
Disparity in Assisted Living: An Honest Self-Assessment

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Much attention has focused recently on health care disparities and the varying care documented between different racial, gender, age, and ethnic groups. One recent landmark study demonstrated that blacks were less likely to undergo potentially life-saving cardiac procedures than their white counterparts purely on the basis of race.¹ These findings are consistent with other studies that clearly demonstrated similar disparities in health care.^{2,3,4}

These reports have resulted in much talk, head shaking, and eyebrow raising. Yet, there has been little in-depth talk about how to address disparity and less discussion about whether or not—and to what degree—disparity exists in long term care settings such as assisted living.

In fact, like it or not, disparity does exist in long term care—including assisted living; and the problems revolve around two core realities. One is funding and benefit design, which is based on the site of care. The other is the income standard for benefits, which is basically an “all or nothing” proposition.

Understanding how disparity works in assisted living won't result in any immediate changes for the better, but it will take the industry a step closer to addressing possible solutions and putting steps in place to make these happen over time.



Payment Following Patients

One of the most significant disparities involving ALF residents is the one that exists just on the basis of care site. Nursing facility residents receive four major benefits under the Medicare Modernization Act (MMA) simply as a result of their place of care. These benefits include access to a special enrollment period that permits residents to switch prescription drug plans on an ongoing basis, elimination of cost-sharing for the dually eligible (those with

Medicare and Medicaid), access to special packaging, and enhanced access to non-formulary medications. These benefits are not available to an identical beneficiary living outside of a nursing facility, as they are tied directly to the site of care and residency.

Centers for Medicare and Medicaid Services (CMS) Administrator Mark McClellan, MD, has mentioned the need for Medicare to move to a system in which payment follows the beneficiary

AHRQ Says Disparities Are Narrowing Overall, But Gap Widens for Some

Quality of health care for Americans has continued to improve at a modest pace, and health care disparities are narrowing overall for many minority Americans. But for Hispanics, disparities have widened in both quality of care and access to care, according to reports by the federal Agency for Healthcare Research and Quality (AHRQ).

The findings are contained in the *2005 National Healthcare Quality Report* and its companion document, the *2005 National Healthcare Disparities Report*. These reports, issued annually, measure quality and disparities in four key areas of health care: effectiveness, patient safety, timeliness, and patient centeredness.

Examples of findings in the AHRQ disparities report include:

- Rates of late-stage breast cancer decreased more rapidly from 1992 to 2002 among black women (169 to 161 per 100,000 women) than among white women (152 to 151 per 100,000), resulting in a narrowing disparity.
- Treatment of heart failure improved more rapidly from 2002 to 2003 among American Indian Medicare beneficiaries (69% to 74 percent) than among white Medicare beneficiaries (73% to 74%, resulting in an elimination of this disparity).
- The quality of diabetes care declined from 2000 to 2002 among Hispanic adults (44% to 38%) as it improved among white adults (50% to 55%).
- The quality of patient-provider communication (as reported by patients themselves) declined from 2000 to 2002 among Hispanic adults (87% to 84%) as it improved among white adults (93% to 94%).
- Access to a usual source of care increased slightly from 1999 to 2003 for Hispanics (77% to 78%) and whites (88% to 90%), with Hispanics less likely to have access to a usual source of care.

The report finds a 10.2% annual improvement in the five core measures of patient safety. These are areas where coordinated national efforts are underway to improve the delivery of specific “best practice”

treatments to improve patient safety and reduce medical errors.

“In many areas, we know the specific treatment steps and procedures that are needed to improve quality. These reports indicate that when we focus on those best practices, we can make rapid improvement, especially when results are publicly reported,” Carolyn Clancy, MD, AHRQ Director, said.

Improvements were greatest in quality measures for diabetes, heart disease, respiratory conditions, nursing home care, and maternal and child health care. The overall rate of change for these measures was 5.4 %.

Dr. Clancy said the findings in the report can help target efforts more effectively to improve quality and

reduce disparities. “These reports are a complex picture of our progress so far. They can help target where improvement is most needed and help show us how to bring those improvements about,” she said.

The quality report employs a wide range of measures, including health care outcomes such as hospital-acquired infections and reductions in deaths from certain diseases. It also measures how well the health care system is using specific treatments that are known to work most effectively. The disparities report compares these

measures by race and ethnicity and by income. It also measures access to care, using indicators such as health insurance status and frequency of visits to a physician. This year, for the first time, the report also shows trends in health care disparities from year to year.

The reports were issued in January at the National Leadership Summit on Eliminating Racial and Ethnic Disparities in Health, sponsored by the HHS Office of Minority Health. The summit marks the 20th anniversary of the issuance of the report of the Secretary’s Task Force on Black and Minority Health, which led to new efforts to improve the health and health care of minority Americans.

The AHRQ reports are available online at www.qualitytools.ahrq.gov, by calling 1-800-358-9295 or by sending an E-mail to ahrqpubs@ahrq.gov.

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from setting to setting. Under such a system, payment or any benefit would be assigned based on individual needs rather than place of care; and any frail senior living in an ALF or any setting would have access to the same level of care as their nursing facility counterparts. This is important, particularly since—increasingly—ALF residents have much the same health profile as their counterparts in nursing homes.

CMS recently announced a test of such a program using adult day services in the place of home care for Medicare beneficiaries in some situations. This program is scheduled to begin early next year and is part of a three-year test program. In this pilot program, 15,000 elders recovering from a condition that normally would require a home visit instead could receive the same services through adult day care. The services provided would be assigned to the beneficiary rather than just being available at home through a home agency. If this pilot works, it could have significant impact for seniors who are unable to receive various covered services simply because of their place of residence.

Even more specific to ALFs, some states have moved to programs that provide room and board funding for nursing home eligible seniors to live in settings outside of nursing homes. One such program is the Program for All-inclusive Care for the Elderly (PACE). PACE receives funding that would have gone to pay for nursing home care but instead can be used to maintain the frail senior in the community.

Other states actually pay for ALFs to care for nursing home eligible residents at a lower cost and with increased freedom than what would occur in a nursing facility. Not only do such programs eliminate—or at least minimize—disparities, but they also help seniors stay in setting where they have the greatest independence and free-

dom while they receive the care and services they need.

All or Nothing Benefit Design

The greatest benefit for LTC currently is only within reach of those seniors with assets and resources at a certain level. For seniors that miss this arbitrary line by even one dollar, there are no benefits. This has resulted in a system in which the very rich and the very poor have the greatest access to care and services, while individuals in the middle—the largest group of seniors—often get little or nothing and have to make choices and sacrifices.

Unfortunately, no programs have been developed to date that address this disparity to any degree. While the Medicare prescription drug bene-



ALFs can work to improve access and quality of care by helping to move the system toward payment that follows seniors and addresses their needs.

fit will help cut prescription drug costs for some of these seniors in the middle, these beneficiaries also will have to face a “donut hole” in which they will be responsible for 100% of prescription drug costs. While this amounts to just a few thousand dollars, this can mean the difference between medication and food or rent for people who are middle class but living on a fixed income.

One option that could help address the all or nothing benefit design is a system based on providing benefits based on real needs. Such a system could provide graduated benefits based on individuals’ income

and resources along the entire continuum, rather than forcing them to hit a certain point before they begin receiving any benefits. These benefits would be based both on financial and health care status and needs. Using graduated benefits, such a system might include a health benefit tax for the very wealthy and/or complete coverage for the very poor.

This type of system is not new. It was proposed as a tax system by Milton Freidman, a Nobel Prize-winning economist who suggested that a more equitable tax/welfare system would be one that provides a negative income tax on a graduated basis to low income Americans.

As the baby boomers move into Medicare and expenditures continue to rise as a result of emerging technological innovations and increased utilization, it is likely that policymakers, legislators, consumer groups, and others will begin looking more aggressively at ways to provide greater financial benefits to middle class seniors. In the meantime, the “donut hole” looms large for these individuals—and the disparity continues.

Pay for Performance

Another disparity worth mentioning is the health care provider payment system. In the current system, physicians are paid the same amount by Medicare regardless of the quality of care that they render. In fact, several studies have demonstrated that there is no relationship between cost and quality.⁵⁶ A system designed to promote improved outcomes would provide incentives in the form of higher reimbursement for those providers that deliver superior results. However, CMS has not provided any payment differential to date.

Nonetheless, managed care plans and other payors have begun looking seriously at the concept of “pay for performance,” and many health care industry observers suggest that this concept is the way of the future for physician and other

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