States' Responses to Federal Health Care "Block Grants": The First Year

RANDALL R. BOVBJERG and
BARBARA A. DAVIS

The Urban Institute

THE REAGAN ADMINISTRATION'S VISION OF A "NEW Federalism" has included the creation of "block grants" as a means of transferring certain policy choices to the states. Approved in modified form by Congress in August 1981, and first available to states in federal fiscal year (FFY) 1982 (beginning October 1, 1981), the new blocks combined formerly categorical grant programs, simultaneously cutting federal support up to 25 percent and increasing state authority and flexibility to meet broadly defined public goals. Four of the nine blocks created in FFY 1982 consolidated health programs.

The study reported here examined the responses of 6 diverse states to the health blocks in the first year of implementation. Since the new health-block-grant structure did indeed streamline federal regulations and gave states new responsibility and freedom to allocate funds, many expected significant shifts. In the blocks' first year, however, states focused on the accompanying federal funding cuts rather than on their new flexibility, since their own fiscal problems have precluded state compensation for the reductions. Ironically, despite FFY 1982 federal cuts, state health administrators have managed largely to maintain services through use of unspent categorical funds left over from previous

Milbank Memorial Fund Quarterly/*Health and Society,* Vol. 61, No. 4, 1983

0160/1997/83/6104/0523-38 $01.00/0

years' grants (overlapping funds). Thus, few major spending adjustments were, at first, necessary. In general, early state adjustments to the new grants suggested more continuity than change.

However, in FFY 1983 and beyond states can be expected to exercise greater latitude, and altered programmatic structures and service patterns should result. The drawing down of the overlapping funds, continued state fiscal problems, and the planning of the use of block-grant flexibility during FFY 1982 should both force certain fiscal adjustments and permit measured programmatic changes consistent with established state priorities.

Changing Grants—The Federal Perspective

Previously, federal support for health programs took the form of categorical grants earmarked for specific purposes and subject to direct federal oversight. Maternal and child health grants date from the mid-1930s, but most were enacted in the 1960s and 1970s. Grants have gone primarily to state governments, which often pass the funds on to other levels of government or to independent entities. Some, however, have gone directly to independent projects or organizations, including local governments, community mental health centers (CMHCs), special maternal and child health projects, and community alcoholism centers. (The Advisory Commission on Intergovernmental Relations [1978: 5–9] presents a typology of categorical and block grants.)

The grants have served diverse purposes, including preserving the public health, funding medical care to specific populations (often income-tested), and developing particular kinds of medical services. Thus, the programs defy simple classification. The kind and scope of program that the grants have supported have varied dramatically by program area and by region. The extent to which each recipient program was dependent on the federal funds has also varied. For some well-established programs, such as the older maternal and child health programs, state funding outweighed federal. For some service providers, such as CMHCs, insurance and other collections (including Medicaid) provided far more revenue than federal categorical funding. Conversely, some programs or projects were almost completely reliant on federal support. Over 70 such grants were made in FFY 1981 (Advisory

Commission on Intergovernmental Relations 1982; Office of Management and Budget 1981).

The Reagan administration believes that decisions on such public services should be left to state and local governments (Reagan 1980: 2064; U.S. Congress 1981a: 26). As a step in this direction, the administration's FFY 1982 budget proposed combining 25 categorical health grants into two "blocks" to be awarded to states, and allowing considerable state discretion in the use and allocation of these funds. The blocks were to be funded at 75 percent of 1981 levels—in recognition both of the need for federal budget savings and of the potential for administrative savings—and allocated among the states in proportion to 1981 allocations of the former categorical grants. The 25 programs composing the blocks accounted for the most important programs and the lion's share of federal funds. Some had gone to the states, others to independent direct recipients, such as local governments and private, nonprofit organizations.

As these proposals entered public debate, predictions as to their impact varied greatly, but all sides believed that programmatic changes would result. Proponents argued that the block-grant mechanism would better serve local health needs, that states could eliminate service duplication and overlap, and that the funding reductions would be "offset by a decrease in administrative costs and by a more efficient delivery of services" (U.S. Congress. Senate. Committee on the Budget. 1981: 869). Block opponents noted that past block-grant experience showed that costs actually increased under decentralized administration and that, without federal programmatic requirements, states were likely to focus services to those groups with political clout, not necessarily those in need (Mott 1981; Coalition on Block Grants and Human Needs 1982: 2). Both sides agreed that significant programmatic changes would occur, albeit for different reasons and with different outcomes. Proponents argued that increased state flexibility to assert local priorities would indeed change programs, but for the better—to achieve greater efficiency and avoid adverse service effects. Opponents also expected big changes, but asserted that a 25 percent funding cut would simply require large reductions in services.

In the final statute, the Reagan administration accomplished much, though not all, of its agenda. Congress consolidated fewer categorical programs into a larger number of blocks, added more federal strings, and imposed lower spending cuts (U.S. Congress 1981). Congress

created 4 health blocks out of 21 programs, rather than 2 from 25 (table 1). (The precise number cited by different observers may vary depending on how "program" is defined.) One "block," Primary Health Care, covered only the Community Health Centers program and retained so many requirements that it remained essentially categorical (see also table 4 below).

Despite the congressional changes, the new block-grant policy indeed broadens the states' discretion and significantly reduces federal aid available for the health programs composing the blocks. Total FFY 1982 federal funds for these functions were initially cut 22 percent below FFY 1981 levels that, due partly to mid-year recisions, were already 9 percent below FFY 1980 (see table 2). Subsequent supplemental appropriations reduced the cut to 16 percent. Thus, through 1982 the average state or local program was coping with federal funding at only 84 percent of FFY 1980 levels—during a period of rapid health care price inflation. Over two years, preventive care suffered the most; maternal and child health and primary care suffered the least.

Changing Grants—The State Perspective

To assess the states' responses to their new authority, we undertook detailed case studies of 6 states during the first year of the new blocks, FFY 1982. Generally, we wished to determine whether, indeed, states enacted major changes in their operating procedures (as expected by both supporters and detractors of block granting) and to what extent economies to forestall service reductions were possible. We used an intensive case-study approach because site visits could supply both timely information on current developments and the program detail needed to assess the significance of policy changes. The states were specifically selected to include a diversity of their fiscal condition, geographic location, and political philosophy.

During the year, we visited California, Kentucky, Michigan, New York, Oregon, and Texas to interview government officials and other knowledgeable observers. Because the blocks were so new, and policy was still evolving, these personal interviews were the best source of information. We buttressed them with such documentary evidence as state budgets, agency spending data, and available plans and analyses.

Whenever possible, we attempted to collect spending levels, by block, for state fiscal years 1980, 1981, and 1982.

However, collection of any meaningful fiscal data proved difficult, hampering both analysis of trends within an individual state and cross-state comparisons. Actual expenditure figures were, of course, not yet available for FY 1982, and 1981 figures, though usually available, were not routinely reported compatibly with FY 1982 budget categories. Furthermore, states were uncertain of federal funding levels—recisions and continuing resolutions meant budgetary guesswork for most states in FFY 1982 and even General Fund estimates were made undependable by emergency reductions undertaken mid-year to offset deficits. As a consequence, budgeted expenditures for programs composing the blocks were frequently revised, often making it difficult, if not impossible, for analysts to maintain current figures and determine intra-state trends.

Comparison across states proved even more difficult. Differences in the state fiscal years varied the states' accounting relationship with the federal fiscal year, and variations in the timing of state block-grant assumption added further complications. Consequently, states received block-grant funding at different points in their different fiscal years; because states report expenditures on a state fiscal year basis, it was impossible to adjust for this variable impact. Meaningful expenditure analysis was simply not possible for this transition year.

As a consequence of the fiscal data problems, we relied heavily on the personal interviews to provide our information. We talked with officials from both the legislative and executive branches, seeking both those with budgetary involvement and those with program responsibilities, and representing both political and civil service appointments, to obtain overlapping perspectives and to verify information. We buttressed the interview data with information from the few available, secondary sources, including a U.S. General Accounting Office (GAO) survey of block-grant implementation developments (General Accounting Office 1982a).

Assumption of Administrative Responsibility

None of our 6 states seriously considered turning down the Maternal and Child Health (MCH), Preventive Health and Health Services (PHHS), and Alcohol, Drug Abuse, and Mental Health (ADM) blocks

TABLE 1
Federal Block-Grant Structure: Proposed versus Final Form

Two Blocks Proposed by the Administration	Old Categoricals	Four Blocks Enacted by Congress
Health services (15 programs)	Community health centers Primary care research and development[a]	1. Primary care (2 programs)
	Maternal and child health grants to states SSI disabled children's services Hemophilia Sudden infant death syndrome	2. Maternal and child health (7 programs, including 3 below)
	Home health services Emergency medical services	3. Preventive health and health services (8 programs, including 6 below)
	Community mental health centers Alcoholism project grants and contracts Alcoholism grants to states Drug abuse project grants and contracts Drug abuse grants and contracts Drug abuse grants to states	4. Alcohol, drug abuse, and mental health (5 programs)
	Migrant health Black lung services	*Not* consolidated—they remain categorical programs
	Family planning services Venereal disease control	

Preventive health (10 programs)	Lead paint poisoning	Also in Maternal and Child Health (no. 2)
	Genetic diseases	
	Adolescent health services	
	Hypertension	
	Health incentive grants (sect. 314[d])[b]	Also in Preventive (no. 3)
	Risk reduction/health education	
	Fluoridation	
	Rodent control	
Not consolidated	Rape crisis centers	

[a] The research and development program was dropped in favor of a transitional planning grant to states for FY 1982 only, which was never funded.
[b] Sect. 314(d) operated as a smaller block grant even before consolidation.
[c] Not funded in FFY 1981; originally created in 1980, outside the Public Health Service.
Source: Price 1981. The original administration proposal included 26 programs, but the immunization program was withdrawn from consolidation after the initial announcement. The number of categorical programs affected varies according to the definition of "program" used. The Office of Management and Budget (1981), for example, counts 28 categorical programs.

TABLE 2
Federal Block-Grant Spending versus Prior Categorical Spending

Block	FY 1980 Appropriations[a] (In millions)	FY 1981 Appropriations[b] (In millions)	FY 1980–81 Percentage Change	FY 1982 Appropriations[a,c] (In millions)	FY 1981–82 Percentage Change	FY 1980–82 Percentage Change
Preventive health	$ 169.9	$ 93.2	−45.1	$ 79.1	−15.1	−53.4
Alcohol, drug abuse, mental health	606.0	519.4	−14.3	428.1	−17.6	−29.4
Maternal and child health	432.8	454.4	+5.0	373.8	−17.6	−13.6
Primary care[d]	320.0	323.7	+1.1	281.2[d]	−13.1	−12.1
Total	1527.9	1390.7	−9.0	1162.1	−16.4	−23.9

[a] Price 1981 (updated by telephone).
[b] U.S. Department of Health and Human Services. Division of Health Budget Analysis, (7/82). Figures reflect midyear recisions in some cases.
[c] Office of Management and Budget 1982 (corroborated by the U.S. Department of Health and Human Services above). Figures reflect the Congressional Continuing Resolution, in absence of the final appropriations bill, and are significantly lower than the authorizations in the Omnibus Budget Reconciliation Act of 1981. Includes a supplemental appropriation made during the summer of 1982 for maternal and child health and primary care.
[d] The Primary Care "block" operated categorically until at least FFY 1983.

which became available to the states on October 1, 1981. The reason is simple: Unless a state accepted these blocks by October 1, 1982, the covered programs would have lapsed altogether. At the other extreme, by year's end no state had definite plans to assume the Primary Care (PC) block, which was not available until October 1, 1982, and could remain under federal categorical administration indefinitely. (In Kentucky, the governor sought funds to accept the PC block but was denied them by the legislature.) All 6 states studied thus accepted all 3 available health blocks during FFY 1982, although the time of assumption varied by state (see table 3). In no case did any state wait until the last available moment—October 1, 1982—to take over a block, but New York postponed assumption of 2 and California of all 3 until July 1, 1982.

In most cases, fiscal circumstances determined the timing of the states' acceptance of the blocks, but political factors also played a role. Texas and Kentucky, for example, accepted all 3 available grants as soon as possible. They wanted to acquire the block funding for immediate use (see the later discussion of overlapping funding) and to avoid having federal overseers deduct funds to pay for continuing, federal categorical administration. They also wanted to signal their political approval of the block-grant concept and devolution of program control to the state level. New York and California were far less satisfied with the blocks as implemented—and as funded. They delayed accepting the public health blocks until July, both to have more time for planning and to send the political message that the cuts were a federal, not a state, responsibility.

State Discretion, Regulations, and Red Tape

While the health-block grants greatly increased state discretion over federal funds, all contained significant allocative restrictions (see table 4). Virtually all state officials questioned noted that these restrictions required continued categorical treatment of much of the supposed "blocks." These requirements drew far more complaints than reporting, auditing, and other administrative rules. For example, the prohibition on using Emergency Medical Services money to buy equipment was a particularly sore point, since some states perceive equipment as the main program need. Most states also complained about the set-asides for hypertension and rape prevention that maintained these programs

TABLE 3
Dates On Which States Studied Accepted Block Administration

	California	Kentucky	Michigan	New York	Oregon	Texas
Alcohol, Drug Abuse, and Mental Health	July 1982	Oct. 1981	Oct. 1981	Oct. 1981	Oct. 1981	Oct. 1981
Maternal and Child Health	July 1982	Oct. 1981	Oct. 1981	July 1982	Oct. 1981	Oct. 1981
Preventive Health and Health Services	July 1982	Oct. 1981	Oct. 1981	July 1982	Oct. 1981	Oct. 1981
Primary Care	Unsure	No	No	No	No	Unsure

Source: State interviews.

TABLE 4
Extent of State Administrative Flexibility in Allocation of Block-Grant Funds

Block	Binding Constraints	Less Binding Constraints	Other Provisions
Alcohol, Drug Abuse, and Mental Health	• Mental Health vs. Substance Abuse funds to be split according to pre-block shares • Alcohol and drug programs each to get 35 percent of Substance Abuse "mini-block," with remaining 30 percent split at state discretion • Maximum 10 percent of funds for state administration • Minimum 20 percent in alcohol and drugs for prevention	• Community Mental Health Centers funded in 1980 and categorically eligible in block year to be funded unless Health and Human Services okays cutoff—but no minimum level is set • Maintenance of effort required	• Community Mental Health Center requirements reduced—e.g., inpatient mental health coverage no longer required • 7 percent of funds transferable to other health blocks • Reasonable evaluation criteria to be developed and independent state review undertaken of cutoffs of previously funded entities
Preventive Health and Health Services	• Hypertension function to be funded in 1982 at 75 percent of the 1981 level, lower thereafter • Emergency Medical Services spending only for planning and initiation of systems—not for cost of equipment or operation	• Emergency Medical Services projects funded in 1981 and categorically eligible in 1982 must be funded under block in 1982—but no minimum level is set • Maintenance of effort required	• 7 percent of funds transferable to other health blocks • Evaluation criteria and review of cutoffs required, as for Alcohol, Drug Abuse, and Mental Health

TABLE 4 (Continued)

Block	Binding Constraints	Less Binding Constraints	Other Provisions
Preventive Health and Health Services	• Rape prevention funding is earmarked not reallocable to other functions • Maximum 10 percent for state administration		
Maternal and Child Health	• ¾ state match required	• Based on prior allocations, "reasonable proportion" of funds must go to each function • "Substantial proportion" of funds must go to health services • "Special consideration" must be given to previously funded projects • Federal set-aside of 15 percent for FFY 1982 used to fund genetic diseased, hemophilia, research training, special projects of regional and national significance	• Funds non-transferable • No fees may be imposed on low-income beneficiaries; others permitted if adjusted for ability to pay

TABLE 4 (Continued)

Primary Care	• Funds can be used *only* to support Community Health Centers • For FFY 1983 (first block year), state must give all 1982 funded Community Health Centers same amount in 1983, unless Health and Human Services approves closing center, may fund other qualifying Community Health Centers with surplus funds • No federal funds may be used for program administration • For 1984, states may fund any qualifying Community Health Center • State must match federal funds (20 percent in 1983, 33⅓ percent in 1984)	• To extent practical, states not to disrupt existing provider-patient relations • States must assure that medically underserved areas continue to receive Community Health Center services	• To qualify as Community Health Center, center must meet same categorical requirements as before • States must provide for independent substantive state review of significant fund cuts on closing in 1984 • No authority to transfer funds to other blocks

Source: U.S. Congress 1981b; see also Price 1981.

as separate funding categories within the PHHS block. Given these restrictions, continued state use of old program categories is not surprising.

Other federal efforts to restrict state spending choices drew more mixed responses. For example, the ADM block required that alcoholism and drug abuse programs each receive at least 35 percent of the substance abuse funds, with the remaining 30 percent spent at state discretion. This formula altered funding from past practice and state preference in California, Kentucky, and New York. Furthermore, in Kentucky and New York, alcohol and drug administrators cited the 20 percent minimum for substance-abuse prevention (as opposed to treatment) as a significant budgetary influence that protected certain substance-abuse programs, mainly education. Yet, Oregon and Michigan thought the same provision virtually trivial given the elasticity of the federal rules and permissible interpretations. In short, not all federal requirements inhibited states equally.

The views by state officials of their flexibility under the blocks seem to have depended not only on federal restrictions, but also on state circumstances—whether existing state statutes and administrative procedures (as well as contracts with service providers) restricted budgetary authority and whether the person interviewed philosophically approved of prior categorical constraints. One official exulted that "the feds" had finally given his state all "green dollars," not blue and red and yellow ones, whereas others derided the programs as "blockagorical." In general, though, the 6 states liked the new arrangement's flexibility, but most felt it did not go far enough—and none felt that the flexibility could ever make up for the magnitude of funding cuts imposed.

Few interviewees cited major changes in administrative burdens from reductions in reporting and other "red tape" requirements, although most appreciated the minor relief obtained. In several instances, state administrative regulations (or state legislative reporting requirements imposed on state administrators) were as detailed as previous federal rules, if not more so, so that the new federal approach did not permit significant streamlining. In addition, some states reported that new administrative responsibility for formerly direct grantees occupied staff who might otherwise have been reassigned to nonblock-grant duties, offsetting possible savings. These views are consistent with Congressional Budget Office and General Accounting Office findings that administrative

costs under earlier block grants were roughly comparable to those for categorical administration (Congressional Budget Office 1981: A-54; General Accounting Office 1982b: 52–65). Other evidence on the expected magnitude of savings comes from negotiations between the states and the Reagan administration before the enactment of the blocks. The National Governors Association and the National Conference of State Legislatures offered to trade full flexibility and relaxed regulations for a 10 percent funding cut (Peterson 1982: 171). Apart from the cost issue, however, states are now free to choose their own methods of oversight, which they typically prefer, even if they are just as expensive as the previous federal methods. During the new blocks' first year, however, many state programs continued to apply earlier federal standards as a stop-gap measure. (See also General Accounting Office 1982a).

Finally, there were some state complaints about the vagueness of the loosened federal requirements. The states liked the ability to establish their own audit procedures without prior federal approval, for example, but were nervous that subsequent federal audits might, therefore, disallow some spending retroactively. On balance, considered independently from budget cuts and unpredictable federal appropriations, officials liked the blocks' regulatory changes.

Fiscal Impact

The cut in federal revenues accompanying the new block grants dominated initial reactions to the blocks by state officials. The states focused on the large reductions in federal support, nearly to the exclusion of the blocks' programmatic and regulatory changes. As recorded in table 2 above, federal FFY 1982 funding dropped 18 percent for ADM grants, 18 percent for MCH, and 15 percent for PHHS. The cuts differed somewhat from state to state and, as noted above, their full impact on individual states is difficult to assess; state accounting methods, fiscal years, and treatment of federal funds vary considerably, especially in reporting those federal funds carried forward from past years. Our 6 case-study states reported FFY 1982 federal revenue reductions ranging from 7 to 26 percent in nominal dollars (see table 5). These preliminary figures varied by state and by individual block grant, apparently reflecting different accounting as well as differential impact.

TABLE 5
Percent of Federal Aid Reductions, Preliminary Estimate by State for FY 1981–1982[a]

State	Alcohol, Drug Abuse, and Mental Health[b]	Maternal and Child Health	Preventive Health and Health Services
California	22	25	25
Kentucky	15	7	25
Michigan	16	17	25
New York	22	20	12
Oregon	Increase[c]	25[e]	26[e]
Texas	10	17	11
All United States[d]	21	24	12

[a] Estimates received during 1982 interviews, unless otherwise noted. States could only estimate federal grant receipts, given unpredictable federal budgeting through continuing resolutions. Supplemental federal appropriations not included.
[b] *Source*: U.S. Alcoholism, Drug Abuse and Mental Health Administration. Loss figures include direct grants in both 1981 and 1982.
[c] Due to two new Community Mental Health Centers receiving federal funding in FFY 1982.
[d] *Source*: Feder et al. 1982. Does not include supplemental appropriation for Maternal and Child Health in summer of 1982.
[e] *Source*: Oregon 1981: 8–9.

However, these FFY 1982 revenue reductions did not immediately translate into reduced spending at the program level, contrary to the expectations of both proponents and opponents of the blocks. This delay occurred because many programs still had available funds from earlier federal categorical grants which could be used along with block funds to support services during FFY 1982. These overlaps (see table 6) were a one-time phenomenon, since they occurred only as a result of the changeover from categorical to block funding. For the health blocks' initial year, at least, the overlaps typically offset most of the cuts and gave most of the health programs a cushion not often enjoyed by programs composed of blocks in other areas (Durman, Davis, and Bovbjerg 1982: 10). This unanticipated circumstance was a major influence on the behavior by the states in this first year.

Most health programs in the 6 states benefited to some degree from such one-time double funding. Hence, cuts in federally funded spending and in services could usually be postponed, most of them until the following year. However, the size of the double funding varied considerably by program and by state. Alcohol and drug abuse formula

TABLE 6
Types of Overlapping Federal Funding

Type	Explanation	Example
Forward-funding	One year's federal categorical grant supports a program whose budget period extends into future federal year(s).	California Emergency Medical Service programs funded through 1983 with FFY 1981 money.
Carry-over funds	Unexpended balances remain at the end of a program's budget period and may be spent in following period(s).	Kentucky Crippled Children's program carries forward unspent 1981 funds into 1982.
Fiscal-year overlap	Federal and state fiscal years overlap so that a state can choose to allocate federal funds from two fiscal years.	New York drug agency plans to use three quarters of both 1982 and 1983 blocks to fund one year's services in state FY 1982–1983.

grants for 1981, for instance, had been reduced two-thirds by mid-year recisions. In some instances, these programs nearly exhausted the one-time fiscal cushion in smoothing out that cut, leaving little to mitigate the block-related reductions in FFY 1982. Differences in the fiscal years of individual projects also had an impact: One project could be funded entirely during FFY 1982 from 1981 funds, another for only a month or not at all.

Generally, these funds were sufficient to support the former categorical status quo, postponing the block-grants' fiscal impact. State administrators often reallocated these overlapping funds among program areas to smooth out discrepancies in different programs' federal funding cycles and in some cases to assert new priorities (see reallocation section below). However, all program and budgetary managers were acutely aware that substantial cuts and realignments would be necessary beyond the first year. Overlapping funds merely bought time to make such changes.

The State Response

The new blocks gave states much greater authority over the content and conduct of federally assisted health programs as well as over their relative spending levels. Some block-grant proponents consequently expected the states' approaches to health programs to change markedly. New categories of programs, after all, could supplement or replace the old federal ones. Existing categories of programs could be realigned, streamlined, or consolidated. Programs could be reassigned to new overseeing agencies, and new budgeting and management systems could be adopted. States could adjust funding levels (from both state and federal sources) to conform to true state priorities by reallocating support for existing and new programs. Finally, new ways of defining, delivering, and financing services within each program became theoretically possible.

As a rule, such wholesale changes have not occurred nor yet appeared on state drawing boards. Most fiscal, administrative, and program shifts enacted in FFY 1982 and planned for the future reflect slight variations on past practices rather than significant departures. States seem most inclined to make changes where they are for the first time managing programs previously funded directly from Washington.

Overall Fiscal Response

Only rarely did states commit state General Fund revenues to make up any block-grant shortfalls. True, the one-time federal cushion mainly obviated the need for immediate state action; nonetheless, both legislative and executive branch sources in each of our 6 states were adamant that they could not and would not raise state spending on blocked programs, citing state fiscal problems or other priorities for state funds as their rationales. This "hard line" of nonreplacement prevailed regardless of the states' political philosophy and previous generosity toward human services.

Despite such a strongly articulated general policy, at least two states appropriated additional state funds for individual blocked health programs in FFY 1982, though the state appropriations occurred before the federal blocks were enacted and funded in their final form. Whether such additional funding indeed constitutes replacement or whether it simply buys new services is difficult to determine. Texas quadrupled its General Fund support for its alcoholism program, designating the new funding for community services. State officials call this a new program but, in fact, it strongly resembles the local alcoholism services formerly supported by lost federal funding. New York began a state-only hypertension program run separately from the federal aid, apparently in expectation of the federal cuts that did in fact occur, and also gave some additional aid to genetics programs. Though examples like these are rare, they suggest that a general policy of state nonreplacement does not necessarily apply to all programs, especially those with a high state priority.

A broader Urban Institute survey of 25 states found that, in FFY 1982, 4 replaced lost MCH funds, 3 PHHS funds, and 1 ADM funds. In contrast, 8 replaced lost federal funds under the Social Services block, which suffered a 20 percent cut and had no forward funding available (Peterson 1982: 178–82). An apparent state unwillingness to stand politically behind federal programs, lack of fiscal necessity (given the availability of overlapping funds), and the poor fiscal condition of many states have made nonreplacement the predominant state position.

States may change this nonreplacement policy in future years. Several hinted that once the federal government has taken the "blame" for the cuts, they might bail out priority programs and receive public credit for the rescue. However, greater *need* for state help seems a

more likely deciding factor; as overlapping funds expire and programs face drastic change, states may intervene with additional appropriations. The degree of future state replacement, though likely to exceed current levels, will vary depending on the extent of federal cuts, state program priorities, and state fiscal condition.

Administrative Responses

States have as yet made few changes in their administrative structures and practices in response to the blocks. Almost without exception, the block grants were simply accepted and administered within each state's existing administrative framework. Not surprisingly, continued use of previous state methods proved easiest for the programs states were already running themselves.

The transition to block funding for programs formerly run by non-state entities was also relatively straightforward where states had existing fiscal relations with the local governments or agencies involved. In Kentucky and Oregon, for instance, almost all public health services are provided at the county level. Even before the blocks, these states passed much categorical money on to counties. After the blocks, the states could easily pass through almost all of the consolidated federal grants for local distribution under existing procedures. Where the blocked programs were managed independently by various levels of government, there were understandably more implementation problems (at least from the state perspective), and more planning time and effort were needed.

The most difficult administrative shifts occurred where states began overseeing projects run by nongovernmental entities formerly funded directly by the federal categorical programs. Again, not surprisingly, such direct recipients probably suffered the most wrenching fiscal, as well as administrative, changes under the new, state block administration, precisely because there were no preexisting state-level structures or constituencies to ease the transition and preserve the direct recipients' funding.

New York's 26 formerly direct-recipient local alcoholism programs were an exception, since the state and the programs had cooperated voluntarily to coordinate the federal program with state planning and funding even before the block automatically rerouted all alcoholism funds through the state. (Even so, 2 of the 26 have been terminated

for FFY 1983 under state administration.) In most states the direct grantees operated outside the state-local service structure and, as administrative and allocative changes occur, will have the most trouble adapting, if indeed they remain in the program.

With respect to administrative procedures—such as contracting (or other methods of distributing program funds to ultimate recipients), budgeting processes, program monitoring, reporting, and audit requirements—states naturally tended to use their own preexisting practices but still incorporated some previous federal requirements. How much difference was made by changing over to state reporting standards depended, of course, on how different continuing state practice was from past, federal categorical practices. Some states continued federal reporting practices because of their perceived utility and through fear that such federal reporting requirements would ultimately be reinstated (or even requested retroactively).

Reactions differed across states and across programs. The Texas Department of Health, for example, retained its categorical reporting system, noting that with so many federal health grants still categorical, it made little sense to alter reporting methods solely for the blocked programs. Oregon reacted by greatly simplifying the requirements imposed on localities receiving federal health funds, effectively passing loosened federal requirements through to the local level. However, in New York, ADM administrators noted that state requirements had already been more thoroughgoing and sophisticated than the federal ones, so that shifting to the state administrative reporting system created no savings. Officials of New York's Department of Health (which administers the PHHS and MCH blocks) agreed, adding that *new* reporting demands made by the state legislature—partly for block-grant planning purposes and partly to assert the legislature's budgetary authority—also precluded administrative savings.

Again, the former direct grantees felt the most change, unless they were already part of an integrated state planning and budgeting system (as with many CMHCs and alcohol or drug projects). Sometimes, states had no reporting, auditing, and other such procedures for these entities, and adopted previous federal standards as an interim measure.

Redefinition or reorganization of the former federal categories would have represented the most significant type of administrative change resulting from block-grant implementation. Though earmarking requirements for hypertension and rape crisis programs, alcohol and

drug functions, existing CMHCs, and so on limited states' discretion in this regard (see table 4), it is nonetheless notable that states undertook very little in this respect. California and Oregon merged their MCH blocks' Supplemental Security Income-Disabled Children's (SSI-DC) funding into the larger, state-federal Crippled Children's Services programs. But SSI-DC had never really been run as independent state programs in these states; the funding had been small, wholly federal, and only intermittently available. Other than this, the only block-inspired reorganization of programs in FFY 1982 seemed to be New York's creation of several small but broadly targeted environmental monitoring and evaluation programs under the PHHS block. New York also reorganized some existing programs into larger categories and plans more consolidation for FFY 1983. (Several states were moving in FFY 1982 and 1983 to deemphasize or terminate some previous categorical programs. Such shifts really constitute fiscal reallocations among visiting programs and are considered in the next subsection.)

Several factors explain the lack of radical administrative change. First, states often had no time to make final plans for the blocks, since blocks were implemented so soon after enactment. Second, they were preoccupied with larger and more pressing problems, such as budget deficits and Medicaid regulatory changes. Furthermore, federal signals about the extent of state discretion were not always clear. The regulations were not final as the blocks began, and the very structure of the federal blocks was expected to change further, especially after the president's FFY 1983 budget proposals for further realignments were announced early in calendar 1982. Federal health aid in most of the covered areas is also only a part of an often much larger state effort, and some state officials noted that changes in the federal tail were not going to wag their dog. Finally, many existing state health program categories evidently correspond to federal categories by choice, not by federal requirement. Many of the past categories, especially the older ones, were not created haphazardly but rather reflect long-standing social-political-medical thinking, influential at all levels of government. Scarce managerial talent was, therefore, not devoted to block-inspired reorganizations.

Slow, state governmental change would not surprise many students of political economy and public finance (e.g., Schick 1980; Wildavsky 1979), though block-grant proponents professed to expect rapid ad-

justment to the lessening of federal requirements. Our findings were also consistent with Greenberg's earlier empirical conclusions. Based on a 3 state study of responses to the Health Incentive block grants during 1966–75, Greenberg (1981: 178–80) concluded that this earlier blocking did not prompt changes in state program organization.

Detailed Fiscal Responses: Reallocation among Programs

The federal earmarkings and other restrictions already noted did clearly influence state spending of blocked funds, just as intended. Hypertension, rape crisis centers, and others were funded at the minimums required—but generally no higher. States also relied upon the 15 percent federal set-aside within MCH as virtually the exclusive source of funding for eligible programs, such as genetic disease projects and hemophilia centers.

Despite these federal mandates, the blocks provided significant opportunities for states to reallocate previously categorical federal aid. At the broadest level, states could move funds between blocks; up to 7 percent of the ADM or PHHS funds could be shifted to another health block. Such reallocations were rare. Only Oregon made such a shift: 7 percent of federal PHHS funds to MCH. Up to 10 percent of the Home Energy Assistance or Social Services block funds could also be shifted to health, among other areas. Shifts from energy to social services occurred in 5 of our 6 states. But only in Kentucky did a health block receive such funds: 1 percent of the energy grant was moved to PHHS.

Within a block, states had wide discretion to move funds among previous categorical programs or to create new programs altogether. But states were reluctant to alter the budgetary status quo. At the program level, almost no preexisting programs were ended or new programs begun in FFY 1982. Almost all programs, even formerly direct-grant programs, continued to be funded during this transitional year. Further, almost all ultimate recipients of program funds continued to be funded (MCH projects, CMHCs, community alcohol projects, etc.). We discovered only a few new programs that had been funded from a health block, within New York's PHHS block. One Kentucky interviewee remarked that starting new programs would have been inappropriate, since there was no new money to fund them.

With respect to the level of funding, as a matter of general policy

the states distributed FFY 1982 federal block-grant dollars on a pro rata basis to each former categorical program consolidated within the blocks. The definition of pro rata varied somewhat: Typically states apportioned the federal block revenues (after the cuts) according to each program's respective historical share of categorical federal funds. This practice hurt most those programs which were disproportionately reliant on federal rather than state or other revenues. Rarely, as in New York's drug program, both state and federal funds were considered together, and cuts were apportioned according to each program's historical share of all spending.

States engaged in this pro rata budgetary holding action just as they postponed administrative changes, and for much the same reasons (see discussion above). In addition, fiscal and budgetary concerns also worked to delay major reallocations among blocked programs. First, block budgeting could not claim full executive or legislative attention in autumn 1981. Many legislatures were out of session in August and September 1981 when the blocks were enacted and implemented, and in no case was there time for a normal budgeting cycle to set new blocked program priorities. (In Texas, the legislature actually enacted a pro rata distribution requirement during its regular Spring 1981 session, allowing no reallocations of the new funds until it could approve them itself during its next session, in early 1983.) Moreover, the much larger problems of General Fund revenue shortfalls and federal cuts in Medicaid and aid to families with dependent children (AFDC)—not blocks—dominated lawmakers' and administrators' agendas throughout this period. Finally, availability of overlapping categorical dollars allowed legislators and administrators to meet immediate needs without long-range reallocations.

The larger executive-legislative dispute over who should control federal funds complicated block budgeting in several states (see also Peterson 1982: 176–77), as did state uncertainty over the extent of block cuts; federal funding levels shifted repeatedly in a series of congressional continuing resolutions. Finally, most felt a general reluctance to make quick budget changes under their new authority that would establish precedents for future funding without due consideration.

These problems made it much more attractive to postpone lasting shifts until the next full, state budget cycle, when all concerned could reevaluate programs, with time for planning, public hearings, and

the like. In the meantime, pro rata allocations of funds (and cuts) were logical and seemed fair; they also avoided time-consuming and politically charged disputes over program changes.

Interestingly, states' allocations of *total* available federal funds (both blocked and overlapping) often departed from pro rata shares. Overlaps were considered "found" money and were not necessarily left in the program where they originated. Instead, states sometimes redeployed such funds across programs. For instance, overlapping funds from program A might be moved directly to program B or, alternatively, they might free up A's pro rata share of the block funds to be moved to B. The practical effect is the same in either case. Rarely, overlapping funds were used to mitigate the cuts pro rata across programs (as in the New York drug program). More commonly, they were targeted to especially needy or high-priority programs.

Examples help clarify these phenomena. The clearest reallocation within our 6 states occurred in California's MCH block. California finally accepted the block on July 1, 1982, the beginning of state FY 1983. Even as it mandated pro rata allocation of the blocked funds for 1983, the legislature approved the Department of Health Service's expansion of its federal perinatal program funding with $1.8 million in forward funding taken from the MCH staff program, Adolescent Pregnancy and SSI-DC. No MCH forward funding was left where it originated; almost half was reserved for future needs rather than appropriated for 1983. Other MCH programs, largely the federal categories that have not had state General Fund support, were allowed to absorb large reductions. Within the PHHS block, California similarly reallocated its double funding, though to a lesser extent.

Perhaps the most unusual use of double funding occurred in New York's drug program. To maintain previous funding levels for state FY 1983, which began six months into FFY 1982, New York borrowed both from the past (forward funding and carryover) and from the *future* (spending FFY 1983 block funds at an accelerated rate). This strategy exhausted the one-time overlap and most of the FFY 1983 funds, leaving a funding gap for state FY 1984, at least six months of which depend on FFY 1983 support. Over the short run, New York's drug program has maintained services, but the program planned to seek state replacement funds for state FY 1984.

Occasionally, amounts would be saved for future use past FFY 1982. California's legislature insisted upon maintaining such reserves to allow

it to consider state priorities more fully. The departments of health in Texas and New York similarly carried forward reserves, albeit in more modest amounts, past FFY 1982.

How states allocated FFY 1982 overlapping funds does tend to show that state priorities do often vary from past, federal categorical allocations, but its significance should not be overstated. Overlapping funds were seldom very large in relation to federal block funds—usually in the 5 to 20 percent range, although incomplete and widely divergent reporting makes precise estimates or comparisons impossible. Much overlapping funding was simply left where it originated and not reallocated. Moreover, the overlaps were a one-time phenomenon, and any reallocations seem to have been dominated by short-range concerns rather than long-run priorities. Many reallocations reflected only administrators' preferences and not final state budgetary decisions. For example, some administrative shifts were made simply to bring a program's previously different fiscal year into line with the state planning and budgeting cycle. Reallocations of overlapping funds did provide instructive hints about state priorities; but with or without any shifts of these funds, the overlaps served the more important function of buying time and postponing still larger changes.

One particular state "reallocative" strategy deserves special mention—that is, passing the decisions of which programs to fund on to the local level. At its most extreme, this strategy takes the form of virtual "mini-blocks" that pass the federal reductions and flexibility straight through to localities. Where most past, categorical federal aid to states had previously been passed through, these mini-blocks did not require even a change in administrative structure. For example, about half of New York's MCH block (with proportionate cuts) was rerouted directly to one major local services grantee in New York City (involving an umbrella nonprofit agency, not the city government, however). In such cases, local rather than state officials make the reallocative choices, and our study did not identify such decentralized decisions.

Other variants are shown by FFY 1983 planning for Oregon and Texas. In Oregon, most MCH and PHHS monies previously flowed to localities, albeit categorically. For 1983, mini-blocks are to continue this pass-through—only with lower funding and with less restrictive, very general program guidelines compared with earlier federal requirements. A large share of Texas PHHS funds is to be earmarked for local governments, but will be distributed on a project basis;

though funded projects will largely reflect local priorities, this mechanism is not quite as unrestrictive as the mini-block. But again, this strategy was easily implemented because a similar administrative procedure had previously been used to distribute federal Health Incentive grant funds to localities (so-called section 314(d)).

Though our study did not systematically cover state activities past the block grants' first year, preliminary state plans suggest that FFY 1983 federal funding allocations will differ more from historical patterns than did FFY 1982 allocations. The mini-blocks have just been mentioned. At the state level, considerably more programs or grantees within programs seem to be slated for termination or reallocation as states depart from pro rata funding to assert program priorities. However, considerable budgetary inertia—and the influence of interests supporting existing allocations—seems likely to inhibit widespread shifts. For example, for its FY 1983, Kentucky's Department of Health conducted an elaborate review of the value of all blocked programs and scored each for cost effectiveness. However, its final budget recommendations were far closer to historical patterns than to its rankings, resulting in much smaller actual reallocations than the planning process indicated originally.

Service Adjustments

For the reasons noted above, most programs' FFY 1982 net federal support did not reflect federal funding reductions, making service adjustments due to federal contraction uncommon. (Of course, even though almost all state interviewees noted that they had been able approximately to maintain 1981 levels of service, some adjustments did occur. Doubtless, from the perspective of a local program recipient, comparatively small shifts could loom considerably larger—as could the inability to expand services to meet increased demand for them during a recession.) However, General Fund cuts in some states hurt blocked programs, especially in states suffering serious fiscal stress (of our 6, Oregon and Michigan). Service adjustments made in response to these budget cuts suggest providers' responses to future drops in federal funds.

Where state cuts occurred, programs dependent on relatively large General Fund appropriations almost always absorbed major cuts. In Michigan and Oregon, these were largely in MCH and Alcoholism—

primarily treatment-related programs. (Of the large General Fund-reliant programs, only Crippled Children's Services managed to escape cuts applied to these programs as a whole. CCS is a priority program in most states.) This pattern is the reverse of the more predictable long-term result of federal block cuts—that programs disproportionately reliant on federal cuts will be hardest hit and face the greatest need to cut or adjust services.

At the program level, the strategies used to bring services into line with reduced budgets fell into these four general categories:

1. ADMINISTRATIVE AND SERVICE CONSOLIDATION. Oregon combined and reduced administrative staff for family planning and maternal and child health programs, while Michigan confined its administrative consolidation to regional substance abuse agencies. Service consolidation in these states involved closing clinics and treatment centers, typically ones in outlying, low-density communities, and serving the affected clients at the next-closest treatment agency. This centralization strategy can virtually eliminate service for certain geographic areas; depending upon whether clients can afford to travel, it may economize by cutting services rather than by delivering the same number more efficiently.
2. TARGETING TREATMENT SERVICES. When confronted with fiscal constraints, governments tend to focus their limited resources on core services, eliminating perceived "frills" (Wolman and Peterson 1981). In the health area, this becomes a "worst first" strategy that focuses on treatment services at the expense of early intervention, prevention, and education services. Michigan, Oregon, and Texas substance-abuse programs have pursued this strategy.
3. TARGETING CLIENTS. Though generally unwilling to deny care outright to particular types of clients (most states seem to have sliding fee scales in preference to absolute income tests for service eligibility), the programs under financial pressure have begun setting client priorities. Texas MCH programs, for example, now focus on children under age 4; Oregon targets its perinatal services to high-risk mothers. Oregon and Michigan give the chronic mentally ill priority over other clients seeking treatment.

   Where funding problems are severe and staff are limited, such client-targeting ultimately can make high-demand clinics or

centers able to serve only the top-priority clients while the lower-priority individuals may languish indefinitely on lengthening waiting lists. Thus far, fiscally pressed programs report longer client waits, although most claim to serve all in need eventually.

4. FEES AND THIRD-PARTY PAYMENTS. Virtually every one of the 6 states is moving to increase payments for services in many categories. Fee and reimbursement structures have long existed to recoup some of the costs of states' MCH care, crippled children's services, alcoholism, drug abuse, and mental health treatment programs. Fees usually vary with client income, and most states make at least a token effort to obtain third-party reimbursement where possible, often from Medicaid.

   Collections from Medicaid are particularly important to community mental health centers, alcoholism providers, and public health clinics providing MCH services. Thus, under budget pressure, these providers seek to maximize Medicaid payments—by helping eligible clients establish Medicaid eligibility, making sure all services covered are submitted for payment, etc. Over a longer period, state policy makers can opt to expand Medicaid coverage of services and beneficiaries to increase the share of costs for public health or mental health programs (where the federal contribution is fixed) that is borne by Medicaid (where it is open-ended) (Feder and Scanlon 1981). Among our states—in California, Michigan, and New York especially—broad Medicaid coverage had already accomplished such shifts to Medicaid before FFY 1982. (Reliance of other state programs on Medicaid payments is another reason such states were more concerned about federal Medicaid changes for FFY 1982 than about the block grants.) In such states as Texas, Medicaid coverage has long been tighter and cost-shifting less popular. In any event, with respect to the health-block programs, whatever level of cost-shifting states want seems to have been established before FFY 1982. No one interviewed thought that any changes in Medicaid coverage were prompted by health-block-grant cutbacks. To some degree, social services block cuts were mitigated by Medicaid changes, however (Durman, Davis, and Bovbjerg 1982).

   Though not all blocked programs in all states are experiencing fiscal pressure at present, the expectation of future shortfalls is sufficiently strong that all 6 states are working to raise fee and

reimbursement collections, and most are studying increases in fee levels as well.

Likely Future Adjustments

As we have seen, during the first year of the blocks, the 6 states we studied in depth typically maintained the categorical status quo. The preexisting categorical programs consolidated into the blocks at the federal level continued to function independently at the state level, normally using preblock program structures and administrative procedures. Almost without exception, no new state programs were begun or old ones terminated in FFY 1982. The new blocked funds have usually been distributed pro rata among previous categorical program recipients, even those not directly run by the states. Long-range reallocations and restructurings were usually postponed. Only small (if any) cuts occurred in actual 1982 program spending (block and carry-over combined), though these could be significant for particular small recipients of funds.

For FFY 1983 and beyond, however, we predict that far more realignments and service reductions will occur. Fiscal pressure, from continued state budgetary distress and exhaustion of carry-over funding, will make funding reductions necessary, just as many originally expected for FFY 1982. Current federal budgetary plans call for no increase in block revenues given to states—which implies continuing cuts in real dollars. Since this article was accepted for publication, Congress enacted supplemental appropriations through the "Emergency Jobs Bill" (H.R. 1718) that substantially increased funding for the ADM, MCH, and PC blocks. These funds—an additional $30 million for ADM, $105 million for MCH, and $70 million for PC—are earmarked for serving the unemployed, but may well permit use that will maintain traditional levels of service otherwise threatened by reduced federal funds. At this writing, it is unclear whether states will use these funds to postpone service reductions (similar to use of the carry-over) or if they will focus these dollars on particular priorities identified during the block-grant planning process.

State administrative savings will be far too small to offset the drop from earlier levels of support. Moreover, states seem almost as unlikely to replace lost federal funds with state money in 1983 as they were

in 1982, since few states' fiscal condition seems likely to improve materially in that time.

Given continuing fiscal pressure, the blocks' flexibility will permit targeting to reflect state priorities. The first year's implementation planning will provide a basis for grant reallocation decisions. States' ability to go through a complete budgeting cycle with adequate preparation will also make reallocations far easier, both politically and administratively, than in the first year.

States' adjustments will surely vary with state fiscal condition and their political and health care priorities. But nonetheless, we anticipate certain general trends that we have identified to continue. We have several bases for predicting likely future adjustments: (a) states' past behavior under fiscal pressure (Wolman and Peterson 1981); (b) experience in 1982 with state General Fund cuts (Michigan and Oregon); (c) preliminary block-grant decisions in 1982 (especially the reallocations of overlapping funds); and (d) block plans made in 1982 or then under consideration for the future. From these indicators, we believe that within the blocks, broad treatment programs aimed at large areas, populations, and problems will likely fare better than those aimed at one or a few localities. Older programs well established at the state level will receive more than relatively new ones. Programs which traditionally received both state *and* federal funds will be favored over those previously supported solely by federal funds, especially if federal funds formerly went directly to recipients, bypassing state administration. The general tendencies noted here are not mutually exclusive or all-inclusive; indeed, a given program may benefit or suffer from multiple advantages or handicaps in these categories.

1. BROAD PROGRAMS PREVAILING OVER NARROW. The states observed have tended to favor comprehensive care programs over more narrowly defined ones that focus on a single disease or a small beneficiary group. Partly a political decision to serve the largest group of constituents, this may also reflect the narrow programs' typical characteristics—relatively small, not state-run, and with low dependence (if any) on state funds. For example, the states' broad Maternal and Child Health programs have received a disproportionate amount of overlapping federal funds in both California and Texas, in both cases at the expense of the "special MCH projects," mainly small pilot or research

programs. Similarly, Michigan plans to budget block-grant funds for the more narrowly focused genetics programs in 1983 only after funds for the basic MCH programs are assured; in effect, this will mean little if any funding for genetics. (Historically, genetics received only federal funds and in FFY 1982 was entirely covered under the 15 percent MCH federal set-aside; it is not viewed as a state program commitment.)

New York also preferred broad programs to narrow projects. In the only significant program realignment noted thus far in our 6 states, New York is reorganizing its PHHS block services into broad categories, such as environmental health protection and chronic disease prevention. Earlier PHHS programs will continue to exist as subcategories but will compete for federal funds with a few new functions.

In all 6 states, Crippled Children's Services were an exception to this general rule. This small group has great political appeal, perhaps because the children have such great medical need and come from all economic strata.

2. STATEWIDE PROGRAMS PROTECTED OVER THOSE LOCALLY TARGETED. Just as states prefer broadly defined programs, they also favor programs providing statewide services over those with limited geographic coverage. As already noted, states favored general MCH programs over special projects, many of which served very restricted areas. Rodent control projects similarly lost funding or had the same funds spread throughout their states; such grants formerly went almost exclusively to large cities. New York is deemphasizing rodent control in favor of PHHS programs that serve the entire state, as is Kentucky. Texas is phasing out preexisting grants and making localities themselves decide whether to ask for rodent control or other projects with PHHS monies made available statewide. Similarly, New York is phasing out fluoridation grants to localities, and Kentucky has already done so. Because the locally targeted grants usually favored urban areas in the past, changes like these also shift funds to more rural locations.
3. PREFERENCE FOR PROGRAMS WITH STATE-LEVEL CONSTITUENCIES. Programs with an existing constituency at the state level will prevail over those without. This preference favors older, established programs, those with significant state funding as

well as federal, and those overseen by states in the past. Older programs, like Title V Maternal and Child Health, have had time to develop a network of advocates and ties to other programs. Programs already receiving General Funds also clearly have state support and a constituency, while federally dependent programs are more likely to reflect federal than state priorities. State-overseen programs, involving an existing bureaucracy, clearly take precedence over those previously under direct federal grants that were operated outside the state-local administrative structure. Hypertension, Genetics, Sudden Infant Death Syndrome, Hemophilia, and Lead-Based Paint Poisoning, among others of this nature, are clearly threatened for one or more of these reasons. In particular, Genetics, Hemophilia, and special programs funded in FFY 1982 from the 15 percent federal set-aside under the MCH block are at considerable risk as special federal support is being phased out.

State decisions on funding previously direct-grant recipients most clearly show the importance of a state-level constituency. In the first year our states typically passed a pro rata share of block funds to these grantees—either directly or through county or regional agencies coordinating the particular health programs. However, 1982 was really a transition year, and more changes seem likely.

As state criteria for service providers replace the former federal standards, some old grantees may no longer qualify. Two of 26 formerly direct alcoholism grantees in New York, for example, have already been cut off for 1983. Where states pass funds to counties coordinating public health care, counties may simply decide not to contract with existing grantees. Other grantees may appear more attractive, or county financial pressures may suggest keeping the funds in the county health department (if the county provides any core services itself). This possibility exists in both California and Oregon. Few of these shifts occurred during FFY 1982, but state officials' comments indicate direct categorical grantees are the most vulnerable of all those in line to receive health-block-grant funds.

4. INCREASING COST-CONTAINMENT ACTIVITY WITHIN PROGRAMS. After interprogram reallocations, *intraprogram* adjustments will occur in all areas hurt, but not eliminated, by budget reductions.

On the basis of broader fiscal-response observations and the experience in the states reducing general funds spent on health, individual programs will increasingly pursue the savings strategies noted earlier:

- consolidating administration and services
- focusing on treatment services
- setting priorities among clients
- increasing fees and third-party payment collection

Most of these strategies will result in reduced services. Longer waiting lists, a smaller number of available centers, a higher (or new) sliding fee scale and elimination of "soft" services (prevention, education, etc.) will place services out of the reach of at least some current recipients. However, basic treatment services will probably still be available to those most in need physically and financially; they will simply become more difficult to obtain.

These general trends will affect the formerly categorical programs within individual block grants in a variety of ways:

1. MATERNAL AND CHILD HEALTH. Crippled Children's Services (CCS), a state-run entitlement program, will exert a strong claim on MCH block funds. The treatment aspects of this program resemble Medicaid, both in paying fast-inflating, usually hospital-set costs for treatment services and in being obligated to pay for care on a third-party, open-ended entitlement basis. (Non-hospital aspects of CCS are less costly and more easily controlled—such as screening for and diagnosing covered conditions. Some states run outpatient clinics for these purposes.) Overall, CCS will require funds with an urgency unmatched by the other, nonentitlement MCH programs, and it appears to have the political constituency to support its growth. As an older, statewide, predominantly state-funded treatment program, CCS has a broadbased and vocal constituency that will protect it in the competition for blocked funds, especially vis-à-vis the small, less-protected Sudden Infant Death Syndrome, Genetics, and Lead Paint programs. Early indications in nearly all states suggest that CCS is a top priority program.

2. PREVENTIVE HEALTH AND HEALTH SERVICES. Nearly all the prevention programs are narrow, new, small, and largely federal—characteristics likely to prove a deadly combination in competition with other programs. Though only Oregon of our 6 states actually transferred PHHS funds to another block, PHHS programs receive little or no state support, either fiscal or programmatic. Emergency Medical Services are the sole apparent exception. In FFY 1983, 2 states—New York and Oregon—plan to use PHHS funds for programs not on the original list of blocked categoricals. More such changes (and possibly additional transfers across blocks) can be expected in the future. State priorities apparently differ from the federal categorical pattern more in the prevention block than elsewhere.
3. ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH. At least half the states pointed to alcoholism as an ADM program priority. Under the block, Alcoholism and Drug Abuse compete for federal funds, with each guaranteed at least a 35 percent share in FFY 1982. In two states, California and New York, alcohol programs historically received less than a 35 percent share of federal substance-abuse funds and, therefore, in the short run gained funding from the federally required floor. The other states split ADM funds pro rata between alcohol and drug programs, allocating the federal funds according to each program's historical share. (In Kentucky, where drug programs ostensibly should have benefited slightly from the 35 percent requirement, state funds were apparently shifted to maintain the status quo of alcoholism's dominance.)

   These federal minimums are scheduled to decline gradually, giving states more discretion to change historical patterns. We expect alcoholism in most states to increase its share of block funds. New York, and perhaps also other urbanized areas with major drug problems, may represent exceptions by supporting drug programs more generously. We reason that as the influence of past federal funding patterns fades, states will allocate federal-source funds more as they do their own General Funds. In most states, alcoholism programs have received far more state support than have drugs. Indeed, this state support has helped alcoholism programs weather federal cuts better than the drug programs,

except in Michigan where General Fund cuts exerted greater impact on the alcoholism budget. Even if the historical alcohol/drug split of the block funds remains constant, alcoholism will still probably gain overall relative to drugs because of the differences in each program's relative dependence on federal funding. The real-dollar value of the federal block will probably decline, so that drugs' greater dependence on federal funding will result in disproportionate real budgetary reductions.

State mental health programs will continue to be little affected by the block grants. Only the Community Mental Health Center (CMHC) grants are included, so block-grant shifts are extremely small relative to the far larger state efforts, both in mental hospitals and community care. Even the federally supported CMHCs themselves can expect relatively little change. The main CMHC categorical grants lasted only eight years. Federal funding declined over time in expectation of full CMHC independence, with care paid for by insurance, Medicaid, and state and local funds. Thus, the new state block administrators can usually maintain past federal commitments to existing grantees even with reduced resources under the blocks, so long as new centers are not added. However, differences in state and federal distributive priorities for these formerly direct grantees seem likely to surface soon, seriously affecting centers still in the program. In Michigan, beginning in FY 1983, blocked funds will be awarded only to CMHCs in the Detroit metropolitan area, effectively shifting support to high-use urban centers. In New York, state administrators have already slightly changed CMHC service delivery, requiring a shift toward children's services.

Assuming cuts are needed, exactly which changes states undertake will vary according to states' existing administrative and delivery structures, their fiscal condition, and the availability of local and private support for health programs. Only one thing seems certain—the cushioning carry-over funds will be largely exhausted in FFY 1983, and the resultant drop in federal support will force decisions that were successfully postponed for most of the blocks' first year. Depending on the degree of the funding loss (and whether the current block-grant structure remains intact), the true extent to which state priorities differ from earlier federal ones will then become fully evident.

References

Advisory Commission on Intergovernmental Relations. 1978. *Categorical Grants: Their Role and Design.* Washington.

———. 1982. *A Catalog of Federal Grant-in-Aid Programs to State and Local Governments: Grants Funded FY 1981.* Washington.

Coalition on Block Grants and Human Needs. 1982. *Briefing Book on Block Grants and the New Federalism.* Washington: Center for Community Change.

Congressional Budget Office. 1981. *An Analysis of President Reagan's Budget Revisions for Fiscal Year 1982.* Washington.

Durman, E.C., B.A. Davis, and R.R. Bovbjerg. 1982. State Fiscal and Programmatic Responses to Block Grants in Health and Human Services: The First Year. Report to the Department of Health and Human Services, Contract No. HHS-100-81-0071, December. Washington: Urban Institute. (Unpublished.)

Feder, J., and W. J. Scanlon. 1981. Program Transfers in Long-term Care: Strategies to Maintain Service at Minimal State Expense. Working Paper No. 1466–15, December. Washington: Urban Institute. (Unpublished.)

Feder, J., J. Holahan, R.R. Bovbjerg, and J. Hadley. 1982. Health. In *The Reagan Experiment,* ed. J. Palmer and I. Sawhill. Washington. Urban Institute.

General Accounting Office. 1982a. *Early Observations on Block Grant Implementation.* Washington.

———. 1982b. *Lessons Learned from Past Block Grants: Implications for Federal Oversight.* Washington.

Greenberg, G.D. 1981. Block Grants and State Discretion: A Study of the Implementation of the Partnership for Health Act in Three States. *Policy Sciences* 13:153–81.

Mott, A.H. 1981. Block Grants. *New York Times,* March 20.

Office of Management and Budget. 1981. *1981 Catalog of Federal Domestic Assistance.* Washington.

———. 1982. *Budget of the United States Government, Fiscal Year 1983,* Appendix. Washington.

Oregon. 1981. Overview: Block Grant and Welfare Reform Issues in the Omnibus Reconciliation Act of 1981. Salem, Oregon: Department of Human Resources. (Unpublished.)

Peterson, G.E. 1982. The State and Local Sector. In *The Reagan Experiment,* ed. J. Palmer and I. Sawhill. Washington: Urban Institute.

Price, R.J. 1981. *Health Block Grants.* Washington: Library of Congress, Congressional Research Service.

Reagan, R. 1980. Acceptance Speech to the Republican National Convention, July 1980. Reprinted in *Congressional Quarterly* 38 (July 19): 2064.

Schick, A., ed. 1980. *Perspectives on Budgeting.* Washington: American Society for Public Administration.

U.S. Congress. 1981a. *Hearings on Health Services and Preventive Health Block Grants, 1981.* Washington.

———. 1981b. *The Omnibus Reconciliation Act of 1981.* P.L. 97-35, August 13, 1981. Washington.

U.S. Congress. Senate. Committee on the Budget. 1981. *Omnibus Reconciliation Act of 1981. Report of the Committee on the Budget.* Washington.

Wildavsky, A. 1979. *The Politics of the Budgetary Process.* 3d ed. Boston: Little, Brown.

Wolman, H., and G. Peterson. 1981. State and Local Government Strategies for Responding to Fiscal Pressure. *Tulane Law Review* 55 (3):773–819.

Acknowledgments: This is an interim report which is subject to revision. Interested users are advised to contact the author(s) before quoting or citing. Opinions expressed are those of the authors and do not necessarily represent the views of the Urban Institute or its sponsors.

The report was written with support from a consortium of private foundations and corporations under the auspices of the Urban Institute's Changing Domestic Priorities project. Research was largely funded by the U.S. Department of Health and Human Services, Contract No. HHS-100-81-0071. The authors wish to thank our colleagues Judith Feder, John Palmer, and George Peterson for their helpful comments on this draft and to acknowledge the insights of Gene Durman, Raul Ramirez, and Fred Teitelbaum, our coworkers on the contract noted above. We regret that space does not permit us to cite all the interviewees, without whom our work would be impossible.

Address correspondence to: Randall R. Bovbjerg, Senior Research Associate, Health Policy Center, The Urban Institute, 2100 M Street, N.W., Washington, DC 20037.