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Medicaid and Faith Organizations

Participation and Potential

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INTRODUCTION

Bush Administration proposals to allow participation by faith-based organizations in federally funded social service programs have touched off considerable controversy. To date, however, there has been little public discussion and no published literature about the involvement of these organizations in the largest intergovernmental social service program the American federal system operates: Medicaid. This program accounted for over $260 billion in federal, state and local spending in FY 2003 for a wide range of services to over 40 million enrollees. The program supports health care, long term care, mental health, prescription drugs, and a variety of other residential and non-residential services for a wide range of client groups ranging from low income women and children to the low income elderly and those who are disabled.

There are several reasons for interest in Medicaid as a potential funding source for religious organizations. First, it is large and growing relatively rapidly — roughly 45 percent since 1999— while funding for other programs advanced as sources of support for these organizations are growing at much slower rates and Medicaid has been relatively unaffected by recent state budget difficulties, while funding for other social programs has been reduced or grown only slowly, if at all[1]. Second, Medicaid is a major source of financial support for mental health and substance abuse programs, service areas where spirituality has received attention as a therapeutic method. While systematic evidence is scarce, one estimate placed annual Medicaid spending for mental health and substance abuse in 1997 at roughly $29 billion[2]; more than 10 times the amount spent annually under the substance abuse and mental health block grant which has been included in the Administration's faith based initiative.

Medicaid is also of potential interest because its payment systems may avoid legal challenges, which have been lodged against other forms of support for faith-based programs. Unlike many other social programs, Medicaid payment is largely tied

[1]For a detailed description of recent trends in social program spending comparing Medicaid and other programs, see Thomas Gais, Courtney Burke and James Fossett, "State Fiscal Changes, Social Program Spending, and Faith-Based Organizations," (Rockefeller Institute of Government, forthcoming).

[2]As reported in Anna Scanlon, "State Spending on Substance Abuse Treatment" National Conference of State Legislatures, 2002. Available on-line at http://www.ncsl.org/programs/health/forum/pmsas.htm; accessed June 17, 2004. Medicaid is particularly significant as a source of funding for public mental health programs. See John Kotler "Seizing the Moment: Redefining State Mental Health Agency Role in Time of Budget Uncertainty" National Technical Assistance Center for State Mental Health Planning (Winter 2002).

to choices of individual patients about which provider they will visit or in which managed care plan they will enroll. This payment on the basis of choice of providers by individual clients may enable payments to be made to faith-based providers that could not withstand legal challenges under alternative funding mechanisms. The Supreme Court has held school voucher payments to religious schools to be constitutional as long as there are secular alternatives available and the voucher payment is the result of a "genuine private choice." While courts could find in any particular case there are no alternatives available or that the choices of clients are coerced in some way, choice-based payment schemes appear to be treated more charitably by courts than direct grants to institutions.[3]

To understand the role of faith-affiliated organizations in health care in general and Medicaid in particular, we examined the role of faith based or affiliated programs and facilities in several aspects of Medicaid programs in ten states, listed in Table 1.

Table 1
Sample States

Arizona	Colorado	Kansas
Michigan	New Jersey	Ohio
Oregon	Texas	West Virginia
	Wisconsin	

These states are not in any sense a statistically representative sample, but vary widely in geographic location, the size and scope of Medicaid programs and other factors that might influence the role of faith organizations. We examined the role of faith organizations in five areas:

- **Hospitals** — This is the largest single expenditure category under Medicaid, accounting for approximately 20 percent of all Medicaid expenditures in FY 2003;

- **Nursing homes and other long-term care** — Nursing homes are the second largest Medicaid expenditure category, accounting for approximately 17 percent of expenditures in 2003. Programs and facilities, which provide long term care outside of nursing homes, have been growing rapidly in many states, but it is difficult to account for Medicaid expenditures on these programs.

[3]See Ira Lupu and Robert Tuttle "Legal Analysis: Zelman, Superintendent of Public Instruction of Ohio et Al v. Simmons-Harris, et Al." The Roundtable on Religion and Social Welfare Policy, 2002. Available on-line at http://www.religionandsocialpolicy.org/legal/legal_update.cfm?id=10; accessed on June 17, 2004.

- **Mental health** — Most states have significantly downsized state psychiatric institutions in favor of community-based programs in local hospitals or outpatient settings. States vary widely in the extent to which mental health programs have been "Medicaided," with some states having moved considerable shares of their mental health spending onto Medicaid. There has been some interest in professional circles on the value of spirituality as a therapeutic method, making this a service area of particular interest.

- **Substance abuse** — Substance abuse is another area where there is some potential claim for spirituality as a therapeutic method. States vary widely in the extent to which they use Medicaid funds to support substance abuse programs, and in the mix of outpatient and residential services, which they provide.

- **Medicaid/ CHIP outreach and marketing** — The final set of programs we examined were community outreach and marketing activities begun in the late 1990's to encourage eligible individuals, particularly children, to enroll in Medicaid and the Children's Health Insurance Program (CHIP). Using funds from CHIP and foundation grants, many states undertook marketing and outreach programs to make eligible clients aware of coverage, encourage them to apply, and provide help in completing the application process.

We examined faith-affiliated activities in these areas using the field network method, in which a network of locally based academic observers prepares reports according to a standardized protocol. This approach, which can be likened to a series of comparative case studies, has been found repeatedly useful in examining complex administrative and programmatic questions, including the implementation of a wide range of social programs.[4] Field researchers for the sample states, who are listed in Appendix A, were asked to assess the size of the faith based or affiliated sector providing each of these services in individual states, and analyze differences and similarities between these providers and others in market/mission; market behavior and Medicaid participation.

In particular, we asked field researchers to distinguish between the involvement of congregation-based organizations and that of religiously affiliated nonprofit organizations. Payments under Medicaid and other public programs have traditionally been made to religiously affiliated nonprofit organizations, which are organizationally distinct from congregations or other overtly religious institutions, although they are related to religious institutions in some way. These organizations range in size from small agencies affiliated with individual congregations to very large national institutions such as Catholic Charities,

[4]For a detailed description of the method, see Irene Lurie, "Field Network Studies" in *Policy Into Action: Implementation and Welfare Reform* (Eds. M.C. Lennon and T. Corbett; Urban Institute, 2001)

Lutheran Social Services, or Jewish Family Services. Congregation-based organizations, by contrast, do not have an organizational distinction between the agency, which provides services and a house of worship or other religious organization.[5] Such bodies as state Councils of Churches can be considered as coalitions of congregation-based organizations. The Bush Administration's faith-based initiative proposes to increase financial support for such organizations.

Our findings are mixed. Measuring the size of the faith-affiliated sector in many states is unexpectedly difficult, since many states do not track this status in any systematic way. Participation in Medicaid by traditional "faith-affiliated" providers such as Catholic Charities varies widely by sector and by state. Religiously affiliated providers are most common among hospitals, nursing homes and other long-term care programs and apparently less common among providers of mental health and substance abuse services. Differences between states in the size of the faith affiliated sector do not appear to be the result of differences in state policy, but rather the result of differences in history and the settlement patterns of particular denominations. State policies towards providers focus on payment, standards for quality of care, and other programmatic issues and do not appear to present any particular obstacles to increased participation by faith-affiliated organizations.

Congregation-based organizations such as Councils of Churches or individual congregations are almost totally absent from Medicaid. The only area where congregation based organizations were active was in Medicaid and CHIP outreach, where a wide range of religious groups were active in many states. Much of this activity was voluntary or collaborative rather than contractual, meaning there was no state financial support of congregation-based activities.

Public funds do support religious activities on a small scale, but they support them on the same basis in both faith-affiliated and other facilities. Medicare makes payments to hospitals to support residency-training programs operated by facilities for clinical chaplains and a variety of other allied health professions. In addition, pastoral counseling is a required part of the hospice benefits supported by both Medicare and Medicaid. Finally, the costs of chaplaincy programs in hospitals or other facilities are counted as 'allowable costs" by Medicare and Medicaid programs.[6] Expenditures on these activities can thus be used to set payment rates in either cost-based or prospective payment systems.

[5]For a more detailed statement of these definitions in the context of a taxonomy of faith-based organizations, see Mark Ragan, Lisa Montiel and David Wright "Scanning the Policy Environment for Faith-Based Social Services in the United States" (Roundtable on Religion and Social Policy, 2003.), Appendix II Available on-line at: http://www.religionandsocialpolicy.org/docs/events/2003_annual_conference/11-17-2003_state_scan.pdf; accessed on 6/25/04.

[6] For more details, see Lerrill White "Pastoral Care Providers: Members of the Health Care Team in Accordance with the Regulations of the Department of Health and Human Services" (Association of Professional Chaplains, 2003. Available on-line at www.professionalchaplains.org; accessed May 20, 2004.) See also Laura Landro, "Tough Times Ahead for the Spiritual Side of the Healing Process" *Wall Street Journal* (December 18, 2003).

There are some differences between faith-affiliated facilities and other facilities. Faith-affiliated hospitals may not offer some services they find theologically objectionable and may manage some patients in a distinctive fashion shaped by religious values[7]. Public programs, however, typically recognize no distinctions between faith-affiliated providers and others. Faith-affiliated facilities are required to meet the same standards for buildings, equipment, and qualifications of personnel, staffing, and quality of care as other facilities in order to receive payment from Medicaid and Medicare. Payments for services provided to enrollees of public health insurance programs are made in the same fashion as to other facilities or programs, whether directly to the facility or indirectly through payments from managed care organizations, which enroll public patients.

Our findings also indicate there may be considerable administrative and financial barriers, at least in the short run, to expanding participation by congregation-based organizations in most Medicaid funded activities. Becoming a qualified Medicaid provider in most states typically requires some form of state license, the hiring of expensive professional personnel with appropriate credentials, a building which meets program guidelines, purchasing large amounts of insurance, and a variety of other actions. Medicaid does not cover these "start up" expenses, which may be beyond the financial and administrative capacity of all but the wealthiest and most sophisticated organizations. Health care and related areas are also "high overhead" activities which require considerable administrative attention on an on-going basis. Those faith-affiliated organizations active in Medicaid and other publicly financed programs have had to develop large, expensive, sophisticated bureaucracies and management systems to manage health and other facilities and programs and the variety of relationships with payers, managed care organizations, accrediting bodies, and state regulators required to operate these programs. Again, developing this management capacity may be beyond the reach of many organizations.

The most attractive opportunities for expanding the participation of congregation based organizations in Medicaid funded activities may lie in program categories where the start-up expenses are relatively low and the on-going administrative demands are less onerous. Congregations have been successful in operating foundation-funded programs to provide transportation and personal services such as house cleaning, grocery shopping, and help with activities of daily living. At least in some states, Medicaid funds similar activities, which might be potential candidates for increased participation by faith-based organizations.

[7]Catholic hospitals are the most visible example of this difference. Church doctrine prohibits these facilities from providing a variety of reproductive health services or managing end of life care in particular ways. The major statement governing practices in Catholic facilities is US Conference of Catholic Bishops "Ethical and Religious Directives for Catholic Health Services, Fourth Edition." Available on-line at http://www.nccbuscc.org/bishops/directives.htm. Accessed May 1, 2004.

HOSPITALS

Religious organizations have been active as founders and operators of hospitals for most of American history. The Catholic Church has been the most active denomination historically and is far and away largest religious hospital operator, with approximately 625 hospitals nationwide. Some Protestant denominations, particularly the Baptists and Lutherans, have also established and operated hospitals, but on a smaller scale.

In most of our sample states, faith-affiliated hospitals are a significant part of the health care system. Table 2 displays data from the American Hospital Association's 2002 survey on the proportion of inpatient hospital beds in faith-affiliated facilities. These data suggest a considerable range in the size of the faith-affiliated sector across states — from 5 percent of all hospital beds in West Virginia to 30 percent in Oregon.[8] In seven of the ten states in our sample, faith-affiliated hospitals account for more than 20 percent of inpatient beds. In several states, the number of faith-affiliated hospitals has declined in recent years as a result of mergers, acquisitions, and other administrative realignments. These consolidations, which have been common for all types of hospitals, have typically been the result of attempts to gain leverage in negotiations with managed care organizations, realize economies of scale in purchasing, take advantage of synergies between organizations, and a variety of other business purposes.

Table 2. Percent of Hospital Beds in Church-Owned Facilities

State	*"Church-Owned"[9] Staffed Beds*	*Inpatient Beds*	*Percent of Beds that are "Church-Owned"*
Arizona	2,221	10,325	22%
Colorado	2,049	9,442	22%
Kansas	2,539	11,211	23%
Michigan	5,092	25,630	20%
New Jersey	2,751	24,580	11%
Ohio	7,419	33,310	22%
Oregon	2,008	6,660	30%
Texas	9,482	56,354	17%
W. Virginia	394	7,906	5%
Wisconsin	4,278	15,597	27%

** Sources: Staffed Beds in Church-Owned Hospitals Estimated from AHA 2002 Hospital Guide (2003 Edition). Total Inpatient Beds estimated from "AHA 2003 Hospital Statistics"*

[8] These data may be out of date in some states because of recent acquisitions, mergers or other organizational changes.

[9] "Church-owned" is the terminology used by the American Hospital Association to describe hospitals with religious affiliations.

Reports from field researchers suggest there is little difference between faith-affiliated and other hospitals in participation in Medicaid or other public programs or most other dimensions. The case in Arizona is typical:

> *"....a faith affiliated hospitals were not found to be distinct from other hospitals in terms of their clientele, political interests, or services. Further, these facilities are not recognized as a cohesive bloc that acts together on specific issues. They appear to be indistinguishable from other hospitals in Arizona. One exception would be in the delivery of abortion services: Catholic hospitals do not provide this service. This differentiation in service provision does not appear to have a significant impact on the role of these faith-affiliated hospitals as there are other hospitals available to perform abortions in all but one small area of the state...The five faith-affiliated hospitals are each participants in Arizona's Medicaid managed care network. There are no licensed faith-affiliated hospitals not participating in this managed care network. There do not appear to be any obstacles to participation specific to (these) hospitals"*[10]

Similar findings were reported in Kansas:

> *"The faith-affiliated sector is not perceived as necessarily unusual in mission, services or size...There are some exceptions; a handful of these hospitals are perceived as different in terms of mission, with a more explicit focus on serving the disadvantaged members of their community. This view is affirmed by the Kansas Hospital Association: an official there notes that...as a group, they seem 'invisible' in the overall scheme of things. These hospitals do not work together as a cohesive block for political or other purposes. For the most part, they appear quite undistinguishable from other hospitals...All known faith-affiliated hospitals participate in Medicaid. (and) there are no major obstacles to expanded participation"*[11]

Differences between faith-based and other hospitals in participation in Medicaid in Wisconsin were also described as small:

> *"...the faith affiliated hospitals receive a slightly lower percentage of their revenues from Medicaid than do other hospitals; general medical and surgical hospitals as a whole received 8.3 percent of their revenues from Medicaid in 2001, while the faith affiliated hospitals received 7.4 percent of their revenues from Medicaid (including through HMO's)...State Medicaid officials do not generally believe that faith-affiliated hospitals play an unusual role in the Medicaid program, either as providers of last resort or as facilities that are avoided by Medicaid HMO's."*[12]

[10] Arizona field report, p.9, 11.
[11] Kansas field report, p. 2, 3
[12] Wisconsin field report, pp. 6.

These findings suggest that faith-affiliated hospitals are seen in almost all states as well-established providers, but not generally distinguishable in mission, services, or Medicaid participation from other types of hospitals. Most, if not all, faith-affiliated hospitals participate in Medicaid and do so at levels that are not appreciably different from other hospitals. Individual facilities may give greater or lesser emphasis to the explicitly religious elements of their mission, but these hospitals do not form a distinctive group in any of the states in our sample. While Catholic hospitals do not provide abortion or certain other reproductive health services, this practice requires no special dispensation or exception from Medicaid.[13] There is no requirement in Medicaid that an individual hospital provide any particular service, and hospitals frequently make decisions not to offer particular services for a wide range of reasons. In states where abortion or other reproductive services not provided at Catholic facilities is covered by Medicaid, Medicaid managed care plans must insure that these services are available somewhere in their network of participating hospitals, but this situation is no different from the need to insure that cardiac surgery or any other service not provided by all hospitals are available as well.

LONG TERM CARE

Nursing Homes

Long term care, particularly nursing homes, is another health care sector in which faith-affiliated providers have traditionally been active. Nursing homes account for a large portion of Medicaid expenditures — approximately 17 percent of payments to Medicaid vendors in FY 2003. Medicaid accounts for a large share of total spending on nursing homes nationally — slightly less than 50 percent, according to most estimates. Faith-affiliated nursing homes are organized and paid in the same fashion as hospitals, and service, staffing and quality standards are the same for all facilities.

Possibly as a reflection of this limited distinction, there are no reliable national listings of faith-affiliated nursing homes, and many states do not track faith-affiliated status in any systematic way. Inventories of nursing homes certified to receive payments from Medicare or Medicaid are maintained by the Center for Medicare and Medicaid Services, but these inventories do not reliably distinguish between faith-affiliated facilities and other non-profit agencies.

[13] The case of abortion in hospitals differs from the explicit exemptions granted by state and federal "conscience clauses" to faith affiliated health maintenance organizations who may be exempt from offering family planning services to Medicaid clients, even though these services are part of the Medicaid benefits package. States are obligated to provide these services to Medicaid clients and do so in a variety of ways. For a more complete discussion of Medicaid funding for family planning, see Rachel Benson Gold and Corey Richards *Medicaid Support for Family Planning in the Managed Care Era* (Alan Guttmacher Institute, 2001). Available on-line at http://www.agi-usa.org/pubs/medicaid.pdf; accessed on June 21, 2004.

Table 3 displays the best available information on the number of faith-affiliated nursing homes in our sample states, drawn from local sources collected by field researchers. Table 4 displays data on the number of nursing homes operated by different denominations drawn from denominational web sites. While direct comparisons are difficult, the faith-affiliated sector seems to be smaller in the nursing home sector than among hospitals in most states. While not complete, these data suggest a considerable range in the size of the faith-affiliated sector across these states, ranging from around four percent of the facilities in Texas to approximately 18 percent in Arizona. A higher range was reported in Kansas, where precise estimates were not available:

Table 3. Nursing Homes that are "Faith-affiliated"

State	*Faith Affiliated*	*Total Nursing Homes*	*Percent of Nursing Homes that are "faith-affiliated"*
Arizona	25	135	18.5%
Michigan	30	341	8.8%
	27	365	7.4%
Texas	36	1,058	3.4%
West Virginia	11	102	10.8%
Wisconsin	60	408	14.7%

Sources: Field researchers used various state sources.

> *"Roughly one quarter to one third of the nursing homes in Kansas is faith (affiliated). In size and location they are fairly typical of all nursing homes...State officials report that there are roughly 181 non-profit/public nursing homes in the state and approximately 164 for-profit facilities. A large percentage of the 138 non-profit facilities are faith-(affiliated)."*[14]

There also appears to be more denominational diversity in nursing home affiliation than in the case of hospitals. While facilities affiliated with the Catholic Church are the most numerous in most states, other denominations are more active as sponsors of nursing homes than of hospitals. Presbyterian and Lutheran facilities appear to be the most common among non-Catholic facilities, but several other denominations also sponsor nursing homes in particular states. Table 4 outlines information from denominational websites, which listed the number of nursing homes in individual states. This listing is obviously not exhaustive; it only includes those denominations that maintain a centralized listing of nursing homes on their web sites.

[14] Kansas field report, p. 4

Table 4. Nursing Homes Providing Skilled Nursing by Denomination

State	*Catholic*	*Presbyterian*	*Evangelical Lutheran (Good Samaritan Society)*
Arizona	0	0	5
Colorado	7	0	2
Kansas	10	13	11
Michigan	10	4	1
New Jersey	15	5	0
Ohio	35	8	1
Oregon	6	4	4
Texas	16	9	3
West Virginia	4	0	2
Wisconsin	36	0	3

Sources: Websites of various denominations.

As in the case of hospitals, the field research suggests that faith-affiliated nursing homes are not distinguishable in most ways from other facilities. Most facilities participate in Medicaid but not at levels that are dramatically higher than other facilities, and few, if any, differences are perceived between faith-affiliated providers and others. In Arizona, for example:

> *"From the (state Medicaid agency) or long-term care plan perspective,[15] there is no differentiation of faith-affiliated providers. .The primary concern is that facilities remained licensed and in 'good standing' with all regulatory and legal entities. According to one long-term health plan representative, the faith-based nature of a provider is only considered at the request of a member. When a plan member requests a certain faith affiliation for services, efforts are made to fulfill this request...Our best assessment is that (Medicaid) patients are not more concentrated in faith (affiliated) facilities than in other types of nursing homes...According to one faith based provider, however, although the number of (Medicaid) patients is not higher, they service those with greater need than other providers"[16]*

In comparable fashion in Kansas:

> *"According to (state officials), Medicaid clients are not concentrated in (faith-affiliated) facilities, and Medicaid reimbursements to (faith-affiliated) providers are not noticeably different from those to other*

[15] Arizona is the only state, which operates its Medicaid long-term care program through a managed care arrangement.
[16] Arizona field report, p.15, 19.

providers. There are places, such as rural Western Kansas, where (faith-affiliated) facilities may be providers of last resort, but they are not seen as providing disproportionate amounts of care to Medicaid recipients"[17]

A similar finding was reported in West Virginia:

"Faith (affiliated) long term care facilities do not appear to occupy a special niche in service delivery in West Virginia...Based on best estimates from public sources, faith (affiliated) facilities received approximately 6.6 percent of Medicaid long term care revenues and compromise 6.8 percent of all long term care nursing facilities. The available data does not suggest a disproportionate share of care being provided by faith (affiliated) facilities."[18]

In Wisconsin, it was noted that faith-affiliated nursing homes actually have fewer Medicaid clients than other facilities:

"Based on data from the 2002 Wisconsin nursing home directory, religiously affiliated homes had a weighted mean of 59.3 percent of their clients funded by Medicaid; for all nursing homes in the state, the percentage of clients funded by Medicaid was 67.3 percent. From a nursing home's financial perspective, the higher the percentage of private pay patients, the better; religiously affiliated homes are probably better able to appeal to private pay patients than other types of homes. Only one religiously affiliated home in the state, however, contained no patients funded by Medicaid...the large majority of religiously affiliated homes have at least 45 percent of their patients funded by Medicaid."[19]

Comparable findings were reported in New Jersey:

"Faith affiliated nursing homes are not seen as significant in New Jersey. More emphasis in this state is placed on whether the homes are non-profit or for-profit providers....For some patients, (however) moving into a faith-managed facility provides a level of familiarity and security that may not be present in other private facilities. Faith affiliated organizations are important because it is assumed that their mission is to serve people, not just to make a profit, and this perception seems to make many consumers more comfortable using them"[20]

These data indicate that faith affiliated nursing homes are seen by state officials as indistinguishable from other providers, are treated the same by public programs, and behave in roughly the same fashion as other providers in the nursing home

[17] Kansas field report, p.4.
[18] West Virginia field report, p.16.
[19] Wisconsin field report, p. 9.
[20] New Jersey field report, p. 8.

market There do not appear to be any barriers to Medicaid participation particular to faith-affiliated facilities. Many providers have complaints and concerns about inadequate Medicaid rates and competition from community based programs, but these problems are not unique to faith-affiliated providers. Faith-affiliated facilities do not appear to serve a disproportionate number of Medicaid clients in most states, and may even enjoy something of a market advantage in competing for private pay patients.

Community Based Care

It is next to impossible to systematically measure the faith-affiliated presence in the increasingly large and complex long-term care sector outside nursing homes. The widely used term "community based care" encompasses a very broad range of services and types of providers, ranging from residential "assisted living facilities"[21] to several different types of programs which provide health care and other services to clients living in their homes. Some of these services are covered by Medicaid and others are not, and some are covered in some states under the terms of Medicaid "home and community based" waivers, but not in others which do not have these waivers. The level and extent of state regulation of these services also varies widely. State regulations governing assisted living facilities, for example, have different definitions of the services such facilities can offer, staffing requirements, assistance with medications, and other issues.[22] In addition, at least some states do not record the religious affiliation of these providers.

These regulatory and definitional ambiguities make it effectively impossible to measure either the size of the community-based sector or the role of the faith affiliated providers within it in any systematic way. Anecdotal evidence from the field research suggests that this sector, particularly assisted living facilities, has expanded rapidly in many states and has driven down nursing home occupancy rates in some areas by providing a cheaper alternative to nursing home care for the less disabled elderly. Declines in nursing home occupancy due to "competition" from community programs were reported in Arizona, New Jersey, West Virginia, and Wisconsin.

The field research also suggests that the size of the faith-affiliated community long term care sector roughly parallels the nursing home sector — states where faith-affiliated nursing homes are common had a larger faith-affiliated community care presence than states where faith-affiliated nursing homes were less common.

[21] Assisted living facilities are residential facilities whose residents are typically less disabled or have less complex health care needs than those in nursing homes. Typically, there is 24-hour on-site supervision, with meals provided. Facilities typically offer a range of support services, including help with activities of daily living, social, religious, or educational services, transportation and the like.

[22] For a recent review of state regulations of these facilities, see National Council on Assisted Living, *Assisted Living State Regulatory Review 2003*. Available on-line at http://www.ncal.org/about/2003_reg_review.pdf; accessed on May 6, 2004.

Thus, in Kansas, which had the largest representation of faith-affiliated organizations among its nursing homes:

> *"There are many assisted living options offered by the Presbyterians (about 14 facilities), the Good Samaritan Society (23 facilities), the Mennonites (8 facilities), and other denominations...According to state officials and others involved in community based long term care, faith(affiliated) facilities represent a substantial portion of the total community based assisted living program. They are not substantially different from other facilities in terms of size or location. In some areas in rural western Kansas, they may be providers of last resort."*[23]

Arizona also has one of the larger faith affiliated sectors:

> *"Faith affiliated 'community long term care' agencies are a thriving part of the service population to (Medicaid) clients making up approximately 10 to 15 percent of the provider population. Additionally, we found a minimum of twelve faith-affiliated providers that have different levels of care (Skilled Nursing, Assisted Living, and Individual Living) on one campus. The faith affiliations with the most dominance and recognition in providing an array of long term (non-skilled nursing) related services are...the Lutheran Social Ministry, Jewish Family Services, and Catholic Social Services...As a result of a Medicaid waiver which allows coverage of adult day homes, assisted living homes, assisted living facilities, and adult day care, faith affiliated organizations may have more opportunities for participation in the Medicaid system in Arizona than elsewhere"*[24]

Somewhat better data is available on faith-affiliation in the home health industry. This industry is dominated by a very large number of small, local firms. A recent report indicates there are approximately 7,000 certified Medicare home health providers, about half of which are non-profit. Medicaid accounts for about 21 percent of these agencies' revenue, but Medicare is typically a more important revenue source for these agencies than Medicaid.[25] Table 5 reports the best available information on the distribution of faith-affiliated home health agencies. This table is derived from a database of Medicare certified home health agencies maintained by the Center for Medicare and Medicaid Services and likely includes the overwhelming bulk of home health agencies, but it is not a count of the total number of home health agencies or of those agencies which participate in Medicaid.[26] Better data is not available for individual states, however.

[23] Kansas field report, p. 4.
[24] Arizona field report, p. 17, 20, 21.
[25] Center for Medicare and Medicaid Services. *Health Industry Market Update: Home Health*. Available on-line at http://www.cms.hhs.gov/reports/hcimu/hcimu_09222003.pdf, accessed May 6, 2004.
[26] This data set, known popularly as "Home Health Compare," is available on-line at http://www.medicare.gov/HHCompare/Home.asp

Table 5. Percent of Community-based Providers that are Religiously-affiliated

State	*Home Health Agencies*	*Number Reporting religious-affiliation*	*Percent*
Arizona	84	4	4.76%
Colorado	140	5	3.57%
Kansas	154	17	11.04%
Michigan	226	20	8.85%
Ohio	513	28	5.46%
Oregon	86	18	20.93%
Texas	1,266	31	2.45%
West Virginia	112	12	10.71%
Wisconsin	251	53	16.33%

Source: Center for Medicare and Medicaid Services (CMS) administrative data.
Note: Reliability of data is uncertain because it is self-reported.

These data again suggest a considerable range in the size of the faith-affiliated sector, ranging from less than 3 percent of home health agencies in Texas to approximately 20 percent in Oregon. The faith affiliated home health sector is typically smaller than the comparable hospital sector and is roughly the same size as the nursing home sector.

Again, there is little evidence of any substantial difference between faith-affiliated agencies and other providers. Anecdotal evidence indicates that faith-affiliated providers may be smaller than such non-profit agencies as Visiting Nurses Associations, but these agencies appear to see the same types of clients and function in the same fashion as other agencies.

BEHAVIORAL HEALTH

Mental health and substance abuse are program areas where faith-affiliated providers have been traditionally less active. The major thrust of mental health policy in many states over the last forty years has been to move patients and financing out of large state psychiatric hospitals and into programs provided by in- and outpatient hospital programs, non-institutional residential treatment facilities, federally supported Community Mental Health Centers, and a wide variety of community based agencies who provide outpatient services of various kinds. Substance abuse services are provided through the same types of providers, and at least some providers provide both types of services.

Measuring the size of the faith-affiliated sector in these areas is difficult, because few states appear to collect data on the affiliation of providers. While at least one state — Michigan — is reworking its grant guidelines in mental health to allow

greater participation by faith based organizations,[27] current policy in most states appears to treat all providers equally. Faith-affiliated providers are subject to the same standards and regulations as other providers, and most appear to follow the same research-based therapy models. Conventionally qualified individual providers may, of course, be making use of faith-based models in their practices, but there is no way to measure the extent of this activity. Anecdotally, while there appears to be some range across our sample states in the relative size of the faith-based sector, in most states it appears to be smaller than in other service areas. In Kansas, for example,

> *"..By far the primary provider for Medicaid and other publicly funded clients is the Community Mental Health Center (CMHC) network, which emphasizes outpatient treatment... By all accounts, the faith (affiliated) portion of the system is quite small. There is one prominent Mennonite full service facility that is also a CMHC, and there are a small number of Methodist facilities...relative to the public CMHC system, these facilities serve a small number of patients."*[28]

The sector was also described as small in New Jersey:

> *"Generally speaking, Catholic Charities is the only religious affiliate who plays a major role in the delivery of mental health services. The Jewish federation provides minimal services. Mental health is one of those areas that faith-based organizations have not really wrapped their arms around compared to childcare or community development. It is felt this is because of the specialized nature of care required and the complications of dealing with people with mental illness"*[29]

Faith-affiliated agencies were described as more common in parts of Arizona:

> *"Faith (affiliated) agencies provide approximately 10 percent or less of services to publicly funded patients in Arizona.... (These agencies) are concentrated in the state's (urban areas)...In (Phoenix), several faith (affiliated) providers provide a significant part of outpatient services. (These include) Arizona Baptist Children Services, Catholic Social Services, Jewish Family and Children Services, Phoenix Interfaith Council, and Presbyterian Service Agency. In Tucson, St. Mary's Catholic Hospital operates one of the five in-patient psychiatric hospitals in the area"*[30]

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[27] Belinda Creel Davis, *Faith Based Organizations and the Delivery of Social Services in Michigan: A Care Study* (Pew Roundtable on Religion and Social Policy; 2004). Available on line at: http://www.religionandsocialpolicy.org/events/2004_annual_conference/Michigan_Narrative_Case_Study_5_24_04.pdf; accessed 5/25/04.

[28] Kansas field report, p. 6.

[29] New Jersey field report, p. 11.

[30] Arizona field report, p. 25.

The involvement of faith-affiliated agencies in the treatment of substance abuse appears to be smaller than in mental health and to involve many of the same agencies that provide mental health services. In Arizona, for example, the same agencies were involved in providing substance abuse and mental health services, and there is only one faith-affiliated residential treatment program in the state.[31] In West Virginia, there were only six faith-affiliated substance abuse treatment agencies — one inpatient facility and five transitional housing programs.[32] In Kansas, state officials estimate that faith-affiliated substance abuse agencies treated 5 percent or fewer of publicly funded substance abuse patients.[33]

Grants for substance abuse services have been made to faith intensive treatment programs from other funding streams and the federal Substance Abuse and Mental Health Services Administration (SAMHSA) is actively involved in the Administration's Charitable Choice Initiative.[34] These grants have not been without controversy, and there has been considerable litigation around the conditions under which these programs do and do not violate the Establishment Clause of the Constitution, which prohibits government support of religious activity.[35] Recent court decisions have been made on the basis of individual program content and administrative arrangements, suggesting to some observers that "the conflict will be litigated and otherwise fought out state-by-state, program-by-program."[36] It may be some time before widely agreed, court sanctioned, programmatic standards emerge from this debate.

Even if such standards finally emerge, it is unclear whether such standards can be easily transferred to Medicaid funded programs. Medicaid's standards for mental health and substance abuse rely heavily on therapy by professionally credentialed providers. The program generally does not pay for other types of counseling services such as peer counseling or self-help programs such as the "twelve step" programs operated by Alcoholics Anonymous and similar groups. Individual therapists, who are reimbursed by Medicaid for their services, may make referrals to such groups for those clients who might benefit from these services, but Medicaid is unlikely to cover the service, whether secular or religious in inspiration.

[31] Arizona field report, p. 28.
[32] West Virginia field report, p. 23.
[33] Kansas field report, p. 8.
[34] For descriptions and analyses of SAMHSA's Charitable Choice Initiative, see http://www.samhsa.gov/faithbased and Ira Lupu and Robert Tuttle, "Legal Analysis of Final Rules and Notices of Proposed Rule Making Concerning the Faith Based Initiative." Available on line at http://www.religionandsocialpolicy.org/legal/legal_update.cfm?id=18. Accessed May 27, 2004.
[35] For summaries of this litigation, see Lupu and Tuttle, "Legal Analysis of Final Rules."
[36] Lupu and Tuttle, *Legal Update: Freedom From Religion Foundation, Inc v. McCallum, 179 F. Supp.2d 950 (W.D. Wisconsin, 2002)*. Pew Roundtable on Religion and Social Policy, 2002. Available on line at http://www.religionandsocialpolicy.org/legal/legal_update.cfm?id=3. Accessed 5/26/2004.

MEDICAID/CHIP OUTREACH

One area where congregation-based organizations have been more active has been in the development of outreach programs in the late 1990's to encourage enrollment, particularly for children, in Medicaid and the Children's Health Insurance Program (CHIP). Medicaid enrollment declined after the implementation of federal welfare reform in 1996. The welfare reform legislation contained funding for activities to insure that Medicaid clients who went off welfare did not lose their Medicaid eligibility, and the CHIP legislation, which was passed in 1997, authorized support for outreach programs to encourage parents of eligible children to enroll their kids. The Robert Wood Johnson Foundation also funded a large national program for states to develop coalitions of public and private organizations to enhance enrollment in these programs.

Individual congregations and other religious groups participated in outreach activities in a variety of ways. Councils of Churches and other religious groups were frequently members of outreach coalitions, and individual congregations and other religious bodies participated in a wide range of outreach activities. These activities ranged from making application forms available in church buildings, to holding health fairs and other promotional events on church property and training volunteers to help parents in filling out Medicaid or CHIP applications. Religious schools were also frequent participants in these activities. West Virginia provides a useful example of this range of activities:

> *"The faith community has been an active participant in promoting the CHIP (and Medicaid) programs. On the most basic level, it is common for places of worship to have on hand CHIP promotion and application materials. Some religious organizations have become active in CHIP promotion and outreach. ..One of the most active FBO's involved in outreach has been the West Virginia Council of Churches..., which served as the fiscal agent for the Robert Wood Johnson Foundation grants that support the West Virginia Healthy Kids Coalition. The council and the coalition have worked closely with the state's CHIP program on outreach activities. For example, the Council of Churches sent 4000 of its member churches information on the CHIP program"*[37]

While there are exceptions, such as a contract to a congregation in New Jersey, most of the involvement of congregations and church groups in Medicaid and CHIP outreach can be described as collaborative rather than contractual. Such volunteer based activities as distributing applications and information, making church facilities available for promotional events, or assisting families in completing applications appear to have been far more common than formal contractual links between public agencies, foundation sponsored organizations and individual churches. Existing faith-affiliated service organizations were also

[37] West Virginia field report, p. 19.

involved in encouraging eligible clients to enroll in Medicaid or CHIP; but there was rarely any explicit financial support for these activities. In Kansas, for example:

> *"...The role of faith (affiliated) organizations in outreach and education is indirect. (These) organizations would advise clients of available Medicaid services and may help them access these services, but, for the most part, they are not directly or financially involved in Medicaid outreach and education"*[38]

Comparable activities by faith-affiliated providers were reported in Arizona:

> *"In Arizona's managed care model for Medicaid, the state does not contract out for outreach and education services. These services are, however, provided by faith (affiliated) organizations and other types of (provider agencies) as part of their own information and service referral activities. Each and every faith-(affiliated) organization we contacted...encouraged participation in public health programs by eligible clients."*[39]

While recent budget difficulties have caused many states to curtail or eliminate explicit outreach programs for Medicaid and CHIP, it might be expected that these activities by provider agencies have continued. These activities provide potential Medicaid or CHIP reimbursement for services that might otherwise have to be provided on an uncompensated basis, making their continuation a cost-effective activity.

CONCLUSION

These findings suggest that Medicaid programs in the states we studied have yet to reflect the changes preoccupying policy debates about the role of religious institutions as providers of publicly funded social services. There is ample long-standing involvement of religiously affiliated providers in Medicaid and a relative absence to date of congregation-based agencies. Public programs recognize few, if any, distinctions between faith-affiliated providers and others. Standards for services, staffing, training, quality, and reporting are the same for both religious and non-religious providers and payment is made in the same fashion in the same amounts for the same services. Faith-affiliated providers are subject to the same market uncertainties, financial stresses, and changes in public payment and other policies as other providers, but there is no evidence, at least in this sample of states, that public policy discriminates against faith-affiliated providers or imposes distinctive obstacles to expanded participation by these organizations.

[38] Kansas field report, p. 9.
[39] Arizona field report, p. 30.

The size of the faith-affiliated sector varies considerably by industry and by state. Faith-affiliated providers are more common in the hospital industry and long term care and less common in mental health and substance abuse. Religious bodies, particularly nursing orders affiliated with the Catholic Church, have been sponsors of hospitals in this country for close to two centuries, while sponsorship of other types of providers has been more broadly diffused. Psychiatric hospitals or other mental health facilities, for example, emerged primarily as a result of public support of state asylums in the mid 19th century.[40]

The size of the faith-affiliated sector also differs significantly between states, but it is difficult to connect these variations to any differences in current state policies or attitudes. The states where the faith affiliated sector is the largest across the services examined here — Wisconsin, Oregon, and Kansas — have little obvious in common in Medicaid policy, demographic composition or other factors that have been shown to influence Medicaid spending. This suggests that the major variables influencing the size of the faith-affiliated sector in individual states may be historical rather than current. Where adherents of particular denominations with strong social service traditions — Lutherans or Catholics, for example — settled upon immigration to this country or on migration from other parts of the country — might, for example, be an important historical determinant of the size of the faith-affiliated sector. In similar fashion, the lack of alternative institutions, either public or private, that were major sponsors of early hospitals in Eastern cities, may have made churches the only organizations with the ability or inclination to establish hospitals in Western states, many of which remained territories for extended periods of time.

These results also suggest that faith-affiliated institutions may be becoming increasingly indistinguishable from other providers in the types of patients they pursue and in their overall market behavior. Public agencies in many states may not track the faith affiliated status of providers because this status is basically irrelevant — their dealings with faith-affiliated providers are about the same issues as those with other types of provider. This increasing homogeneity among providers has two causes — one market, the other regulatory. The widespread diffusion of managed care and other cost containment measures among both public and private payers have produced considerable institutional changes in the larger health care system — a variety of consolidations, mergers, or affiliations — and an increased focus among providers on competitive, "commercial" behavior. Faith-affiliated providers have been affected in the same way by these market developments as other providers, with the result that they may be serving, or at least attempting to serve, the same patients as other providers and may be becoming indistinguishable in their patient mix from their non-profit or for-profit competitors.

[40] Gerald Grob, *Mental Institutions in America: Social Policy to 1875* (New York: Simon and Schuster, 1973).

A second set of forces that reduces the distinctions between faith-affiliated providers and others are the payment and service rules adopted by public and private payers. State licensing requirements for professional personnel, both federal and state program rules establishing common standards for services, the qualifications of personnel, and program quality measures, as well as comparable measures required by private payers, all appear to have contributed to an increasing standardization of services across providers. Both faith-affiliated and secular providers are required to meet the same set of rules and standards in order to receive payment from public and private payers. Both market and regulatory forces have provided all types of provider's incentives to behave in roughly similar fashions and reduced the differences between faith-affiliated providers and others.[41]

Finally, our findings indicate that it may be difficult for congregation based organizations to become active in providing Medicaid funded services because of the large up-front costs and high administrative expenses required to function as a Medicaid provider. Functioning as a provider of publicly funded health care, mental health, substance abuse, or long term care services requires some form of state license and requires agencies to hire expensive professional personnel, acquire appropriate facilities that meet program standards, and develop accounting and other systems for sending out and paying bills, monitoring expenditures, keeping track of medical or other treatment records according to specified standards, and a variety of other tasks. Medicaid and Medicare are both programs that pay for services rendered and do not support hiring or other "start-up" costs. Agencies must have all these elements in place before they can be certified as a provider, which can be paid for services rendered.

The on-going administrative costs of running an agency that provides Medicaid funded services are also substantial. Agencies providing human services must be able to generate and pay bills, keep appropriate accounts, maintain service and other standards required to maintain their license and their eligibility as a provider, deal with patient and other complaints, and generate an increasing amount of data on the type and quality of care provided to clients. While precise estimates are difficult to come by, one recent estimate reported that administrative costs account for between 15 and 35 percent of provider revenue, depending on the type of provider.[42]

[41] These standardizing processes, referred to as institutional isomorphism, have received considerable attention from religious sociologists in other settings. See, for example, Paul DiMaggio and Walter Powell "The Iron Cage Revisited: Institutional Isomorphism and Collective Rationality" in *The New Institutionalism in Organizational Analysis* (Eds. P. DiMaggio and W. Powell; University of Chicago Press, 1991). For a similar argument which holds that denominational service agencies may more closely resemble each other than their parent religious organizations do, see Mark Chaves, "Denominations as Dual Structures: An Organizational Analysis" in *Sacred Companies: Organizational Aspects of Religion and Religious Aspects of Organizations (*Eds. N.J. Demerath, P.D. Hall, T. Schmidt and R. H. Williams; Oxford University Press, 1998)

[42] Steffie Woolhandler, Terry Campbell, and David Himmelstein, "Costs of Health Care Administration in the United States and Canada" *New England Journal Of Medicine* 349(August 21,2003):768-775.

Congregation based providers may find these significant start-up and administrative expenses difficult to meet. The denominations whose agencies that have been most active as faith-affiliated providers have developed sizeable specialized bureaucracies to manage facilities and health care programs. Individual congregations, particularly those in denominations with little organizational infrastructure, may find the administrative requirements associated with receiving Medicaid or other public funds daunting. Even in the outreach programs, where these requirements are dramatically lower, most (though not all) faith-based participation was collaborative rather than contractual. Many congregations, particularly the smaller and less prosperous, may lack the administrative infrastructure to manage sizeable public contracts.

These considerations suggest that the most feasible opportunities for expanding participation in Medicaid by faith based organizations may lie in areas where start up costs are low and on-going administrative responsibilities are limited. Expanded participation in outreach activities might be one possibility, although many of these programs have been recently curtailed or eliminated in many states. Other possibilities are suggested by the Faith in Action program, which has been sponsored by the Robert Wood Johnson Foundation for twenty years.[43] Under this program, small grants are made to coalitions of congregations to provide a variety of volunteer, non-medical services such as transportation, grocery shopping, cooking meals, companionship, and respite services. Over 1,000 grants have been made to a wide range of congregations with a wide range of religious affiliations, including Christian and non-Christian denominations. Inter-faith collaboration is encouraged and proselytizing is prohibited.

Medicaid in many states supports activities roughly comparable to those funded under this program. Non-emergency transportation to medical and other treatment appointments is supported by Medicaid in 44 states, and personal care services such as cooking, shopping, and help with activities of daily living for at least some population groups are supported in 28 states and the District of Columbia.[44] While more complex than those required for foundation funded activities, provider certification and management responsibilities appear less onerous than those in many other Medicaid supported activities. The services provided are simpler and less complex to manage, the personnel required do not need the extensive and expensive professional qualifications of health care providers, and the administrative requirements of managing their activities and securing payment are generally simpler than those associated with managing a hospital or negotiating mental health payments with a managed care company. These features might make it feasible for smaller, less prosperous congregations without the capacity to manage large, complex programs participate in Medicaid as providers of these services.

[43] For a detailed description of the program, see http://www.faithinaction.org. Accessed on May 25, 2004.
[44] Data on coverage is as of January 2003. Source is http://207.22.102.105/medicaidbenefits, accessed Jun 15, 2004.

Appendix A
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Wisconsin	Thomas Kaplan, University of Wisconsin

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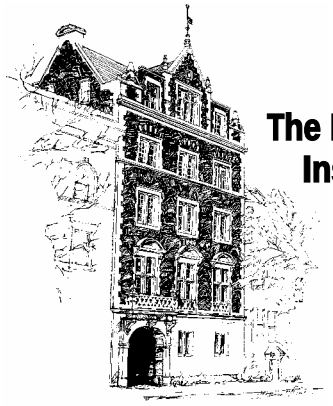

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