The Changing Role of Non-Profit Organizations in the U.S. Long Term Care System

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ABSTRACT
The American long-term care system has changed dramatically over the last several years as the need for care has increased steadily with the aging of the boomer generation. Arguably, the most important change has occurred in the Medicaid-funded part of the system as several states, with strong federal support, have moved toward contracting with large for-profit insurance companies to provide overall administration of Medicaid long-term care services, largely displacing the non-profit organizations that constitute the nation’s Aging Network. We are concerned that the displacement of the mission-oriented model of long-term care that is administered by the Aging Network will negatively affect access, quality, and cost in state Medicaid long-term care programs.

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Long-term care (LTC) for impaired younger and older adults has been a major part of the nation’s health care system for several decades, but until now it has not received much attention from the media or policymakers. With the projected doubling of the population aged 70 years and older over the next thirty years, however, LTC may finally be ready to receive the attention it should (U.S. Department of Commerce, Economics and Statistics Administration, 2010).

The current publicly supported LTC system is a mix of nursing home, assisted living and in-home supportive services. This mix has slowly but steadily been shifting in the direction of home and community-based services (HCBS) over the last 20 years (Ensslin & Kruse, 2016; Kane, 2012). This shift is largely in response to the at least partially proven cost effectiveness of community-based alternatives to nursing home care and the overwhelming preference for them by both older and younger impaired persons rather than living in a nursing home (Barrett, 2014).

Most paid LTC services are funded by the Medicaid program and, to a much lesser extent, the federal Older Americans Act (OAA) funds. In many states, these federal funds are administered through the non-profit Aging Network, which consists of over 600 Area Agencies on Aging (AAAs)
and several thousand mostly non-profit service providers. As documented by AARP in recent reports, state and local Aging Networks have built an extensive infrastructure of HCBS over the last 30 years and administered them in a largely efficient, low-cost manner (Reinhard et al., 2017, 2014).

Arguably, the most important change to America’s LTC system over the last several years has been movement in several states, with strong federal support, toward contracting with large for-profit insurance companies to provide overall administration of Medicaid LTC services through health maintenance organizations (HMOs) and other managed care plans. This shift has largely supplanted the non-profit organizations in these states’ Aging Networks. We are concerned that the displacement of the mission-oriented model of LTC that is administered by the Aging Network will negatively affect access, quality, and cost in these state Medicaid LTC programs.

**Preserving the aging network role in long term care**

For several reasons, we think it is important that the role of the Aging Network in LTC be preserved and even strengthened in the future. First, the older population is growing rapidly and the need for LTC services is projected to double over the next 20 to 30 years, heightening the need for efficient and low-cost administration of services. The Aging Network has a 30-year history of managing LTC services in the community with low administrative overhead costs and minimal increases in reimbursement rates. We are doubtful that for-profit HMOs and other managed care plans can match this record while meeting shareholder profit expectations on a sustainable basis (Leys, 2019a, 2019b).

Due to higher administrative costs and the need to generate shareholder dividends, HMO-administered LTC services could well end up costing state governments substantially more than Aging Network-run services, creating fiscal pressures that lead to rising unmet needs and declining quality of services due to program retrenchment (McSwane & Chavez, 2018). Policymakers and the elderly could, in short, be caught between the escalating need for services and cost increases that could seriously jeopardize the states’ capacity to meet minimally acceptable levels of care. Florida provides an example of how these concerns could emerge. The wait list for LTC services has increased by 20,000 since HMOs began administering the Medicaid LTC program in 2013 (Polivka-West, 2017).

A second reason for maintaining the role of the Aging Network in LTC is the Network’s demonstrated ability to strengthen and maintain informal caregiving. Long-term care is labor intensive and, at its best, depends on close interaction between formal (paid) and informal (unpaid) care from family, friends, neighbors, and volunteers. The social capital (community trust and support) of non-profit organizations in the Aging Network is
essential for building and maintaining the formal-informal caregiving nexus. It is especially important for avoiding the potential crisis described by The President’s Council on Bioethics (2005) where larger proportions of older adults lack family resources: “The danger is that some old people will be abandoned or impoverished, with no one to care for them, no advocate to stand with them, and inadequate resources to provide for themselves.”

We think precisely this scenario is playing out in Florida and other states as the number of persons with unmet LTC needs rises inexorably but in an increasingly for-profit HMO environment. A growing number of baby boomers lack children or spouses to help provide care, which means that we as a nation are facing a major caregiver challenge (Feinberg & Levine, 2015). An Aging Network-based Medicaid-funded LTC system that is deeply embedded in the community has historically played a major role in meeting the needs of those with minimal to no informal caregiving available. The Network should be strengthened to continue and even expand this role in the future (Kwak & Polivka, 2014), not replaced by entities without a track record in this area.

Thinking more broadly, the Aging Network could become an essential part of a more comprehensive, community-based model guided by an “ethic of care” rather than the maximization of profits and shareholder value. This kind of community-embedded and oriented system of care could provide a framework for integrating all domains of care from preventative and acute care services to LTC for the huge number of elderly who will need help over the next several decades (Kwak & Polivka, 2014).

The Aging Network has already demonstrated how this capacity can be developed and function within local and regional communities by providing less intensive supports and services to older persons who need help but are not yet eligible for the Medicaid program. This means that Aging Network organizations across the country are now improving the lives of many persons without Medicaid coverage and helping them delay the onset of more debilitating conditions that often lead to becoming Medicaid eligible. This Aging Network capacity improves lives, saves money in the Medicaid program, and could serve as an integral part of a larger and more comprehensive community health care system (Montgomery & Blair, 2016).

**The move to managed long term care**

The relative effectiveness of community-based care administered by the Aging Network has not kept states such as Florida from seeking to convert Medicaid-supported LTC from non-profit Aging Network administered HCBS systems to managed long-term care (MLTC) systems that are largely controlled by for-profit HMOs (Lewis, Eiken, Amos, & Saucier, 2018). This transition to HMO-run managed LTC systems is occurring in the absence of
evidence that these services can be provided as cost effectively by HMOs, as they have been for decades through the Aging Network. In fact, four studies conducted in Florida between 2003 and 2010 found that the state’s HMO-administered Medicaid HCBS program was consistently less cost effective than the Aging Network-run Medicaid waiver-funded HCBS programs (Polivka & Luo, 2017).

The move toward HMO-administered MLTC programs received a major boost from the federal government through the Dual Eligible Demonstration Project that was part of the Patient Protection and Affordable Care Act (ACA) legislation, implemented in over 15 states over the past five years. Most of these projects are administered by for-profit HMOs under a merged Medicare/Medicaid capitation rate for populations eligible for both the Medicare and Medicaid programs (Burke & Christ, 2017).

Does the future belong to HMO-administered MLTC? Is the Aging Network becoming a LTC side show? In short, has the MLTC train left the station? In some states, the answer would appear to be yes (e.g., Florida, Iowa, Kansas, Texas). In these states the HMO infrastructure for MLTC is established and the Aging Network has either become a limited player in community-based LTC or it was never a major LTC player to begin with. In other states where the Aging Network is established, well-organized, and relatively sophisticated, the train is unlikely to arrive, or, if it does, it would not mean HMOs would displace and marginalize Aging Network organizations (e.g., Colorado, Oregon, Washington, Wisconsin). In the remaining states, mixed models of LTC involving the Aging Network and HMOs are likely to emerge over the next decade (e.g., California, Massachusetts, Minnesota, Ohio). These hybrid models could provide opportunities for extensive partnerships between HMOs and Aging Network organizations, but only if the latter continue to receive sufficient support from the public and policymakers (Montgomery & Blair, 2016).

Why managed long-term care now?

Since the available evidence indicates that the non-profit Aging Network organizations have long been a cost-effective provider of community-based care with the demonstrated capacity to administer an integrated LTC system, why have for-profit HMOs been enlisted to replace them in several states with the support of the federal Center for Medicare and Medicaid Services (CMS)? In our view, this innovation is substantially a product of the public policy agenda that has emerged along with the neoliberal political economy over the last four decades (Estes, 2014).

The neoliberal political economy and policy agenda are based on several ideological assumptions about how the economy and government should work, individuals live, and communities function. Neoliberalism assumes the
supremacy of the free market in determining the value of goods and services and the superiority of market incentives to maximize profits over collective efforts to achieve the common good (Harvey, 2007).

The neoliberal policy agenda prioritizes cutting spending on public programs and privatizing what remains, cutting and virtually never raising taxes, removing as much public regulation as possible from the economy and public sector programs, and maximizing the scope of individual responsibility for every aspect of life from daycare and education to retirement security (Polivka, 2012). The neoliberal agenda also includes a major focus on the privatization of publicly-funded health care programs 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 (Polivka & Luo, 2017)

What’s at stake?

Long-term care is one of the last remaining domains of the U.S. health care system not fully dominated by corporate health organizations. This situation, however, is rapidly changing, as large insurance companies become convinced that they can profitably administer LTC programs created by the nonprofit Aging Network, and as the neoliberal policy agenda has gained traction at the federal and state levels. If the role of the Aging Network is allowed to wither away and the corporate model fails to contain costs or meet quality standards on a sustained basis, the critical LTC challenge facing the U.S. will grow steadily more urgent, confronting lawmakers with little choice but to either give the corporate HMOs what they demand or allow the growing need for LTC services to go increasingly unmet.

In most states the Aging Network organizations are still essential and widely supported elements of their local communities. The displacement of these Aging Network organizations by HMOs would represent a lost opportunity for further development of such systems of community-based and person-centered systems of care. The Aging Network is a civic asset whose benefits radiate throughout their local communities and contribute to the creation of strong communities with a sense of control over their own fate (Polivka & Zayac, 2008).

We think it is important to recognize that of the top 10 states identified by AARP in three comparative assessments of state LTC systems since 2011, most are administered, on the Medicaid side, through non-profit Aging Network organizations. In fact, two states that were in the top 10 in the first assessment in 2011, Iowa and Kansas, fell to 19th and 30th in 2017 after implementing full scale for-profit HMO-administered MLTC programs (Reinhard et al., 2017).
Most of the states that remained in the top 10 performing states in each of the three assessments are all administered by non-profit Aging Network organizations that have created efficient HCBS-oriented LTC systems. In our judgement, these states are models for how other states can most cost effectively prepare to meet the LTC needs of a rapidly growing population of older persons over the next three decades.

Even in those states that move toward comprehensive HMO-administered MLTC systems, Aging Network organizations, including service providers, should be given the chance to evolve in a manner conducive to their survival and capacity to thrive. States with MLTC programs administered by corporate HMOs and that fail to keep their Aging Networks strong could come to regret it if HMOs decide to leave the program, as United Health Care has decided to do in Iowa, unless the HMOs receive contracts states may decide they cannot afford. In the absence of a serious discussion and debate about LTC policy at the federal and state levels and a renewal of aging advocacy activity (Polivka, 2015), Aging Networks in many states with MLTC programs will be at serious risk of losing the service capacities they have built up over a 40 year period.

**Key points**

- Medicaid-funded home and community-based services (HCBS) long-term care programs were largely built by the non-profit Aging Network
- In recent years Aging-Network based HCBS programs in several states have been taken over by largely for-profit corporate managed care organizations
- The shift from the Aging Network-based to a corporate-based model of managed long-term care does not have a compelling research-based rationale
- Among the states regarded as having the best long-term care systems, most are still administered as non-profit, Aging Network programs

**Disclosure statement**

No potential conflict of interest was reported by the authors.

**References**


