Unforeseen Consequences: Medicaid and the Funding of Nonprofit Service Organizations

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Abstract Medicaid reimbursements have become a key source of funding for nonprofit social service organizations operating outside the medical care sector, as well as an important tool for states seeking resources to fund social service programs within a devolving safety net. Drawing on unique survey data of more than one thousand nonprofit social service agencies in seven urban and rural communities, this article examines Medicaid funding of nonprofit social service organizations that target programs at working-age, nondisabled adults. We find that about one-quarter of nonprofit service organizations—mostly providers offering substance abuse and mental health treatment in conjunction with other services—report receiving Medicaid reimbursements, although very few are overly reliant on these funds. We also find Medicaid-funded social service nonprofits to be less accessible to residents of high-poverty neighborhoods or areas with concentrations of black or Hispanic residents than to residents of more affluent and white communities. We should expect that the role of Medicaid within the nonprofit social service sector will shift in the next few years, however, as states grapple with persistent budgetary pressures, rising Medicaid costs, and decisions to participate in the Medicaid expansion provisions contained within the 2010 Patient Protection and Affordable Care Act.

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Introduction

Medicaid, a federal-state jointly financed public program that provides health coverage for low-income children, adults, and elderly, has become one of the most prominent and costly components of the contemporary American safety net. In 2010 Medicaid program outlays totaled $404 billion for health and specialized care coverage to nearly 54 million children, adults, and elderly persons (HHS, SAMHSA, OA 2012). A majority of Medicaid expenditures finance health care coverage for elderly and disabled populations, although Medicaid spends roughly $70 billion annually to provide insurance coverage for nonaged, nondisabled populations (Holahan and Ghosh 2005; Zedlewski et al. 2006). Medicaid expenditures and enrollment have increased steadily over the past decade, driven by the rising number of elderly, children, and uninsured working-poor Americans eligible for coverage (Holahan et al. 2011). Implementation of the Patient Protection and Affordable Care Act (ACA) should continue to increase the number of nonelderly, nondisabled adults eligible for Medicaid-covered services (Holahan et al. 2012).

Research surrounding Medicaid focuses primarily on the financing and provision of health insurance for low-income and at-risk eligible populations. Social policy and welfare state researchers give far less attention to the role that Medicaid plays in the funding of social service programs assisting low-income populations outside the formal health care system. Social service organizations, mostly community-based nonprofit organizations, provide a wide array of assistance with job training, adult education, counseling, child welfare services, and temporary emergency food or cash assistance to millions of low-income Americans. Delivering more than $100 billion in services and assistance to low-income populations each year, nonprofit social service organizations have become increasingly important actors within the antipoverty safety net and critical sources of support for nondisabled working-age adults in the past few decades (Allard 2009b; Smith 2008, 2012). Evidence suggests that Medicaid reimbursements have become more prominent sources of funding for nonprofit social service providers operating outside the formal health care system during this period, although data limitations inhibit precise assessments of the degree to which Medicaid funds now extend into this portion of the nonprofit sector (Allard 2009b; Holahan and Ghosh 2005; Smith 2008; Vladeck 2003; Walker and Osterhaus 2010).

Increased Medicaid support of nonhealth, nonprofit social service organizations has a number of implications for the provision of safety-net

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assistance in America that strongly suggest the need for greater scholarly inquiry. First, Medicaid financing of social service programs is a creative solution to dilemmas surrounding public funding of devolved safety-net programs in the American federal system. Medicaid allows state government to fulfill growing social service program responsibilities while shifting a portion of the financial burden for these safety-net responsibilities to the federal government. For nonprofit service providers, Medicaid can be a very useful tool given that other sources of program funding such as the Social Services Block Grant or state funding have become increasingly scarce and less predictable. Second, not all social service organizations or low-income individuals can participate in the Medicaid program. Client eligibility criteria and administrative requirements for Medicaid reimbursement favor certain population subgroups, services (e.g., home care and mental health), and types of nonprofit providers over others. Unequal access to Medicaid-funded social service programs may follow, with many high-need populations and communities having inadequate access to assistance and funding. Third, with nearly half of all states opting out of the Medicaid expansion provisions of the 2010 ACA that will provide greater funding opportunities for social service providers, even greater state and regional inequalities in access to services may emerge in the coming years.

Data limitations have prevented significant scholarly inquiry into how Medicaid matters to nonprofit social service organizations and the communities those organizations serve. Existing data sources cannot accurately assess the degree to which Medicaid has penetrated these critical components of the nonprofit social service sector (Allard 2009b; Smith 2008, 2012). Medicaid program data often do not specify the types of organizations or providers that receive funding; nonprofit finance data commonly commingle Medicaid reimbursements with a number of other governmental and private insurance sources of fee revenue. Overall, then, these data limitations leave scholars with little information about the share of nonprofit social service organizations outside the health care system that receive Medicaid reimbursements, the characteristics or locations of those organizations, and the degree to which those organizations are reliant on Medicaid dollars.[1]

A lack of basic information about the role of Medicaid in nonhealth social service provision may lead scholars of social welfare policy and

1. One exception is research examining the delivery of home care and community care for the mentally ill and developmentally disabled. See Kaiser Commission on Medicaid and the Uninsured 2012a.

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policy makers to overlook the implications that changes in the landscape surrounding Medicaid should have for nonprofit social service organizations serving millions of needy individuals each year. Even though low-income adults may experience greater Medicaid program eligibility in the coming years, financial pressures created by eligibility expansion and state decisions to opt out of the ACA's Medicaid expansions may limit the degree to which Medicaid-funded social services are available. Ironically, because of a lack of capacity or providers, increased Medicaid eligibility may not increase access to many types of social services currently funded through the program.

Without a more detailed understanding of Medicaid's role in nonprofit social service provision, however, assessing exactly how Medicaid policy change might translate to street-level service provision is difficult. Several key questions about the role of Medicaid within the contemporary nonprofit social service sector remain open in this very fluid policy environment: Why has Medicaid become a prominent financier of nonhealth, nonprofit social service provision? Which types of nonprofit social service organizations receive Medicaid funding? How does Medicaid funding fit into the revenue portfolios of community-based nonprofit social service providers? Are nonprofit social service organizations receiving Medicaid more likely to target certain population or client subgroups than they are others?

To answer these questions, we begin with a brief overview of the nonprofit social service sector and how programs are funded today, including a discussion of how Medicaid reimbursements fit into the nonprofit fiscal landscape. Next, we examine receipt of Medicaid reimbursements among a diverse set of more than one thousand nonprofit social service organizations in metropolitan Chicago, Los Angeles, and Washington, DC (including the Virginia and Maryland suburbs), as well as organizations operating in rural regions of Kentucky, Georgia, and New Mexico and the rural border counties of Oregon-California. These survey data are particularly useful to understanding the role of Medicaid in nonprofit service provision because the organizations surveyed primarily serve working-age nondisabled adults outside the formal health care system and thus are not commonly part of the discussion surrounding the Medicaid program. Contrary to what social welfare policy scholars might expect, we show that Medicaid funding is deeply connected to nonprofit social service organizations whose primary mission lies outside health care. In fact, Medicaid is funding many nonprofit organizations that provide employment and basic assistance programs. In this study, we identify key organizational factors

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associated with receipt of Medicaid and then examine whether social service providers receiving Medicaid funds are spatially accessible to places with concentrations of low-income households or racial and ethnic minorities, population subgroups particularly likely to be eligible for Medicaid. Finally, we conclude with a discussion of the policy implications of our findings and directions for future research.

Nonprofit Social Service Organizations and Today's Antipoverty Safety Net

Nonprofit social service organizations have become a prominent source of support for low-income populations as part of the American antipoverty safety net. We define nonprofit social service organizations broadly to be legally incorporated, 501c(3) tax-exempt entities that are registered with the Internal Revenue Service (IRS) as primarily providing one or more of the following types of services: mental health, substance abuse, domestic violence counseling, care for the disabled, legal aid, employment and job training, food assistance, housing and shelter assistance, adult education and literacy, youth development, child and family services, elder services, and community development (Allard 2009b; Grønbjerg and Smith 1999; Smith 2012).[2] Oftentimes nonprofit social services complement public cash or in-kind programs of assistance, such as Temporary Assistance for Needy Families or the Supplemental Nutrition Assistance Program, by filling needs those programs do not cover. Social service programs also reach low-income populations not eligible for public benefits. With total public and private social service expenditures exceeding $150 billion annually, the American safety net is more highly dependent on a publicly financed, privately administered nonprofit social service sector than scholars of social welfare policy commonly understand (Allard 2009b).

Local social service nonprofits vary in organizational form and size. Some large local nonprofit service organizations, such as the YMCA, support multimillion-dollar operations with hundreds of staff and are part of large regional or even national networks. Many other local nonprofit providers operate on more modest budgets and staffing levels. While most social service assistance is delivered through secular nonprofit organizations with no formal religious affiliations, many nonprofit providers maintain affiliations with religious organizations, have administrative or

2. Nonprofit organizations filing with the IRS are classified as providing services in one core area according to categories specified by the National Taxonomy of Exempt Entities (NTEE) code and classification system. See NCCS 2012.

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financial connections to religious congregations, and/or embrace a faith-related mission. Ranging from large organizations such as Catholic Charities to small church-based programs, faith-based service organizations often are sources of emergency food or shelter assistance, but many provide assistance with education, employment, or personal counseling needs (Allard 2009b; Smith and Sosin 2001).

Despite significant variation in size, form, and scope, the vast majority of nonprofit social service organizations are supported at least partly by public funds, and many are highly reliant on those public sources of revenue (Allard 2009b; Froelich 1999; Grønbjerg 2001; Salamon 1992; Smith 2012). Government funding for social services typically comes through competitive grants and contracts or voucher payments, but it can also be accessed through other tools such as tax credits (Smith 2012). Most funding comes through the federal and state governments, although county and municipal governments also commit resources to supporting nonprofit service provision. Once modest in scope, government funding of social service programs has grown steadily since the late 1960s (CRS 2003; Grønbjerg 2001; Smith 2012). Increased availability of public funding has facilitated growth of the nonprofit social service sector, which has more than doubled in size in the past fifteen years to more than one hundred thousand nonprofit social service organizations reporting revenues just over $100 billion annually (Allard 2009b; NCCS 2010, 2012). This arrangement is mutually beneficial for government and nonprofit organizations. Government funds allow federal, state, and local agencies to provide a wider array of services with greater flexibility than would be possible through direct public delivery. Nonprofit service organizations have historically regarded public funds as more stable revenue streams than private grants and donations, as opportunities to increase their scope of services and community impact, and as pathways to building capacity that advances core organizational missions.

Here we focus on two prominent tensions that arise within a federal safety net deeply reliant on publicly funded nonprofit social services.[3] First, the rising costs of social service programs and persistent budget deficits in recent years have created pressures for state governments to reduce their own-dollar program expenditures (Gais, Dadayan, and Bae 2009). In the face of vocal social service program stakeholders and

3. Other important normative concerns arise around private provision of publicly funded social services, particularly around issues of accountability, fairness, and accessibility of services (Allard 2009b; Soss, Fording, and Schram 2011).

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constituencies opposing cuts, therefore, state governments have sought alternate sources of program support that reduce the state's financial burden. Recognizing these same pressures, nonprofits also have sought new and more durable sources of program funding to buffer against future volatility in state program funding (Sosin et al. 2010; Smith 2012). Second, expansion of the nonprofit social service sector reflects increased "second-order" devolution of social welfare policy responsibilities to local government (Kim and Fording 2010). Even when programs are funded with federal and state dollars, those funds pass through local county and municipal governments, which then often contract with community-based nonprofit providers. Social service provision, therefore, is an inherently local activity that reflects the preferences and capacity of local communities. The localness of social service delivery corresponds to substantial local and neighborhood variation in the availability and accessibility of social service programs (Allard 2009b; Hasenfeld and Garrow 2012; Smith 2012; Sosin 1986). As we discuss in the next section, these tensions feature prominently in the emergence of Medicaid as a funding source for nonprofit social service organizations.

Medicaid Funding of the Nonprofit Social Service Sector

Scholarly and popular discussion of Medicaid often focuses on basic health insurance coverage. Yet Medicaid provides critical funding to nonprofit social service organizations that operate outside the formal health care sector (Burke 2007; Smith 2012; Vladeck 2003; Holahan and Ghosh 2005; Holahan et al. 2011). Medicaid reimburses state-certified nonprofit organizations for a variety of social services that states choose to provide as part of their Medicaid program (e.g., drug and alcohol treatment, mental health counseling, home care, and community care).[4] Reimbursements are available only for low-income Medicaid-eligible individuals as defined by the federal government and states (Holahan et al. 2011; Walker and Osterhaus 2010). In most instances, nonprofit providers combine Medicaid funds with other public or private sources of funding to provide more holistic or comprehensive care for particularly vulnerable populations (Walker and Osterhaus 2010; Vladeck 2003; Smith 2012). Medicaid-eligible services quite often are part of a much larger portfolio of support or care that an organization offers to low-income populations. For example,

4. Most social services funded by Medicaid fall under optional service categories, and states select the precise bundle of services to cover through the program. See Robinson et al. 2005.

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a nonprofit offering employment services might also provide counseling for low-income adults with mental health problems. Employment services could be financed through a number of mechanisms, including workforce development contracts and grants from charitable foundations; mental health services delivered to eligible populations could be financed by Medicaid. Medicaid-eligible client services may not be the primary focus of the organization, but Medicaid funds would support services for a particularly vulnerable client population.

Use of Medicaid to support social services is a relatively recent development. Medicaid dollars first began to be used to support social services in the 1980s as a response to growing demand for community care for aged and disabled populations (GAO 1984). Data limitations make it difficult to accurately portray the scope of Medicaid funding within the social service sector today, but even a few data points are telling. Medicaid funding of mental health and substance abuse services nearly doubled from 1993 to 2003. By 2003 Medicaid was the single largest source of public or private funding for mental health and substance abuse care, accounting for 25 percent of all private and public expenditures and totaling roughly $30 billion (Mark et al. 2007). Medicaid funding of social services such as home care, residential care for the disabled, and programs for children with special needs has grown from 13 percent of total Medicaid long-term care expenditures in 1990 to 42 percent in 2008 (Smith et al. 2010).[5] A study of Medicaid spending in Illinois found that nearly $1.4 billion in Medicaid funding (about 15 percent of total state Medicaid spending) was appropriated to the Illinois Department of Human Services for long-term care services for the disabled, mental health services, rehabilitation services, and alcohol and substance abuse treatment programs (Joseph 2004).

States have discretion over which types of optional social service programs or treatments to cover through Medicaid, including inpatient hospitalization for mental health or substance abuse treatment, outpatient mental health or substance abuse treatment, long-term care, and case management services. States also can extend Medicaid coverage to adult populations beyond federal mandated coverage (Robinson et al. 2005). This discretion allows states to tailor Medicaid support of social services to reflect state priorities and preferences. To demonstrate how state approaches can vary, table 1 presents select characteristics of optional Medicaid coverage in 2003 for mental health and substance abuse services in the

5. Medicaid through its Home and Community-Based Waiver Program has also promoted a decided shift away from institutional care for the developmentally disabled to smaller-scale community living supported through an array of community services (Braddock 2007).

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District of Columbia and the states from which we gathered the survey data analyzed below. Even this small group of states varies widely across optional program eligibility standards and optional service coverage. For example, Virginia, Georgia, and Kentucky offer limited expanded Medicaid eligibility to working-poor parents—with Virginia and Georgia electing to opt out of Medicaid expansion through the ACA. Virginia, like Illinois and Maryland, however, uses Medicaid to cover many different optional outpatient and residential mental health and substance abuse services. Georgia and Kentucky offer Medicaid support for a more narrow set of programs. Washington, DC, offers expanded eligibility, but it covers fewer optional social services than other states in table 1.

Because Medicaid is jointly financed by the federal and state governments, states find it an attractive source of support for social service programs. Every $1.00 that a state spends on Medicaid-eligible social services brings with it at least $1.00 in federal matching funds, with the average state receiving about $1.33 in matching funds. States can use the federal match to reduce their own expenditures and liabilities by at least half yet not dramatically cut service provision. Replacing own-source revenues with Medicaid makes budgetary sense in good economic times, but it is particularly attractive during recessionary periods when budgetary pressures increase and state or local government may be forced to cut own-source funding of social service programs (Gais, Boyd, and Dadayan 2012; Joseph 2004). Medicaid funding has been more secure than many other sources of social service program funding in recent years, as the program has a countercyclical property, with caseloads expanding during economic downturns.

Medicaid also resolves common financial tensions confronting nonprofit social service organizations for several reasons. The Medicaid program provides funding for services targeted at costly high-risk groups and often reimburses at a higher rate than other sources of support for such population subgroups (HHS, SAMHSA 2006). Medicaid reimbursement rates also provide resources for nonprofit social service organizations to cross-subsidize other programs and operations that may not always be adequately funded given demand (Smith 2007). Many other sources of social service program funding are fixed or capped, regardless of the number of clients served. But because Medicaid reimbursements follow the client, an agency that serves more eligible clients will receive more money without having to bill clients. Finally, expansion of Medicaid coverage and enrollments in the past few decades has increased the pool of eligible clients for nonprofits.

Table 1 Select State Medicaid Coverage of Special Populations and Mental Health or Substance Abuse Services

		Optional Service Availability in 2003				
State	Income Eligibility for Working Parents	Extensive Outpatient Services[a]	Residential Services[b]	Crisis Services[c]	Psychology[d]	Mental Health Clinics[e]
Maryland	TANF families	MH/SA	MH/SA	MH	No	Yes
Washington, DC	Up to 185% of FPL	MH	MH	MH	No	No
Virginia	Limits vary, ~30%–60% FPL	MH/SA	MH/SA	MH	Yes	Yes
Illinois	Families that would have qualified for TANF (~38% FPL)	MH/SA	MH/SA	MH	Yes	Yes
California	Parents of deprived children who meet certain property standards	MH/SA	MH/SA	MH	Yes	No
New Mexico	Only program participants in New Mexico Works	MH/SA	None	None	No	No
Oregon	Up to 100% FPL (MH/SA benefits only to TANF families)	MH/SA	MH	MH/SA	No	No
Kentucky	Families that would have qualified for TANF (~25% FPL)	MH	MH	MH	No	Yes
Georgia	Families that would have qualified for TANF	MH/SA	None	MH	Yes	Yes

Source: Robinson et al. 2005

Notes: TANF = Temporary Assistance for Needy Families (TANF is also known as welfare cash assistance); FPL = federal poverty line; MH = mental health; SA = substance abuse; MH/SA = mental health and substance abuse

[a]Extensive outpatient services include facilities where individuals can receive day (nonresidential) treatment for MH/SA conditions.

[b]Residential services include any form of long-term, residential care.

[c]Crisis services include crisis management, assertive community treatment (ACT) teams, crisis intervention, and crisis assistance.

[d]State Medicaid covers the cost of a psychologist or psychological services as part of behavioral health treatment.

[e]State Medicaid covers treatments at mental health clinics.

States must certify nonprofit social service organizations to be eligible Medicaid providers in order to reimburse them for services to Medicaid-eligible populations. Certification typically requires nonprofit providers to submit more detailed accounting and reporting than may be the case with other sources of funding. The process of certification subjects nonprofits to periodic inspection by state and federal Medicaid authorities (CMS 2013). Certification as a Medicaid provider has other potential advantages. For one, it can allow nonprofits to receive program referrals from state government agencies and increase their client caseloads (HHS, SAMHSA 2006). The administrative capacity required to process Medicaid reimbursements also may enhance an organization's competitiveness for other governmental grants and contracts.

As a funding mechanism, Medicaid is quite complex. Medicaid payments to social service agencies are based on a vendor rate or fee-for-service model, where state Medicaid officials essentially tell agencies the amount that will be paid for a unit of a particular service. The state determines how much it will spend on a certain service, and documentation of the actual costs of providing that service is not required to receive payment. For instance, a state agency might pay $15 an hour for home care services. State officials would not require the agency to document its costs, and the agency need only submit proof that the hour of home care has been provided to receive payment. The vendor rate model may be advantageous for nonprofits, but it shifts risk to the service provider. Because funding is tied to the client and clients may be able to choose where to receive services, providers must serve enough Medicaid-eligible clients to ensure consistent flow of revenues. Also, nonprofit providers are responsible for managing service delivery in a way that is financially sound and conforms to Medicaid reimbursement levels for a given service. The state will only offer a certain rate for outpatient mental health counseling services, for example, regardless of an individual agency's own internal cost structure.

We can be certain that Medicaid helps resolve dilemmas present in contemporary intergovernmental financing of the safety net by cost shifting the burden of social service programs from state government to the federal government and by providing cash-strapped nonprofits with access to a steady source of revenue. Yet the actual role of Medicaid in social service provision remains uncertain. Available data make assessing the extent to which nonprofit service providers have drawn on Medicaid revenues difficult. Moreover, whether greater Medicaid financing of social services will translate into greater accessibility for clients is unclear. Reimbursements are only available to Medicaid-eligible clients for qualified services,

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which can vary state by state. Low-income persons who qualify for Medicaid may not live in places where particular optional services are covered or may find it difficult to locate a provider with available slots. Because nonprofit service organizations have discretion over which services to offer, which client populations to serve, whether to accept Medicaid reimbursement, and where to locate, Medicaid-eligible clients or high-need communities may not have access to nonprofit organizations that partner with the Medicaid program. To our knowledge, scholars have not examined the local availability or accessibility of social service providers offering Medicaid-reimbursed services. Finally, the uncertain state and federal policy environment surrounding Medicaid threatens to reduce the degree to which the program can support social service provision for eligible individuals. Future changes to Medicaid eligibility and coverage may have a significant impact on nonprofit providers that depend on Medicaid reimbursements to boost their overall revenues and diversify their revenue portfolios. How such policy developments will reverberate throughout the nonprofit social service sector remains an open question, especially given the uncertainty in the implementation of ACA.

To advance scholarly understandings of the role that Medicaid funding plays within the nonhealth components of the nonprofit social service sector, we examine questions of which types of nonprofit social service organizations receive Medicaid, how Medicaid funding fits into the revenue portfolios of community-based nonprofit social service providers, and whether nonprofit social service organizations receiving Medicaid are more likely to target certain population or client subgroups over others. We expect that Medicaid will be more common among organizations with relevant service missions, with client populations eligible for Medicaid reimbursements, and with greater organizational capacity to navigate Medicaid administrative requirements. The analyses that follow provide more precise answers to these questions, highlighting the manner in which Medicaid is implicated within the nonprofit social service sector with greater precision than other studies to date. Answers to these questions also will generate insight into broader trends in the American welfare state that are of importance to a broad array of social welfare policy scholars.

Data

Exploring the extent to which community-based nonprofit social service organizations receive Medicaid funding or are dependent on such funds is difficult because of data limitations. Medicaid reimbursements are tied to

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individuals, and most publicly available data are thus about enrollment, rather than services received or social service providers participating in the program. To our knowledge, no publicly available organizational-level data sets exist that contain information about the degree to which nonprofit social service providers receive Medicaid or the share of clients supported through Medicaid. The IRS 990 forms require nonprofit organizations to report public program revenues, most often fees for services or commercial revenues, but the IRS does not require organizations to detail the source of those revenues. Even if assessing the presence of Medicaid revenue in the IRS 990 forms were possible, these data do not contain useful information about the location of local service providers or organizational characteristics that might help scholars understand factors related to whether or not organizations provide Medicaid-reimbursed services.

In this study, we examine the role of Medicaid funding with specific reference to nonprofit social service organizations that deliver *employment services* (e.g., education and training, job search assistance, and work supports), *temporary emergency food* or *cash assistance*, or *outpatient substance abuse* or *mental health treatment* outside the formal health care system. These types of programs rest at the core of the social service safety net available to low-income working-age, nondisabled adults. While these organizations are not the hospitals, residential or inpatient facilities, health clinics, or other types of agencies specializing in health care services most commonly identified with Medicaid, we believe that an examination of these particular types of nonprofit social service agencies will provide telling insight into the importance of Medicaid reimbursement for the nonprofit social service sector.

To examine the role of Medicaid across this critical slice of the nonprofit social service sector, we analyze data from two surveys of social service organizations: the Multi-city Survey of Social Service Providers (MSSSP) in metropolitan Chicago, Los Angeles, and Washington, DC (including the Virginia and Maryland suburbs), and the Rural Survey of Social Service Providers (RSSSP) in four rural regions in southeastern Kentucky, south-central Georgia, southeastern New Mexico, and the border counties of Oregon-California.[6] These surveys are not a random sample of cities or rural regions, but they are accurate snapshots of the social service sector

6. Resource and time constraints limited the MSSSP and RSSSP samples to a specific subset of the social service sector that provides outpatient or nonresidential services to low-income populations broadly. Of particular relevance to the focus of this article, these surveys excluded agencies that only offered medical services for the poor or programs such as community care for the developmentally disabled, mentally ill, and individuals with HIV/AIDS, all of which have a high dependence on Medicaid funding.

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within each site (Allard 2009a, 2009b). As a whole, these data provide insights into the role of Medicaid in funding nonprofit social service agencies in different contexts. With response rates that exceed 60 percent, these surveys are unique in that they provide the most comprehensive and geographically sensitive data about social service provision currently available (Allard 2009b).

Each survey was completed with executives of public and nonprofit organizations that primarily provided employment-related services (e.g., job search assistance, adult education, and vocational training), temporary emergency food or cash assistance (e.g., food pantries), outpatient substance abuse services, and/or outpatient mental health treatment. Respondents were asked over one hundred questions that gathered detailed information on location, services provided, clients served, funding, and organizational characteristics from these public and nonprofit service providers. Survey data were collected between November 2004 and June 2006 from 1,766 governmental and nonprofit service organizations. Our analysis focuses on 1,139 nonprofit social service agencies offering employment, emergency assistance, and outpatient substance abuse services or outpatient mental health treatment at the time of the survey.[7]

Of particular relevance here, nonprofit executives and program managers provided information on whether their service delivery site offered services that received funding through Medicaid reimbursements during the most recently completed fiscal year. Respondents indicating receipt of Medicaid funds were asked to approximate the share of total funding for services for low-income individuals from Medicaid in the most recently completed fiscal year and whether that amount from this source of funding increased, decreased, or stayed the same over the previous three years.

A few caveats about these survey data should be noted at the outset. First, these survey data are cross-sectional, meaning that we can only identify associations between organizational characteristics and Medicaid funding. Thus, these data cannot address changes in Medicaid financing over time. Second, because these data were collected before the Great Recession and subsequent waves of state budget austerity, they also may less accurately capture the fiscal realities in today's nonprofit social service sector. Third, these data predate debate and passage of the ACA, which will affect the role of Medicaid within the social service sector.

7. The surveys interviewed 272 nonprofits in the four rural sites and 931 nonprofits in the three urban sites.

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Nevertheless, we believe that these surveys highlight how Medicaid has become integrated with the nonprofit social service sector and provide many advantages over other sources of information on nonprofit social service provision. We believe that data about Medicaid's role in the nonprofit service sector collected before 2007 offer a more useful baseline to which future studies might compare, than data collected during a period of greater volatility or policy change.[8] Organizations interviewed provide a precise portrait of the nonprofits serving working-age, nondisabled adults outside the health care sector. In addition, the MSSSP and RSSSP collect information about social service provision, revenue sources, budgets, caseload size, and staffing levels that are difficult to glean from other IRS data or other social service data sources. Finally, these survey data provide information about the location of service delivery sites and caseload demographics, information that is not readily available from IRS data, directories, or administrative data. Such information makes it possible to attach Medicaid reimbursements to neighborhood characteristics in a unique manner and allows us to discuss distributional effects across communities. The online technical appendix contains more detail about these two surveys.[9]

Nonprofit Receipt of Medicaid Reimbursements

Consistent with our expectations, a significant share of nonprofit social service organizations interviewed in these seven urban and rural areas receive some funding through Medicaid, even though they are not formal health care providers. Almost one-quarter of nonprofit service organizations participating in these surveys report receiving Medicaid funding in

8. In the little information available on Medicaid funding of social services at any point in time, no data to our knowledge track funding over time across nonprofit organizations. Unfortunately, the MSSSP and RSSSP do not contain longitudinal data on Medicaid receipt. The level of Medicaid funding might change over time within an organization for many reasons: needs could change, service offerings could change, and/or state policy could change to affect eligible populations or services. Program service revenue data for nonprofit substance abuse and mental health providers (NTEE codes F20, F21, F22 F30, and F32) drawn from IRS 990 forms by the National Center for Charitable Statistics (NCCS) include Medicaid reimbursements along with other public and private fee or commercial revenues. Although Medicaid funding cannot be separated from the total, these NCCS data indicate that program service revenues for this portion of the nonprofit service sector increased significantly during the previous decade. Whereas program service revenue totaled $8.6 billion in 2005, this portion of the nonprofit sector saw that increase by nearly 18 percent to $10.1 billion in 2008. Given expanded eligibility and financial pressures on state own-source revenues, some of this expansion in program service revenue likely captures growth in Medicaid funding to social service programs.

9. To access this appendix, please click on the "Supplemental Material" link that appears in the box to the right of the online article (doi.org/10.1215/03616878-2822610).

the most recent fiscal year (22.7 percent; see column 1 in the top row of table 2). More than half of nonprofits specializing in outpatient mental health and substance abuse services for low-income populations reported Medicaid revenues (52.7 percent). As an indication of how Medicaid indirectly supports nonhealth social services, however, 43.5 percent of nonprofits that offered employment and/or emergency assistance along with mental health or substance abuse services also reported Medicaid revenues. Few workforce development or emergency assistance programs would fit within Medicaid coverage guidelines by themselves, thus explaining why only a very small share of nonprofit organizations that offered some type of employment or emergency assistance without a substance abuse or mental health service mission reported receiving Medicaid funds (3.2 percent). Overall, these findings indicate that many nonprofit social service organizations receiving Medicaid reimbursements maintain complex and highly professionalized service missions.

The degree to which Medicaid composes a large share of nonprofit operating budgets provides insight into how the program has penetrated the social service sector. The second set of columns in table 2 show that Medicaid reimbursements are a modest source of support—less than 25 percent of the organization's budget—for slightly more than half of the social service nonprofits reporting receipt of Medicaid funds (50.9 percent; see column 2). This result is to be expected given that Medicaid is still a relatively modest portion of the total funds supporting social service programming. More surprising given the nature of our sample, however, is that nearly one-third of nonprofit social service providers receiving Medicaid (30.8 percent; see columns 4 and 5) were reliant on the program for more than half of their operating budget. This finding underscores substantial reliance of nonprofit social service organizations outside the traditional health sector on Medicaid. Dependence on Medicaid does not vary much across nonprofits that were primarily outpatient mental health and substance abuse treatment providers versus those that combined those services with other employment or emergency assistance services.

Even though receipt of Medicaid funds did not vary significantly across urban and rural nonprofit social service providers, rural nonprofits are more likely to be dependent on Medicaid for more than half of their operating budget than urban nonprofits. Slightly more than half of all rural nonprofit organizations interviewed, 51.4 percent, were dependent on Medicaid, compared to 26.8 percent of urban nonprofits (columns 4 and 5). Rural-urban differences in Medicaid receipt reflect the realities of financing social services in each locale. Rural nonprofit service organizations have

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Table 2 Medicaid Funding among Nonprofit Social Service Providers

	% of Nonprofit Organizations with Medicaid Revenues in Most Recent Fiscal Year	Of Nonprofits Receiving Medicaid, Medicaid's Share of Operating Budget in Most Recent Fiscal Year				
		0%–25%	26%–50%	51%–75%	+75%	
	(1)	(2)	(3)	(4)	(5)	*N*
All nonprofit service providers	22.7	50.9	18.2	17.7	13.1	1,138
Types of core services or assistance provided						
Outpatient mental health / substance abuse services	52.7[ab]	51.8*	16.5	20.0	11.8	186
Outpatient mental health / substance abuse with employment and/or emergency assistance	43.5[ac]	46.9	21.2	17.7	14.2	322
Employment and/or emergency assistance	3.2[bc]	75.0	6.3	6.3	12.5	630
Location of nonprofit organization						
Urban	23.5	58.1*	15.1	15.1	11.7	899
Rural	19.6	14.3	34.3	31.4	20.0	240
Type of nonprofit organization						
Secular	29.9[a]	48.3*	20.2	18.0	13.5	717
Religious	8.7[a]	74.1	7.4	7.4	11.1	392

Sources: 2004–6 Multi-city Survey of Social Service Providers; 2004–6 Rural Survey of Social Service Providers

Notes: Reported numbers are row percentages. Percentages are rounded up, so rows may not total to 100 percent. Data on Medicaid share of operating budget in most recent fiscal year include only nonprofits reporting Medicaid revenue at time of survey.

[a, b, c] Notations identify sets of paired cells within each panel where the percentage-point difference in Medicaid receipt is significant at the 0.05 level or below.

*Pearson's chi-square test rejects null hypothesis that variables in panel are independent at the 0.05 level or below.

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access to fewer local and private philanthropic sources of support than their urban counterparts. As a result, rural nonprofits often exhibit a greater dependence on public funds than urban nonprofits (Allard 2009a). Within this funding landscape, Medicaid may be particularly important to rural nonprofits with fewer sources of revenue than to comparable urban nonprofit organizations.

Medicaid funding also is largely flowing to secular nonprofit service providers in our seven study sites. About two-thirds of nonprofits surveyed self-identified as secular organizations, and one-third self-identified as religious nonprofit organizations. Based on these self-reports, secular nonprofits are more than three times as likely to receive Medicaid reimbursements as religious or faith-based nonprofits (29.9 percent vs. 8.7 percent, respectively). Secular nonprofits receiving Medicaid also appear more likely to rely on those funds than religious nonprofits receiving Medicaid do. These findings are consistent with what we know about the division of labor across secular and religious nonprofits in urban and rural America. Many religious or "faith-based" nonprofit service organizations predominately focus on the material needs of the poor (Allard 2009b; Smith and Sosin 2001). Religious nonprofit service organizations, particularly those in poor rural counties, often lack the administrative and staff resources necessary to pursue Medicaid reimbursement for services. Moreover, faith-based service providers that integrate a strong religious component into their services (such as mission shelters) are not eligible for public support of their programs and choose not to seek public funds.

Other organizational characteristics should be associated with Medicaid receipt as well. Of particular importance is the role of Medicaid within the organization's overall revenue portfolio, as certain revenue strategies may be more conducive to Medicaid receipt than others. To this point, the top portion of table 3 examines how nonprofits combine one of four categories of funding with Medicaid: federal, state, or local governmental grants or contracts outside of Medicaid; funds from charitable foundations and other nonprofit organizations; private giving from individuals; and commercial or earned revenue outside of Medicaid.[10] Nonprofits receiving program funding from government sources (other than Medicaid) are almost twice as likely to report Medicaid revenues as those that do not receive other public support (26.3 percent vs. 13.9 percent, respectively).

10. Since most nonprofit organizations draw on at least two of these different sources of revenue, sorting organizations into mutually exclusive categories is difficult. The top portion of table 3, therefore, identifies organizations only according to whether or not they receive a given source of revenue.

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The association between government revenue and Medicaid receipt aligns with expectations that nonprofit service providers experienced in securing government funding for services may be better positioned to certify for Medicaid reimbursement, although this cross-sectional relationship could easily flow in the opposite direction. Also, as we would expect given Medicaid's fee-for-service model, about one-third of nonprofits drawing on other sources of earned or commercial revenue also receive Medicaid, nearly double the rate observed among nonprofits without earned or commercial revenue (33.2 percent vs. 17.8 percent, respectively). In contrast, nonprofits reporting private funding from charitable philanthropies or from individual donors are slightly less likely to receive Medicaid.

The administrative and service quality demands of Medicaid lead us to expect that organizational size and capacity is associated with receipt of Medicaid. For example, table 3 indicates that 41.3 percent of nonprofit service organizations with annual budgets over $1 million report receiving Medicaid, compared to 14.0 percent of nonprofits with budgets between $200,000 and $1 million. Nonprofits with more than twenty professional staff were almost six times more likely to report Medicaid funding in the most recent fiscal year than nonprofits with five or fewer professional staff (47.8 percent vs. 7.9 percent, respectively). In fact, the average nonprofit reporting Medicaid funding in the most recent fiscal year had an average professional staffing level four times as large as nonprofits not reporting Medicaid funds (sixty-one vs. thirteen professional staff; not shown in table 3).

Organizational capacity also involves the strength of networks and connections with state or local administrators and policy makers. Closer lines of communication with public officials can help nonprofits clarify questions about eligibility, reimbursement, and funding mechanisms, as well as identify program areas where funding may become available. Thus, each survey asked nonprofit providers about the frequency of their communication with their representatives to the state legislature and with local or state administrative agency staff.[11] Similar to findings on budget and staff size, nonprofit organizations reporting frequent communication with elected representatives to the state legislature or with administrators from city, county, or state governmental agencies are more likely to receive Medicaid than organizations that occasionally or never communicate with

11. Specifically, respondents were asked, "How often—frequently, occasionally, or not at all—do you contact or communicate with your elected representatives to the state legislature?" And, "How often—frequently, occasionally, or not at all—do you contact or communicate with administrators from city, county, or state governmental agencies?"

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Table 3 Organizational Characteristics of Nonprofit Social Service Providers and Receipt of Medicaid Funding

Organizational Characteristic	% of Nonprofit Social Service Organizations Receiving Medicaid
Federal, state, or local government programs	
Received in most recent fiscal year	26.3[a]
Did not receive in most recent fiscal year	13.9[a]
Charitable foundations or nonprofit organizations	
Received in most recent fiscal year	20.4[a]
Did not receive in most recent fiscal year	27.1[a]
Private individual giving	
Received in most recent fiscal year	18.5[a]
Did not receive in most recent fiscal year	36.2[a]
Commercial or earned revenue (apart from Medicaid)	
Received in most recent fiscal year	33.2[a]
Did not receive in most recent fiscal year	17.8[a]
Annual operating budget	
+ $1 million	41.3[ab]
$1 million to $200,000	14.0[ac]
< $200,000	4.9[bc]
Number of professional staff	
More than 20	47.8[ab]
6–20	26.9[ac]
Fewer than 5	7.9[bc]
Communication with elected representatives to state legislature	
Frequent	38.0[a]
Occasional / not at all	18.4[a]
Communication with state administrative agencies	
Frequent	27.5[a]
Occasional / not at all	19.2[a]
N	1,138

Sources: 2004–6 Multi-city Survey of Social Service Providers; 2004–6 Rural Survey of Social Service Providers

Note: Reported numbers are row percentages.

[a, b, c] Notations identify cell pairs where the percentage-point or mean difference between those receiving Medicaid and those not is significant at the 0.05 level or below.

such officials. For example, 38.0 percent of nonprofit service organizations reporting frequent communication with elected representatives to the statehouse received Medicaid financing for services, yet only 18.4 percent of nonprofits reporting occasional or no communication with state legislators receive Medicaid.

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Given Medicaid eligibility requirements, we might expect Medicaid-supported nonprofits to serve larger shares of low-income individuals, racial or ethnic minorities, and female client populations most likely to receive Medicaid coverage than nonprofits lacking Medicaid funding. When looking at caseload characteristics and Medicaid receipt in table 4, however, we find that nonprofits serving larger percentages of highly eligible population subgroups are less likely to receive Medicaid funding than organizations serving smaller shares of these highly eligible population subgroups. For example, nonprofits receiving Medicaid are no more likely to serve large percentages of clients below the federal poverty line than those nonprofits without Medicaid. In fact, findings appear to show that nonprofits are more likely to report Medicaid funding if they serve caseloads composed of smaller shares of poor persons. Similar findings can be seen when looking at the share of clients who are black, nonwhite Hispanic, or female. For instance, nonprofits with caseloads that are more than three-quarters female are about half as likely to receive Medicaid as nonprofits with caseloads where women compose between 25 and 50 percent of the caseload (14 percent vs. 30 percent, respectively). Medicaid providers appear to be slightly less likely, or at least no more likely, to serve population subgroups most likely to be eligible for the Medicaid program. We return to this point later in our analyses.

To better highlight factors associated with Medicaid reimbursement among this sample of nonhealth social service organizations, we estimate a logit model of Medicaid funding in the most recent fiscal year with several different organizational characteristics and contextual factors as covariates. We include dichotomous measures of an organization's service offerings: outpatient mental health or substance abuse, employment services, and emergency assistance. We include measures to reflect the presence of government funding (apart from Medicaid), support from other charitable philanthropies or nonprofits, private giving from individuals, and commercial revenue (again outside of Medicaid) in revenue portfolios. Associations between organizational capacity and Medicaid receipt are captured through the size of the annual operating budget and frequency of communication with members of the state legislature or administrative staff from public agencies. To control for caseload characteristics, we include measures of whether a nonprofit's client caseload is majority poor, black, Hispanic, and/or female. We control for context with a measure indicating whether the nonprofit was located in an urban or rural setting and a measure of the poverty rate in the surrounding census tract. Finally, to control for state policy differences in Medicaid financing of social services,

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Table 4 Caseload Characteristics of Nonprofit Social Service Providers and Receipt of Medicaid Funding

% of Clients	% of Nonprofit Social Service Organizations Receiving Medicaid
At/below the federal poverty line	
0–25	20.4
26–50	33.3[a]
51–75	26.4
+ 75	19.7[a]
Black	
0–25	24.3
26–50	19.8
51–75	20.9
+ 75	21.9
Nonwhite Hispanic	
0–25	27.4[ab]
26–50	14.4[a]
51–75	19.4
+ 75	14.2[b]
Female	
0–25	23.9
26–50	30.0[ab]
51–75	21.5[a]
+ 75	14.0[b]
N	1,116

Sources: 2004–6 Multi-City Survey of Social Service Providers; 2004–6 Rural Survey of Social Service Providers

Note: Reported numbers are row percentages.

[a, b] Notations identify cell pairs where the percentage-point or mean difference between those receiving Medicaid and those not is significant at the 0.05 level or below.

we include dichotomous variables for the state in which an organization was located.

Results from this logit model are reported in table 5 and are largely consistent with our expectations and descriptive results. We find that secular nonprofits and those offering outpatient mental health and/or substance abuse services are more likely to receive Medicaid reimbursement. Similarly, nonprofit organizations with other earned revenue in their funding portfolio also are more likely to receive Medicaid. Indicative of the significant administrative capacity necessary to process Medicaid

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reimbursements and the advantages larger organizations have in accessing Medicaid, we find that nonprofit organizations with budgets over $1 million are more likely to report Medicaid funding than nonprofits with budgets under $200,000. At the same time, evidence suggests that nonprofits receiving funds from private charitable philanthropy or from individual donors are less likely to receive Medicaid funds.

When accounting for a range of organizational characteristics, nonprofits serving caseloads that are at least 50 percent poor are more likely to report Medicaid revenue in the most recent fiscal year than those that serve smaller percentages of poor persons. Such findings are more consistent with expectations that organizations will be more likely to receive Medicaid reimbursement if they share Medicaid's focus on low-income households. However, the evidence remains that nonprofit organizations serving majority black or female caseloads are less likely to report Medicaid funding for services.

Finally, consistent with state-level variation in optional service coverage reported in table 1, state-level dummy variables provide indication that nonprofit receipt of Medicaid might vary by state even after controlling for organizational characteristics. For example, Illinois, Maryland, and Washington, DC, all cover several different types of optional social services through Medicaid. Nonprofits located in these places are more likely to report Medicaid funding even when accounting for several other organizational factors. Our data are limited in their ability to explore how state-level Medicaid policy variation may matter at the street level, but these findings suggest that future research might explore how state-level policies shape local nonprofit decisions about funding streams and revenue sources.

Figure 1 reports predicted probabilities to highlight the marginal effect of different key control measures on the likelihood of Medicaid receipt compared to the baseline case.[12] The strong association between budget size and mental health or substance abuse service provision and receipt of Medicaid is clearly apparent. For example, secular nonprofits providing mental health or substance abuse with annual budgets over $1 million are predicted to be twice as likely to receive Medicaid as the same nonprofit service provider with a budget under $200,000 per year (88 percent vs. 44 percent, respectively). Similarly, the negative association between the racial and gender composition of clients and Medicaid receipt is shown clearly in figure 1. The predicted probability of Medicaid receipt for a

12. The baseline case here is defined as a small urban secular nonprofit in Illinois that does not provide mental health or substance abuse services and maintains caseloads that are less than 50 percent black or female and with the rest of the variables in the model set to their means.

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Table 5 Factors Associated with Nonprofit Receipt of Medicaid Funding in Most Recent Fiscal Year, Logit Coefficients

	B	SE
Types of core services or assistance provided		
Outpatient mental health / substance abuse services	3.044**	0.342
Employment assistance	–0.333	0.254
Emergency assistance	–0.478+	0.258
Funding sources reported in most recent fiscal year		
Federal, state, or local government programs	0.222	0.339
Charitable foundations or nonprofit organizations	–0.624*	0.293
Private individual giving	–0.541+	0.292
Commercial or earned revenue (apart from Medicaid)	0.470+	0.258
Urban nonprofit	–1.120	0.778
Secular nonprofit	1.272**	0.335
Annual operating budget (< $200,000 = excluded category)		
+ $1 million	2.237**	0.413
$1 million to $200,000	0.542	0.422
Frequent communication with . . .		
Elected representatives to state legislature	0.931**	0.306
State administrative agencies	–0.500+	0.271
Majority of clients . . .		
At or below the federal poverty line	0.795*	0.348
Black	–1.003**	0.328
Hispanic	–0.415	0.361
Female	–0.580*	0.246
Tract poverty rate in location (< 10% = excluded category)		
11%–20%	–0.288	0.346
21%–40%	–0.200	0.341
+ 40%	0.158	0.498
State (California = excluded category)		
Illinois	1.711**	0.356
Washington, DC	1.717**	0.446
Maryland	2.201**	0.645
Virginia	0.694	0.538
Georgia	–0.525	1.273
Kentucky	0.462	0.895
New Mexico	–0.458	1.156
Oregon	–0.316	0.934
Constant	–4.526**	0.951
Pseudo R^2	0.469	
Log likelihood	–253.719	
N	924	

Sources: US Census Bureau 2005–9; 2004–6 Multi-city Survey of Social Service Providers; 2004–6 Rural Survey of Social Service Providers

Notes: B = coefficient; SE = standard error; mean of the dependent variable = 0.227.
$^{+}p \leq 0.10$; $^{*}p \leq 0.05$; $^{**}p \leq 0.01$

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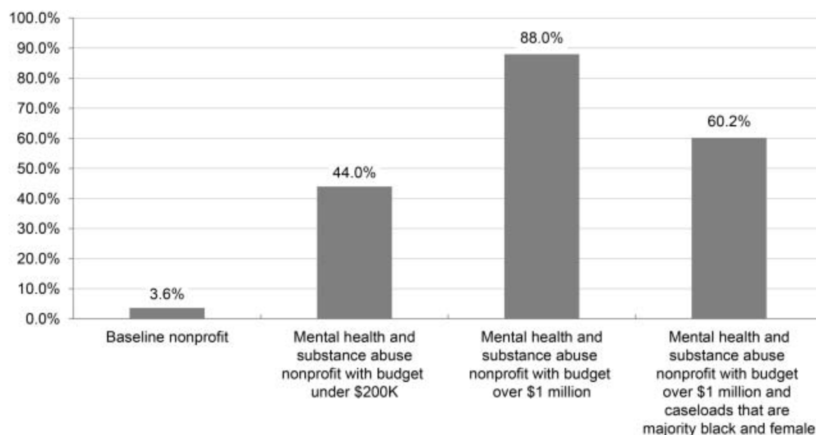

Figure 1 Predicted Probabilities of Nonprofit Medicaid Receipt

Sources: US Census Bureau 2005–9; 2004–6 Multi-City Survey of Social Service Providers; 2004–6 Rural Survey of Social Service Providers

Note: The baseline case is an urban secular nonprofit in Illinois that does not provide mental health or substance abuse services with an operating budget of less than $200,000 per year. This baseline case also serves caseloads that are less than 50 percent black and less than 50 percent female. To calculate the baseline predicted probabilities, all other variables in the model are set to their means.

secular nonprofit with an annual budget over $1 million that provides mental health or substance abuse decreases by about one-third if that organization serves a caseload that is majority black and majority female (88.0 percent vs. 60.2 percent, respectively).

While Medicaid program dollars follow clients, our findings indicate that this funding might follow clients to certain types of nonprofit service agencies. Organizations must have a service mission that, at least in part, connects to programs and client populations eligible for Medicaid reimbursements. Larger nonprofit organizations should be better able to offer a range of resource- and staff-intensive services that qualify for Medicaid reimbursement. Larger organizations also should be better equipped to manage the administrative work required to complete the complex billing paperwork that precedes Medicaid reimbursement for services. Smaller nonprofit service providers—those with fewer staff and less familiarity with government or fee-for-service contracting—are less likely to receive Medicaid funds, regardless of their service mission.

Again, important to note is that causality likely runs in both directions, as Medicaid funding may allow organizations to scale or build capacity. Moreover, Medicaid certification can lead to increased professionalization

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within nonprofit service providers that often results in the addition of programmatic and administrative personnel. Our findings also are consistent with the notion that the increased organizational capacity needed to participate in the Medicaid system may advantage nonprofit service organizations in other fee-for-service or government contracting settings. Even if Medicaid fuels organizational growth, it does so for certain nonprofit service organizations and advantages those organizations in a competitive funding environment over other types of nonprofits that may be unable to access streams of Medicaid reimbursement.

Seemingly counterintuitive findings about the role of race and gender, as well as local context, remain. Consistent with our descriptive analysis, nonprofit service organizations are significantly less likely to receive Medicaid funds when blacks and women compose a majority of clients. Similarly, we find no relationship between the poverty rate in the tract where a nonprofit service organization is located and receipt of Medicaid funding. Organizations located in higher-poverty areas are no more likely to receive Medicaid reimbursements than those in lower-poverty areas. These findings are puzzling because we would expect Medicaid-financed organizations to target Medicaid-eligible population subgroups and to be connected to areas with large numbers of Medicaid-eligible individuals.

As we discuss in the next section, however, we believe that these empirical observations may be tied to the geography of the social service safety net. As is the case with other types of nonprofit social services, we note the possibility that nonprofit providers receiving Medicaid locate offices that create mismatches between the areas where Medicaid-financed services are delivered and the areas where the low-income population subgroups most likely to be eligible for Medicaid are concentrated (Allard 2009b).

Access to Medicaid-Funded Nonprofit Service Organizations

Nonprofit social service provision is an inherently local activity. Not only do nonprofit social service providers have discretion over whether to seek Medicaid reimbursements and serve Medicaid-eligible clients, but they choose where to locate operations. Certain neighborhood locations may serve different stakeholders than other locations. For example, providers offering Medicaid-eligible social services may try to locate where they can find qualified professional staff. Or nonprofit service organizations may locate where they can find fee-paying clients or those with private insurance covering treatment. Nonprofits may need to find suitable office space

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or facilities to provide services, but not all areas have affordable and properly fitted space available to rent (Allard 2009b). Moreover, Medicaid-eligible individuals seeking help may not want to do so in their immediate neighborhood for risk of stigma. Alone or in some combination, these factors may lead nonprofit service providers to select locations that are not in high-poverty or predominately minority areas, even though a disproportionately large share of the population in those areas is Medicaid eligible.

To more precisely determine whether Medicaid-funded social service providers are accessible to different communities and neighborhoods within the three metropolitan areas of the MSSSP, we calculate service accessibility scores in the three urban sites to reflect a residential census tract's relative access to nonprofit organizations receiving Medicaid funding.[13] These access scores weight for the number of clients served within three miles of a given tract to control for supply of services and for the number of persons with household income below the federal poverty line within three miles to account for potential demand for services. We calculate two different access measures for this study: access to all nonprofit providers receiving Medicaid and access to those nonprofits dependent on Medicaid for more than half of their operating budget. More detail about the calculation of service accessibility measures can be found in the online technical appendix.

Service accessibility scores reflect the distribution of Medicaid-funded social service providers across different types of census tracts or neighborhoods. Scores have been scaled in each city, so that the average level of access to a Medicaid-funded provider in a given city is 1. A score above 1 indicates greater access to service opportunities, compared to the average tract or neighborhood. For example, neighborhood A, with an access score of 1.10, is located within three miles of 10 percent more service opportunities through organizations funded by Medicaid than the metropolitan mean tract controlling for supply and demand. A score below 1 indicates weaker levels of access than the average tract or neighborhood. If neighborhood B has an access score of 0.90, it can be said to be located near 10 percent fewer service opportunities through Medicaid-funded organizations than the metropolitan mean tract. Also, it means that neighborhood A has access to 22 percent more service opportunities through Medicaid-funded organizations than neighborhood B ($1.10 \div 0.90 = 1.22$).

13. Given the nature of geography in the rural sites, calculating similar access measures in the four rural regions is difficult.

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Table 6 presents mean access scores across tracts with low versus high rates of poverty and by tract concentration of non-Hispanic whites, non-Hispanic blacks, and Hispanics, using demographic data from the 2005–9 American Community Survey. The top panel in table 6 compares mean service provider accessibility scores across census tracts in Chicago, Los Angeles, and Washington, DC, with low poverty rates (10 percent poor or less), moderate poverty rates (11–20 percent poor), high-poverty tracts (poverty rate between 21 and 40 percent poor), and extreme high-poverty neighborhoods (poverty rate greater than 40 percent). The bottom three panels in table 6 compare mean access across areas with low concentration of a particular racial or ethnic group (more than half of a standard deviation below the metropolitan tract mean percentage), moderate concentration (within half of a standard deviation above or below the metropolitan tract mean), and high concentration (more than half of a standard deviation above the metropolitan tract mean percentage).[14] If Medicaid-funded service providers are more accessible to disadvantaged communities, we would expect access scores to be greater in higher-poverty than in lower-poverty neighborhoods. If Medicaid-funded service providers are as accessible to racial and ethnic minority neighborhoods as to predominately white neighborhoods, we would expect areas with greater concentrations of blacks and Hispanics to have access similar to that in areas with greater concentrations of whites.

Results presented in the top panel of table 6, however, suggest that neighborhoods with higher poverty rates have lower levels of access to Medicaid-funded providers compared to lower-poverty tracts. Low-poverty neighborhoods (poverty rate less than 10 percent) have about 25 percent greater access to Medicaid-funded providers than neighborhoods where the poverty rate is between 21 and 40 percent (1.06 vs. 0.85, respectively). Similar patterns can be seen when looking at access to Medicaid-dependent providers in column 2, although these differences in mean access only approach conventional levels of statistical significance. Findings here suggest, however, that persons living in low-poverty tracts have greater access to nonprofits receiving Medicaid and Medicaid-dependent nonprofit service providers than persons in higher-poverty tracts do.

Disparities in access by race and ethnicity also are evident in the bottom three panels of table 6. Census tracts with the highest concentrations of whites have roughly twice as much access to Medicaid providers as tracts

14. The categorization of tracts is site specific, but mean access scores reported in table 6 are pooled across sites.

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Table 6 Access to Nonprofit Social Service Providers Receiving Medicaid Revenues

	Mean Access to Providers Receiving Medicaid Revenue	Mean Access to Providers Dependent on Medicaid Revenue
Poverty rate in census tract, 2005–9 (*N*=4,275)		
0%–10%	1.06[a]	1.05
11%–20%	1.02	1.04
21%– 40%	0.85[a]	0.92
More than 40%	0.89	0.73
White population concentration in tract		
Low concentration (*N*=1,798)	0.71[ab]	0.81[a]
Moderate concentration (*N*=965)	1.00[ac]	1.01
High concentration (*N*=1,483)	1.34[bc]	1.22[a]
Black population concentration in tract		
Low concentration (*N*=1,832)	1.13[a]	0.89[a]
Moderate concentration (*N*=1,424)	1.10[b]	1.21[ab]
High concentration (*N*=990)	0.59[ab]	0.89[b]
Hispanic population concentration in tract		
Low concentration (*N*=1,788)	1.09[a]	1.05[a]
Moderate concentration (*N*=1,248)	1.04[b]	1.25[b]
High concentration (*N*=1,210)	0.81[ab]	0.67[ab]

Sources: US Census Bureau 2005–9; 2004–6 Multi-city Survey of Social Service Providers
[a, b, c] Notations identify sets of paired cells within a panel where the mean difference in service access between the two cells is significant at the 0.05 level or below.

where only a small fraction of the population is white (1.34 vs. 0.71). Neighborhoods with high concentrations of whites have access to about 50 percent more service opportunities delivered through Medicaid-dependent providers than tracts where a small percentage of residents are white (1.22 vs. 0.81, respectively). Areas with concentrations of black or Hispanic residents have far lower levels of access by comparison. For example, tracts with the highest concentrations of blacks have half as much access to Medicaid providers as tracts with comparatively fewer black residents (0.59 vs. 1.13). Similar disparities in access are present when comparing concentrations of nonwhite Hispanic residents. Areas with high percentages of racial and ethnic minorities compared to the broader community

appear to have lower levels of access to nonprofits receiving Medicaid and to those highly reliant on Medicaid for funding.

We interpret these results to reflect several features of contemporary Medicaid funding of nonprofit social service agencies. Location decisions of mental health and substance abuse service providers most likely to receive Medicaid are shaped by many factors apart from the location of Medicaid-eligible populations; consequently, client access to providers may be surprisingly limited in jurisdictions with high concentrations of Medicaid-eligible populations. Also, as noted above, expansion of Medicaid eligibility has allowed providers to reach individuals with income near the poverty line. While services are now more accessible to many near poor families, providers may have less incentive to locate in high-poverty neighborhoods. Understanding the spatial dynamics of social service provision also helps explain why Medicaid-funded providers in our survey appear less likely to serve large percentages of women and minorities. Finally, we should note that lower service access scores in these three metropolitan settings ought not to be interpreted as an absolute absence of Medicaid providers in high-poverty areas. Instead, these findings suggest that, on average, Medicaid-funded nonprofit providers in high-poverty areas of these three cities maintain lower caseload levels relative to potential demand in the community, compared to Medicaid-funded providers in lower-poverty areas. Nevertheless, low levels of access to Medicaid providers may coincide with longer waiting times, fewer choices about where to receive treatment, and fewer treatment options (Allard 2009b).

Conclusion: Medicaid Funding of Social Services and the Contemporary Safety Net

Medicaid finances a significant share of nonprofit social service organizations operating outside the health care sector in the seven urban and rural sites examined in this study. Given the diversity of our sites and survey respondents, this finding is generalizable to many other urban and rural settings. Our survey data offer insight into why many nonprofit service organizations do not or are unable to access Medicaid revenue streams. Not all nonprofit service providers serve Medicaid-eligible clients or deliver Medicaid-eligible services. Decisions about office location may prevent some nonprofit providers from accessing large pools of Medicaid-eligible clients. State certification and complex administrative processes tend to favor nonprofits with larger capacity, extensive experience in public

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reporting systems, and a familiarity of the daily politics of program administration and funding.

We also find that Medicaid-funded nonprofit organizations are less accessible to low-income neighborhoods and neighborhoods with large percentages of racial or ethnic minorities than we might expect. If capacity to secure Medicaid funding is not well matched to neighborhoods where large numbers of Medicaid-eligible populations reside, the provision of Medicaid services may be poorly distributed across the geography of local communities and neighborhoods. On average, we should expect Medicaid-eligible individuals living in areas with weaker access to nonprofits receiving Medicaid to face greater challenges receiving necessary treatments or support than those living in places with greater access to providers eligible for reimbursement through Medicaid. If Medicaid-certified nonprofit providers offer higher-quality services than those nonprofits not certified for Medicaid, spatial inequalities in access could reflect significant differences in the quality of care received by Medicaid clients.

Instead of being a passive source of funding, Medicaid has the potential to transform the local playing field of social service provision. The generosity of Medicaid's reimbursement rates for qualified social services compared to other funding sources may allow some nonprofit service organizations to subsidize staff and overhead costs associated with other programs where funding may be more limited. A new set of "haves" and "have-nots" may emerge in local nonprofit communities, where certain organizations become highly advantaged and others become more disadvantaged depending on their access to Medicaid funds. Such inequality is likely to be encouraged, albeit unintentionally, by state officials who increasingly focus on maximizing federal matching funds through programs like Medicaid as a pathway to supporting social service programs in a time of fiscal austerity. Nonprofit service providers without Medicaid certification, therefore, may be more likely to have their funding reduced or face difficulties obtaining government contracts. In the extreme, larger providers with Medicaid certification could increasingly dominate local service systems. Such developments are not necessarily negative, as larger Medicaid-funded nonprofit providers may offer higher-quality services to a greater number of individuals. Such organizations, however, may not be as spatially accessible or engaged in the local community. Fewer larger providers may also decrease the diversity of services offered by nonprofit providers.

Many unanswered questions remain, and we see this study as an important step forward into an area of social policy inquiry that should

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become increasingly important in the coming years. Given the central place of social services within the American welfare state, scholars and policy makers should devote more attention to the intended and unintended consequences of greater reliance on Medicaid for funding of these critical safety-net resources for the poor. As we argue here, Medicaid funding of social services shapes the behavior of state government and nonprofit organizations, which in turn can affect whether and how Medicaid-eligible social services are available at the street level. More detailed understanding of the role states play in shaping the flow of Medicaid funding to nonprofit social service organizations and the calculations of nonprofits as they approach decisions on Medicaid certification would be helpful to scholars and policy makers as they anticipate how Medicaid funding of social services might respond to future budgetary pressures, periods of economic downturn, and increased demand for community-based services for low-income individuals, the disabled, and the elderly.

Part of the challenge lies in overcoming the data limitations inherent to this area of social policy research. New sources of data are required to illuminate how Medicaid funds are distributed throughout the nonprofit social service sector and shifts in funding over time. Greater inquiry into nonprofit decisions to become Medicaid certified also may shed light on the forces or considerations driving observed patterns of Medicaid resource distribution. Our data in this study are limited to the characteristics of nonprofit social service organizations, but future work should examine how public agencies draw on Medicaid funding when delivering services and whether public agencies are more accessible to communities with larger concentrations of Medicaid-eligible populations. In addition, future research should assess how Medicaid-eligible clients seek and use social service programs. Tracing individual-level behavior should generate valuable insight into the impact of Medicaid-funding support on the health of low-income populations and the operations of nonprofit social service agencies.

Future research also should explore the impact of several relevant shocks to the economic and policy environment that our survey data cannot capture. The Great Recession has had a significant effect on the role Medicaid plays in the funding of social services. Indeed, the Great Recession has exposed vulnerabilities within the nonprofit social service sector, particularly given its heavy dependence on public funds (Allard 2009b; Smith 2012). Federal and state government face persistent pressures to reduce social program expenditures even as the country proceeds into a slow

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recovery and moves well past the formal end to the Great Recession (Dadayan 2011; Leachman, Williams, and Johnson 2011). State governments have had to cut their own state funding for mental health services, substance abuse services, counseling, and programs for the disabled (Lutterman 2011). Even so, Medicaid remains one of the largest components of state government budgets—about 13 percent of total state spending and caseloads still remain well above their prerecession levels (CBPP 2011; KCMU 2012a; Smith et al. 2012). Several states have reduced mental health program services covered by Medicaid or imposed cost-containment measures on home and community-based long-term care services (Smith et al. 2010; Johnson, Oliff, and Williams 2011).

Complicating matters, the ACA will lead to increased Medicaid funding to social service organizations in at least half of all states. Under the ACA, states can choose to extend Medicaid coverage to all persons with income below 133 percent of the federal poverty line, allowing states to provide Medicaid coverage—almost completely federally funded—to millions of low-income adults without dependent children (KCMU 2011d). In the twenty-five participating states and the District of Columbia, expanded coverage should create greater demand for eligible social services and possibly greater resources targeted at service provision through community-based organizations. States extending Medicaid coverage, however, might incur higher program costs through enrollment of previously eligible individuals who were not engaged with the program. At the same time, those states choosing not to participate in Medicaid expansion will still have to draw on own-source dollars if they are to cover individuals traditionally not eligible for Medicaid. Thus, the ACA leaves states to reconcile the pressure to reduce state Medicaid costs with the potential to expand health services for many disadvantaged individuals and the possibility of long-run cost savings through earlier intervention, more prevention, and better health management.

Despite the countervailing pressures, we should expect that the linkage between Medicaid funding, local capacity to deliver social services, and state fiscal policy will intensify. The ACA should provide all states with opportunities to redesign or realign their systems for delivering behavioral health and medical care to low-income populations. Determinations about which social services Medicaid will cover and for whom should emerge slowly, in a state-by-state fashion, over the next few years. We should expect state governments to remain essential in the management of Medicaid-funded social services such as community care for low-income

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individuals, the disabled, and the aged. With only half of all states participating in Medicaid expansion at the time of publication, however, we should expect state-level and regional inequalities in social service capacity to widen in the coming years. Moreover, social service providers in states opting out of Medicaid expansion will likely be much more vulnerable to changes in the economic and fiscal environment than participating states, where federal Medicaid funds will expand during downturns to meet rising need and demand for services. The consequence of state choices to participate or not participate in Medicaid expansion for social service provision will be a particularly important area of research moving forward.

Finally, nonprofit service providers find themselves in a similar quandary to states as they weigh the opportunity presented by Medicaid funding of social services. Because many key Medicaid eligibility decisions reside at the state level, nonprofit social service agencies are extremely vulnerable to shifts in state fiscal health and the state politics of Medicaid. Whereas Medicaid once might have been a stabilizing source of revenue, moving forward it also may ebb and flow with the economy as do other sources of social service program funding. Since it is a modest source of revenue for many nonprofits, greater instability and unpredictability may make Medicaid a less desirable source of revenue. Nevertheless, nonprofit service providers certified to receive Medicaid will be more advantaged in the uncertain fiscal terrain ahead than those providers not eligible for Medicaid and reliant on ever more elusive state-sourced program dollars. Regardless of how the ACA is implemented, however, the nonprofit social service sector is likely to face more consolidation and greater competition as organizations strive to secure funding and clients in an era of public budget austerity. That Medicaid will be a neutral actor in how these competitive processes play out among local nonprofit service organizations, we believe, is unlikely.

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