A DIVIDED COMMUNITY: THE EFFECTS OF STATE FISCAL CRISES ON NONPROFITS PROVIDING HEALTH AND SOCIAL ASSISTANCE

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Executive Summary

The nonprofit sector and federal and state governments depend on one another, especially in the area of health and social services. Governments rely on nonprofits to provide services, and nonprofits rely on governments to fund their operations. The current fiscal crisis in the states, however, poses threats to some nonprofits. States have acquired greater flexibility in recent years with expanded choices under Medicaid and the block-granting of major social programs, such as Temporary Assistance for Needy Families (TANF) and the Child Care and Development Fund (CCDF). While this flexibility allowed states to expand the range of services provided to people during prosperous times, it also gave states more options to choose from in making cuts during periods of fiscal stress. The consequence may be a more intense competition for resources, a competition pitting a wide range of programs and major policy areas against one another, including medical assistance, income supports, and a wide variety of nonhealth social services.

This paper examines the current state revenue crisis, demand for social services, the distribution of social assistance nonprofits, and both long-run and short-run changes in state expenditures to estimate the effects of state fiscal crises on the nonprofit sector associated with human service programs. This study finds divisions among nonprofits that affect the severity of these effects. These divisions are both functional and geographic:

1. *Nonprofits with and without access to Medicaid funding.* Medicaid spending increased substantially in nearly all states through the 1990s. It has continued to grow, even during the recession. Other social assistance spending has experienced slower growth and has been cut in some places and for some functions. Thus, nonprofit organizations that can draw on Medicaid dollars are in a much better position than other nonprofits.

2. *States of high and low fiscal capacity.* Nonprofits in states with low fiscal capacity, based on their per capita personal income, have been more vulnerable to the fiscal crisis than those in states with high fiscal capacity states:

- ***a.*** States with high fiscal capacity have seen sharp declines in tax revenue in recent years, but these drops came after astonishing revenue increases partly due to capital gains during the 1990s. Cash assistance rolls have not risen in rich states. Their spending on nonassistance services under TANF has continued to rise through early 2003. Nonprofits in rich states are not as dependent on government for revenue. Finally, human service budgets in rich states are more balanced across health and nonhealth expenditures.

- ***b.*** Very different developments are found in states with low fiscal capacity. They have seen significant increases in human needs, putting pressures on both nonprofits and governments. Cash assistance rolls and expenditures on basic assistance have begun to rise. At the same time, Medicaid has become an even larger portion of social program budgets in poor states, as

spending on this program grows as fast or faster than in richer states. In some cases, Medicaid is protected from budget cuts, leaving other social welfare programs very vulnerable during a fiscal downturn, especially since nonprofits in poorer states rely more heavily on public funding than those in wealthier states.

At the level of individual programs outside the health area, we note that states are especially likely to cut programs that are not targeting core or mandated constituencies or that provide services viewed as logically essential to achievement of basic program goals or performance standards. For example, many child care subsidies have been cut back to cover only TANF cash recipients or people who have recently left welfare—the groups most directly involved in TANF's performance requirements. Fatherhood programs, after-school programs, youth services, some job services, and programs that are not viewed as critical in the short-run to moving targeted clients into jobs or keeping them there are also more likely to be cut or eliminated.

Financial pressures on social assistance programs in states with low fiscal capacity are likely to continue for some years. First, although many states have been able to avoid major cuts to social assistance programs because of the surpluses they have generated in their TANF funds, these funds are being depleted quickly. Second, poor states tend to rely more on sales taxes, which will probably not recover quickly. Thirdly, the elderly population is increasing in size, especially in relatively poor southern and western states, and this will increase Medicaid spending. Finally, federal policy changes, such as the recent federal tax cuts and unfunded mandates, will increase fiscal stress on all states for years to come.

The findings from this study suggest many questions for further analysis. One study might continue to explore micro-level choices regarding which programs to preserve and which to cut. Another might examine how nonprofits in the human services area have responded to the fiscal crisis, including strategies of advocacy and reorganization. One important analysis would be aimed at developing a plan for tracking federal and state spending, at the state and even city level, in ways that are useful to different nonprofits. Still another study could focus on how private sources of funding for nonprofit services relate to the trends and geographical patterns found in the public sector. Finally, a study could examine the effects of fiscal crisis on whether states and local governments are expanding, contracting, or reforming privatization initiatives.

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PROVIDING HEALTH AND SOCIAL ASSISTANCE

By

Thomas Gais, Courtney Burke, and Rebecca Corso

Fiscal stress in the states has not always threatened spending on social programs and the many nonprofit organizations used to deliver services. As recently as the late 1980s, major social programs—such as Aid to Families with Dependent Children (AFDC) and Medicaid—were typically entitlements that were closely linked to one another and whose basic parameters changed little in the short-run at the state level. Given these fairly fixed benefit levels and eligibility criteria, bad economic times pushed up spending on social programs by expanding the eligible populations, and if nonprofits were delivering the services, such organizations might do well.[1]

A lot has changed in the last decade and a half, however, and it is reasonable to be concerned about how budgets for such programs are faring now and about the effects of spending changes on nonprofits providing social services. States face the fiscal crisis starting in 2001 with more choices than they had in the past. They have acquired greater flexibility since the 1980s in the largest of all social programs, Medicaid; and they have acquired an enormous range of options in the benefits and services they provide and the people they may serve since the mid-1990s with the enactment, expansion, or amendment of Temporary Assistance for Needy Families (TANF), the Child Care Development Fund (CCDF), the Workforce Investment Act, the Welfare-to-Work Block Grant, and other programs. These potential choices mean that states may expand and contract programs as their governing coalitions choose, a capacity that not only allows states to adjust their programs to changing fiscal conditions but may also create a more intense and wide-ranging competition for resources in state budget offices, governors' staffs, administrative agencies, and legislatures.

We argue that state flexibility, competition, and related trends in program spending and nonprofits have made some nonprofits, in some states, especially vulnerable to state fiscal crises. In states with low fiscal capacity—as measured by real per capita income—nonprofit service providers outside the health area may be severely squeezed for resources. This squeeze may be exacerbated by the tendency of many states to exempt

[1] For example, in the years between 1987 and 1992 (spanning the U.S. recession of 1990-1991), nonprofits delivering nonhealth social services grew in number by a third, from 49,180 to 65,756. Their revenue increased by 70 percent and their receipts from government grew by 97 percent (U.S. Bureau of the Census 1989; 1996).

education, one of the largest expenditures for state governments, from severe budget cuts (National Governors Association and the National Association of State Budget Officers 2003; Finegold, Schardin and Steinbach 2003). Within the remaining and fairly fixed social program pie, both rich and poor states are seeing roughly equal and substantial increases in their Medicaid budgets. As Medicaid spending grows in all states, funding streams serving nonprofits outside the health area are highly constrained in poor states. These poor states have lower grants (such as TANF) available for services outside of health; their cash assistance spending has declined about as much as can be expected and may in fact be rising; and other federal grants have been correlated with state wealth.

Through the first quarter of 2003—the latest spending figures we have available for analysis—most states were still drawing down surplus funds or using other methods to stave off a severe crunch between expanding healthcare spending and static or slightly expanding cash assistance expenditures. The surpluses are dwindling, however, and given the likelihood that fiscal stringencies will continue, we expect the problems of funding nonhealth services in states with low fiscal capacity will soon become acute. Already we are seeing increases in basic assistance spending among the poor states and growing differences between poor and rich states in their support of nonassistance programs.

Compounding the problems for nonprofits, those in the social assistance area—particularly in states with low fiscal capacity—have increased their dependence on government funding in recent decades. This dependence is even higher in low fiscal capacity states. For these and other reasons, competition for social program resources in the current state fiscal crises provides advantages for nonprofits in the health area and in high fiscal capacity states—and severe disadvantages for other nonprofits in other states.

State Fiscal Crises

The current state revenue crisis has been called "the worst state fiscal crisis since World War II."[2] Since state tax revenues began to decline in mid-2001, states have drawn down reserve funds, cut spending, and, more recently, increased taxes (Boyd 2003; Jenny 2003). But though nearly all states have faced some economic and budgetary stress, the mix of demand and supply problems has varied among the states, and these differences have shaped the challenges faced by nonprofits in providing social services.

To understand why the current crisis has been so severe and its impact so varied, we need to understand the growth of state revenues in the decade leading up to the current crisis.[3] By any measure, the middle and late 1990s were good for state finances. Between 1990 and 2000, nominal state revenues grew 90 percent (32 percent in real per capita terms). Some of this growth came from the federal government, as intergovernmental transfers to states grew by 119 percent over the decade (51 percent in real per capita dollars). Yet state "own source" revenues, mostly taxes, also grew substantially: 81 percent in nominal dollars and 26 percent in real per capita terms.

[2] Originally stated by the Chairperson of the National Governor's Association, Raymond Scheppach.
[3] This discussion of the state fiscal crisis relies heavily on Boyd (2003).

Tax revenues in the latter half of the decade benefited from the long economic boom. Substantial growth in jobs and earnings—average unemployment remained below 5 percent from 1997 until the end of 2001—boosted revenues in all states. However, some states benefited from the economic boom more than others. The extraordinary run-up in the stock market, whose value tripled between the end of 1994 and March 2000, led to a surge in capital gains. Growth in tax revenues was especially strong among states that relied heavily on corporate and progressive personal income taxes (including capital gains) and had many residents with high incomes, such as California, Connecticut, New Jersey, and Massachusetts. Many of these states enacted large tax cuts in the late 1990s (Knight, Kusko, and Rubin 2003). Despite the cuts, however, state revenues continued to rise sharply through mid-2000. States also benefited from strong personal consumption growth and non-recurring sources of revenue, such as the tobacco settlement.

This growth in revenues also led states to increase their spending by 26 percent between 1990 and 2000 after adjusting for inflation and population growth. Virtually all areas of state spending increased substantially in the 1990s. Medicaid dominated state spending growth in the first half of the 1990s, while elementary and secondary education played a greater role in the second. Nonetheless, states did not spend themselves into the budget crises. The rate of expenditure growth in the 1990s was neither high nor low in historical terms. It was slower than the growth of the 1960s and 1980s but greater than that of the 1950s and 1970s. Expenditures did not grow as fast as revenues, allowing states to build their reserve funds to a 20-year high of $48.8 billion, for all states, or 10.4 percent of revenues (Springer 2003; Boyd 2003).

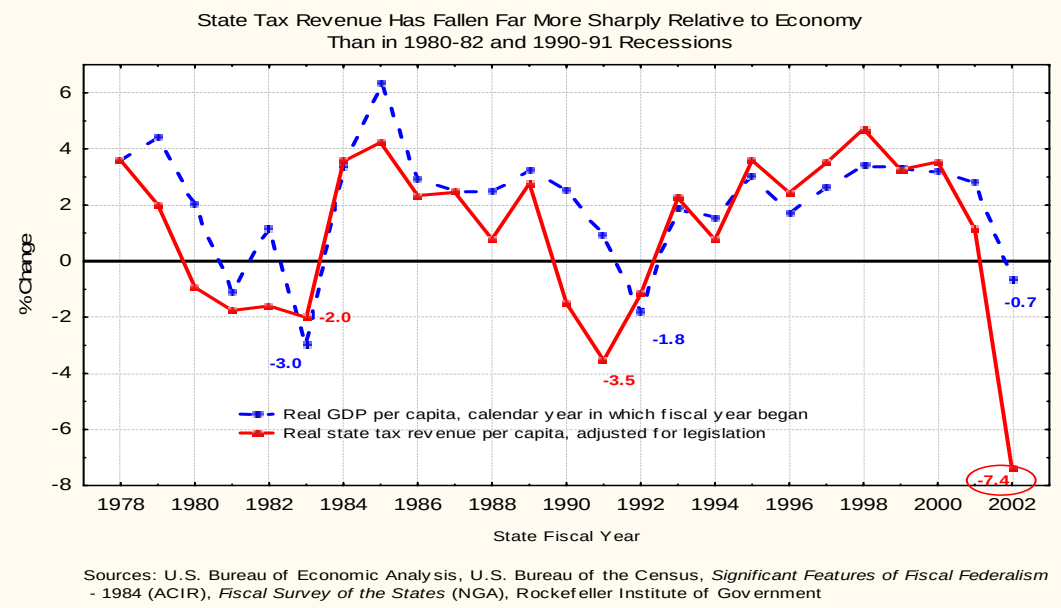
When the economy weakened in 2001, and the stock market began its long decline, the conditions generating rapid growth in revenues and expenditures evaporated. But state tax revenue was hit harder than might have been expected. As Figure 1 (from Boyd 2003) shows, fiscal year 2002 produced a 7.4 percent decline in real per capita tax revenue, more than twice as steep as state tax revenue declines that accompanied the 1990–91 and "double-dip" 1980–82 recessions. Yet declines in basic economic indicators, such as real GDP per capita, were less severe in 2002 than in the two previous recessions. The sharp losses in state tax revenues were largely a function of the rapid drop in capital gains.[4] As Donald Boyd noted in a recent paper:

> After stock markets fell for two consecutive years, this surge [in capital gains during the 1990s] was followed by a sharp drop of approximately 50 percent in 2001. The late 1990s' increase [in capital gains] was unlike any other sustained increase in the prior 50 years . . . . The huge drop in 2001 contributed to massive tax revenue shortfalls in the states, which were especially pronounced when 2001 tax returns were filed in April of 2002 [Boyd 2003].

Just as state differences in tax systems and residents generated different rates of revenue growth during the 1990s, these same differences produced different revenue losses among the states. States in the Northeast—most of which have long relied on income

[4] For an analysis arguing that state tax cuts in the 1990s were the major factors behind the drop in revenues, see Knight, Kusko, and Rubin (2003).

Figure 1



taxes—saw a one-year loss of nominal revenues between FY 2001 and FY 2002 of 15.3 percent; the Far West states experienced a fall-off in tax revenues of 11.3 percent; while the Middle Atlantic and Rocky Mountain states saw revenue declines of 7.3 percent and 7.1 percent, respectively (Boyd 2003). By contrast, state revenues dropped by less than 3 percent in the Great Lakes, the Southwest, the Southeast, and the Plains states—as many of these states relied more on consumption taxes and less on income taxes.

To see the geographical variation produced by these factors in greater detail, Table 1 shows the amount of total revenue collected by each state from 2001 to 2003 and provides the percent change in revenues from 2001 to 2003. The major declines occurred between state fiscal years 2001 and 2002, though revenues continued to drop between 2002 and 2003. As expected, the largest and earliest declines occurred among states in the Northeast (Massachusetts, Connecticut, New York, Rhode Island) and Far West (California, Alaska, Oregon), though nearly all states experienced some year-to-year revenue losses by 2003.

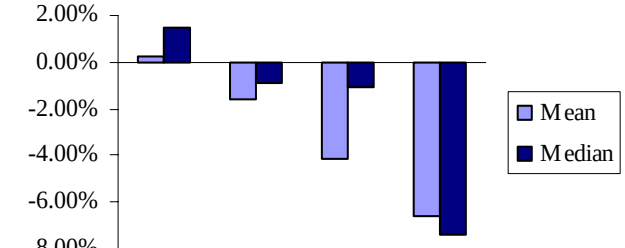
In some ways, the largest revenue declines occurred among states that had the most private resources to manage them. The states of the Northeast and Far West that saw the largest declines in tax revenues not only experienced greater than average revenue growth in the 1990s, they also tended to be *wealthy* states. That is, they had higher fiscal capacities in the sense that their taxable resources were greater and more able to support efforts to increase revenues through future tax increases.

We can see these differences in Figure 2, which compares the average revenue changes for states according to their fiscal capacities, as measured by the most widely available indicator, real per capita personal income (i.e., the mean per capita personal income for the years 1998, 1999, and 2000). The states in the lowest quartile include 13 poor states

such as West Virginia, Idaho, Mississippi, Louisiana, North Dakota, New Mexico, Arkansas, and Montana. The states in the highest quartile include Connecticut, New York, New Jersey, New Hampshire, Minnesota, and Massachusetts, and California. (See Appendix A for a listing of states by fiscal capacity.) Among the states in the lowest quartile, revenue changes between 2001 and 2003 were weak yet on average they showed slight gains. By contrast, states in the highest quartile showed the largest declines in state revenues—around a 7 percent drop between fiscal years 2001 and 2003—while the two intermediate quartiles showed revenue declines between these extremes.

The geographical pattern of severe revenue declines might suggest that the fiscal crisis hit states in a way that makes social programs and their beneficiaries less likely to be harmed. The states that suffered the greatest revenue losses in the last couple of years were those that had the greatest private resources to draw on; they also tended to be the states that, in the past, had offered the most generous benefits and services to low-income families (Gais and Weaver 2002). These comparatively wealthy states also experienced the biggest revenue increases in the 1990s, so it is possible that such states could cut back on programs or program expansions that were recent in origins without ripping the basic safety net in human service programs.

Figure 2. Changes in Revenues, 2001-2003, By State Fiscal Capacity (Per Capita Personal Income)



	Lowest	2nd	3rd	Highest
Mean	0.24%	-1.59%	-4.12%	-6.60%
Median	1.48%	-0.88%	-1.05%	-7.38%

However, the story is more complicated and less benign than that. Although revenue declines in the poor states were not as steep as those in the wealthier states, many states with low-fiscal capacity also saw revenue shortfalls. More important, these states experienced above average increases in social needs, as indicated by increases in poverty and enrollments in income support programs.

Table 2 shows changes in three measures of demand or need for social programs. Average poverty rates increased the most among the poorest states between 2000 and 2002 in the lowest quartile of states ranked according to per capita personal income, while states in the second poorest quartile also showed larger than average increases in poverty rates. Food Stamp recipients per thousand population were not only highest among the states with lower fiscal capacity—as one would expect—they also increased at a faster rate between 2000 and 2002, so that the differences between richer and poorer states actually grew. Food Stamp caseloads are useful (though not perfect) indicators of differences in state needs because their eligibility and benefit criteria are determined by national laws and because most poor families are eligible for some benefits, including many near-poor households up to 130 percent of the Federal Poverty Level.

Table 1. Total State Revenues, State Fiscal Years, 2000-2003

	State Revenues, by Fiscal Year			
	2001	2002	2003	% Change 01-03
Alaska	1,318,000	948,000	1,022,600	-28.89%
Massachusetts	16,646,000	14,209,000	13,307,900	-25.08%
California	76,436,000	62,957,000	64,730,000	-18.08%
Wyoming	652,000	570,000	553,900	-17.71%
Colorado	6,356,000	5,716,000	5,421,300	-17.24%
Virginia	11,054,000	10,619,000	9,479,700	-16.61%
Rhode Island	1,985,000	1,864,000	1,711,000	-16.01%
Connecticut	9,238,000	7,610,000	7,983,200	-15.72%
Oregon	5,063,000	4,035,000	4,397,000	-15.15%
New York	44,158,000	42,475,000	39,681,100	-11.28%
Delaware	1,708,000	1,779,000	1,556,200	-9.75%
Oklahoma	4,804,000	4,561,000	4,378,700	-9.71%
Georgia	13,688,000	12,978,000	12,640,300	-8.29%
Idaho	2,457,000	2,206,000	2,274,800	-8.01%
Vermont	905,000	817,000	845,500	-7.04%
New Jersey	17,829,000	16,752,000	16,781,800	-6.24%
Illinois	18,912,000	18,218,000	17,942,000	-5.41%
Maryland	8,255,000	7,869,000	7,874,100	-4.84%
New Mexico	3,050,000	3,017,000	2,917,917	-4.53%
Arizona	6,192,000	6,252,000	5,943,000	-4.19%
Utah	3,805,000	3,661,000	3,675,600	-3.52%
Kansas	4,145,000	3,891,000	4,012,000	-3.32%
Texas	29,868,000	28,858,000	28,917,100	-3.29%
Michigan	20,527,000	20,211,000	20,067,800	-2.29%
South Carolina	5,350,000	4,983,000	5,230,900	-2.28%
Louisiana	5,936,000	6,024,000	5,805,533	-2.25%
Nevada	2,360,000	2,395,000	2,311,100	-2.12%
Missouri	7,295,000	7,231,000	7,231,000	-0.89%
Iowa	4,776,000	4,662,000	4,735,000	-0.87%
Maine	2,437,000	2,368,000	2,432,200	-0.20%
Nebraska	2,457,000	2,366,000	2,456,400	-0.02%
Washington	10,410,000	10,248,000	10,423,800	0.13%
Hawaii	3,158,000	3,049,000	3,182,000	0.75%
North Dakota	887,000	848,000	900,100	1.46%
Arkansas	4,010,000	3,985,000	4,071,600	1.51%
Wisconsin	9,117,000	9,051,000	9,263,400	1.58%
Pennsylvania	20,091,000	19,574,000	20,497,100	1.98%
North Carolina	12,870,000	12,825,000	13,163,100	2.23%
Kentucky	6,775,000	6,721,000	6,976,000	2.88%
Alabama	5,897,000	6,026,000	6,130,700	3.81%
Ohio	15,650,000	15,474,000	16,318,000	4.09%
Florida	18,921,000	19,073,000	19,743,100	4.16%
Mississippi	4,912,000	4,886,000	5,129,500	4.24%
South Dakota	639,000	637,000	671,250	4.80%
West Virginia	2,790,000	2,895,000	2,975,900	6.25%
Minnesota	11,423,000	11,880,000	12,284,000	7.01%
Indiana	9,052,000	8,709,000	9,880,100	8.38%
Tennessee	7,675,000	7,482,000	8,440,900	9.07%
Montana	1,111,000	1,179,000	1,227,700	9.51%
New Hampshire	1,128,000	1,197,000	1,248,600	9.66%
U.S. Total/Average	***486,178,000***	***457,841,000***	***460,843,500***	***-3.67%***

Finally, TANF cash assistance caseloads have not fallen as much among poorer states as they have among comparatively wealthy states. Among the poor states, caseloads tended to be static—with no general tendency up or down—while continued declines in cash assistance cases were not uncommon among wealthier states.

TABLE 2

Changes in Need for Low-Income People
(Mean Need Levels for Each Quartile of Fiscal Capacity)

		State Fiscal Capacity--Quartiles, Per Capita Personal Income, 1998-2000			
		Lowest	*2nd*	*3rd*	*Highest*
Poverty Rates (Percentages)	*2002*	15.5	11.3	9.5	10.0
	2000	14.0	10.4	9.4	9.5
	Change	1.5	0.9	0.1	0.5
Food Stamp Recipients Per Thousand Population	*2002*	91	72	61	55
	2000	81	61	56	54
	Change	10	11	5	1
TANF Assistance Recipients Per Thousand Population	*2003*	14	17	17	21
	2000	14	16	20	25
	Change	0	1	-3	-4
Number of states =		13	13	13	12

These differences among the states should not be overdrawn. All states are seeing major revenue slowdowns, and nearly all are experiencing increases in need or demand for social programs. Still, there is an important divide and it is likely to affect the nonprofit sector. In the wealthier states, nonprofit service providers may be hurt by sharp, short-run revenue losses if states respond by cutting services. In poorer states, growing demands for services—combined with little or no growth in revenues—may not only create greater competition for government resources but also confront nonprofits with many human needs not being met by government programs.

The Fiscal Crisis and the Distribution of Nonprofits

The picture for the nonprofit sector becomes even more fractured when we look at where it *is*. How do the diverse effects of the economic downturn relate to the geographic distribution of the nonprofit organizations providing social services? Two distinct stories emerge. On the one hand, the human services part of the nonprofit sector is most prevalent among the wealthier states, which have seen the largest declines in tax revenues. If large revenue declines generate proportionate cuts in social services, we would expect that a major part of the nonprofit sector would be affected. On the other hand, the poorest states have the weakest nonprofit sectors—and thus would seem to be less able to deal with growing human needs.

To estimate the distribution of nonprofit organizations in the human services area, we examined per-capita employment in such organizations, based on data from the 1997 U.S. Economic Census.[5] Per capita employment in nonprofit organizations not only indicates the relative importance of such entities in state economies, it also compares the density of the sector's most important resource, its people, across the states.[6]

Figure 3 shows the distribution of employment (on a per capita basis) across states of different fiscal capacities for three types of nonprofit organizations: social assistance organizations, hospitals, and nursing and residential care services. These are three of the four divisions in the "Health and Social Assistance" category developed by the North American Industry Classification System (NAICS) and used by the U.S. Census Bureau.[7] The three groups include:

1. *Nursing and residential care services:* Industries in this sub-sector provide residential care combined with either nursing, supervisory, or other types of care as required by the residents. The care provided is a mix of health and social services with the health services being largely some level of nursing services. Most of the industry is for-profit, but a large part of the sub-sector (40 percent of employment in 1997) is in tax-exempt organizations.

2. *Hospitals:* This sub-sector provides medical, diagnostic, and treatment services that include physician, nursing, and other health services to inpatients and the specialized accommodation services required by inpatients. Hospitals may provide outpatient services as a secondary activity, but their primary activity is the provision of inpatient health services. The industry is largely composed of nonprofits (90 percent of the employment in 1997).

3. *Social assistance organizations:* Industries in this grouping provide a wide variety of social assistance services directly to their clients. They include child care providers, services for the elderly and persons with disabilities, vocational rehabilitation services, child and youth services, and community food, housing, and emergency services. These services do not include residential or accommodation services, except on a short-stay basis. Most of the industry is tax-exempt (72 percent of the employment in 1997).

Figure 3 shows that these nonprofit industries are larger (in per capita terms) in the wealthiest states and smaller in the poorest states. The relationship is neither simple nor linear, nor is it identical for all three sub-sectors. Nonetheless, the relationships are strong enough to suggest that the severe short-run revenue shortfalls among the wealthier

[5] Data from the 2002 Economic Census will not be available before 2004.

[6] Other measures—such as the number of organizations or their total receipts—might also be used to understand the relative size of the nonprofit sector. These indicators, however, are distributed in much the same way as employment, at least within basic types of industries, and would not affect the basic portrait of the sector.

[7] The fourth sub-sector is "ambulatory health care services," which is not included here because it is overwhelmingly composed of for-profit organizations. In 1997, only 3.3 percent of this sub-sector was composed of tax-exempt organizations, and only 15.2 percent of the people employed in this industry worked for nonprofits.

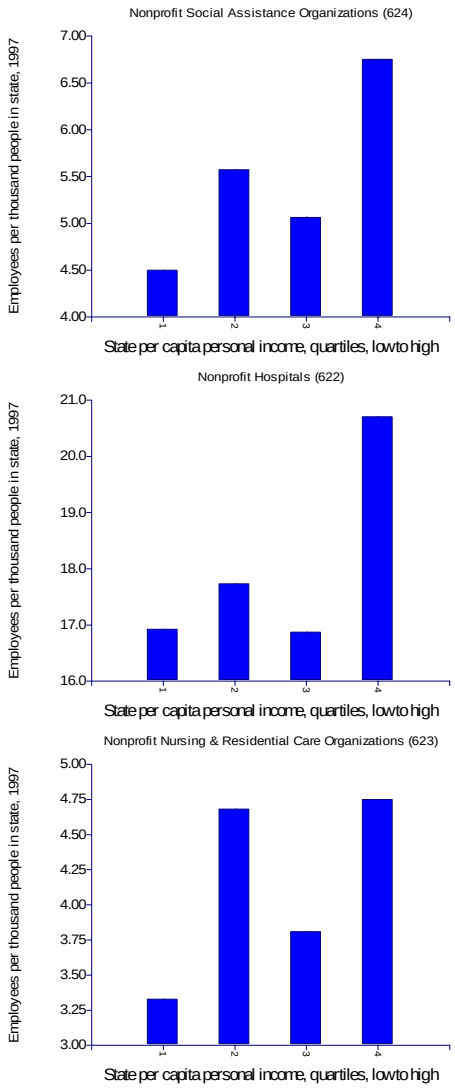
states are hitting these particular nonprofit sub-sectors where they are most prevalent. For that reason alone, the fiscal crisis could have a disproportionate impact on nonprofits providing human services. In the poorest states, a different situation is developing. In states where such nonprofits are weakest, the recession brought about the biggest increases in human needs. Thus, the problems facing human service nonprofits differ across states, and these differences appear to be related, whether directly or indirectly, to state fiscal capacity.

Reliance on Public Money

The impact of the fiscal crisis has been compounded by a recent change in the relations between governments and nonprofit organizations delivering social welfare services: These organizations have come to rely more on government funding. Table 3 used data from the Census of Business Organizations, conducted every five years, to show the growth in the proportion of total receipts that nonprofit "social assistance" organizations received from government sources.[8] For these organizations, government receipts came from two sources: (1) payments for services, and (2) contributions, gifts, and grants. Health organizations were not included, since it was difficult to discern where payments for health care ultimately came from, though it is clear that Medicaid became a major support for a wide range of health care providers (Smith 2002; Gray and Schlesinger 2002).

FIGURE 3
AVERAGE EMPLOYMENT IN NONPROFIT SOCIAL SERVICE ORGANIZATIONS IN STATES, BY STATE FISCAL CAPACITY, 1997

Employment Measured as Employees per Thousand State Population



SOURCE: U.S. Census Bureau (2000).

[8] Comparisons across time are complicated by the change in the classification of organizations from the SIC to the NAICS between 1992 and 1997. Here we compare SIC numbers 832, 833, 836, 839 in 1987 and 1992 to NAICS 624 in 1997. Unfortunately, 832 and 833 are comparable to parts of 624 but 826 is comparable to parts of 623, and there are further difficulties with 839 in the NAICS classification system. Another problem is that the 1987 survey report does not break out 832, 833, 836, and 839 but clumps them together, while the 1992 report does distinguish them. For all these reasons, comparisons between 1997 and earlier years are inexact. However, the general tendencies and conclusions are probably robust. State-level trends and differences seem reasonable, such as the considerable stability over all three years in some states (such as Arkansas), while other states showed constant rates of change (such as Pennsylvania).

TABLE 3
Percent Receipts from Government Sources for Nonprofit Social Services/Assistance Organizations

State	1987	1992	1997
Maine	66.8	70.8	81.5
Mississippi	md	48.0	76.4
New Mexico	50.3	md	74.0
Wyoming	67.1	63.3	72.4
Alaska	79.3	72.1	70.5
Louisiana	62.4	51.3	69.6
West Virginia	66.4	70.8	68.9
Vermont	53.9	55.2	68.5
Montana	61.3	60.2	67.1
Arkansas	68.6	66.2	67.0
Connecticut	48.4	57.0	66.8
Florida	34.3	43.8	66.3
Rhode Island	37.8	33.9	65.8
New York	36.8	51.5	65.8
Massachusetts	61.1	63.8	64.2
Utah	32.8	md	64.1
Arizona	42.4	53.7	63.5
Pennsylvania	48.7	54.7	63.2
California	43.3	51.0	63.2
Kansas	46.6	47.2	62.1
South Carolina	37.8	44.5	62.1
New Jersey	44.1	56.8	61.2
Idaho	64.0	53.0	61.1
Delaware	31.0	46.8	60.9
Maryland	38.8	49.2	60.7
Illinois	42.4	50.3	60.2
Michigan	45.9	52.6	59.9
Minnesota	43.3	43.7	59.2
Oklahoma	40.7	42.0	59.1
Indiana	45.2	55.3	59.0
Texas	29.7	37.5	58.8
Alabama	44.0	53.4	57.4
Missouri	43.3	42.8	57.4
Iowa	57.0	58.1	56.8
New Hampshire	60.6	62.1	56.5
Washington	41.1	45.8	56.0
Ohio	41.7	49.2	55.1
Oregon	38.5	43.7	55.1
Kentucky	41.8	48.2	55.0
Wisconsin	43.3	43.1	54.5
North Dakota	Md	54.0	54.5
District of Columbia	30.8	md	54.3
South Dakota	Md	54.5	54.1
Hawaii	47.6	42.2	52.3
Nevada	52.5	46.3	51.1
Nebraska	20.6	23.2	50.9
North Carolina	36.6	39.5	48.5
Tennessee	39.2	37.7	47.6
Colorado	35.3	44.3	43.7
Virginia	35.3	27.0	40.0
Georgia	25.5	33.0	38.9
50 State Average	**46.0**	**49.9**	**60.1**

Table 3 shows that in 1987, government sources constituted less than half, 46 percent on average, of the total receipts of social assistance organizations. This percentage grew to 50 percent in 1992, and by 1997, social assistance organizations relied on government sources for at least 60 percent of their funding. These figures probably underestimate the role of government, since in recent years governments have relied more on vouchers and even cash payments to support many services, such as child care and job training, and the payments may not always be attributed to public sources.

Not all nonprofit social assistance organizations relied on government funding to the same extent. Table 4 shows the percentage of total revenues drawn from government sources for the major subcategories of social assistance nonprofits in 1997. Organizations providing vocational rehabilitation, services for the elderly and disabled people, and other individual and family services depended most heavily on government funding—typically for about two-thirds of their revenues. Child day care organizations, child and youth service agencies, and organizations providing community food, housing, and emergency services relied less on government.

TABLE 4

Revenues from Government Sources, Nonprofit Social Assistance Organizations, 1997

	Total Revenues from Government (Thousands of Dollars)	Percent Revenues from 5451*	Percent Revenues from 9000**	Percent Revenues from Govern-ment
Vocational rehabilitation services	$4,366,305	39.8	27.7	67.5
Individual & family services	$16,650,989	34.6	28.4	63.0
Services for the elderly & persons with disabilities	$6,196,397	41.2	34.2	75.4
Other individual & family services	$6,644,940	30.4	32.8	63.2
Child & youth services	$3,809,652	33.2	16.2	49.4
Child day care services	$3,158,428	31.8	23.0	54.8
Community food & housing/emergency, other relief services	$2,828,114	18.0	28.5	46.5
Community housing services	$1,828,646	25.3	36.6	61.9
Community food services	$566,108	17.7	17.8	35.5
Emergency & other relief services	$433,360	4.3	24.0	28.3
All social assistance organizations (exempt)	**$27,003,836**	**32.7**	**27.6**	**60.3**

***Payments for counseling, community food shelter, vocational rehabilitation, child care, and related social assistance services provided to individuals and families—government payers only.*
***Contributions, gifts, and grants from government.*

Nonprofit social assistance organizations in poor states were more vulnerable to cuts in public spending: They depended more on public sources of revenue, perhaps because these states offered fewer private resources to nonprofits. Table 5 shows the average

percent of nonprofits' budgets coming from government sources in 1997 by state fiscal capacity. Social assistance organizations as a whole received an average of 64 percent of their revenues from government sources in the poorest states, higher than all the other state quartiles. Child day care services and individual family services generated most of these differences. Organizations involved in vocational rehabilitation and community relief showed no consistent pattern with respect to state fiscal capacity.

Long-Run Trends in State Spending

The state fiscal "crisis" thus shows two different faces. The wealthier states saw precipitous drops in revenues, though the fall-offs came extraordinary increases in revenues due in part to capital gains in the middle and late 1990s. These drops occurred in states where the human service nonprofits were strongest and most concentrated, suggesting that any cuts that states make in response to the fall-off in revenues could have a disproportionate impact on the national nonprofit sector—an impact that might be greater now than in past recessions because nonprofits have come to rely more on government funding in recent years.

TABLE 5

Average Percentage of Nonprofit Organization Revenues Obtained Directly from Government Social Assistance Organizations, 1997 Census Survey

	State Fiscal Capacity; Quartile of States Ranked by Per Capita Personal Income, 1998-2000			
Type of Nonprofit Social Assistance Organization	***Lowest Quartile***	***2nd Quartile***	***3rd Quartile***	***Highest Quartile***
Vocational rehabilitation services	70%	75%	62%	72%
Individual & family services	67%	60%	59%	61%
Child day care services	61%	52%	50%	49%
Community food & housing/emergency & relief services	51%	54%	42%	52%
All social assistance organizations (exempt)	***64%***	***59%***	***55%***	***60%***

But there is another, perhaps more complicated face to the economic crisis. In states with low fiscal capacity, the short-run drop in revenues was not as great, but human needs have grown even faster than in the wealthier states. Because the nonprofit sector is smaller in the poorer states on a per capita basis, private human service organizations are more likely to be strained to meet these needs—and whatever budget cuts in social services that states do impose may have a larger impact on the nonprofits in these states, since they tend to rely more on government funding. As we will see in the remainder of this paper, the stresses on the nonprofit sector in states with low fiscal capacity appear to be even more acute when we consider both long-run and short-run developments in state human service expenditures.

To examine expenditure trends over time, we use the U.S. Census Bureau's survey of government expenditures, which includes annual data on spending by state and local

governments on several components of the very broad expenditure category of "Public Assistance." Although there are six subcategories in Public Assistance, we simplified them by creating three types of expenditures:

1. "Cash assistance" includes direct payments to people under federal assistance programs, such as TANF and SSI, as well as other cash payments made directly to needy persons, such as programs of general or home relief, emergency relief, energy assistance, housing expense relief, and other benefits.

2. "Medical assistance" is simply the Census Bureau subcategory "Vendor Payments for Medical Care." It includes "payments under public welfare programs made directly to private vendors . . . for medical assistance and hospital or health care . . ." Although limited Medicaid spending may be found in other Census subcategories, this one may be reasonably treated as a proxy for Medicaid.

3. "Other public welfare" collapses three Census subcategories, "Other public welfare," "Vendor payments for other purposes," and "Welfare institutions." These expenditures include payments to private vendors for services and commodities (other than medical, hospital, and healthcare) on behalf of needy persons; provision, construction, and maintenance of public nursing homes, veterans' homes, and homes for the elderly or aged; children services, such as day care, foster care, adoption, and nonresidential shelters; welfare-related community action programs; social services for the physically disabled; and administrative costs, including case management, for welfare and other assistance programs.

Although nonprofits have substantially increased their roles in administering TANF assistance programs in recent years—as in certain cities and counties in Wisconsin, Arizona, and Texas—most of the "Public Assistance" dollars going to nonprofits are funneled through the latter two categories, with health-related organizations receiving the bulk of the "medical assistance" dollars and non-health organizations getting support for their services through the catchall "other public welfare" category.

To determine whether and how funding for needy families has changed in recent decades, we examined these three categories of expenditure data between 1980 and 2000 (the most recent year available). The data were adjusted for inflation (in 2000 dollars) and standardized by expressing the expenditures per total persons in the state (i.e., per capita) and per poor person (using a three-year average to reduce measurement error). The data are displayed in five-year intervals in Table 6.

The overall trends in the last two decades appear to be good for nonprofit organizations. After controlling for general inflation, the two spending categories most likely to involve private service providers—"medical assistance" and "other public welfare"—grew substantially over the years. On a per capita basis, "medical assistance" more than tripled between 1980 and 2000, while "other public welfare" doubled. By contrast, cash assistance declined in real terms, especially after 1995. The result is a very different profile of public welfare spending in 2000 than in previous years. In 1980, cash assistance was $83 out of a total of $334 per capita spending on public assistance—about

25 percent of the total. Three-fourths of the public welfare budget was spent in ways likely to involve many private organizations, including nonprofits. By 2000, only 7 percent of the public welfare budget involved direct cash payments to individuals—the remainder tended to involve services and benefits, many of which were provided by nonprofits. Since the total dollar amounts increased even after adjustments for inflation, there is little question that nonprofits and other private service organizations have gained access to a much larger part of the state human service budgets.

The changes have been especially pronounced since the mid-1990s. As the right-hand column of Table 6 demonstrates, cash assistance dropped in real per capita terms by $21 between 1995 and 2000—a fall of 28 percent. Medical assistance—again, on a real per capita basis—increased by 10 percent, while other public welfare spending grew by 17 percent. Since the number of poor people fell during this five-year period, these two increases in spending were even greater relative to the number of poor people in the states. "Other public welfare" spending, for example, grew on a per-poor-person basis by 45 percent between 1995 and 2000.

TABLE 6
Changes in Median State Expenditures on Social Programs, 1980-2000
Spending in 2000 Dollars

1. Expenditures per capita (median)						
	1980	*1985*	*1990*	*1995*	*2000*	*1995-2000*
Cash assistance	83	63	68	75	54	-21
Medical assistance	159	187	255	488	537	49
Other public welfare	92	102	126	158	185	27
2. Expenditures per poor person (median)						
	1980	*1985*	*1990*	*1995*	*2000*	*1995-2000*
Cash assistance	632	527	585	650	521	-129
Medical assistance	1,139	1,276	1,966	4,039	5,205	1,166
Other public welfare	695	814	1,010	1,238	1,790	552

This recent transformation in spending on social programs was examined in greater detail in a study by the Rockefeller Institute—in collaboration with the Brookings Institution and the U.S. General Accounting Office—by examining changes in federal and state spending in 17 states between 1995 and 1999 (with some data from 2000). Using common data instrument, the three institutions compared social program spending through state budgets before and after the implementation of welfare reforms (Boyd and Billen 2003).

The results were similar to the patterns in Table 6 though they provided greater detail regarding nonhealth expenditures. Cash assistance declined in all states and more than 50 percent in nominal terms in over half of the states (9 out of 17), while non-cash-assistance spending increased substantially in all but one state. The most widespread increases in spending occurred in child care. Yet spending on "work support" functions—such as basic job services, employment-related training and education

programs, transportation, post-employment services, and state earned income tax credits—also increased widely and vigorously, with only two states showing declines.

Child welfare services—including adoption assistance, foster care, independent living programs, and many others—also grew in nearly all states. Spending growth was less consistent though generally weaker in the two remaining non-cash-assistance categories: "other welfare-related services," including juvenile justice, family formation/pregnancy prevention, and substance abuse and treatment programs; and "other basic needs," usually in-kind benefits such as housing and food assistance programs in the state budget (e.g., not Food Stamps).

In general, then, spending increased between 1980 and 2000, and especially since 1995, in ways likely to benefit nonprofit service organizations. Less money is spent through state budgets on cash assistance, while more dollars are spent on medical assistance and a wide variety of services that tend to support work activities, provide in-kind benefits, and remedy certain severe barriers to work and independence, such as substance abuse.

State Fiscal Capacity and Differences in Spending

There are, however, important state differences in these trends, and those differences are correlated with state fiscal capacities. Figures 4A, 4B, and 4C show median state expenditures per poor person on the three basic social program functions between 1980 and 2000 and compare these trends for states of different fiscal capacities. Fiscal capacity is again measured in terms of per capita personal income in each state. Because we are interested in changes over a longer period of time, fiscal capacity was estimated by averaging per capita personal income over the 20-year period.[9]

States of all fiscal capacity levels—whether in the poorest ones in the lowest quartile or the wealthiest states in the highest quartile—showed the same general trends toward lower spending on cash assistance, rapid increases in spending on medical assistance, and moderate growth in spending on "other public welfare." Yet there were important differences. Declines in cash assistance spending were strong among the states with higher fiscal capacity between 1995 and 2000 (Figure 4A). These were states that typically offered more generous cash grants, and as many families left the rolls either voluntarily or no, the states saw large declines in spending on cash assistance. States with low fiscal capacity, on the other hand, generally offered smaller cash grants, less generous earnings disregards, and stricter asset limits. As a result, people in these states tended to use cash assistance for short periods of time, and spending on cash assistance was never very high. That meant, however, that these states got little fiscal dividend

[9] Although state fiscal capacity certainly varies over such a long period, there is surprisingly little movement from one quartile to another over this period. In later sections when we analyze post-2000 changes in spending, we use a different time period for estimating states' fiscal capacities, namely, the average per capita personal income for 1998 through 2000. This more recent division of states is very closely correlated with the division created from the 20-year averaging, with no states showing more than a one quartile difference between the two distributions. See Appendix A for a cross-tabulation between these two measures.

Figure 4A. Average State Spending Per Poor Person on Cash Assistance, By State Fiscal Capacity, 1980-2000

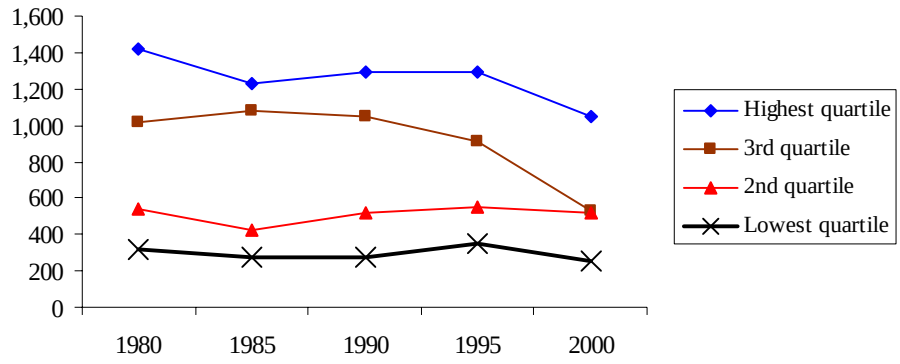


Figure 4B. Average State Spending Per Poor Person on Medical Assistance, By State Fiscal Capacity, 1980-2000

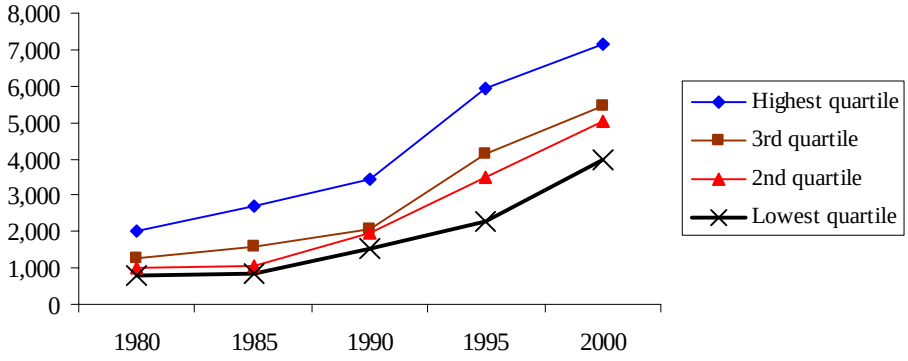
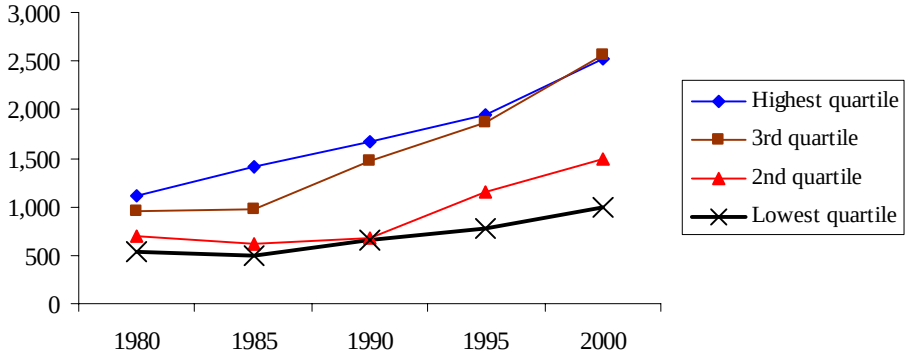


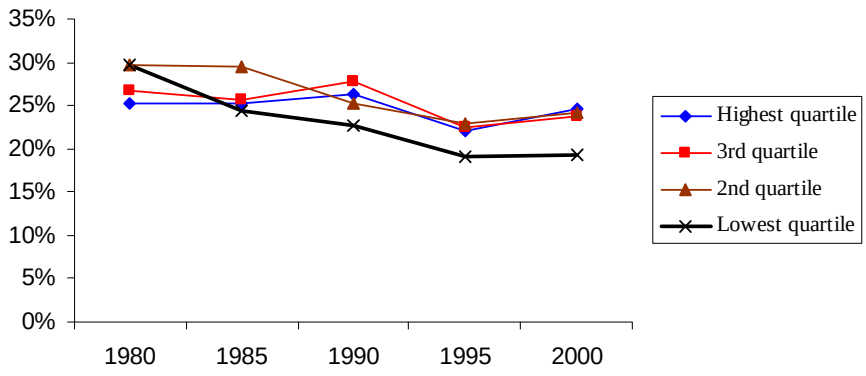
Figure 4C. Average State Spending Per Poor Person Other Other Public Welfare Services, By State Fiscal Capacity, 1980-2000



when TANF caseloads declined in the late 1990s (also see Boyd and Billen 2003). The 1990s thus brought large financial savings to wealthy states, savings they could apply to noncash forms of assistance, an opportunity poor states did not have.

By contrast, spending on medical assistance grew in all states during the 1990s, quickly in the early 1990s and steadily in the latter half of the decade (Figure 4B). The growth was stronger among the poorer states. One consequence was that by 2000, the differences in spending by rich and poor states on medical assistance per poor person had diminished. In 2000, states in the highest quartile spent 1.8 times as much ($7,173 per poor person) as those in the lowest quartile ($3,999 per poor person). That ratio was down from the 2.6 in 1995—and was the lowest ratio in the two decades. These changes meant that an increasing share of human service spending was being absorbed by medical assistance among poor states. By 2000, medical assistance constituted 75 percent of the total public welfare budget in the poorest states, compared to 65 percent in the richest quartile.

Figure 4D. Percentage of Public Welfare Spending on "Other Welfare" (Neither cash nor medical assistance), 1980-2000



The lack of a large fiscal dividend from falling expenditures on cash assistance and the rapid growth of spending on medical assistance suggest that poor states might have fewer resources to spend on "other public welfare" functions, including many of the services traditionally provided by nonprofit social assistance organizations outside the health field. In the resource-rich late-1990s, this problem had not yet appeared. In constant dollars, as Figure 4C shows, spending grew for this function among the poor states in the 1990s. Yet the rate of growth was much slower in these states. As a result, *a growing divide between poor and rich states emerged by the late 1990s in their spending on "other public welfare" functions.* As a percentage of total public welfare spending, these "other public welfare" expenditures declined substantially in the poorest states—from 30 percent of the total in 1980 to only 19 percent in 2000 (see Figure 4D). By contrast, in the wealthiest quartile, "other public welfare" spending remained nearly constant throughout this period at about 25 percent of the total public welfare budget.[10]

[10] Although we do not have direct evidence about how much nonprofit social assistance organizations rely these "other public welfare" expenditures, we have some indirect evidence. We regressed the per capita number of employees in social assistance organizations in 2001 (using the Bureau of Labor Statistics ES-202 data, which includes for-profit as well as nonprofit organizations) on a number of state-level variables,

The spending trends at the end of the decade thus produced an asymmetry among the states. The poorest states were being pressed by a rapidly growing medical assistance budget. Their cash assistance expenditures had virtually no more room to go down. The consequence was that their non-health, non-cash public welfare spending—the spending most likely to go to nonprofit providers outside the health area—was becoming a smaller part of the public welfare pie.

Post-2000 Changes in State Spending

To understand how and where nonprofits are being affected by the current fiscal crisis, we need to know how different states are changing their social program spending—and especially how states of different fiscal capacities are responding to the challenges posed by the economic downturn.

TANF and Child Care

TANF

One funding stream where states have great flexibility in supporting social programs is the federal block Temporary Assistance for Needy Families (TANF), enacted in 1996 as part of the nation's welfare reforms. States have the authority to use the block grant for many purposes, including the promotion of work, marriage, two-parent families, reducing out-of-wedlock births, and helping needy children live with their parents. They have used their flexibility in spending TANF and Maintenance of Effort (MOE) funds to generate great diversity and change among state public welfare policies and budgets (see Gais, Nathan, Lurie and Kaplan, 2001).

We should note, however, that TANF is more likely to reinforce than counteract differences in state fiscal capacity. TANF grants were based on federal spending levels under Aid to Families with Dependent Children (AFDC), which themselves were

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including per capita spending on "cash assistance," "medical assistance," and "other public welfare" in 2000. The independent variables also included state per capita personal income (as a private source of financial support) and the state's poverty rate in 2001 (as an indicator of need). The estimated regression equation showed that state spending on "cash assistance" and their poverty rates had no impact on per capita employment in social assistance organizations. Per capita personal income had a marginally significant but not a very strong effect. By contrast, "other public welfare" and "medical assistance" spending showed significant relationships to employment in social assistance organizations. The estimated effects of spending and nonprofit employment was about 2.4 times greater for "other public welfare" expenditures than for "medical assistance." See estimated equation below:

Dependent variable: Employment in social assistance organizations, per capita, 2001	***Regression coefficient***	***t-value***
Intercept	-1.32×10^{-3}	
Federal poverty rate (1998-00 avg)	7.17×10^{-3}	0.78
Per capita personal income (1998-00 avg)	1.23×10^{-7}	1.89
Cash assistance spending per capita, 2000	3.57×10^{-6}	0.77
Medical assistance spending per capita, 2000	3.71×10^{-6}	2.36
Other public welfare spending, per capita, 2000	8.92×10^{-6}	2.85
N = 51 $R^2 = 0.62$		

strongly correlated with state fiscal capacity (Plotnick and Winters 1985). The size of the grants varied greatly across states. As Kent Weaver noted:

> [T]here are immense disparities across states in the block grants received per low-income child. In the 10 states receiving in the least generous federal grant [nearly all of which are states with low fiscal capacity], the TANF block grant providers only $429 per low-income child, while in the 10 states receiving the most federal dollars [nearly all of which are states with high fiscal capacity], TANF provides around five times as much [2002].

The TANF block grant essentially froze a major part of the resource base for nonhealth social service spending and limited the ability of states with low fiscal capacity to respond to large and unequal increases in social needs. We might thus expect different dynamics between rich and poor states as they adapt their TANF grants to the fiscal and economic crises.

We began to see some changes not long ago as we received reports on local TANF implementation from the Rockefeller Institute's last round of TANF field research in late 2001 and 2002 (for a brief overview of some of our findings, see Fossett, Gais, and Thompson 2003). Only a few states had been hit by the economic downturn early enough to strongly affect FY 2002 budget decisions, but even at this early stage we discerned some of the criteria states and localities were using to distinguish between which programs would remain and which would be eliminated. Arizona—a states with low fiscal capacity—was one of the first states to be hit hard by the recession, and its budget crisis was exacerbated by the passage of a citizen initiative (Proposition 204) that greatly expanded Medicaid spending by increasing the program's eligibility limit from about 30 percent of the federal poverty level to 100 percent of the federal poverty level.

This voter initiative plus an early economic downturn pushed up TANF cash assistance rolls and led Arizona to make several cuts. Most of the cuts were in recently enacted service programs in which nonprofits participated, including a transportation program, a program to help "young fathers" become self-sufficient and involved with their children, a parenting skills program, a character education program for youths (people under 19), and post-employment training for TANF families. Arizona also reduced its administrative staff and even eliminated job services (except by phone contacts) for one group of TANF recipients, namely, single-parent families in rural districts. These families were singled out as expensive to serve and more likely to meet their federal performance criteria than were the two-parent families.

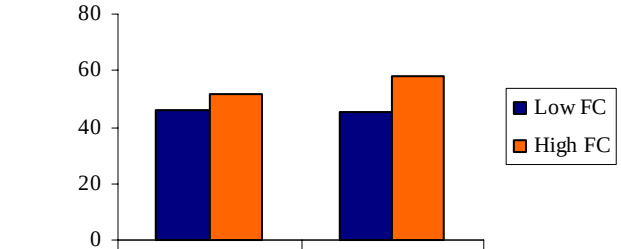
Another poor state, West Virginia, reduced its cash assistance grants by cutting its earned income disregard from 60 percent to 40 percent in early 2002. The state also reduced the size of its diversionary cash payments by 25 percent and lowered its definition of economically needy from 185 to 150 percent of the federal poverty level. The state also gave formal notification to many community service organizations and others that $27 million in contracts and grants would not be renewed for the 2003 state fiscal year, though some of these were eventually reinstated.

Wealthier states also made changes. Michigan slashed its administrative staff, largely through early retirements. It eliminated "fatherhood" programs and after-school programs for youths. Washington State cut after-school programs and programs for parenting and family management skills; it increased co-payments on child care benefits; and it also imposed reductions in administrative staff.

To get a more precise and up-to-date understanding of TANF responses to the economic downturn, the Rockefeller Institute requested the quarterly TANF financial report, ACF-196, from a selection of states that were hit hard by the economic downturn, ensuring diversity in state fiscal capacity as well as whether the states were mostly affected by increases in need (measured by Food Stamp caseloads) or declines in state tax revenues. The list of 19 states from which we obtained reports may be found below.[11] To see how spending patterns changed before and after the recession, we obtained second quarter reports for federal Fiscal Years 2000 and 2003 from the U.S. Administration for Children and Families. These second quarter reports cover state spending for the first six months of each federal fiscal year, from October 1 through March 31. Since the ACF-196 Form breaks down expenditures in several categories of assistance, nonassistance, and services, it permits us to see whether and how states are reshaping their spending priorities in response to new budgetary pressures. Thus far, we have obtained paired reports for 10 low-capacity and 9 high-capacity states (based on median per capita state income averaged over 1998-2000).[12]

One question is whether the recession affected *who* was being served by the TANF program. In the 1990s, there was a substantial shift away from "assistance" (mostly cash but also child care for nonworking parents and some other services that did not support work) and toward "nonassistance" (including just about any other benefit or service, though mostly child care, transportation, and job services for working families or families seeking work). The question is important for nonprofits not only because it is roughly related to the cash *vs.* services dichotomy but also because it affects

Figure 5. Average Percent TANF Spending on Nonassistance, By Year and State Fiscal Capacity



	2000	2003
Low FC	46.1	45.6
High FC	51.8	58.3

[11] Arizona, California, Colorado, Connecticut, Illinois, Kansas, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, New Jersey, North Carolina, Oregon, South Carolina, West Virginia, and Wisconsin. These states were selected because they had larger than average revenue declines between 2000 and 2003 or had larger than average increases in Food Stamp caseloads. We also added some low fiscal capacity states that were near-average on these change indicators in order to ensure balance with respect to low and high fiscal capacity.

[12] We have requested reports from all states under a Freedom of Information request, but we do not expect to receive the remaining reports until late November at the earliest.

whether certain groups (such as working families, who tend to benefit from nonassistance) will be needing services to compensate for public cuts.

As Figure 5 shows, states with low fiscal capacity *reduced* the proportion of their expenditures going to nonassistance between 2000 and 2003. By contrast, states with high fiscal capacity states continued to *increase* the proportion of expenditures going to nonassistance. The net effect was a growing difference between the clienteles served by high-capacity and low-capacity states—and a reversal of the typical pattern in the 1990s, when poor states spent a larger share of their TANF money on nonassistance.[13]

This shifting balance between nonassistance and assistance is only one of the many changes states are making in their human service budgets. To understand the changes relevant to nonprofit sector in greater detail, Table 7 divides TANF spending into four main categories:

1. Basic assistance—mostly cash assistance delivered, though not always, through public agencies;

2. Services, which are often provided through nonprofits, including work-related services, child care, supportive services (mostly transportation), family structure programs (e.g., promoting marriage and preventing out of wedlock births), and "other" services (including transfers to the eclectic Social Services Block Grant).

3. Other direct payments to individuals, such as state refundable earned income tax credits and individual development accounts; and

4. Administrative costs and information systems, which typically go to public agencies rather than nonprofit providers.

These categories were selected in part because they suggest different impacts on nonprofits. We should note, however, that their assumed mapping onto nonprofits at best reflects general tendencies. In Milwaukee, for example, nonprofits dominate the delivery of Wisconsin's W-2 program, the closest thing the state has to a "cash assistance" program (Kaplan 2000). Some for-profit organizations provide a wide variety of services in some states, especially in the work-related areas of job placement and preparation. And, of course, many child care providers are for-profits. Also, there are substantial shifts in states from one type of provider to another—and some "taking back" of functions once contracted out to nonprofits—so a single funding stream will have a shifting relationship to the nonprofit sector and its components. For example, our field research team in Missouri learned that one of the first responses by the state to budget scarcities in FY 2002 was to eliminate contracted case management services (admittedly, not a large program) and bring all such services in-house. Still, these categories roughly

[13] One reason why low fiscal capacity states put less of their TANF money into cash assistance in the 1990s was because they typically offered smaller cash grants and less generous earnings disregards (see Gais and Weaver 2002). Thus, during a period when labor participation rates were expanding, even part-time workers lost eligibility for basic assistance and were more likely to be part of the state's "nonassistance" population.

connect major nonprofit sources to the reporting categories available under the federal TANF reporting system.

The table cells show per capita spending (for two quarters only, since we received the mid-year reports) for each of the functions, divided by year and state fiscal capacity.[14] The main categories are in bold italics. Below the large services category, there are several subcategories. These subcategories sum to the main category above them. We also show the size of the TANF grant for the two quarters covered in 2000 and 2003 and the "unobligated balance."

TABLE 7
TANF Spending on Selected Functions, 2000-2003

Table entries are per capita dollars spent on function for the first two quarters (six months) Of the federal fiscal years 2000 and 2003

	Low Fiscal Capacity States		High Fiscal Capacity States	
Functions	2000	2003	2000	2003
Basic assistance only	***8.3***	***10.3***	***14.4***	***14.5***
Services	***11.0***	***12.4***	***21.3***	***23.0***
Child care (child care for families on assistance, nonassistance, as well as transfers to CCDF)	3.6	5.4	12.7	12.0
Work-related activities (work subsidies, education and training, job services, etc.)	2.2	2.4	3.2	2.5
Support services (transportation, etc.)	1.1	1.1	.5	.8
Family structure (programs promoting marriage and 2 parent families; preventing out of wedlock pregnancies)	0.8	0.1	0.2	1.1
Other services (includes transfers to the Social Services Block Grant)	3.3	3.4	4.7	6.6
Other direct benefits to individuals (refundable earned income tax credits, individual development accounts, non-recurrent SR benefits)	***1.5***	***1.0***	***2.2***	***3.7***
Administrative expenditures/systems	***2.7***	***2.3***	***3.4***	***3.4***
Unobligated funds	***7.2***	***4.5***	***10.3***	***4.9***
Total TANF grant (2 quarters)	***20.2***	***22.1***	***32.6***	***32.6***
Number of states =	10	10	9	9

As expected, poorer states spent much less under TANF on a per capita basis than wealthier states for all types of spending. Differences between states with high fiscal capacity and ones with low fiscal capacity were especially great for services. In 2003, states with low fiscal capacity spent $12.4 dollars per capita per six months on services, while states with high fiscal capacity spent $23.0 dollars per capita during the first two quarters of the fiscal year—85 percent more than poor states. The differences in spending on child care spending were especially great. States with high fiscal capacity spent 122 percent more than states with low capacity in 2003. Differences were not as

[14] We use per capita spending rather than "per poor person" to standardize data since data on the number of poor people is not available in the most recent years, while population data are.

substantial for basic assistance. In 2003, states with high fiscal capacity spent $14.5 dollars per capita per half year on basic assistance, 41 percent more than the $10.3 spent by states with low fiscal capacity. Thus, wealthier states were putting more of their TANF grants and MOE expenditures into service programs that frequently involve nonprofits.

States also differed in the changes they made between 2000 and 2003. Poor states substantially increased their spending on basic assistance—that category grew on a per capita basis by nearly 20 percent between 2000 and 2003. Wealthier states showed no significant per capita increase—perhaps reflecting the different caseload dynamics we noted in Table 2.

Somewhat surprisingly, poor states also increased their spending on child care, while states with higher fiscal capacity cut theirs (mostly by transferring less money into CCDF). Poor states also kept up their spending on other services with the exception of the small amounts previously spent on family structure services—funding for these programs in poor states was nearly eliminated by 2003. Wealthy states increased spending on programs related to marriage and pregnancy prevention; direct benefits to individuals (such as diversion payments or refundable earned income tax credits); and especially "other" functions, such as transfers to SSBG.

How were poor states able to increase spending on both basic assistance and services? They cut administrative expenses, spending on information systems, and other direct benefits to individuals (e.g., diversion payments). They also reduced their "unobligated funds" under TANF by nearly 40 percent. States with low fiscal capacity also benefited from an increase in their TANF grants between 2000 and 2003, largely a result of supplemental funding that kicked in during the economic downturn. We can therefore see the expected pressures on the poor states in these data; only child care providers got a little a more money. But it is also clear that the pressures through early 2003 had been alleviated by TANF surpluses and the extra federal assistance during the recession.

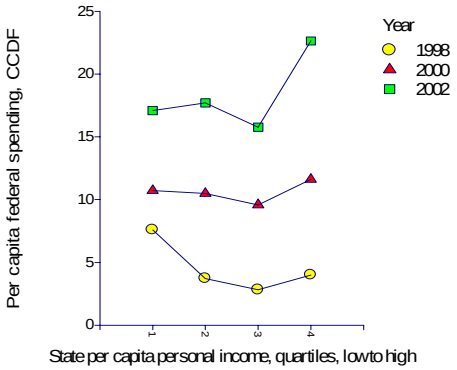


Figure 6. Average state spending (from federal sources only) on the Child Care Development Fund, 1998-2002; By State Fiscal Capacity

SOURCE: U.S. CENSUS BUREAU. FEDERAL AID TO STATES (1999, 2001, 2003).

These mitigating factors, however, are quickly dwindling, making it unlikely that the increased spending on services between 2000 and 2003 can be sustained. Although only one of the 19 states in our sample had zeroed out its "unobligated balance" under TANF in 2000, five states had reached that point in 2003. The U.S. General Accounting Office also found that, starting in 2001, states had begun to draw heavily on their TANF reserves, and that these reserves have declined quickly through FY 2003 (U.S. General Accounting Office 2003).

We should also note that though there is some prospect that child care funding may be increased when TANF is reauthorized, the current bills under consideration by the U.S. Congress do not increase TANF grants to the states, making it more difficult for states with low fiscal capacity to increase their spending on TANF services if their basic assistance spending continues to rise.

Child care

Child care spending in the TANF budget represented only some of the funds available for that function. The Child Care and Development Fund block grant has grown substantially since the mid-1990s. However, even over the four-year period between 1998 and 2002, there was an important shift in the distribution of these funds, one that reinforced the correlation in TANF between spending on child care and state fiscal capacity. Figure 6 presents part of the picture by showing average state spending from federal sources (which constitutes the great bulk of spending under CCDF) in 1998, 2000, and 2002—broken down by state quartiles with respect to per capita personal income.

The increase in spending under CCDF was substantial for all states, but the greatest increase occurred among the wealthiest. In 1998, CCDF federal spending had a mild inverse relationship to state fiscal capacity—which one would expect, given the greater proportion of poor and near-poor families in such states. By 2002, however, the relation had become mildly positive, with higher levels of federal spending on child care among the wealthiest states. Thus, even though direct child care spending under TANF declined slightly between 2000 and 2003 (Table 9) among the wealthier states, and such spending increased among the poorer states, these changes are counterbalanced by other shifts in child care spending, with the effect of creating greater differences between poor and rich states in spending on nonprofit child care organizations.

General patterns and criteria

Although TANF and child care budget figures are still fairly stable through mid-2003, that does not mean that there are not major shifts in who is getting services, what kinds of services they are getting, and which organizations are delivering them. That sort of updated detail requires field research, however. The Rockefeller Institute is now conducting such research in six states as part of a study with the Lewin Group on factors affecting state spending on social programs—under contract with the U.S. Department of Health and Human Services. However, the results of that study will not be available until the late winter of 2004. In the meantime, we summarize a number of recent studies by other organizations regarding detailed changes in TANF programs and related child care subsidies as well as our findings from the 2001-02 field research.[15]

Several patterns stand out as relevant to nonprofit organizations:

[15] We only discuss enacted changes. Gubernatorial proposals or budget bills are often changed before they reach their final form and often misleading.

1. Social welfare programs that do not serve core constituencies—constituencies whose short-run behavior is key to program performance or other critical program goals—are more likely to be cut. After-school programs and other programs serving youths are not faring well. In Colorado, for example, the first programs to be cut in 2002 were youth diversion programs and some other TANF programs directly serving children.[16] Fatherhood programs and other efforts to serve noncustodial parents have also been reduced or eliminated. Note, for example, the cuts in mentioned above in Arizona, Michigan, and Washington State. Mississippi also eliminated its fatherhood programs, which constituted a large part of its charitable choice initiative (Bartkowski 2003). The Center for Budget and Policy Priorities (CBPP) found similar cuts, such as a Wisconsin work-based learning program for youths (Parrott and Wu 2003).

2. Services that do not seem to be necessary conditions for the achievement of key goals are also vulnerable. For example, many job and training services have been cut or eliminated. CBPP also found cuts in job and educational services, including literacy programs (Parrott and Wu 2003). Such services may be viewed as effective but are not always viewed as necessary conditions for getting people into jobs, since many people are seen as willing and able to get jobs on their own (particularly now, as many new TANF entrants come from the workforce).

3. On the other hand, services that are viewed as logically required for basic program objectives—such as transportation and child care—are less vulnerable to large cuts. It is true that CBPP found cuts in transportation programs in a number of states (in our sample, they would include Massachusetts, Arizona, and Wisconsin), and it found many cuts in child care. However, at least through FY 2003, many of the transportation programs have survived (perhaps if for no other reason than because they are too small to save much money), and the child care cuts have typically not hit the core TANF constituency, i.e., people on the cash assistance rolls or those who have recently left.

4. Where cuts have been made in child care, they have been imposed on families outside the core TANF constituency (i.e., families on TANF or those who have recently left welfare). A recent study by the U.S. General Accounting Office (2003a), for example, found that, based on a survey completed in March and April of 2003, about one-third of the states (15) reported no changes since January 2001 in their child care subsidy programs; 23 states reported reductions; 9 states indicated expansions; and 3 states showed a mix of cuts and expansions. Many of the cuts involved reductions in eligibility for working families who were neither on TANF nor recently on welfare, and who are viewed as less the state's basic performance criteria (e.g., work participation rates or caseload reductions). Other reductions in access included increases in co-payments. These changes may reduce child care providers' income somewhat, but they do not seem likely to threaten the nonprofit child care industry in a major way. There are, however, exceptions. Texas (on the basis of per capita income, a state with moderately low

[16] Communication with Malcolm Goggin, RIG field research associate in Colorado.

fiscal capacity) made major cuts in child care in FY 2003, including an $80 million reduction in transfers to CCDF.

5. Indeed, some of the direct payments to child care providers have been the least likely elements of the child care programs to be cut. In the GAO study, 28 out of 32 states *increased* reimbursement rates to child care providers. Only four states cut those rates. States also reported increases in their child care quality improvement programs in 22 states, while only 10 states reported decreases.

6. The budget data presented above as well as our own field research in a number of program areas suggest that this budget crisis will differ from earlier ones in the size of the cuts in administrative staff and system improvements. Nonprofits may have a particularly important role to play in helping low-income families navigate through increasingly harried and overwhelmed eligibility workers and case managers.

7. There is plenty of anecdotal evidence that one of the major changes in TANF spending will be its use as a funding source for programs whose own funding sources are cut or endangered. The increased spending on "other" services is just one bit of evidence. Another GAO study found that states were using TANF to replace some of the cuts in federal funds in the Social Services Block Grant (SSBG) (U.S. General Accounting Office, 2003b). Texas has greatly increased the TANF and MOE dollars allocated to a wide range of state agencies. The budget of the state's Department of Protective and Regulatory Services increased its reliance on TANF/MOE funds from 10 percent to 29 percent between 1997 and 2001. Competition for TANF/MOE dollars may be encompassing a much wider range of agencies and programs.

Of course, FY 2004 and FY 2005 may show different pictures, probably worse. For the moment, however, the nonprofits that are most likely be hurt thus far are those serving adolescents and at-risk youths; providing after-school programs; offering education, training, and job services to low-income people; helping low-income fathers or other noncustodial parents; and (though this will vary greatly across states) providing child care to low-income families. And all of these tendencies will probably be much more severe in low fiscal capacity states.

Medicaid

Medicaid is not only the largest and fastest-growing part of state public welfare budgets, it is, on average, the second largest component of state spending after education. Medicaid pays for a wide range of services, including physician services, hospital care and long-term care. Nonprofits that are providers—whether they are hospitals, skilled nursing facilities, or mental health facilities—have long relied on Medicaid funding. Since Medicaid costs have been growing in recent years from prescription drugs, hospital costs, increased enrollment, and other factors, the program has been the focus of many state budget debates.

As noted above, states with low fiscal capacity saw rapid growth through 2000 in the *percentage* of state spending occupied by Medicaid. This trend emerged out of (1) strong growth in Medicaid spending in all states, including the poor ones, even on a per capita basis and controlling for inflation; and (2) lower growth rates in other forms of social program spending, especially cash assistance, especially among poor states. The last section noted that in recent years, the economic downturn has pushed cash assistance spending back up a bit in states with low fiscal capacity. In this section, we will note that Medicaid spending is continuing to grow even in recent years of budgetary scarcity. Assuming that public welfare spending as a whole will be under some pressure from education spending, corrections, roads and highways, and other basic functions not to expand its total share of the state budget, the combination of continued growth in

TABLE 8
Changes in Medicaid Spending: State, Federal and Total, 2000 – 2003
(Based on Federal Fiscal Years)

	State/Local			Federal			Total		
State	2000	2003*	% Change in State/Local Share	2000	2003*	% Change in Federal Share	2000	2003*	% Change in Total Spending
High fiscal capacity states									
Connecticut	475	541	14%	480	566	18%	955	1,107	16%
New Jersey	372	482	30%	375	489	30%	746	971	30%
Massachusetts	517	647	25%	523	660	26%	1,040	1,307	26%
New York	816	1,035	27%	824	1,048	27%	1,640	2,083	27%
Colorado	232	295	27%	236	301	27%	468	596	27%
Illinois	327	290	-12%	336	294	-12%	663	584	-12%
Minnesota	346	492	42%	373	500	34%	719	992	38%
California	318	426	34%	349	443	27%	667	868	30%
Michigan	336	390	16%	413	477	16%	749	867	16%
Wisconsin	264	414	57%	375	583	55%	639	997	56%
Oregon	268	357	33%	404	542	34%	673	899	34%
Lower fiscal capacity states									
Kansas	222	282	27%	332	428	29%	554	710	28%
Missouri	290	378	31%	440	592	35%	729	970	33%
North Carolina	266	321	21%	439	535	22%	705	856	21%
Maine	333	444	34%	641	860	34%	973	1,304	34%
Arizona	146	120	-18%	313	257	-18%	459	377	-18%
South Carolina	209	581	178%	479	311	-35%	688	893	30%
Louisiana	239	319	34%	555	781	41%	793	1,100	39%
New Mexico	191	268	40%	521	804	54%	712	1,072	51%
West Virginia	208	263	27%	589	755	28%	797	1,018	28%
Mississippi	170	242	42%	548	782	43%	718	1,025	43%

*The first two quarters of FFY 2003 are real expenditures. To get the full fiscal year, we doubled the first two quarters, except for Maine and Wisconsin, which is the first quarter multiplied by four because the second quarter expenditures were not available.

SOURCE: The Medicaid expenditure data came from the Centers for Medicare and Medicaid Services. Data for 2000 came from the web site at http://www.cms.hhs.gov/medicaid/mbes/sttotal.pdf. Data for 2003 were obtained directly from CMS.

Medicaid and a reversal or halt in the decline in cash assistance spending will put some pressure on nonhealth human services—to the probable detriment of nonprofit providers that cannot tap into Medicaid.

As Table 8 indicates, the growth we saw in the Medicaid "proxy" in the spending data seems to have continued through early 2003, for rich and poor states alike. The table shows Medicaid spending per capita for 2000 and 2003—the latter is estimated based on the first two quarters of spending (the most recent reports available). Growth in both state and local spending as well as federal funding continued in nearly all states, typically at high rates. Because the states are ranked in the table according to their fiscal capacity—from the wealthiest, Connecticut, to the poorest, Mississippi—it is possible to see how fiscal capacity relates to state and local spending on this program. There is, in fact, a relationship, with richer states typically paying more per capita of their own revenues on Medicaid. But it is also clear that poor states have been increasing their own spending on Medicaid more quickly than wealthier states in recent years.

TABLE 9.

Average State/Local and Federal Spending on Medicaid Per Capita Spending and Percent Change in Per Capita Spending, 2000-2003

	Low Fiscal Capacity States		High Fiscal Capacity States	
	2000	2003	2000	2003
State/local spending on Medicaid, per capita	231	325	400	501
Percent change, 2000-2003	40.7%		25.3%	
Total spending on Medicaid, per capita	709	929	829	1,037
Percent change, 2000-2003	31.0%		25.1%	
Number of states =	11	11	10	10

Table 9 shows these patterns more directly. Summarizing the changes represented in Table 8, Table 9 shows that growth in state and local spending on Medicaid was especially strong among states with low fiscal capacity, though growth was substantial nearly everywhere. Thus, while we are seeing growing differences among states with respect to fiscal capacity outside the health area, states' spending for Medicaid is converging. Indeed, as suggested already, this rapid growth in health spending across all states may have contributed to the growing divergence among states *outside* the health area.

Still, many states have tried to rein in Medicaid spending in recent years, and these efforts to control Medicaid costs can have varying impacts on the nonprofit sector. For instance, cuts in provider payments impact nonprofits because many of these providers rely upon Medicaid payments. Charging Medicaid recipients' co-payments may also have a peripheral effect on nonprofits because there could be a subsequent decline in the number of people served, due to the deterrent effect of co-pays on service utilization. Similarly, cuts in eligibility could also impact nonprofit organizations because with a smaller eligible population, nonprofit organizations could experience a decline in the amount of fees collected for services. Medicaid benefit reductions could also impact nonprofits providing the particular benefit or service that was cut. Other actions, such as

pharmacy cost controls, or programs to decrease fraud and abuse may have less of an impact on nonprofit organizations.

Of course, it is possible that states can rein in Medicaid spending, and nearly all states are trying to do that in some ways. These Medicaid "cost control" measures, such as holding provider rates constant, implementing cost and utilization controls for prescription drugs, eliminating certain benefits from coverage, charging co-pays or cracking down on fraud and abuse, may also have major impacts on nonprofit providers. What is interesting, however, is that although most media reports about Medicaid make it appear as though the program is being significantly cut in the current fiscal crisis, a closer examination of state actions reveals that Medicaid has in fact fared well in state budgets through FY 2003 and FY 2004. A study of 17 states' budget actions in FY 2003 revealed that most states shied away from large cuts to eligibility and instead took actions to control prescription drug costs or hold provider rates constant (Fossett and Burke 2003).

(1) Benefit Cuts: A closer examination of benefit cuts in FY 2004 shows that most states targeted cuts at particular services—with some types of services and populations being hit more often than others. For instance, specialized services—such as dentists, podiatrists, chiropractors and therapists were more likely to be cut. Interestingly, many states that cut these benefits in FY 2003 restored them FY 2004 (Smith, et al. 2003, p. 20). For instance, Kansas restored vision, audiology and diapers, while Massachusetts restored Medicaid coverage of orthotics and prosthetics.

(2) Eligibility Cuts: Similar to changes in benefits in FY 2004, several states not only cut eligibility but many also *restored* or *added new categories* of eligibility in FY 04. For instance, Illinois added children with family incomes up to 200 percent of the federal poverty level to SCHIP, as well as adding certain parents and seniors to the Medicaid program. New York added a buy-in program for the working disabled, while Oregon expanded SCHIP from 185 percent to 200 percent. Some states did cut back eligibility. For instance, Massachusetts tightened eligibility for disability, capped enrollment for some populations and eliminated benefits for Special Status Immigrants (Smith, et al. 2003; see Appendix I). Minnesota rolled back a recent eligibility expansion of the federal poverty level requirement (from 170 percent federal poverty level 150 percent) and reduced newborn eligibility from 24 to 12 months. Even with these "cuts," one could argue that the impact on nonprofits providers was minimal—since most states had recently expanded eligibility to new categories. In fact, given the fiscal situation of states, it is surprising that so many were able to maintain the eligibility expansions that were common in the late 1990s and 2000.

(3) Provider cuts: The most broad-based actions taken by states to control costs and most likely to impact nonprofits, were cuts to provider payments. The amount that nonprofit health care providers receive from government varies. For instance, some hospitals receive a substantial amount of money from government while others do not. Recent changes to provider payments ranged from substantial rate cuts to less drastic measures such as not implementing planned payment increases. Here are the actions that were taken by states to change provider payments in FY 2004:

1. Managed Care Organizations: Rates were cut or unchanged in 19 states, including five states that cut rates and 14 states that froze rates.

2. Nursing Homes: Six states cut and 13 states froze rates.

3. Hospitals: Ten states cut and 22 states froze hospital payment rates. Hospital rates were actually *increased* in 22 states in FY 2003 and in 19 states in FY 2004.

4. Physicians: Three states cut and 35 states froze physician rates. Physician rates were increased in 11 states in FY 2003, and again in 11 states in FY 2004.

It appears that the budget action that was most common was to leave rates unchanged, whether the rates were for managed care organizations, nursing homes, hospitals, or physicians. Also interesting is the fact that many providers received *increases* in their rates in both FY 2003 and FY 2004. Also, hospitals, which include a large number of nonprofits, fared relatively well in both FY 2003 and FY 2004 considering the fiscal situation of many states. For states that did cut provider rates, it is difficult to discern whether or not nonprofit organizations will suffer more or less than for-profit providers. In some states, cuts to provider payments may impact only certain types of providers—such as dentists—whereas in other states, cuts in provider payments could impact hospitals or a range of therapy providers. The distribution of nonprofit providers and the services they deliver also varies from state to state, again making it difficult to determine the precise impact of provider cuts.

Medicaid has withstood major cuts in most states, and most evidence suggests that the nonprofit health care organizations that draw on Medicaid dollars have as well. Medicaid's robustness may be due to a number of factors: the high matching rate for Medicaid, which makes it undesirable for states to cut; the strong and organized constituency of Medicaid providers and populations that rely upon Medicaid money that were successful at abating cuts; and the perception of "health care" as a positive government program as opposed to other social assistance programs seen as less desirable. As Medicaid has become a larger part of state budgets and eligibility has been expanded, the number of people receiving benefits or business from the program's existence has grown, making program cuts more difficult—perhaps leaving fewer resources for other nonprofit social service providers.

Other Social Programs

We do not have state and local spending data on the multitude of social programs in which nonprofits participate, but we can put the developments we have discussed above in a fuller context by examining how important federal intergovernmental grant programs have fared in recent years. Only a few have been selected for trends and differences across states of different fiscal capacity. These programs typically have extensive participation by nonprofit organizations in their administration:

1. *Head Start.* This early childhood development program targets poor preschool children. It has a funding ceiling. Eighty percent of its funding comes from the federal government. Many of its service providers are nonprofits.

2. *Social Services Block Grant.* SSBG (or Title XX of the Social Security Act) is a capped entitlement program, with each state entitled to a share of the funds based on population. States apply the funds to a wide range of goals and activities, including preventing child abuse, providing child care, and offering community or home-based care for the elderly and disabled. Actual spending by states may vary on a per capita basis because states differ in how they spend the monies across years and how much (if any) they transfer TANF money to SSBG programs. Many if not most of the providers are nonprofits.

3. *Substance Abuse and Mental Health Services Administration.* This agency of the U.S. Department of Health and Human Services supports the Mental Health and Substance Abuse Prevention and Treatment Block Grant Programs, which encourage states to address substance abuse prevention, addiction treatment, and mental health services. Many of the service providers are nonprofits. For example, in a 2002 survey of facilities providing substance abuse treatment, 61 percent of the facilities were nonprofits, followed by private for-profits (25 percent), and state and local governments (11 percent) (Substance Abuse and Mental Health Services Administration, Office of Applied Studies 2003).

4. *Emergency Shelter and Homeless Assistance.* Funds are distributed by formula and competition and may be used for a variety of housing activities, supported on a short-term, emergency basis or on a more permanent basis, including acquisition, rehabilitation, new construction of facilities, tenant rental assistance, and supportive services. Although data on providers are scarce, many would appear to be nonprofits.

5. *Community Development Block Grant.* This is a federal entitlement program in which funds are allocated to states and local governments to provide decent housing, a suitable living environment, and expanded economic opportunities for low- and moderate-income families. This is one of the most flexible funding programs. Nonprofits can apply to their local government for CDBG funds.

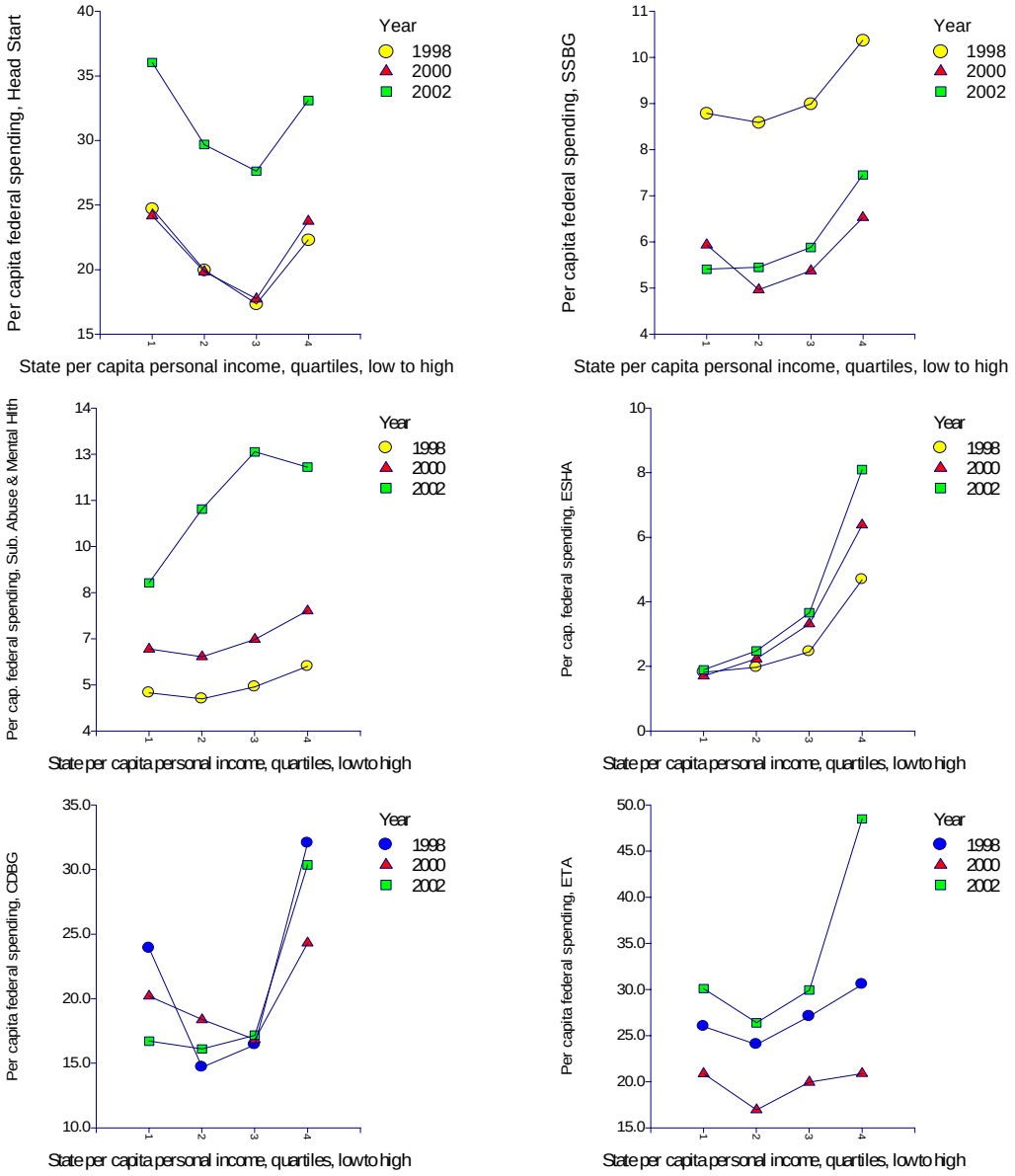
6. *Employment and Training Administration.* This program provides job training and employment services for adults, youth, and displaced workers. Many providers of these services are nonprofits.

Figure 7 shows the average per capita funding levels of these programs across the four fiscal capacity quartiles. The funding only includes the federal dollars (dominant or exclusive among these programs) and covers 1998 through 2002.

Even a cursory review of these programs suggests that they are not likely to compensate for the problems faced by social assistance nonprofits in states with low fiscal capacity. Among these six, Head Start is the only program or group of programs that (1) has grown

Figure 7. Selected Federal Intergovernmental Grants to State and Local Governments, By State Fiscal Capacity: 1998, 2000, and 2002

Points are Averages (Means) for Each Federal Fiscal Year and for Each Quartile of States According to their Fiscal Capacity (1=Lowest/poorest to 4=Highest/wealthiest)



Programs included above:

(1) Head Start
(2) Social Services Block Grant
(3) Substance Abuse and Mental Health Services Admn
(4) Emergency Shelter and Homeless Assistance
(5) Community Development Block Grant
(6) Employment and Training Administration

SOURCE: U.S. CENSUS BUREAU. FEDERAL AID TO THE STATES (1999, 2001, 2003).

substantially in funding since 1998 and (2) provides largely equivalent per capita funding to poor and rich states. SSBG provides roughly similar levels of funding across states of different fiscal capacity (though there is some tilt toward the richer ones, probably as they have built up greater reserves over the years and transferred more money from TANF). However, the program has lost considerable value even in nominal terms since 1998. Interestingly, as the program has become smaller in recent years, states have put a greater share of the money into child welfare (especially protective) services and less into day care—perhaps indicating a triage effect (U.S. Department of Health and Human Services, Administration for Children and Families, Office of Community Services 2003:105).

The federal aid programs provided by the Substance Abuse and Mental Health Services Administration have increased in value in recent years, but the greatest increases by far have occurred in states with higher fiscal capacity. Emergency Shelter and Housing Assistance, already a small program, has grown very little overall and not at all in the states with low fiscal capacity. The Community Development Block Grant decreased substantially in nominal terms among the poorest states between 1998 and 2002; states with the highest fiscal capacity experienced an increase in value between 2000 and 2002. Employment and Training Administration programs experienced a similar pattern, with states with the highest fiscal capacity seeing the greatest increases in recent years. At least among these programs, federal funding has not mitigated the squeeze faced by nonprofit service organizations unable to tap into Medicaid.

Conclusions and Implications

Rather than a uniform impact, we found an increasingly divided sector, both geographically and functionally, in the effects of state fiscal problems on nonprofits involved in social programs. One division was between nonprofits that can access Medicaid funds and those that cannot. Medicaid spending has grown substantially in nearly all states—and it is continuing to grow in the first years after the recession. By contrast, funding streams outside of the health area showed slower and more varied growth before the recession, and parts of the nonhealth social services budget have either been cut or appear to be quite vulnerable.

A second and related division was between rich and poor states. It is true that wealthy states saw steeper drops in tax revenues at the start of the decade, and that most of the nonprofits in the health and social assistance area were located in such states. However, several factors mitigated the effects of state fiscal problems on nonprofits in states with high fiscal capacity. The declines in revenue among these states were in part attributable to the extraordinary growth in revenues among such states in the 1990s, as their income tax systems reaped the benefits of unprecedented growth in capital gains. Indicators of needs, such as cash assistance rolls, did not rise as fast in wealthy states as elsewhere. Nonprofits in states with high fiscal capacity were less dependent on government for revenues. Finally, the human service budgets of wealthy states were more balanced across health and nonhealth expenditures, perhaps reflecting the larger federal grants that such states received under TANF and other nonhealth programs likely to involve nonprofit service providers.

By contrast, states with low fiscal capacity have seen significant increases in human needs, putting pressures on nonprofits as well as governments. Poor states have not benefited in recent years from fiscal dividends generated by declines in cash assistance rolls. Instead, their cash assistance rolls have bottomed out or begun to creep back up.

At the same time, Medicaid spending in the poor states has grown just as fast—in many cases, faster—than health spending in much wealthier states. Medicaid has thus become an even larger part of poor states' social program budgets in recent years, and the program's importance for funding a wide variety of services and major institutions in these states have made it even more difficult to control. Since there is little to cut in these poor states in the cash assistance area, the only place left to make reductions during a fiscal crisis is in the many services and in-kind benefits *outside* the health area. Such cuts could have a particularly harsh effect on nonprofits in poor states since such organizations rely more on government sources of revenue to for financial support.

Through FY 2003, there remained enough slack in the system (such as TANF surpluses) to alleviate the severity of this budgetary logic. But if state fiscal pressures and spending dynamics continue, we would expect to see major losses in government support among non-health nonprofits in poor states.

Unfortunately, despite recent increases in state revenues (Jenny 2003), these fiscal pressures and spending trends on human service spending will probably continue for some years. Spending pressures outside of human services have shown little signs of weakening: Education expenditures, for example, have been exempted from interim cuts in many states even as recently as early 2003, and pressures to keep up such spending will probably continue as more attention is given to student test scores.

Also, sales taxes may be depressed for some years as consumption, which has grown faster than income in recent years, resumes a growth rate more in line with income. Sales taxes also face the long-run problems of taxing services and internet commerce, both growing components of the economy (Boyd 2003; Lav 2003). Because states with low fiscal capacity rely heavily on consumption taxes, these problems may exacerbate the fiscal challenges facing poor states.

Nor are increases in Medicaid spending likely to be curtailed unless states make unprecedented reductions in eligibility and coverage. As Boyd argues:

> A major looming risk to Medicaid is that the cost of long-term care, hospital care, prescription drugs and other expenditures that are particularly important for the elderly will rise as the population ages. Medicaid expenditures per elderly beneficiary are more than three times as large as expenditures for the non-elderly. . . . [A]bout three-quarters of projected growth in Medicaid expenditures is attributable to rising costs of care for the aged and disabled [2003].

These effects, Boyd goes on to say, will first hit many southern and western states, many of which have low fiscal capacity.

Finally, a number of federal policy changes aggravate these fiscal problems. Recent federal tax cuts have reduced state revenues "because of linkages between federal and state tax codes" (Lav 2003:1). Unfunded mandates are being imposed on the states, including homeland security and education requirements. And federal health policies have encouraged cost-shifting from Medicare, which is fully funded by the federal government, to the Medicaid program, especially for low-income elderly and disabled people (Lav 2003:2-3).

If these or other factors sharpen the division between rich and poor states in their human service budgets—particularly outside the health area—parts of the nonprofit sector may become more concentrated geographically. It is possible that rather than complementing the public sector service system, distribution of private nonprofits would magnify differences among states with respect to their human service policies and budgets. Such a development might also hurt the nonprofit sector in politics at the national level by reducing the number of members of Congress representing districts or states where nonprofit service organizations are diverse, plentiful, and employ many citizens.

These trends may also produce other changes among nonprofits. Barriers to entry are high for organizations wanting to access Medicaid funds—the program generally requires considerable professionalism in service providers and their staff—and to the extent that it becomes the major source of funding for nonprofits, more voluntaristic, less formal organizations will need to rely more on private funding, if funding can be obtained at all. Many faith-based organizations, in particular, would have limited opportunities in Medicaid-dominated systems.[17]

Many questions emerge from this study that are worth exploring in future analyses:

1. *Micro-level choices about budget priorities:* Much more research could be done on the characteristics of programs and their providers that are critical in state budget decisions about which services to cut and which services to sustain. We noted that a crucial element for the survival of a program may be a logically tight linkage to a core constituency, one that the state or agency is mandated to serve or that directly and immediately affects performance requirements. But for a systematic comparison of these choices across states, field research is needed. The research could also explore the relative weights of fiscal funding formulas, the perceived human stakes in programs (e.g., some programs involve life-and-death issues, such adult and child protection programs, while many do not), agency reputations for good or bad management, and many other factors.

2. *Nonprofit strategies and adaptations:* Once these choices are understood, including their variation from state to state, we can then develop better predictions about which programs are more likely to be vulnerable to economic cycles and which programs are more likely to survive. These insights ought to help nonprofit advocacy in how to structure and relate programs to constituencies and performance requirements. But the insights can be further developed by an

[17] The authors thank Jim Fossett of the Rockefeller Institute and SUNY-Albany for these points.

analysis that focuses on how health and nonhealth nonprofits have adapted to and otherwise dealt with the fiscal crisis and the trends described in this paper. The study could examine advocacy tactics as well as longer-run organizational strategies, such as the use of institutional mergers or other cooperative arrangements across the health-nonhealth divide to help nonprofits smooth expected resource flows over time.

3. *Tracking federal and state spending, by state and perhaps by major city, in ways convenient to nonprofits in the human services area:* The enormous state variations in what they spend on different social service functions are not captured well by the highly aggregated U.S. Census Bureau categories or the highly complex and varied administrative data on individual programs. A study that develops, in close cooperation with nonprofits, a classification system for state-level expenditures that can be updated with available administrative data could be quite useful for nonprofit advocates, federal and state officials, journalists, and policy analysts. It would especially useful if the study formulates a business plan for organizing and supporting the updating of such data on an annual basis and for making the information easily accessible to such different audiences (as the Rockefeller Institute is already doing with many data sets in its Gateway to State and Local Information Project; see http://stateandlocalgateway.rockinst.org/). As part of this initial study, the work begun in this paper could be expanded to include a wider range of human service programs to see a more complete and detailed picture of recent and long-run trends and state variations in human service spending. Also, since the Gateway Project is planning to track the economic conditions and finances of large cities, where many nonprofits operate, this monitoring could be expanded to include major municipalities.

4. *Understanding the effects of private sources of funding:* Our work has focused on the changes and variations in public spending for human services. We have not examined the question of whether and how private giving reinforces or helps to compensate for these patterns. For example, we have not examined the question of whether private giving has followed the same trend toward health needs and away from nonhealth supports. Nor do we know whether or not the private giving shifts toward programs or services that are most vulnerable to public cuts. Some interesting work has been done on how private charitable giving is distributed across states. Dan Rygorsky and Dick Winters found that, contrary to the "crowding out" thesis, states that were more generous in their public programs also had citizens who were more generous with charitable contributions to human service organizations (2002). This finding may imply that states with low fiscal capacity (and thus less likely to support generous public programs) do not tend to generate high levels of voluntary contributions. But much more research on these issues remains to be done, including analyses that distinguish between private funds from different sources (such as foundations as opposed to individuals) and between different needs (such as health vs. nonhealth programs).

5. *Structural responses:* We do not know whether the fiscal crisis has led to intensified efforts at privatization, or a pulling back of functions from nonprofits

or for-profits. Some states may attempt to save money by privatizing functions, while others may decide that they must perform functions "in house" to sustain a basic level of staffing in their agencies. In our 2001-02 TANF field research, for example, one of Missouri's first responses to budget cutbacks was to eliminate contracts for case management services and perform all such services with state employees. Whether privatization efforts are being renewed, expanded, eliminated, or added—and whether such efforts differ from those launched a few years ago under very different economic conditions—could be a very useful study for nonprofits. The study might also explore whether other arrangements are being developed between public and private agencies, such as greater efforts at local coordination of activities or even joint public and private initiatives.

This state fiscal crisis follows in the wake of enormous changes in social programs and federalism. Policymaking and budgetary power have been devolved down to states and localities. Spending has shifted away from cash assistance and toward a complex array of services. Service delivery systems and sometimes major public administrative functions have been privatized. Medicaid coverage has been greatly expanded and the program has become of critical importance to a wide variety of health needs and industries. These and other changes have fundamentally altered the competition for resources for social programs in the states, alterations that nonprofits should understand and to which they may need to adapt if they want to survive through future periods of fiscal stress.

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APPENDIX A

State Quartile Rankings, Based on Per Capita Personal Income, Averaged over 1998-2000 and 1980-2000

Per Capita Personal Income (1998-2000) Quartiles

Per Capita Personal Income 1980-2000 (average) Quartiles	1st	2nd	3rd	4th
1st	AL, AK, ID, KY, LA, MS, MO, NM, ND, SC, UT, WV	SD		
2nd	OK	AZ, IN, IA, ME, MO, NC, TN, TX, VT, WY	GA, NE	
3rd		KS, OR	FL, MI, OH, PA, RI, VA, WI	CO. MN, WA
4th			AK, DE, HI, NV	CA, CT, DC, IL, MD, MA, NH, NJ, NY

1st = lowest per capita personal income
4th = highest per capita personal income