much progress has been made in reducing infant mortality and improving the health of mothers and children, these groups continue to experience access to care problems. Efforts to deal with these problems continue to be disorganized and fragmented among different programs and organizations.

Third, the structure of the MCH program already provides the basis for a block grant program. The bulk of MCH funding is distributed to the States through a formula grant. With some exceptions, it appears that the activities carried out under these separate programs are already authorized by the title V formula grant program. Accordingly, the authorizing

legislation for these programs could lapse and funding could be transferred to title V. Also, title V could be modified to eliminate those provisions which are considered too restrictive, such as the program of projects requirements, and to authorize any additional activities the Congress believes are desirable.

Fourth, States already have administrative units to plan, coordinate, manage, and evaluate State-based maternal and child health programs. Although these units have varied in the degree to which they have fulfilled their responsibilities, their capacities could be improved and they could either assume additional responsibilities for other programs or be merged into a larger organizational unit having responsibilities for basic health services. In several cases, State MCH agencies already administer several different Federal programs in the maternal and child health area, such as MCH, Sudden Infant Death Syndrome, Family Planning, Genetic Diseases, WIC, and Early and Periodic Screening, Diagnosis, and Treatment.

Relationship between programs designated for health block grants and other programs

The block grant proposals we have seen contain little information on the relationship of the block grants to other programs, such as WIC, Early and Periodic Screening, Diagnosis, and Treatment under Medicaid, or Education for All Handicapped Children. These are closely related to the health

programs slated for the block grants, particularly the MCH program. Both our January 1980 report on infant mortality and our February 1979 report on the WIC program identify the need for closer ties between WIC and health programs in a number of areas.

The December 1980 report of the Select Panel for the Promotion of Child Health, "Better Health for Our Children: A National Strategy," reaffirms the problems identified in our January 1975 report on Early and Periodic Screening, Diagnosis, and Treatment. We and the Panel reported on the failure of the program to reach a large segment of the target population. Major impediments to accomplishing program objectives have been the lack of organized, aggressive efforts to reach, screen, and followup on eligible children and lack of participation by physicians because of low Medicaid reimbursement rates or other factors.

Consolidation of at least the outreach and screening components of Early and Periodic Screening, Diagnosis, and Treatment and the MCH program, or a block of MCH programs, should enhance the effectiveness of both. Health departments have traditionally sponsored child screening programs. The additional funding and impetus of such a consolidation should put them in a position to improve and enlarge their efforts.

Lessons learned from previous GAO reviews

Many GAO reviews completed during the last several years on previous program consolidations or the programs slated for inclusion in block grants identified problems or cautions which we believe the Congress should consider in its deliberations on the Administration's block grant proposals. Some of these are that:

--All expected benefits may not materialize;

--Provisions for accountability are necessary;

--The proposed funding allocation formula may not accurately reflect need;

--States will need time to prepare for block grants; and

--A uniform definition of low-income among the health and social service blocks may be desirable.

Following is a discussion of these.

All expected benefits may not materialize

Conversion of Federal categorical programs into block grants may not always result in improved program management and funding allocations that better match needs and resources. For example, in our December 1975 report on how States plan and use formula grant funds for maternal and child health and comprehensive public health services (section 314(d) of the Public Health Service Act which consolidated 16 categorical programs), we stated that the three States we studied had

neither established adequate planning procedures to identify needs nor gathered sufficient data to establish priorities or measure program results. Also, the health services provided were fragmented and not well-managed. The same activities were continued each year, with little management review, while major unmet needs existed in many areas. Similar problems were reported in our January 1980 report on efforts to reduce infant mortality.

Need for accountability

Our studies have repeatedly shown that lack of focus and emphasis on maternal and child health at the Federal and State levels has resulted in diminished efforts; ineffectiveness; lack of meaningful planning, needs assessments, prioritization, coordination, and change; or lack of accountability. In our opinion, block grant programs must include provisions for ensuring accountability for proper use of Federal funds, achieving broad national objectives and priorities, and prohibiting substitution of Federal funds for State funds. We believe that such provisions are consistent with and should enhance the Administration's goals of (1) improving health service delivery effectiveness, (2) giving States greater control over resources, and (3) making more efficient use of resources.

Some of the accountability provisions we recommend are:

--Clearly stated Federal objectives and priorities, phrased in a manner so that results can be objectively measured.

--Preparation of a State plan setting forth needs, priorities, objectives, and intended use of funds.

--Periodic financial management monitoring and programmatic evaluation. Audit requirements should be in accordance with Office of Management and Budget circulars and "Standards For Audit of Governmental Organizations, Programs, Activities, & Functions."

--Reasonable State reporting on use of funds and accomplishment of Federal and State objectives.

--Maintenance of effort requirements with waiver authority to allow for bona fide State spending reductions.

Again, these provisions are consistent with the design features suggested by the Advisory Commission on Intergovernmental Relations for developing block grant legislation.

Current funding allocation may not reflect need or demand for services

The Advisory Commission on Intergovernmental Relations recommends that block grant funding be distributed to the States based on need. We understand that the Administration, after considering several alternatives, plans to allocate block grant funds based on the amount of funding currently being given to each State under the programs slated for block grants. However, current funding allocations may not accurately reflect need,

particularly with respect to project grant programs, such as Community Health Centers or Family Planning.

For example, Federal funds for Community Health Centers generally bypass State agencies and are awarded to private local organizations. Our recently completed review of this program, as well as some of the other programs proposed for consolidation, showed major problems in the mechanisms used to determine the need for program funds and location of projects.

In our view, States will need sufficient time to evaluate their needs and priorities in relation to the projects funded by HHS.

<u>States need time to gear-up for block grants</u>

States will need sufficient time to prepare for administering those aspects of block grants that they currently are not involved in. For example, our June 1972 report on the conversion of the MCH project grant program to formula grants pointed out that it took several years for the States to plan and prepare for the conversion.

Consolidating programs currently administered by State MCH agencies should not pose major startup problems for most States. However, transferring other programs to State control that HHS currently administers as project grants may be a different story. States will probably need sufficient time to prepare for administering funds from such project grant

programs as Community Health Centers and Migrant Health. This is particularly true in view of our findings that current funding allocations in the former program may not reflect need.

Need for uniform definition of low-income

The Administration's proposals for health, preventive health, and social services are aimed particularly at helping low-income persons. The Congress should specify a uniform definition of low-income persons applicable to the three different block grants. Lack of such a definition has resulted in inconsistencies and inequities among persons receiving family planning services under the MCH, title X Family Planning, and title XX Social Services programs. MCH and title XX Social Services programs permit, but do not require, collection of fees from persons with the ability to pay, while title X requires collection of fees from persons who are not from low-income families. These programs do not use the same definition of low-income families. Each program is designated to be included in a separate block grant under the Administration's proposals.

In summary, we believe that the Congress will need to provide for a special focus on maternal and child health and accountability requirements if it wants to ensure that the objectives of title V are effectively and efficiently met

nationwide under block grants. This concludes our statement. Mr. Chairman, we would be pleased to answer any questions you or other Members of the Committee may have.

SELECTED GAO AND OTHER REPORTS THAT MAY BE USEFUL TO THE COMMITTEE

GAO REPORTS

"Better Management and More Resources Needed to Strengthen Federal Efforts to Improve Pregnancy Outcome," (HRD-80-24, Jan. 21, 1980.)

"The Sudden Infant Death Syndrome Program Helps Families But Needs Improvement," (HRD-81-25, Feb. 6, 1981).

"Evaluating Benefits and Risks of Obstetric Practices--More Coordinated Federal and Private Efforts Needed," (HRD-79-85, Sept. 24, 1979).

Letter Report to the Director, Department of Human Resources, Government of the District of Columbia, on infant mortality problems in the District (Oct. 31, 1978).

"The Special Supplemental Food Program for Women, Infants, and Children (WIC)--How Can It Work Better?" (CED-79-55 Feb. 27, 1979).

"Preventing Mental Retardation--More Can Be Done," (HRD-77-37, Oct. 3, 1977).

"How Federal Developmental Disabilities Programs Are Working," (HRD-80-43, Feb. 20, 1980).

"HUD Not Fulfilling Responsibility to Eliminate Lead-Based Paint Hazard in Federal Housing," (CED-81-31, Dec. 16, 1980).

"State Programs For Delivering Title XX Social Services to Supplemental Security Income Beneficiaries Can Be Improved," (HRD-79-59, Apr. 11, 1979).

Federal Assistance System Should Be Changed to Permit Greater Involvement By State Legislatures," (GGD-81-3, Dec. 15, 1980).

"Proposed Changes in Federal Matching and Maintenance of Effort Requirements for State and Local Governments," (GGD-81-7, Dec. 23, 1980).

GAO REPORTS (Continued)

"Returning the Mentally Disabled to the Community: Government Needs To Do More," (HRD-76-152, Jan. 7, 1977).

"Administration of Federal Assistance Programs--A Case Study Showing Need for Additional Improvements," (HRD-76-91, July 28, 1976).

"How States Plan For And Use Federal Formula Grant Funds to Provide Health Services," (MWD-75-85, Dec. 9, 1975).

"Fundamental Changes Are Needed in Federal Assistance To State And Local Governments," (GGD-75-75, Aug. 19, 1975).

"Improvements Needed to Speed Implementation of Medicaid's Early and Periodic Screening, Diagnosis, and Treatment Program," (MWD-75-13, Jan. 9, 1975).

"Review of Selected Communicable Disease Control Efforts," (B-164031(2), June 10, 1974).

"Maternal and Child Health Programs Authorized by Title V, Social Security Act," (B-164031(3), June 23, 1972).

OTHER REPORTS

"Better Health For Our Children: A National Strategy, The Report of the Select Panel for the Promotion of Child Health: 1980" (DHHS (PHS) Publication No. 79-55071).

"Hearing Before the Subcommittee on Child and Human Development of the Committee on Labor and Human Resources, U. S. Senate, Oversight on Efforts to Reduce Infant Mortality and to Improve Pregnancy Outcome," June 30, 1980.

"Summary and Concluding Observations, The Intergovernmental Grant System: An Assessment and Proposed Policies," Advisory Commission on Intergovernmental Relations, June 1978.