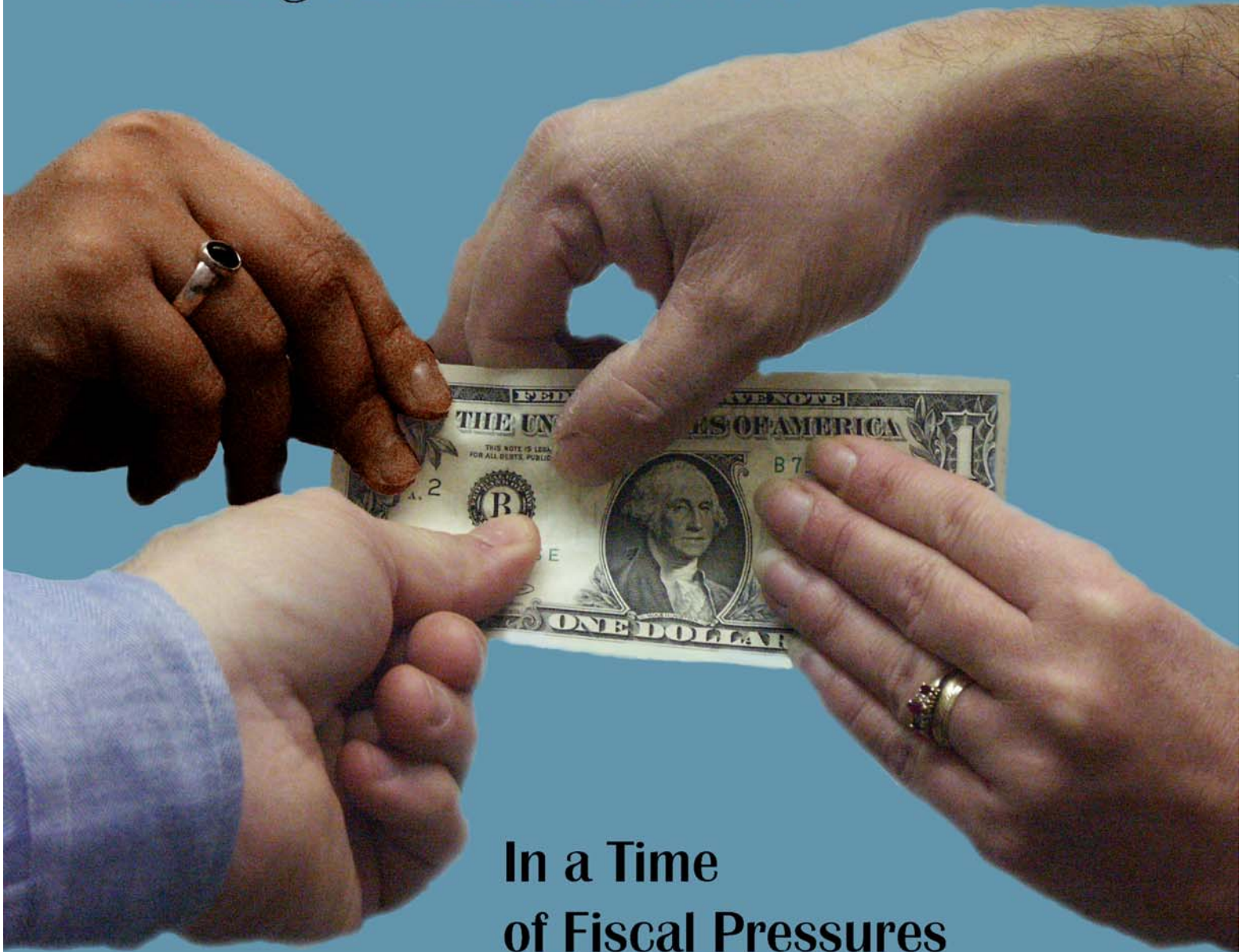




**The Roundtable**

on Religion and Social Welfare Policy

## Funding Faith-Based Services



### In a Time of Fiscal Pressures

By Courtney Burke,  
James Fossett & Thomas Gais

A project of the Rockefeller Institute of Government  
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# **Funding Faith-Based Social Services in a Time of Fiscal Pressure**

By Courtney Burke, James Fossett and Thomas Gais  
The Roundtable on Religion and Social Welfare Policy

*October 2004*

## Funding Faith-Based Social Services in a Time of Fiscal Pressures

### INTRODUCTION

In 1996, the U.S. Congress enacted the first Charitable Choice initiative as part of the federal welfare reform law. Then-Senator John Ashcroft pushed to include a provision in the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) that “significantly revamped the relationship between government and faith-based organizations [FBOs]”<sup>1</sup> providing social services.<sup>2</sup> Governments, insofar as they were using federal resources authorized under PRWORA, would no longer exclude faith-based organizations, including congregations, from receiving federal grants because of their religious character. Federal efforts to enlist FBOs in implementing public programs were then strengthened under the Clinton Administration and after 2000 under the second Bush Administration, largely through executive actions.<sup>3</sup>

State efforts were also underway in the 1990s. In 1994, Mississippi launched its own faith-based initiative, “Faith in Families,” a program which recruited churches to mentor low-income families and see after their well being. In late 1996, then-Governor George W. Bush in Texas worked closely with Marvin Olasky of the University of Texas at Austin to encourage religious organizations to play greater roles in providing social services. After the enactment of PRWORA, more states established charitable choice initiatives, though they were usually modest in size. The initiatives ranged from having FBOs perform program outreach, to providing capacity-building grants to FBOs, to direct contracts for services.<sup>4</sup>

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<sup>1</sup> The term “faith-based organizations” encompasses a wide array of organizations ranging from individual congregations to faith-affiliated nonprofit service organizations, such as Catholic Charities, Lutheran Social Services, the Salvation Army, as well as faith-affiliated hospitals and nursing homes. Congregations or any entities without an organizational separation between their religious and service activities were excluded from receiving public funds before the enactment of Charitable Choice laws. In this paper, the term FBO refers to congregations and faith-affiliated nonprofits. When we distinguish between these entities, we use the terms “faith-affiliated” organizations and “congregations” or “congregation-based” organizations.

<sup>2</sup> Anne Farris, Richard P. Nathan, and David J. Wright, *The Expanding Administrative Presidency: George W. Bush and the Faith-Based Initiative*. (Albany, NY: Rockefeller Institute of Government, Report by the Roundtable on Religion and Social Policy, 2004, p. 4).

<sup>3</sup> Ibid.

<sup>4</sup> Mark Ragan, Lisa Montiel, David Wright, *Scanning the Policy Environment for Faith-Based Social Services in the United States: Results of a 50-State Survey*. (Albany, NY: The Rockefeller Institute of Government, Roundtable on Religion and Social Welfare Policy, October 2003).

Many constitutional, statutory, and policy issues are raised by such initiatives.<sup>5</sup> Yet one practical question is whether FBOs can take advantage of whatever statutory flexibility they have been afforded. To do so, two ingredients are needed: a favorable political and administrative environment and a favorable fiscal environment. Regarding the first condition, the Bush Administration has made a concerted effort to expand opportunities for partnership between governments and faith-based social service providers. These activities have included regulatory reforms intended to remove real and perceived barriers to such partnerships, and to inform interested groups about the availability of funding for social services delivered by nongovernmental organizations. Federal agencies have also awarded individual contracts and grants under their direct control to FBOs, and they have worked with state and local governments to do likewise on programs they administer that involve federal or a mix of federal and local funding.

This paper addresses the second condition: the practical question of how underlying, long-term fiscal trends are affecting the availability of public funding for services delivered primarily by congregations and congregation-based social service organizations. Since most of the contracting for social services occurs at the state and local levels, one concern is whether state and local governments have adequate resources to expand their social service systems to include new actors, such as congregations or other FBOs not traditionally involved in implementing public programs. If resources are scarce, it is nonetheless possible that some states and localities will reduce or eliminate contracts with secular nonprofits and transfer funding to FBOs. Yet that would be difficult to do, politically as well as administratively. For the most part, then, expanded reliance on FBOs—particularly congregations—would probably require substantial and sustained growth in fiscal resources at the state and local levels, especially relative to social needs. In a situation of fiscal retrenchment, contract opportunities for FBOs are likely to be fewer, smaller, and more heavily fought over by non-governmental organizations.

This report describes recent changes in this fiscal environment and how it has changed since the first Charitable Choice initiatives. We focus on a limited number of federal social service programs as well as two health programs (Medicaid and CHIP) because of their significance as sources of support for the social service system. To understand the fiscal environment for these programs, we ask: Which funding streams are most accessible to FBOs, and what has happened to them in recent years? For example, have these programs been affected by the recession beginning in 2001 and subsequent state fiscal crises? Also, how have programs accessible to FBOs fared under long-run trends? And how has federal and state spending on social services been distributed geographically relative to the distribution of potential faith-based social service

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<sup>5</sup> See, for example, the website of the Roundtable on Religion and Social Welfare Policy at [www.ReligionandSocialPolicy.org](http://www.ReligionandSocialPolicy.org).

providers now receiving government money for social service delivery, such as congregations?

Our analysis of the fiscal conditions affecting FBOs yielded the following findings:

*Finding #1. In the 1990s, when faith-based initiatives at the federal and state levels were first launched, spending in program areas comparatively accessible to FBOs was expanding. This expansion was a product of important, albeit short-run policy and economic developments.*

*Finding #2. However, the relative surplus of state resources compared to social needs, found in the late 1990s, has largely vanished. State fiscal conditions deteriorated rapidly after 2001 and have not fully recovered, although there have been several quarters of steady revenue growth.*

*Finding #3. Federal funding streams most accessible to FBOs—that is, programs where requirements have been made more flexible or where Charitable Choice efforts have been most evident—tend to be small and have shown little real growth in recent years. By contrast, Medicaid—a funding stream much less accessible to FBOs—dwarfs these other programs and has grown vigorously.*

*Finding #4. One major potential source of funding for FBOs—the TANF block grant—has experienced increasing competition for service dollars, due to short-run economic changes as well as longer-run developments in the program.*

*Finding #5. State-level spending on Medicaid and related health-care programs—which are not very accessible to FBOs—has increased substantially in recent years, despite the recession. This growth in Medicaid spending may, in some states, be squeezing expenditures on non-health services, which FBOs are likely to provide.*

*Finding #6. Finally, from the perspective of congregations, there is a spatial mismatch between their distribution across states and the availability of funding for social services. In states where congregations are most common and potentially able to play a much a larger role, accessible funds for social programs are lowest.*

In sum, the fiscal conditions for a major expansion of FBOs in the social service systems at the state and local levels have deteriorated in recent years, and though they may improve in the short-run due to recent improvements in state and local finances, they are very likely to be vulnerable to important long-run trends.

## PUBLIC FUNDING FOR FAITH-BASED ORGANIZATIONS

Several federal and state programs are at least potentially accessible to FBOs, though the degree of accessibility is difficult to determine with precision. Research on the receipt of government funds by faith-based organizations indicated that at least 14 different federal programs were likely to supply significant funds to FBOs. We identified these programs using several criteria. Foremost were programs identified by Charitable Choice legislation. Also included are programs specifically tied to federal funding streams in FFY 2005 budget language, and programs known to be potential sources for FBOs identified through previous research.<sup>6</sup> Our search for programs only included those involving domestic social services. We did not include, for example, education-related programs or international programs.

It is difficult to calculate the exact amount of government money received by FBOs, but general conclusions were drawn about which programs were more likely to be used by FBOs, and which were less. A first category contains programs with explicit Charitable Choice provisions that have been adopted in law. They include:

- *Temporary Assistance for Needy Families (TANF)*<sup>7</sup>—in particular, *TANF services, not cash assistance payments*. A 50-state study conducted by the Roundtable on Religion and Social Welfare Policy found that TANF was by far the most commonly used program for FBOs of all types.<sup>8</sup> TANF funds are provided by the federal government as well as by states under the program's "maintenance of effort" (MOE) requirement. TANF money has been used for a wide variety of services, ranging from childcare to employment assistance programs.
- *Children and Family Service programs (including the Community Services Block Grant- CSBG)*. CSBG is the only program under the broad category of "Children and Family Services Programs" that is specifically covered by Charitable Choice in law. Other programs under the Children and Family Services Programs were not included in the Charitable Choice legislation but are likely funding sources for FBOs such as Healthy Marriage and Fatherhood Programs.<sup>9</sup> The fact that all these programs were lumped together in the FFY 2005 Proposed Budget, yet not all were subject to Charitable Choice, made it difficult to categorize given our taxonomy. Ultimately, we decided to keep "Children and Family Service

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<sup>6</sup> For more information about programs identified through previous research see Lisa Montiel, *The Use of Public Funds for Delivery of Faith-Based Human Services, 1<sup>st</sup> edition*. (Albany, NY: Rockefeller Institute of Government, The Roundtable of Religion and Social Welfare Policy, 2003).

<sup>7</sup> Family Support payments were gradually replaced by TANF, however, both programs were examined.

<sup>8</sup> Ragan, et al, p. 23.

<sup>9</sup> Appendix of FY 05 Federal Budget, p. 457. [http://www.acf.hhs.gov/prgorams/ccf/citizens/citz\\_about\\_ccf.html](http://www.acf.hhs.gov/prgorams/ccf/citizens/citz_about_ccf.html) (accessed on 4/12/04).

Programs in this first category given the relevance of the Community Services Block Grant to Charitable Choice.

- *Substance Abuse and Mental Health Services (SAMHS)*. The SAMSHA “Faith-Based and Community Initiative,” provides technical assistance to FBOs and works to assure more faith-based providers are equipped to deliver substance abuse and mental health services.<sup>10</sup> The federal agency administering SAMSHA has developed a set of “core competencies” to help FBOs build their capacity to deliver services.
- Although Welfare-to-Work was also included in early federal Charitable Choice legislation, the program was phased out and thus is not included in our research.

Of the programs in this first category, TANF is by far the most common source of funds for FBOs. Some research has been able to track the number of contracts and amount of TANF dollars going to Charitable Choice<sup>11</sup> but this has been in a limited number of states over a limited time frame.

A second group of programs were linked to FBOs through administrative and budget initiatives rather than Charitable Choice legislation. Federal administrative initiatives were launched to increase FBOs’ organizational capacity to apply for grants and contracts, while federal budget language in appropriations bills encouraged the involvement of faith-based and community-based organizations. This list of programs is not comprehensive; administrative efforts to augment funding for FBOs included other programs as well. But the programs in this category were larger and fit most clearly within a strict definition of “health and social services.” The programs included:

- *Training and Employment (including the Workforce Investment Act block grant)*. Funding under this program includes a wide variety of initiatives such as “Job Corps,” the “Community College Initiative,” and the “prisoner re-entry initiative,” which specifically funds grants to faith-based and community organizations under administrative actions by the Bush Administration.<sup>12</sup>
- *HUD Community Development Fund (including the Community Development Block Grant)*. The HUD Community Development Fund, which includes the Community Development Block Grant, was considered to have been a significant funding source for FBOs prior to Charitable Choice. Most counties have Community Development Commissions that administer CDBG funds, the recipients of which may be FBOs.<sup>13</sup> These

<sup>10</sup> Information on the “Faith-Based and Community Initiative” project accessed on 4/9/04 at <http://www.samhsa.gov/faithbased/>.

<sup>11</sup> Amy Sherman, *Collaborations Catalogue*, (Hudson Institute, 2003).

<sup>12</sup> Appendix of FY 05 Federal Budget, p. 706.

<sup>13</sup> John Orr, *Locating Public Funds for Faith-Based Human Services Programs: A Road Map*. (USC Center for Religion and Civic Culture).

grants support community and economic development activities. Faith-based organizations receiving HUD funds have tended to be larger corporations or coalitions such as Habitat for Humanity.<sup>14</sup> The proposed FY 2005 federal budget also includes \$5 million for a pilot program to increase the participation of faith-based and community organizations.<sup>15</sup>

- *Social Services Block Grant (SSBG)*. SSBG—which funds a wide range of services including but not limited to employment and training, adoption, child protective services and childcare—is potentially a funding source for FBOs because of its flexibility, because many of the services it has historically funded have involved FBOs, and because the program receives TANF transfer funds. However, research has not been able to ascertain how much in SSBG funds are being provided to FBOs at the state or local levels, although field research suggests that it has been a source of funding for FBOs.<sup>16</sup>
- *National and Community Service (which includes the Corporation for National and Community Services-CNCS)*. CNCS is the umbrella organization for such programs as Learn and Serve, Americorps, the Points of Light Foundation, Teach for America, and other programs. FBOs and community-based organizations have been encouraged to participate in these programs and CNCS recently released information on the level of involvement by FBOs in service delivery.<sup>17</sup>
- *Homeless Assistance Grants*. Programs funded under Homeless Assistance Grants include Shelter Plus Care, Supportive Housing, Section 8 Moderate Rehabilitation Single Room Occupancy programs and Emergency Shelter Grants as authorized under subtitle B of Title IV of the McKinney-Vento Homeless Assistance Act.<sup>18</sup> The Emergency Shelter Grants Program is frequently a funding source for FBOs.<sup>19</sup> Housing and community development assistance have been administered, for example, by such FBOs as Habitat for Humanity and the Salvation Army.<sup>20</sup>
- *Emergency Food and Shelter Program (EFSP)*. This program is governed by a national board that includes several faith-based groups. Several state and local entities have provided EFSP contracts to FBOs at the state and county level.<sup>21</sup>

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<sup>14</sup> Montiel, page 5, 6.

<sup>15</sup> Appendix to FY 05 Federal Budget, pp. 525-527.

<sup>16</sup> Field researchers in a Rockefeller Institute of Government 50-State Survey had a difficult time identifying SSBG allocations. For example, Arizona researchers reported that about \$2.3 million in SSBG funds go to FBOs for “youth services,” while Illinois had over \$30 million going to FBOs for a variety of services.

<sup>17</sup> Appendix of FY 05 Federal Budget, pg. 1097. Also see *Break the Silence on Americorps Funding*, (The Christian Science Monitor, August 11, 2003) and [www.nationalservice.org](http://www.nationalservice.org).

<sup>18</sup> Appendix of FY 05 Federal Budget, page 529.

<sup>19</sup> Lisa Montiel, *The Use of Public Funds for Delivery of Faith-Based Human Services, 2<sup>nd</sup> Edition*, (Albany, NY: Rockefeller Institute of Government, Roundtable on Religion and Social Welfare Policy, June 2003).

<sup>20</sup> Montiel, page 6.

<sup>21</sup> Ragan, et al.

- *Child care programs, including the Child Care Development Fund (CCDF) and the Childcare Entitlement.* The Bush Administration has emphasized the role of faith-based and community-based organizations in providing childcare and related services.<sup>22</sup> The Child Care and Development Block Grant specifies that religious organizations are eligible to participate.<sup>23</sup> However, the statutes did not actually increase flexibility, as Charitable Choice provisions did.<sup>24</sup> Some FBOs do not provide childcare services themselves but instead benefit indirectly from these funds by renting space to nonprofit childcare centers. In California, it is reported that at least one in five licensed centers is either run by or housed in a congregation, with most cases being the latter.<sup>25</sup>
- *Commodity Donations/Assistance and Child Nutrition Programs.* The USDA's Faith-Based and Community Initiatives has encouraged the involvement of FBOs in a variety of programs and such activities as providing feeding sites, transporting individuals to sites, preparing meals, and other services.<sup>26</sup>
- *Foster and Adoption Assistance.* The Bush Administration has encouraged the involvement of faith-based organizations in assisting with foster and adoption services.<sup>27</sup> The Department of Health and Human Services Child Bureau has numerous adoption-related programs for which FBOs can compete.<sup>28</sup>

All of these programs have various links with faith-based organizations but efforts to involve FBOs' are not legislated, only outlined in executive authority or budget language.

To understand how both groups of programs accessible to FBOs fit into the larger human service system, we will compare them with two major health programs that have offered much less direct access to congregation-based and other faith-infused FBOs. These programs include:

- *Medicaid.* Participation in this program is more burdensome than participation in other non-health social services. Medicaid providers must meet professional requirements including licensing or certification and be willing to accept payment for services, exclusive of start-up costs, and only as reimbursement for costs after services have been provided. This

<sup>22</sup> Excerpts from a Statement of Tommy G. Thompson, Secretary, Department of Health and Human Services, on Welfare Reform and Child Care before the House Committee on Education and the Workforce, April 9, 2002 (archive accessed on 4/13/04).

<sup>23</sup> Ibid, Ackerman, page CRS-6. (42 U.S.C.A. 9858 et seq.)

<sup>24</sup> Ibid, Ackerman, page CRS-6. (42 U.S.C.A. 9858 et seq.)

<sup>25</sup> The California Council of Churches, <http://www.calchurches.org/projects4.html> accessed on 8/19/04.

<sup>26</sup> See <http://www.usda.gov/fbci/programsfnsl.html> (accessed on 4/8/04).

<sup>27</sup> See Executive Order at <http://usinfo.state.gov/usa/faith/e121202.htm> (accessed 8/9/04).

<sup>28</sup> Comments from Lisa Montiel, Research Scientist, (Albany, NY: Rockefeller Institute of Government, 8/18/04).

makes the program likely to be inaccessible to all but the most sophisticated and financially secure organizations.

- *State Child Health Insurance Program (SCHIP)*. The lack of accessibility for faith-based providers is similar for SCHIP, which in many states is an extension of Medicaid. Faith-based organizations have been involved in outreach for SCHIP, but this is most often collaborative and no money is received for services.

Faith-affiliated hospitals, nursing homes, mental health or substance abuse programs have been active participants in Medicaid since the program's beginning, but these nonprofit institutions have been organizationally distinct and legally separate from religious bodies with which they are associated. They have also developed large, sophisticated, and expensive bureaucracies to handle the increasingly complex management demands of health and other programs produced by the advent of managed care and the growing competitiveness of the health care system. As such, they are, by and large, quite different from congregations and similar religious entities that have been the focus of Charitable Choice.<sup>29</sup>

The enormous size and rapid growth of Medicaid, especially when compared to other federal and state public social service programs, make it important to pay special attention to the access barriers it poses for certain kinds of FBOs. Individual congregations or coalitions of congregations find it difficult to provide Medicaid-funded services for several reasons. Functioning as a provider of publicly funded health care, mental health, substance abuse, or long-term care requires some form of state license. Licensing, in turn, requires agencies to hire expensive professional personnel, acquire appropriate facilities that meet program standards, and develop accounting and other management systems for sending out and paying bills, keeping track of medical records according to specified standards, and many other tasks. Many of these tasks are not necessarily required to deliver other types of social services, differentiating Medicaid and CHIP from those programs in category two. Also, Medicaid only pays for services rendered, which means it does not support hiring or any other “start-up” costs—any of the costs of building capacity. Agencies must have these elements in place *before* they are certified for reimbursement for services provided to Medicaid clients.<sup>30</sup> Other social service programs do not require as many “start up” costs.

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<sup>29</sup> For a description of the size of the faith-affiliated sector and its involvement in Medicaid in ten states, see James W. Fossett and Courtney Burke, *Medicaid and Faith Organizations: Participation and Potential*. (Albany, NY: Rockefeller Institute of Government, Roundtable on Religion and Social Welfare Policy, July 2004).

<sup>30</sup> In addition, Medicaid services to low-income families and children in many areas are provided through managed care organizations such as health maintenance organizations (HMOs). Under these arrangements, managed care organizations are paid a set payment, known as a capitation payment or premium, for every client who enrolls with the organization. The HMOs must pay for all care the client requires out of these payments. In order to keep costs down, managed care organizations may restrict the number of providers with which they contract, limit the care a particular patient may be provided, or require advance approval for services. In addition to incurring large start-up costs, faith-based providers may also be required to convince managed care organizations to accept them in their

Congregation-based providers would likely find these start-up and on-going administrative expenses difficult to meet. The denominations whose agencies have been most active as Medicaid providers have developed large specialized bureaucracies to manage facilities and health care; individual congregations may find the administrative requirements associated with receiving Medicaid daunting. Although a few congregations are large and wealthy and could afford the necessary expenditures, most are comparatively small, lacking access to the capital required to start such programs as well as the administrative expertise to operate them. Many congregations have only a few full-time employees, are dependent on “collection plate” revenues for capital, and rely on volunteers to manage church finances and other administrative tasks. While many congregations do participate in social service activities, these activities are typically small and involve the support of activities of other organizations rather than operating programs directly.

## THE CHANGING FISCAL ENVIRONMENT OF FBOs

Shifts in spending across diverse programs greatly affect the ability of FBOs to compete for service contracts. Spending changes are, in turn, influenced by general fiscal conditions at the state and federal levels. As we detail below, changes in fiscal conditions and social welfare spending at the state and federal levels are inhibiting the ability of FBOs to expand their roles in providing social services.

### The Economic Context

***Finding #1. In the 1990s, when FBO initiatives at the federal and state levels were first launched, spending in program areas accessible to FBOs was expanding. This expansion was a product of short-run policy and economic developments.***

When Charitable Choice initiatives were launched in the 1990s, they were established during a time of considerable growth in spending for social service programs, especially when compared to social needs. To show this, Figure 1 compares changes in state and local spending for three types of programs: cash assistance (such as TANF cash assistance and state general assistance programs), medical assistance (mostly Medicaid), and non-health social services (such as programs for the homeless, energy assistance, nutrition programs, programs for the disabled, childcare, child welfare, and so on). Medicaid and cash assistance programs have been relatively inaccessible to FBOs, while non-health social services have encompassed many of the programs where Charitable Choice

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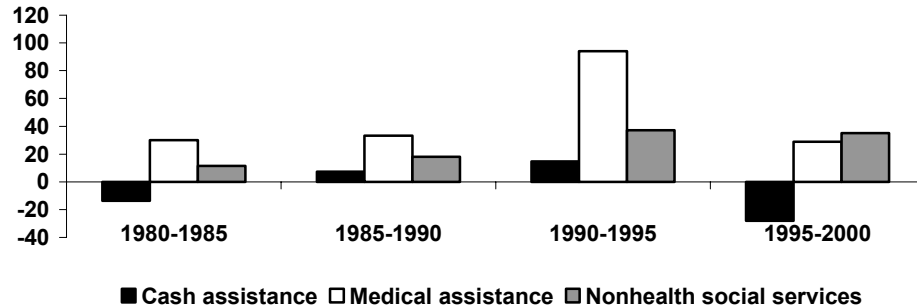
networks of providers and develop methods for accommodating treatment limits or prior approval requirements before they can even begin receiving payments for services.

initiatives were initiated and greater flexibility for FBOs was encouraged through administrative actions.

Changes were calculated as percentage shifts in spending across five-year periods between 1980 and 2000, using state and local spending data from the U.S. Bureau of the Census. We adjusted spending for inflation using the GDP deflator. Spending was also adjusted in terms of social needs, which, for these programs, were roughly related to the number of low-income persons in a state. Thus, the changes in Figure 1 show the *average state change in real spending per poor person*.

Figure 1 reveals that when Charitable Choice initiatives were introduced in the mid-1990s, they were launched at a time when state social service program expenditures were growing rapidly. Medicaid spending grew quickly in the early 1990s and slowed in the late 1990s. Cash assistance expenditures were more volatile. They grew in the early 1990s and fell in the late 1990s.

**Figure 1**  
**Average percent change in real state spending per poor person; calculated for five-year periods, 1980-2000**



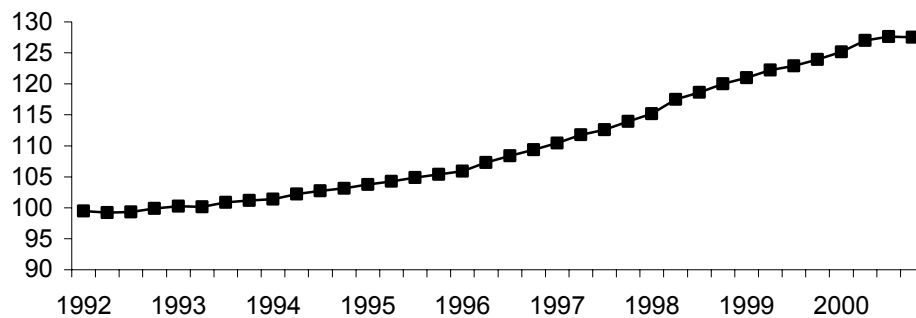
Non-health social service spending—the category including many of the 14 programs listed above as involving FBO initiatives—increased steadily throughout the 1990s and at a rate higher than in the 1980s. In fact, non-health social service spending increased faster than medical assistance between 1995 and 2000—for the only time during the 20-year period. The strong growth in spending on services in the 1990s suggested that resources were available for an expanded range of service providers, including FBOs.

What accounts for these changes in spending, especially in the 1990s? In a study recently completed by the Rockefeller Institute and the Lewin Group for the U.S. Department of Health and Human Services, we found that Medicaid and cash assistance expenditures varied in a countercyclical fashion, growing during periods of high unemployment (e.g., during the early 1990s) and contracting

during economic booms (e.g., during the late 1990s). By contrast, spending on non-health social services showed no significant relationship to employment cycles. Instead, such spending depended largely on a state’s overall resources, such as a state’s fiscal capacity (measured by real per capita income) and other revenue sources.<sup>31</sup>

Indeed, states had considerable resources to apply to their social service budgets in the 1990s. State tax revenues were growing. Quarterly data on average state revenues between 1992 and 2000—after controlling for inflation and standardized to equal 100 in 1992—are displayed in Figure 2. Although average state revenue growth was slower before 1997, it was nonetheless steady in the early 1990s. From 1997 through 2000, revenues grew dramatically, only slowing in the last two quarters of 2000.

**Figure 2**  
**Average state tax revenues, per capita;**  
**Adjusted for inflation and standardized (1992=100),**  
**1992-2000**



While revenues and service expenditures grew in the 1990s, most indicators of social needs declined. As Figure 3 shows, unemployment and poverty levels dropped substantially in the late 1990s. These declines in need helped reduce cash assistance spending and cut down the growth rate of Medicaid spending.<sup>32</sup> These changes probably encouraged the growth of non-health service spending in the late 1990s.

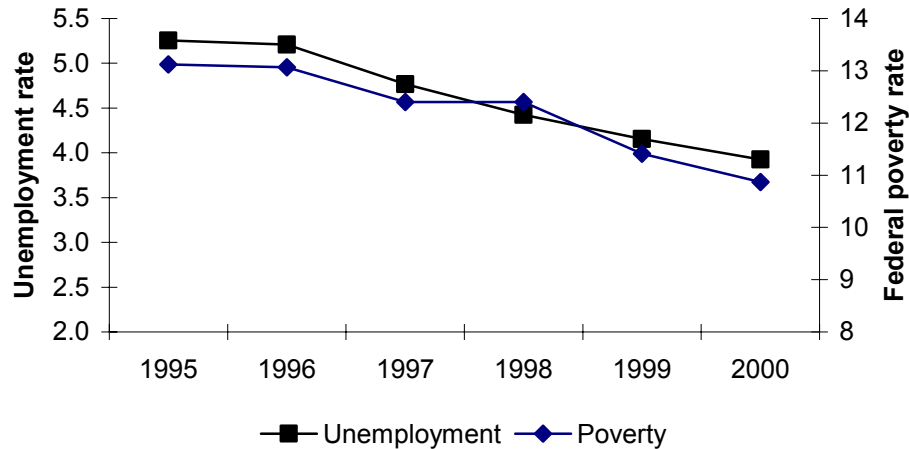
In sum, when Charitable Choice provisions were initially enacted in the 1990s, they were put forward in a context of rising state revenues, declining social needs,

<sup>31</sup> On factors influencing state spending on social welfare programs, see *Spending on Social Welfare Programs in Rich and Poor States*, Final Report, Prepared for the U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, by the Lewin Group and the Nelson A. Rockefeller Institute of Government (Washington, DC: Department of Health and Human Services, 2004). Report available at <http://aspe.hhs.gov/hsp/social-welfare-spending04/index.htm>.

<sup>32</sup> Ibid.

and growing expenditures on non-health social services—a broad functional area that, on the whole, was relatively accessible to faith-based organizations.

**Figure 3**  
Average state unemployment and poverty rates, 1995-2000

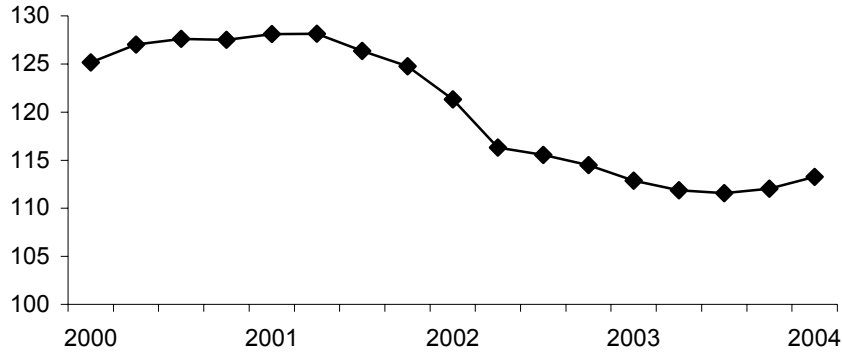


***Finding #2. However, the relative surplus of state resources compared to social needs in the late 1990s has largely vanished. State fiscal conditions deteriorated rapidly after 2001 and have not fully recovered, although there have been several quarters of steady revenue growth.***

While the increased flexibility given to states to use faith-based organizations in the 1990s occurred in a context of declining needs, growing state revenues, and expanded spending for non-health services, at least two of these conditions—declining needs and growing revenues—had reversed as early as late 2001.

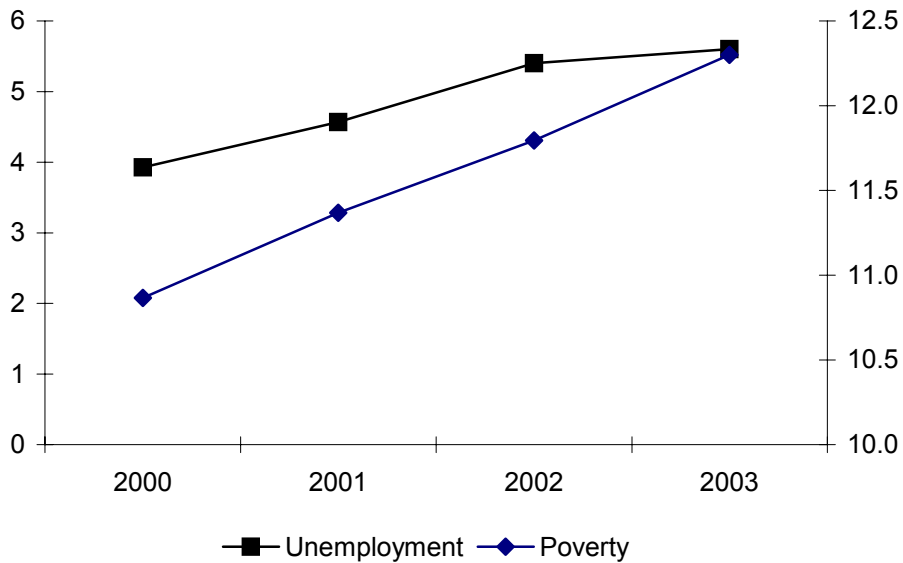
We can see the changes in state revenues in Figure 4, which displays average state per capita revenues between 2000 and the first quarter of 2004. The drop in revenues—after adjusting for inflation—began in the third quarter of FY 2001 and accelerated in the first half of FY 2002. Average state revenues continued to drop until the last quarter of FY 2003, when they showed a slight rebound. However, even in the first quarter of 2004, average state revenues recovered only to the point where they were at in 1997.

**Figure 4**  
**Average state tax revenues, per capita; adjusted for inflation and standardized (1992=100)**



At the same time, indicators of social needs ended their decline and began to increase. As Figure 5 shows, average state unemployment rates (indicated on the left axis) grew by a point, from around 4 percent to over 5 percent between 2000 and 2002—and continued to grow through 2003. The average state poverty rates (using the federal government’s traditional Census Bureau definition) also increased after 2000, from 10.8 percent in 2000 to 12.3 percent in 2003.

**Figure 5**  
**Average State Unemployment and Poverty Rates, 2000-2003**



### The Federal Spending Context

***Finding #3. Federal funding streams most accessible to FBOs—that is, programs where Charitable Choice efforts have been legislated or administrative barriers reduced—tend to be small and have shown little real growth in recent years. By contrast, Medicaid—a funding stream much less accessible to FBOs—dwarfs these other programs and has grown vigorously in recent years.***

In addition to economic conditions, another influence on state and local spending is federal funding. A comparison of federal funding for Charitable Choice programs (see top of Table 1) showed little real growth. Funding for TANF and SAMHSA grew slowly in the early 2000s. One exception was the budget category, Children and Family Services Programs (CFSP). Children and Family Services Programs include a broad array of initiatives, such as violence prevention, services for runaway children, and child abuse protection.<sup>33</sup> Most of these programs were not targeted under original Charitable Choice legislation – with exception of the Community Services Block Grant (CSBG).

In the second category of programs—which have been made more accessible to FBOs through administrative means— growth rates varied greatly. Some programs even experienced cuts. One of the biggest declines in funding occurred in the Social Services Block Grant, which has long been a flexible source of funding for a variety of nonprofit service providers, including FBOs. The Commodities Donations Program and the Corporation for National and Community Service (which administers Americorps and other volunteer programs) also experienced funding declines while most other programs saw slow growth.<sup>34</sup>

The two exceptions to these slow growth rates in this second category were the Homeless Assistance Grants (which includes Emergency Shelter Grants) and the Child Care and Development Block Grant. The increase in CCDF was not surprising given the emphasis on childcare as a work support for people leaving welfare. It should be noted though, that funding for the CCDF block grant and entitlement, after adjusting for inflation, slowed between 2002 and 2004 and the entitlement actually declined after 2003. Also, part of the growth in the Homeless Assistance Grant can be attributed to an expansion of the various programs falling under this category.

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<sup>33</sup> Appendix of FY 05 Federal Budget, page 456.

<sup>34</sup> Findings about CNCS funding are less conclusive because the program experienced an overdraw in the National Trust which required some financial restructuring and an additional allocation by Congress to meet demand when issues arose with the trust. For more information see the annual report of CNCS at <http://www.nationalservice.org>.

**Table 1**  
**Changes in Federal Outlays, 2000-2004\***

	Federal Outlays, 2000 (millions)	Federal Outlays, 2004 (millions)	Percent Change in Fed. Outlays 2000-04
<i><b>Programs with legislated Charitable Choice initiatives</b></i>			
Temporary Assistance for Needy Families	17,172	19,055	11%
Children & Family Services Programs (CSBG)	6,489	8,336	28%
Substance Abuse and Mental Health	2,144	2,291	7%
<i><b>Programs accessible to FBOs through administrative measures</b></i>			
Child Nutrition Programs	10,061	11,408	13%
Foster and Adoption	6,055	6,506	7%
HUD Community Development Fund (CDBG)	5,502	6,050	10%
Training & Employment	3,284	3,693	12%
Child Care Entitlement	2,484	2,888	16%
Social Services Block Grant	2,029	1,785	-12%
Child Care Development Block Grant	1,183	2,252	90%
Homeless Assistance Grants (ESG)	983	1,467	49%
Commodities Donations Program	299	162	-46%
Nat & Community Services Program	227	170	-25%
Emergency Food & Shelter Program	122	154	26%
<i><b>Health programs; not made more accessible to FBOs</b></i>			
Medicaid	130,949	180,975	38%
CHIP	1,355	5,284	290%

\* All figures are adjusted for inflation (based on 2005 actual proposed outlays) using Bureau of Economic Analysis Table 3.9.4. Congressional Budget Office forecasts were used to predict inflation for 2004 and 2005.

Aside from childcare and the Homeless Assistance Grants, only one non-health social service program grew at an average rate of over 5 percent per year--the Emergency Food and Shelter Program (EFSP). Funding for non-health social service programs was particularly slow in recent years. The average annual increase in funding between 11 programs<sup>35</sup> from 2000-2004 fell from 7.2 percent (2000-2001) to 0.8 percent (2001-2002), -2.9 percent (2002-2003), and -0.2 percent (2003-2004).<sup>36</sup> This slowdown suggests a fairly fixed pool of federal resources. Given this tight federal fiscal picture, competition for funding among service providers likely became quite vigorous.

In contrast to these small and typically slow-growing federal funding streams, total federal outlays for Medicaid and the Children's Health Insurance Program (CHIP) have been enormous and have grown rapidly. Even after adjusting for inflation, the increase in Medicaid was 39 percent between 2000 and 2004. CHIP's growth rate was much higher, in part because many states were still in the process of implementing and expanding CHIP eligibility during these years. Yet

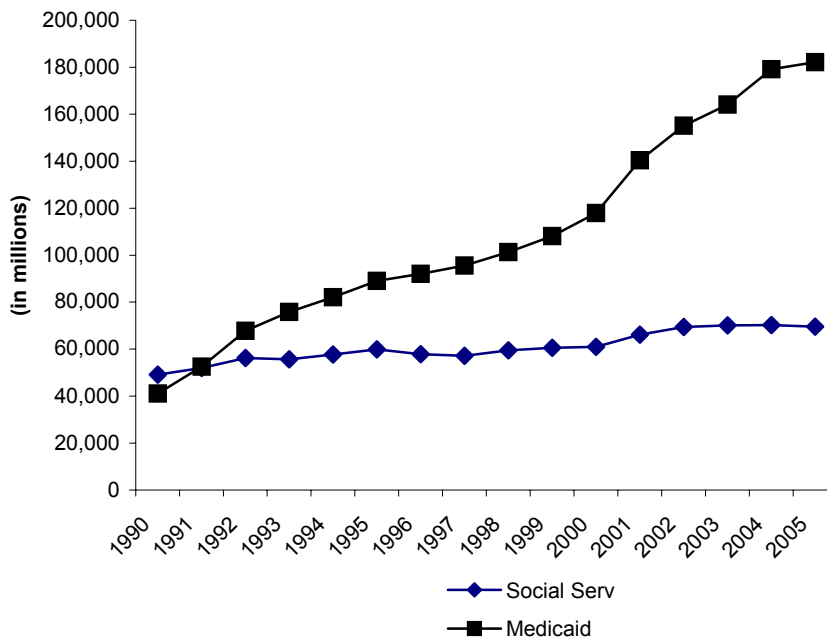
<sup>35</sup> To avoid skewed results, SCHIP was excluded from this analysis because it required higher than normal outlays as states initially expanded programs. National and Community Service was also excluded because of a huge drop in FY 04 which was subsequently supplemented in FY05 and Homeless Assistance Grants were also excluded.

<sup>36</sup> FY 2005 is proposed and all results are adjusted for inflation.

these health programs offer fewer opportunities for congregation-based or other religiously infused service organizations.

The contrast in federal spending trends between Medicaid and other social programs, especially after 2000, is starkly revealed in Figure 6, which compares total federal Medicaid outlays to total federal outlays for the 14 non-health social services in categories one and two. In 2004, federal Medicaid spending was nearly three times that of spending for the 14 other non-health social services programs in which FBOs had greater access.<sup>37</sup>

**Figure 6**  
**Total Federal Outlays, 1990-2005\*, 14 Social Service Programs vs. Medicaid (adjusted for inflation)**



<sup>37</sup> The 14 social service programs are the ones described earlier as targeted by legislative or administrative efforts to expand FBO access. They include: TANF (before 1997, AFDC and other predecessor programs), SSBG, SAMHSA, Community Development Fund, Homeless Assistance Grants, Commodities Donations/Assistance, Family Support Programs, Child Nutrition, Childcare Entitlement, Child Care Development Block Grant, Emergency Food and Shelter, National and Community Service, Training and Employment, and Foster and Adoption.

State Spending Changes

***Finding #4. One major potential source of funding for FBOs—the TANF block grant and related programs (including child care)—has experienced increasing competition for service dollars, due to short-run economic changes as well as longer-run developments in the program.***

Charitable Choice has been strongly associated with the TANF block grant. The original Charitable Choice provision in 1996 was enacted with TANF, as both were parts of the Personal Responsibility and Work Opportunity Reconciliation Act. The great flexibility states were given to shift money from cash assistance to services offered states an opportunity to expand service spending *and* the types of service organizations used. TANF is also a large program when compared to others that are accessible to FBOs. For these and other reasons, it is not surprising that studies have found that TANF has been by far the most important source of funding for state and local efforts to enlist the efforts of FBOs.<sup>38</sup>

The flexibility states have in using their federal TANF block grants—as well as the Maintenance of Effort (MOE) dollars they spend from their own revenue sources—may benefit FBOs in several ways. States may use TANF or MOE dollars to support many services that theoretically could be provided by FBOs, such as employment services, parenting or pregnancy prevention programs, programs for at-risk youth, transportation services, clothing programs (for school children, job interviewees, etc.), after-school programs, and others. Also, money spent on childcare often directly or indirectly supports congregations—usually indirectly as many nonprofit childcare providers use congregations’ facilities and pay rent.

In the early years of TANF implementation, this flexibility was enhanced by three developments. First, with the promulgation of the federal TANF “nonassistance” rule in 1999, states were allowed to commit resources to a wide variety of social services without invoking time limits, work requirements, and other restrictions that applied to basic assistance.

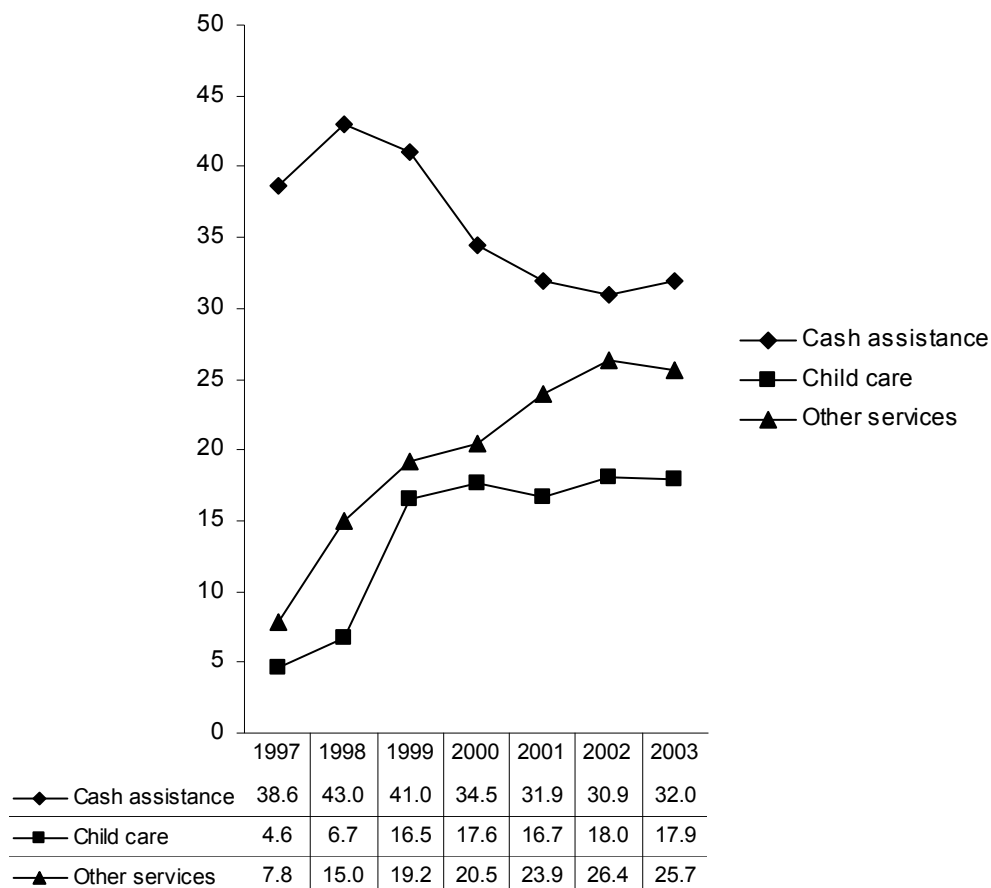
Second, the rapid decline in cash assistance caseloads—combined with the fact that TANF block grant levels were based on historically high spending levels in the mid-1990s—created fiscal windfalls for many states. That is, states were getting more money under TANF than they would have had they still operated AFDC. The windfalls produced surpluses in the TANF block grant that states could carry from one year to another and apply to their cash assistance programs. States could then devote a greater share of their *current* TANF grants for social services rather than cash assistance.

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<sup>38</sup> Ragan, et al.

Third, by the end of the 1990s, it was clear to many states that they would have little difficulty meeting federal work participation requirements under TANF. The continued decline of cash assistance caseloads meant that states still enjoyed large caseload reduction credits in meeting their participation requirements. The ease with which states could meet their work requirements allowed states to put money into services that did not directly affect work participation rates. It permitted, for example, states to invest in programs aimed at longer-run effects (such as parenting classes, youth programs, pregnancy prevention programs, and so forth) and to experiment with new service provision strategies.

**Figure 7**  
Average (mean) per capita spending by states under TANF/MOE, by type of expenditure, 1997-2003



In response to these events, TANF spending on services grew rapidly in the 1990s. As Figure 7 indicates, average state per capita spending on childcare increased from \$2.20 in 1997 and \$5.50 in 1998 to \$13.50 in 2000. Average state per capita spending on other services—including employment services, work supports (such as transportation), education programs, and other programs for

families—also grew, from a total of \$15.00 per capita in 1998 to \$20.50 in 2000. The growth in service expenditures was made possible in part by the decline in spending on cash assistance, from \$43.00 per capita in 1998 to \$34.50 in 2000.

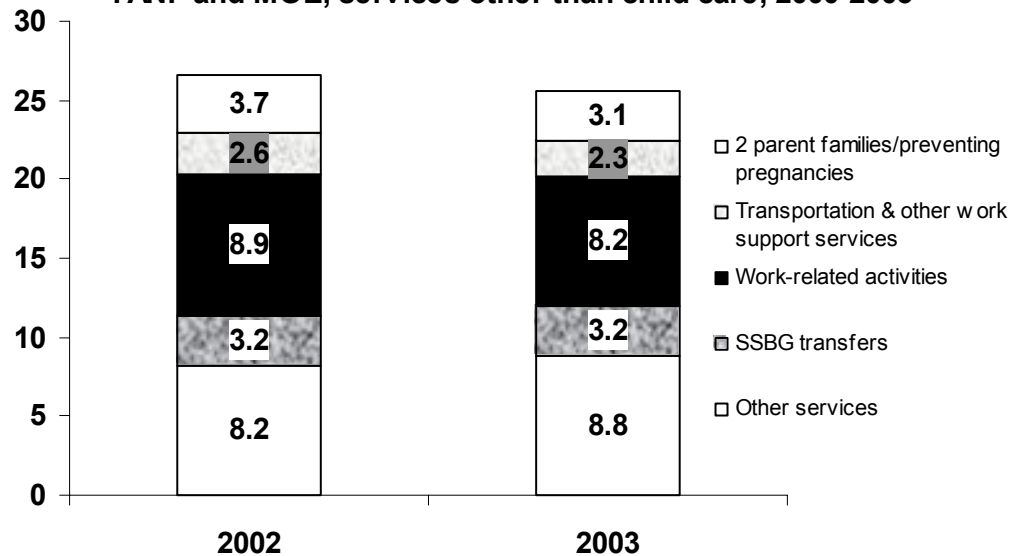
After 2000, however, average per capita spending on childcare leveled off and remained stable through 2003. Also, the decline in spending on cash assistance began to slow after 2000. Annual declines through 2002 were much smaller than in the 1990s—and in 2003, cash assistance spending actually grew in per capita terms, from \$30.90 in 2002 to \$32.00 in 2003. The stable level of child care funding and the recent growth of spending on cash assistance after the recession may have squeezed TANF/MOE spending on other services, the broad residual category of services most likely to involve FBOs. Indeed, average per capita state spending on these services fell slightly between 2002 and 2003 from \$26.40 to \$25.70.

As states struggled with the recession of 2001-02 and its effects on state revenues in 2003 and thereafter, state TANF spending on services began to change in ways that would appear to affect FBO funding. Figure 8 shows a detailed breakdown of the TANF/MOE services labeled “other services” in Figure 7 for fiscal years 2002 and 2003. These “other services” include (1) services that promote two-parent families and discourage out-of-wedlock births; (2) transportation and other support services; (3) work-related services, including education and training, job preparation, and work subsidies; (4) transfers to the Social Services Block Grant (SSBG); and a variety of other services.

Between 2002 and 2003, average state per capita spending declined in (1) programs encouraging marriage and two-parent families and discouraging out-of-wedlock pregnancies; (2) transportation and other work-support services; and (3) work-related activities. Transfers to SSBG remained more or less constant. By contrast, spending on the residual category of “other services” increased substantially between 2002 and 2003.

States seemed to cut back on programs that were less essential to the more or less immediate attainment of core goals—and even these goals were cut back in some states. In West Virginia, for example, the state responded to its fiscal crisis by emphasizing the employment and income support goals of TANF and reducing, at least temporarily, its somewhat longer-run efforts to support marriage, two-parent families, better parenting, pregnancy prevention, and so on. Mississippi cut its faith-based parenting program almost immediately after the fiscal crisis.

**Figure 8**  
**Average (mean) per capita spending by states under**  
**TANF and MOE, services other than child care, 2000-2003**



These changes in spending after the recession appeared to reduce funding opportunities for FBOs. Based on our own field research and other reports, TANF programs promoting two-parent families and marriage and preventing out-of-wedlock pregnancies were more likely than other TANF-funded programs to involve FBOs. FBOs also seemed to be more involved in providing limited work support services, such as transportation assistance or help in getting clothes for a new job (or clothes for schoolchildren); and some FBOs provide assistance in helping people find jobs. Yet spending on all these services declined in per capita terms between 2002 and 2003.

The growth of spending in the residual “other service” category is harder to interpret but also appears to reduce available funding for FBOs. In a study of six low fiscal capacity states for the U.S. Department of Health and Human Services, TANF and MOE funds were found to be increasingly used after state fiscal crises to support a wider array of social programs, most of which did not involve faith-based organizations. For example, states were using TANF funds to sustain certain politically popular programs—such as pre-kindergarten educational programs—through difficult budgetary times. Some state executives were using TANF to support programs they viewed as critical yet not commanding adequate political support during fiscal crises, such as child protective services, foster care, and other child welfare programs. That is, overall these programs were losing funds, and TANF was used to mitigate the losses.<sup>39</sup> Child welfare programs in many states have long contracted with faith-affiliated service organizations, though they have traditionally not used congregations.

<sup>39</sup> See *Spending on Social Welfare*.

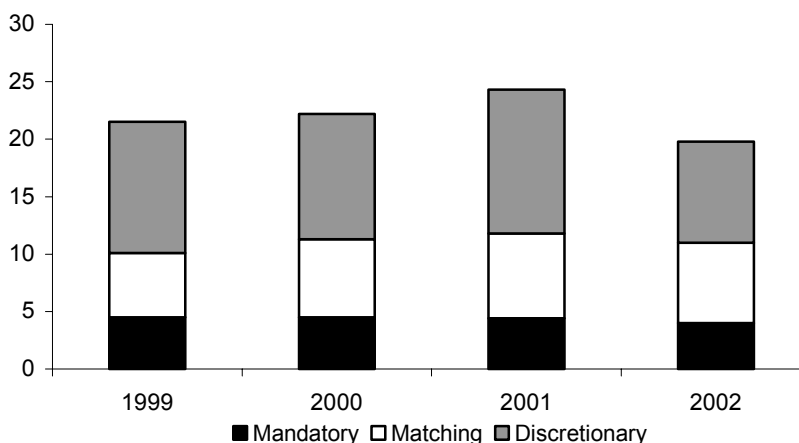
The fiscal crisis thus increased competition for TANF and MOE resources. First, FBOs, like other service organizations, have been forced to compete for a share of a slightly smaller pool of funding for services. Second, at least in some states, FBOs have had to compete with a wider array of programs and organizations, as some states used their TANF and MOE dollars to support programs not previously reliant on the block grant. Third, where FBO programs aimed at long-term goals, their funding became particularly vulnerable as states struggled to support more immediate needs.

A program closely related to TANF—the Child Care Development Fund (CCDF)—was also affected by the fiscal downturn in the states, and perhaps to the detriment of FBOs. As we noted before, child care programs help support many congregations—though often indirectly—and the Bush Administration has, as part of its executive actions, attempted to encourage greater FBO participation in child care programs. However, although average child care spending under the TANF block grant, using federal dollars, had been sustained at least through Federal Fiscal Year (FFY) 2003, declines in spending under CCDF were apparent as early as FFY 2002.

We can see these changes in Figure 9, which shows the average state spending (per capita) of federal and state dollars under CCDF between 1999 and 2002. Most of the dollars spent were federal. States must meet maintenance of effort (MOE) requirements to get some of the available federal dollars (under the “matching” component of CCDF), and they may pull down additional funds if they spend beyond the MOE. The figure shows that the average state per capita funding of CCDF grew between 1999 and 2001, then fell in 2002. A drop in what is called “discretionary” funding accounted for most of the decline between FFYs 2001 and 2002. Some of this decline in discretionary spending was due to a drop in transfers from the TANF block grant to CCDF. However, state “matching” funds also declined. This drop in CCDF spending was the first experienced by the program since 1992.

In sum, TANF and related funding streams have stopped growing and competition for funds has become more severe. Cash assistance has stabilized and even grown slightly. It is unlikely to decline enough in the near future to provide a large source of revenues that states may use to boost services. Indeed, service spending declined slightly in FFY 2003 under TANF, especially in areas where FBOs were likely to play a major role. Other developments have increased competition for service dollars under the block grant. These include the greater priority given to services with more immediate and concrete effects, and the use of TANF funds for programs that had not before relied on TANF resources. In many ways, these developments are not just short-run responses to fiscal problems in the states but also reflect likely long-term developments under TANF. If these trends continue, TANF will not generate substantial funds for major expansions in services or service providers, a change that can clearly inhibit FBO involvement.

**Figure 9**  
**Average state spending on child care (CCDF),**  
**per capita, by type of grant, FFY 1999-2002**



***Finding #5. State-level spending on Medicaid and related health-care programs—which are not very accessible to FBOs—has increased substantially in recent years, despite the recession. This growth in Medicaid spending may, in some states, be squeezing expenditures on non-health services, which FBOs are more likely to provide.***

Despite great variation in how states administer Medicaid and in what they spend on the program, one thing is certain: Medicaid spending dwarfs spending on non-health social services programs.<sup>40</sup> And unlike retrenchment of many other social services, Medicaid fared well during the fiscal downturn.<sup>41</sup> The program grew at a steady pace, enrollments grew, and many states were reluctant to cut back on Medicaid programs.<sup>42</sup>

Faith-affiliated organizations have long been Medicaid service providers. To receive Medicaid money, FBOs, no less than other providers, must meet a range of criteria for certification and can only receive reimbursement for “Medicaid approved” services. The largest Medicaid service expenditure category under which FBOs receive money is Hospital Care.<sup>43</sup> A close second to Hospital Care is Nursing Facility Services. These two categories alone account for nearly 40 percent of Medicaid spending. Table 2 shows spending in five areas where FBOs

<sup>40</sup> As demonstrated earlier in Figure 6.

<sup>41</sup> See James W. Fossett and Courtney E. Burke, *Is Medicaid Retrenching? A Study of State Budgets and Medicaid Enrollment in 2002 and Medicaid and State Budget FY 2004: Why Medicaid is so Hard to Cut*, (Albany, NY: Rockefeller Institute of Government. February 2003, July 2004).

<sup>42</sup> *Ibid.*, (July 2004).

<sup>43</sup> Our definition of “Hospital Care” in this instance includes inpatient care, outpatient care and inpatient Disproportionate Share Hospital Payments. Estimates are based on Form 64CMS expenditure data.

(in particular, faith-affiliated non profit organizations, and not generally congregations) participate in Medicaid.

**Table 2**  
**Changes in Total, Federal, and State Medicaid Expenditures**  
**for Select Services, 2000-2003**

<b>Service Category</b>	<b>Total Spending 2000-03</b>	<b>Federal Spending 2000-03</b>	<b>State Spending 2000-03</b>
Inpatient Hospital - Reg. Payments	33.3%	37.7%	27.7%
Outpatient Hospital Services	34.2%	39.8%	26.8%
Nursing Facility Services	13.0%	16.4%	8.6%
Home Health Services	25.3%	28.2%	21.8%
Home and Community	42.8%	47.4%	36.8%
Total Change for all Medicaid services	34.0%	38.1%	28.5%

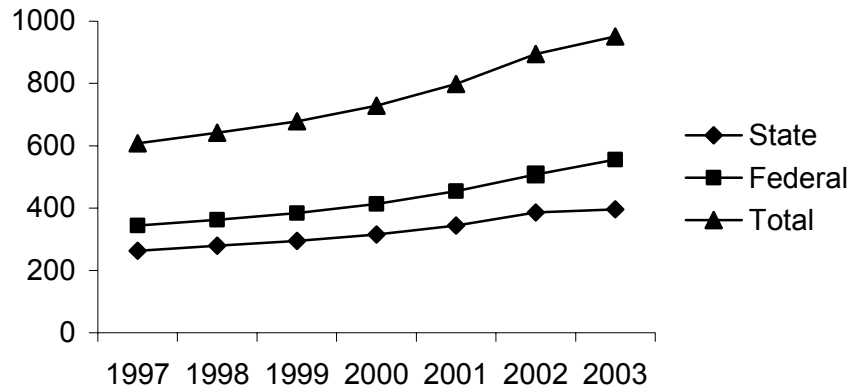
\* Source: Centers for Medicare and Medicaid Services, Form 64 Data

These data demonstrate that Medicaid grew substantially in these service categories between 2000 and 2003, i.e., before and after the fiscal downturn. Federal spending grew more quickly than state spending (in part because of a temporary increase in the federal matching formula) and there was little evidence of retrenchment in Medicaid spending. Total nominal spending grew by 34% in just three years.<sup>44</sup>

We also see substantial growth in Medicaid spending when we look at average state per capita spending, which is tracked in Figure 10. The figure shows average state per capita spending on Medicaid from federal fiscal years 1997 through 2003. Medicaid spending grew faster after 2000, largely driven by the strong rate of growth in federal spending (which we noted above; see figure 6). State spending grew even after the recession, though not as strongly as before.

<sup>44</sup> Data is from CMS Form 64 data – 2003 data was obtained from CMS staff on 2/17/04.

**Figure 10**  
**Average state per capita spending on Medicaid,**  
**1997-2003**



Despite Medicaid and CHIP’s robust growth during this time, our recent field research indicated that many states enacted some measures to slow Medicaid’s growth. The result was that Medicaid grew at a slower rate than private insurance spending during this time. Growth containment measures may have impacted certain types of providers.<sup>45</sup> However, lessening the burden of cuts on faith-affiliated FBOs was the fact that states focused their cost control efforts on certain services such as dental care, prescription drugs, or physical therapy. Faith-affiliated FBOs were less likely to be involved in delivering these services.

One area where FBOs, and in particular, congregations, were impacted by budget cuts was outreach for Medicaid and CHIP. Starting in the late 1990s, congregation-based FBOs were among the many nonprofit organizations participating in outreach and enrollment efforts for Medicaid and especially CHIP. Almost every state used FBOs for this purpose. However, with the fiscal downturn, Medicaid outreach was one of the first activities to be cut. These cuts may not have hurt all participating FBOs—many were providing outreach without receiving funds for their services. But the elimination of the outreach efforts probably reduced FBO involvement in such activities.

The fact that Medicaid is so large compared to non-health social service spending, and that it keeps getting larger, may eventually produce a “crowding out” of funding for non-health services.<sup>46</sup> Fewer resources may be available for non-health social services, the area where faith-based organizations are more likely to be involved. As a result, FBOs may be forced to compete for a smaller and smaller piece of the social welfare pie.

<sup>45</sup> Ibid, Fossett and Burke (July 2004).

<sup>46</sup> *Spending on Social Welfare Programs*.

***Finding #6. Finally, from the perspective of faith-based institutions, there is a spatial mismatch between their distribution across states and the availability of funding for social services. In states where congregations are most common and potentially able to play a large role in many communities, accessible funds for social programs are lowest.***

Among the most important characteristics of social welfare spending in the U.S. are the great differences among states expenditures. States of different fiscal capacities—measured by their per capita personal incomes—show large differences in how much they spend on social welfare programs and what kinds of programs they support.<sup>47</sup>

These differences across states may have important implications for Charitable Choice initiatives. To the extent that such initiatives are aimed at engaging congregations in the implementation of public programs, one basic *federalism* problem is that the states where congregations are most numerous (at least relative to the number of state residents) also tend to be the states that spend the least on social programs, especially the non-health social services in which FBOs are most likely to get involved. That is, states that have the most extensive religious-institutional structure to draw on in using FBOs are also the states that have the fewest public resources to apply to such initiatives.

The top of Figure 11 reveals one aspect of this problem. States were classified into four quartiles based on the number of congregations in a state per resident in 2000.<sup>48</sup> The first quartile had the least number of congregations by population, while the fourth quartile had the most congregations. The figure indicates that federal and state spending under TANF was higher among the states with the fewest congregations per capita. Public and religious resources were thus very differently distributed across states. States with many potential religious institutions to use had few public resources to devote to initiatives, while states with fewer religious institutions had more money to exploit.

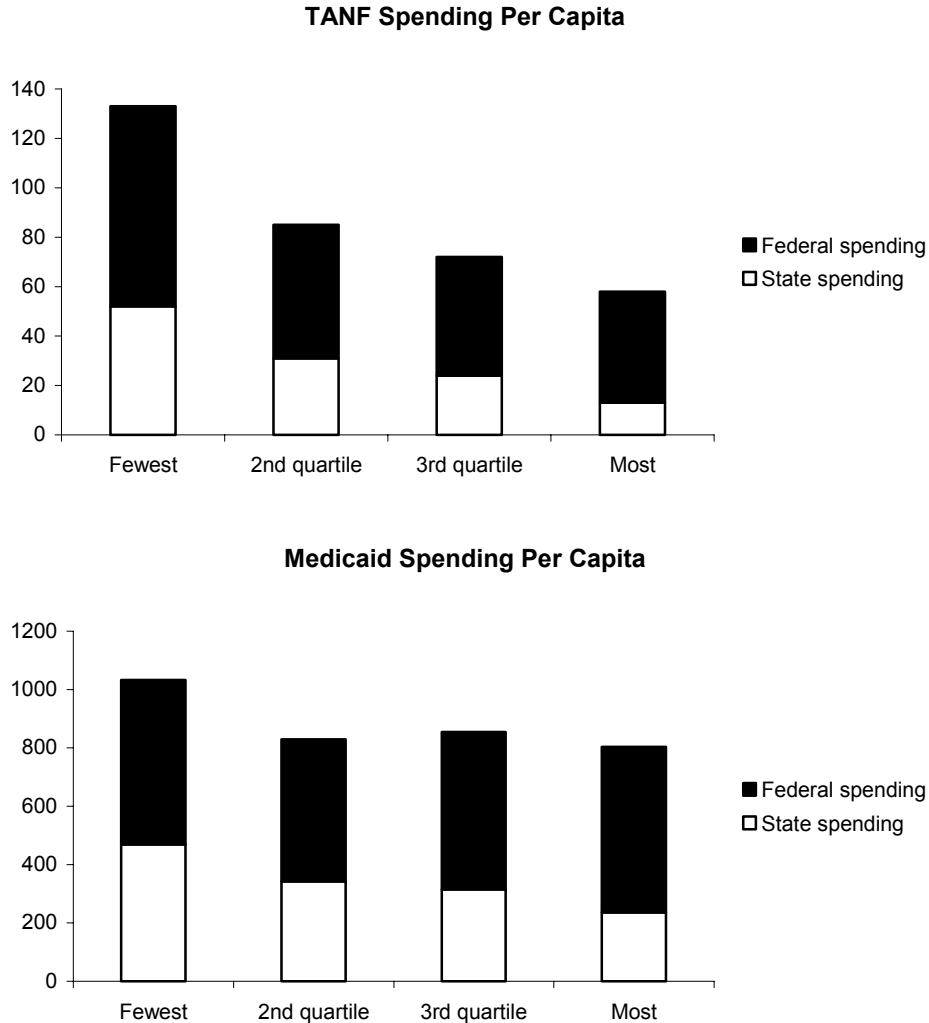
This correlation was much less pronounced when we look at Medicaid spending (see the bottom of Figure 11). Thus, in states with the most congregations per capita, social welfare spending by states is most likely to be dominated by health assistance, which is the least accessible set of programs for FBOs, especially congregations.

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<sup>47</sup> Ibid.

<sup>48</sup> Data on religious congregations were obtained from the Glenmary Research Center, which conducts the Religious Congregations Membership Study. Congregations are surveyed by collecting data from 149 religious groups about their congregations. The groups encompass many religions, including Protestant, Catholic, Jewish, Mormon, Muslim, Eastern Christian (Orthodox), other Eastern religions, and Unitarian Universalists. State data on congregations were obtained from: Jones, Dale E., Sherri Doty, Clifford Grammich, James E. Horsch, Richard Houseal, Mac Lynn, John P. Marcum, Kenneth M. Sanchagrin, and Richard H. Taylor. 2002. *Religious Congregations and Membership in the United States 2000: An Enumeration by Region, State and County Based on Data Reported by 149 Religious Bodies*. See <http://ext.nazarene.org/rcms/>.

**Figure 11**  
**Average state spending on TANF and Medicaid—from federal and state sources,**  
**by density of congregations in the states, FY 2002**  
 (“Fewest” means lowest density of congregations; “Most” means highest density)



We do not claim any causal relationship behind these correlations. Many of the states with high concentrations of congregations are in the South, and states in that region tend to spend less on public welfare programs (especially non-health programs) for a variety of economic and political reasons.<sup>49</sup> However, the fact of the correlation is important whether or not any causal relationship exists. Charitable Choice initiatives have been particularly popular in states where churches and church-going is quite widespread—such as Texas and Mississippi. Yet these states have little in public resources to support these efforts. By contrast, states that spend higher amounts on social welfare programs have fewer

<sup>49</sup> Ibid.

congregations to engage. These latter states probably have more and larger secular nonprofit organizations, which would compete for these public resources.<sup>50</sup>

## FUTURE DEVELOPMENTS

### FY 2005 Proposed Federal Funding

It may be some time before state fiscal conditions rebound to what they were prior to the economic slowdown. At the federal level other programs and issues are making the environment for funding more competitive. In fact, proposed funding levels in FFY 2005 for select social services<sup>51</sup> are slightly lower than FFY 2004 levels (-0.2 percent when adjusted for inflation). Table 3 compares the proposed FFY 2005 funds to the outlays in FFY 2004. FFY 2005 follows a year in which estimated spending on these programs already dropped -2.9 percent from the previous year.<sup>52</sup> A Congressional Budget Office examination of all grants-in-aid for FFY 2005, which includes some of the programs in our analysis, concludes that the President's proposed FFY 2005 budget has slightly less funding for all such grants when compared to the previous fiscal year<sup>53</sup> and if programs such as SSBG continue to be level-funded, their real value will decline.

Other predictions point to a continued decline in domestic discretionary spending and declines in spending on certain social service programs.<sup>54</sup> Rising expenditures on programs for the elderly and less tax revenue will also contribute to an expected decline in spending on other social services in the near future.<sup>55</sup> Current military obligations and a growing federal deficit, also make it less likely that spending on domestic social service programs will rise any time soon.

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<sup>50</sup> For information on this topic see Thomas Gais, Courtney Burke, and Rebecca Corso, *The Impact of the State Fiscal Crises on Nonprofits Providing Health and Social Assistance*, (The Aspen Institute: November 2003).

<sup>51</sup> This includes the programs in table F2 – except for SCHIP and CNCS.

<sup>52</sup> The 14 social service programs include: TANF (before 1997, AFDC and other predecessor programs), SSBG, SAMHSA, Community Development Fund, Homeless Assistance Grants, Commodities Donations/Assistance, Family Support Programs, Child Nutrition, Childcare Entitlement, Child Care Development Block Grant, Emergency Food and Shelter, National and Community Service, Training and Employment, and Foster and Adoption.

<sup>53</sup> Congressional Budget Office, *An Analysis of the President's Budgetary Proposals for Fiscal Year 2005*, (Washington DC, March 2004).

<sup>54</sup> Jennifer Mezey, Sharon Parrott, Mark Greenberg and Shawn Fremstad *Reversing Direction on Welfare Reform: President's Budget Cuts Child Care for More Than 300,000 Children*. (Washington, DC: Center on Budget and Policy Priorities and The Center for Law and Social Policy, February 10, 2004) and Isaac Shaprio and David Kamin *Concentrating on the Wrong Target: Bush Cuts Would Reduce Domestic Discretionary Spending, As a Share of GDP, To Its Lowest Level in 46 Years*. (Washington, DC: Center on Budget and Policy Priorities, March 5, 2004).

<sup>55</sup> C. Eugene Steuerle, *The Incredible Shrinking Budget for Working Families and Children*, (Washington, DC: The Urban Institute, December 2003).

**Table 3**  
**Changes in Federal Outlays 2004-2005\***

	2004	2005	Percent Change 2004- 2005*
<i><b>Programs with Legislated Charitable Choice Initiatives</b></i>			
TANF	19,055	18,354	-4%
Children & Family Services Program (CSBG)	8,336	8,490	2%
Substance Abuse & Mental Health	2,291	2,428	6%
<i><b>Programs with Administrative Initiatives That Increased Access to FBOs</b></i>			
Child Nutrition Programs	11,408	11,441	0%
Foster and Adoption	6,506	6,693	3%
HUD Community Development Fund (CDBG)	6,050	5,586	-8%
Training & Employment	3,693	3,623	-2%
Child Care Entitlement	2,888	2,710	-6%
Child Children Develop Block Grant	2,252	2,161	-4%
Social Services Block Grant (SSBG)	1,785	1,769	-1%
Homeless Assistance Grants (including ESG)	1,414	1,467	4%
National & Community Services Program	170	350	106%
Commodity Donations Program	162	176	9%
Emergency Food & Shelter Program	154	153	0%
<i><b>Health Care Programs—Less Accessible to FBOs</b></i>			
Medicaid	180,975	182,170	1%
State Children’s Health Program	5,284	5,299	0%

\* 2005 proposed. All figures are adjusted for inflation (based on 2005 actual proposed amount) using Bureau of Economic Analysis Table 3.9.4. Congressional Budget Office forecasts were used to predict inflation for 2004 and 2005.

### Federal Policies

Current and proposed federal policies also suggest an emphasis on restrained spending. The National Catholic Reporter points out that the Bush Administration is fairly clear about limiting spending when it quoted the Administration as saying “*The federal government must restrain the growth of any spending not directly associated with the physical security of the nation.*”<sup>56</sup> This policy bodes well for two programs in our analysis – the Emergency Food and Shelter Program, which is now part of the Department of Homeland Security, and National Community Service, which, among other things, focuses on homeland security.<sup>57</sup>

However, the majority of the nation’s social service programs in our analysis do not deal directly with physical security. Consequently, most of the programs are not a high priority and policies have been proposed to devolve responsibility for

<sup>56</sup> Joe Feurherd, *Fiscal mess, drive to war put social services on the block*, National Catholic Reporter. (Online, accessed on 2/14/03).

<sup>57</sup> See FY 05 Federal Budget Appendix, Page 1097.

these programs to the states through block grants.<sup>58</sup> In all, there are eight social service programs that President Bush proposed block granting since taking office. The programs include: Head Start, Unemployment Insurance, Medicaid/SCHIP, Child Welfare, Section 8 Housing, and Transportation for Job Access, Food Stamps, and Job Training.<sup>59</sup> Although there has been little success to date in block-granting these programs, incremental steps are being taken to implement this policy ideal. For example, even though the Bush Administration's proposal to block grant Medicaid and CHIP was not well received by states, the Administration is encouraging the use of waivers that allow block grants on a state-by-state basis. So far one state, New Hampshire, has announced its intention to change its Medicaid program to a block grant. The net effect of block grants is more flexibility and responsibility for states, but also less federal funding as the value of the grant declines over time.

### Demographic Trends

Two other factors influencing the future of social services are the growing elderly population and influx of immigrants. The impacts of these trends are already being realized with more public resources being spent on health care for the elderly. Medicaid is one of the major payers for healthcare for the elderly – and is the largest payer for long-term care. The fact that the elderly population will increase in the coming years makes it likely that Medicaid will continue to consume the lion's share of resources, perhaps “crowding out” the availability of public dollars for other services. In fact, one econometric analysis, which looked at variations in Medicaid and higher education spending across the states, concluded that “*each new dollar in state Medicaid spending crowds out higher education appropriations by about six to seven cents.*”<sup>60</sup>

Demographic trends also show a steep increase in the number of immigrants who are becoming or are eligible to be naturalized. Research shows that certain geographic areas are absorbing the large majority of these immigrants – and thus certain states, such as New York, California and Illinois, will be more impacted by this trend than others.<sup>61</sup> The combination of an expanding elderly population and a sudden increase in the number of new immigrants who are becoming naturalized means more, not fewer resources will be needed for health and social services.

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<sup>58</sup> By block grants, we mean that the federal government will not match spending of state and local governments, however high that spending is (as is the case for Medicaid). Rather, the federal government provides a more or less fixed block of money to states to spend on a particular function.

<sup>59</sup> For details about the status of each of these Block Grant proposals see *Block Grant Proposals That Threaten Services for Families and Communities, Shifting Responsibility for Programs Without the Resources to Pay for Them* at <http://www.chn.org>.

<sup>60</sup> Thomas J. Kane and Peter R. Orszag, *Higher Education Spending: The Role of Medicaid and the Business Cycle*. (Washington, DC: Brookings Institution, September 2003).

<sup>61</sup> Michael Fix, Jeffery Passel and Kenneth Sucher, *Immigrant Families and Workers, Trends in Naturalization*. (Washington, DC: Urban Institute, September 2003). The states absorbing the most immigrants include New York, New Jersey, California, Florida, Texas and Illinois.

### Fiscal Trends

State revenues have been slow to recover since they first dropped so precipitously in 2001. However, there have now been several straight quarters in which revenues have grown when adjusting for legislation and inflation.<sup>62</sup> The recovery has allowed states to avoid further cuts to programs. Encouraging as the revenue numbers are, it may be some time before states see real revenue levels equal to those prior to the recession.<sup>63</sup> This means that retrenchment may be over but the effects of the retrenchment will continue to be felt until states fully recover. Therefore, health and social service providers, whether faith-based or not, are not likely to see large improvements from their already retrenched existence.

### CONCLUSIONS

This paper suggests that efforts to expand the role of FBOs in providing publicly funded social services to low-income families have run up against a confluence of fiscal developments, including recent cut-backs due to the recession of 2001-2002 and its aftermath as well as long-run changes in patterns of social welfare spending. Perhaps the greatest challenge for FBOs—especially those that are faith-intensive, not just affiliated with certain denominations—has been the robust growth of Medicaid. This growth is driven by many factors not easily controlled by federal and state governments—and Medicaid’s strong state and local constituencies, attractive federal match, and entitlement structure all make the program difficult to cut back. Also, given the problems of health coverage among working class families, cutting back on such a program is not likely to be politically compelling to many citizens and elected officials.

However, that dynamic creates challenges for faith-based organizations. With the exception of outreach activities—which are typically done without public financial support—Medicaid does not offer many opportunities for the more faith-intensive or congregational faith-based organizations. Such FBOs—as opposed to the many hospitals, nursing homes, and other health-care institutions with loose affiliations with Judaism and various Christian denominations—rarely have the professional staff or management capacity to qualify as Medicaid service providers or, even if qualified, handle the substantial costs of providing such services.

If FBOs are to expand their roles in providing social services, they must therefore find funding from other sources or take advantage of what opportunities exist in other areas,<sup>64</sup> or look to areas where there has been some effort to increase

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<sup>62</sup>Nicholas Jenny, *State Revenue Report (various)* – at <http://www.stateandlocalgateway.rockinst.org>.

<sup>63</sup> Ibid.

<sup>64</sup> For more on these funding opportunities see “Medicaid and Faith Organizations: Participation and Potential,” by James W. Fossett and Courtney E. Burke (Albany, NY: Rockefeller Institute of Government, Roundtable on Religion and Social Welfare Policy, July 2004).

administrative and legal flexibility. Certainly federal and state efforts have been made to increase flexibility for faith-based organizations. Yet many of these efforts are being made in programs that are small or that are shrinking in real size (or growing very slowly). One of the larger programs where Charitable Choice efforts have been particularly prominent—Temporary Assistance for Needy Families—did indeed contribute to a substantial growth in spending on non-health social services in the late 1990s. However, growth in TANF services is unlikely to continue as cash assistance spending has largely ended the substantial declines experienced in the 1990s; as there seems little prospect of real growth in the size of future TANF block grants after TANF reauthorization; and as a variety of factors increase pressures on states to achieve higher work participation rates (e.g., the termination of remaining AFDC waivers, the possible increase in required rates and hours, and the elimination of caseload reduction credits). More stringent performance requirements may, for example, pressure states to expand child care spending and other work support programs. Yet FBOs have less direct involvement in child care and other work supports than in other service areas.

The economic and revenue problems that most states experienced may have left lasting impressions on state TANF and MOE programs—impressions that, again, are unlikely to benefit FBOs. After several years of initiating new programs, sometimes with new service providers, states were forced to establish stronger priorities and pare down services to those that were critical to core and immediate goals. Programs that promised long-run benefits or that served clients whose behavior was not measured as an element of program performance—such as fatherhood programs, parenting programs, after-school programs, pregnancy prevention efforts, and so on—were less likely to survive budget cuts than were basic work support services. Also, the flexibility afforded by TANF and MOE made it possible for these grants to support other, politically popular programs during times of fiscal stress. We found, for example, a growing tendency for such funding to cover educational programs, such as pre-kindergarten programs that serve a relatively larger (i.e., less exclusively poor) clientele.

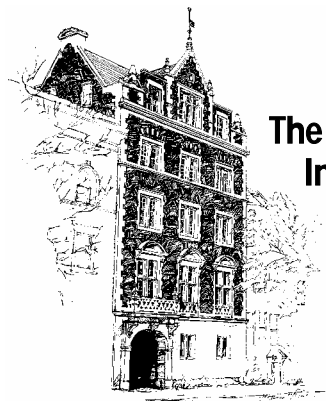
Other non-health service programs are, with some exceptions, not growing much in real terms. Some of the more flexible block grants, such as SSBG, are actually declining in nominal as well as real levels, while programs that are growing relatively rapidly and that offer substantial flexibility to FBOs are typically small.

For all these reasons, competition for funding under TANF and MOE has become more acute in recent years, and FBOs must compete with a wider array of service providers. As spending growth is most robust in health care programs, expanded roles for FBOs will also depend on FBOs' abilities to upgrade their professional and management capacities.





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