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From the Editor

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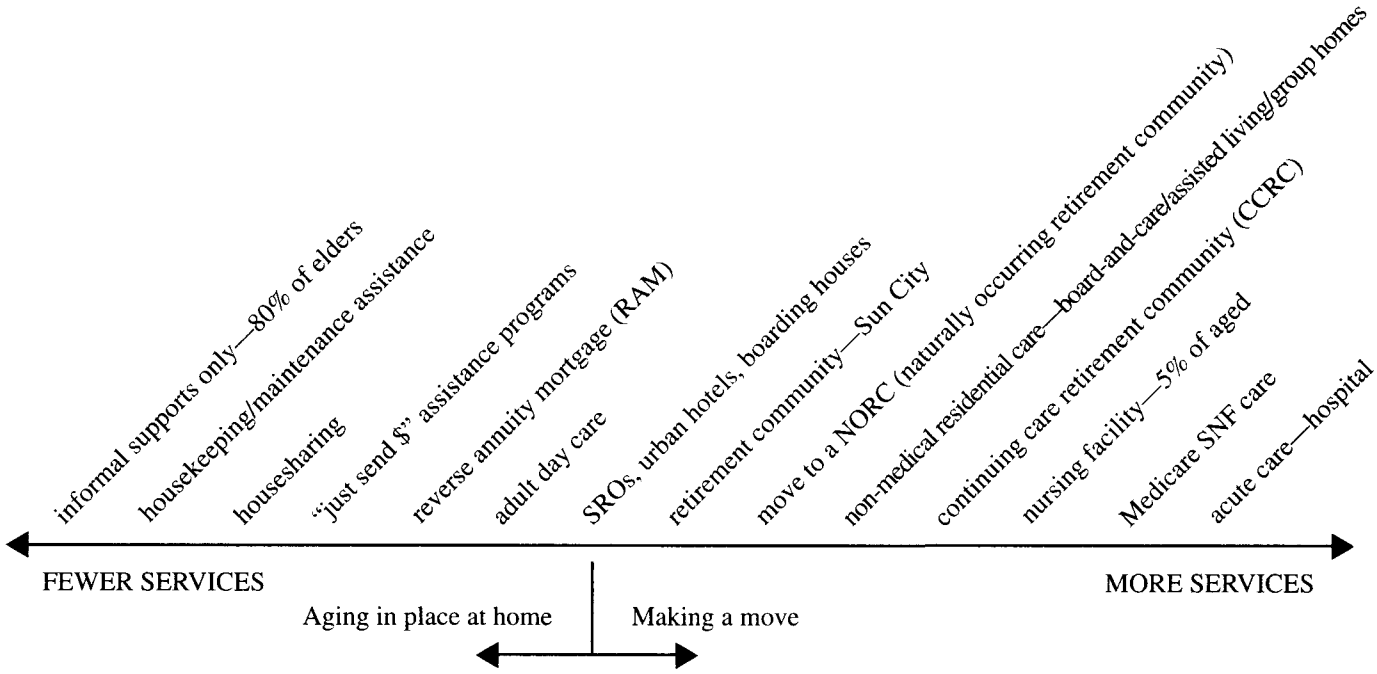
Surely, you have all heard of "level of care," the combination of patient needs, provider education and capabilities, and facility accommodations and equipment that converge to determine where and how an aging or disabled person's needs can be met, and how much a third-party payer will pay for those services. The most formal and frequently recognized levels of care are nursing home care and acute, or hospital, care. As health care has become more costly, legal and industry-sponsored "gatekeepers" have been established for these levels of care to assure that no one is admitted unless they are in need of services of the type and intensity available in such facilities. The days are gone when one could check into a hospital for a "rest cure." And, who would want to?

Other levels of care are less often discussed, in part because they are more fluid, with similar services available in the home or in a residential facility, for example. The continuum of care depicted in the Exhibit (p. iv) captures a wide range of levels of care, which might be identified primarily by the licensing of the facility or provider, or by the source of the funds used to purchase services. To receive the more formal levels of care, an individual must change residence, at least temporarily. By combining extra services with more independent housing, however, an individual can avoid moving in order to achieve a higher intensity of assistance.

Typically, the market identifies a number of combinations of housing and services that meet common needs due to impairments of aging, and sets a going rate. For example, an aging homeowner might hire a housekeeper to clean weekly, and a home health aide to assist with bathing and grooming, all for little more than minimum wage per hour. However, if the homeowner is unwell or has a faulty memory, or any combination of impairments that make it unwise or impossible to conduct screening, hiring, and supervision, the market will supply a homemaker/home health aide from a home health agency, along with supervision by a nurse and payroll services. The cost will more than double per hour, and typically the agency will require visits of not less than four hours, though the ideal might be only an hour or two of assistance each day. The market places a premium on the professional activities of choosing and supervising workers and assuring that replacement services are available.

Most elder law professionals think a lot about level of care, or at least about combinations of housing and services that will meet

Exhibit. Housing and Services Continuum



their clients' needs at a price they can afford. But, have you heard of "level-of-care creep?" Most elder law advocates have not, though it is taking place all around them. It is a cousin of "DRG creep," a quasi-fraudulent activity discovered by Congress late in the 1980s, in which hospital administrators or physicians designate for a patient a category of services that probably somewhat exceeds the patient's apparent needs at the time of admission, to be sure that Medicare's capitated payment for inpatient services is sufficient to cover costs. "Creep" refers to the evolution of an organizational system to serve specified goals, such as triggering more reimbursement, identifying more potential customers, or minimizing administrative costs. Creep can be good or bad, legitimate or not.

Level-of-care creep involves the evolution of levels of care, which might take place in two principal ways. First, there is upward level-of-care creep, in which a designated level of care expands to include services of greater intensity than were formerly allowed by licensing or undertaken by specified care providers. Second, downward creep takes place when the constraints on quality assurance and safety are loosened to make the delivery of more care less costly. Similar services, less administration and oversight, lower costs per unit of service.

An example in the formal levels of care is the creation of sub-acute care as a specific range of services for a newly designated range of Medicare reimbursements. Sub-acute care consists of very intensive nursing home services with some aspects of hospital-based care, which meets the needs of extremely impaired, chronic patients such as those in persistent vegetative state. It was created to meet the needs of patients and to fairly compensate nursing homes undertaking the difficult work of maintaining them.

However, it also answered the needs of some overgrown hospitals to fill beds left empty when prospective payments reduced the average length of inpatient stay from nine days to five and a half. For hospitals in search of more patients, this might be considered "downward" creep in hospital services by providing less skilled services in an acute care site. The infrastructure of the hospital and its high cost per square foot of space still determine how much it costs the hospital to maintain sub-acute space, and the payer will not pay for all the hospital resources not necessary to the sub-acute patient. Thus, a fair rate of reimbursement is not much more than the hospital's costs, but it is better fiscally than leaving an empty bed.

Another example of upward level-of-care creep is the evolution of nonmedical residential care

facilities, including traditional board-and-care homes and more upscale assisted-living facilities. The numbers of board-and-care homes, and the rapid growth of the assisted-living industry, points to the fact that many older people want or need the security and services of nonmedical residential care, including meal preparation, homemaking, assistance with some aspects of bathing and dressing, transportation, and companionship and recreation. The question is, when must an aging and increasingly impaired resident move to a more intensive level of care?

Twenty years ago, significant controversy existed over the question of providing home health care in board-and-care homes. Few states required regular nursing supervision in board-and-care homes, many of which catered to low-income elderly who typically were poor consumer advocates with their caregivers. States were uneasy about leaving an elder who needed nursing care in a board-and-care facility, and in their surveys strictly enforced the limits of nonmedical care by requiring that a more impaired resident transfer to a nursing home.

This was safer, preventing inappropriate care and possible neglect, but it was also inefficient in that many board-and-care residents recovered from temporary need for nursing home care—but few ever moved back to board-and-care. The resident moved to unnecessary permanent institutional care, often became less capable because living in the higher level of care requires less activity, and the cost of care tripled or quadrupled.

States, burdened with high Medicaid costs, initially set time limits on the visits of Medicare visiting nurses to board-and-care residents. For example, upon return from the hospital, a resident might have continuous visiting nursing home care for not more than two weeks at a time. For a decade, however, board-and-care facilities have been subject to more stringent licensing requirements. Operators as well as facilities require licenses, which were based on fulfilling specific education requirements and testing. Many states have enacted requirements for a new level of licensing for board-and-care, with nursing staff requirements and limits on the proportion of nursing care patients and their specific needs. Thus, the super-board-and-care joined the market, a creation of level-of-care creep. It fulfills the needs of residents and their families for continuity of care in a more homelike residence. It fills the states' needs for a care option less costly than nursing home care, and their need for a measure of accountability for the safety of board-and-care residents. It fills the desire of entrepreneurial board-and-care operators for a growing market of residents.

The assisted-living industry is a product of this entrepreneurial energy. Assisted-living facilities originally were envisioned as nonmedical facilities. But, with the average age of entering residents being around eighty, the need to accommodate aging in place was almost immediate. Assisted-living facilities were better able to satisfy states' concerns about quality of care in large part because of their more affluent market. Facilities were modern and designed for their purpose, making sanitation and food services more reliable. Residents were more likely to view themselves as consumers and express their wishes and dislikes to staff, visiting family, and state inspectors. And, administrators from the start were licensed professionals, well aware of regulatory requirements for staffing and for generating reimbursements for services from private insurers and government programs. States permitted assisted-living facilities routinely to utilize Medicare-paid home health and hospice benefits.

Toward the aging-in-place-at-home end of our continuum, a number of the entries (e.g., reverse annuity mortgages, housesharing) indicate the way elderly homeowners can generate additional income to pay for services they can no longer provide for themselves. Among them, you find a type of program I call "just send money," a concept that maximizes autonomy and minimizes administrative costs and bureaucratic hassle. Older people are assessed to determine their services needs and their income eligibility, and receive a stipend estimated to cover those services. Who they hire and what actually is done for them is left for them to choose. Over the past two decades, various states have had demonstration projects that provided cash to people with disabilities in need of services to continue at their current level of independence in housing. Kansas, for example, embarked on such a demonstration in the early 1900s, encouraged by good reports from other states. Florida had such a program for younger adults with disabilities in the 1980s. Most programs have involved younger adults, perhaps reflecting concern for greater vulnerability in older people. But, do older people, especially poor elderly, want that freedom and responsibility? Or, is it a burden and a risk of exploitation?

We are very pleased to publish, as our lead article, the results of careful study in the *Cash and Counseling Demonstration and Evaluation.* This original research compares the cost, quality, and satisfaction of consumers who receive traditional in-home services from a services provider with the responses of consumers who receive cash and the training to use it well.

Cash and Counseling is a fitting introduction to the four-article *Symposium on Diversity* in this issue. These articles, three of which were presented at the Annual Meeting of the Association of American Law Schools in San Francisco in January 2001, explore the special concerns of older citizens who are African American, Pan Asian, American Indian, or gay, lesbian, or bisexual. Important issues of identity, cultural integrity, and equity warrant attention from all professionals who serve the elder population. Perhaps we can better understand how an individual's choices are informed by a lifetime, and provide better counsel and advocacy.

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Errata:

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