

Forum

Neoliberal Long-Term Care: From Community to Corporate Control

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Abstract

Publicly (mainly Medicaid) funded long-term care (LTC) services have evolved from a nursing home dominated system of service to a much more balanced system including home- and community-based services (HCBS) programs over the last 30 years. The HCBS programs have been largely administered by the state and local level nonprofit aging networks (ANs) consisting of Area Agencies on Aging and thousands of service providers. Over the last decade, however, for-profit HMOs administered primarily by large insurance companies have begun to displace AN organizations. State policymakers have embraced for-profit privatizations under the rationale that this approach will generate greater savings, efficiencies, and higher quality outcomes than the traditional public or private nonprofit models of program administration. As we show here, there is very little evidence for this rationale; yet, this lack of evidence has not prevented the continuing growth of for-profit managed LTC programs supported more by an ideology of market fundamentalism than empirical evidence. We also describe six possible consequences of the trend toward corporate control of public LTC services in the years ahead.

Keywords: Long-term care, Home- and community-based care and services, Public policies, Politics, Management

Long-term care (LTC) services supported by public funds have changed dramatically over the last 30 years. Nursing home use has slowly declined, as home- and community-based services (HCBS), like in-home personal care services and assisted living, have gained traction (Kane, 2012; Reinhard et al., 2014). Most of these HCBS programs have been funded by Medicaid dollars, which until the early 2000s were used primarily to fund nursing home care. In 2013, HCBS LTC programs received over \$75 billion through the Medicaid programs, which accounted for a majority (51.3%) of Medicaid LTC expenditures for the first time. From 2011 to 2013, the nation experienced 3 years of consecutive increases in HCBS spending and decreases in institutional spending (Eiken, Sredl, Burwell, & Saucier, 2016). This shift has been enormously beneficial from the perspective of care recipients and their families (Barrett, 2014).

Yet, it is unclear that the shift in administration from community-embedded nonprofit Aging Network (AN) organizations to for-profit managed care organizations (MCOs) over the last decade has also been beneficial. ANs consist of Area Agencies on Aging, which were created over 40 years ago through the Older Americans Act, service providers, and advocacy organizations (Kwak & Polivka, 2014). By 2015, however, managed LTC (MLTC) programs, administered by Health Maintenance Organizations (HMOs), were poised in several states to displace or very much diminish the role of the nonprofit ANs. In 2013 alone, expenditures for MLTC programs grew 44%, from \$10 billion to \$14.4 billion (Dickson, 2016; Eiken, Sredl, Burwell, & Saucier, 2016; Ensslin & Kruse, 2016).

In this article, we first assess the rationales for this shift starting with a review of the research. We then analyze the

larger political, economic, and cultural forces we consider responsible for this movement to what we refer to as “neoliberal LTC.” We argue that this for-profit corporate model will work no better in LTC than it has in the rest of the U.S. health care system and is inconsistent with a commitment to the public interest.

From there, we consider the possible trajectories for LTC policy and for advocacy efforts to strengthen ANs and protect the nonprofit, mission driven, and ethic of care governed model of publicly funded LTC services. We conclude with an analysis of the political and cultural implications of the neoliberalization of LTC.

The Shift From Community to Corporate Control of LTC

As noted above, the AN has developed and administered an extensive infrastructure of HCBS programs since the 1980s. These developments have been especially pronounced since the late 1990s, with 23 states and the District of Columbia now spending more than 50% of their Medicaid LTC funds on HCBS programs and serving more than 60% of their LTC recipients in the community (Eiken, Sredl, Burwell, & Saucier, 2016).

ANs have been able to substantially replace nursing home care with the kinds of community-based services that a vast majority of the elderly and their families prefer (Saucier, Burwell, & Kasten, 2012). A substantial body of research now indicates that these programs are relatively cost-effective (Harrington, Ng, & Kitchener, 2011). According to a recent literature survey:

“The aging network has been effective in most states in developing community-based LTSS systems that have helped reduce dependency on nursing home care and provide the less expensive home and community-based alternatives many frail elderly persons vastly prefer” (Kwak & Polivka, 2014, p.68).

Yet, as of 2015, over 20 states had eliminated or reduced, such programs, or were preparing to do so, in favor of MLTC models. Given the success of HCBS programs, what are the rationales behind the shift away from this long-standing nonprofit model to a proprietary MLTC model administered by MCOs?

The main rationale is that “market” incentives will presumably induce the MCOs to provide LTC services at a lower cost than the nonprofit AN organizations have been able to achieve, and that they will do so without diminishing access and quality of care (Saucier & Fox-Grace, 2005). According to this rationale, proprietary HMOs can reduce the already low costs achieved by the nonprofit ANs while generating efficiencies large enough to permit profit margins satisfactory to shareholders without restricting access or quality (Saucier, Burwell, & Kasten, 2012).

The claim that HMOs are more efficient than the nonprofit AN organizations in administering LTC programs

in the major reason the for-profit HMOs have been able to move into Medicaid LTC even as the role of the for-profit nursing homes in Medicaid plateaued years ago and has actually declined recently. The nursing home industry remains powerful, however, even in states with Medicaid MLTC programs, and may well complicate state policymakers’ plans to achieve cost containment in their LTC programs by using HMO-administered MLTC programs to reduce nursing home costs.

Despite the lack of empirical support for its claims, this rationale for HMO-administered MLTC has been increasingly accepted by state and federal policymakers. In fact, the evidence substantiating the cost effectiveness of the AN-administered LTC programs is far more substantial than that supporting for-profit MLTC programs. Florida, for example, has had a large HMO-administered Medicaid waiver funded for-profit MLTC program since 1999. The Nursing Home Diversion Program was the largest HCBS Medicaid waiver program operated by the state before the Medicaid LTC program was taken over by eight HMOs between August 2013 and April 2014. From 2003 to 2014, the Nursing Home Diversion Program was compared to three other HCBS programs administered through nonprofit AN organizations on four separate occasions, looking at per person costs and a set of outcome measures, including hospital and nursing admissions. The results of all four evaluation studies showed that the AN-administered HCBS waiver programs achieved outcomes, such as reduced nursing home use, comparable to those in the Nursing Home Diversion Program, but at costs 25% to 40% lower than those accrued in the Nursing Home Diversion Program (Mitchell, Salmon, Polivka, & Soberon-Ferrer, 2006; OPPAGA Report, 2010). The Florida legislature nevertheless proceeded with the conversion of the Medicaid LTC program to corporate managed care through legislation passed in 2011. The waiver proposing the conversion was approved by the Center for Medicare and Medicaid Services (CMS) in 2013 even though the results of these studies were clearly communicated to CMS in letters requesting that the agency reject the Florida waiver request (Goodhue, 2011).

A second rationale for the displacement of the nonprofit AN approach to LTC is that HMOs are better prepared to integrate Medicare and Medicaid funds and services than are the ANs. This argument hinges on the claim that the dually eligible population is a uniquely high-cost group of beneficiaries and that the lack of integration of the two programs is key to the group’s high cost. According to this rationale, while the AN may be able to provide an effective administrative framework for the financing and delivery of community-based and nursing home care, as they have done in some states (Oregon, Washington, and Wisconsin) for many years, the Medicare program is beyond their capacity to administer. This kind of integration has already occurred in a few states and is now underway in the Dual Eligible Demonstration projects in several more states (The Henry J. Kaiser Family Foundation, 2016).

Though it is true that the dual eligible population is a relatively high-cost group, only a small percentage (4–5%) are simultaneously high-cost beneficiaries in both programs (Coughlin, Waidmann, & Phadera, 2012). For the vast majority, the high costs occur in one or the other program, with little evidence to support the claim that an integrated design would significantly reduce combined costs (Coughlin, Waidmann, & Phadera, 2012). The limited research available on this issue finds little evidence that the currently existing integrated programs operate at lower cost (Coughlin, Waidmann, & Phadera, 2012). The research also has failed to find significant improvement in the quality of care in integrated programs. Moreover, person-centered care management in AN-administered HCBS programs often does the work of ensuring that clients are receiving the acute- and chronic-care services they need on a timely basis (APS Healthcare, Inc., 2005).

AN organizations should do more at the state and local levels to ensure that the persons they serve receive all of the care and support they need including care for acute and chronic medical needs through more extensive collaborations with medical care organizations. These collaborations, however, do not require corporate HMOs to better serve dually eligible beneficiaries. They can also be created by AN organizations that administer care management programs designed to identify and respond to all of AN individual's needs, social and medical, as in the Wisconsin Family Care program. Furthermore, the empirical basis for the argument that integrated managed care systems for the dually eligible are necessary for greater quality and efficiency of medical and LTC services is, thin at best (Jung, Trivedi, Grabowski, & Mor, 2015; Kane, Homyak, Bershadsky, Lum & Siadat, 2003; Kane et al., 2005;). This may change as the evaluations of the dual eligible demonstration projects are completed, but for now a bit of skepticism would seem to be advisable.

Given the impressive outcomes generated by AN-administered LTC programs, why would policymakers in states across the country decide to abandon a well-established and increasingly stable nonprofit Medicaid LTC system in favor of unproven corporate-administered MLTC systems (Polivka & Zayac, 2008)?

The Neoliberal Economy and Health Care

The most plausible explanation is the emergence of neoliberal ideology in the political economy and in the moral culture since the late 1970s and the growing power of corporate health care over the same period (Kelly, 2016). These two factors are tightly related, in that corporate health interests have greatly benefitted from the ascendancy of an ideology (neoliberalism) based on the principle that proprietary firms competing in unregulated markets will invariably produce superior, more efficient outcomes than nonprofit public programs operating without the disciplining effects of the profit-maximizing incentives of

competitive free markets. According to the neoliberal ideology, this market principle potentially applies to virtually all publicly funded programs now administered by mission-driven, nonprofit organizations (Harvey, 2007).

The United States has evolved in the direction of a neoliberal political economy over the last four decades, as have most western countries and much of the global economy as a whole. The main properties of neoliberalism include reduced taxes on high incomes and wealth, reduced regulations (especially of the financial sector and the labor market), slowed or stagnant funding for social programs (and media attacks on their legitimacy), and increased privatization of these and other public programs (Polivka, 2011). These trends have been supported by an ideological rationale that draws on neoclassical economics by prioritizing the free market as the fundamental source of freedom and efficiency, attacking the public sector for its inefficiency and its threat to the freedom created through largely unregulated competition in markets, and elevating economics over politics as the central organizing principle for societies. From the neoliberal perspective, democracy is dependent on and is largely a function of capitalist economies (Brown, 2015).

This ideology and associated policy agenda have thrived since the Reagan Administration, as health, education, military, corrections, intelligence, and many other services have been increasingly contracted out to private for-profit firms on the ideological assumption that these are less expensive and more efficient than the government-run versions. As this ideology became ascendant and legitimized, the growth and exercise of corporate power in politics, public policy has become steadily more neoliberal across all policy domains (Hacker & Pierson, 2011; Hacker & Pierson, 2017; Polivka, 2012;). The empirical evidence for advantages resulting from neoliberal privatization is very thin at best, but the absence of evidence has done little so far to slow the privatization avalanche at every level of government (In the Public Interest, 2013).

Health care has become a far more corporate enterprise since the 1970s, as predicted by Paul Starr in his influential 1982 book, *The Social Transformation of American Medicine* (Starr, 1982). Corporate control has gradually spread to every area of health care and is now extended to publicly supported LTC through the contracting out of Medicaid LTC programs in several states. This accelerating shift from a primarily nonprofit, managed fee-for-service model of publicly funded LTC to a corporate model of MLTC is unsurprising when considered in the context of the neoliberalization of the larger U.S. political economy, including the widespread privatization of public programs.

A recent analysis of these trends (Larsen & Stone, 2015) argues that neoliberal health care is a two-way street, with both health care corporations and governments gaining something of potential value (either profits or lower costs), depending on the design of the privatized program. Larsen and Stone theorize that neoliberal health care has two faces, one of which is the privatization of public care

services for the purpose of providing corporate health care with expanded markets in which to pursue profits. The second face of neoliberalism, however, is the potential for corporate health firms to help federal and state governments achieve their goals, which include cost containment, greater operational efficiency and better quality outcomes.

In our judgment, while these two faces of neoliberalism in health care may be theoretically feasible, and while the empirical evidence in support of the first face is substantial, empirical support for the second face is much weaker. For example, Medicare Advantage (MA), the privatized portion of the Medicare program, now serves almost one-third of Medicare beneficiaries and costs 4 to 5% more than the regular Medicare program, despite specific provisions in the ACA to at least equalize its costs with the regular program (Kelly, 2016). Moreover, no consistent evidence shows that these greater costs result in higher quality care in the MA program. The same cost trends have shown up in the Medicare hospice program over the past several years. The traditional nonprofit hospice program costs Medicare about 25–30% less for the same kind of patients than the for-profit hospice providers, with no evidence of improved quality of care (Whoriskey & Keating, 2014).

The second face of neoliberalism in health care may exist in other, more publicly managed health care systems, but the chances that it might emerge in the corporate-dominated U.S. health care system, including LTC, seem slight at best. In fact, the concept of neoliberalism's second face is very similar to the argument made by supporters of privatization: that proprietary management of public programs will save taxpayer dollars and improve program outcomes. As we have indicated, this argument has very little support in the research literature, not only for health care and LTC, but also for other policy domains (In the Public Interest, 2014).

The second face of neoliberalism concept that governments can use the corporate sector to achieve public purposes, functions primarily as ideological justification for the increasing penetration of corporate interests into the public sector policy making process and the redirection of public revenues to the private sector (Gilens & Page, 2014). This blurring of public and private sector boundaries has been underway for more than 30 years and accelerated considerably in the health care sector with the passage of MA in 2003 and the Affordable Care Act in 2010. This blurring of boundaries has worked to the advantage of corporate health interests by giving them increasing leverage over health care policy, regulation, and funding.

According to Wolfgang Streeck (2014), almost 40 years of neoliberalism has increased corporate control over the public sector to such an extent that the variously social Democratic states that emerged after WWII, would now be more accurately described as neoliberal corporate states. These states, led by the United States, are increasingly influenced by corporate interests, especially the financial sector, whose major policy priorities include maximum

privatization of public assets and services, low taxes on wealth, disempowerment of labor unions, deregulation of critical economic sectors, especially finance, energy and health care, and deep cuts in public programs not amenable to privatization. The institutionalism of the neoliberal corporate state would seem to leave increasingly less room for the second face role of neoliberalism in health care or any other policy domain.

Neoliberal Tendencies in LTC Policy and Practice

Now that proprietary firms (HMOs) have established a foothold in the public LTC systems of several states and the number of Medicaid beneficiaries is rapidly growing, where are current trajectories likely to take LTC policy and practice over the next several years? We can only speculate, of course, but from our perspective, the following six tendencies are likely to gain traction and become dominant.

- *Tendency #1: Growing Bi-Partisan Support for HMO Takeover of Public MLTC.* The apparently bi-partisan support for publicly funded HMO-administered LTC makes the continuing expansion of this model highly likely as long as policy parameters, monitoring regimes, and Medicaid funding levels are sufficient to maintain acceptable profit levels for the HMOs. These are significant contingencies, but there are few signs at this point that they will jeopardize these programs anytime soon. A major fiscal crisis, however, could suddenly change policy parameters and funding levels and make Medicaid services, including LTC, significantly less attractive financially to for-profit HMOs and to policymakers.
- *Tendency #2: Expansion of HMO LTC through Medicare-Medicaid Demonstration Projects.* Momentum in support of corporate-administered programs to integrate Medicaid and Medicare within a managed care framework will grow as the current Medicare-Medicaid demonstration projects are implemented. The long-standing Programs for All Inclusive Care for the Elderly (PACE)—made up of 120 such programs across the states—provide a framework for integrated-care. For 25 years, PACE has been a highly regarded community-embedded nonprofit program. Following Federal Legislation passed in 2015, however, the PACE program is now permitted to operate as a proprietary model, which is likely to accelerate its expansion and absorption by larger corporate organizations or investment firms, especially in the private equity sector (CMS, 2015; Gonzalez, Forthcoming).
- *Tendency #3: Declining Role of the AN in MLTC.* AN organizations' role in Medicaid-funded LTC services is likely to decline as the corporate health role expands, although this trend is unlikely to unfold uniformly across the country in either timing or extent. If this trend becomes as dominant as it now appears, with

the exception of states such as Wisconsin, Washington, and Oregon (Stein & Boulton, 2016), AN organizations will increasingly be reduced to administering the Federal Older American Act (OAA) programs, whatever Medicaid-funded services HMOs may be willing to contract with them for, and the generally small general revenue (GR) funded aging programs provided by some states. Total funding for the OAA and state GR programs comes to about \$3 billion, already far less than the Medicaid LTC budget, for the HCBS programs only (Eiken, Sredl, Burwell, & Saucier, 2016). As its role in Medicaid-funded LTC services diminishes, the AN's programmatic reach will likely return to the limited scope it operated within 25 years ago, with the result that one of the last enclaves of nonprofit health services would be greatly reduced or eliminated.

- *Tendency #4: Erosion of Public Control of LTC Services.* The cumulative effects of the above tendencies (corporate expansion and AN decline in Medicaid LTC) are likely to include the steady erosion of public control of LTC services. This will happen through the public policy process and structures of accountability, as HMOs organize their programs to maximize profits and increase shareholder value. Some of these profits can be used to increase corporate leverage over the policy process (lobbying and campaign contributions) and public opinion through marketing and other activities (Hacker & Pierson, 2010). Profit-maximization strategies and the administrative activities designed to achieve them are likely to exert downward pressure on the use of public funds for services and to force policymakers to steadily increase funding above the projected levels agreed to by the corporate-health firms when the MLTC programs were initiated with the expectation that they would reduce projected Medicaid costs without affecting the quality of services. Alternatively, policymakers could decide to give the HMOs increased authority to contain costs while protecting their profit targets by allowing them to reduce services for Medicaid beneficiaries and remove any remaining priority on service quality. Essentially, we may enter a "policy and political environment that...we may have difficulty leaving" (Kelly 2016).
- *Tendency #5: Increasing reliance on the informal care system.* This issue is to some extent inherent in the shift from nursing home to HCBS programs over the last 30 years as more LTC recipients live in the community and are more available for family assistance with their needs (Greenfield, 2014; Hong & Casado, 2015; Simon & Hodges, 2011). This greater availability may be an incentive for policymakers to limit Medicaid LTC funding and to, at least indirectly, push more of the caregiving on to family members and away from paid caregivers. This familiarization of caregiving is likely to increase in MLTC HMOs, which must respond to both insufficient

public funding to meet caregiving needs and shareholder demand for adequate profit margins. Familiarization of care however is increasingly limited by the declined availability of family caregivers, which could certainly cause increases in the level of unmet need in the community as both formal (paid either privately or through public Medicaid sources) and informal services decline and the number of persons needing LTC services grows dramatically over the next decades with the aging of the population. If the Trump Administration and congressional Republican proposals for reducing Medicaid funding and block granting the program to the States become law, this kind of maneuver by the states (greater familiarization of care is more likely to occur in many of them making the current gap between the need for care and the resources to provide them substantially worse in the years ahead). Increasing the gap between need for care and availability of publicly supported services will in all likelihood increase the burden on family and other informal caregivers.

- *Tendency #6: Greater activism on LTC by the Aging Advocacy Community.* If the above tendencies develop as we are suggesting, pressure on policymakers is likely to grow, as the number of older and impaired persons increases rapidly and the neoliberal policy agenda (low taxes, privatization, deregulation, etc.) remains dominant. This outcome is, of course, a recipe for growing levels of unmet need and public frustration without a clear map for reaching a resolution in an environment of declining public leverage over corporate interests.

Champions of AN LTC need to step forward and begin to use available assets to make the fiscal and moral arguments for the value of nonprofit community-embedded LTSS systems like those built and administered by the AN for more than 25 years in most states (Estes, 2014). AN organizations and advocacy groups can argue with confidence that the history of state local networks demonstrates their capacity to create and administer HCBS. The two AARP LTC snapshot reports published over the last 6 years provide detailed documentation of the AN's extensive community LTC programs in most states (Reinhard et al., 2014).

In addition, research indicates that AN-managed LTSS programs are efficient and cost-effective. The corporate model requires a substantial profit margin to remain viable along with considerable administrative resources used to generate these margins. These are costs the AN programs do not have to bear, which puts them at a distinct cost advantage in comparison to the corporate managed care programs. Advocates should work to elevate this issue and keep it from being buried under an avalanche of corporate marketing information and ignored by the media and policymakers.

AN supporters should also insist that service programs provided by both AN organizations and MLTC HMOs be evaluated annually on the basis of quantitative outcome

(nursing home and hospital admissions, functioning levels) and cost (per person expenditures) measures. The evidence from Florida indicates that AN programs perform well in terms of these cost effectiveness measures and are likely to benefit from the routine collection and analysis of this performance information.

Conclusion

The LTC system has long had a very large public nonprofit sector, mainly in the community, and an even larger for-profit sector in terms of total funding, mainly nursing home services. The former has been administered by the AN with primarily Medicaid funds since the 1980s and has grown faster than the for-profit nursing home sector since the early 2000s. AN-administered LTC programs have proven to be cost-effective and popular alternatives to nursing homes, which accounts for their rapid expansion in most states since 2000. This success, however, has not been sufficient to prevent the rapid expansion of corporate LTC.

Policymakers' justification for this expansion is that the market-based approaches will increase service-delivery efficiencies and contain costs to a greater extent than will smaller nonprofit agencies. This position, however, is driven more by ideological convictions and corporate lobbying than empirical evidence, which is also true in other policy domains where privatization has resulted in extensive corporate penetration and increasing control of public resources. This trend has been driven by the emergence of the neoliberal public policy priorities of privatization and deregulation. In several states, the public LTC system may now be more accurately described as "neoliberal LTC," reflecting the shift from community to corporate control. This shift is occurring even in the face of clear evidence that nonprofit community-based organizations can provide home- and community-based LTSS more cost-effectively than for-profit firms. These facts indicate that objective research findings are less dispositive than ideology and corporate interests in a neoliberal political environment.

The growing displacement of nonprofit AN by corporate-health firms has, in our judgment, serious negative implications for the future LTSS for older impaired persons. The loss of community-based LTC services to outside corporate interests reduces communities' investment in the lives of their older residents and their families, and it weakens communities. The erosion of a community's sense of moral responsibility for its members, especially vulnerable members like the frail elderly, undermines any sense of collective efficacy or the sense that the community has a critical role to play in addressing policy challenges like LTC. This loss of a collective sense of efficacy and the social capital it helps create weakens communities at a time when we need them to become stronger and to give their members a greater sense of their capacity to shape their own fate and not feel powerless in the face of such challenges as the population aging, climate change, and economic inequality.

This sense of a collective fate and capacity to shape it is fundamentally at odds with the neoliberal moral culture that has arisen in America since the 1970s, as a kind of justifying ideological framework for the neoliberal political economy and public policy agenda of privatization and cuts in public programs. The neoliberal moral culture claims superior moral authority for the unregulated operations of the private market and the pursuit of profit through the market by corporations and individuals. The market is seen as the true arbiter of value, and any intervention by governments to achieve a public benefit or fix a market failure is considered a moral violation. The neoliberal moral culture valorizes the individual and essentially dismisses the concept of the public, which undermines the moral significance of collective initiatives like nonprofit LTC. Yet, efforts to strengthen the role of communities in meeting the LTC needs of their residents through the AN can enhance the moral and political stature of other collective initiatives seeking to address a wide range of policy concerns and help build the strong communities our future depends on (McKibben, 2008).

Conflict of Interest

None reported.

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