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### Articles

**The Government's Cap on Dying: Why Is the Medicare Hospice Benefit Cap Being Exceeded and How Should This Problem Be Addressed?**

Marc Adler ............................................................... 1

**Finding the Keys to the Problem of Aging Drivers**

Genevieve Essig ......................................................... 27

**Taking Great Pain: The Role of Palliative Care in the Legal Competence Analysis**

Emily M. Demiray ....................................................... 55

**Interstate Guardianship: A New Phenomenon and Accompanying Problems**

Ni Yun ................................................................. 73

**Speaking Up for Grandma: Does the Long-Term Care Ombudsman Program Provide Effective Advocacy?**

Patricia J. Meier ......................................................... 89

**The Nursing Home Reform Act’s Codified Standard of Care for the Long-Term Care Industry: The National Standard of Care or Mere Mantra?**

Robert C. Powers ..................................................... 113

**Ending the Silent Suffering: Protecting Long-Term Care Patients from Sexual Abuse**

Katherine Milane ....................................................... 139

**Closing the “Estate” Loophole: A Uniform, Federal Solution to Improve the Effectiveness of Medicaid Estate Recovery**

Korey L. Henson ....................................................... 153

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THE GOVERNMENT’S CAP ON DYING: WHY IS THE MEDICARE HOSPICE BENEFIT CAP BEING EXCEEDED AND HOW SHOULD THIS PROBLEM BE ADDRESSED?

Marc Adler∗

Abstract: Hospices participating in the Medicare Hospice Benefit are increasingly faced with financial limitations due to the Aggregate Hospice Cap (“cap”). In short, the cap limits the reimbursement amount hospices may receive from the government under the Benefit. It is unclear, however, why more and more hospices are being subjected to the cap. This paper clears up the confusion by showing how the cap problems under the Medicare Hospice Benefit are primarily the result of an influx of hospices with “high-risk” characteristics. This paper also explores various remedies the government should implement in order to address this growing problem.

I. INTRODUCTION
II. BACKGROUND
   A. Description of the Medicare Hospice Benefit
   B. Description of the Cap on the Medicare Hospice Benefit
   C. The Growing Problem of Exceeding the Cap
III. WHY HOSPICES ARE EXCEEDING THE CAP
   A. Cap Problems for Hospices in the Southern and Western States
   B. Why Small Hospices are Exceeding the Cap
   C. Why Rural Hospices are Exceeding the Cap
   D. Why For-Profit Hospices are Exceeding the Cap
      1. Care for Non-Cancer Patients can be more profitable than for Cancer Patients
      2. The Suitability of For-profit Admission Patterns
   E. Why Freestanding Hospices are Exceeding the Cap
IV. SOLUTIONS TO THE CAP PROBLEM
   A. Leaving the Cap in its Current Form

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I. INTRODUCTION

There is a quietly exploding trend that will likely change the way you or your loved ones are cared for before death. An increasing number of terminally ill patients are choosing care in a hospice setting as an alternative to traditional medical care. As opposed to traditional medical care where the goal is curative, a hospice program provides palliative care and treatment aimed at relieving symptoms. In addition to minimizing the patient’s physical discomfort, hospice care is designed to treat the patient and family as a “unit of care” and focus on both the physical and psychological needs of the patient and family.1 In America, hospice has become an important part of the medical establishment because it may provide financial benefits to our healthcare system as well as the humanistic benefits described above.

Hospice care – when used appropriately – can save the patient and taxpayer money by serving as an alternative to costly curative treatment that may not improve, and could worsen, the patient’s quality of life. Taxpayers generally benefit when a patient opts for hospice care because the care is covered as a benefit under the government-funded program of Medicare (“Medicare Hospice Benefit” or “Benefit”)2 and the cost is typically less expensive3 than ongoing treatment the patient would have received under Part A4 of the Medicare benefit. Therefore, in light of the increased quality of care the patient receives from hospice in conjunction with the potential for financial savings, it is an important public policy goal to protect and possibly expand patient access to hospice care. Alarmingly, however, recent studies indicate a threat to the financial viability of hospice care in America.5

Hospices participating in the Medicare Hospice Benefit are increasingly faced with financial limitations due to the Aggregate Hospice Cap (“cap”). In short, the cap limits the reimbursement amount hospices may receive from the government under the Benefit.6 It is unclear, however, why more and more hospices are being subjected to

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2. See definition of hospice at 42 U.S.C. § 1396d (2008); see also 42 U.S.C. § 1396(dd); see Hospice Care, 42 C.F.R. § 418 (2008).
4. Part A includes the provision of care from inpatient hospital services, skilled nursing facilities and some home health care.
the cap. This paper clears up the confusion, however, by showing how the cap problems under the Medicare Hospice Benefit are primarily the result of an influx of hospices with “high-risk” characteristics that relate to the hospice’s size, setting, organizational structure and operational basis.

Specifically, hospices are at a higher risk of exceeding the cap if they are comprised of any or all of the following traits: smaller size, rural setting, for-profit structure or are freestanding. Therefore, to reduce the risk that hospices will continue to exceed the cap, the government should strongly consider a variety of modifications to the cap. In order to determine which options are appropriate, it is necessary to balance the competing interests of three important public policy goals. These policy aspirations include: 1) increasing access to hospice care under the Medicare Hospice Benefit, 2) ensuring the provision of quality care and 3) limiting taxpayer obligations.

The paper is divided into three parts. Part I provides background information on the Medicare Hospice Benefit and its cap, as well as describing the growing problem of how hospices are exceeding the capped reimbursement amount. In Part II, this paper explores why some hospices are exceeding the cap at an increasing rate by examining each high-risk trait. In Part III, the paper addresses possible solutions to the cap problem, and determines which solutions best resolve the problem in light of important competing policy interests. The best remedies include: 1) increasing the reimbursement amount under the cap for hospices in rural areas, 2) including an outlier subsidy policy where Medicare would subsidize a percentage of hospice cost for stays exceeding the six-month threshold, 3) increasing the per diem payments for the more costly beginning and end days of the stay, while lowering the payment amount for middle days and 4) attaching a specific cap amount to each particular illness. In addition, the government should also consider additional steps outside of cap modification, such as tax incentives to encourage the formation of larger hospice entities to share costs, as well as a moratorium on outstanding cap repayments.

II. BACKGROUND

A. Description of the Medicare Hospice Benefit

The Medicare Hospice Benefit pays for the provision of palliative care to individuals who are terminally ill. In order to receive the Hospice Benefit, a Medicare beneficiary must be entitled to Medicare Part A services and certified by her physician as terminally ill, which the enabling statute defines as a medical prognosis of a life

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7. See Haiden A. Huskamp et al., Providing Care At The End Of Life: Do Medicare Rules Impede Good Care?, HEALTH AFF., at 204, http://content.healthaffairs.org/cgi/reprint/20/3/204.pdf., which states that Medicare covers 80% of Americans who die each year; see also MedPAC, Medicare’s hospice benefit: Recent trends and consideration of payment system refinements, Jun. 2006, at 61, which states that a projected $9.8 billion was spent on hospice care alone in 2006, representing the majority of U.S. hospice spending.
expectancy of six (6) months or less if the illness runs its normal course. A beneficiary who enrolls in a hospice program waives his or her rights to all curative care related to his or her terminal illness, although the hospice enrollee may, at any time, cancel hospice care in lieu of curative care. In addition, while it is not a large concern with respect to this paper, it is worth noting that Medicare will continue to pay for services furnished by the patient’s non-hospice attending physician and for the treatment of conditions unrelated to the terminal illness.

The Medicare Hospice Benefit differs from conventional care by providing the terminally ill patient with a full team of providers which may include a visiting nurse, physician, social worker, chaplain, home health aide and community volunteer. The Benefit also covers other supplies and pharmaceuticals that are otherwise not covered by Medicare. Hospice comprises four separate levels of care, including routine home care, continuous home care, inpatient respite care and general inpatient care. The majority of Medicare Hospice Benefit enrollees receive services in their home; in fact, routine home care accounts for ninety-five (95) percent of hospice care days. Finally, although some studies indicate that hospice care provides little or no cost savings for medical expenditures, the majority of studies indicate that savings are likely when hospice care is used appropriately.

There is a disagreement surrounding how much – if any – savings result from electing to receive hospice care as opposed to traditional medical care. This disagreement is due in large part to the variation of costs depending on the patient’s length of stay in a hospice as well as the age of the patient. In general, however, it appears that ten to seventeen (10-17) percent of savings can be expected for a six-month hospice stay. Savings generally increase up to a point for a shorter stay (i.e., where the patient dies before six months), and decrease for a longer stay.

8. See 42 C.F.R. 418.3; see also MEDICARE BENEFIT POL’Y MANUAL, Chapter 9 – Coverage of Hospice Services Under Hospital Insurance, § 10 (2004).
10. See id.
12. Id.
16. Donald H. Taylor, Jr. et al., supra note 3, at 1467, cites four studies (not including its own study) that identify savings, as opposed to two studies which did not find savings. The question of savings is very nuanced and difficult to address, however, due to the natural variations between “similar” patients as well as the challenge of identifying similar points in patients’ terminal decline.
18. See Donald H. Taylor, Jr. et al., supra note 3, at 1474, concluding that Hospice use reduced Medicare program expenditures for most days in the last three months of life.
19. Id.
Moreover, the inclusion of older patients usually translates into less savings, and hospice costs may even be more than traditional medical costs for some patients over the age of eighty-five (85).20

An influential Duke University study found that savings is typically greater for non-cancer patients than for cancer patients,21 and today more Medicare hospice patients have non-cancer principle diagnoses than cancer diagnoses.22 Furthermore, the Duke University study found that the mean cost of Medicare program expenditures between hospice initiation and death is $7318, in contrast to the cost for patients in acute care which amounted to $9627.23 Thus, this study at least concludes that Medicare expenditures were $2309 less, on average, after electing hospice than they would have been if hospice had not been used.24 In addition to the potential financial savings to government spending, hospices may also improve the quality of care that patients receive.

One of the most beneficial qualitative aspects to hospice care is the coordination of efforts within one team of providers for each patient. While traditional medical care is comprised of distinct sets of professionals who care for the patient, hospice care generally features a cohesive set of professionals who are in frequent communication with one another.25 This aspect of hospice care limits the patient’s task of expressing her needs or concerns to a rotating group of professionals. Furthermore, some studies even indicate that certain terminally ill patients who choose hospice care live longer on average than similar patients who do not choose hospice care.26 Although this study may seem counter-intuitive and suggests possible selection bias among study participants, a plausible explanation for this conclusion would attribute the increased life-span to the different type of care which focuses on relieving mental and physical anguish.

With the ability to control healthcare costs while still improving the quality of care, the government (arguably) realized at the outset of the Medicare Hospice Benefit that hospice may be a valuable resource in the medical establishment. Despite this advantage, however, the government was concerned that the Benefit could be abused and offset the possible cost savings and qualitative advantages offered by hospice care. Therefore, the government implemented a mechanism to help prevent hospice costs from exceeding the costs of traditional medical care.

23. Id. at 1471.
24. Id.
26. See Bruce Pyenson et al., supra note 17, at 207.
B. Description of the Cap on the Medicare Hospice Benefit

The cap on the Medicare Hospice Benefit serves as the government’s tool for limiting reimbursement under the Benefit. There are actually two different types of caps placed on the Hospice Benefit program which limit program liability for hospice spending. The first cap (which will not be discussed in any great length in this paper) limits the share of inpatient care days an agency may provide to all Benefit enrollees to twenty (20) percent of its total patient care days each year. The second cap limits the average annual payment a hospice can receive from the Benefit for each patient.

The purpose of the second cap on the Medicare Hospice Benefit has been disputed by many involved in the hospice industry. Nevertheless, according to Thomas Hoyer, the retired Director of the Centers of Medicare and Medicaid Services (hereinafter “CMS,” formerly the Health Care Financing Administration) who was largely responsible for drafting the original hospice Medicare regulations, the purpose of the cap is to “guarantee that the hospice principle would not exceed the cost of conventional care” because the cap is the “only effective check on abuse of the [B]enefit.” The following paragraph describes how hospices are subject to the cap, and a corresponding footnote demonstrates the reimbursement methodology with numerical examples.

Hospice is paid on a per-diem basis for the days patients are enrolled throughout the year. This helps the hospice survive financially by allowing it to get paid for the days of services it provides. In order to determine the hospice’s total reimbursement cap amount for the year, the total number of patients enrolled in the Medicare Hospice Benefit is multiplied by the per-patient cap amount. So, the overall limit on Medicare reimbursements ensures that the total reimbursement does not exceed the average individual cap amount for the particular hospice. The cap, in other words, incentivizes hospices to keep their lengths of stay within the suggested six-month

27. 42 C.F.R. § 418.98(c); see also MedPAC, Medicare’s hospice benefit: Recent trends and consideration of payment system refinements, Jun. 2006, at 64.
30. See 42 C.F.R. § 418.302 (describing payment procedures for hospice care).
31. According to the CMS Update to the Hospice Payment Rates, Hospice, Hospice Wage Index and the Hospice Pricer for FY 2008, the most recent hospice cap amount for each patient for the cap year ending October 31, 2007, was $21,410.04. Therefore, if a hospice patient is enrolled in a hospice program for the full six months, the hospice will be reimbursed $21,410.04, regardless of whether the patient stays longer. The link to this update can be found here: http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5685.pdf
period of “terminal illness” as defined by the regulations.\textsuperscript{32} If the hospice exceeds the cap, it must repay Medicare the excess amount.\textsuperscript{33}

\textbf{C. The Growing Problem of Exceeding the Cap}

Dating back to the inception of the Medicare Hospice Benefit in 1983, hospices have historically avoided exceeding the cap amount.\textsuperscript{34} This indicates that Medicare reimbursement was largely sufficient to cover the costs of hospice care and helped prevent the risk that hospices would incur a deficit. Recently, however, the cap has become an increasing problem for hospices, although the reasons for this phenomenon have been unclear. According to the National Alliance for Hospice Access (“NAHA”), in 1999 only three states had hospices which exceeded the cap.\textsuperscript{35} Conversely, in 2005, the Medicare Payment Advisory Commission (“MedPAC”)\textsuperscript{36} is reporting that 220 hospices (or about one in every thirteen providers) in at least twenty-five (25) states exceeded the cap by an estimated amount of $166 million – although NAHA claims that the number is closer to 250 hospices and $200 million.\textsuperscript{37}

Industry observers disagree as to whether there is a problem and, if so, what the cause is. Some argue that the escalating frequency with which hospices are exceeding the cap indicates that the cap amount is too low. For instance, the NAHA asserts that the formula to determine the cap amount needs to be modified beyond the usual annual update which is tied to the Consumer Price Index (“CPI”).\textsuperscript{38} One reason this update

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32. By way of example, imagine that a hospice has 20 patients enrolled in the Medicare Hospice Benefit. Now, multiply the number of patients (20) by the yearly cap amount determined by CMS (for simplicity’s sake, imagine it to be $20,000). This equals $400,000, meaning that Medicare will reimburse the hospice up to $400,000, but nothing more.

33. Note, the hospice does not necessarily need to repay an amount if, for example, only one patient exceeds the cap. The capitation amount is a cap on the aggregate amount of expenditures for all of the hospice patients. Therefore, if only one patient exceeded the cap but that deficit is offset by profits made on the other patients in the hospice, then the hospice does not need to repay any amount.


36. The Medicare Payment Advisory Commission serves as Medicare’s watchdog. The commission is an independent federal body established to advise Congress on issues affecting the Medicare program. MedPAC provides analysis on providers in Medicare’s traditional fee-for-service program, as well as analyzing access to care, quality of care, and other issues affecting Medicare. MedPAC meets publicly to discuss policy issues and formulate its recommendations to the Congress.


38. See Social Security Act § 1814, 42 U.S.C. § 1395f (i)(2)(B) (2008), which provides that the “cap amount” for a year is $6,500, increased or decreased, for accounting years that end after October 1, 1984, by the same percentage as the percentage increase or decrease, respectively, in the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average), published by the Bureau of Labor Statistics, from March 1984 to the fifth month of the accounting year.
\end{flushleft}
may be inadequate is because healthcare costs rise faster than the CPI. Accordingly, U.S. Senator Pete Domenici (R-NM) has asked the leadership of the Senate Finance Committee to impose a three-year moratorium on cap repayments (spanning 2005-2007) while Congress works on a long-term solution. The difficulty in evaluating the merits of these ideas is that it is unclear why hospices are exceeding the cap. Without understanding why the capitation threshold is being surpassed, it is difficult to determine whether a modified cap amount is an appropriate solution and how – specifically – the cap should be modified. Therefore, the next part of this paper explains why hospices are exceeding the cap.

39. See Sam Zuckerman, Consumer price index a real guessing game, SAN FRANCISCO CHRONICLE, Feb. 24, 2008, at C1, which explains that the index measures only the actual costs of particular goods and service, but does not factor in who pays or how much is actually spent.
III. WHY HOSPICES ARE EXCEEDING THE CAP

A. Cap Problems for Hospices in the Southern and Western States

In order to discover why hospices are suddenly exceeding the aggregate hospice cap at an alarming rate, a variety of statistics and data must be examined. The first step is to determine in which areas of the country hospice cap overpayments are the most common. This can be found in a MedPAC’s June 2006 report to Congress. In the report, MedPAC divides the country into four regions and shows how many hospices in each region went over the cap as well as the total overpayments for the region. To represent its data, the report included the following table (Table 1):
According to the table, the problem appears to be most prevalent in the Palmetto region of the country which covers many Southern states. In fact, the data indicates that the overpayment amount in the Palmetto region has risen from $5.9 million in the year 2000 up to $94.6 million in 2004. Meanwhile, the rest of the country has few – if any – overpayments.

Clearly, there is some facet of the Palmetto region’s hospice industry which increases the likelihood of capitation problems. In order to find which states in the Palmetto region have the greatest difficulty operating under the cap, one helpful resource is produced by Palmetto GBA, a Medicare Regional Home Health and Hospice intermediary. Palmetto GBA has analyzed the 2005 hospice cap overpayments by state. The table (see “Appendix A”) suggests that, in addition to cap problems in rural Western states such as Arizona and New Mexico, the states with the largest cap overpayments are rural states such as Alabama, Mississippi and Oklahoma.

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41. See MedPAC, supra note 3, at 65. In the note portion of the chart, MedPAC lists all of the states that are included in each of the four regions of the country.

42. See id.

43. See id.

44. See Palmetto GBA Provider Education, Palmetto GBA Hospice Coalition Questions & Answers, Palmetto GBA, at Appendix E (Aug. 14, 2007), http://www.palmettogba.com (search “Hospice Coalition”; then follow “August 14, 2007” hyperlink). The table is included as “Appendix A” of this paper at the end of this paper.

45. See id.; According to the U.S. Census Bureau, the 2007 population estimates of the following states are: Arizona (6,338,755), New Mexico (1,969,915), Alabama (4,627,851), Mississippi (2,918,785) and Oklahoma (3,617,316).
B. Why Small Hospices are Exceeding the Cap

Few elderly residents reside in the three rural states with the most significant overpayments (Alabama, Mississippi and Oklahoma) which also happen to have more hospices (90, 61 and 99, respectively) than more populated states, such as Florida (which has 36 hospices). This can be explained, however, due to the presence of larger hospices in “urban states” such as Florida where the average hospice serves 439 patients daily as opposed to the daily patient census of 68 served nationally. Therefore, without any evidence to the contrary, an initial hypothesis might be that smaller hospices found in rural areas in Southern and Western states are exceeding the cap for the Benefit at a greater frequency and amount than larger hospices found in more densely populated states. This idea is consistent with others’ findings which suggest that cap problems are most common with smaller hospices, although these sources admit that the reasons for this claim are “not fully understood.” Fortunately, a closer look at more statistics reveals why small hospices in rural areas are at risk for cap problems.

C. Why Rural Hospices are Exceeding the Cap

One of the main challenges facing small hospices (i.e., hospices with a small number of patients) is the inability to spread risk among patients with extraordinary lengths-of-stay, which this paper will refer to as “length-of-stay outliers.” In other words, if one patient has a length of stay that costs the hospice a lot of money, the hospice does not have many other patients to profit from in order to offset the cost. A length-of-stay outlier encompasses stays that produce a deficit for the hospice because

46. See Palmetto GBA Provider Education, Palmetto GBA Hospice Coalition Questions & Answers, Palmetto GBA, at Appendix E (Aug. 14, 2007), http://www.palmettogba.com (search “Hospice Coalition”; then follow “August 14, 2007” hyperlink). The table is included as “Appendix A” of this paper at the end of this paper.

47. See Palmetto GBA Provider Education, Palmetto GBA Hospice Coalition Questions & Answers, Palmetto GBA, at Appendix E (Aug. 14, 2007), http://www.palmettogba.com (search “Hospice Coalition”; then follow “August 14, 2007” hyperlink). The table is included as “Appendix A” of this paper at the end of this paper.

48. Florida is home to VITAS Healthcare, the largest for-profit hospice organization in the U.S; see Barry M. Kinzbrunner, editorial, For Profit vs. Not-for-Profit Hospice: It is the Quality that Counts, J. PALLIATIVE MED., Vol. 5, No. 4, at 483 (2002).

49. See Palmetto GBA Provider Education, Palmetto GBA Hospice Coalition Questions & Answers, Palmetto GBA, at Appendix E (Aug. 14, 2007), http://www.palmettogba.com (search “Hospice Coalition”; then follow “August 14, 2007” hyperlink). The table is included as “Appendix A” of this paper at the end of this paper.

50. See Palmetto GBA Provider Education, Palmetto GBA Hospice Coalition Questions & Answers, Palmetto GBA, at Appendix E (Aug. 14, 2007), http://www.palmettogba.com (search “Hospice Coalition”; then follow “August 14, 2007” hyperlink). The table is included as “Appendix A” of this paper at the end of this paper.

51. See Palmetto GBA Provider Education, Palmetto GBA Hospice Coalition Questions & Answers, Palmetto GBA, at Appendix E (Aug. 14, 2007), http://www.palmettogba.com (search “Hospice Coalition”; then follow “August 14, 2007” hyperlink). The table is included as “Appendix A” of this paper at the end of this paper.
the stay is either too short or too long. Short stays are detrimental because the hospice incurs higher costs at the beginning of the stay (because of costs associated with creating a care plan and arranging the necessary services and equipment) and the final days (because of the more intensive use of emotional support services and nursing care). Thus, a short stay prevents the hospice from being able to profit from the low-cost, middle-of-the-stay days. Similarly, a long length of stay poses a financial risk for the hospice because reimbursement for patient care is subject to the cap limitation. In other words, if the patient survives for longer than the expected six-month prognosis, Medicare does not cover the excess cost above the six-month threshold and the hospice is then responsible for the cost. Therefore, if a small hospice has just one outlier patient that produces a significant deficit, the hospice may be unable to recover the cost due to the small number of “profitable patients” with normal lengths of stay.

Another problem that small hospices encounter due to their low patient volume is that they are less likely to experience economies of scale. In other words, when smaller hospices purchase items such as pharmaceuticals and medical supplies, the hospices do not receive the same discount larger hospices (or hospices affiliated with larger healthcare entities such as hospitals) receive because the smaller hospices are typically unable to buy the items in bulk unless they are part of a group purchasing organization. Therefore, as a result of these inefficient business patterns, smaller hospices endure higher costs than large hospices even when providing the same drugs and supplies to their patients.

Small hospices in rural settings usually have an added challenge of travel that increases the risk for a cap problem. As described above, because the vast majority of patients receive hospice care in a home setting, hospice providers in rural areas may have to travel great distances to serve their patients. Nevertheless, reimbursement rates for patients in rural areas are lower than for those in urban areas. This is true because the rates take into account factors such as lower wages in rural areas, but the current reimbursement formula does not consider travel distance, even though travel expenses – including mileage and staff time – can be much higher for rural hospices.

The failure of the reimbursement system to take into account in costs such as travel expenses may still be considered appropriate. The rationale for this opinion is that hospice care is being over-utilized and should not be so widely available. For instance, patients in remote, rural locations should not always have the luxury of receiving hospice care in their own homes; rather, they should receive care in a more

52. See Haiden A. Huskamp et al., supra note 7, at 207.
53. Id.
54. See 42 C.F.R. 412.308.
56. Lina Cheung et al., supra note 15, at 3.
57. Haiden A. Huskamp et al., supra note 7, at 207
58. Id.
59. See id.; see also Michelle M. Casey et al., supra note 55, at 363.
convenient and efficient setting such as a hospital or central hospice agency. Therefore, the omission of travel costs under the Benefit’s reimbursement formula may justifiably discourage hospices from treating remote patients who are unwilling to receive care in a central location.

Despite evidence indicating the financial challenges that a rural setting poses, some argue that rural settings are not the cause of hospice cap problems. This position is supported by data showing that hospices in other rural states, such as South Dakota, North Dakota and Wyoming, have typically avoided any cap overpayments. The argument that rural settings are not the cause of cap problems fails to take into account, however, the annual percentage of deaths occurring in areas that are “unserved” by hospices. For instance, one study shows that, in 2002, the annual percentages of deaths occurring in unserved areas of South Dakota, North Dakota and Wyoming were 23.1%, 19.6% and 17.9%, respectively. This is in stark contrast to the large majority of states, including the aforementioned rural states of Mississippi, Alabama and Oklahoma, which experienced death rates in unserved areas of 0.3%, 0.1% and 0.1%, respectively. While this discrepancy is not directly addressed in the study, one reasonable explanation would be that the hospices in states with higher percentages of unserved areas are unwilling or unable to serve larger geographic areas, thus saving on hospice costs (such as time and travel expenses) and preventing cap overpayments, but possibly incurring greater costs overall to the Medicare system.

Others will likely reject the rural setting hypothesis on the basis of data produced from Medicare cost reports distinguishing urban and rural hospices with cap problems. This data shows that of the 152 hospices which exceeded the cap (6.1% of all hospices) in 2005, 91 reside in urban areas, whereas 61 reside in rural areas. At first glance, this may indicate that urban hospices are more likely to exceed the cap; however, these numbers are not considered in proper context. The claim can be disputed because there are more urban hospices than rural hospices, so it would be foreseeable that urban hospices would constitute a higher number of cap hospices. In fact, MedPAC determined that there were 1,554 total hospices in urban areas and 921 total hospices in rural areas. When dividing the number of urban cap hospices by total urban hospices (91 / 1554), only 5.86% of urban hospices exceeded the cap; in contrast, 6.6% of rural hospices (61 / 921) exceeded the cap. Thus, these percentages reveal that there is at least no statistical significance suggesting that urban hospices are more likely than rural hospices to experience cap problems.

60. See MedPAC, supra note 3, at 65, which shows that the Cahaba region (including South Dakota, North Dakota and Wyoming) has maintained little or no cap payments since 2000. The 2007 U.S. Census Bureau population estimates of the following states are: South Dakota (796,214), North Dakota (639,715) and Wyoming (522,830).
61. Beth A. Virnig et al., supra note 46, at 1296.
62. Id.
63. MedPAC preliminary data is based on Medicare hospice cost reports and 100% hospice claims standard analytical files from CMS.
65. Id.
As shown above, a strong argument can be made that inadequate reimbursement, limited risk-spreading and a broad network of hospice coverage increase the possibility of cap issues for small hospices in rural settings. Within these types of hospices, however, evidence further suggests that admission patterns relating to organizational structure (i.e., non-profit status versus for-profit or proprietary status) exposes for-profit hospices to an even greater risk of cap problems.

D. Why For-Profit Hospices are Exceeding the Cap

Early hospices were primarily non-profit\(^6^6\) organizations that relied upon volunteers and philanthropy.\(^6^7\) The hospice movement in America took root in the 1960s and 1970s and was established and sustained mainly by volunteers dissatisfied with the depersonalized care dying patients – and in particular, cancer patients – received from the medical establishment.\(^6^8\) Because there was no system of government assistance to help pay for this new enterprise, hospice tended to seek tax-exemption to help subsidize their operations. Since 1983, however, the Medicare Hospice Benefit has attracted for-profit agencies to the hospice world. According to a MedPAC study (see “Table 2” below), the presence of for-profit (“proprietary”) hospices exploded between 2000 and 2006 – an increase of nearly 140 percent – while non-profit hospices have declined by nine (9) percent.\(^6^9\) In fact, in 2005 the total number of for-profit hospices eclipsed the number of non-profit hospices for the first time.\(^7^0\)

\(^6^6\). For a definition of non-profit hospices, see Rick W. Williams, Letters, 9 Am. J. Hospice & Palliative Med., at 4 (May/June 1992), which defines a non-profit as “[a] legally constituted, nongovernmental organization, granted an exemption from the payment of income taxes, seeking to contribute to the public welfare, as its primary objective.”

\(^6^7\). Lenora Finn Paradis & Scott B. Cummings, supra note 1, at 371.

\(^6^8\). See Lenora Finn Paradis & Scott B. Cummings, supra note 1, at 370-71.


\(^7^0\). See id.
The increased presence of for-profit hospices is significant because their admission patterns (i.e., the type of patients they admit and care for) generally differ from non-profit hospices. Although the Medicare Hospice Benefit was designed to primarily treat patients dying of cancer,\textsuperscript{71} studies show that for-profit hospices tend to provide services to a higher proportion of non-cancer patients.\textsuperscript{72} Non-cancer diagnoses include illnesses such as congestive heart failure, dementia and Alzheimer’s disease.\textsuperscript{73} The problem, however, is that it is harder to predict how long patients with non-cancer diagnoses are expected to live as opposed to cancer patients who have shorter and more predictable prognoses.\textsuperscript{74} Thus, not only do non-cancer patients increase the

\begin{table}[h]
\centering
\caption{The number of proprietary hospices has increased, while the number of nonprofits has declined}
\begin{tabular}{|c|c|c|c|c|}
\hline
Year & Voluntary & Government & Proprietary & Other \\
\hline
2000 & & & & \\
2001 & & & & \\
2002 & & & & \\
2003 & & & & \\
2004 & & & & \\
2005 & & & & \\
2006 & & & & \\
\hline
\end{tabular}
\end{table}

\begin{flushright}
\textsuperscript{71} See John J. Mahoney, supra note 25, at 140.
\textsuperscript{72} Kevin Sack, supra note 37, at A1; see also Karl A. Lorenz et al., Cash and Compassion: Profit Status and the Delivery of Hospice Services, J. PALLIATIVE MED., Vol. 5, No. 4, at 507 (2002), which provides a detailed study specific to California hospices. Here, the percentage of diagnoses at for-profits was 46% cancer and 54% non-cancer, whereas the percentage at non-profits was 72% cancer and 28% non-cancer.
\textsuperscript{73} Haiden A. Huskamp et al., supra note 7, at 207; for a more detailed list of non-cancer diagnoses based on 2005 preliminary data, see James E. Matthews, supra note 64, at 10.
\textsuperscript{74} Kevin Sack, supra note 37, at A1.
\end{flushright}
likelihood of long length-of-stay outliers (which, as shown above,\textsuperscript{75} is particularly problematic for smaller hospices), but one study indicates that hospices – on average – suffer a deficit after 233 days for cancer patients, whereas it only takes 154 days to create a deficit for non-cancer patients.\textsuperscript{76} This data is consistent with MedPAC data which shows that in 2005, 132 of the 152 hospices that exceed the cap were for-profit hospices.\textsuperscript{77} Therefore, with the increased risk of money-loss and potential capitation problems, it begs the question, “Why do for-profit hospices treat a higher proportion of non-cancer patients?”

1. Care for Non-Cancer Patients can be more profitable than for Cancer Patients

Understanding the priorities of for-profit and non-profit hospices is a helpful starting point when considering the variance of patient selection. In simple terms, the ultimate mission of non-profit hospices is to maximize community welfare, although a main goal in fulfilling that mission is to make a profit.\textsuperscript{78} On the other hand, the ultimate mission of for-profit hospices is to make a profit, but a main goal in fulfilling that mission is to provide quality care.\textsuperscript{79} In general, non-profits are able to prioritize care over profits due in part to their reliance on charitable supplements.\textsuperscript{80} For-profits, however, are limited in their ability to solicit and utilize charitable donations;\textsuperscript{81} besides that, for-profits pay taxes. Moreover, the cap on the Medicare Hospice Benefit encourages cost-control measures because hospices cannot influence their reimbursement rates.\textsuperscript{82} Therefore, it would make sense that for-profits would tend to admit patients with a greater potential for profitability.

As noted above, non-cancer patients typically have longer lengths-of-stay than cancer patients. In theory, this increases profitability\textsuperscript{83} by minimizing the effect of high-cost care which occurs in the very beginning and end of the stay.\textsuperscript{84} In addition, the cost of care provided to non-cancer patients is usually less expensive because non-cancer patients generally require a lower level of skilled care due to the nature of their illness.\textsuperscript{85} Nevertheless, it appears that profitability depends on the type of non-cancer diagnosis. For instance, in 2004 the mean cost per day for hospice enrollees diagnosed

\textsuperscript{75} See discussion supra section B.3
\textsuperscript{76} Donald H. Taylor, Jr. et al., supra note 3, at 1475.
\textsuperscript{77} James E. Matthews, supra note 64, at 8. Note, only 16 of the 152 cap hospices were non-profits.
\textsuperscript{78} See Rick W. Williams, supra note 66, at 4.
\textsuperscript{79} See id.
\textsuperscript{80} Karl A. Lorenz et al., supra note 72, at 512. Charitable supplements include financial or other donations that are granted tax-exempt status under Internal Revenue Service regulations.
\textsuperscript{81} Id.
\textsuperscript{82} Id.
\textsuperscript{83} Note, however, that profitability decreases if the length of stay exceeds 180 days because the Medicare Hospice Benefit no longer reimburses the hospice for care provided after the 180\textsuperscript{th} day.
\textsuperscript{84} See Haiden A. Huskamp et al., supra note 7 at 207; see also Karl A. Lorenz et al., supra note 72, at 513.
\textsuperscript{85} See Karl A. Lorenz et al., supra note 72, at 513.
with Alzheimer’s disease was $134.97. Still, other non-cancer diagnoses – such as congestive heart failure and stroke – had higher mean costs per day of $252.94 and $265.03, respectively. Therefore, even though cancer patients are “more expensive to treat than non-cancer patients while in hospice,” these numbers suggest that certain non-cancer diagnoses may be more costly (and less profitable) than some types of cancer diagnoses.

Despite the overall evidence that non-cancer patients may be more profitable, non-profit hospices appear willing to accept the minimal profitability of cancer patients because it benefits the community and the profit differential can be offset by charitable donations. In contrast, for-profit hospices seem to prefer non-cancer patients because it gives the hospice a greater chance of earning a profit in light of their inability to fundraise. This is troublesome, however, for smaller, rural hospices that are unable to overcome the potentially high cost of a single outlier patient which is more likely to occur in non-cancer patients.

2. The Suitability of For-profit Admission Patterns

Before advancing to the next substantive point, it is an important policy point to briefly assess the suitability of for-profit admission patterns. Some argue that the conclusion that for-profit hospices are “selecting” non-cancer patients is speculative. This argument contends that for-profit hospices are making use of their ability to fulfill a desire to reach out to these underserved patients who have historically made limited use of hospice care. Although this may be possible, it seems unlikely – especially with respect to smaller hospices – because there does not appear to be any evidence which suggests that for-profit hospices have a much greater financial ability to provide care to underserved patients.

One may also argue that it is the non-profit hospices that are “selecting” cancer patients due to increased regulatory scrutiny. Hospices are wary of government scrutiny of the eligibility rule of a prognosis six months or less in connection with the government’s efforts to reduce Medicare fraud and abuse. For instance, in 1995 the U.S. Department of Health and Human Services implemented the “Operation Restore Trust” initiative to reduce errors and systematic fraud and abuse in hospice under the Medicare program. Hospices believe – and rightly so – that this has contributed to

86. See Bruce Pyenson et al., supra note 17, at 205. The mean cost per day is calculated by dividing the overall mean cost of the disease for hospice enrollees ($29,828) by the mean time until death (221 days).
87. See id.
89. Barry M. Kinzbrunner, supra note 48, at 484.
90. Id.
91. Id.
92. Haiden A. Huskamp et al., supra note 7, at 207.
93. Id.
the trend of later referrals (i.e., closer to death) and shorter stays even though CMS clarified that stays of more than six months are not illegal.\footnote{Id.}

Also in 1995, the NHPCO (“the National Hospice and Palliative Care Organization,” then the National Hospice Organization) published the Medical Guidelines for the Determining of Prognosis in Selected Non-Cancer Diseases.\footnote{Barry M. Kinzbrunner, Hospice: 15 Years and Beyond in the Care of the Dying, J. PALLIATIVE MEDICINE, Vol. 1, No. 2, at 129 (1998).} This document provided criteria to help identify patients with a prognosis of six months or less.\footnote{Id. at 129-30.} Shortly thereafter, the medical directors of the hospice fiscal intermediaries converted the guidelines into local medical review policies for determining patient eligibility for the Medicare Hospice Benefit.\footnote{Id. at 130.} Unlike the guidelines, however, the policies mandated that patients meet the given criteria in order to be eligible for the Benefit.\footnote{Id.} Furthermore, even if the patient who was ineligible upon admission died within the six months, the hospice still may not receive Medicare reimbursement.\footnote{Id.} Nevertheless, despite the increased regulatory scrutiny, there does not seem to be a strong government influence which has coerced non-profits to “select” cancer patients – not to mention the fact that hospices have historically cared for a large proportion of cancer patients even prior to the increased scrutiny.

It appears that for-profits admit more non-cancer patients in large part because of the non-cancer patients’ higher profitability margins. Many opponents of for-profit hospice care have used this interpretation as an indictment of the for-profit industry, claiming that the benefits of serving an “underserved” population are offset by the allegedly lower quality of care provided in the for-profit setting. The opponents cite studies which indicate that patients of for-profit hospices receive a “significantly narrower range of services” than patients of non-profit hospices.\footnote{See Melissa D. Carlson, et al., Ownership Status and Patterns of Care in Hospice: Results From the National Home and Hospice Care Survey, 42 MED. CARE, at 432 (2004).} These studies are questionable, however, given the disparity between cancer and non-cancer patients and the potentially larger range of services needed for cancer patients. Moreover, this data can be skewed if the majority of for-profits are smaller and therefore unable to offer all of the same services. Interestingly, another study concluded that the figures were equal between both type of organizational structures when examining the intensity of nursing care and the availability of chemotherapy and radiotherapy, although for-profits discharged more patients prior to death than non-profits.\footnote{Karl A. Lorenz et al., supra note 72, at 513.}

When considering this evidence in its entirety, some claim that for-profit hospices are “bad” and perhaps should not be participating in the Medicare Hospice Benefit.\footnote{See Hospice Patients Alliance, For Profit and Nonprofit Hospices, http://www.hospicepatients.org/hospic46.html (last visited Apr. 12, 2008).}
Yet, one thing is for certain; regardless of the range of services and the motive to select certain patients, it is clear that the influx of for-profit hospices has enabled access to hospice care for many patients who would have otherwise been excluded from receiving it. Therefore, with the understanding that it is always precarious in the healthcare arena when profit is the bottom line, the for-profit hospice industry serves an important public policy goal of enabling access to hospice care for underserved populations. Consequently, the government – through revision of its reimbursement obligations – should provide fair and reasonable accommodations to for-profits in order to help ensure profitability for the small but rapidly growing number of hospices that are struggling financially. In doing so, the government will improve the ability to provide high quality care to non-cancer patients.

E. Why Freestanding Hospices are Exceeding the Cap

Hospice services are delivered by providers that operate in a variety of locations, including either freestanding agencies or provider-based locations such as hospitals, skilled nursing facilities and home health agencies. Freestanding hospices are usually independently owned and may feature both inpatient care buildings and home care hospice services. In 2001, more than half of all Medicare Hospice Benefit enrollees were served by freestanding entities. Furthermore, as shown below in Table 3, between 2000 and 2006 the number of freestanding hospices doubled while the number of hospices in the other types of settings decreased or virtually remained the same. Consequently, as these statistics indicate, the operations of freestanding hospices warrant close attention because they are a prominent part of the hospice industry and the Medicare Hospice Benefit, in general.

103. See MedPAC, supra note 3, at 67. Recall, however, that the majority of hospice services are provided as routine home care, but the hospice agency operates out of a variety of locations.

104. See American Cancer Society, Making Treatment Decisions: What is Hospice Care (Jan. 23, 2007), http://www.cancer.org/docroot/ETO/content/ETO_2_5X_What_Is_Hospice_Care.asp


106. See MedPAC, supra note 57, at 193.
The increased presence of freestanding hospice facilities is significant to the Medicare Hospice Benefit because of the estimated 152 hospices that encountered cap problems in 2005, 142 of them were freestanding and only ten (10) were provider-based. A possible explanation is due to the fact that per-diem costs for hospital-based and home health agency-based hospices are lower than freestanding hospices. One reason for this is that the provider-based hospices are able to allocate overhead costs between the hospice and the hospital or home health agency, but the freestanding hospice must incur all costs itself. Furthermore, small freestanding hospices “are more likely than other hospices to be located in rural areas.” Similar to the analysis above, the rural setting presents additional financial obstacles, including lower Medicare reimbursement payments because of the lower wage index adjustments for rural areas. Also, it does not appear that urban freestanding hospices exhibit cap problems. This is most likely attributed to the higher reimbursement payments urban

107. James E. Matthews, supra note 64, at 8.
109. See id.
110. Id. at 5.
111. See discussions supra sections B.2 and B.3.
112. See also U.S. Government Accountability Office, supra note 105, at 5.
freestanding hospices receive than rural freestanding hospices, which offset the higher costs for wages that the urban locales create.

Given the inherent challenges of freestanding hospices, it is reasonable to determine whether such hospices should be discouraged from providing hospice care under the Benefit, or perhaps the current system already discourages such a business model. With budgetary constraints, it is hard to argue that freestanding hospices should be accommodated for their potential inefficiencies. Still, the freestanding form has provided an important role by increasing hospice access for patients, particularly in underserved areas with untraditional diagnoses. Therefore, given the influx of freestanding hospices and the likelihood of residing in rural settings\textsuperscript{113} with low patient volumes, steps need to be taken to prevent the cap problem from continuing to worsen.

IV. SOLUTIONS TO THE CAP PROBLEM

Clearly, the growing frequency of hospices participating in the Medicare Hospice Benefit that exceed the aggregate cap amount is not simply the product of rising healthcare costs. On the contrary, this cap problem is directly related to the recent influx of hospices with any or all of the four high-risk characteristics, namely: 1) small size, 2) rural setting, 3) for-profit structure or 4) freestanding basis. There are three general solutions to address this problem. This paper analyzes all three solutions by listing the benefits and detriments of each proposal and balancing these qualities with the three important public policy interests related to hospice care, which are increasing access, ensuring the provision of quality care and limiting taxpayer obligations.

A. Leaving the Cap in its Current Form

The first and simplest possible solution is for the cap to remain unchanged. The primary benefit of this option is that it would relieve taxpayers from having to increase funding to the Benefit. In addition, it would solidify the one true safeguard preventing wasteful abuse of the Benefit. One rationale for this option is that the growing cap problem attributed to providers within a specific set of characteristics is evidence of inefficiency and over-utilization of hospice care – particularly in rural areas of the country. Although this rationale may be cogent, it is not compelling enough to trump the other public policy interests.

Although the cap problems could represent inefficiency in the hospice industry in terms of the older perception of hospice care which caters to cancer patients and urban areas, the newer trend in hospice care seeks to offer these important services to a wider array of patient diagnoses, even if those patients live in more remote locations. Given the high value of hospice care – both financially and humanistically – it is in the public’s best interest to expand access to hospice care for those in need of its services. Moreover, the decision to leave the cap in its current form may detrimentally affect

\textsuperscript{113} Although there does not appear to be publicly available data indicating what percentage of freestanding hospices are rural, as shown above, the U.S. Government Accountability Office confirms that small freestanding hospices tend to be rural in location. \textit{Id.}
quality. As more and more hospices are faced with cap problems, there may be an urge to reduce costs and limit services which would likely result in a lower quality of care.

In addition, there is a strong argument that the cap is due for a readjustment because it has not been modified since its inception despite other significant regulatory actions that can burden hospices. For instance, in 1998, Congress removed the limit on the number of days (i.e., length of stay) that a patient could receive Medicare hospice coverage. Therefore, due to fairness concerns as well as other public policy interests, it would be inappropriate if the government did not adjust the cap.

B. Increasing the Cap by a Flat Amount

The second option the government may consider is to raise the aggregate cap amount by a certain percentage for all Medicare Hospice Benefit providers. The benefit of this decision is that it will likely increase access and quality of care for the services offered by hospices. In the current hospice climate, some physicians decide not to refer certain patients with a terminal illness who might otherwise benefit from hospice care. The patient’s condition may require high-cost supportive treatments that will ease pain and possibly extend life but not cure a terminal condition. In fact, a study affiliated with Harvard Medical school reported that one physician determined that such care would put a strain on the hospice’s budget and therefore elected to continue treatment in the conventional medical format. Nevertheless, a higher cap would increase hospice budgets and enable the hospice to provide a higher quality of care as well as increasing the access to hospice care through physician referrals.

The negative aspect of this proposal is that it would create a windfall for the majority of hospice providers and does not limit taxpayer obligation. Although increased funding for government healthcare programs will almost always promote greater access and higher quality care, such an untargeted increase in the cap would be an inefficient use of resources. The flat increase would improve hospice care in urban areas for larger hospices that have had little or no cap problems and still provide excellent care to a large number of patients. The increase does not target the hospices with the biggest cap problems, such as smaller, rural hospices. Therefore, this option is inappropriate because it does not improve hospice care in an efficient manner that would properly utilize taxpayer funding.

115. Haiden A. Huskamp et al., supra note 7, at 206.
116. According to the article, some high-cost treatments include: erythropoetin (a glycoprotein that can decrease anemia and transfusion requirements for cancer patients), pamidronate (used to decrease calcium levels in persons with bone metastases and relieve problems such as confusion, nausea, and pain) and leuprolide (which decreases pain and tumor load in prostate cancer patients).
117. Haiden A. Huskamp et al., supra note 7, at 206.
118. See id.
C. Modifying Specific Parts of the Cap & Additional Steps

The final option is to increase the cap by modifying specific parts or including other mechanisms within the cap that limit the financial burden some hospices encounter. When developing new ideas which may change the cap, it is important to remember the four aforementioned high-risk characteristics which increase the likelihood of cap problems for hospices. Any changes should attempt to offset the inherent risk that these characteristics present in regard to hospice care. The appropriate changes will increase access to care – particularly in rural areas – and allow hospices to provide a higher quality of care because they would not be faced with such significant budgetary restrictions. In addition, targeted changes to the cap amount would maximize taxpayer funding by focusing on specific problems within the Medicare Hospice Benefit.

The first change that should be considered is increasing the reimbursement amount under the cap for hospices in rural areas. Currently, the cap amount is lower for rural hospices because it is adjusted merely according the wage index. While it is true that the cap amount should be adjusted lower because wages are lower in rural areas, the cap amount should also take into account factors which increase hospice cost in rural areas. Therefore, after the wage adjustment, the cap amount should be adjusted for other factors which relate to the provision of care, such as higher travel expenses and other variations (e.g., time and labor) that are connected with increased travel.

Another change to the calculation of the cap amount which would likely benefit smaller hospices (especially for-profits) is the inclusion of an outlier subsidy policy where Medicare would subsidize a percentage of hospice cost for stays exceeding the six-month threshold. Hospices should not be penalized for providing care that may have enabled the patient to live longer than the six-month or less prognosis. Therefore, it would be fair and reasonable to subsidize a percentage of care which would only cover average hospice costs above the cap’s six-month threshold. In doing so, the hospice would not be profiting from an extended stay, but it would not be forced to incur a deficit either. This outlier subsidy would cover an additional six months (i.e., a one-year stay in total) in accord with studies which conclude that cost savings with respect to hospice care (in lieu of traditional care) max out after one year. The benefit of this policy is that it would limit the risk smaller hospices encounter for long length-of-stay outliers.

Similarly, the risk that hospices (especially smaller entities) are subject to for short length-of-stay outliers can be reduced by altering the per diem payments. For instance, the payments should be increased for the more costly beginning and end days of the stay, while lowering the payment amount for low-cost middle days. In doing so, hospices would not be penalized for providing care to patients with a very short length-of-stay. Furthermore, this may help alleviate concerns in regard to patient

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119. Another more stringent variation of this option would be to only reimburse (or only increase reimbursement for) provider-based hospices in rural areas, thereby discouraging inefficient, freestanding models from participating in the Medicare Hospice Benefit.
selection because cancer patients with short prognoses and non-cancer patients with longer prognoses would be deemed similarly profitable.

Another change which would limit the need for patient selection, particularly among for-profit hospices, would be to attach a specific cap amount to each particular illness. This system, which would be similar to the diagnosis-related group (“DRG”) system in traditional medical care, would reimburse hospices a higher amount for the higher cost of treatment. Therefore, patients with high-cost supportive treatments for their terminal illness, such as for cancer or HIV, would be reimbursed at a higher amount than low cost care for an illness such as Alzheimer’s disease.

One additional option the government may consider is to factor in the operational basis with respect to reimbursement payments. This would help alleviate the financial burden freestanding hospice facilities encounter because they are unable to allocate costs in the way that larger, provider-based facilities are able to do. Still, despite the likely reduction in cap overpayments that this option may bring, it seems to contradict sound market theory by favoring an entity for its inefficient operational basis. A better option would be to encourage freestanding facilities (which are generally smaller and in rural settings) to join or form larger entities in order to share cost (including the purchase of drugs and supplies). This can be achieved through a variety of means, but the best avenue would likely be through tax incentives rather than an alteration of the cap amount.

Finally, the government may consider a moratorium on outstanding cap repayments until final changes are made to the Medicare Hospice Benefit cap. This option would allow hospices to pay back the amounts in which they exceeded the cap at a later date. A moratorium would acknowledge that recent reimbursement levels and capitation amounts did not adequately conform to the needs of hospices participating in the Medicare Hospice Benefit. The advantage of this decision is that it would not force hospices to make immediate cutbacks in regard to patient access and the provision of quality care. Also, taxpayers would not be significantly harmed because the overpayments would eventually be refunded to the government once a more appropriate cap system is in place. Of course, a moratorium is only a temporary solution and the hospice industry – as well as the general public, would be better served by also choosing any or all of the options mentioned above in order to resolve potential cap problems for the long term.

120. State action would likely be needed to pursue this initiative.
V. CONCLUSION

Given the tremendous financial and humanistic benefits that hospice care offers, it is imperative that the Medicare Hospice Benefit be protected and able to expand as more patients and their families seek comfort during their final days. For hospices participating in the Benefit, the frequency of reaching the aggregate cap amount will continue to swell unless the government takes action and offers a long-term solution which modifies the capitation amount. This paper assists the government’s decision by demonstrating why the cap is being exceeded in order to enable the government to tailor a proper response.

Four high-risk characteristics are highlighted which increase the likelihood that certain hospices will exceed the cap amount. First, smaller hospices are at risk because their low patient volume makes it more difficult to overcome the high cost of length-of-stay outlier cases. Second, rural hospices are also in danger because reimbursement amounts under the Benefit are too low to cover higher costs associated with the need to cover greater distances within their regions. Third, for-profit hospices are exposed to higher risk due to their patient selection of non-cancer diagnoses which increases the likelihood of long length-of-stay outliers. Finally, freestanding facilities are subject to a higher risk of cap problems because of their inability to allocate costs and their predominantly small, rural establishments. With these high-risk qualities in mind, the government should modify the cap amount – along with other suggested proposals – in order to reduce the risks inherent in these types of hospices.

This paper offers many different options for the government to consider. Each option targets specific risks within the Medicare Hospice Benefit which has caused the increase of cap overpayments. Moreover, in order to offset the continuing influx of hospices with high-risk characteristics, these options appropriately address this problematic trend by balancing the public policy concerns of 1) increasing access to hospice care under the Medicare Hospice Benefit, 2) ensuring the provision of quality care and 3) limiting taxpayer obligations.

The options set forth in this paper include: 1) increasing the reimbursement amount under the cap for hospices in rural areas, 2) including an outlier subsidy policy where Medicare would subsidize a percentage of hospice cost for stays exceeding the six-month threshold, 3) increasing the per diem payments for the more costly beginning and end days of the stay, while lowering the payment amount for middle days and 4) attaching a specific cap amount to each particular illness. The government should also consider additional steps outside of cap modification. These steps include initiatives such as tax incentives to encourage the formation of larger hospice entities to share costs, as well as a moratorium on outstanding cap repayments. By following these recommendations, the government would encourage continued cost savings through participation in the Medicare Hospice Benefit. In addition, these recommendations allow Americans to receive increased access to the high quality of specialized care that patients and their families desperately need in the final days of life.
## Appendix A

### Palmetto GBA - Palm Harbor

#### 2005 Hospice Cap Overpayments by State

<table>
<thead>
<tr>
<th>Item Number</th>
<th>State Code</th>
<th>State</th>
<th>Total Providers</th>
<th>Providers With O/P</th>
<th>%</th>
<th>O/P Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>Alabama</td>
<td>90</td>
<td>42</td>
<td>47%</td>
<td>$36,805,206.00</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>Arizona</td>
<td>5</td>
<td>4</td>
<td>80%</td>
<td>$11,546,295.00</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>Arkansas</td>
<td>19</td>
<td>2</td>
<td>11%</td>
<td>$441,356.00</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>California</td>
<td>10</td>
<td>0</td>
<td>N/A</td>
<td>$0.00</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td>Colorado</td>
<td>1</td>
<td>0</td>
<td>N/A</td>
<td>$0.00</td>
</tr>
<tr>
<td>6</td>
<td>8</td>
<td>Delaware</td>
<td>1</td>
<td>0</td>
<td>N/A</td>
<td>$0.00</td>
</tr>
<tr>
<td>7</td>
<td>10</td>
<td>Florida</td>
<td>35</td>
<td>3</td>
<td>8%</td>
<td>$1,346,356.00</td>
</tr>
<tr>
<td>8</td>
<td>11</td>
<td>Georgia</td>
<td>72</td>
<td>10</td>
<td>14%</td>
<td>$7,500,228.00</td>
</tr>
<tr>
<td>9</td>
<td>14</td>
<td>Illinois</td>
<td>51</td>
<td>3</td>
<td>6%</td>
<td>$2,337,608.00</td>
</tr>
<tr>
<td>10</td>
<td>15</td>
<td>Indiana</td>
<td>42</td>
<td>7</td>
<td>17%</td>
<td>$2,319,848.00</td>
</tr>
<tr>
<td>11</td>
<td>16</td>
<td>Iowa</td>
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<td>N/A</td>
<td>$0.00</td>
</tr>
<tr>
<td>12</td>
<td>17</td>
<td>Kansas</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>$1,086,508.00</td>
</tr>
<tr>
<td>13</td>
<td>18</td>
<td>Kentucky</td>
<td>18</td>
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<td>N/A</td>
<td>$0.00</td>
</tr>
<tr>
<td>14</td>
<td>19</td>
<td>Louisiana</td>
<td>64</td>
<td>3</td>
<td>5%</td>
<td>$1,323,543.00</td>
</tr>
<tr>
<td>15</td>
<td>22</td>
<td>Massachusetts</td>
<td>6</td>
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<td>N/A</td>
<td>$0.00</td>
</tr>
<tr>
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<td>Michigan</td>
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<td>0</td>
<td>N/A</td>
<td>$0.00</td>
</tr>
<tr>
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<td>Minnesota</td>
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<td>0</td>
<td>N/A</td>
<td>$0.00</td>
</tr>
<tr>
<td>18</td>
<td>25</td>
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FINDING THE KEYS TO THE PROBLEM OF AGING DRIVERS

Genevieve Essig*

[ABSTRACT: Making decisions related to whether an aging person should continue to drive is difficult but vitally important for not only aging individuals, but also their families who care about and for them, the policy makers who regulate them, and the wider community who share the roads with them. The time when it is no longer safe for an individual to be driving a car must be identified properly and the appropriate actions then taken. This paper analyzes a sample of the various approaches available for doing so, focusing on how each addresses the psychological and practical interests of not only the drivers but also their caretakers, while remaining cognizant of the political and administrative boundaries within which policy makers must work and the critical importance of protecting public safety to the greatest degree possible. The paper suggests that, while many of the discussed approaches do or could play an important role in the solution, it is ultimately government, through its administrative agencies charged with responsibility for public safety on the roads, which must be the gatekeeper for ensuring that unsafe older drivers – along with all unsafe drivers – stay off the roads.]

I. INTRODUCTION .......................................................... 28

II. BACKGROUND .............................................................. 30

A. The Problem, Statistically Speaking ............................... 30
B. Characteristics of Older Drivers that Cause Concern .......... 32
C. Framework and Methods for Evaluating Potential Approaches to the Problem ................................................................. 35

III. ANALYSIS ................................................................. 35

A. The Interests of the Older Driver ........................................ 35
B. The Interests of Caregivers of Older Drivers ....................... 37
C. Locus 1: The Individual Driver ........................................... 39

* Genevieve Essig is the second place winner of the 2008 NAELA Student Journal Writing Competition, and will graduate from The University of Virginia School of Law in 2009. She would like to extend a note of gratitude to Professor White of the University of Virginia School of Law for his help in reviewing her paper.
I. INTRODUCTION

According to major car manufacturers such as Chevrolet, after baseball, hotdogs, and apple pie, there is nothing more American than driving a car.\(^1\) Though marketing teams have a penchant for embellishing reality, Chevrolet may not be so far out on a limb of the symbolism tree in this case: the US is one of the most mobile nations in the world, with more than four trillion miles of passenger travel recorded annually.\(^2\) Certainly, since its invention, the car has captured the fascination of the American public, symbolizing freedom, mobility, and independence. Young Americans look forward to their sixteenth birthdays as a gateway to adulthood; adults look forward to car ownership as a point of arrival on the world scene.

For older Americans, a significant (and quickly growing) portion of the population,\(^3\) one’s relationship with the car takes on yet another dimension. For many, driving is a link to society at a time of life when other ties such as employment and long-time friends have fallen away, and the sense of independence it provides assumes even more significance in a setting where one may fear dependence the most. Driving can symbolize membership in the community of useful humans, banishment from which feels like the equivalent of a death sentence.\(^4\) This sentiment has been


demonstrated in a vast array of psychological and sociological studies and surveys, though the conclusions are perhaps stated with a less dramatic choice of words.\(^5\)

Hanging up the keys may also mean practical difficulties, as all age groups have seen an increased dependence on the car as a primary source of transportation.\(^6\) One needs a reliable and convenient way to get to doctor’s appointments and to obtain essential items, for example. When one is unable to drive, the pressing question of how these basic needs will be met arises, particularly in places where few alternatives to driving exist.

Thus, on the very surface of it, making decisions related to whether an older person should continue to drive is difficult. As thorny as it may be, however, it must be faced. It is vitally important for all concerned: not only aging individuals, but also their families who care about and for them, the policy makers who must regulate them, and the wider community who share the roads with them; for everyone’s physical and mental abilities wane once enough time goes by, albeit at different rates and in different ways, and, for many – who might be called “the lucky ones,” considering the alternative – there will come a time when it is no longer safe to be driving a car.\(^7\) It is in the interest of all to ensure that that time is identified properly (not too early and not too late) and that the appropriate actions are then taken.

There is growing consensus that this issue is not being addressed adequately, and that elderly drivers who are no longer fit to drive remain on the roads, posing a danger to themselves and to society. This paper analyzes a sample of the various approaches which have been applied or suggested toward a solution, using a framework which focuses on how each approach addresses the psychological and practical interests of not only aging drivers but also their caretakers (who often take on a principal’s care on top of existing responsibilities), while remaining cognizant of the political and administrative boundaries within which policy makers must work and the critical importance of protecting public safety to the greatest degree possible.

The paper also makes recommendations toward a solution, suggesting that, while many of the discussed approaches do or could play a role in the solution, it is ultimately the government, through its administrative agencies charged with responsibility for public safety on the roads, which must be the gatekeeper for ensuring that unsafe older drivers – along with all unsafe drivers – stay off the roads.

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7. See id.
II. BACKGROUND

A. The Problem, Statistically Speaking

Once in a while, the public is stunned by news of a tragic accident involving an elderly driver who, the public usually decides, probably “should not have been driving in the first place.” For example, in 1998, a 15-year-old was struck by a 96-year-old driver, who, the media took care to emphasize, had apparently not taken a road test since he received his driver’s license in 1918.8 In 2003, an 86-year-old hit the gas instead of the brake during a fender-bender and ended up roaring through an outdoor market, killing ten people and injuring more than fifty others.9

For years, concerned scholars have cited certain statistics to argue that elderly drivers pose (an increasing) risk to their own and to the public’s safety. A summary is as follows:

**Older Americans comprise a significant portion of the population:** In 2006, 12% of the total US population (37 million, 1 out of 8 people) were 65 or older.10

**The number of older Americans is increasing, quickly:** The number of Americans aged 45-64, who will reach 65 over the next two decades, increased by 40% during the past decade. The 65 and over population, which was 35 million in 2000, will increase to 40 million by 2010 (a 15% increase) and then to 55 million by 2020 (a 36% increase for that decade).11 In fact, older adults are the fastest-growing segment of the U.S. population.12

**The number of extremely old Americans is increasing quickly as well:** The 85+ population is projected to increase from 4.2 million in 2000 to 6.1 million in 2010 (a 40% increase) and then to 7.3 million in 2020 (a 44% increase for that decade).13

**A large number of older Americans are licensed drivers and their percentage of all licensed drivers appears to be increasing:** In 2005, there were 29 million licensed drivers over 65 (a 17% increase from 1995, whereas the total number of licensed drivers increased by only 14%).14 Older drivers comprised 15% of all licensed drivers in 2005, compared with 14% in 1995.15 In addition, future generations of older drivers

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15. Traffic Safety Facts, *supra* note 3. See also Vasiliki L. Tripodis, Note, *Licensing Policies for Older Drivers: Balancing Public Safety with Individual Mobility*, 38 B.C.L. Rev. 1051 at 1055 (1997) (noting that research indicates that older drivers have increased in number and in proportion of the total driving population); GAO, *supra* note 3 at 1 (stressing that “older driver safety issues will become increasingly significant in the future because older adults represent the fastest-growing...
are expected to drive more miles per year and at older ages compared with the current older-driver cohort.\footnote{16} On the basis of miles traveled, older drivers are more likely to be involved in a fatal crash. The GAO has reported that drivers aged 65 to 74 are more likely to be involved in a fatal crash than all but the youngest drivers (aged 16 to 24), and that drivers aged 75 and older are more likely than drivers in all other age groups to be involved in a fatal crash.\footnote{17} In 2006, older individuals accounted for 8% of all the people injured in traffic crashes during the year and made up 14% of all traffic fatalities.\footnote{18} Some studies show that one of the most important factors affecting a person’s risk of injury in a car crash is the age of the person (older drivers are more likely to sustain severe injuries in crashes).\footnote{19}

These statistics resist explanation by common risk factors such as night-time driving and intoxication: Most traffic fatalities involving older drivers in 2006 occurred during the daytime (81%).\footnote{20} Older drivers involved in fatal crashes in 2006 had the lowest proportion of intoxication of all adult drivers.\footnote{21}

Some particular driving mistakes appear to be more prevalent in the older age group: In 25% of two-vehicle fatal crashes involving an older driver and a younger driver in 2006, the older driver was turning left (failure to yield). This rate is 5 times greater than that of younger drivers.\footnote{22} These statistics seem to indicate that a threat to public safety exists with regard to older drivers. Older drivers are a significant and growing part of the driving population and are involved in a significant number of serious accidents. Though it may be pointed out that, when viewed in terms of pure number of accidents, the record of elderly drivers does not demand particular concern,\footnote{23} consideration of accidents per

\footnote{16} GAO, \textit{supra} note 3 at 9. 
\footnote{17} \textit{Id.}
\footnote{18} \textit{Traffic Safety Facts}, \textit{supra} note 3.
\footnote{19} \textit{Characteristics of Crash Injuries Among Young, Middle-aged, and Older Drivers}, National Highway Traffic Safety Administration, Nov. 2007.
\footnote{20} \textit{Traffic Safety Facts}, \textit{supra} note 3.
\footnote{21} \textit{Traffic Safety Facts}, \textit{supra} note 3. \textit{See also} Francine Russo, \textit{Driving Us Crazy}, \textit{TIME}, Aug 8, 2005. \url{http://www.time.com/time/generations/article/0,9171,1090887-1,00.html} (reporting that “drivers who are cognitively impaired – about 25% of the 65-and-older group – are 7.5 times as likely as nonimpaired drivers to be at fault in a crash, exceeding the rate for even drunk drivers”).
\footnote{22} \textit{Traffic Safety Facts}, \textit{supra} note 3. \textit{See also} GAO, \textit{supra} note 3 at 9 (warning, “Intersections pose a particular safety problem for older drivers. Navigating through intersections requires the ability to make rapid decisions, react quickly, and accurately judge speed and distance. As these abilities can diminish through aging, older drivers have more difficulties at intersections and are more likely to be involved in a fatal crash at these locations.”).
\footnote{23} \textit{See, e.g.,} Elizabeth K. Tulloch, \textit{What Shall we do About Miss Daisy’s Driving: Background for the Elder Law Attorney}, 27-OCT Colo. Law. 81 at 81 (noting that drivers in the youngest bracket (under 25) still have the highest crash rates). \textit{See also} Rosenfield, \textit{supra} note 6 at 453 (referencing a
mile driven (older drivers tend to drive fewer miles), and the seriousness of the accidents which do occur (older drivers are less likely to survive a crash than younger drivers are24), should25 In addition, this statistical increased risk per mile exists in spite of efforts older drivers as a group currently make to modify their driving habits to increase safety.26 Add in that the types of mistakes most likely to be made by older drivers in causing accidents, such as failure to yield,27 are of a different character than those likely to be made by younger drivers (speeding),28 and the case for the existence of a unique and serious problem is made.

B. Characteristics of Older Drivers that Cause Concern

The usual explanation for the statistics above and reason for the continuing concern with elder drivers is the age-correlated decline of certain physical capabilities likely to affect functional abilities critical to safe driving.29 The limitations that older people face in the context of driving generally relate to one or more of three categories: common physical problems of aging, cognitive loss such as that caused by Alzheimer’s, and side-effects of drug use.

Common physical problems of aging relating to driving include vision loss, diminished motor response, hearing loss, decreased physical strength and flexibility, NHTSA study indicating that only 4691 drivers over the age of 70 were involved in fatal accidents in 2000, compared to 17,525 drivers ages 21 to 34).

24. Ruth Welsh, Andrew Morris & Ahamedali Hassan, Crash Characteristics and Injury Outcomes for Older Passenger Car Occupants, 9 TRANS. RES. PART F: TRAFFIC PSYCHOL. & BEHAV. 322 (Sep. 2006). Comparing injury outcomes in passenger car crashes for belted occupants of different ages, the study found older occupants more likely to be killed or to sustain serious injury. See also David V. Lampman, Comment, Fun, Fun, Fun Til Sonny (or the Government) Takes the T-bird Away: Elder Americans and the Privilege to be Independent, 12 ALB. L.J. SCI. & TECH. 863 at 870 (2002) (citing evidence that as people age, physical changes such as bone loss and overall loss of strength make them more susceptible to being injured in an accident).


29. See, e.g., Tripodis, supra note 15, referencing Karlene Ball & Cynthia Owsley, Identifying Correlates of Accident Involvement for the Older Driver, 33 HUM. FACTORS 583 (1991) (indicating that visual, cognitive, and physical impairments elevate crash risk and impair on-road performance in older drivers).
The Problem of Aging Drivers

and slowing of risk-evaluation and decision-making abilities. Such physical declines may reduce one’s ability to perform movements required to control the vehicle. It has been posited that vision is the primary sense used in driving, possibly responsible for up to 95% of driving related inputs. Vision decline may reduce the ability to see other vehicles, traffic signals, signs, lane markings, and pedestrians.

Though there are a variety of ailments which commonly affect the eyes of older people, such as glaucoma, and older people may require more light to see properly, some argue that it is actually loss of visual attention and cognitive processing speed, rather than age, eye health, or medical diagnosis alone, that more reliably predicts whether older drivers are likely to get into an accident. In one study, drivers who had suffered a reduction in their “useful field of view” (defined with regard to measurements including how long it takes a driver to process information, how well drivers can divide attention, and how well drivers deal with distractions) were found to be sixteen times more likely to have had an accident in the previous five years.

It has been suggested that older drivers who suffer from cognitive loss, not just general age-related physical loss or visual acuity loss, present the most danger when behind the wheel. As alluded to above, cognitive functions important for safe driving include memory, attention, information processing, rapid decision making, and problem solving; illnesses causing dementia, which disproportionately affect older adults, impair these functions. Thus, cognitive decline may reduce the ability to recognize traffic conditions, remember destinations, and make appropriate decisions in operating the vehicle.

Dementia is an umbrella term for assorted disorders which, through damage to brain cells, cause irreversible cognitive decline in at least two of the following areas, to a degree severe enough to affect daily life: 1) memory, 2) ability to generate coherent speech or understand spoken or written language, 3) capacity to plan, make sound judgments and carry out complex tasks, and 4) ability to process and interpret visual

30. Tripodis, supra note 15 at 1056.
31. GAO, supra note 3 at 5.
33. GAO, supra note 3 at 5.
35. Rosenfield, supra note 6 at 455 (referencing studies suggesting that drivers over 60 need three times more light than they needed at age 20).
36. Rosenfield, supra note 6. See also Karlene Ball & George Rebok, Evaluating the Driving Ability of Older Adults, 13 J. OF APPLIED GERONTOLOGY 1, and Ball & Owsley, referenced supra note 29.
37. Kanoelani M. Kane, Comment, Driving into the Sunset: A Proposal for Mandatory Reporting to the DMV by Physicians Treating Unsafe Elderly Drivers, 25 U. HAW. L. REV. 59 at 65 (2002). See Lampman, supra note 24 at 870 (citing figures that indicate that around 15% of the population over 65 suffer from some kind of dementia and that cognitive impairments such as dementia increase the crash rate by fifty to sixty percent).
38. GAO, supra note 3 at 5.
information. Alzheimer’s is the most common form of dementia and it is estimated that currently more than 5 million Americans suffer from it; the Alzheimer’s Association has reported that the greatest risk factor for Alzheimer’s “by far” is age.

It is important to note that those suffering cognitive loss are likely to suffer, gradually or otherwise, diminishment not only in abilities directly critical to driving such as visual processing but also in more generalized cognition, which may affect one’s ability to judge whether or not one is too impaired to drive. In other words, in contrast to drivers who suffer from strictly physical ailments and presumably alter their driving habits accordingly, drivers with cognitive loss are likely to have less insight into their limitations and therefore less ability to self-regulate their driving.

One psychological literature review discovered, for example, that driving problems are the most often reported safety symptom by caregivers of people with dementia. Finally, medications taken for various physical and cognitive impairments can themselves cause limitations in one’s ability to drive, adding yet another wrinkle to the issue. The U.S. Department of Transportation National Highway Traffic Safety Administration (NHTSA) conducted an extensive literature review in 2006 which, inter alia, referenced research examining the effect on driving ability of various drugs commonly used among the elderly. The review begins with a national survey of U.S. non-institutionalized adults that reports that more than 90% of people 65 or older use at least one medication per week and that more than 40% of that population use five or more, while 12% use ten or more. The review identifies the medications most frequently used to be benzodiazepines, opioids, antidepressants, and antidiabetics; the prescription drugs most likely to be associated with car crashes by older drivers are

40. Id. The document notes that, in 2007, an estimated 5.1 million Americans had Alzheimer’s disease, including 4.9 million people age 65 and older. The number of people age 65 and older with Alzheimer’s is estimated to be 7.7 million in 2030 (over 50% increase from the current number).
41. See Nancy R. Barbas and Elizabeth A. Wilde, Competency Issues in Dementia: Medical Decision Making, Driving, and Independent Living, 14 J. OF GERIATRIC PSYCHIATRY AND NEUROLOGY 199, Win. 2001 (noting that patients with degenerative dementia experience gradual and progressive impairment of abilities which may affect competency in a variety of realms, including driving).
43. Tulloch, supra note 23 at 81.
44. David W. Coon & Nancy A. Pachana, Introduction to Special Section on Driving and Older Adults, 30 CLINICAL GERONTOLOGIST 1, 2006.
the psychological and practical interests of aging drivers as well as those of their caretakers, while remaining cognizant of the political and administrative boundaries within which policy makers must work and the critical importance of protecting public safety to the greatest degree possible. More specifically, the analytical method will include identifying central interests of older drivers with regard to driving, as well as burdens affecting their potential or actual caretakers (such as family members), then evaluating how each approach balances these interests with the public’s interest in road safety. Potential approaches run the gamut as to where the locus of responsibility should be placed for ensuring safety and include the following:

The individual driver. Ex: Relying on individuals to self-monitor and alter their driving habits based on their own recognition of changing abilities.

The driver’s informal caregivers. Ex: Imposing a legal duty on family members to ensure that their elderly principals do not injure others while driving.

The driver’s physician. Ex: Imposing a legal duty on physicians to report to the DMV patients who have been diagnosed with a condition that could lead to driving impairment.

Government. Ex: Refining driver fitness assessment procedures in licensing.

Relevant considerations include position to evaluate individual driving ability and means to implement and enforce policy and decisions.

III. ANALYSIS

A. The Interests of the Older Driver

The elder driver has psychological and practical interests in maintaining his driver’s license for as long as safely practicable. Elder law attorney Elizabeth Tulloch observes, “Loss of the driving privilege is more than an inconvenience to older drivers; it represents a significant and unacceptable psychological loss of independence and control over their own lives.”48 Others have characterized driving as reinforcing one’s identity as a functioning and socially capable adult.49 Seniors who can no longer drive may also worry that they have become a burden to family and friends since they must depend on them for transportation and other needs.50

48. Tulloch, supra note 23 at 80.
49. Tripodis, supra note 15 at 1052.
50. Lampman, supra note 24 at 872.
Some of the main values identified by researchers investigating older drivers and driving cessation include independence, freedom, mobility, control, autonomy, identity, and connectedness. These interests are likely more threatened when people live in rural areas, or even the suburbs, where access to the greater community revolves around transportation by car.51

In a study of older women and driving cessation, Bauer et al. found that remaining independent and mobile was important when deciding to stop driving,52 and that planning ahead for the driving cessation and making the decision voluntarily helped adjusting to the change,53 evidence that autonomy and self-determination are important to older drivers.

Another study, which investigated driving behavior of rural elders, found that participants who continued to drive despite advice to stop driving did so in part because they feared isolation if they could not drive.54 Another study found that participant drivers favored finding ways of extending safe driving through support to cessation.55 Others have found that driving cessation in older adults is associated with increased depression and feelings of social isolation,56 generating negative feelings, including anger, sorrow, and loneliness.57

On a policy level, the population of older citizens has also expressed an interest in preventing discrimination on the basis of age. Rules and decisions made purely on the basis of age are over-inclusive and are also stigmatic. As a matter of good policy, rules governing whether or not the state may deny or revoke a driver’s license, no light matter to individuals, should be narrowly tailored to identify the truly at-risk and to avoid penalizing individuals who should be allowed to retain the valuable privilege of driving. It has been pointed out, for example, that older drivers show the “greatest variability in performance of any age group,” so, despite the fact that the probability of declining performance increases as people age, there are enough individual differences to make the argument that no specific chronological age can be chosen as the “right” age at which to deny a license automatically.58

51. Rosenfield, supra note 6 at 480 (noting nearly 70% of the elderly population lives in suburban and rural areas).
52. Bauer et al., supra note 5. See also Monica S. Yassuda, Jennifer J. Wilson, & Otto von Mering, Driving Cessation: The Perspective of Senior Drivers, 23 EDUC. GERONTOLOGY 525 (Sep. 1997) (finding that driving was associated with feelings of independence and freedom).
53. Bauer et al., supra note 5.
54. Johnson, supra note 5.
55. Yassuda et al., supra note 52.
The Problem of Aging Drivers

Marshal Kapp describes society’s attitudes toward older persons as “schizophrenic,” arguing that in certain contexts society believes that older persons should receive equal treatment and protection against unfair discrimination, while in other contexts older persons are an identifiable group with unique characteristics warranting different treatment (ex: protective federal statutes such as the ADEA). Part of this difficulty may stem from the fact that aging is not a process which occurs in the same way, at the same rate, in all people. Linda Whitton asserts, that, while it is true that a certain percentage of the elderly population suffers from “chronic disability,” supporting the conclusions of ageist stereotypes, modern research has made it very clear that such disability is “by no means inevitable” – in fact the trend points in the opposite direction: defined as a group, the elderly are actually “more heterogeneous than homogeneous.” She concludes with self-tests that an attorney could use to evaluate his or her practices for unintentional ageism, including asking oneself whether one’s advice would be the same if the client were 30 years younger. Policymakers would do well to ask themselves the same when considering the “problem” of aging drivers.

B. The Interests of Caregivers of Older Drivers

Informal caregivers for the elderly, especially today, must endure a particularly complicated set of burdens, both psychological and practical, which should be taken into careful consideration when making policy decisions regarding the elderly. These caregivers are of very high value to the US’s already overtaxed welfare system and should be cultivated in view of the onslaught of elderly citizens predicted to occur over the coming years.

The driving issue is emotionally strenuous not only for the older individuals themselves, but also for those who care for them. The issue may arise because a caregiver has noticed his or her parent’s or spouse’s gradually changing abilities, but, for many, the issue is brought to immediate attention because of a sudden, stressful event, such as an accident. Psychologically, family members experience feelings

60. Linda S. Whitton, Re-examining Elder Law Practices: Reflections on Ageism, 12 Prob. & Prop. 8 (Jan./Feb.1998). She goes on, “This conclusion is based on well documented findings that the degree and rate of aging vary among individuals without regard to chronological age and that even within the same person, physiological and cognitive changes tend to occur at very different rates…older people actually become more diverse rather than more similar with advancing years.”
61. See Kevin Fleming, Jonathan Evans, and Darryl Chutka, Caregiver and Clinician Shortages in an Aging Nation, Mayo Clinic Symposium on Geriatrics, 78 Mayo Clin. Proc. 1026, 1031-32 (2003) [hereinafter Shortages]. The authors note, inter alia, that data suggests that informal care in the US, if it were paid at professional care rates, would be worth from $45-95 billion per year.
62. Johnson, supra note 57 at 206 (noting that the inability to drive may compound isolation and create additional stress for the elder as well as for his or her family and friends so individuals may continue to drive even when it is no longer safe to do so).
63. Jerald Winakur, What are We Going to do with Dad? 24 Health Affairs 1064 at 1071 (2005).
including worry, tension, discomfort, and responsibility with regard to the driving of a potentially impaired older family member.64 One research participant described her experience vividly: “Worried sick is the best way to put it. Worried that dad shouldn’t be driving because of his slow responses and eye trouble, worried he would hurt someone, worried that I was the one who had to talk to him about it, and worried about the outcome of what would be a difficult discussion.”65 Thus, part of the difficulty lies in the pain that the decision will cause to the older driver.66

Part of the difficulty may also lie in the uncertainty and discomfort which comes from the role reversal inherent in younger family members (such as adult children67). Nina Kohn characterizes the relationship between elders and their families as “dynamic, subject to change as elders’ physical and mental capacities change or their families’ perceptions of those capacities change.”68 Kohn also observes that difficult issues such as this one tend to exhibit low levels of communication, as a result of desire to avoid uncomfortable situations or to protect the principal from upsetting information.69 Others have also recognized the reluctance of families, who may be in a good position to know a driver’s ability, to intervene in this situation.70

On the practical side, informal caregivers such as family members typically are overwhelmed with duties from many sources, and obligations that come with the cessation of driving by an elder family member add to the list. A publication by the Mayo Clinic describes the typical caregiver for the dependent elderly as a female family member who is married and in her mid-40s, and who works full time while spending, on average 11 hours per week providing care (with 36% spending 21 hours per week).71 Many have responsibilities to children as well as to elderly parents, as

64. Johnson, supra note 57 at 211.
65. Id. at 212.
66. See also National Resource Center for Respite and Crisis Care Services Fact Sheet Number 40, http://www.archrespite.org/archfs40.htm (observing, “Most caregivers will acknowledge experiencing the emotions of grief when they witness the pain, sadness, and difficulties of others on a regular basis and when the painful experiences of others tap into their own reservoirs of unresolved grief and pain.”) (last accessed Jan. 10, 2008).
67. Nina A. Kohn, Elder Empowerment as a Strategy for Curbing the Hidden Abuses of Durable Powers of Attorney, 59 Rutgers L. Rev. 1 at 8 (2006) (noting that typically, informal caregivers for the elderly are either the spouse or adult child of the elderly individual and citing studies that find that the elderly exhibit a strong preference for close family members when choosing a surrogate decision maker).
68. Kohn, supra note 67 at 16. The author adds that a number of studies have shown that as older adults age, they enter into a “re-negotiation” of sorts within their families with regard to their independence.
69. Id. at 48.
70. Lampman, supra note 24, 872-73 (referencing studies that found that only one third of families facing the senior driving issue were willing to discuss it with the affected senior member).
71. Shortages, supra note 61 at 1031.
The Problem of Aging Drivers

well as employment responsibilities. In addition, cultural norms of filial responsibility are growing more attenuated as a result of increasingly individualistic values, falling birth rates, trends toward postponed childbearing and childlessness, and family fragmentation from divorce, remarriage, and geographic mobility, leaving fewer and fewer informal caregivers for the growing number of elderly adults.

Fleming et al. argue that, despite these facts, the health system, part of an economic system that actually “penalizes” the family caretaking role, fails to provide families with support necessary to fulfill care obligations.

Given this research, the most desirable solution to the problem of aging drivers would be one which takes into account both 1) the need to protect the independence, autonomy, identity, mobility, connectedness, and general psychological health of affected drivers through avoidance of unnecessary, over-inclusive age discrimination, and 2) the importance of avoiding the creation of excessive additional burdens for the diminishing pool of valuable informal caregivers, and which perhaps even creates new sources of support for these caregivers in carrying out their responsibilities.

C. Locus 1: The Individual Driver

At one end of the spectrum, one might imagine a regime in which the issues lay entirely within the discretion of older drivers. Individuals would be relied upon to self-monitor, adjusting driving behaviors as necessary to correlate with any significant changes in driving ability and hanging up the keys when the time comes. Individuals could receive assistance in making these decisions from driver improvement courses, such as those currently offered by the AARP, and any costs associated with driving, such as accidents, could be addressed by the courts through tort law or by the insurance industry through private adjustment.

Such an approach would certainly allow individuals to hold onto driving and the concomitant freedoms and psychological/logistical benefits as long as possible, and would free caregivers from the practical burdens that come with supporting a non-mobile principal. However, many caregivers would still carry psychological burdens such as pressure to monitor the principal’s self-monitoring to ensure that the principal does not become a danger to himself. In addition, there are problems with the approach when its performance is considered with regard to the third factor, the public’s interest in safe roads.

72. Id. at 1032. The authors further describe the opportunity costs and economic vulnerability this position entails. They note that more than 10% of employees are engaged in elder care and of those with heavy caregiving duties, 30% have had to give up work entirely.

73. Id. at 1032.

74. Id. at 1032.

75. See Brinig, supra note 56 at 414 (positing that a result of policies causing more people to lose their licenses is that “older persons are not causing accidents at a cost of additional burdens on families and facilities.”).

76. See AARP’s driver education web page, http://www.aarp.org/families/driver_safety/driver_ed/.
There is actually a good deal of evidence that, even now, many older drivers do in fact practice responsible self-monitoring, either ceasing to drive or adjusting in recognition of impairment, but the statistics described above continue to persist. For example, many decide not to drive at night; however, 2006 crash statistics indicate that a significant number of traffic fatalities still involved older drivers that year and that those fatalities occurred during the daytime. Additionally, these statistics hold fast, even though significant risk factors such as driving under the influence of alcohol and speeding are very low in the older age group.

There are three possible explanations for why self-monitoring has thus far not been able to minimize the accident rate for older drivers satisfactorily. The first is that cognitive loss, in addition to reducing ability to make appropriate decisions in operating the vehicle, etc., may also limit one’s ability to self-regulate, especially given its usually gradual nature. The second is that, given the strong need for what driving offers, i.e., independence and access to certain necessities, a sort of willful blindness may develop, causing an otherwise cognitively sound driver to overestimate his or her capabilities – short of that, individuals may simply not realize that they cannot evaluate their own abilities as well as they thought. Finally, recall that various medications commonly taken by older adults may affect abilities important to safe driving, and in some circumstances to a degree underestimated by patients. Therefore, it seems that self-monitoring would be insufficient with regard to protecting public safety.

In addition, the idea of relying on the tort system to supply post hoc remedies for ventures into the margin of error is morally unpalatable and unsatisfactory with regard to protecting public safety. Tort remedies would carry only questionable deterrent value in this context, as many of the relevant tortfeasors are likely to be incapable of responding to deterrents; i.e., attempting to apply due care incentives in a context in which insight into one’s own impairment could be compromised would likely be more

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77. See, e.g., Summer Ruechel & William C. Mann, Self-Regulation of Driving by Older Persons, 23 PHYSICAL & OCCUPATIONAL THERAPY IN GERIATRICS 91 (2005) (finding that many older drivers alter their driving habits in order to continue to drive safely).


79. Id.

80. GAO, supra note 3 at 5.

81. Tulloch, supra note 23 at 82.

82. See, e.g., William Jeanes, Driver’s Ed for Grownups, AARP, http://www.aarp.org/families/driver_safety/driver_safetyissues/drivers_ed_for_grownups.html (commenting on his attitude going into the AARP driver improvement course, inter alia, “Sooner or later, even well-schooled know-it-alls find out how much they don’t [know].”) (last accessed Jan. 10, 2008).

83. See Tripodis, supra note 15 at 1053 (referencing studies which show that many older drivers take medications which reduce their driving skills); see also Rosenfield, supra note 6 at 456 (referencing studies which indicate that many elderly drivers may not be aware of the adverse side effects posed by the medications they take).
problematic than beneficial. Essentially, the system would be allowing foreseeable, serious, and preventable harms to occur.

Tennessee takes this rather unregulated approach to older drivers, in effect allowing all people to drive, regardless of their risk factors, and revoking a license only after the driver is involved in a serious accident – drivers are licensed forever once they reach age sixty-five. The state suffers from the sixth highest accident rate of drivers over age sixty-four, so it seems that this approach allows many unsafe drivers to remain on the road.

**D. Locus 2: The Driver’s Informal Caregivers**

Based on a widely held assumption that family members tend to be in the best position to know when driving has become too difficult for an older driver, there have been some attempts to place culpability on individuals who are related to the impaired elderly driver, e.g., assignation of responsibility for tortious acts of elderly impaired drivers to their informal caregivers.

One of the most serious flaws with this idea is that it would likely tend to deter, rather than encourage, family involvement in care for their elder relatives. It might alternatively cause caregivers to be overly cautious and paternalistic toward their older family members, cramping the autonomy of the older driver by reducing her overall freedom through insistence on earlier driving retirement than necessary. Putting the interests of driver and caregiver in more strongly adverse positions by heightening the stakes would increase tension in the relationship. The caregiver would no longer be weighing two psychological burdens – the principal’s health, happiness, and freedom versus the caregiver’s guilty desire not to acquire the heavier burden of a dependent principal; she would be juggling two psychological burdens and a legal risk. The only reasonable positive that this approach could offer is that the threat of authoritative intervention, especially one that might affect more of the family (an award of any sort of damages against the family could be quite devastating), could give family members dealing with an obstinate older driver who really has reached the retirement point a bit more bargaining power.

There has been only been a very little bit of case law considering this idea, and it has not had much success. The argument is generally presented using the common law special relationship and public policy concepts of tort negligence. Using analogies to parental duty to control the conduct of their children for the reasonable protection of others (§ 316 of the *Restatement (Second) of Torts*) and cases in which parents have
been held liable for the negligent acts of their adult children, Pat Martin evaluates the idea in a law review article.  

In the cases considering a parent’s duty to protect another from imminent harm by an adult child, there is a duty to warn or control only when the parent has intimate knowledge of the child’s violent, criminal, or mentally disturbed tendencies; a duty would attach only if the parent could foresee the imminent harm to another and could control the adult child’s actions in the prevention of that harm. The Texas Court of Appeals, in Daniel v. Webb, rejected applying this theory of vicarious liability to the assumption of care by an adult child for his parent or grandparent, declining to establish duty for the granddaughter of a 92-year-old driver who was involved in a motor vehicle accident, reasoning that there was “no authority imposing a duty upon Webb to control her grandfather’s driving simply because she is his granddaughter.” 

Martin interprets the court’s holding as evidence of its reluctance to establish liability “in situations where family members have stepped forward to care for their relatives” because it “might discourage family involvement,” recognizing that such a standard would be essentially punitive. If the goal is to encourage participation of family members in the screening and monitoring of physical and mental conditions that may impair the ability to drive, it would be essential to avoid penalizing those who, in good faith, make a reasonable effort to control or prevent their elderly family members from hurting themselves or others. Martin suggests that, to alleviate this effect, the elements for establishing the proposed duty could be enabled by establishing a cooperative program of direct communication among all the persons who have knowledge of the functional abilities of the driver – the program would involve convincing a family member to assume a position of formal responsibility for monitoring the aging driver and mandating healthcare professionals to report a driver’s declining functional ability to that responsible family member. This proposal does not make the option of creating a duty for family members much more appealing. Beyond the concerns with this possibility addressed above, Martin’s proposal would involve a paternalistic circumvention of the individual driver’s right to participate (or to decline to participate) in the decision making process and the creation of the equivalent of a spy network of sorts which would have the potential to worsen the psychological impact of the situation on the individual and on the family. It also strays into contentious territory relating to the doctor-patient privilege (see below). 

Overall, it is evident that placing the burden in this locus is fraught with potential for conflict, psychological harm, over-deterrence, and judicial recalcitrance, given that it would compel courts to consider the intimidating ramifications of adult liability for

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88. Martin, supra note 86 at 269-88.
89. Martin, supra note 86 at 271-72.
91. Martin, supra note 86 at 273.
92. Id. at 276.
another adult and creating new special relationships, so it does not hold much promise.

E. Locus 3: The Driver’s Physician

Another, though controversial, approach involves imposing a duty on physicians to report to the DMV when a patient has a condition which could impair driving ability. Maine, Oregon, and Pennsylvania are states that have tried this option, coupling licensing standards with mandatory physician reporting of dementia or vision problems. Maine has a low number of accidents per older driver (0.0029%), and California’s rate of 0.024% is “well below the norm.”

At first gloss, the approach seems to perform well under this paper’s framework: it preserves individual interests in that it is tuned to the individual, rather than an age group, it moves the burden of the driving cessation decision from the elder person’s family to his physician, and it serves public safety in that it catches problem drivers earlier, between license renewals – the statistics are on its side as well. However, there are still some aspects of the approach that raise concern. For example, it endangers the individual’s autonomy interest, as it allows the physician to report over his head. It also puts the physician in a difficult position with regard to fundamental precepts of his profession.

Many have noted the physician’s unique position to identify and assess physical and mental conditions that could affect a person’s ability to drive safely. A physician not only specifically trains with the goal of becoming expert at recognizing, treating, and determining the implications of bodily impairments, so is arguably the most well-equipped to make an informed assessment of a patient’s ability to drive, but he or she also holds a special role in society – physicians are the one factor that most people, particularly the elderly, have in common. That is, most people have occasion to engage in one-on-one interactions with physicians, be it for routine examinations or for administration of treatment. In fact, some studies suggest that older drivers explicitly consider physician participation in license renewal testing to be appropriate.

The main snag, however, lies in something which contributes to the physician’s unique position: to provide the highest quality care, the physician requires patient disclosure of all information that could be important to diagnosis and treatment. A patient or client would be much less willing to discuss sensitive issues openly without the security of knowing that what he reveals will be protected from disclosure to third

93. Martin, supra note 86 at 288.
94. Brinig, supra note 56 at 416.
95. Id.
96. Kane, supra note 37 at 66, asserting that “physicians are the professionals most qualified to determine whether a person is mentally and physically incapable of driving.”
97. Tripodis, supra note 15 at 1082.
98. Sullivan, supra note 2 at 20.
parties – confidentiality is considered the foundation of the patient-physician relationship, just as it is “the hallmark of the client-lawyer relationship.” Medical confidentiality is not only important to physicians as an ethical mainstay of the practice of medicine. It is also law under various state statutes and federal legislation such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It is only reasonable, then, to have some reservations about a physician reporting approach, which would require physicians to tarry so close to clear lines drawn by both law and ethics.

An argument in favor of using physician reporting measures despite the tough position in which it puts physicians is that the public’s interest in reducing danger on the road from at-risk drivers is stronger than the interest physicians and patients have in confidentiality of certain kinds of health information. By virtue of their unique “gatekeeper” position, physicians have a duty not only to their individual patients but also to the public at large, when safety is at stake.

As far as the common law goes, courts do not seem to have a unified opinion about this position – some have found no duty to the general public, and others have found such a duty. In the context of psychotherapist communications, confidentiality may be overridden by a duty to warn when disclosure is essential to avert danger to a readily identifiable, foreseeable victim. Trying this standard on in the context of physician reporting of potentially unsafe drivers to the DMV, however, does not yield a very good fit. “The general motoring public” is hardly a “readily identifiable, foreseeable victim.” The court in *Schmidt v. Mahoney* worried that increasing physician exposure to liability for driving advice given to patients would make physicians become too cautious in their assessments, perhaps making overly restrictive recommendations not in their patients’ best interests.

The *Tarasoff* court, quoting the Principles of Medical Ethics of the American Medical Association (AMA) (1957), Section 9, notes that medical ethics identifies two instances in which physician-patient confidentiality may be suspended: “A physician may not reveal the confidence entrusted to him in the course of medical attendance... unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.” Therefore, when a law mandates physician disclosure, the dilemma is technically solved – proponents of the physician-reporting approach point out this fact in support of their argument. They also argue that the medical ethics community has softened to reality over time and now makes

100. Sullivan, supra note 2 at 20.
101. Model Rules of Prof’t Conduct R. 1.6 cmt.2.
102. Sullivan, supra note 2 at 20.
103. Sullivan, supra note 2 at 22.
105. Schmidt v. Mahoney, 659 N.W.2d 552 (Iowa 2003).
106. Tarasoff, supra note 104 at 441.
disclosure permissible when there are strong enough public policy reasons, and that confidentiality laws allow exceptions for public health and safety. 107

Regardless of whether the ethics and liability issues have been technically resolved, however, physicians will likely continue to guard the confidentiality of their relationships as much as possible, potentially leading to underreporting when reporting is not mandatory. 108 In other words, even if an ethics committee or a court would not find a doctor at fault for disclosing information about his clients with regard to driving, the doctor might still face reduced patient candor stemming from the fear of being reported to the DMV. AMA policies, while recognizing that the safety of older drivers is a public health concern, evidence this reluctance to breach the covenant as well, detailing many actions to be taken short of reporting to the DMV, reserving that option for when mandated by law. 109

In addition, mandatory reporting laws, as noted above, run the risk of compelling physicians to report more information than may be needed to protect the public in an effort to shield the physician from liability. 110

Thus, though this option appears to satisfy the prongs of the framework tolerably well, it remains unsatisfactory. The heart of the matter is that the burden it places on the shoulders of doctors, who already have their hands full with trying to make people well and are exposed to plenty of other legal vulnerability along the way, seems unfair because it requires doctors to take on a large part of the task of licensing people for a functional privilege, which already has an entire government department devoted to it, and at great potential cost to the integrity of their own profession. Also, the state, in considering the mandatory option, must navigate the politically troublesome matter of choosing between improving public safety and compromising of a basic tenet of an important profession. There must be a better way.

107. Kane, supra note 37, argues that Opinion 5.05 of the AMA Code “recognizes that overriding social considerations may legally and ethically permit a breach of confidentiality”; see also Sullivan, supra note 2 at 25 (noting that HIPAA permits a physician to disclose protected health information when public safety is at risk, that is, if disclosure is “necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public” and the disclosure is made to “a person or persons reasonably able to prevent or lessen the threat”). Sullivan also reports that several states have similar laws that allow the disclosure of confidential medical information to the DMV, many offering immunity for the physician from civil or criminal liability.

108. Kane, supra note 37 at 72, citing Shawn C. Marshall & Nathalie Gilbert, Saskatchewan Physicians’ Attitudes and Knowledge Regarding Assessment of Medical Fitness to Drive, 160 CAN. MED. ASSOC. J. 1701-02, 03 (1999) (finding, in a survey of 523 physicians, that more than 42% indicated that they were “hesitant to report or noncommittal to reporting” unfit drivers, and that, “though [the physicians] thought public safety should prevail over interests of individual driver and that physicians were the most qualified professionals to determine a person’s fitness to drive, they prioritized concern that disclosure would damage the physician-patient relationship.”).


110. Kane, supra note 37.
F. Locus 4: Government Licensing and Related Tools

Some elderly persons independently decide to stop driving; some will stop driving upon being told by the physician that they should do so; others refuse to stop driving until presented with test results; and still others deny any impairment no matter what they are told and, ultimately, the only solution is license revocation.\textsuperscript{111}

As suggested by the quote above, when push comes to shove, who should and should not be on the road is up to the DMV; through its power of licensing drivers, it plays a critical role in executing the duty of the state to promote the well being of the public, which includes safety on the roads. It is remarked above that one factor that all people have in common is the physician; it is also true that a factor that all drivers have in common is the DMV. Therein lies a key opportunity for improving driver safety in a fair, effective way. The use of a non-discriminatory licensing process well-tailored to functional ability would address the individual driver’s interest in driving as long as safely possible; movement of the decision-making burden from caregivers to the agency specifically charged with the task would address the interest of caregivers in reduced burdens; and the resultant decrease of unsafe drivers on the roads would address the interest of the public in safer roads.

Rather than being a federal endeavor, licensing is currently left essentially to the states, under the police power, which gives states power to enact and enforce laws in order to protect the health, safety, and welfare of its citizens.\textsuperscript{112} The licensing regimes vary widely across the states, with most following the Uniform Vehicle Code, which prohibits unsafe drivers generally and gives state DMVs discretion to require additional testing as reasonably necessary to determine fitness to drive.\textsuperscript{113} There are two main issues relevant to fitness testing – 1) when testing is required and 2) what kind of testing is required.

States have tried a variety of approaches with regard to the question of when people should receive fitness testing, including age thresholds and referral by family and neighbors. Age thresholds – in which procedures for licensing and license renewal become more restrictive (ex: renewal cycles start to shrink) once an individual has reached a certain age – can run afoul of anti-discrimination interests. In the context of state action, such transgressions can be undesirable on many levels: they may lean too far towards the public safety prong at the cost of the individual interest and caregiver interest prongs by being over-inclusive,\textsuperscript{114} they can be against the law or settled policy,\textsuperscript{115} and they can be politically risky – lobbying groups for older Americans such as the AARP traditionally oppose as discriminatory any legislation

\begin{itemize}
  \item \textsuperscript{111} Megan C. Harney & Piero G. Antuono, \textit{Driving and Dementia: A Physician’s Perspective}, 6 \textit{Marq. Elder’s Advisor} 135 (2004).
  \item \textsuperscript{112} Rosenfield, \textit{supra} note 6 at 456.
  \item \textsuperscript{113} Tripodis, \textit{supra} note 15 at 1059.
  \item \textsuperscript{114} GAO, \textit{supra} note 3, points out that NHTSA “recognizes that only a fraction of older drivers are at increased risk of being involved in an accident.”
  \item \textsuperscript{115} Tripodis, \textit{supra} note 15 at 1061, noted, for example, that Massachusetts’ DMV specifically avoids age-based testing because it believes it is discriminatory.
\end{itemize}
that targets older individuals. With more than 35 million members encompassing nearly 25% of the voting masses, the AARP wields considerable political influence capable of completely shutting down proposed laws affecting the interests of their constituents; therefore, state legislators are loathe to cross it. Nevertheless, more than half of the states have implemented licensing requirements for older drivers that are more stringent than requirements for younger drivers. Requirements generally involve more frequent renewals (16 states), mandatory vision screening (10 states), in-person renewals (5 states), and mandatory road tests (2 states) for older drivers.

In addition, all states accept physician reports and third-party referrals of concerns about drivers (ex: note of concern from a family member) as a trigger for testing by the DMV. Such referrals, if the parameters are constructed carefully so as to prevent malicious use, hold promise from the public safety standpoint because it allows the state to take a closer look at drivers who may be impaired between renewal periods. From the caregiver’s standpoint, it provides some relief in that, if the driver in question is deaf to the advice of his family or family circumstances make it impossible to have a constructive conversation about the problem, and other less restrictive alternatives such as advice from respected community members such as priests or doctors have been unsuccessful, there is a way to draw input from the ultimate authority for monitoring and enforcing the driving privilege. With regard to the individual’s interests, the testing decision will not have been made purely on the basis of categorical age and can be reserved as a last resort after less restrictive alternatives. An important caveat is that family members are less willing to make reports to the DMV if the older person may discover who contacted the DMV. Also, knowing that a family member is the reason for action behind one’s back could be psychologically damaging to the individual’s sense of autonomy as well as damaging to the family dynamic, so anonymity would be key.

Once an individual is to be tested, there are a variety of methods (the “what kind of testing” question) for assessing the individual’s driving fitness. In order to promote the interests described in this paper, it would be desirable for the DMV to use only those tools which are most effective in identifying at-risk drivers. Ten states require older drivers to undergo vision assessments as part of the license renewal process, generally testing for visual acuity or sharpness of vision. Several states require in-person, as opposed to mail-in, renewal after a certain point. Two states, New

117. Kane, supra note 37 at 80; Brinig, supra note 56 at 426 (reporting that ratio of AARP lobbyists-per-state legislator significantly affected the likelihood that older drivers would be licensed).
118. GAO, supra note 3.
119. GAO, supra note 3 at 3.
120. GAO, supra note 3 at 3 (noting, “A recent survey of state licensing agencies found that nearly three-fourths of all referrals came from law enforcement officials (37 percent) and physicians or other medical professionals (35 percent). About 13 percent of all referrals came from drivers’ families or friends, and 15 percent came from crash and violation record checks, courts, self-reports, and other sources.”).
121. Tulloch, supra note 23 at 82.
Hampshire and Illinois, require older drivers to pass road examinations upon reaching 75 years and at all subsequent renewals. Thirty-five states and D.C. employ Medical Advisory Boards (MAB), consisting of practicing health care professionals, to assist licensing agencies in evaluating people with medical conditions or functional limitations that may affect their ability to drive.\textsuperscript{122}

However, it has been pointed out that assessment of driver fitness is not currently comprehensive because cognitive and physical functions are generally not evaluated to the same extent as visual functions\textsuperscript{123} – as noted above, though vision is a primary sense used in driving,\textsuperscript{124} visual attention and cognitive processing speed more reliably predicts of whether older drivers are likely to have an accident.\textsuperscript{125} The empirical effectiveness (reliability in identifying at-risk drivers) of current state assessment practices is largely unknown.\textsuperscript{126}

Failure of driving assessment often results in revocation, but many states have accommodated older drivers through methods such as provisional licensing. Restrictions imposed by provisional licenses vary, from daylight-only driving to no highway driving, driving for business or employment only, driving only with power steering, or driving using special controls or equipment.\textsuperscript{127} However, provisional licensing may be of doubtful use to protecting public safety. For example, drivers with restricted licenses may have a higher crash rate than those without restrictions.\textsuperscript{128} In addition, restricted licenses may sometimes be granted for wrong reason, such as pity.\textsuperscript{129}

All states also offer driver improvement courses,\textsuperscript{130} as does AARP,\textsuperscript{131} which are frequently incentivized by means of state-mandated insurance discounts.\textsuperscript{132}

\textsuperscript{122} GAO, \textit{supra} note 3 at 3.
\textsuperscript{123} Id.
\textsuperscript{124} Tripodis, \textit{supra} note 15 at 1060 (citing studies indicating that mandatory vision tests and road knowledge tests contributed to reduced rate of fatal crashes involving older drivers in study).
\textsuperscript{125} Tripodis, \textit{supra} note 15 at 1056, citing various studies.
\textsuperscript{126} GAO, \textit{supra} note 3 at 3 (referencing research that indicates that “in-person license renewal is associated with lower accident rates for older drivers…but vision screening, road tests, and more frequent license renewal cycles are not always associated with lower older driver fatality rates…Because there is insufficient evidence on the validity and reliability of driver fitness assessments, states may have difficulty discerning which assessments to implement.”). \textit{See also} Brinig, \textit{supra} note 56, 420-22.
\textsuperscript{127} Brinig, \textit{supra} note 56 at 411.
\textsuperscript{128} Id.
\textsuperscript{129} Tripodis, \textit{supra} note 15 at 1085
\textsuperscript{130} Tripodis, \textit{supra} note 15 at 1062
\textsuperscript{131} AARP History, \textit{supra} note 28, reports that its driver improvement course, 55 ALIVE, begun in 1979, teaches defensive driving techniques and provides information on age-related cognitive and physical changes that affect driving and how to adjust driving in response to those changes. Each year over 700,000 people complete the AARP Driver Safety Program nationwide, and the program has graduated over 9 million persons since its inception.
Effectiveness research has indicated a correlation between the courses and reduction in traffic violations, but a relationship has not been established with a reduction in actual crashes.  

**IV. RECOMMENDATIONS AND CONCLUSIONS**

While the discussed approaches, or aspects of them, could serve an important role in solving the problem of aging drivers, the state and its administrative agencies responsible for public safety on the roads must be the ultimate gatekeepers in terms of ensuring that unsafe older drivers – and all unsafe drivers – stay off the roads. Though the aged are not a protected class in the constitutional sense under the Equal Protection Clause, and it would not take too much to find a way for age-based licensing restrictions to satisfy rational basis review, the state should, from a public policy perspective, try to achieve its “legitimate state interest” in safe roads without unnecessarily trammeling (in the ordinary, rather than legal, sense) the interests of those others who are in fact safe drivers or the interests of those who care for them (or other things of value to society, such as the effective practice of medicine). This paper suggests the following:

**A. Better research on driver safety initiatives.**

The patchwork nature of the licensing tools and strategies used by various states, and the almost across-the-board uncertainty as to their empirical validity is not conducive to building a fair and effective solution which will maximize all the relevant interests. Recall that driving cessation is made easier by stable expectations. Two points, then: 1) There is a need for focused research identifying the most dangerous problems associated with aging drivers and the most effective and cost-effective tools for keeping the risks from reaching the road; and 2) There is a need for a more uniform and effective licensing system approach across states. Short of a federal mandate, both points could be addressed by better knowledge sharing with regard to older driver safety initiatives among the states, as suggested by the GAO.

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132. Tripodis, *supra* note 15 at 1062 (reporting that 34 states and the District of Columbia have laws requiring auto insurers to offer insurance premium discounts to older drivers who complete a driver improvement course).


135. Bauer et al., *supra* note 5.

136. See generally Rosenfield, *supra* note 6, for a discussion of the barriers to federal regulation of driver licensing.

137. GAO, *supra* note 3, (noting that officials interviewed by the GAO indicated that they believed states could benefit from knowledge of other states’ initiatives, and that the GAO recommends that the Secretary of Transportation direct the FHWA and NHTSA Administrators to implement a mechanism to allow states to share information on older driver safety practices.).
B. Improvement of existing licensing tools and procedures.

In order to reach the optimal public policy result, the procedures and tests used in licensing should be as accurate and appropriate as possible. Treating licensing policy almost as though the aged were a protected class (in terms of narrow tailoring) would meet the needs of the individual driver who does not wish to encounter over-inclusive measures, the needs of the individuals’ caregivers who do not wish to encounter either over-inclusive measures (which would unnecessarily increase the dependence of their principals) or under-inclusive measures (which would place the burden to regulate the driving of their principals more on their shoulders), and the needs of the other members of the motoring public who do not want under-inclusive measures (which would let more unsafe drivers onto the roads).

By this reasoning, purely age-based rules are not finely tuned enough, and maybe medical-condition-based rules are not finely tuned enough – it is functional loss, not underlying characteristics, that relates to driving ability. Thus, we must reevaluate the tests themselves. Current testing tends to focus on visual acuity, medical evaluations, and sometimes road tests. It has been argued that focusing mostly on visual acuity (ability to resolve small details in the distance) does not catch perceptual difficulties, which lets dementia go undetected; also, road tests do not really test how drivers will respond to emergencies on the road, which involve reaction time and motor skills. Testing should go beyond these measures, testing field of view (which necessarily involves the type of cognitive processing used in driving), physical reflexes (fast reactions are relevant to avoiding accidents when the unexpected occurs), and knowledge of vehicle operation and road rules.

Already, technology is emerging that will allow better functional ability testing. For example, some researchers are working on driving simulators which can identify drivers with cognitive, motor, and visual processing difficulties likely to cause accidents. Ball and Owsley, who have done a great deal of work in the area of older drivers (ex: developing methods of field of view testing which measure how long it takes a driver to process information, how well drivers can divide attention, and how well drivers deal with distractions), may be developing a short version of their testing procedures amenable to budgetary and time constraints at the DMV. At least some states are starting to experiment with field of view testing. The GAO, in its recent study of state approaches to older driver safety, has acknowledged the promise of driving simulators currently being studied “as a means of testing driving ability and

138. Martin, supra note 86 at 268.
139. Tripodis, supra note 15 at 1082.
140. Geri Adler, Susan Rottunda, & Kathy Christensen, Driving SAFE: Development of a Knowledge Test for Drivers with Dementia. 5 INT’L J. OF SOC. RES. AND PRAC. 213 (May 2006) (finding that direct assessment of driving knowledge is important to driving assessment).
141. Tripodis, supra note 15 at 1081.
142. Id. at 1081 (reporting that Hawaii, New York, and South Carolina use 20/40 acuity and 140-degree field of vision standards for licensing); Brinig, supra note 56 at 414 (reporting that California, Maryland, and Pennsylvania are testing Owsley-Ball simulators).
retraining drivers in a manner that is more reliable and consistent than on-road testing,” commenting that “virtual reality driving simulation is a potentially viable means of testing that could more accurately identify cognitive and motor impairments than could on-road tests that are comparatively less safe and more subjective.”

The procedural improvements accompanying these testing changes should avoid explicit age-based cutoffs as much as possible. If the tests are effective enough, they may reduce administrative costs currently associated with other methods of evaluation, which would open the door to more frequent and thorough testing of all drivers. Therefore, it might be possible to have a regime in which one is tested by means of simulator (covering physical and cognitive abilities), a road rules test (for necessary knowledge), and a short driving test (covering how to operate a car) when one first receives his license, then just tested on the simulator for renewals at reasonably short fixed periods (perhaps four or five years).

As for the need for between-renewal options when people get older and the risk for functional decline grows, the process could be supplemented by provision for the following triggers of between-renewal testing: anonymous reporting by family and referral by the police for patterns of accidents or traffic violations. People could also be encouraged to undergo more frequent testing based on incentives in the form of insurance discounts, much like the system which is already in place in many states in the context of the driver improvement courses offered by DMVs and the AARP (see below).

C. Improvement of and increased participation in older driver education courses

Many older drivers have not had any additional driver’s education since they began driving, which, for some, is a very, very long time, during which period much has changed aside from their bodily abilities. Improving their skills and updating their knowledge may help them become safer drivers and remain so longer. As the courses exist currently, however, usually consisting of an in-class session of several hours, their actual effectiveness in reducing accidents is unproven. By way of improvement, it has been suggested that training combine classroom, simulation, and in-car instruction so that participants have a chance to practice and internalize what they are learning. There is also the possibility, acknowledged by the GAO, of

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143. GAO, supra note 3 at 34.
145. The AARP website presents some whimsical reflections by older drivers; e.g., http://www.aarp.org/families/driver_safety/driver_safetyissues/a2004-06-22-thenandnow.html.
146. See AARP History, supra note 28.
147. Tripodis, supra note 15 at 1086.
148. GAO, supra note 3 at 34, reports: “A computer-based training tool is being developed to help older drivers improve the speed with which they process visual information. This tool is a self-administered interactive variation of validated training techniques that have been shown to improve visual processing speed. The tool is being designed as a cost-effective mechanism that can be
utilizing driving simulators, such as those based on the Owsley research, as training tools. Thus these courses can be transformed from mere educational tools to actual training tools.

These driver improvement courses hold a lot of promise as a tool for improving older driver safety and autonomy, but, for them to work, people must attend. It is possible that the lack of demonstrable effect in crash reduction state-wide is partly attributable to participation not being high enough. One way to improve participation is to provide incentives for that participation, such as insurance discounts and/or reduction of infraction points. Currently, thirty-six states and DC have passed laws requiring auto insurers to offer insurance premium discounts to older drivers who complete a driver improvement course. Minnesota offers a particularly high incentive, requiring insurance companies to give a mandatory 10% discount to those who complete the course; it has the highest participation rate in the nation. The AARP estimated that, in 2002, the insurance savings by participants in its course was at least $45.5 million.

D. Encouragement of road and vehicle improvements

Another way of improving driving safety and longevity for older drivers includes making improvements to roads and signs to make them more sensitive to the special needs of aging drivers. The added bonus of such an effort is that the improvements will very likely benefit younger drivers as well, by generally increasing navigability. As noted by the GAO, the Federal Highway Administration (FHWA) has put together recommendations for practices that will make roadways easier for older drivers to navigate. Sample recommendations include using larger letters on signs and positive offset left-turn lanes. Other suggestions include widening pavement markings and placing reflective markers closer together.

There is also a growing trend in the automobile industry to design cars with features tuned to the needs of the elderly (ex: bigger buttons and mirrors to reduce glare) – such efforts should be encouraged. Elinor Ginzler, an older-driver expert at AARP, praises such innovations as in the Lexus LS460, which “parks itself” and the

broadly implemented, at social service organizations, for example, and made accessible to older drivers.”

149. Hoff, supra note 144 at 328.
150. AARP History, supra note 28.
151. Hoff, supra note 144 at 325.
152. AARP History, supra note 28.
153. See, e.g., Jennifer Oxley, Brian Fildes, & Bruce Corben, Intersection Design for Older Drivers. 9 Transp. Res. Part F: Traffic Psychol. and Behav., 335 (Sep 2006) (finding that “road design plays a major role in road safety and is likely to contribute to the driving difficulties of the elderly because of the general lack of consideration of the needs of older road users…intersections, in particular, stand out as a major problem for older road users”).
154. Id. at 15.
155. Tripodis, supra note 15 at 1064.
Volvo S80, which has an automatic collision-warning system.\textsuperscript{156} Prof. Ryuta Kawashima, who helped develop Nintendo’s “Brain Age” games, is working with Toyota to develop cars that help seniors drive safely.\textsuperscript{157} These cars may have technologies that can determine a driver’s driving patterns and curb dangerous activity (ex: slowing the car if it senses the driver is hitting the gas pedal for no reason), as well as navigation systems and temperature controls that help drivers stay alert.

\textit{E. Investment in stronger public and shared transportation systems.}

One of the main practical reasons people give for their reluctance to give up driving is that they lack suitable transportation alternatives.\textsuperscript{158} Even where public transportation exists, it may require skills which older individuals may be less amenable to learning.\textsuperscript{159} To serve truly as an adequate alternative to driving, the transportation must be safe, rapid, convenient and economical. Taxis and “Dial-A-Ride” type programs have been criticized for being too expensive. In some cases, however, successful alternatives have developed, such as the Portland-based “Independent Transportation Network,” which provides 24-hour service and reduced fare opportunities for seniors who share a ride or trade in their car for credit, costing in the end half as much as a taxi service.\textsuperscript{160} To put things in proper perspective, however, with regard to cost, the National Aging Institute offers the following advice:

“If you do not have these services where you live, look into taking taxis. Too expensive, you think? Well, think about this: the AAA now estimates that the average cost of owning and running a car is about $6,420 a year. So, by giving up your car, you might have as much as $123 a week to use for taxis, buses, or to buy gas for friends and relatives who can drive you!”\textsuperscript{161}

One final suggestion is possibly creating financial incentives for family caretakers in the form of a rebate on motor-vehicle-licensing fees or a state-tax credit.\textsuperscript{162}

Thus, first and foremost, the primary tool of the state in this area, licensing, can be strengthened thorough procedural and technological improvements to the actual licensing process, supported by research into the most effective procedures for identifying impaired drivers and increased information transfer between states as to what works and what does not. By coupling these efforts with improvement and increased provision of older driver education courses, incentives for participating in them and for getting tested, encouragement of vehicle and road improvements,

\begin{footnotes}
\footnote{158. Yassuda et al., supra note 52.}
\footnote{159. Tulloch, supra note 23 at 81.}
\footnote{160. Lampman, supra note 24 at 876.}
\footnote{161. Age Page: Older Drivers, National Aging Institute, http://www.niapublications.org/agepages/drivers.asp.}
\footnote{162. Martin, supra note 86 at 279.}
\end{footnotes}
investment in stronger public and shared transportation systems, and other similar efforts, costs and burdens would be more fairly distributed between drivers, caregivers, private sources such as insurance carriers, and the state, and the country would be on its way toward a healthy relationship between driving and aging – which holds the keys to unlocking the store of benefits offered by a safe, happy, and mobile national community.
TAKING GREAT PAIN: THE ROLE OF PALLIATIVE CARE IN THE LEGAL
COMPETENCE ANALYSIS

Emily M. Demiray*

I. WHAT IS PAIN? ..........................................................................................................56

II. PAIN IN COURT: HOW PALLIATIVE MEASURES HAVE AFFECTED A TESTATOR’S
COMPETENCY.....................................................................................................59
A. Establishing Competence ..............................................................................60
B. Testators Found Incapacitated by Pain and Palliative Measures ..............61
C. Testators Found Competent Despite Pain and Palliative Measures ..........63

III. GUIDANCE FOR THE LAWYER .................................................................................65
A. Assessing Capacity: An Approach for the Lawyer in the Field .................65
B. Enhancing Capacity: Tips for Practice .......................................................69
C. Summary .......................................................................................................70

IV. CONCLUSION...........................................................................................................70

Black’s Law Dictionary defines pain and suffering as “Physical discomfort or
emotional distress compensable as an element of damages in torts.”1 Anyone who has
ever experienced pain, however, knows that this definition fails to convey pain’s true
nature. This is especially true for someone suffering from a terminal illness.
Pain is a powerful teacher, a fierce intimidator, and an insistent burden. If
extreme enough, pain can alter a person’s basic nature. As described by J. David
Velleman in his article A Right to Self Termination?:
What do we mean in calling pain unbearable?...Not to bear pain is somehow to
fall apart in the face of it, to disintegrate as a person. To find pain unbearable is to find
it thus destructive not just of one’s well-being but of oneself. But then we make a
mistake if we describe the patient in unbearable pain as if he were his rational old self,
weighing the harm of pain against the benefits of existence. If his pain is truly
unbearable, then he isn’t his rational self any longer: he is falling apart in pain.2

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paper.
If pain alone can cause a person to become irrational, then how should a lawyer regard a client who is also a person in pain? Is the client legally competent? It can be easy to dismiss this question as archaic—certainly modern medicine has provided physicians with numerous therapies to relieve the patient of any pain he is experiencing. However, those solutions can instead beget more problems.

One such problem confronts the attorney whose client wants to create an estate plan while receiving palliative care. Many pain medications affect the mental state of the patient. The most commonly prescribed family of pain medication is the opioid family, whose effects include sedation and confusion. This, combined with the fact that a terminal stage illness often causes mental disturbances that the patient may not even be aware of, can create a serious question in the legal competency analysis when a client wants to sign her will.

This paper will explain why and how we feel pain, how the medications used to relieve pain work, and why their effects can eliminate a client’s testamentary capacity. Next, it will analyze court cases where testamentary capacity has been either established despite the use of therapeutic narcotics, or has been found to be lacking because of these drugs. Finally, it will review practical suggestions for the legal practitioner who wants to make sure that her client’s testamentary documents will stand in the case of a will contest, despite the palliative care that her client is receiving.

I. WHAT IS PAIN?

In order to properly analyze how pain and pain suppressant medications fit into the competency analysis, it is helpful to have a basic understanding of how each affects the mind. Pain itself can be defined as “an unpleasant sensation signaling actual or possible injury.” The experience of pain varies widely from person to person, from injury to injury, and from circumstance to circumstance. Pain is especially common among older people, who are also more likely to experience the side effects of pain more seriously, such as exhaustion, loss of appetite, depression, and loss of autonomy. Older people are also more likely to have side effects from palliative medications, which can be made more severe due to age, a combination of medications, or disorders likely to increase the chance of harmful side effects, such as cardiovascular system conditions or kidney problems.

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4. Id.
6. Id.
7. Id.
8. Id.
The sensation of pain is the end product of a complicated neurological process. The peripheral nervous system connects the skin, muscles, and internal organs to the spinal cord. Some of these peripheral nerves end in structures called nociceptors, which allow the nerves to detect tissue damage. When a nociceptor perceives a harmful stimulus, it sends an electrical impulse through the peripheral nerve and into the spinal cord. The spinal cord receives the messages in an area known as the dorsal horn. In response, the dorsal horn area releases neurotransmitters that enable the message to travel up the spinal cord and into the brain. Once in the brain, pain messages are received and processed by the thalamus, which distributes the information to three areas of the brain: “the physical sensation region (somatosensory cortex), the emotional feeling region (limbic system) and the thinking region (frontal cortex).” These regions of the brain then decide how to respond to the stimulus.

Numerous factors can affect or otherwise alter this process, however. For example, if the pain sensed by the nociceptor is severe, the electrical message moves much more quickly and goes directly to the brain. If the pain is mild, the message may be altered or altogether filtered out by the spinal cord. The brain can also trigger the release of chemicals that act as natural painkillers, such as endorphins or enkephalins. There are also numerous psychological factors that influence how severely pain is perceived, including “emotional state, memories of past pain experiences, upbringing, attitude, expectations, beliefs and values, age, sex, and social and cultural influences.”

Pain medications work by interfering with the physiological process required to deliver a pain stimulus to the brain. The oldest type of analgesic, the opioid family, works by blocking pain messages by attaching to receptors in the body that would normally transmit the impulses conveying pain messages to the brain. Opioids thus physically prevent the pain messages from being sent to the brain.

10. Id.
11. Id.
12. Id.
13. Id.
14. Id.
15. Id.
16. Id.
17. Id.
18. Id.
19. Id.
20. Id.
22. Id.
The opioid family of medication is the most powerful group of analgesics available today, and as such these drugs are commonly used to treat acute or chronic pain.\textsuperscript{23} This family of drugs, also known as narcotics, includes Morphine, Fentanyl, Oxycodone, and Codeine.\textsuperscript{24} As can be expected, such strong drugs have potentially strong side effects. “A side effect from a medication simply means that something else results from a medication that was not wanted or intended for the medication to cause.”\textsuperscript{25} Side effects of opioids include drowsiness, constipation, nausea, vomiting, and itching.\textsuperscript{26} Another possible side effect of opioids is confusion, which can be especially pronounced in the elderly.\textsuperscript{27}

The “psychological effects of morphine outlast the painkilling action by several hours.”\textsuperscript{28} However, medical research indicates that as a patient builds up a tolerance to the effects of a palliative medication, the patient will also build up a tolerance to the mental affects of the drug.\textsuperscript{29} In addition, if a patient is experiencing a great deal of pain, that patient will be able to tolerate a larger dose of the drug without experiencing the accompanying increase in effects.\textsuperscript{30} On the other hand, certain medical conditions can cause palliative medications to have an even greater impact on the patient’s mental state.\textsuperscript{31} For example, if “the patient’s kidneys and liver are not operating properly, the effects of a dose of morphine which ordinarily would have no mental effects may persist and increase with repeated dosage.”\textsuperscript{32}

A second group of pain relieving medications is called the nonopioid analgesics.\textsuperscript{33} This group includes acetaminophen, aspirin, ibuprofen, and nonsteroidal anti-inflammatory drugs (NSAIDs).\textsuperscript{34} NSAIDs reduce pain and inflammation, and can be used in conjunction with opioids for additional pain relief.\textsuperscript{35} Used on their own, however, these drugs usually do not produce serious side effects that could affect the mental capacity of the patient.\textsuperscript{36}


\textsuperscript{25} Opioids, supra n. 21 at \url{http://www.merck.com/mmhe/sec06/ch078/ch078d.html}.

\textsuperscript{26} Treatment, supra n. 23 at \url{http://www.merck.com/mmhe/sec06/ch078/ch078d.html}.

\textsuperscript{27} Id.

\textsuperscript{28} 9 A.L.R.3d 15 § 15.

\textsuperscript{29} Id.

\textsuperscript{30} Id.

\textsuperscript{31} Id.

\textsuperscript{32} Id.

\textsuperscript{33} Treatment, supra n. 23 at \url{http://www.merck.com/mmhe/sec06/ch078/ch078d.html}.

\textsuperscript{34} Id.

\textsuperscript{35} Id.

\textsuperscript{36} Id.
II. PAIN IN COURT: HOW PALLIATIVE MEASURES HAVE AFFECTED A TESTATOR’S COMPETENCY

According to American Jurisprudence, “The circumstance that a testator, at the time of executing his will, is suffering from acute pain or is on his deathbed does not take away his testamentary capacity.” While this general rule may be true, some states have acknowledged the severely debilitating affect of pain on the mental state of an individual. For example, Ohio has recognized that “weakness of intellect, sufficient to negate testamentary capacity, may be traceable to old age, disease, and bodily infirmities, and the pain or effect of a disease may be such that one cannot be held to have a sound and disposing mind and memory.”

The court system “displays a heavy bias in favor of finding, in close cases, that a person, now dead, possessed testamentary capacity at the time the will in question was executed...” is a good example of the sort of evidence a court will require in order to overcome the presumption of testator competence. In this case, the family of Bernice Grimes split in two, with some contesting the will and others defending it. The trial court invalidated the will on the grounds of lack of capacity. The appeals court reversed, finding the will to be valid and ordering the trial court to enter a judgment as a matter of law on behalf of the will proponents. The contestants petitioned the Supreme Court of Alabama for a writ of certiorari, which was then granted.

The Alabama Supreme Court reviewed the case de novo. At trial the contestants had presented much evidence about the testator’s pain medication, Lortab, and its affect on Grimes. Her doctor testified about her condition, saying that “Bernice’s pain and her medication affected ‘her mental state, her mental ability to be cognitive and clear.’” A registered nurse who gave expert testimony about the affects of Lortab described the drug as one that “normally affects a person’s mind – that Lortab can cause a patient to lose the ability to concentrate or to lose the ability to know what he or she is doing.” The nurse went on to say that “if Bernice ‘on January 15, 1997,
signed a will and was taking Lortab, she would be doing so with the propensity of that medication affecting her. “”

The Supreme Court of Alabama, however, still did not feel satisfied that the contestants had made a strong enough case to receive the judgment as a matter of law. Instead they remanded the case to answer the issue of fact regarding the capacity of the testator at the time the will was made. They said that evidence “offered as to the mental and physical condition of the testatrix, either before or immediately after execution of the will, is admissible since it tends to indicate her condition when the will was signed.” The court remanded the case because “neither the proponents nor the contestants have presented direct testimony to the particulars of Bernice’s testamentary capacity.” The evidence presented at trial was circumstantial that tended to either rebut or support the presumption of testamentary capacity, but was not enough to deserve a judgment as a matter of law.

Although the consideration of pain and palliative medications and their impact on a testator’s capacity certainly must be done on a case-by-case basis, there are several common threads that appear in a court’s analysis of these factors when determining testamentary competency.

A. Establishing Competence

Every state has its own law defining the requirements a testator must meet to be considered competent to make a legal will. Generally speaking, however, the threshold is rather low. In order to have testamentary capacity at the time of signing his will, a person must simply understand that the document before him will be the official document that will control the distribution of his assets after his death. He must also have a general understanding of the nature and extent of his assets and be able to remember who the natural objects of his bounty are. “Just so long as they can do all three of these things simultaneously, even if only for a few minutes now and again[,] they possess testamentary capacity…”

In cases where there is a question of testamentary capacity, courts work off of an assumption that the maker of the will was capable, and the person contesting the will

49. Id.
50. Id. at 1147.
51. Id. at 1147.
52. Id. at 1147.
53. Id.
54. Id.
55. Fleming, supra n. 34, at 8.
56. Id.
57. Id.
58. Id.
59. Id.
must prove otherwise. Courts have also been “immensely reluctant to hold attorneys liable for not having taken great pains to determine the mental acuity of a testator.”

B. Testators Found Incapacitated by Pain and Palliative Measures

The administration of palliative medication can render a testator incapacitated to make a will in the eyes of the court. The strongest example of pain medication robbing a patient of her testamentary capacity can be found in a Louisiana case from 1984, Succession of Remont.

In this case, the testator was found to be lacking sufficient testamentary capacity because of the considerable amounts of painkillers and sedatives given to her during her hospital stay. The testator was an 82-year-old woman, Alice Remont, who had been hospitalized for about a month as a result of a broken hip. She was “under heavy medication for much of the period immediately prior to [executing her will].” Indeed, upon review of her hospital records, the appeals court described Remont’s medications as “massive amounts of sedatives and painkillers.” One of the witnesses to Remont’s will stated that she thought the testator was disoriented on the day of the will signing. Furthermore, at trial, Remont’s doctor “stated without qualification that decedent could not have been in a sufficient state of mind to adequately understand the consequences of what she was doing.” Based on the totality of the evidence, the court in this case found that the testator lacked sufficient capacity to make a will as a direct result of her palliative care regimen.

In a similar case, Matter of Estate of Wagner, the timing of a testator’s dose of a painkiller caused the court to find a lack of testamentary capacity. The testator in this case, Martha Wagner, had been hospitalized for a number of conditions, including pneumonia, jaundice, and cancer. While in the hospital, Wagner asked her attorney to prepare a codicil to her will, but refused to execute it because he had left a blank to fill in the date on which the associated will had been executed. The attorney left the codicil at the hospital with Wagner. Several weeks later, Wagner executed the codicil - about two hours after Wagner had been given her scheduled daily dose of the painkiller.
painkiller Darvocet. Side effects of Darvocet include confusion and drowsiness, and the witnesses to the codicil execution gave testimony that indicated Wagner was suffering from both. She faded in and out of sleep, could not remember what a notary was, and did not seem alert. After Wagner’s death her niece contested the validity of the codicil, claiming that Wagner lacked testamentary capacity at the time the codicil was executed. (There is some irony in this case that her niece was the one who helped Wagner execute the codicil – evidently unaware that the instrument halved the niece’s share of Wagner’s estate.)

On appeal, the court agreed that Wagner did in fact lack the required capacity to legally execute the codicil based on two factors – her jaundice and her pain medication. Wagner’s doctor testified that a build up of both bile and Darvocet in Wagner’s system would have rendered her confused and disoriented at the time she executed the codicil. He also made a specific reference to the timing of Wagner’s dose of Darvocet, saying that “in a patient that is weak and ill and elderly,” the confusion and drowsiness caused by Darvocet ‘may be exaggerated quite significantly.’ This testimony from Wagner’s doctor, combined with the statements of witnesses that Wagner seemed disoriented and confused on the day of the codicil execution, led the court to conclude that Wagner lacked sufficient testamentary capacity and declared the codicil invalid.

In Miami Rescue Mission, Inc. v. Roberts, the District Court of Appeal of Florida, Third District, determined that Ethel Manucy’s will had to be thrown out due to lack of testamentary capacity. Mrs. Manucy executed the will while hospitalized “with severe pain and under the influence of very strong medication.” In the days before her death, Mrs. Manucy became convinced that her longtime caregiver, Ms. Fair Ellen Roberts, “had abandoned [Mrs. Manucy], let her dog die, and was stealing from her.” At trial, Roberts and her daughter both testified credibly that they had continued to care for Mrs. Manucy, her dog, and her finances.

In order to determine the source of Mrs. Manucy’s changed perceptions of Roberts, the court relied on testimony from Mrs. Manucy’s doctors, who “detailed how the medication given to Mrs. Manucy affected her in the days leading up to her

73. Id.
74. Id.
75. Id.
76. Id. at 293.
77. Id. at 294.
78. Id. at 296-297.
79. Id.
80. Id. at 296.
81. Id. at 297.
82. Miami Rescue Mission, Inc. v. Roberts, 943 So.2d 274, 276 (Fla.App. 3 Dist., 2006).
83. Id. at 274.
84. Id.
85. Id.
passing."\textsuperscript{86} Her doctors stated that the patient’s personality totally changed and her mental state deteriorated to the point that a psychiatric consultation resulted in a diagnosis of hallucinations or delusions.\textsuperscript{87} The court in this case found that Mrs. Manucy’s condition, as described by her doctors, created a state of insane delusion, rendering her incapable of making an effective will.\textsuperscript{88} Citing \textit{Newman v. Smith}, the court explained, “where there is an insane delusion in regard to one who is the object of the testator’s bounty, which causes him to make a will he would not have made but for that delusion, the will cannot be sustained.”\textsuperscript{89} Mrs. Manucy’s perceptions qualified as an insane delusion because they were a “spontaneous conception and acceptance as a fact of that which has no real existence except in imagination” and “persistently adhered to against all evidence and reason.”\textsuperscript{90} In this case then, the evidence presented was sufficient to convince the trial court that there was no factual basis for Mrs. Manucy’s beliefs.

\textbf{C. Testators Found Competent Despite Pain and Palliative Measures}

In contrast, several courts have found that without a medical record reflecting mental incapacitation as a result of illness or medication, a testator must be found to have testamentary capacity. For example, a man being treated for severe pain was found to possess testamentary capacity on the day of his will execution, despite his narcotic medications, simply because there was no evidence of mental incapacitation in his medical records.\textsuperscript{91}

The affect of a medication on the mental capacity of a specific individual is a key issue in cases where testators receiving palliative care have been judged to be competent. This was the case with John Hollyfield.\textsuperscript{92} Mr. Hollyfield entered the hospital on June 21, 1996, suffering from severe respiratory failure.\textsuperscript{93} While hospitalized, Mr. Hollyfield was given both a pain killer (Darvocet) and an anti-inflammatory medication (Prednisone).\textsuperscript{94} It was during this hospital stay and while on these medications that Mr. Hollyfield executed the will that was submitted for probate after his death.\textsuperscript{95}

During the will contest, the court heard testimony from a pharmacist, with no firsthand knowledge of the case, that a patient on the same medications as Mr. Hollyfield “would be mentally impaired to some extent.”\textsuperscript{96} Although the trial court

\begin{itemize}
  \item \textsuperscript{86} \textit{Id.}
  \item \textsuperscript{87} \textit{Id.} at 275-276.
  \item \textsuperscript{88} \textit{Id.} at 276.
  \item \textsuperscript{89} \textit{Id.}
  \item \textsuperscript{90} \textit{Id.}
  \item \textsuperscript{91} \textit{Harper v. Watkins}, 670 S.W.2d 611, 630. (Tenn. App. 1983)
  \item \textsuperscript{92} \textit{Balletti v. Muldoon}, 991 S.W.2d 633 (Ark. App. 1999).
  \item \textsuperscript{93} \textit{Id.} at 635.
  \item \textsuperscript{94} \textit{Id.}
  \item \textsuperscript{95} \textit{Id.}
  \item \textsuperscript{96} \textit{Id.} at 636.
\end{itemize}
found this testimony to create a material issue of fact and refuse to probate the will, the appeals court disagreed. Instead, the appeals court said that the proper evidence of Mr. Hollyfield’s capacity at the time of the will execution was the testimony of his longtime doctor and the witnesses to the will signing, all of whom indicated that Mr. Hollyfield was alert, aware of his actions, and able to understand the affect of the instruments he signed that day. The appeals court stressed that physical incapacity, some mental lapses, forgetfulness, or abnormal acts do not establish that a testator was lacking capacity, as long as “the testator has sufficient capacity to remember the extent and condition of his property and who his beneficiaries are.”

Similarly, in Maxwell v. Dawkins, the court required specific proof that the testator’s medications affected his mental capacity. Here, the court distilled the contestant’s argument against capacity down to three facts: that the testator had chronic obstructive pulmonary disease, he used oxygen and numerous medications, and some of his caregivers had said there were times when the testator was not alert. The testator’s medications included Xanax, Percocet, morphine, DuoNeb, Q-bid, Chloracon potassium replacement, albuterol, furosemide, captopril, Levaquin, and Oxycontin. According to the contestant, “the presence of these types of drugs alone would create a genuine issue of fact as to [the testator’s] capacity.” The court disagreed however, and upheld the summary judgment in favor of the will proponents. Without some “evidence in the record, from a medical expert or otherwise, indicating that COPD or the oxygen and medications that [the testator] sometimes took affected his mental acuity in any way” the contestant had no case.

In addition to the specific affects medications can have on a testator’s capacity, courts also examine the behavior of the testator on the specific day he executed his will. In re Last Will and Testament of Bascombe is such a case. In this case, the court held that pancreatic cancer and medications did not render the testator incapacitated, largely because his medical records gave no indication that either the cancer or his medications affected his mental state. The court further narrowed its examination of capacity to the day the testator had executed his will, explaining that the day of execution is the proper time to determine capacity. On the day this particular testator executed his will, he “showed no signs of incapacitation” according

97. Id.
98. Id. at 638.
99. Id.
100. Maxwell v. Dawkins, 2006 WL 3692427 (Ala.) (not yet released for publication)
101. Id.
102. Id.
103. Id.
104. Id.
105. Id.
106. In re Last Will and Testament of Bascombe, 856 So.2d 742 (Miss. App. 2003)
107. Id. at 746.
108. Id. at 745.
to his lawyer and longtime friend Billy Gilmore.\textsuperscript{109} Gilmore also testified that the testator was well aware of the natural objects of his bounty and fully understood the contents of his will.\textsuperscript{110} Gilmore also said that he would not have permitted the testator to sign the will if the testator had seemed incapacitated.\textsuperscript{111} The court was content to rely on Gilmore’s testimony about the testator’s mental acuity on the day of the will execution, despite there being some contradictory testimony from a cousin.\textsuperscript{112} The cousin had not in fact seen the testator on the day he signed his will, and as the court stressed, “capacity at the time of execution is the only factor.”\textsuperscript{113} The court went on to clarify, “the testator could have not had testamentary capacity days, weeks, or months before as long as he had capacity at that moment.”\textsuperscript{114}

In summary, there are two key issues concerning the intersection of palliative care and testator competence. These include the specific effect of a medication or combination of medications on the testator and the behavior and capacity of the testator at the exact time the will is executed. A lawyer who is creating an estate plan for a client receiving palliative care must be aware that these factors can be determinative of testator competence, for it is only through knowledge and preparation that a lawyer can acquire and protect the evidence needed to preserve her client’s estate plan.

III. GUIDANCE FOR THE LAWYER

\textit{A. Assessing Capacity: An Approach for the Lawyer in the Field}

In a client service setting such as estate planning, there are at least two times a lawyer must assess her client’s capacity.\textsuperscript{115} The first is when the lawyer makes the initial determination of whether or not that prospective client has the capacity to enter into a contract for the lawyer’s services.\textsuperscript{116} The second is when the time comes to actually carry out the specific legal transactions ordered by the client, such as making a will or executing a trust.\textsuperscript{117} Although for most adults capacity is obvious,\textsuperscript{118} as we have seen there are time when medications can cause a client to lose his testamentary capacity. In order to avoid drafting and executing a will that will be declared void if contested, a lawyer must make some basic assessments about a client’s mental

\textsuperscript{109} Id.
\textsuperscript{110} Id.
\textsuperscript{111} Id.
\textsuperscript{112} Id. at 746.
\textsuperscript{113} Id., citing \textit{Edwards v. Edwards}, 520 So.2d 1370, 1373 (Miss. 1988)
\textsuperscript{114} Id.
\textsuperscript{116} Id. at 125.
\textsuperscript{117} Id.
\textsuperscript{118} Id.
capacity and whether it meets the testamentary requirements of the state. A lawyer whose client is in pain and receiving palliative care needs to consider the totality of the client’s circumstance and how it could affect the court’s perception of that person’s testamentary capacity, should it be called into question later.

In addition to the simple idea of accomplishing what the client has hired the lawyer to accomplish, there is another reason for a lawyer to determine whether or not her client is mentally competent to draft a will – malpractice. Intended or possible beneficiaries of a client’s estate have sued their prospective benefactor’s lawyer on the grounds that the lawyer failed to assess whether the testator had the capacity to make a will.119 Historically, lawyers have not been found liable in these situations for two reasons: a “lack of ‘privity of contract’ between the lawyer and the disinherited third party” and a minimal standard of practice regarding assessment of capacity by the lawyer.120 However, as time goes on, and the awareness of the need to assess capacity increases, and the principle of privity of contract continues to decrease in prevalence, the threat of legal action grows more and more real.121 Therefore, it is in the best interests of both the client and the lawyer if the lawyer has some familiarity with how to determine whether a client on analgesics has the capacity to make an effective will.

New Comment [6] to Model Rule 1.14 provides a lawyer with some guidance as to how to assess client capacity:122

“In determining the extent of the client’s diminished capacity, the lawyer should consider and balance such factors as: the client’s ability to articulate reasoning leading to a decision; variability of state of mind and ability to appreciate consequences of a decision; the substantive fairness of a decision; and the consistency of a decision with the known long-term commitments and values of the client. In appropriate circumstances, the lawyer may seek guidance from an appropriate diagnostician.”123

Fortunately, these factors fall well within the scope of the average client interaction.124 However, the difficult questions arise when the lawyer has that feeling that something simply isn’t “right” with the client.125 This could conceivably be the case with a client on pain medication, who may be suffering side effects such as confusion and sedation.126

According to Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers, a joint work by the American Bar Association and the American Psychological Association, the lawyer’s task in a situation where the client has

119. Id. at 126.
120. Id.
121. Id.
122. Id. at 127.
123. Id.
124. Id.
125. Id. at 125.
questionable capacity is one of “observation, legal analysis, and capacity judgment.” The authors of this handbook have devised a series of steps for the lawyer to use when determining her client’s capacity. The first step is to look for signs of diminished capacity. This step is focused on decisional abilities, especially as they have changed or continue to change over time. They suggest looking for short-term memory loss, problems communicating or comprehending, a “lack of mental flexibility,” problems doing math, and disorientation. The procedure also reminds the lawyer to look for severe emotional distress or delusions and hallucinations that could affect a client’s capacity. Once signs of diminished capacity have been observed, the lawyer should investigate any possible mitigating factors that could enhance capacity. These capacity enhancers include “reversible medical factors” where “signs of disorientation and confusion could be due to a host of medical conditions and medication factors.”

Thus, the lawyer should ask the client about the amount of pain the client is experiencing and how the client is being treated for that pain. The baseline rule is that “testamentary incapacity does not arise from the fact that the decedent was taking medication for pain and was hallucinating and disoriented at times, where no evidence was presented of such disability on the day of the execution.” However, in a will contest, the factfinder must determine that testamentary capacity existed at the time the will was executed, and should consider factors such as “decedent’s relevant declarations, decedent’s appearance, conduct, habits and conversation before and after execution, his health, and his medications.” Therefore, it is appropriate that the lawyer be aware of her client’s pain medications, because they could later create doubt as to the client’s capacity to make a will.

The lawyer should also ask the client to ask his doctor about any notes the doctor is making about the affect of the medications on the client. Although the client may not remember exactly what the doctor says, the lawyer may be able to get an idea of any potential problems the doctor’s notes may cause.

The second step suggested by the ABA and APA is to compare the client’s level of mental capacity with the legal elements of capacity required for their specific legal transaction. Thus, for a client on pain medication who wishes to make a will, the lawyer should compare the client’s ability to function with the statutory requirements

127. Id. at 137.
128. Id.
129. Id.
130. Id. at 138.
131. Id. at 138-139.
132. Id. at 139-140.
133. Id. at 141.
134. Id.
136. Id.
137. ABA-APA Handbook, supra n. 110, at 141.
for testamentary capacity. The lawyer should be careful to delineate between regular conversation and discussions that demonstrate the client can satisfy the testamentary capacity requirements – the client may lack lucidity in one but still satisfy the other.\textsuperscript{138}

The third step is for the lawyer to consider any ethical implications as analyzed under Rule 1.14 of the Model Rules of Professional Conduct.\textsuperscript{139} The recent revisions to Rule 1.14 allow a lawyer more leeway in dealing with a client with diminished capacity.\textsuperscript{140} The basic idea of the rule is the same – that a lawyer should maintain as normal a relationship as possible with a client whose mental capacity is suffering.\textsuperscript{141} The Comments to the new rule, however, provide an important recourse to the lawyer who is questioning his client’s capacity.\textsuperscript{142} “New Comment [5] expressly authorizes the lawyer to consult with the client’s family members or surrogates.”\textsuperscript{143} New Comment [7] suggests requesting a guardian ad litem be appointed for a client with questionable capacity instead of initiating a guardianship proceeding.\textsuperscript{144} In general, “the changes to Rule 1.14 and the accompanying Commentary make clear that the modern approach favors a consultative, assistive response to a client’s diminishing capacity.”\textsuperscript{145} Although the drafters of the Rules most likely contemplated the client suffering dementia rather than a client suffering physical pain, there is still valuable information in this Rule for the lawyer of a palliative care patient.

The next step in the process is to “perform the legal analysis and categoriz[e] the legal judgment.”\textsuperscript{146} The article stresses that the lawyer must examine all the information as a whole, and even provides a worksheet to the lawyer to use throughout the process in order to keep everything organized and well documented.\textsuperscript{147} The lawyer’s end conclusion about whether or not a client is competent to make a will “is ultimately a professional judgment that is aided by the systematic consideration of signs of incapacity, the client’s understanding of the legal transaction, and the factors laid out in the Model Rule.”\textsuperscript{148} If the lawyer is still unsure about the client’s mental capacity, the lawyer should consult with a clinician.\textsuperscript{149}

The final step in the process is recording the lawyer’s observations and assessments about the client’s capacity.\textsuperscript{150} Such documentation can serve as evidence

\begin{footnotesize}
138. \textit{Id.} at 142.
139. \textit{Id.}
140. Fleming, \textit{supra} n. 34, at 9.
141. \textit{Id.}
142. \textit{Id.}
143. \textit{Id.}
144. \textit{Id.}
145. \textit{Id.}
146. ABA-APA Handbook, \textit{supra} n. 110, at 143.
147. \textit{Id.}
148. \textit{Id.}
149. \textit{Id.}
150. \textit{Id.}
\end{footnotesize}
in the unfortunate case of a will contest if the lawyer has determined that the client has capacity.

B. Enhancing Capacity: Tips for Practice

There are also certain client interaction techniques that a lawyer can utilize to assure herself that her client possesses testamentary capacity. These ideas come from Robert B. Fleming, who suggested they be used with clients developing dementia. However, these ideas can also help a lawyer determine the extent of the affect of pain and analgesics on her client’s mental capacity. First, the lawyer should speak clearly and avoid legalese. Even clients not on pain medication may glaze over when confronted with too many unintelligible words and too much information. Second, contacting the client multiple times during the drafting process, varying the time of day and location, if possible, will give the lawyer a good idea of how, when, and if the client’s testamentary capacity varies. Ask the client for legal direction, and repeat the same question more than once, slightly altering the language each time. If a client must give different answers in order to supply consistent direction, it will show that the client was aware and understood what was being asked.

The American Bar Association also made several recommendations regarding steps a lawyer can take to improve a client’s capacity at the time of execution for a legal act. Although the majority of the recommendations are designed to assist older clients who may be experiencing the decline of mental acuity and physical ability as a result of age, several of the suggestions could be helpful when dealing with the palliative care patient. For example, the handbook recommends taking steps to build client trust, such as stressing that the relationship is confidential, encouraging client participation, and setting aside more time. These tactics could also be helpful to the lawyer trying to evaluate whether a client is suffering side effects of medication. In addition, a client who trusts his lawyer is more likely to answer questions about medications and how they are feeling in general.

The handbook also makes several recommendations specifically for clients who “may be in the murky gray area of ‘questionable capacity’” because they are showing signs of cognitive impairment. Generally, the guidelines emphasize allowing more time for clients who are of questionable capacity. Ample time will allow the lawyer to assess the best pace for the interview, give the client time to find words and indicate

151. See generally Fleming, supra n. 34.
152. Fleming, supra n. 34, at 11.
153. Id.
154. Id.
155. Id.
156. ABA-APA Handbook, supra n. 110, at 151.
157. Id.
158. Id.
159. Id. at 152.
160. Id. at 153.
that he understands what is being discussed, and will preclude the need to discuss multiple issues at once, which can help make information easier to process. The lawyer should also “repeat, paraphrase, summarize, and check periodically for accuracy of communication and comprehension.” Simply asking the client if he understands is not really enough – the lawyer should encourage the client to interact at a level that genuinely demonstrates the client’s comprehension.

C. Summary

The ACTEC Commentaries on the Model Rules of Professional Conduct (Fourth Edition, 2006) strongly emphasize that a lawyer “should not prepare a will, trust agreement or other dispositive instrument for a client who the lawyer reasonably believes lacks the requisite capacity.” However, “because of the importance of testamentary freedom, the lawyer may properly assist clients whose testamentary capacity appears to be borderline.” The ACTEC Commentary encourages the lawyer with a “gray area” client to preserve any and all evidence relevant to the mental capacity of the client. The question of client capacity is a sensitive one, and can be made even more difficult when a non-medical professional like a lawyer is trying to determine the effect of pain and palliative medications on a client’s competence. However, there are techniques the lawyer can turn to in order to assess and enhance capacity. The most crucial element is the lawyer’s awareness – awareness of her client’s situation, awareness of the potential issues created by the use of pain medication, and awareness of how to protect and serve the interests of her client.

IV. CONCLUSION

“Pain is no evil, unless it conquer us.”

The invention of palliative medications revolutionized the way people practice and regard medicine. Analgesics, narcotic or otherwise, allow a patient to be “free of crippling pain and unbearable suffering so that they can finish their lives in ways that bring comfort, peace, and completion.” This is truly the essential function of palliative care – to give a person the ability to make the most of the time they have. For many, some of this time will be spent putting their affairs in order, including the

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161. Id.
162. Id.
163. Id.
165. Id.
166. Id.
development of an estate plan. It is up to the lawyer to make sure that the precious
time spent by the testator on the creation of these documents is not in vain.

A lawyer must be mindful of the legal issues that can arise as a result of the
medicinal use of narcotics, and take steps to prevent side effects of palliative care from
sabotaging the dispositive intentions of her client. The cases where a will has been
defeated for lack of testamentary capacity due to the use of analgesics are
heartbreaking – they almost seem to say that a person can have relief from pain or
dispose of their estate as they see fit, but not both. However, there is ample case law to
demonstrate that this sort of outcome can be avoided if the lawyer takes the time.

No lawyer should ever have to ask her client to choose between being pain free
and possessing testamentary capacity. Awareness of a specific client’s situation,
knowledge about testamentary capacity requirements, and strategies to enhance
capacity are all tools available to the estate planner who wants to establish
testamentary capacity for the palliative care client. By taking the time to address a
specific client’s needs, a lawyer can ensure that the client’s true wishes are expressed
and effectuated through his estate plan – and perhaps even avoid a malpractice lawsuit.
Indeed, the estate planner for the palliative care patient is in the unique and important
position of making sure the client’s wishes – be they taking care of family, giving to
charity, satisfaction of debts - will be followed after the client has passed. And in many
cases, the relief of that stress is in and of itself a form of palliative care.
INTERSTATE GUARDIANSHIP: A NEW PHENOMENON AND ACCOMPANYING PROBLEMS

Ni Yun*

I. PROBLEMS OF INTERSTATE GUARDIANSHIP .............................................................. 74
   A. Simultaneous Jurisdiction ............................................................................. 74
   B. Recognition of Foreign Guardianship ........................................................... 76
   C. Transfer of Existing Guardianship ................................................................. 76
II. PROPOSED SOLUTIONS ............................................................................................. 77
   A. Uniform Guardianship & Protective Proceedings Act.................................. 78
   B. National College of Probate Judges .............................................................. 79
      1. A Proposed Addendum to the National Probate Court Standards ........... 80
      2. Model Legislation for the Interstate Transfer of Guardianship
         Orders ................................................................................................... 82
         a. Receipt and Acceptance of Foreign Guardianship............................ 82
         b. Transfer of Guardianship to a Foreign Jurisdiction .......................... 83
III. ISSUES NOT ADDRESSED BY PROPOSED LEGISLATION ............................................ 84
IV. SUGGESTIONS TO THE PROPOSED LEGISLATION..................................................... 84
   A. Simultaneous Jurisdiction ............................................................................. 84
      1. An IP’s Domicile in a Litigation ............................................................ 85
   B. Recognition of a Foreign Guardianship ........................................................ 87
CONCLUSION ................................................................................................................. 88

Interstate guardianship usually arises under three circumstances: (1) when an alleged incapacitated person (hereinafter “AIP”) visits a foreign state temporarily but in an urgent need of a guardian,1 (2) when more than one competent court may have valid jurisdiction over a guardianship petition,2 and (3) when an incapacitated person (hereinafter “IP”) moves permanently to another state.3

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Two major factors had contributed to the phenomenon of interstate guardianship. The first factor is an aging society. “The proportion of the U.S. population age sixty-five and older increased from 4% in 1900 to over 12% in 1990[,]” and the number is predicted to go up.\(^4\) In addition to the increasing population of senior citizens, the longer life expectancy plays a role here as well. The fact that senior citizens are living longer now will result in a high percentage of senior citizens in frail old ages.\(^5\)

Another factor is an increasing mobility. As transportation becomes more and more convenient, nearly five percent of the Americans who change their residence every year are age sixty-five and older.\(^6\) The combination of these two factors has led to increasing number of interstate guardianship cases in probate courts.\(^7\)

Because interstate guardianship is a relatively new phenomenon, most states are not well equipped to accommodate this issue; therefore, problems have ensued. When there are more than one competent court, questions include which court should be the one to make a ruling and what procedure should a court adopts to accept or transfer an existing guardianship.

I. PROBLEMS OF INTERSTATE GUARDIANSHIP

Inherent in the phenomenon of interstate guardianship are three common problems a court may face: (1) simultaneous jurisdiction over a guardianship proceeding, (2) recognition of guardianship granted by a foreign state, and (3) transfer of an existing guardianship or pending proceeding.\(^8\)

A. Simultaneous Jurisdiction

The problem of simultaneous jurisdiction in an interstate guardianship proceeding can occur in two situations: when an AIP (1) is in a foreign state temporarily\(^9\), or (2) is purposefully removed from his or her domiciliary state,\(^10\), the AIP needs a guardian appointed immediately due to sudden illness or other emergencies. Under such circumstances, courts of both states are confronted with the question of which state should have jurisdiction over the guardianship proceeding.

If the AIP’s domiciliary state should retain jurisdiction, it would be difficult for its court to obtain necessary documents and information concerning the circumstances surrounding the petition of guardianship. Without necessary documents and
information, it will be a challenge for the court of the AIP’s domiciliary state to render a decision.\(^{11}\) It will inevitably delay the entire proceeding and can adversely affect the AIP’s interests. For example, if the AIP contracts a life-threatening disease while visiting a foreign state and needs an operation immediately; however, due to the illness, the AIP is unable to give consent to the operation, and there is no family member can be reached. If the guardianship is delayed, the AIP’s sudden illness may ultimately claim his or her life.

On the other hand, granting the foreign state jurisdiction over the guardianship proceeding does not guarantee a problem-free solution. For instance, if the foreign state has a less strict standard than the AIP’s domiciliary state for a guardian to be appointed, the issue of forum shopping emerges.\(^{12}\) When someone who does not have the AIP’s best interest in mind but simply wishes to be appointed guardian in order to control the AIP’s person and property, such person can move the AIP to a foreign state with lesser guardianship requirements and falsely declare that the AIP needs immediate protection.\(^{13}\) With a less strict standard, such individual could be appointed guardian, while a guardianship would not be granted in AIP’s domiciliary state under the same circumstances.\(^{14}\) For example, in Mack v. Mack,\(^ {15}\) the wife of the IP, who was in persistent vegetative state, petitioned to have him moved from Maryland to Florida with the intention to remove his gastrostomy tube. The opportunity this may provide to an evil person to control the AIP adverse to the AIP’s interests should make courts wary of establishing guardianships for individuals who have only recently came to a new state.

Another situation where the issue of simultaneous jurisdiction may arise is when the guardian moves the IP to another state in order to commence an action in the federal court on the ground of diversity. The question needs to be answered is whether the guardian has the power to change IP’s domicile.\(^ {16}\) The answer to this question will affect whether the action can be brought in a federal court predicated on diversity jurisdiction or in a state court.\(^ {17}\) Courts are split on this issue.

In Acridge v. Evangelical Lutheran Good Samaritan Soc., the Court of Appeals for the Fifth Circuit held that the guardian has the power to change the IP’s domicile.\(^ {18}\) Courts agreeing with the Fifth Circuit Court take the view that since the guardian has

\(^{11}\) Daniel & Hannaford, supra note 4, at 353.

\(^{12}\) Hurme, supra note 8; Mack 618 A.2d at 745-48.


\(^{14}\) Daniel & Hannaford, supra note 4, at 365-66.

\(^{15}\) Mack, 618 A.2d at 747-48.

\(^{16}\) Vincent, supra note 13, at 517-20.

\(^{17}\) Id, at 520-21.

\(^{18}\) 334 F.3d 444, 450-52 (5th Cir. 2003).
the powers over IP’s person and property, it is only reasonable that the guardian also has the authority to change the IP’s domicile.\(^\text{19}\)

On the other hand, Court of Appeals for the Fourth Circuit in Long v. Sasser\(^\text{20}\) and some commentators hold the view that such change will upset the certainty and purpose of diversity jurisdiction because diversity can be manufactured.\(^\text{21}\)

### B. Recognition of Foreign Guardianship

The issue of whether a court should recognize a foreign guardianship happens most often when an IP has assets (such as real property, money, chattel) in another state and often the circumstances are rather limited. For example, a guardianship was granted by State A, and the IP has assets in State B, then State B may temporarily give effect to the foreign guardianship and allow the guardian to make necessary arrangement regarding the IP’s assets (such as a sale or transfer of title). New York Mental Hygiene Law section 81.18 provides that “[w]here the person alleged to be incapacitated is not present in the state and a guardian... has been duly appointed pursuant to the laws of any other state, territory, or country... to assist such person in property management, the court in its discretion, may make an order appointing the foreign guardian as a guardian under [Article 81 of the Mental Hygiene Law] with powers with respect to property management within this state on the foreign guardian’s giving such security as the court deems proper.”\(^\text{22}\)

If the foreign guardianship is to be recognized, the next question that a court must answer is whether the foreign state should give effect to all powers granted to a guardian by the original state, or it should limit a guardian’s powers according to the local law. Different states take different approaches, New Hampshire accords a foreign guardianship full faith and credit\(^\text{23}\), but Ohio prefers appointment of a “resident guardian.”\(^\text{24}\)

### C. Transfer of Existing Guardianship

For various reasons, the IP may move to a foreign state permanently after guardianship was granted by the court of the IP’s previous-domiciliary state. Since the guardianship is already in place, the issue of simultaneous jurisdiction (when more than one court have valid jurisdiction over a pending guardianship proceeding) no

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\(^{19}\) See Dakuras v. Edwards, 312 F.3d 256, at 258 (7th Cir. 2002) (guardian may change the domicile of her IP); Rishell v. Jane Phillips Episcopal Memorial Medical Center, 12 F.3d 171, at 174 (10th Cir. 1993) (the guardian could change the domicile of the IP if the move was in the IP’s best interests); McEachron v. Glans, 983 F. Supp. 330, at 334-35 (N.D.N.Y. 1997) (as long as the change of domicile is in the IP’s best interest, the guardian has the authority to do so).

\(^{20}\) 91 F.3d 645, 647-48 (4th Cir. 1996) (a guardian cannot change the IP’s domicile, even if such change is in the IP’s best interest).

\(^{21}\) Vincent, supra note 13, at 513-15.

\(^{22}\) N.Y. Mental Hyg. Law § 81.18 (Consol. 2007).


\(^{24}\) Ohio Rev. Code Ann § 2111.37 (LexisNexis 2007).
longer exists; instead, the question of whether the foreign state should give effect to the existing guardianship, under the doctrine of full faith and credit.25

If the foreign state refuses to give effect to the existing guardianship, a new guardianship proceeding must be commenced. It would be a burden to both the guardian and the foreign state because it will incur additional costs to the guardian and waste time and judicial resources in the foreign state.

If the foreign state is willing to give full faith and credit to the existing guardianship, it will lead to the third issue in an interstate guardianship: the transfer of guardianship.

The National College of Probate Judges Advisory Committee on Interstate Guardianship proposed standards and legislation26 in order to facilitate peaceful and smooth transfer of an existing guardianship, because “[a]fter [an IP] has moved from the jurisdiction in which the guardianship was established, it becomes increasingly difficult to enforce and monitor... the guardianship order. The better practice is to transfer the guardianship to the jurisdiction in which the [IP] resides.”27

Compared to simultaneous jurisdiction and recognition of a foreign guardianship, the transfer of guardianship is a relatively simpler issue. However, to a certain extent, it still intertwines with the issue of recognition of a foreign guardianship; only when the foreign state is willing to give effect to the existing guardianship, is the transfer appropriate. The only question here is whether the new domiciliary state should allow the guardian to retain all the powers granted by the previous domiciliary state or limit the powers in accordance with the law of the new state.28 Some states will allow the guardian to retain all the powers granted by the original court; some states will limit guardian’s powers to those allowed by local laws.29

II. PROPOSED SOLUTIONS

In an effort to solve these interstate guardianship issues, the Commissioners on Uniform State Laws (hereinafter “CUSL”) and National College of Probate Judges (hereinafter “NCPJ”) had each proposed a set of model laws to address these issues: CUSL published the Uniform Guardianship & Protective Proceedings Act (1997) (hereinafter “UGPPA”) and NCPJ published A Proposed Addendum to the National Probate Court Standards (1998) and Model Legislation for the Interstate Transfer of Guardianship Orders (1998).

25. Enos, 670 N.E.2d at 968-69 (it is undisputed that Florida has both personal and subject matter jurisdiction, thus there is no reason not to accord full faith and credit to the guardianship granted by the Florida court); Mack, 618 A.2d at 749 (“[t]he mandate of Art. IV, § 1 of the United States Constitution, requiring courts in each state to accord full faith and credit to judgments of courts in other states, is not absolute”).
26. These standards and legislation will be discussed in Section II(B).
29. Id.
A. Uniform Guardianship & Protective Proceedings Act

The UGPPA was published by CUSL in 1997. Section 107 of UPGGA provides:

(a) After the appointment of a guardian or conservator or entry of another protective order, the court making the appointment or entering the order may transfer the proceeding to another State if the court is satisfied that a transfer will serve the best interest of the [IP].

(b) If a guardianship or protective proceeding is pending in another State or a foreign country and a petition for guardianship or protective proceeding is filed in a court in this State, the court in this State shall notify the original court and, after consultation with the original court, assume or decline jurisdiction, whichever is in the best interest of the [IP].

(c) A guardian, conservator, or like fiduciary appointed in another State may petition the court for appointment as a guardian or conservator in this State if venue in this State is or will be established. The appointment may be made upon proof of appointment in the other State and presentation of a certified copy of the portion of the court record in the other State specified by the court in this State. Notice of hearing on the petition, together with a copy of the petition, must be given to the [IP], if the [IP] has attained 14 years of age, and to the persons who would be entitled to notice if the regular procedures for appointment of a guardian or conservator under this Act were applicable. The court shall make the appointment in this State unless it concludes that the appointment would not be in the best interest of the [IP]. Upon the filing of an acceptance of office and any required bond, the court shall issue appropriate letters of guardianship or conservatorship. Within 14 days after an appointment, the guardian or conservator shall send or deliver a copy of the order of appointment to the [IP], if the [IP] has attained 14 years of age, and to all persons given notice of the hearing on the petition.30

UGPPA section 107 focuses primarily on the transfer aspect of an interstate guardianship. Subsection (a) of section 107 provides that after the guardianship proceeding was completed in the original state, if the court of the original state deems that transferring of the guardianship would serve the “best interest”31 of the IP, then it should allow the transfer. Similarly, under subsection (b), if a guardianship proceeding is still pending in the original state, also for the best interest of the IP, the court of the original state should transfer the proceeding to the foreign state. Lastly, subsection (c) requires notices be given to all interested parties, including the IP, if the IP reaches the age of fourteen or older, when transfer is necessary.

Several states had modeled their guardianship transfer statutes after UGPPA section 107 with some variances.32 These states adopting UGPPA section 107, their

30. UGPPA § 107 (emphasis added).
31. UGPPA § 107(a).
statutes require their courts to make decisions based on the best interest of the IP. In addition to the “best interest” standard, some states require alteration of the existing guardianship. Indiana statute, for example, will limit or terminate the previously granted guardianship after the guardian changes the physical presence of the IP. The Kansas statute will terminate the existing guardianship upon appointment by Kansas courts, and its statute prescribes what should be included in a petition for termination, such as the petition’s name and address, the IP’s name, age, date of birth and address, when and where the guardianship was granted, names and addresses of the IP’s family members or any interested parties, any pending court proceedings involving the IP or the guardian, the IP’s assets, names and addresses of the witnesses, suggested guardian candidates, declaration by the petitioner to terminate the proceedings in the other state, and a request the court appointing a guardian for the IP in Kansas.

B. National College of Probate Judges

Compared to UGPPA section 107, a set of five standards and proposed legislation published by NCPJ is more detailed and complete. In 1993, in order to promote “uniformity, consistency, and continue improvement in the operation of the nation’s probate courts[,]” the NCPJ appointed a committee to accomplish this task: the Commission on National Probate Court Standards (hereinafter “Commission”). The Commission published the National Probate Court Standards, which contains a set of ninety standards that the Commission designed to promote uniformity. Among these ninety standards, Standard 3.1.8 “urged probate courts to exchange relevant information in the event that parties subject to a guardianship order leave the original jurisdiction.” The Commission reasoned that although “[i]nterstate communication has become relative commonplace in several areas of law... [i]n probate and guardianship proceedings, however, such communication is the exception, not the rule.”

In light of “the absence of any widely accepted model of interstate communication for probate courts,” the NCPJ initiated a research project with the National Center for State Courts (hereinafter “NCSC”). This research project included interviews of probate judges, court staff, attorneys, and other persons familiar with the problems associated with interstate guardianships. Based on this research project, NCPJ’s attempt to provide uniformity in interstate communication between probate courts was made via two channels: (1) a proposed addendum to the National

35. NCPJ, supra note 27.
36. Id.
37. Id.
38. Id.
39. Id.
Probate Court Standards, and (2) model legislation for the interstate transfer of guardianship orders.40

1. A Proposed Addendum to the National Probate Court Standards.

The five standards deal with communications, reviews, transfers, acceptances and hearings.

UGPPA directs that, for the best interest of the IP, the court that originally granted a guardianship may transfer the guardianship to another state.41 NCPJ Standards 3.5.3 – 3.5.5 also address the issue of transferring an existing guardianship, but with further guidance.

**Standard 3.5.3 Transfer of Guardianship**

Upon receipt of proper notice of an intended transfer of a guardianship, and a satisfactory final report of the guardian, and in the absence of meritorious objections by interested persons, the probate court should transfer the guardianship to a foreign jurisdiction within a reasonable amount of time.

The [IP] and all interested persons should be served with proper notice of the intended transfer and be informed of their right to file objections and to request a hearing on the petition.

The final report of the guardian should contain sufficient information for the court to determine that the general plans for the [IP] and his or her assets in the foreign jurisdiction are reasonable and sufficient.42

Standard 3.5.3 requires the guardian to furnish a satisfactory final report to the receiving court, and the receiving court has to notify all interested parties of such intended transfer.

**Standard 3.5.4 Receipt and Acceptance of a Transferred Guardianship**

Upon receipt of a properly executed request for a transfer of a guardianship certified by a foreign jurisdiction, subject to the provisions of standard 3.5.5, the probate court should recognize the appointment and powers of the guardian and accept the guardianship under the terms as specified in the transferred guardianship order. Acceptance of the transferred guardianship can be made without a formal hearing unless one is requested by the court *sue sponte* or by motion of the ward or by any interested person named in the transfer documents. The court should notify the foreign court of its receipt and acceptance of the transfer.43

Furthermore, Standard 3.5.4 directs that when the receiving court receives a “properly executed request for a transfer of a guardianship” from the sending court, the receiving court should give full faith and credit to the appointment and powers of the guardian.

40. *Id.*

41. § 107(a).

42. NCPJ, *supra* note 27, at app. C.

43. *Id.*
Standard 3.5.5 Initial Hearing in the Court Accepting the Transferred Guardianship

No later than ninety (90) days after acceptance of a transfer of guardianship, the probate court should conduct a review hearing of the guardianship during which it may modify the administrative procedures or requirements of the guardianship in accordance with local and state laws and procedures.

Unless a change in the IP’s circumstances warrants otherwise, the probate court should give effect to the determination of incapacity and recognize the appointment of the guardian and his or her duties, powers and responsibilities as specified in the transferred guardianship.

However, Standard 3.5.4 does not render the receiving court “powerless,” Standard 3.5.5 gives the receiving court discretion to “modify the administrative procedures or requirements of the guardianship in accordance with local and state law and procedures.” It should be noted that this power to modify does not include the IP’s adjudicated incapacity, “[u]nless a change in the [IP’s] circumstances warrants otherwise.”

In addition to transfer of guardianship, the remaining two NCPJ standards deal with the issue of simultaneous jurisdiction.

Standard 3.5.1 Communication and Cooperation Between Courts

Probate courts in different jurisdictions and states should communicate and cooperate to resolve guardianship disputes and related matters. Working in consultation with appropriate groups and organizations, probate courts should develop and implement... administrative procedures that encourage communication and cooperation between and among courts.

Standard 3.5.1 promotes communication and cooperation between the sending and receiving courts. These two courts should exchange necessary information to facilitate the development of a common administrative procedure to determine how the guardianship proceeding should proceed.

Standard 3.5.2 Screening and Review of Petition

As part of its review and screening of a petition for guardianship..., the probate court should determine that:

the proposed guardianship is not a collateral attack on an existing or proposed guardianship in another jurisdiction or state; and,

for cases in which multiple states may have jurisdiction, the petition for guardianship has been filed in the court best suited to consider the matter.

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44. Id.
45. Id.
46. Id.
When... guardianship petitions are filed in two or more different courts..., the probate court in which the earliest petition is filed should, upon review of the petition, determine the proper venue for hearing the case. 47

Secondly, Standard 3.5.2 asks the receiving court to determine whether the guardianship petition is genuine. If it is, and when more than one court may have jurisdiction over the guardianship proceeding, the court with the earliest filing should “determine the proper venue for hearing the case.” Commentary of Standard 3.5.2 suggests that the court that receives the earliest filing should have information about: “(a) the current location and residence(s) of the [AIP]...; (b) the petitioner, guardian, and other interest persons; (c) location of all assets...; (d) any existing, pending or previous guardianships, including temporary ones, in other jurisdiction; (e) outstanding protective order of any type in any jurisdiction; and (f) any existing... fiduciary instruments or mechanisms[,]”48 in order to make proper determination.

The most important provision among these five standards is the proposed solution to the issue of simultaneous jurisdiction. It gives the court with the earliest filing the discretion to make a determination of which of these competing courts is the most appropriate venue to hear the petition. 49

2. Model Legislation for the Interstate Transfer of Guardianship Orders

As for proposed legislation, NCPJ suggested “the creation of a two-part administrative procedure (for ‘sending’ and ‘receiving’ jurisdictions) that authorizes courts with probate jurisdiction to transfer guardianship....”50 “The administrative procedure recognizes the validity of the transferred guardianship with full faith and credit given for the determination of incapacity and the powers and responsibilities of the guardian.”51 For the receiving courts of transferred guardianship, the proposed legislation permits the courts to “modify the administrative provisions of the guardianship order... to comply with state law.”52

The NCPJ proposed legislation provides further detailed administrative procedures to the sending and receiving courts of a transferred guardianship. The legislation has two major sections: (1) receipt and acceptance of foreign guardianship, and (2) transfer of guardianship to a foreign jurisdiction.

a. Receipt and Acceptance of Foreign Guardianship

Article I of the section for receiving and accepting a foreign guardianship directs who may file petition for transfer of guardianship, and where such qualified petitioner should file the petition. Because the petition seeks the permission of a foreign state to

47. Id.
48. Id.
49. Id.
50. Id, at app. D.
51. Id.
52. Id.
accept an existing guardianship, the petition should be filed in the court of the foreign state.

Articles II and III include requirements for the information that should be included in the petition (such as a certified copy of the foreign guardianship order, any pending guardianship petitions, name, age, principal residence, and current address of the IP) and notice (such as the IP has a right to a hearing, the procedure of the guardianship proceeding, consequences of the transfer), and to whom the notice should be served.

Article IV governs the request for a hearing. Any interested party may request a hearing to object to the transfer or to modify the terms of the guardianship. The receiving court should also hold a hearing if the transfer petition includes a request to modify the original terms of the guardianship. Article V also states that if the receiving court finds the request for transfer is genuine, proper and meets all requirements stated in Articles I and IV, the receiving court should give effect to the foreign guardianship.

Finally, under Article VI, “[w]ithin a reasonable period of time after the receipt and acceptance of the foreign guardianship, the [court] shall review the provisions of the guardianship.” If the court deems necessary, it may modify the terms of the received guardianship. However, this provision may raise an interesting question concerning the full faith and credit doctrine. If the receiving court has the discretion to determine whether to modify the guardianship that is just transferred pursuant to local laws, does the receiving state in actuality accord the judgment by the transferring state with full faith and credit?

b. Transfer of Guardianship to a Foreign Jurisdiction

The second section of NCPJ proposed legislation deals with the administrative procedures of the sending court. Similar to the first section, Article I of the Transfer of Guardianship to a Foreign Jurisdiction starts with the requirement of jurisdiction. This Article states that only when an IP is considered permanently moved to the foreign state, the transfer is necessary. The IP may be presumed to have moved permanently to a foreign jurisdiction if: “(1) he or she has resided in the foreign jurisdiction for more than 12 consecutive months; (2) the guardian notifies the [court] that the [IP] intends to move or has moved permanently to the foreign jurisdiction; or (3) a foreign court of competent jurisdiction notifies the [court] of the filing of a petition for guardianship for the [IP] in the foreign jurisdiction.” Because the petition requests to transfer the guardianship, it should be filed with the court of the original state.

53. Id.
54. Id.
55. Id.
56. Id.
57. Id.
Article III requires that all interested parties have to be notified of this intended transfer. If any interested party requires or “on the court’s own motion...[,] the [court] may hold a hearing to consider the petition to transfer the guardianship....” If the court finds the petition to transfer the guardianship is genuine, the sending court should grant the transfer.

Subsection B [sic] of Article V promotes communication and cooperation. Once the sending court grants the transfer, it should cooperate with the receiving court “to facilitate the orderly transfer of the guardianship.” If the sending court finds it necessary, it has the discretion to delay the transfer, condition the transfer, create concurrent jurisdiction over the guardianship, or make other arrangements.

III. ISSUES NOT ADDRESSED BY PROPOSED LEGISLATION

Neither UGPPA section 107 nor NCPJ’s proposed standards and legislation fully covers all the problems generated by the phenomenon of interstate guardianship. UGPPA only provides a general guideline that pertains to transfer of either existing guardianship or pending guardianship proceeding, and such guideline is very vague. How should a court decide whether to grant or to accept a transfer of guardianship? UGPPA says the decision should be based on the “best interest” of the IP, which really means that each judge should use his or her best judgment to determine what the best interest is for an IP. It is silent on the issues of simultaneous jurisdiction and recognition of a foreign guardianship.

Although NCPJ’s standards and legislation are much more detailed and complete, as to the transfer of guardianship, it only briefly touches upon the issues of simultaneous jurisdiction. The solution suggested by the NCPJ legislation is that the court receiving the earliest petition should rule on which court is the most appropriate locus of subject matter jurisdiction. However, the possibility of forum shopping remains with such suggestion. Moreover, the solution does not resolve the issue of the IP’s domicile in litigation brought by a guardian on behalf of the IP.

IV. SUGGESTIONS TO THE PROPOSED LEGISLATION

A. Simultaneous Jurisdiction

The court of AIP’s domiciliary state should be the court that has the default jurisdiction over a guardianship proceeding concerning an AIP. Although, if an AIP is in urgent need of protection and is currently in a foreign state, requiring a petitioner to

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58. Id.
59. Id.
60. Id, Article V(B) [sic].
61. Id, Article V(C) [sic].
62. § 107.
63. Id.
64. NCPJ, supra note 27, at app. C (Standard 3.5.2(b)).
provide necessary documents from the foreign state, would burden the petitioner and cause delay to the guardianship proceeding. However, the possibility of forum shopping (that the petitioner does not have AIP’s best interest in mind may move the AIP to a foreign state and quickly file a petition and persuade that court to retain jurisdiction) should outweigh such inconvenience. Once an individual is adjudicated incompetent, he or she will forever lose personal liberty and control of his or her property. The strong interest of the domiciliary state in protecting the liberty interests of its citizens argues for default jurisdiction in the domiciliary state in such instances.

Advanced technology, one of the factors that contributed to the phenomenon of interstate guardianship, will have positive effect here. All the necessary documents can be transmitted via electronic means (such as e-mail, facsimile) or expedited carrier (overnight delivery), so the proceeding will not be delayed.

Some may further argue that even if documents can be easily obtained, presenting witnesses at the hearing can still render a problem for a petitioner. Again, advanced technology can play an important role here; witnesses can be presented via telephone conference, or even video conference.

As an alternative, when there are more than one court that has valid jurisdiction over a guardianship proceeding, the court of AIP’s domiciliary state should be the court to decide which of these competent courts is the appropriate venue because one’s domiciliary state “usually is the one most deeply concerned with [his or her] welfare.”65 Using the witness example above, if the court of AIP’s domiciliary state determines that it would be unreasonably inconvenient for a petitioner to produce witnesses from a foreign state, it may on its own motion decline jurisdiction.

Only when the court of an AIP’s domiciliary has jurisdiction (or default jurisdiction) over a guardianship proceeding, whoever does not have AIP’s best interest in mind will not be able to shop for a more favorable forum and manufacture a reason for petitioning for guardianship.

Conflict of law and simultaneous jurisdiction are two separate issues. Once the question of which court should have jurisdiction is determined, whether the laws of that jurisdiction should apply requires further and more careful analysis, which exceeds the scope of this paper.

1. An IP’s Domicile in a Litigation

Since forum shopping is a serious concern, a guardian should not have the power to change his or her IP’s domicile for the purpose of diversity jurisdiction in an action brought by the guardian on behalf of the IP.

As Vincent stated in his article, As America Ages, allowing a guardian to change the IP’s domicile for the diversity purpose, it will “upset[] the certainty and defeats the historical purpose of diversity jurisdiction.”66 He proposed that courts should apply the “per se rule that an [IP’s] domicile for diversity purpose cannot be changed by his
Rejecting the “per se rule” will result in “non-diverse plaintiffs to manufacture diversity by moving a ward to a neighboring state in order to sue a party in the former home state.”68 Furthermore, there is also a possibility that if a guardian is allowed to change the IP’s domicile for diversity purpose, it will prevent “legitimate diversity cases where an incompetent person is brought to another state and attempts to sue residents in the new forum.”69

Vincent’s view is fundamentally correct. First, because the federal diversity statute (28 U.S.C. § 1332) does not define the meaning of state “citizenship”, courts have developed a test of state citizenship (domicile test): the standard doctrinal formulation provides that state citizenship depends on physical presence and intent to remain indefinitely.70 Other than presence, courts require intent to determine the issue of domicile, and intent is one thing that an IP probably lacks. Based on the historical purpose of diversity jurisdiction, an IP’s domicile should remain the place where he or she resided before being adjudicated to be incapacitated.

Many courts have held that because a competent court granted the guardian powers to manage an IP’s person and property, likewise, a guardian should have the power to change an IP’s domicile.71 This is not the better view. Although a guardian does have the power to manage an IP’s person and property, a guardian should not be able to manufacture diversity jurisdiction when it does not exist. Preventing a guardian from changing an IP’s domicile does not mean the guardian cannot move the IP to a different location (may be a foreign state) when necessary.72 Therefore, prohibiting a guardian from changing an IP’s domicile will not affect the IP’s need for better or alternative medical treatment or care from a foreign state because generally, a guardian can decide and make arrangements for an IP to be relocated.73

Furthermore, allowing a guardian to change an IP’s domicile may result in barring an action with legitimate diversity from being heard in federal court.74 As demonstrated in Acridge, a diversity action could not be brought in federal court because the Fifth Circuit Court adopted the view that a guardian’s action moving an IP to a foreign state can change the IP’s residence for the purpose of diversity.75

The IP in Acridge resided in New Mexico, but his wife and guardian moved him to another nursing home in Texas.76 The IP was later killed by his roommate in that Texas nursing home, and the estate commenced an action in federal court against the...
nursing home. The plaintiff argued that because intent is required to change domicile, and the IP lacked the ability to form intent, he should remain a resident of New Mexico. On the other hand, the defendant contended that the IP should be presumed a Texas resident by the operation of law since he had resided in the Texas nursing home for more than two years and applied for medical benefits.

The Fifth Circuit Court adopted the view that a guardian can change an IP’s domicile, thus the Acridge IP was deemed a resident of Texas; consequently, there was no diversity, and the Fifth Circuit Court dismissed the action for lack of subject matter jurisdiction. It is a perfect illustration that allowing a guardian the power to change the IP’s domicile can sometimes produce adverse results when the diversity between parties is legitimate. Therefore, as suggested by Vincent, the best way to preserve the certainty of residence in questions of diversity jurisdiction and to prevent manufacture of diversity is to have an IP remain the resident of the state where the IP resided while competent.

B. Recognition of a Foreign Guardianship

Most states recognize a foreign guardianship on a temporary basis. New Hampshire temporarily recognizes foreign guardianships and conservatorships by allowing “[a]ny person who has been appointed guardian of the estate or conservator for any [IP] by... any other state shall, upon petition and filing of a certified copy of that appointment with the court, be appointed guardian of the estate or conservator of the [IP] in [New Hampshire] without further notice or hearing.” For “[a]ny person who has been appointed guardian of the person for [an IP] who is temporarily in this state by... any other state shall be accorded the powers of guardianship as reflected in the order appointing the guardian, with full faith and credit.”

At the other end of the spectrum, some states have strict requirements imposed upon a foreign guardian. For example, if an IP has assets in the State of Ohio, Ohio court will appoint a “resident guardian... to manage, collect, lease, and take care of the [IP’s] property[,]” and if the court deems necessary, it can even appoint a resident guardian regardless whether “a ward has a guardian, trustee, or other conservator in the state of the [IP’s] residence, and, if the [IP] has a guardian, trustee, or other conservator in the state of the [IP’s] residence, the control and authority of the resident guardian appointed in Ohio shall be superior as to all property of the [IP] in Ohio.”

77. Id.
78. Id. at 452.
79. Id. at 450.
80. Id. at 453.
81. Vincent, supra note 13, at 531-32.
83. Id. § 464-A:44(II).
85. Id.
Moreover, “the control and authority of the resident guardian... shall be superior as to all property of the [IP] in Ohio.”

Other states take a middle approach. New York is one of them. As cited in Section I(B), New York Mental Hygiene Law section 81.18 provides that a foreign guardian may be allowed to manage his or her IP’s property within the State of New York; however, such power is subject to New York law.

The Ohio approach will inevitably burden the foreign guardian and the court of the state where the IP’s assets are located. The foreign guardian only comes to the state to exercise guardianship powers temporarily in order to manage IP’s assets, to require a resident guardian to be appointed for this limited purpose takes extra time, money and judicial resources.

On the other hand, while according a foreign guardianship order with full faith and credit may seem to be the most convenient way to deal with this issue, but there is a potential problem. When the foreign guardian possesses more powers than a resident (local) guardian would have, and if the guardian does not properly perform his or her duties, the state where the IP’s assets are located may have difficulty monitoring and disciplining the guardian.

Thus, among these different approaches, the New York approach and similar statutes are the most reasonable and economic in the situation where a foreign guardian has to manage an IP’s assets located in another state. They can serve the best interest of both the IP (no extra cost for a resident guardian) and the local court (no need for additional judicial intervention and ease of monitoring).

CONCLUSION

“With rapid advancements in health, medicine, and science, Americans live longer than ever. Seventy-seven million baby boomers will soon join the ranks of the forty million seniors already in the United States.”

Interstate guardianship is not a local phenomenon, and soon it will widely spread to the entire country; therefore, now would be the best time for states that have no statute dealing with interstate guardianship to seriously consider adopting one, and for states that already have a basic frame of legislation concerning this issue to perfect it.

86. Id.
87. Daniel & Hannford, supra note 4, at 362.
88. Vincent, supra note 13, at 513.
SPEAKING UP FOR GRANDMA: DOES THE LONG-TERM CARE OMBUDSMAN PROGRAM PROVIDE EFFECTIVE ADVOCACY?

Patricia J. Meier*

I. INTRODUCTION ..........................................................................................................90
II. WHAT IS A LONG-TERM CARE OMBUDSMAN PROGRAM? .......................................91
   A. The Development of the Term ‘Ombudsman’ ..............................................92
   B. Evolution of the Long-Term Care Ombudsman Program .........................93
      1. The 1970s ...............................................................................................93
      2. The 1980s ...............................................................................................94
      3. The 1990s ...............................................................................................95
      4. Since 2000 ..............................................................................................96
   C. Status of Long-Term Care Ombudsman Program Today .........................96
III. FEDERAL GOALS FOR LONG-TERM CARE OMBUDSMAN PROGRAM .......................98
   A. Congress Intended OAA to Support Elders at Home............................98
   B. OBRA ‘87 Introduced Rights, Elevated Expectations ............................101
   C. Health and Human Services Regulates Long-Term Care ....................102
   D. Social Security Administration Reinforces OAA .................................103
   E. Olmstead Decision Opens Doors Out of Facilities ..............................103
   F. New Freedom Initiative Encourages Community Services ................105
IV. EVALUATIONS EXPOSE BARRIERS TO SUCCESS FOR OMBUDSMEN ......................106
   A. Institute of Medicine Affirms Need, Identifies Barriers .......................107
   B. Office of Inspector General Documents Continuing Issues .................109
   C. Institute of Health and Aging Echoes Earlier Reports .......................110
   D. NASUA Identifies Outcome Measures ...............................................110
V. IN SUMMARY: IMPORTANT PROGRAM COULD DO MUCH MORE ......................111

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I. INTRODUCTION

The number of Americans age 60 and older is growing at an unprecedented rate. The country counted 50 million residents age 60 or over in 2006, the year the post World War II Baby Boom generation started turning 60. Every day now, 8,000 individuals born between 1946 and 1964 celebrate sixtieth birthdays. And with more of them living longer than their progenitors, demographers predict there will be 74.4 million 60-plus year-olds in the United States by 2020.

“Boomers are expected to live longer than any previous generation of Americans. Of the 3.4 million born in 1946—including Bill Clinton, George and Laura Bush, Donald Trump, Susan Sarandon, Steven Spielberg, and Sylvester Stallone—2.8 million are still alive. The men can expect to live another 22 years, the women another 25.” By 2030, when the first Boomers reach 84, more than 20 percent of the population will be over 65, compared to only 13 percent today.

As the Boomers age, the demand for health care and social services typically needed by the elderly undoubtedly will grow. Some researchers predict the increased demand will outpace even what the population numbers alone suggest, especially the demand for nursing home care. The results of a 2003 study indicated a higher percentage of the upcoming elderly population will need nursing home care than the current elderly population. “In recent years, the rate of institutionalization among the elderly has been falling. It is predicted that this trend will reverse itself within the next decade, and that we will see substantial increases in the incidence of institutionalization among the elderly. This result is generated by our prediction of rising disability among the younger cohorts that are beginning to approach old age.”

Nursing home residents need advocates because they often are ill-equipped to advocate for themselves. In 2002, the United States General Accounting Office wrote, “The 1.5 million elderly and disabled individuals residing in nursing homes are a

5. Id.
highly vulnerable population. They often have multiple physical and cognitive impairments that require extensive assistance in the basic activities of daily living, such as dressing, feeding, and bathing. Many require skilled nursing or rehabilitative care.7 Such individuals may be unable to lodge complaints, or unwilling to speak against the staff upon whom they depend.

Even when residents are able and want to voice complaints, they may not be aware of the proper avenue for doing so effectively, the report continued. “Individuals... may encounter a confusing array of numbers both public and private in their local telephone directory. In the three states we visited we reviewed the government and consumer pages in nine telephone books and identified a wide variety of organizations, which, by their names, appeared capable of addressing complaints. However, many did not have the authority to do so.”8

Congress created the Long-Term Care Ombudsman Program to create advocates for nursing home residents. Ombudsmen receive complaints from residents of nursing homes and assisted living centers, or their families, and help those residents pursue resolutions. The Older Americans Act (OAA) defines the programs and provides federal funding. The Act mandates that every state maintain an ombudsman program to advocate for residents of nursing homes and assisted living facilities. It leaves the design, implementation, and administration of the programs up to the states. Thus, the programs vary widely from one state to the next. However, even when such a program is well funded, well staffed, and meets many of its stated goals and objectives, often “the general public is not fully aware of the ombudsman program and its mission.”9

This paper provides an overview of the national Long-Term Care Ombudsman Program and analyzes how effectively it advocates for nursing home residents. Section II explains what an ombudsman is, how the OAA ombudsman program developed, and how it operates now. Section III discusses the OAA’s goals and objectives for ombudsman programs and how the program has—or has not—fulfilled its mandate. Section IV summarizes evaluations of the program.

Despite a clear Congressional mandate, a 30-year history, and multiple evaluations, the national Long-Term Care Ombudsman Program continues to inconsistently affect the quality of care nursing homes deliver to residents. Insufficient funding, staffing issues, and highly variable state implementations hobble the program and prevent it from fulfilling Congress’s mandate. Now, a shifting emphasis in policy raises questions about the ongoing role for the program.

II. WHAT IS A LONG-TERM CARE OMBUDSMAN PROGRAM?

The Long-Term Care Ombudsman Program was created in a time when many public and private organizations were establishing ombudsman positions to address complaints. This section of the paper describes what an ombudsman is, traces the

8. Id.
9. The Long-Term Care Ombudsman Program: Are We Ready for the Coming ‘Age Tsunami’? Orange County Grand Jury 2005-2006, 12.
development of the Long-Term Ombudsman Program, and provides an overview of the program as it operates today.

A. The Development of the Term ‘Ombudsman’

The word “ombudsman” originated in medieval Germanic tribes, in which a third party was enlisted to collect fines imposed on those who broke the law and deliver the money to the person who was harmed. “Om” meant “about” and “buds” referred to “offering” or “bribe.” So the person who came to collect the fine was called an ombudsman. The term eventually came to refer to anyone acting as a general agent for another. 10

The first named ombudsman office was created in 1809 in Sweden, where the new democracy’s parliament designated a “justitieombudsman” to resolve complaints about the government. 11 “[T]he ombudsman’s role was to serve as an agent of the government, while at the same time supervising and prosecuting governmental wrongdoing. In later years, the role became that of a ‘citizen-defender, concerned with resolving public complaints against the public bureaucracy.’” 12 That definition holds today, including the uncomfortable dichotomy of being both a government representative and a watchdog against abuses by the government.

In the last 30 years or so, ombudsman offices have sprouted throughout the United States in both the private and public sectors. 13 Federal administrative agencies have created many ombudsman offices, often pursuant to Congressional mandates. According to the American Bar Association, “Ombuds protect the legitimate interests and rights of individuals with respect to each other; individual rights against the excesses of public and private bureaucracies; and those who are affected by and those who work within these organizations.” 14 The ABA defines four types of ombudsman: legislative, executive, organizational, and advocate. 15 A legislative ombudsman is part of the legislative branch of government. An executive, organizational, or advocate ombudsman may work for a public or private entity. An executive ombudsman works to resolve complaints about an organization. An organizational ombudsman receives complaints from within an entity. An advocate ombudsman also receives complaints, but has the additional responsibility to “advocate on behalf of individuals or groups found to be aggrieved.” 16


11. Id.

12. Id. at 98 (citing Gerald E. Caiden et al., The Institution of Ombudsman, International Handbook of the Ombudsman: Evolution and Present Function 9, 10 (1983).


15. Id.

16. Id.
The long-term care ombudsman is most accurately classified as an advocate ombudsman. Congress charged long-term care ombudsmen with helping individual residents of nursing homes or assisted living facilities resolve complaints as well as advocating for and protecting residents’ rights.

“The Ombudsman shall... identify, investigate, and resolve complaints that are made by, or on behalf of, residents;... provide services to assist the residents in protecting the health, safety, welfare, and rights of the residents; [and]... represent the interests of the residents before governmental agencies and seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the residents.”

B. Evolution of the Long-Term Care Ombudsman Program

Congress passed the Older Americans Act in 1965 to support Americans age 60 and over. It was—and is—the government’s principle advocacy tool for elders. The Act authorizes distribution of federal money to states to pay for services to support elders. The OAA allocates funds according to the state’s share of elderly residents who need services. The states create and administer specific programs they determine their seniors need. Common programs under the OAA today include congregate and home-delivered meals, community support and long-term care services, elder abuse identification and prevention, family caregiver support, senior community service jobs, legal services, and the Long-Term Care Ombudsman Program.

1. The 1970s

Congress mandated state Long-Term Care Ombudsman Programs in 1978. However, the program traces its history six years earlier. In 1972, the Health Services and Mental Health Administration—a predecessor of the Department of Health and Human Services—launched demonstration projects to receive and respond to nursing home residents’ complaints in five states. The projects implemented one element of an eight-point presidential initiative to improve nursing home care. In 1973, the department added demonstration sites in two more states and transferred the budding

17. 42 U.S.C.A. §3058g(a)(3).
23. Id.
program to the Administration on Aging. In 1975, Congress passed amendments to the Older Americans Act that authorized grants to establish state ombudsman programs in nursing homes nationwide. All but two states applied for and received grants. The Administration on Aging provided about $1 million to start state programs.24 The emphasis was on creating networks of volunteers to advocate for residents. Success was measured by how many communities launched programs and how effectively the programs resolved individual complaints.25

Over time, the focus broadened. In 1977, the Administration on Aging provided training funds for state “ombudsman development specialists.” In 1978, the AoA provided additional money for advocacy for systems as well as individuals.26 Amendments to the Older Americans Act that year required every state to have a Nursing Home Ombudsman Program and defined the responsibilities of those programs.27 The next year, further amendments to the Act granted money to the National Citizens’ Coalition for Nursing Home Reform (NCCNHR) to provide training and information to the programs.28

2. The 1980s

The ‘80s brought an expansion of duties, guidance, program size, and legal protections to state Long-Term Ombudsman Programs. The decade also marked the first time the government expressly recognized the rights of nursing home residents.

Congress expanded state ombudsmen duties to include advocacy for residents of assisted-living facilities as well as nursing homes. The OAA changed the name of the programs to reflect the changed duties: the Nursing Home Ombudsman Program became the Long-Term Care Ombudsman Program. The Administration on Aging offered more guidance to the state programs in the form of “program instructions” and a series of papers that became the Ombudsman Technical Assistance Manual.29 The programs grew in size during the ‘80s, too. Fifty percent more paid staff members worked for state Long-Term Care Ombudsman Programs in 1984 than had worked for them in 1982.30 Amendments to the Older Americans Act in 1987 provided ombudsmen with greater legal protections by guaranteeing ombudsmen access to residents and their records as well as protection from interference, retaliation, and legal action over the good faith performance of their duties.31

Congress passed the 1987 amendments to the Older Americans Act as a part of the Omnibus Budget Reconciliation Act that year. The Act—Congress’s response to a 1986 Institute of Medicine report that documented widespread abuse of nursing home

24. Id.
25. Id.
26. Id. at 2.
27. Id.
28. Id.
29. Id.
30. Id.
31. Id.
residents’ rights—was “widely hailed as the most significant federal legislation affecting nursing homes since the creation of the Medicare and Medicaid programs in 1965.” OBRA ‘87 included the 1987 Nursing Home Reform Act, which articulated nursing home residents’ rights for the first time:

- The right to freedom from abuse, mistreatment, and neglect;
- The right to freedom from physical restraints;
- The right to privacy;
- The right to accommodation of medical, physical, psychological, and social needs;
- The right to participate in resident and family groups;
- The right to be treated with dignity;
- The right to exercise self-determination;
- The right to communicate freely;
- The right to participate in the review of one’s care plan, and to be fully informed in advance about any changes in care, treatment, or change of status in the facility; and
- [t]he right to voice grievances without discrimination or reprisal.

The list includes two rights that particularly concern a long-term care ombudsman. The first is the right to a 30-day notice of transfer or discharge. The notice must include the reason for transfer or discharge, the effective date, the location to which the resident is transferred or discharged, a statement of the right to appeal, and the name, address, and telephone number of the state long-term care ombudsman. The second is the right to “immediate access by a resident to a personal physician, health department officials, and ombudsman personnel.” With OBRA ‘87, the focus shifted from simply maintaining residents of nursing homes to requiring the facility to “attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.” Since then, the Older Americans Act has increasingly emphasized protecting the rights of seniors, especially those who live in long-term care facilities.

3. The 1990s

In 1992, changes to the OAA included a new Title VII that mandated elder rights protection activities, including the requirement that each state develop an Elder Rights Plan. In 1993, the National Association of State Units on Aging—which the
Administration on Aging had first funded in 1988—and the NCCNHR launched the Long-Term Care Ombudsman Resource Center “to enhance the skills, knowledge and management capacity of the State programs to enable them to handle residents’ complaints and represent resident interests.”\footnote{National Long Term Care Ombudsman Resource Center, available at \url{www.ltcombudsman.org}}

Older Americans Act amendments in 1992 strengthened the ombudsman programs and moved them under Title VII, Vulnerable Elder Rights Protection Activities. The move tied the work of state Long-Term Care Ombudsman Programs more closely to the work of adult protective services programs. The final decade of the 20th Century also brought onsite assessments of the state programs, national training conferences, and the National Long-Term Care Ombudsman Reporting System (NORS), which collects data on the state programs.\footnote{Id. at 3.}

4. Since 2000

In 2006, Congress again reauthorized the Older Americans Act. The reauthorized version emphasizes offering elders choices in the services that support their health and activities of daily living. The Administration on Aging now encourages states to rebalance existing resources to create more home and community-based services. The United States spends $140 billion each year on elder care programs, according to Josefina G. Carbonell, assistant secretary for aging with the U.S. Department of Health and Human Services.\footnote{Id.} Sixty percent of the expenditures go to nursing home care.\footnote{Id.} “If we could redirect just 1 percent, it would be nearly $1 billion for more home-based care.”\footnote{Id.} Of course, it would also mean nearly $1 billion less for nursing home care, just as the demand for those services is expected to swell. States’ ability to move resources from nursing homes to home- and community-based services is unclear. The effect of such a shift on advocacy for a growing population of nursing home residents also is unclear.

C. Status of Long-Term Care Ombudsman Program Today

The Administration on Aging website reports about 1,000 paid ombudsmen and 14,000 volunteers across the country. Eight thousand of the volunteers have completed enough training to be considered certified. Collectively, paid and volunteer ombudsmen investigate more than 260,000 complaints and provide information to more than 280,000 individuals annually.\footnote{Id.} Most of the state programs operate as part of a State Unit on Aging, although 15 states administer their programs under another auspice. Alaska, for example, houses its program in the Department of Revenue.\footnote{http://www.aoa.dhhs.gov/prof/aoaprog/elder_rights/LTCombudsman/LTC_ombudsman.asp.}
Kentucky and Wisconsin create independent state agencies with cabinet-level status. Other states administer their programs through legal or social assistance programs.46

Many state Long-Term Care Ombudsman Programs recruit community volunteers to visit facilities regularly, to create relationships with residents, and to keep a watchful eye on the institution. Volunteers must meet only minimal qualifications. In Arkansas, for example, volunteers merely need to be 18 or older; have reliable transportation; experience working with older people; and no conflict of interest with the facility they visit.47

Duties of volunteer ombudsman vary by state, but generally consist of regularly visiting a facility and assisting the paid ombudsman with receiving and resolving complaints. Northern California requirements are typical: A volunteer ombudsman there must complete state certification training and annual training; visit assigned facilities regularly “for the purpose of identifying, investigating and resolving complaints made by or on behalf of residents;” attend monthly case-management meetings, keep records; make monthly reports; and “provide ombudsman advocacy services in a manner consistent with the Federal and State requirements, as well as the local program policy and procedures.”48

Although the government network of state ombudsman programs provides almost all the advocacy services available to residents of long-term care facilities, private ombudsmen also occasionally are available to advocate for residents. One such program, the non-profit Nursing Home Ombudsman Agency of the Bluegrass in Lexington, Kentucky, illustrates the limits of state programs that depend on volunteers.49 With an annual budget of $519,000 the private agency is able to resolve many more complaints than the state program in nearby Louisville, which has twice as many nursing home beds—and twice as many potential complaints—but a budget of only $177,000. “They are able to actually hire their staff rather than rely heavily on volunteers,” said the Kentucky Long-Term Care Ombudsman Larry Smith.50

Under the leadership of the assistant secretary for aging in the U.S. Department of Health and Human Services, the Administration on Aging distributes Congressional allocations through the 57 state agencies, 660 Area Agencies on Aging, and thousands of local service organizations that make up the “Aging Network.”51 Funding has not kept up with inflation or demographic changes, however.52 “The Older Americans Act has lost ground over the past 20 years due to our rapidly increasing frail, older population, those most in need of services, and relatively level federal funding that has not kept pace with inflation,” according to the National Committee to Preserve Social

51. Id.
52. Kassner, supra at note 20.
Security and Medicare. The situation is not likely to improve soon. “The FY 2008 request for the Administration on Aging of $1,335,146,000 is a decrease of $28 million from current funding in the continuing resolution for Fiscal Year 2007... In addition, the President’s budget request... reduces funding for... the long-term care ombudsmen program.”  

Title III and Title VII of the Older Americans Act provide federal funding to Long-Term Care Ombudsman Programs. States are required to match some of the Title III funding. Most states provide additional funding, although several do not, adding to the wide variety and levels of services offered by ombudsmen nationwide. Local governments and charitable groups also supplement funding for some programs. Funding remains problematic, however, and many ombudsmen complain the lack of funding hinders their effectiveness.

III. FEDERAL GOALS FOR LONG-TERM CARE OMBUDSMAN PROGRAM

Congress, federal administrative agencies, and the Supreme Court collectively shape the public policy and law that provides advocacy to residents of long-term care facilities. The goals and objectives of the Long-Term Care Ombudsman Program are embedded in that law. To evaluate whether the Long-Term Care Ombudsman Program meets its mandate, one must consider the program within the context of relevant legislation, administrative agency regulations, judicial rulings, and presidential initiatives. Here, those measures include the Older Americans Act, OBRA ‘87, regulations of the Department of Health and Human Services and the Social Security Administration, the Supreme Court decision in Olmstead v. L.C. ex. rel. Zimring, 527 U.S. 581 (1999), and the New Freedom Initiative.

A. Congress Intended OAA to Support Elders at Home

The ombudsman programs are a small part of the Older Americans Act. This section looks at Congress’s intent in the Older Americans Act generally, and then at Congress’s intent in the ombudsman provisions of the Act. The original intent of the OAA was to help states provide as much care as possible to the elderly in their homes, rather than in residential facilities.

It is the purpose of this subchapter to encourage and assist State agencies and area agencies on aging to... foster the development the implementation of comprehensive and coordinated systems to serve older individuals... to secure and maintain maximum independence and dignity in a home environment for older individuals capable of self care with appropriate supportive services; remove individual and social barriers to economic and personal independence for older individuals; provide a continuum of

55. Institute of Medicine, Real People, Real Problems: An Evaluation of the Long-Term Care Ombudsman Programs of the Older Americans Act, 44 (1995).
care for vulnerable older individuals; and secure the opportunity for older individuals to receive managed in-home and community-based long-term care services.\(^{56}\)

Despite the intent to keep elders in their homes, in practice, most services for the frail elderly have been delivered in long-term care facilities rather than at home. In many cases, even relatively able elders are given only one choice when they need support services: a nursing home. Congress reaffirmed its original intent in the OAA when it passed the OAA reauthorization of 2006. Congress again called on the states to develop programs that support elders in their homes. The key language in the 2006 reauthorization is in Title III, Grants for State and Community Programs on Aging:

The State agency shall, consistent with this section, promote the development and implementation of a State system of long-term care that is a comprehensive, coordinated system that enables older individuals to receive long-term care in home and community-based settings, in a manner responsive to the needs and preferences of the older individuals and their family caregivers.\(^{57}\)

Congress’s intent in establishing the Long-Term Care Ombudsman Program is less clearly articulated than the intent of the OAA overall, although Congress clearly intended to authorize official advocates for residents of long-term care facilities. “The individual in the nursing home is powerless. If the laws and regulations are not being applied to her or to him, they might just as well not have been passed or issued,”\(^{58}\) said the former commissioner on aging, Arthur S. Flemming, in 1975. The OAA mentions the Long-Term Care Ombudsman Programs in Title I, Title II, Title III, Title IV, and Title VII. Title I, Definitions, covers many relevant terms, including “abuse,” “frail,” and “long-term care facility.”\(^{59}\) Title II, Administration on Aging, establishes the office of Long-Term Care Ombudsman Program in the AoA, creates a director’s position, and defines the director’s functions.\(^{60}\) Those functions include serving “as an effective and visible advocate on behalf of older individuals who reside in long-term care facilities.”\(^{61}\) Additionally, “the Director shall advocate, monitor, and coordinate the Federal and State activities of Long-Term Care Ombudsmen.”\(^{62}\) Title II also creates the National Ombudsman Resource Center and requires the National Ombudsman Report.\(^{63}\) Title III, Grants for State and Community Programs on Aging, requires the assistant secretary on aging to provide training and technical assistance to state ombudsman programs and provides funding allotments.\(^{64}\) Title IV, Training, Research, and Discretionary Projects and Programs, authorizes grants for demonstration projects to study cooperative ventures with agencies that provide legal, protective, or advocacy

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56. 42 U.S.C.A. §3021.
58. Id.
60. 42 U.S.C.A. §3011(d).
63. 42 U.S.C.A. §3011(d)(3)(H) and (J).
64. 42 U.S.C.A. §3021(c) and §3024(d).
systems for people with developmental disabilities or mental illness. The Ombudsman shall... identify, investigate, and resolve complaints that are made by, or on behalf of, residents and relate to action, inaction, or decisions, that may adversely affect the health, safety, welfare, or rights of residents; assist the residents in protecting the health, safety, welfare, and rights of the residents; inform residents about means for obtaining services; ensure that the residents have regular and timely access to the services provided by the Office and that [they] receive timely responses; represent the interests of the residents before governmental agencies and seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the residents; provide administrative and technical assistance to [entities to whom the ombudsman delegates duties]; analyze, comment on, and monitor the development and implementation of Federal, State, and local laws, regulations, and other governmental policies and actions that pertain to the health safety, welfare, and rights of the residents with respect to the adequacy of long-term care facilities and services; provide for training representatives; and carry out such other activities as the Assistant Secretary determines to be appropriate.

Congress intended the ombudsman to be a watchdog for residents of long-term care facilities. At the federal level, the director is to be “an effective and visible advocate” for residents. At the state level, the ombudsman is to proactively identify, investigate, and resolve complaints. Additionally, Congress expects the state ombudsman to educate residents about available services; advocate for the elderly residential cohort before legislators; and keep up with changes in federal, state, and local laws and regulations that affect residents. Congress also expects ombudsmen to advise policymakers on those laws and regulations. The OAA charge to ombudsmen is to provide personal advocacy, education, and systemic advocacy.

In practice, ombudsmen may operate very differently. No two state programs are exactly alike. The OAA gives states great latitude in designing ombudsman programs. States may or may not enact laws to supplement the OAA. Likewise, states may or may not allocate additional state funds to the programs. In Texas, for example, the director of an ombudsman program said ombudsmen wear three hats: friend and visitor to the residents, mediator between residents and facilities, and—when diplomatic
attempts to resolve conflicts fail—adversary to a facility. 76 “We’re there to listen, primarily. So the hat we wear most often is the ‘friend’ hat.”

Nowhere does the OAA direct ombudsmen to befriend residents. Personal advocacy may often require mediation, although the OAA does not use the word mediate. Likewise, resolving complaints may sometimes put the ombudsman in an adversarial role to a long-term care facility, but the OAA does not describe the ombudsman as an adversary. The roles described in the OAA only loosely align with the roles as described by the Texas ombudsman program director.

Given the variability in state programs, ombudsmen may or may not fulfill the roles congress intended. A state-by-state evaluation is the only way to determine if and where state ombudsmen fulfill their Congressional mandate under the OAA.

B. OBRA ‘87 Introduced Rights, Elevated Expectations

OBRA ‘87 constituted a sea change for long-term care residents in two ways. First, it introduced a “Residents’ Bill of Rights”: “A nursing facility must protect and promote the rights of each resident.” 77 The statute then enumerated a long list of specific rights. Second, OBRA ‘87 demanded a higher level of care for residents. “A nursing facility must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.” 78 Congress intended in OBRA ‘87 to elevate both the status and the level of care for elders in residential facilities. In OBRA ‘87 Congress also intended ombudsmen to protect residents’ newly articulated rights. OBRA ‘87 included amendments to the OAA that protected residents’ rights to immediate access to the ombudsman and gave ombudsmen the right of access to a resident’s record.

Since OBRA ‘87, many regulations and state statutes further codified residents’ rights and ombudsmen access to resident records. A Google search of “ombudsman access to records” returns more than a million documents. So, in that sense, Congress’s mandate has been met. However, other OBRA ‘87 objectives have yet to be implemented. As recently as May 2, 2007, at a hearing on the state of the nursing home industry 20 years after OBRA ‘87, the General Accounting Office testified that many facilities providing poor care have not been sanctioned and “may therefore not be motivated to make the lasting improvements necessary to protect the health and safety of all residents.” 79

76. Diane I. Persson, director of the Ombudsman Program, Center on Aging, University of Texas Health Center at Houston, in comments delivered as part of Ombudsman: A Nursing Home's Friend or Foe?, at the 2007 Joint Conference of the American Society on Aging and the National Council on Aging, March 7-10, 2007.
77. 42 U.S.C. §1369r(c)(1)(A).
78. 42 U.S.C. §1396r(b)(2).
C. Health and Human Services Regulates Long-Term Care

Congress intends the Department of Health and Human Services to regulate long-term care facilities. HHS is home to the Administration on Aging as well as the Centers for Medicare and Medicaid (CMS). CMS administers Medicare, which provides health-care benefits to any American over age 65, and Medicaid, which provides health-care benefits to financially needy Americans, including seniors. The AoA participates through the Long-Term Care Ombudsman Program. CMS regulates through its nursing home survey and certification process.

The vast majority of the nation’s nursing homes qualify for Medicare or Medicaid funding. Medicare covers short-term stays in skilled nursing facilities; Medicaid covers long-term care for qualified residents. Medicaid is jointly administered by the federal government and each state. About 70 percent of nursing home residents are supported at least in part by Medicaid. Therefore, CMS provides the bulk of most nursing homes’ revenue. CMS sanctions can include heavy fines or revocation of a facility’s Medicaid or Medicare payment qualification. Therefore, CMS regulations have a profound effect on the industry.

The U.S. Department of Health and Human Services also spearheads the government efforts to evaluate and improve quality in the nation’s long-term care facilities. Such efforts are intrinsically linked to the advocacy role of the long-term care ombudsman. The 2002 Nursing Home Quality Initiative, for example, names two goals: 1) To provide consumers with information about the quality of nursing home care, and 2) To help providers improve quality of care. The quality of care initiative further specifies a four-prong effort to achieve its goal: 1) regulation and enforcement by state survey agencies and CMS, 2) improved consumer information on nursing home quality, 3) continual, community-based quality improvement programs for nursing homes, and 4) collaboration and partnership to leverage knowledge and resources.

The goals and strategies of the Nursing Home Quality Initiative focus on enforcement, information, quality, and collaboration. They parallel and reinforce the functions of a state long-term care ombudsman. “The Ombudsman shall inform the residents about means of obtaining services provided by providers or agencies; represent the interests of the residents before governmental agencies and seek

82. Id.
83. Id.
84. Id.
85. Id.
86. Id.
87. Id.
88. Id.
89. Id. at (3)(C).
administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the residents.”90 With common goals for a common cohort, it is reasonable to assume Congress intended CMS and the state Long-Term Care Ombudsman Programs to work in concert.

D. Social Security Administration Reinforces OAA

The Social Security Act supports Congress’s goals for the LTC Ombudsman Program by requiring facilities to give notice to residents before their residence at the nursing home ends and directing the facility to provide the resident with contact information for the state LTC Ombudsman Program.91 The Social Security Act also requires facilities to allow access to resident records by the state LTC Ombudsman Program.92 The Deficit Reduction Act of 2005 amended the Social Security Act, aligning it more closely with the OAA.93 DRA ‘05 added two new subsections to §1915. “Optional Choice of Self-Directed Personal Assistance Services (Cash and Counseling),” which took affect January 1, 2007, allows states to create plans that let recipients make decisions about their own services.94 “Expanded Access to Home and Community-Based Services for the Elderly and Disabled,” allows states to offer home and community-based services as an option under their state plans.95 The new provisions affirm Congress’s emphasis on consumer choice and home-based services.

E. Olmstead Decision Opens Doors Out of Facilities

The Supreme Court decision in Olmstead v. L.C. ex. rel. Zimring further confirms a public policy of choice, self-determination, and home-based services. Olmstead laid a legal foundation upon which consumers can demand alternatives to nursing home care.96 The Olmstead plaintiffs sued because they remained institutionalized even after their conditions of mental retardation and mental illness stabilized and their health-care providers decided their needs could be met through community-based programs.97 The Supreme Court ruled that placing individuals with physical and mental disabilities in nursing homes when their needs could be met through alternative service providers violates Title II of the Americans with Disabilities Act.98 The Court said such treatment is a form of discrimination. “Institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that

90. 42 U.S.C.A. §3058g.
91. 42 U.S.C. 1395i-3.
92. Id.
95. Id.
98. Id.
persons so isolated are incapable or unworthy of participating in community life... Confine men in an institution severely diminishes the every day life activities of individuals.”

The court’s language applies to elders at risk of institutionalization as well as individuals with disabilities. “Because the Americans with Disabilities Act (ADA) has no age limits, the Olmstead case has many implications for older persons who are themselves disabled,” said Jo Ann Lamphere, senior policy advisor to the AARP Public Policy Institute. Olmstead is considered landmark among advocates for elders and individuals with disabilities.

The decision can be thought of as a Brown v. Board of Education for institutionalized persons with disabilities. In Brown, the Supreme Court determined that legal segregation by race violated the U.S. Constitution, and ordered the integration of schools. Similarly, in Olmstead the Court declared unnecessary institutional segregation to be unlawful discrimination and ordered integration. Writing for the Court, Justice Ginsberg articulated what is essentially an ‘all deliberate speed’ standard (i.e., the Brown standard) for eliminating inappropriate institutionalization from the design of state programs.

Olmstead gives ombudsmen “new tools to respond to the most frequent complaint of nursing home residents and their families, ‘I do not want to be here. I want to go home,’” said Hollis Turnham in a report for the National Long Term Care Ombudsman Resource Center. “The decision supplies Long-Term Care Ombudsman Programs, through a state-initiated Olmstead planning process, a forum to work with consumers and other advocates to create a long term care system that works.”

A key point of Olmstead is that the states must take affirmative steps to implement the decision. The court imposed a standard of “reasonable modifications” on the states. A state meets this standard if it can demonstrate “a comprehensive, effectively working plan for placing qualified persons... in less restrictive settings.”

A state is not required to provide community-based services that would constitute “fundamental alterations” of existing services or programs, but the presumption lies in favor of community care. The state bears the burden of proving that an accommodation constitutes a “fundamental alteration.”

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102. Turnham, supra at note 41.
103. Hollis, supra at note 83.
104. Id. at ii.
105. Id.
Olmstead strengthens the mutually beneficial relationship between advocates for the elderly and advocates for those with disabilities. That alliance has become increasingly important for two reasons. First, as the federal policy direction has moved toward delivery of more services at home, the two constituencies have more opportunities to work together to obtain services efficiently. Second, as it has become clear that service providers are expected to realign existing resources rather than look for additional appropriations, providers are highly motivated to find efficient methods to deliver services. Coordinating the efforts of ombudsmen and advocates for those with disabilities makes sense. For one thing, the advocates for individuals with disabilities have blazed many trails ombudsmen may need to travel. Ombudsmen can learn from advocates for those with disabilities, according to Patrick Flood, a former state ombudsman. Indeed, in his state of Vermont, advocates for both groups officially work together under Flood, who is the commissioner of Vermont Department of Disabilities, Aging, and Independent Living.

The Older Americans Act empowers a state ombudsman only to advocate for elders in long-term care facilities. The effect of an increased emphasis on home-based services and of transitions out of facilities per the Olmstead decision is unclear. Will ombudsmen be expected to identify residents whose needs could be served at home? Should they conduct an assessment of the feasibility of moving a resident out of a facility each time a resident expresses a desire to go home? Will the ombudsmen be responsible for coordinating the home-based services needed to serve a former resident? If the resident has complaints after the transition, is the LTC ombudsman the appropriate person to resolve those complaints? To achieve efficiency, should ombudsmen represent long-term care residents with disabilities who are younger than 60? Would state LTC Ombudsman Programs be able to fulfill such additional duties?

F. New Freedom Initiative Encourages Community Services

The Olmstead decision precipitated President George W. Bush’s New Freedom Initiative in 2001. In the initiative and subsequent Executive Order 13217, the president directed federal agencies “to work together to ‘tear down the barriers’ to community living by developing a government-wide framework for helping provide elders and people with disabilities with supports necessary to learn and develop skills, engage in productive work, choose where to live and fully participate in community life.”107 The Centers for Medicare and Medicaid launched several programs in response to the presidential directive and the Deficit Reduction Act of 2005.108 Among them are a Money Follows the Person program, which provides grants to states to help

106. Patrick Flood, commissioner of the Vermont Department of Disabilities, Aging and Independent Living and 2nd vice president of the National Association of State Units on Aging, also a former licensed practical nurse and state ombudsman, comments delivered as part of Modernizing the Older Americans Act, at the 2007 Joint Conference of the American Society on Aging and the National Council on Aging, March 7-10, 2007.


individuals move from institutional to home and community-based care; Real Choice Systems Change Grants, to develop programs to deliver more community and home-based care; and grants to support transitions out of institutional care.

The OAA provides little guidance on the role the state LTC Ombudsman Programs should play in the transition of residents out of residential facilities. Some states involve ombudsmen in transition activities, others do not. Where ombudsmen participate, they see their role as reactive rather than proactive. "Ombudsman programs... perceive their primary role in nursing home transition efforts as providing information and assistance to residents who ask about returning to the community, rather than proactively identifying and approaching residents about transitioning back to their homes or communities." The extent of their role varies, according to the National Association of State Units on Aging. "Many ombudsman programs coordinate with community agencies to assist residents with transitioning back to the community. However some programs described more active involvement in nursing home transition initiatives, such as Real Choice Systems Change Grants, state-funded transition programs and Olmstead-related initiatives."

Transition activities can be very time-consuming. In Montana, for example: "In a typical case in which the Ombudsman Program was involved, the resident’s multiple physical and mental health needs required numerous planning meetings and careful delineation of the programs/agencies which could best provide the services needed."

Overall, the intent of Congress, the Supreme Court and the president is clear: As much as possible, services to support the elderly are to be delivered at home and in the community. It is unclear how such an emphasis will affect the LTC Ombudsman Programs. No one expects nursing home occupancy rates to go down as the Baby Boomers age. Even if the states successfully implement many home-based service programs, the demand for LTC ombudsman services probably will not decrease. On the contrary, a larger network of home- and community-based services is likely to create a new, parallel demand for ombudsman services to support elders who use that network.

IV. EVALUATIONS EXPOSE BARRIERS TO SUCCESS FOR OMBUDSMEN

Evaluations of the effectiveness of the Long-Term Care Ombudsman Program show a genuine need for the program, but barriers to its success. The state ombudsman programs generate a lot of data through the National Ombudsman Reporting System. However, the programs do not always report data in a standard way, which makes

110. Id.
111. Id. at 4.
113. Id.
114. Miller, supra, note 112.
regular evaluations of effectiveness difficult. In reports to Congress, the AoA focuses on demonstrating efficiency through complaint resolution.\textsuperscript{115} The AoA uses one measure to demonstrate efficiency, the “increase in the number of ombudsman complaints resolved or partially resolved per million dollars of AoA funding.”\textsuperscript{116} That measure shows minimal growth: a four percent increase from 2002 to 2005.\textsuperscript{117} Congress charged the ombudsman programs with providing individual advocacy, information, and system advocacy. Complaint data is a measure of individual advocacy, but by itself it cannot demonstrate overall effectiveness. The data the AoA depends on to demonstrate program effectiveness can show—at most—effectiveness in only one-third of Congress’s mandate. Several groups have evaluated the nationwide Long-Term Care Ombudsman Program more thoroughly. This section summarizes an Institute of Medicine study mandated by the OAA in 1992, several reports from the Office of Inspector General, a 2004 nationwide study of factors associated with perceived effectiveness by the Institute of Health and Aging at the University of California in San Francisco, and a 2006 report on a National Association of State Units on Aging project to identify program outcome measures.

\textit{A. Institute of Medicine Affirms Need, Identifies Barriers}

The AoA commissioned the Institute of Medicine to conduct a comprehensive study of the effectiveness of the national LTC Ombudsman Program pursuant to a 1992 amendment to the OAA. The OAA required analysis of the availability of services, unmet need for services, effectiveness of programs, the adequacy of federal and other resources available to the state programs, compliance and barriers to such compliance of the programs, actual and potential conflicts of interest in administration and operation, the need for and feasibility of providing ombudsman services to elders who are not in long-term care facilities.\textsuperscript{118}

The IoM appointed a 16-member expert committee to examine four issues:

1. the extent of compliance with the program’s federal mandates, including conflict of interest issues;
2. the availability of, unmet need for, and effectiveness of the ombudsman program for residents of [long-term care] facilities;
3. the adequacy of federal and other resources available to operate the programs; and

\textsuperscript{116} AoA Program Performance Analysis, excerpted from: FY 2008 Justification of Estimates for Appropriations Committees, Department of Health and Human Services, Administration on Aging, 77 (Fiscal Year 2008).
\textsuperscript{117} \textit{Id.}
\textsuperscript{118} 42 U.S.C.A. §3001.
4. the need for and feasibility of providing ombudsman services to older individuals who are not residing in [long-term care] facilities.119

The IoM published the results of the study in 1995. The study found that the LTC Ombudsman Program serves a vital purpose. “Every year the LTC ombudsman program helps many thousands of individual LTC facility residents... The committee thus takes a strong supportive stance with respect to the ombudsman program.”120 But the report also said “the individual and systemic successes attributed to the ombudsman program occur despite considerable barriers. Obstacles to effective performance include inadequate funding, resulting staff shortages, low salary levels for paid staff, structural conflicts of interest that limit the ability to act, and uneven implementation among and within states.”121 The study found not all residents who needed services had access to them.122 In many cases, residents were not aware of ombudsman services.123 Implementation was uneven across the states.124 “The ombudsman program activities of too many states are piecemeal, fragmented, and focused primarily on responding to complaints that relate to individual residents.”125 The AoA had not mandated a level of implementation for the state programs and had not developed materials to guide the states on how to develop a fully implemented ombudsman office.126 The State Units on Aging seldom fulfilled their responsibility to ensure access to adequate and independent legal counsel for ombudsmen.127 On the question of conflict of interest, the IoM found “State ombudsmen operate in a politically charged environment accentuated by the fact that most often the state ombudsman is a state employee.” Also, the committee recommended the AoA improve data collection and develop valid and reliable measures for assessing effectiveness relative to resident well-being.128

The committee was particularly concerned about staffing and funding. “[S]taffing resources were minimal to inadequate from a national perspective.”129 The report suggested the AoA set a ratio of one paid staff member for every 20-40 volunteers.130 Also, “the full intent of Congress... has not been met in all—indeed, perhaps not in any—state... At the heart of many of the problems lie deficiencies of financial resources rather than lack of interest or basic commitment.”131

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120. Id. at 11.
121. Id. at 12.
122. Id. at 4.
123. Id. at 5.
124. Id.
125. Id.
126. Id.
127. Id.
128. Id. at 13, 15.
129. Id. at 16.
130. Id.
131. Id.
The IoM committee concluded that if the AoA adopted its recommendations for increased funding, minimized conflict of interest, program compliance measures, and enhanced information systems, policymakers would have better information to guide decisions within ten years.\footnote{132} Unfortunately, Congress and the AoA have not followed many of the suggestions.

B. Office of Inspector General Documents Continuing Issues

A series of studies by the HHS Office of the Inspector General show the barriers identified by IoM continued to impede success for the LTC Ombudsman Program. A 1999 report examined complaint trends. It found “from 1989 to 1994, total complaints in the 10 sample states increased 44 percent.”\footnote{133} From 1996-97, complaints increased another 7 percent.\footnote{134} In 1997, 32 percent of all complaints concerned resident care, and 31 percent focused on resident rights.\footnote{135} Most of the care complaints resulted from inadequate staffing.\footnote{136} “Both the volume and nature of complaints reported to ombudsmen suggest that more must be done to improve nursing home care.”\footnote{137} Another 1999 OIG study looked at the overall capacity of the ombudsmen to promote and monitor quality of care in LTC facilities.\footnote{138} Its findings enumerated several factors that limited the ombudsman program, including insufficient staffing. “Staffing levels... vary considerably, ranging from a ration of 5,003 beds per paid staff person in Florida to 1,115 beds per paid staff person in California.”\footnote{139} The report also cited the lack of a common standard for resolving complaints, lack of important performance measurement data, and not enough collaboration with the CMS survey process.\footnote{140} However, despite deficiencies, the report found ombudsmen “play an important role in assuring quality of care in nursing homes.”\footnote{141} It recommended the AoA work with the states to strengthen the program, especially in the staffing area. OIG suggested the states meet the IoM recommendation of one full-time equivalent staff person for every 2,000 beds.\footnote{142}

A third 1999 report studied quality of care.\footnote{143} It found 13 of 25 quality of care deficiencies had increased, and that complaints to ombudsmen had been steadily increasing as well. The report attributed the increases to inadequate resources.\footnote{144}
The ombudsman program has several functions to promote and monitor quality of care in nursing homes... However, the ombudsman program is limited by inadequate resources, including inadequate staffing... This lack of adequate staffing is particularly evident in the limited extent to which ombudsmen make regular nursing homes visits. The program is further constrained by the lack of a common standard for complaint response and resolution, inconsistent advocacy, a lack of support, and limited collaboration with surveyors.145

An OIG report in 2003 again analyzed complaint trends.146 It studied complaint data in NORS between 1996-2000, finding that the total number of complaints had increased, but the types of complaints had not changed.147 The study cautioned against depending on NORS data, and recommended the AoA “clarify and refine” the data. “Local ombudsmen do not report all nursing home complaints into NORS. Furthermore, ombudsmen do not always use the same NORS categories to classify complaints, and they sometimes report a single complaint in several different categories.”148 As of 2005, the AoA had not addressed the OIG recommendations to improve overall capacity and consistency of data for the ombudsman program.149

C. Institute of Health and Aging Echoes Earlier Reports

In 2004, a nationwide telephone survey of ombudsmen by researchers at the Institute of Health and Aging at the University of California at San Francisco found many of the IoM issues persisted, including insufficient funding, staffing, and autonomy. “The potentially deleterious consequences for [long-term care] quality will become an increasingly salient issue as the demographics of aging continue increasing the demand for [long-term care].”150

D. NASUA Identifies Outcome Measures

In 2006, the National Long-Term Care Ombudsman Resource Center published the final report of a three-and-a-half-year project of the National Association of State Units on Aging (NASUA) that aimed to identify outcome measures to describe the effectiveness of the ombudsman program on LTC residents and on the system as a

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144. *Id.* at 1-2
145. *Id.* at 3
147. *Id.* at 2.
148. *Id.*
The project facilitated the adoption of a mission statement by the national ombudsman program.

The mission of the long term care ombudsman program is to improve the quality of life and care of residents of long-term care facilities. The program’s mission is accomplished through: consumer education activities designed to inform and empower long-term care consumers; investigation and resolution of individual complaints; and system advocacy that includes legislation and public policy activities, promotion of community involvement in long-term care facilities and other activities designed to improve long-term care service delivery and oversight.152

The project group also identified three levels of outcomes—initial, intermediate, and long term—for each of four areas: outreach and education, complaint handling, systems advocacy, and program quality.153 Four participating states tested the outcome measures, but the results could not be compared because of the disparity in the programs and differing time periods in which the programs were able to implement the tests.154 Still, the report recommended the AoA use the findings of the project to identify outcome measures in addition to the complaint resolution rate it currently uses.155 Additionally, the report made four broad recommendations for the ombudsman program: base outcome measures on the program values, goals, objectives, and plans; create both system and resident outcome measures; create a reporting system that can provide rapid feedback; consider using outcome-measures data to justify funding increases.156

V. IN SUMMARY: IMPORTANT PROGRAM COULD DO MUCH MORE

The Older Americans Act recognized the particular vulnerability of elders in long-term care facilities and created the national Long-Term Care Ombudsman Program to advocate for these residents. Throughout the ‘70s, ‘80s and ‘90s Congress passed OAA amendments that strengthened and expanded the program. The OAA directs ombudsmen to provide individual advocacy, education, and system advocacy for long-term care residents. Congress clearly intended the OAA to support a broad array of needs for older citizens, preferably in their homes. The OAA authorizes states to create programs as needed in nutrition, health care, family caregiver support, and legal services, among others. The Supreme Court and the executive branch have reinforced this Congressional intent. Over the 42 years since Congress passed the OAA, amendments and related legislation have reinforced the rights of elders and increasingly emphasized the importance of providing older citizens with choices in support services. The latest reauthorization of the OAA is clear: the AoA should facilitate a shift from facility-based to home- and community-based services.

151. Virginia Dize, Ombudsman Program Outcome Measures, National Long-Term Care Ombudsman Resource Center (May 2006).
152. Id. at 1.
153. Id. at 4.
154. Id. at 18.
155. Id. at 20.
156. Id. at 21.
However, the statute does not address who will advocate for elders who choose home-based services.

Ombudsmen disagree on whether they should absorb the duties. Some ombudsmen already advocate for home-based elders.\footnote{Miller, \textit{Ombudsman Program Connections to Home and Community Based Services}, National Association of State Units on Aging, (July 2004), \textit{available online at} http://www.nasua.org/pdf/Ombudsman\%20Connections\%20to\%20HCBS.pdf.} Others consider such expansion \textit{ultra vires}, or outside the intent of the legislation that authorizes their programs. In hearings preceding the 2006 reauthorization of the OAA, the National Association of State Units on Aging suggested Congress amend Title VII to create a Home Care Ombudsman Program.\footnote{Committee on Senate Health, Education, Labor and Pensions: Hearing Before the Subcomm. on Retirement Security and Aging, 109th Cong. (Feb. 14, 2006) (statement of Patrick Flood, 2nd Vice President, National Association of State Units on Aging), accessed through LexisNexis Congressional.} The change was not included in the final version of the reauthorization.\footnote{Pub. L. No. 109-364.}

Evaluations of the ombudsman program consistently find the program addresses a unique need, but faces barriers that prevent it from fulfilling the OAA mandate. Major obstacles include insufficient funding, inadequate staffing, and too much variability among the state-implemented ombudsman programs. Also, researchers cite a lack of dependable data for evaluating the effectiveness of the programs. Though serving a real need, the programs, therefore, are marginally effective and meet only a small part of the duties Congress intended them to perform.
THE NURSING HOME REFORM ACT’S CODIFIED STANDARD OF CARE
FOR THE LONG-TERM CARE INDUSTRY: THE NATIONAL STANDARD OF
CARE OR MERE MANTRA?

Robert C. Powers*

I. INTRODUCTION: THE ELDERLY POPULATION REQUIRES GREATER PROTECTION
FROM MISTREATMENT, ABUSE AND NEGLECT .............................................. 114
II. THE REQUIREMENT FOR LONG TERM QUALITY CARE ................................. 116
   A. Activities of Daily Living ................................................................. 117
   B. Common Injuries Among Long-Term-Care Facilities ....................... 117
III. BACKGROUND: CONGRESSIONAL ATTEMPT TO PREVENT ELDERLY ABUSE
     AND NEGLECT .................................................................................. 117
IV. FEDERAL ENFORCEMENT OF THE NHRA STANDARD OF CARE ............... 120
   A. Nursing Home Survey And Certification ......................................... 120
      1. Surveying The NHRA Standard Of Care ....................................... 120
      2. Documenting The NHRA Standard Of Care .................................... 121
   B. Nursing Home Compliance And Enforcement .................................... 121
      1. Available Sanctions ................................................................. 121
      2. Imposed Sanctions ............................................................... 122
   C. Enforcement Policies Do Not Deter Abuse And Neglect ..................... 123
V. ESTABLISHING THE NHRA STANDARD OF CARE THROUGH PRIVATE
   LITIGATION ........................................................................................... 124
   A. Establishing A Legal Standard Of Care ............................................ 124
   B. NHRA Informs A Standard Of Care .................................................. 126
      1. Dooley Ex Rel. Estate Of Pannell v. Cap-Care Of Ark., Inc. (Recognizing
         The Existence Of A National Standard Of Care) ............................ 126
   C. NHRA Establishes The Standard Of Care ......................................... 127
      1. Hayward v. Jack’s Pharmacy, Inc. (Recognizing The Purpose For A
         National Standard Of Care) .......................................................... 127
      2. Frantz v. HCR Manor Care, Inc. (Applying The National Standard
         Of Care To A Specific Violation) .................................................. 128

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  The author would like to dedicate this note to Mr. Charles Marquardt, Long-Term Care
  Ombudsman for Washington D.C. and Mrs. MaryJo McGill for their advocacy on behalf of nursing
  home residents.
I. INTRODUCTION: THE ELDERLY POPULATION REQUIRES GREATER PROTECTION FROM MISTREATMENT, ABUSE AND NEGLECT

The elderly in our nation’s nursing homes require greater protection. On any given day, the three million elderly and disabled people living in our nation’s 18,000 licensed nursing homes and 40,000 residential care facilities face a substantial risk of

The Nursing Home Reform Act’s Codified Standard of Care

abuse or neglect. Although the definition of elder abuse and neglect varies from state to state, “broadly defined, abuse may be: physical abuse, emotional abuse, sexual abuse, exploitation, neglect, or abandonment.” According to the National Center on Elder Abuse (NCEA), elder abuse is “any knowing, intentional, or negligent act by a caregiver or any other person that causes harm or a serious risk of harm to a vulnerable adult.” In the latest of its continuing investigations, the Government Accountability Office (GAO) found that a “significant proportion of nursing homes nationwide continue to experience quality-of-care problems.” In 2006, twenty percent of the nation’s nursing homes caused actual harm or placed a resident in immediate jeopardy. In fact, the number of facilities reporting no deficiencies in the U.S. decreased to less than nine percent in 2005. In the past decade, GAO has reported horrific conditions of abuse and neglect ranging from individual acts of rape, battery, and assault by nursing staff to patterns of systemic abuse, mistreatment, and neglect by nursing homes.


4. Id.


6. Id. at 3; see generally 42 C.F.R. § 488.301 (2007) (“immediate jeopardy means a situation in which the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident”).


Despite the passage of the Nursing Home Reform Act of 1987 (NHRA) requiring that “each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being,” the Department of Health and Human Services (HHS) and the nursing home industry have failed to prevent widespread abuse and neglect of our nation’s elderly and disabled. Clearly, the solution to protecting our nation’s elderly citizens is not mere dependence on government regulation, but an increased reliance on the tort system. The residents of long-term care facilities are in an extremely vulnerable position because of the inadequate enforcement of the NHRA by government agencies. Private litigation facilitated by a national standard of care can serve an important role in maintaining adequate quality of care for the elderly.

II. THE REQUIREMENT FOR LONG TERM QUALITY CARE

The nation’s highly vulnerable disabled and elderly population often finds it is impractical to remain in their private homes; therefore, turning to a nursing home or skilled nursing facility (SNF) for their care. A nursing home provides physical, occupational, and other rehabilitative therapies following an accident or illness. In addition to constant nursing care, the home provides significant assistance with activities of daily living (ADL). The healthcare field uses the term “activities of daily living” as a tool to describe and assess a person’s functional status. In the care of the elderly, nursing homes are especially concerned about a person’s ability to eat, dress, ambulate, toilet, and provide for their own hygiene. Consequently, nursing homes must conduct a “comprehensive, accurate, standardized, reproducible assessment of each resident’s functional capacity,” known as a “Care Plan” that addresses a resident’s ADLs.

10. See David A. Hyman & Charles Silver, The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?, 90 Cornell L. Rev. 893, 894 (2005) (arguing the tort system’s major deficiency is its failure to subject healthcare providers to sufficient economic pressure to overcome defective incentives and norms).
11. See generally Harrington et al., supra note 7, at 78 (identifying the type and number of nursing home quality of care problems).
12. See Rustad, supra note 2, at 368 (arguing “private litigation for the public interest fills the breach caused by lax public enforcement at the state level” regarding nursing home negligence).
14. Id. at 140; see also CRS Rep. 2007, supra note 1, at 6.
15. Frolik, supra note 15, at 138-57 (discussing long-term care insurance eligibility requirements); see also CRS Rep. 2007, supra note 1, at 3 (most medical insurance policies do not include coverage for assistance with ADLs except by specialized long-term care policies).
16. See Frolik, supra note 15, at 159-60.
A. Activities of Daily Living

Providing assistance with ADLs is extremely labor intensive, yet critical to a resident’s health. Studies show that when nursing homes fail to provide more than four hours of nursing care per patient each day, “residents will almost certainly be harmed [and will] suffer from pressure sores, dehydration, malnutrition, fractures, infections, and other conditions that cause pain, decline in functioning, avoidable hospitalizations, and death.” In contrast, a recent study conclusively demonstrated that increased nursing care resulted in fewer pressure sores, urinary tract infections, catheterization, weight loss, and overall deterioration in ADLs. For many residents the quality of their care and injuries is proportional to the amount of nursing staff.

B. Common Injuries Among Long-Term-Care Facilities

Common injuries among nursing home residents include falls, pressure sores, improper use of restraints, medication errors, malnutrition, elopement, and physical abuse. Unfortunately, many of these common injuries, especially “falls and pressure ulcers are often avoidable.”

III. BACKGROUND: CONGRESSIONAL ATTEMPT TO PREVENT ELDERLY ABUSE AND NEGLECT

Nearly twenty years ago, Congress responded to the substandard safety and quality throughout the nation’s long-term care facilities by passing the Nursing Home Quality Reform Act (NHRA), part of the Omnibus Budget Reconciliation Act of 1987


22. Id.

23. Id. at 3-4 (supporting Rep. Henry Waxman’s Nursing Home Staffing Act calling for workforce measures designed to improve compliance with the standards of the NHRA); see also Harrington 2007 Rep., supra note 2, at 4 (testifying that numerous Institute of Medicine studies demonstrate a positive relationship between nurse staffing and quality of care).


Congress incorporated many of the recommendations made in a 1986 Institute of Medicine report into the NHRA. Congress amended Titles XVIII (Medicare) and XIX (Medicaid) of the Social Security Act to establish statutory requirements regarding the minimum standard of care for a federally certified long-term facility, and directed that it “is the duty and responsibility of the Secretary [of Health and Human Services] to assure that requirements which govern the provision of care in skilled nursing facilities... are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.”

This landmark legislation protects each resident of a federally certified nursing facility even when a resident is not eligible for any type of government reimbursement.

With passage of the NHRA, Congress proclaimed a Residents’ Bill of Rights, and intended that each resident receive “the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being.” Passage of the NHRA resolved Congress’ and the court’s impatience with what the public perceived as CMS’s ineffectual regulation of nursing homes.

To ensure compliance, Congress conditioned the receipt of Medicare and Medicaid payments for long-term care residents on substantial conformity with the

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27. See Marshall B. Kapp, Quality of Care and Quality of Life in Nursing Facilities: What’s Regulation Got to Do with It?, 31 McGeorge L. Rev. 707, 711 (2000); see generally Institute of Medicine, Improving the Quality of Care in Nursing Homes (1986).
28. §§ 1395i-3(f)(1) and 1396r(f)(1); see 42 C.F.R. § 409.20 (coverage of services) (2007) (post-hospital SNF care means the following services furnished by a qualified provider: 1) Nursing care provided by or under the supervision of a registered professional nurse; 2) Bed and board in connection with the furnishing of that nursing care; 3) Physical, occupational, or speech therapy; 4) Medical social services; 5) Drugs, biologicals, supplies, appliances, and equipment; 6) Services furnished by a hospital with which the SNF has a transfer agreement in effect under § 483.75(n) of this chapter; and 7) Other services); see also 42 C.F.R. § 409.31 (2007) (level of care requirement) (skilled nursing care are services that are: 1) ordered by a physician; 2) so inherently complex that they can only be performed safely and effectively by or under the supervision of technical or professional personnel; 3) furnished directly by or under the supervision of technical or professional personnel; 4) rendered for the same condition for which the patient received inpatient treatment or a condition that arose while the patient was in a skilled nursing facility after inpatient treatment; 5) only performed in a skilled nursing care facility on an inpatient basis; 6) require the skill of technical or professional personnel; and 7) provided on a daily basis).
29. Eric M. Carlson, Long-Term Care Advocacy § 2.03 (2007).
30. § 483.25.
Act’s requirement to meet a minimum standard of quality care. The Act defines “substandard quality of care as one or more deficiencies related to participation requirements under § 483.25,... which constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.” Immediate jeopardy means a situation in which the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. “Deficiency means a [home’s] failure to meet a participation requirement specified in the Act” or in 42 C.F.R. §§ 483 et seq.

The NHRA requires that a federally certified long-term care facility provide a specified level of services at a minimum standard of care. The required services include: periodic assessments for each resident; a comprehensive plan of care; nursing services; social services; rehabilitation services; pharmaceutical services; dietary services; and where the facility maintains 120 or more beds, a full-time social worker. The requirements ensure that residents receive the care needed to protect their health and safety, such as preventing avoidable pressure sores, falls, and unnecessary restraints.

Under the Residents’ Bill of Rights, a nursing home resident has the right to: freedom from abuse, mistreatment, and neglect; freedom from physical restraints; privacy; accommodation of medical, physical, psychological, and social needs; participate in resident and family groups; to be treated with dignity; self-determination; communicate freely; participate in the review of one’s care plan, and to be fully informed in advance about any changes in care, treatment, or change of status in the facility; and to voice grievances without discrimination or reprisal.

32. 42 C.F.R. § 488 (2007); §§ 1395i-3 and 1396r; see also CMS Chart Book, supra note 1, (federal dollars pay for the majority of nursing home care).
33. § 488.301.
34. Id.
35. Id.
36. See 42 C.F.R. § 483.10 (2007) (Residents’ Bill of Rights); see also Barbourville Nursing Home v. United States HHS, 174 F.App’x. 932, 933 (6th Cir. 2006) (“The federal government, through the agency of the Department of Health and Human Services... requires facilities that choose to participate in the Medicare or Medicaid programs to comply with certain minimum standards of care”).
37. Id.
IV. FEDERAL ENFORCEMENT OF THE NHRA STANDARD OF CARE

To monitor compliance with the NHRA, Congress established a certification process involving routine inspections and complaint investigations. The Centers for Medicare and Medicaid Services (CMS) oversees quality assurance by contracting with state survey agencies to assess whether long term-care facilities comply with the federal quality requirements. Additionally, under the “look behind” statute, CMS may conduct its own validation survey of a nursing facility and may terminate participation in the Medicaid program despite a state survey agency’s finding of compliance. Currently, over four-thousand surveyors (inspectors) conduct routine inspections of long-term care facilities to assess compliance with the federal quality and safety requirements.

A. Nursing Home Survey And Certification

Routine inspections, known as “standard surveys,” are unannounced surveys conducted at irregular intervals at least once every 15 months. On average, surveyors inspect a nursing home once every twelve months. Every Medicare or Medicaid participating home must receive a standard survey every 15 months, and the statewide average interval for these surveys must not exceed 12 months. In 2007, the GAO reported one area of concern was that most nursing homes recognize that they will not receive another inspection for at least eleven months after the completion of their annual “standard survey.”

1. Surveying The NHRA Standard Of Care

Generally, nursing home standard surveys focus on residents’ rights, quality of care, quality of life, and required services. However, upon receipt of a nursing home complaint, inspectors will conduct targeted surveys or investigations. Unlike standard surveys, complaint investigations only occur if residents, family members, or nursing home employees make specific allegations regarding resident abuse or neglect.

40. § 488; §§ 1395i-3(g) and 1396r(g); see also CMS SOM PP, supra note 39 (Nursing Facility Survey Protocols and Interpretive Guidelines).
41. §§ 1395i-3(g)(1)(a), and 1396r(g)(1)(a).
42. § 1396a(a)(33)(B).
43. Farris, supra note 1, at 2.
44. Id.
45. Id.; see also Allen, supra note 5, at 5.
46. Farris, supra note 1, at 2.
47. Allen, supra note 5, at 5.
48. Id.
49. Farris, supra note 1, at 2-3.
50. Id. at 2.
During the standard survey, surveyors note a deficiency whenever they identify a gap between the NHRA and the nursing home’s actual practice. The regulation categorizes a deficiency by severity (minimal harm to immediate jeopardy) and scope (isolated to widespread). When surveyors identify a deficiency, the facility must prepare a plan that will correct the problem. Later, surveyors will evaluate the delinquent facility’s plan of correction by reviewing evidence that demonstrates compliance or by returning to the site. A nursing home remains “noncompliant” until it corrects the noted deficiencies or CMS terminates its Medicare and Medicaid participation.

2. Documenting The NHRA Standard Of Care

Since 1998, CMS has posted on its Nursing Home Compare website the standard survey results and complaint investigations for individual nursing homes. Additionally, CMS posts data pertaining to quality measures that originate from clinical data that individual nursing homes submit as part of the Minimum Data Set (MDS). The CMS collects the MDS at regular intervals for every resident in a CMS certified nursing home. The MDS is a mandatory process for assessing all residents in a federally certified nursing home, and provides a comprehensive assessment of each resident’s functional capabilities. In an attempt to monitor the resident’s health issues, the MDS addresses factors such as the resident’s general health, physical functioning, mental status, and overall well-being. A facility must make a MDS assessment at admission, quarterly, annually, and whenever a resident experiences a significant change in health.

B. Nursing Home Compliance And Enforcement

1. Available Sanctions

The NHRA authorizes enforcement and sanctions when a long-term facility is determined noncompliant. CMS must consider four factors when imposing Civil

51. Id. at 3.
52. Id.
53. Id.
54. Farris, supra note 1, at 3
55. Id.
56. Id.
57. Allen, supra note 5, at 4.
58. Id. at 5.
59. Farris, supra note 1, at 3.
60. Id.
Monetary Penalties (CMP): 1) the scope and severity of the deficiency; 2) the facility’s
degree of culpability; 3) prior history of noncompliance; and 4) the facility’s financial
condition. For minor violations involving minimal harm and an isolated event, CMS
affords the nursing home an opportunity to correct the deficiency before imposing a
sanction. Nursing homes that conduct widespread patterns of abuse and place
residents in immediate jeopardy face the highest level of sanctions. CMS may impose
any or all of the following sanctions to enforce the NHRA: 1) Directed plan of
correction; 2) Directed in-service staff training; 3) Temporary management; 4) State
monitoring; 5) CMP; 6) Deny payment for all new Medicare or Medicaid admissions;
and 7) Termination of payment for all Medicare or Medicaid residents.

For cases of "immediate jeopardy," the imposition of Temporary management,
Termination, or both is mandatory; however, CMS is not required to impose a CMP. For
deficiencies occurring in the middle of the spectrum of the scope and severity
scale ("actual harm"), CMS must impose either 1) Temporary management; or 2)
Denial of Payment for new admissions; or 3) CMP; or 4) any combination thereof.
CMS imposes Denial of Payment for new admissions when a delinquent facility
remains noncompliant greater than three months after a deficiency finding. CMS
terminates a delinquent facility from the Medicare and Medicaid program if it remains
noncompliant greater than six months after a deficiency finding. Additionally, the
NHRA directs CMS to minimize the time between identification of a violation and the
imposition of a sanction.

2. Imposed Sanctions

Over half of the federal sanctions imposed from fiscal years 2000 through 2005
were civil monetary penalties. Civil monetary penalties may be for either a per-day,
or per-instance violation. CMS’s regulations specify that a per-day CMP may range from $50 to $10,000 for each day a home is noncompliant; and for a per-instance violation, the penalty may range from $50 to $3,000 for non-immediate jeopardy, and $3,050 to $10,000 for an immediate jeopardy violation. The fine increases the longer a home remains noncompliant. However, a CMP may not exceed $10,000 for each day of noncompliance.

One quarter of the federal sanctions imposed from fiscal years 2000 through 2005 were Denial of payment for new Medicare or Medicaid admissions. CMS denies a noncompliant nursing home payment for any new admissions until it corrects the noted deficiencies. The remaining twenty percent of the imposed sanctions were directed plan of correction, state monitoring, directed in-service training, and temporary management. Although the NHRA authorizes CMS to terminate a nursing home from participation in Medicare and Medicaid, terminations represented less than one percent of all sanctions imposed for fiscal years 2000 through 2005.

C. Enforcement Policies Do Not Deter Abuse And Neglect

The government’s current enforcement policy does not deter nursing homes from harming residents. During fiscal years 2000 through 2005, authorities sanctioned nearly forty percent of the nursing homes for placing residents in immediate jeopardy. Yet, in some cases, authorities did not impose immediate sanctions for widespread patterns of actual death and serious injury. When CMS did impose sanctions, GAO discovered that the agency did not use the full range of its sanctions authority, and generally imposed a CMP in the lower end of the allowable range. One CMS official noted that the imposed CMPs were hardly enough to “make nursing homes take notice.” Further, some nursing homes consider CMPs the “cost of doing business,” and merely a “slap on the wrist.”

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71. See § 1395i-3(h)(2)(B)(ii) (authorizing HHS to impose a CMP on a skilled nursing facility in noncompliance with 42 C.F.R. § 483.25).
73. 42 C.F.R. § 488.438(a)(1)(i) (immediate jeopardy fine).
75. §1395i-3(h)(2)(D)(ii) and §1396r(h)(3)(C)(ii).
76. GAO Rep. 2007, supra note 38, at 11 (DPNA comprised 26 percent of the imposed penalties).
77. Id.
78. Id.
79. Id.
80. Id. at 35; see also Hedt, supra note 20, at 5 (claiming entities are permitted to violate the NHRA because our enforcement system is too often health provider centered rather than patient focused).
82. Id. at 26-27.
83. Id. at 23.
84. Id. at 23.
85. Id.
According to recent GAO reports, the nation’s nursing homes are “repeatedly harming residents.”86 Despite federal enforcement policies, nearly half the nursing homes with a history of “serious quality problems” cycle in and out of compliance with the NHRA.87 These nursing homes are permitted to “yo-yo” in and out of compliance for years, “resulting in severe suffering and sometimes death.”88 In one GAO investigation, seventy-five percent of the twenty-seven homes sanctioned for placing residents in immediate jeopardy were cited in a subsequent survey for similar abuse and neglect.89 Further, CMS’s fragmented data systems and incomplete national reporting capabilities impede its ability to track and monitor compliance.90 Consistent with its previous investigations, GAO confirmed that the current enforcement policy permits a home to comply with the NHRA only temporarily, and that by the next inspection a home again would be guilty of abusing and neglecting its residents.91

V. ESTABLISHING THE NHRA STANDARD OF CARE THROUGH PRIVATE LITIGATION

In the field of law, the standard of care is a legal metric for measuring the presence of negligence. Black’s Law Dictionary defines “standard of care,” as the “degree of care that a reasonable person should exercise.”92 Reasonable care, a “test of liability for negligence [is] the degree of care that a prudent person and competent person engaged in the same line of business or endeavor would exercise under similar circumstances.”93 The standard of care of a reasonable person may be established by: 1) legislative enactment or regulation; 2) adopted by the court from a legislative enactment or administrative regulation; or 3) established by judicial decision.94

A. Establishing A Legal Standard Of Care

Negligence and negligence per se doctrines developed separately in the field of law.95 The elements necessary to establish negligence are: 1) a duty or obligation

87. Id. at 26.
88. Hedt, supra note 20, at 5.
89. GAO Rep. 2007, supra note 38, at 35.
90. Id. at 46.
91. Id. at 27 (nursing homes recognize another survey is unlikely for another eleven months).
92. Black’s Law Dictionary 1413 (7th ed. 1999); see also Black’s Law Dictionary 1273 (reasonable person is “a person who exercises the degree of attention, knowledge, intelligence, and judgment that society requires of its members for the protection of their own and of others’ interests”).
93. Id. at 204; see also Myers v. Heritage Enters., 820 N.E.2d 604, 609 (Ill. App. Ct. 2004) (in case where two nurses dropped resident during bed transfer court noted “[a]dequate care” has been deemed synonymous with ‘ordinary care,’ ‘due care,’ or ‘reasonable care,’ the terms used to describe the standard of care for negligence”).
94. Restatement (Second) of Torts § 285 (1965).
recognized by law, requiring the actor to conform to a certain standard of care; 2) a
defendant’s failure to conform to that standard; 3) a causal connection between the
defendant’s conduct and the resulting injury; and 4) damage or actual loss suffered by
the plaintiff.96

Generally, statutes and regulations that relevant agencies enforce will establish
the standard of care.97 Courts refer to this standard of care through the doctrine of
negligence per se, which presumes negligence if: 1) a statute or regulation is violated;
2) injury results from the violation; 3) the injured party is within the class of persons
protected by the statute or regulation; and 4) the injury that occurred is the type of
injury that the statute or regulation is designed to prevent.98

“[T]he breach of a federal statute may support a negligence per se claim as a
matter of state law.”99 Recently, the Supreme Court noted that the “violation of federal
statutes and regulations is commonly given negligence per se effect in state tort
proceedings.”100 Consequently, the violation of a Medicare or Medicaid regulation can
“establish that a defendant breached a duty owed to a plaintiff as a matter of law.”101
Further, it is “sufficient if the violation is capable of having a causal connection with
the injury and [the] damage inflicted [and it] is not essential that the injury inevitably
flow[ed] from the violation.”102

Legislation to Negligence Cases: A Reexamination, 23 Santa Clara L. Rev. 427, 428-29 (discussing
the judicial tension between the two doctrines).

96. W. Page Keeton, et al., Prosser and Keaton on the Law of Torts, 164-65 (5th ed. 1984); see also
Restatement (Second) of Torts § 281 (1965).

97. Restatement (Second) of Torts § 286 (1965); see Pratico v. Portland Terminal Co., 783 F.2d 255,
262 (1st Cir. 1985) (holding harm related to noncompliance with a Occupational Health and Safety
Act (OSHA) safety regulation will support a finding of negligence per se “when the violation of a
statutory duty caused precisely the kind of harm the statute was meant to prevent”); see also
Timothy S. Jost, Our Broken Health Care System and How to Fix It, 41 Wake Forest L. Rev. 537,
538-39 (2006) (noting that in the field of health law, “what has superseded the common law [of
tort] is a very complicated, sometimes contradictory, web of regulatory law”); see also Timothy S.
Jost, Health Law and Administrative Law: A Marriage Most Convenient, 49 St. Louis U. L.J. 1, 5-
7, 11-12, 28-29 (2004) (noting the interdependence between health law and administrative law).

98. Restatement (Second) of Torts § 286 (1965) (when standard of conduct defined by legislation or
regulation will be adopted); see also Grable & Sons Metal Prods., Inc. v. Darue Eng’g & Mfg., 545
U.S. 308, 318-19 (2005) (noting other jurisdictions treat a violation of a federal statute as evidence
of negligence or as creating a rebuttable presumption of negligence).


100. Grable, 545 U.S. at 318-19 (citing Restatement (Third) of Torts, proposed final draft, § 14, cmt. a;
(considering negligence per se claim based on violation of Medicare and Medicaid regulations).

101. McLain, 631 S.E.2d at 437 (citing Grable, 545 U.S. at 318-19); see also Burney v. 4373 Houston,
("states may incorporate provisions of federal law such as the Medicare and Medicaid Acts into
state standards of care without giving rise to a federal question").

102. McLain, 631 S.E.2d at 437.
B. NHRA Informs A Standard Of Care

At a minimum, the NHRA serves as a standard for measuring the quality of nursing home care, and essentially codifies good nursing practice throughout the nation’s nursing homes.\(^\text{103}\) Despite widespread recognition that the NHRA is the appropriate standard of care, many courts only acknowledge the NHRA as a mere measurement of quality.

1. *Dooley Ex Rel. Estate Of Pannell v. Cap-Care Of Ark., Inc.* (Recognizing The Existence Of A National Standard Of Care)

For some jurisdictions, the NHRA serves as a mere measurement of nursing home care especially in jurisdictions that hold that the local standard of care is determinative. For example, in Arkansas a plaintiff must use expert testimony to establish the standard of care in negligence cases involving nursing homes when the alleged negligence is not a matter of common knowledge.\(^\text{104}\) The expert must testify to “the degree of skill and learning ordinarily possessed and used by... the medical care provider [who is] in good standing, [and] engaged in the same type of practice or specialty in the locality in which he [defendant] practices or in a similar locality.”\(^\text{105}\)

In *Dooley ex rel. Estate of Pannell v. Cap-Care of Ark., Inc.*, 338 F. Supp. 2d 962 (E.D. Ark. 2004), the decedent’s daughter sued the nursing home for negligent care and treatment alleging that her father’s death was caused by the stress of pressure sores and associated infections.\(^\text{106}\) At trial, the daughter provided an expert witness who testified that she was familiar with the standard of care for nursing homes based upon her knowledge of federal guidelines and state regulations governing long-term care.\(^\text{107}\) The deposition of the estate’s qualified witness included the following questions and answers:\(^\text{108}\)

Q. Do you know what the standard of care in a nursing home, long-term facility is in eastern Arkansas?
A. Yes, sir.

\(^{103}\) H. Kennard Bennett, NHRA Fixes Standards For Private Suits By Establishing A Benchmark For Quality Of Care, The Act Has Become The Basis For A Number Of Lawsuits Against Nursing Homes, 9/9/96 Nat’l L.J. B7 (1996).


\(^{105}\) *Dooley*, 338 F. Supp. 2d at 966.

\(^{106}\) *Id.* (Defendant claims decedent “died from pneumonia which probably resulted from multiple decubitus ulcers”).

\(^{107}\) *Id.* at 964-66.

\(^{108}\) *Id.* at 965.
Q. And tell me how you are familiar with that.
A. Well, I’m familiar with that through the federal guidelines, which are regulating the standards in nursing homes across the nation.
Q. So when you are looking in a chart to determine whether the care was substandard or not your opinion is based on whether it met the federal guidelines or not?
A. Yes, sir.109

The Court admitted the testimony into evidence “not because those [federal] guidelines create a private right of action or a national standard of care, but because such testimony would show, at a minimum, the degree of skill and learning used by nursing homes in Forrest City or a similar locality.”110 The Court observed that the expert witness “seemed to say that nursing homes in Forrest City [Arkansas] and similar localities ordinarily possess and use, at a minimum, the degree of skill and learning prescribed by the [federal] guidelines for nursing homes that participate in the Medicare program.”111

C.NHRA Establishes The Standard Of Care

1. 

Hayward v. Jack’s Pharmacy, Inc. (Recognizing The Purpose For A National Standard Of Care)

An increasing number of jurisdictions permit the Nursing Home Reform Act to establish the standard of care by reasoning that local communities cannot choose a lesser standard of care. In Hayward v. Jack’s Pharmacy, Inc., 115 P.3d 713 (Idaho 2005), the Supreme Court of Idaho held that an out-of-state medical expert can establish the standard of care concerning the prescription of pharmaceuticals in nursing homes because specific and relevant federal regulations created a national standard of care.112

In Hayward, the son of a deceased resident sued Valley Vista Nursing Home and Jack’s Pharmacy (which had filled the decedent’s prescriptions) for negligence.113 The

109. Id. at 963 (nursing home argued the expert witness lacked “the expert testimony necessary to prove the degree of skill and learning ordinarily possessed and used by long-term care facilities in Forrest City, Arkansas, or a similar locality”).
111. Id.; see also Owens v. Coosa Valley Health Care, Inc., 890 So. 2d 983, 987 (Ala. 2004) (upholding the enforeceability of an arbitration clause, the Alabama Supreme Court noted the uncontested fact that “the nursing home was almost completely controlled by federal regulations”).
112. Hayward v. Jack’s Pharmacy, Inc., 115 P.3d 713, 719 (Idaho 2005); see also McDaniel v. Inland Northwest Renal Care Group-Idaho, L.L.C., 159 P.3d 856, 860 (Idaho 2007) (distinguishing that “Hayward does not stand for the proposition that a national standard of care is automatically implicated simply because the federal government has created some general regulatory scheme for a given area of medicine”).
113. Hayward, 115 P.3d at 715.
trial court refused to allow the testimony of the son’s expert witness.\textsuperscript{114} The expert witness, with personal knowledge of the national standard of care, had familiarized himself with the local standard of care by confirming with a local physician that the local standard did not differ from the national standard.\textsuperscript{115} The son appealed the trial court’s decision.\textsuperscript{116} Reversing the trial court’s judgment that Hayward’s expert did not establish the required standard of care, the Supreme Court of Idaho concluded that because “nursing homes are required to follow federal and state guidelines relating to patient care, including the prescription of pharmaceuticals... they are responsible when those standards are not met.”\textsuperscript{117}

The Court reasoned:

The alternative [holding] makes no sense: if a... nursing home does not meet the standard to which the facility is held, or follows a lesser, local community standard, the nursing home... has failed to meet the [required] standard. To allow this result would thwart the purpose of the state or federal regulation – hence, our rule that in cases where state or federal laws or regulations set forth minimum requirements for licensure of health care providers, local communities are not free to adopt lower standards.\textsuperscript{118}

The Court concluded, “it follows that the standard of care for a physician treating a patient in a nursing home would be governed by those [required] standards.”\textsuperscript{119}

2.\textit{Frantz v. HCR Manor Care, Inc.} (Applying The National Standard Of Care To A Specific Violation)

An increasing number of jurisdictions permit the Nursing Home Reform Act to establish a standard of care when it concerns a specific violation. In \textit{Frantz v. HCR Manor Care, Inc.}, 64 Pa. D. & C. 4th 457 (Schuylkill Cty. 2003), a Pennsylvania court permitted the plaintiff to make a claim of negligence per se based on a specific violation of 42 C.F.R. § 483.25(j) (hydration); however, the Court prohibited the plaintiff from broadly basing all of her claims as negligence per se under the NHRA.\textsuperscript{120}

In \textit{Frantz}, a resident died six days after his admission, and the decedent’s widow sued for the wrongful death of her husband.\textsuperscript{121} The nursing home moved to dismiss

\begin{footnotesize}
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\item \textsuperscript{114} \textit{Id.} at 717.
\item \textsuperscript{115} \textit{Id.}
\item \textsuperscript{116} \textit{Id.}
\item \textsuperscript{117} \textit{Id.} at 719 (noting both parties agreed the federal and state guidelines established the standard of care).
\item \textsuperscript{118} \textit{Hayward}, 115 P.3d at 719
\item \textsuperscript{119} \textit{Id.}
\item \textsuperscript{120} \textit{Frantz v. HCR Manor Care, Inc.}, 64 Pa. D. & C. 4th 457, 468-69 (Schuylkill Cty. 2003) (in “a claim based on negligence per se, the purpose of the statute must be to protect the interest of a group of individuals, as opposed to the general public, and the statute must clearly apply to the conduct of the defendant”).
\item \textsuperscript{121} \textit{Id.} at 459-60.
\end{itemize}
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The widow’s general use of the NHRA regulations to establish a standard of care. Sustaining the motion, the Court reasoned that the intent of NHRA was “to improve the standard of care in nursing homes generally.” The Court stressed that the NHRA regulations cited in the widow’s complaint (except for 42 C.F.R. § 483.25(j) (hydration)) merely “set goals to be attained by long-term facilities... rather than as exact standards of care.” The Court cautioned that there “must be a direct connection between the harm sought to be prevented by the statute and the injury.” However, the Court acknowledged that the plaintiff could use the principles enunciated in the federal regulations to prove that the nursing home failed to conform to the standard of care expected of a nursing home under the theory of negligence rather than negligence per se.

3. Mariner Health Care, Inc. v. Estate of Edwards (Applying The National Standard Of Care To A Specific Violation)

Like Pennsylvania, Mississippi also permits a plaintiff to use the Nursing Home Reform Act to inform the standard of care for a specific act. In Mariner Health Care, Inc. v. Estate of Edwards, 964 So. 2d 1138 (Miss. 2007), Edward’s family sued the nursing home for the wrongful death of their son, alleging the home failed to monitor his feeding and bowel movements. The Supreme Court of Mississippi held that “federal regulations applicable to nursing homes may be used to inform the standard of care.” However, the court voiced concerns similar to those announced in Frantz that a court should ensure a connection existed between the harm the NHRA regulations intend to prevent and the resulting injury. Although noting that the defendant nursing home provided unpersuasive authority to reject the jury instructions concerning the federal standard of care, the Court cautioned against using jury instructions that recite vague and abstract regulations “as there is no connection relating the facts to the elements of standard of care and causation.”

122. Id. at 468.
123. Id.
124. Id. at 468-69
126. Id. at 469 (noting “failure to comply with the aforementioned [NHRA] regulations even though not negligence per se may constitute some evidence of negligence”).
127. Mariner Health Care, Inc. v. Estate of Edwards, 964 So. 2d 1138, 1143-44 (Miss. 2007).
128. Edwards, 964 So. 2d at 1155 (quoting Moore v. Memorial Hosp., 825 So. 2d 658, 665 (Miss. 2002); see also Hill v. Beverly Enters.-Miss., Inc., 305 F. Supp. 2d 644, 650 (S.D. Miss. 2003) (holding that statutes or regulations can establish a legal duty, standard of care, or serve as evidence of negligence).
129. Edwards, 964 So. 2d at 1155.
130. Id. (reversing $ 6.5 million jury award against the nursing home for other reasons, namely juror misconduct).
4. **Norman v. Life Care Centers of America, Inc.** (Allowing The National Standard Of Care In Jury Instructions)

Several jurisdictions permit jury instructions that instruct the jury that a violation of the Nursing Home Reform Act is an act of negligence. The Court of Appeals of California, reversing the trial court’s refusal to instruct the jury that a NHRA violation could establish negligence per se, held that “like statutes, applicable [NHRA] regulations are a ‘factor to be considered by the jury in determining the reasonableness of the conduct in question.’”

In *Norman v. Life Care Centers of America, Inc.*, 132 Cal. Rptr. 2d 765 (Ct. App. 2003), a resident died shortly after incurring multiple falls from her bed, and the decedent’s daughter sued the facility. The daughter argued that the State Agency’s determination that the home violated her mother’s Care Plan demonstrated negligence per se. Relying on *Conservatorship of Gregory*, 95 Cal. Rptr. 2d 336 (Ct. App. 2000) that held the NHRA regulations described the nursing home standard of care, the Court concluded that the NHRA “regulations were designed to protect nursing home residents by defining the care that was due them,” and the trial court improperly denied the inclusion of the NHRA regulations in its instructions. The Court reasoned that the regulations regarding the resident’s care plan existed to prevent the type of harm alleged, and the daughter provided sufficient evidence that the violation caused her mother’s injury.

5. **McLain v. Mariner Health Care** (Using The National Standard Of Care To Establish Negligence Per Se)

Georgia uses the Nursing Home Reform Act to establish the standard of care and considers a violation of the NHRA as negligence per se. In *McLain v. Mariner Health Care*, 631 S.E.2d 435 (Ga. Ct. App. 2006), the Georgia Court of Appeals held that a negligence per se claim arising from violations of federal or state statutes is permissible as long as: 1) the plaintiff is in the class of persons the statute was intended to protect; 2) the harm was the same harm the statute was intended to guard.

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132. Id. at 768-70.
133. Id.
134. Id. at 775 (quoting *Gregory*, 95 Cal. Rptr. 2d at 342).
135. Id. at 777.
136. *McLain*, 631 S.E.2d at 436 (considering negligence per se claim based on violation of Medicare and Medicaid regulations); see also *McCain v. Beverly Health & Rehab. Servs.*, No. Civ.A. 02-657, 2002 WL 1565526, at *1, No. 02-657, 2002 U.S. Dist. LEXIS 12984, at *3-4 (E. D. Pa. July 15, 2002) (holding “statute may still be used as the basis for a negligence per se claim when it is clear that, despite the absence of a private right of action, the policy of the statute will be furthered by such a claim because its purpose is to protect a particular group of individuals”).
The Nursing Home Reform Act’s Codified Standard of Care

against; and 3) the violation of the statute or regulation proximately caused the plaintiff’s injury.\textsuperscript{137}

In \textit{McLain}, a deceased resident’s daughter appealed the trial court’s dismissal of her alleged negligence and negligence per se claims against the nursing home for the wrongful death of her father.\textsuperscript{138} Reversing the trial court, the Appellate Court held that violations of Medicare/Medicaid statutes and regulations supported claims for negligence and negligence per se.\textsuperscript{139} The Court noted that the violation of a Medicare/Medicaid regulation, “no less than that of a statute,” could establish as a matter of law that a defendant breached a duty owed to a plaintiff.\textsuperscript{140} Further, it is not essential that the injury inevitably flowed from the violation, only that the violation was capable of having a causal connection with the inflicted injury.\textsuperscript{141} The Court distinguished that the absence of a private cause of action under the Medicare or Medicaid Act did not prevent a state from adopting standards from federal law and incorporating them into state law causes of action.\textsuperscript{142}


Just as the Georgia court in \textit{McLain} considered a violation of the NHRA as negligence per se, the District Court in \textit{McCain v. Beverly Health & Rehabilitation Servs.}, No. 02-657, 2002 U.S. Dist. LEXIS 12984 (E.D. Pa. July 15, 2002), also held that a statute may be the basis for a negligence per se claim “when it is clear that, despite the absence of a private right of action, the policy of the statute will be furthered by such a claim because its purpose is to protect a particular group of individuals.”\textsuperscript{143} In \textit{McCain}, the estate of a nursing home resident who died from pressure sores brought a negligence per se claim against the home. Overruling \textit{Chalfin v. Beverly Enterprises, Inc.}, 745 F. Supp. 1117 (E.D. Pa. 1990),\textsuperscript{144} the Court held that the policies expressed in the Nursing Home Reform Act statutes and regulations supported the plaintiff’s negligence per se claim.\textsuperscript{145} The Court reasoned that “a more expansive and more current view” concerning § 288 of the Restatement (Second) of

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\textsuperscript{137} \textit{McLain}, 631 S.E.2d at 437 (citing \textit{Cecile Indus., Inc. v. United States}, 793 F.2d 97, 99-100 (3d Cir. 1986) finding negligence per se where the intent of the statute, at least in part, is to protect the interest of the plaintiff individually).

\textsuperscript{138} \textit{Id.} at 436.

\textsuperscript{139} \textit{Id.}

\textsuperscript{140} \textit{Id.} at 437.

\textsuperscript{141} \textit{Id.}

\textsuperscript{142} \textit{McLain}, 631 S.E.2d at 438.

\textsuperscript{143} \textit{McCain}, 2002 WL 1565526, at *1, 2002 U.S. Dist. LEXIS 12984, at *3-4.


\textsuperscript{145} \textit{McCain}, 2002 WL 1565526, at *1, 2002 U.S. Dist. LEXIS 12984, at *3-4.
\end{flushleft}
Torts supported the holding that the absence of a private right of action no longer prevented a negligence per se claim.


Previously many jurisdictions refused to acknowledge that the Nursing Home Reform Act established a national standard of care because Congress did not provide a private right of action. However, in Herbert v. Frontier of Northeast Connecticut, Inc., CV010065465, 2004 Conn. Super. LEXIS 229 (Conn. Super. Ct. Jan. 29, 2004), a Connecticut court rejected the defendant’s argument that the absence of a private right of action prevented a negligence per se claim. In Herbert, the estate of a deceased resident sued the nursing home alleging violations of several NHRA regulations. The Court noted that the “regulations cited by the plaintiff are intended to prevent the injuries allegedly suffered by the decedent,” and “all pertain to the minimum standard of care a Medicare nursing home is required to provide.” The Court concluded that the federal regulations set the standard of care for a negligence cause of action.

D. NHRA Does Not Establish The Standard Of Care

1. Brown v. Sun Healthcare Group, Inc. (Denying A National Standard Of Care Because The Regulations Are Too Vague)

Despite widespread use of the NHRA regulations by the nation’s nursing homes, several jurisdictions decline to use the federal regulations to establish the standard of care. In Brown v. Sun Healthcare Group, Inc., 476 F. Supp. 2d 848 (E.D. Tenn. 2007), the District Court for the Eastern District of Tennessee held that “a plaintiff

146. Restatement (Second) of Torts § 288 (when standard of conduct defined by legislation or regulation will not be adopted).
147. McCain, 2002 WL 1565526, at *1, 2002 U.S. Dist. LEXIS 12984, at *3-4 (citing Sharp v. Artifex, 110 F. Supp. 2d 388, 392 (W.D. Pa. 1999) that despite the absence of a private right of action in the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. § 301, the statute could serve as a basis for a negligence per se claim when it is clear that the statute’s purpose is to protect a particular class).
149. Herbert, 2004 Conn. Super. LEXIS 229, at *8 (the alleged violations of federal regulations were § 483.20 (resident assessment), § 483.25 (quality of care), § 483.30 (nursing services), § 483.35 (dietary services), and § 483.40 (physician services)).
150. Id. at *11.
151. Id.
could not state a claim for negligence per se under the federal regulations found in 42 C.F.R. § 483.\footnote*{152} In \textit{Brown}, the widow of a resident who died after developing pressure sores and suffering from dehydration and malnutrition sued the nursing home for the wrongful death of her husband.\footnote*{153} The widow argued that “state and federal regulations establish[ed] a minimum standard of care for nursing homes operating in Tennessee and that a breach of that minimum standard of care” supported her negligence claims.\footnote*{154}

The District Court rejected the widow’s argument.\footnote*{155} Relying on \textit{Conley v. Life Care Ctrs. of Am.}, No. M2004-00270-COA-R3-CV, 2007 Tenn. App. LEXIS 13 (Tenn. Ct. App. Jan. 4, 2007), that rejected the use of the NHRA standards, the Court held that “the federal regulations are simply too vague and general to constitute a standard of care by which a jury, or for that matter a Court, can effectively judge the acts or omissions of health care providers and nursing home operators.”\footnote*{156} Following \textit{Conley}, the District Court concluded that the claim against the nursing home must be held to the local standard of care pursuant to the Tennessee Medical Malpractice Act,\footnote*{157} and the “plaintiff’s attempt to rely upon the federal regulations to establish a ‘national standard of care’ must fail.”\footnote*{158}

2. \textit{Satterwhite v. Reilly} (Denying A National Standard Of Care Because The Regulations Merely Serve To Certify Medicare/Medicaid Participation)

Several jurisdictions continue to hold that the Nursing Home Reform Act merely established certification standards to receive Medicare and Medicaid reimbursement. In \textit{Satterwhite v. Reilly}, 817 So. 2d 407 (La. App. 2 Cir. 5/8/02), the Louisiana Court of Appeals affirmed the trial court’s finding that “nothing in the [federal] regulation sets forth a standard of care for [nursing home] medical directors; the purpose is plainly to qualify providers for the Medicare and Medicaid programs.”\footnote*{159}

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\footnote*{152} \textit{Brown v. Sun Healthcare Group, Inc.}, 476 F. Supp. 2d 848, 849, 851 (E.D. Tenn. 2007); see 42 C.F.R. § 483 (requirements for States and Long Term Care Facilities).
\footnote*{153} \textit{Id.} at 849-50.
\footnote*{154} \textit{Id.} at 850-51.
\footnote*{155} \textit{Id.} at 851.
\footnote*{159} \textit{Satterwhite v. Reilly}, 817 So. 2d 407, 412 (La. App. 2 Cir. 5/8/02).
\end{footnotesize}
In Satterwhite, a resident and her son sued Dr. Reilly, the nursing home’s medical director. Mr. Satterwhite, the son, asserted that Dr. Reilly failed to adhere to 42 C.F.R. § 483.75(i)(2), the federal regulations that establish a medical director’s responsibility for the “implementation of resident care policies” and “the coordination of medical care in the facility.” Although the trial court found that Dr. Reilly failed to meet all the requirements of the federal regulations, and that the resident suffered injury from her inadequate care at the nursing home, the trial court found that the record did not demonstrate the resident’s “injuries were caused by the breach of any duty or responsibility owed by or imposed upon Dr. Reilly as the medical director.”

On appeal, Mr. Satterwhite argued that because Dr. Reilly was the medical director, he was liable under the federal regulations, and that his breach of duty harmed his mother. The Appellate Court rejected Mr. Satterwhite’s claim. The Court reasoned that the cited federal regulations merely set forth “standards for certifying long term care facilities to participate in the Medicare and Medicaid programs.” The Court concluded that the regulation failed to establish the standard of care or duty a medical director owed his residents, and a violation of the regulation could not support a negligence per se claim. The Court cited Raney v. Hall, No. 05-98-01908-CV, 2002 Tex. App. LEXIS 44 (Tex. App. Jan. 7, 2002), as additional support for its holding.

3. Raney v. Hall (Denying A National Standard Of Care Because No Authority Exists To Support A National Standard)

Some jurisdictions deny the existence of a national standard of care and hold that the nursing home must be measured by the local standard of care. In Raney, the Texas Court of Appeals affirmed the trial court’s holding that the nursing home federal statutes and regulations did not establish the standard of care. Raney’s estate appealed the trial court’s refusal to use a Texas Department of Health and Human Services’ report as an expert medical report. The estate argued that the report, which cited the nursing home’s violations of federal and state regulations, demonstrated the home was negligent per se in violation of 42 C.F.R. § 483.10

160. Id. at 409.
161. Id. at 411.
162. Id. at 410 (internal quotations omitted).
163. Id. at 411.
164. Satterwhite, 817 So. 2d at 411-12.
165. Id.
166. Id. at 412.
169. Id. at *1.
The Nursing Home Reform Act’s Codified Standard of Care

(resident’s rights), § 483.25 (quality of care), § 483.75 (administration), and the corresponding Texas Administrative Codes.170

The Appellate Court, rejecting the report’s findings, held that “the findings that the nursing home was deficient in its care... were not based on an ordinary nursing home standard but were based on standards set by state and federal statutes and regulations.”171 The Court noted that Raney’s estate cited “no authority for his contention that the regulations and statutes establish[ed] the accepted standard of care which a nursing home owes its residents.”172 The Court concluded that “the report does not qualify as an expert report because it does not contain a discussion of the applicable standard of care.”173

4. Tinder v. Lewis County Nursing Dist. (Denying A National Standard Of Care Because Regulations Are Merely Part Of A Regulatory Scheme)

Some jurisdictions deny the use of the Nursing Home Reform Act as establishing the national standard of care because Congress did not provide a private cause of action. In Tinder v. Lewis County Nursing Home Dist., 207 F. Supp. 2d 951 (E.D. Mo. 2001), the District Court dismissed a negligence per se claim based on the alleged violation of the NHRA federal regulations.174 In Tinder, the estate of a resident who died after another resident beat him repeatedly with a cane sued the nursing home for its alleged failure to comply with specific provisions of the NHRA.175 The Court, extensively quoting Brogdon v. Nat’l Healthcare Corp., 103 F. Supp. 2d 1322 (N.D. Ga. 2000) regarding the history of Medicare, OBRA and the NHRA, reasoned that the federal regulations were merely “part of a regulatory scheme designed to bring long term care facilities into substantial compliance with federal Medicare and Medicaid requirements and were not intended to establish an independent cause of action for violations of those requirements.”176 Citing three cases as authority, the Court concluded that the “majority of courts to consider this issue have concluded consistently that a private cause of action does not exist under Medicare/Medicaid and the OBRA amendments.”177

170. Id. at *7.
171. Id. at *12-13.
172. Id. at *12.
175. Id. at 956.
176. Id. at 956-58.
E. NHRA Establishes The Standard Of Care In Assisted Living Facilities

1. Peskin v. Seasons Health Care (National Standard Care Applies To Those Who Most Need It)

Reasoning that the Nursing Home Reform Act’s ultimate purpose was to protect persons who reside in facilities that are unaccountable, one court held an Assisted Living Facility (ALF) to the national standard of care. In *Peskin v. Seasons Health Care L.P.*, 751 N.E.2d 546 (Ohio Ct. App. 2001), the Ohio Court of Appeals held that the Nursing Home Patients’ Bill of Rights applied to an unlicensed Assisted Living Facility (ALF).

In *Peskin*, the granddaughter of a resident in an unlicensed assisted living facility appealed the trial court’s decision that the Patients’ Bill of Rights did not apply to an unlicensed “home.” The ALF argued that the Patients’ Bill of Rights did not govern its actions because an unlicensed facility does not meet the statutory definition of “home.” Reversing the trial court, the Appellate Court held that “a facility that meets the statutory definition of ‘home’ is subject to the Patients’ Bill of Rights regardless of whether the Department of Health allows it to operate unlicensed.” The Court reasoned that the Nursing Home “Patients’ Bill of Rights was considered necessary because both state and federal regulations had ‘largely failed to ensure humane treatment of all nursing home residents, whose special needs have often been sacrificed to administrative convenience, efficiency, and economy.’” The Court concluded that “experience dictates, however, that persons who reside in unlicensed facilities that are unregulated and unaccountable to the director of health are those most in need of private enforcement of a Patients’ Bill of Rights.”

VI. CONCLUSION

Increasingly jurisdictions accept the Nursing Home Reform Act (NHRA) as establishing the national standard of care within the nursing home industry. The spectrum of acceptance that the NHRA establishes the standard of care ranges from holding that violations of the NHRA is negligence per se to holding that a standard of care is nonexistent. However, courts are recognizing that States and the nursing home industry have indistinguishably incorporated the NHRA regulations into the nursing home protocol. The local nursing home standard of care protocol is the national

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179. Id.
180. Id.
181. Id.
182. Id.
184. Id. at 550.
standard of care, if the home wishes to receive federal funds and avoid potential but sporadic sanctions.

Unfortunately for many elderly, nursing homes do not comply with their established standard of care. Because of the inadequate enforcement of the NHRA by government agencies, residents of long-term care facilities are in an extremely vulnerable position. Private litigation facilitated by an established national standard of care would ensure adequate quality of care for the elderly residing in our nation’s nursing homes. The more jurisdictions that hold a violation of the NHRA is negligence per se, the less likely residents of long-term care facilities will be neglected and abused by an inadequately regulated industry.
ENDING THE SILENT SUFFERING: PROTECTING LONG-TERM CARE PATIENTS FROM SEXUAL ABUSE

By Katherine Milane*

I. INTRODUCTION

“A civilized society certainly must take all possible measures to understand the sexual victimization of its most vulnerable citizens, prevent the occurrence of this type of crime, and respond ethically, humanely, swiftly, and effectively when it does occur.”

—Holly Ramsey-Klawsnik

At 77 years old, Virginia Thurston could no longer care for herself. The once-active mother who loved to cook had developed severe dementia. Mrs. Thurston’s daughter felt she had no choice but to place her mother in a nursing home. Southwood Nursing Center was supposed to be a safe place where Mrs. Thurston would receive the care she needed. Instead, it became the setting for a violent and disturbing crime. Mrs. Thurston was sexually assaulted by an 83-year-old resident with a long criminal

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history—including charges of sexual assault. Despite her brutal victimization, Mrs. Thurston was fortunate. Mrs. Thurston had a trusted and attentive relative—her daughter—to whom she could report the abuse. Her daughter was able to advocate on Mrs. Thurston’s behalf and hold both the nursing facility and the offender responsible for their actions.

Unfortunately, many elders suffer this type of abuse in silence. Sexual abuse of elders has traditionally been the “least perceived, acknowledged, detected, and reported type of elder victimization.” In recent years, however, politicians and researchers have begun to pay more attention to elder abuse, and consequently, to the issue of sexual abuse of elders. Though sexual abuse of elderly people, like sexual abuse of the general population, may occur in many settings, this paper will focus on the problem of sexual abuse of elders in long-term care facilities. While some researchers contend that “no reliable date exist on the prevalence of abuse, neglect, or exploitation in...long-term care settings,” nearly all acknowledge that “residents in long-term care settings are especially vulnerable to abuse, neglect, exploitation.” This paper will explore the scope and severity of the problem of sexual abuse in long-term care settings as well as the role governmental regulations and law enforcement agencies can play in identifying and preventing such abuse.

II. THE NATURE OF THE PROBLEM

Before one can determine the best methods by which to prevent sexual abuse in long-term care settings, one must first understand the scope of the problem. Sexual abuse against elders comes in many forms and can be committed by a range of individuals; from trusted caregivers to other long-term care residents. Once the specifics of the problem are understood, solutions can be crafted to best suit the needs of long-term care residents.

A. Sexual Abuse Defined

The National Center on Elder Abuse (“NCEA”) defines sexual abuse as “nonconsensual contact of any kind with an elderly person.” Sexual abuse includes “all types of sexual assault or battery, such as rape, sodomy or coerced nudity, as well as unwanted touching and uninvited exposure to sexually explicit photography.” Sexual contact with any person incapable of giving consent is also considered sexual

3. Id.
6. Teaster, supra note 4, at 106
8. Id. at 610
abuse.\textsuperscript{9} In 2000, Adult Protective Services received 473,095 domestic and institutional reports of the mistreatment of vulnerable adults; 4,150 allegations involved sexual abuse.\textsuperscript{10}

While the NCEA’s definition provides a useful overview of the types of abuse that can occur, the problem can be further defined in other terms. Sexual abuse can also be classified by the nature of the offender. Holly Ramsey-Klawnsnik’s study, “Sexual Abuse of Vulnerable Adults in Care Facilities: Clinical Findings and a Research Initiative,” (“Ramsey-Klawnsnik study”) identifies five basic types of sexual abuse involving older adults, delineated by the type of perpetrator.\textsuperscript{11} In general, sexual abuse against elders is committed by a stranger or acquaintance, a care provider, a partner or spouse, a care facility resident, or in the context of incest.\textsuperscript{12}

Ramsey-Klawnsnik’s study uncovered disturbing examples of these various types of sexual abuse, including female nursing home residents who were repeatedly sexually molested by a 67-year-old male patient with chronic mental illness and a long-term care resident in a persistent vegetative state who was sexually touched, and ultimately raped by, her husband.\textsuperscript{13}

Sexual abuse can further categorized by the general nature of the offense. As Brian Payne explains in his study, “The Criminal Justice Response to Elder Abuse in Nursing Homes: A Routine Activities Perspective,” (“Payne Study”) sexual abuse cases can be classified as hands-on, harmful genital contact, and hands-off.\textsuperscript{14} Hands-on abuse occurs when the offender touches the victim sexually, but does not engage in sexual intercourse with the victim.\textsuperscript{15} Payne cites the example of a nursing assistant at a health care and rehabilitation facility engaging in inappropriate conduct while bathing an elderly patient.\textsuperscript{16} The assistant shaved the patient’s pubic region, then, claiming he needed a “specimen,” the assistant digitally penetrated the patient.\textsuperscript{17} Harmful genital contact sex abuse cases are those in which “intercourse (including oral, vaginal, and anal sex) occurs.”\textsuperscript{18} Hands-off sexual abuse “occurs when a when offenders commit some sexually abusive act without touching the patient.”\textsuperscript{19} The Payne study found two instances of hands-off abuse where an aide exposed his genitals to a patient.\textsuperscript{20}

A study by Pamela B. Teaster and Karen A. Roberto and their research team, “Sexual Abuse of Older Women Living in Nursing Homes,” (“Teaster study”) found

\textsuperscript{9} Id. at 609
\textsuperscript{10} Teaster, supra note 4, at 106
\textsuperscript{11} Ramsey-Klawnsnik, supra note 1, at 332
\textsuperscript{12} Id. at 333
\textsuperscript{13} Ramsey-Klawnsnik, supra note 1, at 333
\textsuperscript{14} Payne, supra note 5, at 75
\textsuperscript{15} Id.
\textsuperscript{16} Id.
\textsuperscript{17} Id.
\textsuperscript{18} Id.
\textsuperscript{19} Id.
\textsuperscript{20} Id.
two that two types sexual abuse occur most frequently.\textsuperscript{21} According to Teaster and Roberto, “the most common type of sexual abuse involved sexualized kissing and fondling.”\textsuperscript{22} This type of abuse accounted for 76 percent of the cases uncovered by the five year study. Accounting for 38 percent of cases in the sample, “unwelcome sexual interest in the woman’s body” was the second most frequently reported type of abuse.\textsuperscript{23}

\textbf{B. Abusers Identified}

There is no single type of person who commits sexual abuse against the elderly. Sexual abuse cases can involve other long-term care residents, staff members, and even the victim’s relatives or friends. The Ramsey-Klawsnik study does not identify which category of perpetrator most often commits acts of sexual abuse. Other researchers, however, have attempted to do so. The Teaster study determined that in 90\% of abuse cases, the alleged offender is a male long-term care resident, 70 years of age or older.\textsuperscript{24} The “next most frequent perpetrator,” according to Teaster, “was facility staff.”\textsuperscript{25} The Payne study identified 10\% of the incidents of sexual abuse in the sample as occurring at the hands of aides.\textsuperscript{26}

“Residents who sexually offend against other residents,” the Ramsey-Klawsnik study found, “pose serious challenges to facility staff.”\textsuperscript{27} Residents who commit sexually abusive acts “may lack mental capacity, require skilled nursing care, or skillfully evade staff supervision.”\textsuperscript{28} These residents may have long criminal records, including a pattern of a sexual offenses, but “the danger they pose to fellow residents may not be recognized due to their advanced age or impaired health status.”\textsuperscript{29} Because staff members may not be aware of the danger such residents pose to their peers, they are not always able to supervise them in a way that sufficiently protects other residents.

Though the research does not indicate that facility staff members are the most frequent offenders in sexual abuse cases, “sexual offenders who can find their way into employment within care facilities can be extremely manipulative and skilled at gaining the trust of supervisors, fellow workers, and vulnerable residents.”\textsuperscript{30} These employees may be well regarded by coworkers and supervisors, and may even volunteer for undesirable duties such as night shifts and the care of unpleasant or difficult patients.\textsuperscript{31}

\begin{thebibliography}{99}
\bibitem{21} Teaster, \textit{supra} note 4, at 111
\bibitem{22} Id.
\bibitem{23} Id.
\bibitem{24} Id.
\bibitem{25} Id. at 108
\bibitem{26} Payne, \textit{supra} note 5, at 74
\bibitem{27} Ramsey-Klawsnik, \textit{supra} note 1, at 334
\bibitem{28} Id.
\bibitem{29} Id.
\bibitem{30} Id.
\bibitem{31} Id.
\end{thebibliography}
However, “these assignments lead to greater opportunity to be alone with the most vulnerable residents.”

Douglas J. Edwards explores the problem of staff sexual abuse of long-term care residents in his article “Thinking about the unthinkable: staff sexual abuse of residents.” Edwards recognizes that “historically, virtually all institutional environments had incidents of sexual abuse.” He further explains that institutional settings such as long-term care facilities have several characteristics that increase the possibility of sexual abuse for residents. First, long-term care populations are composed of “highly vulnerable” individuals who “often lack the ability to give consent or defend themselves.” Second, long-term care populations tend to be homogenous, or “faceless,” making it easier for abusers to dehumanize their victims. Finally, patients in long-term care facilities often have needs, such as assistance with toileting and bathing, which “require close contact with caregivers.” Unfortunately, it is difficult to determine the prevalence of this type of abuse with any precision. As Edwards states, “staff sexual abuse of residents is a topic you don’t hear much about—except when it happens.”

In recent years, politicians and researchers have also considered the possible threat registered sex offenders living in long-term care facilities poses to other residents. A March 2006 report conducted by the United States Government Accountability Office (“GAO”) found that “because data are not available nationally...abuse perpetrated specifically by residents who have prior convictions, the potential risk for abuse by offenders residing in long-term care facilities cannot be accurately estimated.” According to the report, there were approximately 700 registered sex offenders living in long-term facilities in 2005. This number represented .05 percent of the 1.5 million long-term care residents at that time. The report is careful to note however, that “given the small percentage of facilities identified as housing offenders, the risk [of abuse from such offenders] may not be widespread.”

32. Id.
34. Id.
35. Id.
36. Id.
37. Id.
38. Id.
40. Id. at 3
41. Id.
42. Id. at 17
C. Motivation for Abuse

Sexual abuse against elders can take many forms; the motivation for its commission varies as well. As Edwards notes in his article, “not all sexual abusers have the same motivation...many incidents in institutional settings...are not done with a threat of violence or physical hurt.”43 Some abusers, according to Edwards, do not mean to harm their victims, but rather receive some sort of personal gratification from their abusive behavior.44 “Molestation,” Edwards explains, “is a selfish way of getting one’s own needs met, and there often isn’t an intent to hurt. It’s not an issue of being cruel. It’s just really inappropriate, bad behavior that is ultimately hurtful.”45 Abusers who seek gratification in this way often rationalize that their victims don’t understand what is happening to them and reason that even if the victims are aware, they will be unable to report the abuse because of their lack of cognitive abilities.46

Other abusers, however, do intend to hurt their victims. They are, as Edwards notes, “fascinated by the power they have.”47 As with the motives behind other forms of rape and molestation, sexual abuse of elders in institutions “becomes a way of showing power and control.”48 Edwards likens the power dynamic behind this type of institutional sexual abuse to “the one behind some U.S. soldiers’ infamous sexual humiliation of prisoners in Iraq’s Abu Ghraib prison.”49

D. Most Common Victims

Though all long-term care residents may share some traits that leave them vulnerable to sexual abuse, research demonstrates that women, especially those with a high level of dependency on others, are most likely to be victimized. According to the Teaster study, women are more likely than men to be victims of sexual abuse in long-term care facilities.50 Teaster attributes this in part to the fact that “there are a disproportionate amount of women compared to men living in long-term care facilities.”51 Teaster’s study found that women ages 80 to 89 “[are] more likely to experience multiple types of abuse than those between the ages of 70 and 79.”52 The Payne also found a correlation between age and abuse. Payne found that patients 81 years of age or older accounted for 52.4 percent of those considered to be “suitable targets” for abuse.53

The Teaster study also found a correlation between the level of dependency on others for care and the likelihood of victimization. Women “who needed more

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43. Edwards, supra note 33
44. Id.
45. Id.
46. Id.
47. Id.
48. Id.
49. Id.
50. See Teaster, supra note 4
51. Id. at 108
52. Id. at 111
53. Payne, supra note 5, at 76
assistance with ambulation” were more likely to “experience more than one type of sexual abuse than women who did not need assistance.” Cognitive impairment also makes a patient more likely to be targeted for abuse. According to Payne’s findings, “approximately 36% of sexual abuse victims had some form of a cognitive impairment compared to about 23% nonsexual abuse victims.” Patients with Alzheimer’s, dementia, and mental retardation, as well as other forms of cognitive impairment were all found to be more vulnerable than patients who were not cognitively impaired, regardless of impairment type.

III. POSSIBLE SOLUTIONS

As Edwards opines in his article, “of course, preventing sexual abuse in the first place is the goal.” While no perfect solution exists, private researchers and government agencies, such as the GAO, have identified several areas in which improvements should be made to better protect the elderly. From more thorough employment screening, to better staff training, to better utilization of law enforcement agencies, there are a variety of possible solutions which could—and should—be implemented in long-term care settings.

A. Employment Screening

Employment screening can be a valuable tool in protecting long-term care residents from sexual abuse at the hands of nursing home employees. “Care must be taken,” the Ramsey-Klawsnik study urges, “to screen out potential and actual abusers and to screen in individuals who are motivated to create safe environments for residents.” Though staff members are not the primary abusers of long-term care residents, proper employment screening can help to eradicate this class of abuse. If employment screening is to effectively detect individuals with a history of abuse, however, changes will need to be undertaken. There are myriad problems with the way this type of screening is currently conducted.

Currently, “there is no federal statute requiring criminal background checks of nursing home employees, nor does Centers for Medicare and Medicaid Services (“CMS”) require them.” Though most states have laws requiring some form of background check for potential nursing home employees, the GAO has found these to be widely “insufficient.” Only nursing homes in North Carolina and Ohio require nationwide background checks on prospective employees.

54. Teaster, supra note 4, at 111
55. Payne, supra note 5, at 76
56. Id.
57. Edwards, supra note 33
58. Ramsey-Klawsnik, supra note 1, at 334
60. Id. at 5
61. Id. at 18
As explained in the GAO’s 2002 report on protecting nursing home residents from abuse, three main tools are available to screen prospective employees. Nursing homes may utilize criminal background checks conducted by local law enforcement, as well as criminal background checks conducted by the Federal Bureau of Investigation. Nursing homes may also consult state registries that contain information regarding abuse by nursing home aides. However, “CMS does not require that the results of criminal background checks be included in nurse aide registries.” Additionally, the GAO found that the information included in all of these sources is “often not complete or up to date.”

Of the three states the GAO surveyed (Georgia, Illinois, and Pennsylvania), only Georgia required criminal background checks to be completed before the employee could begin work. Pennsylvania allows new employees to work for 30 days and Illinois allows them to work for 3 months before the background check is completed.

Another problem lies in the fact that there is no centralized data base of abuse claims against non-licensed long-term care facility personnel. While “facilities can screen licensed personnel, such as nurses and therapists, by checking the records of licensing boards for disciplinary action...screening other facility employees, such as laundry aides, security guards, and maintenance workers, is limited to criminal background checks.” This poses a serious problem when employees of this nature are accused of abuse at one facility, but not criminally prosecuted. “Unless such employees are convicted of an offense,” the GAO report explains, “problems with their prior behavior will not be detected.” Even a non-licensed employee with a criminal history may escape detection if the background check conducted is limited only to the state in which he or she is currently seeking employment.

The Health and Human Services Office of the Inspector General has recommended that a national abuse registry be developed and that state registries be expanded to include all nursing home employees cited for abuse. Though this registry has not yet been put into place, there are steps that facilities can take to maximize the effectiveness of employment screening.

Ramsey-Klawsnik suggests that long-term care facilities, in addition to conducting criminal background checks, should consult sexual offender registries, and

63. Id.
64. Id.
65. United States Government Accountability Office, supra note 59, at 18
66. Id.
67. Id.
68. Id.
69. Id. at 10
70. Id.
71. Id.
72. Id. at 10, 11
perform careful interviews and reference checks before hiring any new staff member. Edwards, too, advocates a multifaceted pre-employment background check. “Since the best predictor of future behavior is past behavior,” his article explains, “individuals with histories of sexual abuse pose a definite risk to long-term care facilities” Edwards cautions against “one-dimensional” background checks that are limited to a single source, such as statewide criminal checks or nurse aide abuse registry checks. “Instead of stopping the background check there,” Edwards says of single-source checks, “[long-term care facilities] should take advantage of the many information sources available to facilities and close potential gaps in an employee’s background that can leave a facility open to liability.”

To best prevent abusive individuals from gaining employment in long-term care facilities, a basic background check should be comprehensive. Employers should include identity verification, employment verification, professional license or credential verification, sex offender registry checks, nurse aide abuse registry checks, and checks of “additional healthcare databases of ‘sanctioned’ individuals” in their pre-employment screening of all nursing home employees. It is also beneficial for facilities to perform checks outside their immediate geographic area. “This practice,” Edwards explains, “not only protects the legality of facility’s background check process, but may also reveal individuals with past problems in one type of job who are applying for another type of job. For example, a nurse aide with a history of abuse may apply for a job at a long-term care facility as an office manager or food service worker.”

The enactment of a national abuse registry for all classes of long-term care facility employees would be highly beneficial in protecting residents from abuse at the hands of staff members. It would prevent abusive individuals from moving from facility to facility to facility undetected and would aid administrators in making wise hiring decisions. While the creation of such a registry would only aid in eliminating one class of abusers, it would be an important step toward a safe environment for long-term care residents. A federal law setting forth the requirements for background checks and mandating that states complete them before new hires begin to work would also be beneficial. Such a law would create a uniform standard among the states and prevent abusers from having access to residents before the results of their check are known.

Until a federal scheme for conducting background checks is enacted, long-term care facilities should take all steps possible to conduct a thorough background check of each and every potential employee. These checks are beneficial to the facility as well as the residents as thorough pre-employment screening can prevent abuse and the expense of any resulting lawsuits. Any cost or inconvenience involved in conducting

73. Ramsey-Klawsnik, supra note 1, at 334
74. Edwards, supra note 33
75. Id.
76. Edwards, supra note 33
77. Id.
78. Id.
79. Id.
thorough pre-employment screening is far outweighed by the benefits of keeping would-be abusers away from long-term care residents.

B. Staff Education

Educating long-term care facility staff is crucial to the recognition and reporting of abuse as well as its prevention. As staff members are likely to be the ones who witness abuse or its symptoms, “it is imperative to train facility staff...regarding the importance of reporting problems that occur in the nursing home.”80 If staff members are taught to immediately recognize signs of sexual abuse, they will be able to respond swiftly and appropriately. “If assisted in recognizing particular vulnerabilities,” the Teaster study found, “[staff members] may be able to prevent some of the abuse from occurring in the first place.”81 Staff members who are trained to identify likely targets of abuse can offer better protection and supervision for such residents.

Long-term care facility administrators and staff should be trained to identify common signs of abuse.82 The following changes in residents are examples of “key indicators” of sexual abuse:83 “difficulty in walking or sitting, pain or itching in genital areas, the occurrence of sexually transmitted diseases, unexplained bruising, welts, lacerations, fractures or other injuries, decreased socialization, fear of specific people or places, [and] habit disorders, such as pulling hair or ears.”84 If those in position of authority are not properly trained, they may miss or misinterpret signs of abuse.85 The Ramsey-Klawsnik study cites the example of an elderly woman who began to insist on wearing multiple layers of clothing.86 Rather than recognizing this behavioral change as an attempt to self-protect from ongoing sexual abuse, staff members attributed it to dementia.87

Long-term care personnel must also be taught not to minimize sexually offensive behavior by residents and to take seriously all complaints of sexual abuse.88 Improperly trained staff may mistake sexual assault for consensual sexual activity or assume that cognitively impaired residents will not experience any negative effects from involuntary sexual activity.89 They may also be inclined to discount reports of sexual abuse as delusional thinking or cognitive impairment.90 As the GAO’s study found, “nursing home staff may be skeptical that abuse occurred,” and, a result, may not report it in a timely fashion.91

80. Teaster, supra note 4, at 115
81. Id.
82. Edwards, supra note 33
83. Id.
84. Id.
85. See Ramsey-Klawsnik, supra note 1, at 334
86. Id.
87. Id.
88. Id.
89. Id.
90. Id.
91. United States Government Accountability Office, supra note 59, at 11
Protecting Long-Term Care Patients from Sexual Abuse

A report prepared at the request of Representative Henry A. Waxman uncovered a disturbing example of this type of staff dismissal of a resident complaint. A female resident of a New Jersey long-term care facility said that “a male aide had made vulgar, sexual remarks to her while assisting her in the shower... [and] would come into her room while she was in bed and feel her breasts. On one occasion, he exposed his genitals to her.”92 The resident reported this behavior to the facility staff, but “state inspectors found that the facility neither investigated the allegations nor reported the allegations to the proper authorities.”93 While it is not impossible that a cognitively impaired resident could make an ultimately false claim of abuse, the only way to fully protect residents is to treat each report as legitimate and conduct a proper investigation.

An increase in the quantity of training hours required, as well as the quality, could also be beneficial in preventing and reporting abuse. The Center for Medicare Advocacy recommends that “Congress...enact legislation to improve training for certified nurse assistants and to increase the minimum number of hours of required training.”94 As the Center’s statement to the Senate Special Committee on Aging details, “abuse and neglect occur because staff have too little training and too few skills to understand how to deal appropriately with residents.”95 The Center’s statement further explains that the current nurse aide training requirements, adopted in 1987, require only 75 hours of training.96 This requirement is “clearly inadequate to meet the needs of today’s nursing home residents who are more frail and disabled and have greater health care needs than ever.”97 The more hours of education staff members receive, the greater the opportunity they will have to fully comprehend the scope of their duties.

Even when staff members are trained to detect abuse, they may not be aware of how, or to whom, to report their observations. “The federal government,” Edwards notes, “requires nursing homes to report all allegations of abuse to state survey agencies and other state officials.”98 Staff members must be made aware of their legal duty to report actual or suspected sexual abuse to the proper authorities.99 While the specifics of reporting vary from state to state, there is frequently a requirement that “[Adult Protective Services], certification and public health officials, and law enforcement” be contacted in cases of alleged sexual abuse of long-term care

93. Id.
95. Id.
96. Id.
97. Id.
98. Edwards, supra note 33
99. Ramsey-Klawsnik, supra note 1, at 335
residents. Staff members must be educated to the reporting requirements of their state as well as “the duty to take seriously and report any disclosed or any suspected victimization.” However, as the Ramsey-Klawsnik study found, if staff members do not feel comfortable talking to management, they will not report abuse. For this reason, it is important for nursing home administrators to maintain open communication with their staff.

Congress should follow the Center for Medicare Advocacy’s suggestion and mandate more training hours for nurse aides. This training should include information on identifying and preventing abuse with an emphasis on the duty to report. If staff members can readily identify actual or potential problems with the residents under their care and are familiar with the proper way in which to report abuse, they will be better able to protect the vulnerable long-term care population. Also, nursing home administrators should focus on encouraging communication between management and staff so that intimidation or unfamiliarity does not prevent staff from freely reporting abuse situations.

C. Better Utilization of the Criminal Justice System

Long-term care residents and their families “do not always view abuse as a criminal matter.” Residents and their family members are not obligated to notify law enforcement officials in cases of alleged abuse, nor is there a federal requirement that nursing homes do so. As a result, victims of abuse in long-term care facilities are not utilizing the criminal justice system to the extent that they could. Lack of police involvement contributes, in part, to very few prosecutions in long-term care sexual abuse cases, which in turn leads to a lack of justice for many victims.

As the GAO explains, “victims of crimes ordinarily call the police to report instances of physical and sexual abuse, but when the victim is a nursing home resident, the police appear to be notified infrequently.” The majority of the local police departments surveyed by the GAO stated that they were “seldom summoned to a nursing home following an alleged instance of abuse.” The GAO found that nursing homes were generally compliant with requirements that they contact state survey agencies regarding allegations of abuse. However, law enforcement officials were

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100. Id.
101. Id.
102. Edwards, supra note 33
103. See Edwards, supra note 33
104. United States Government Accountability Office, supra note 59, at 9
105. United States Government Accountability Office, supra note 59, at 9, Only 2 states, PA and IL, currently require that nursing homes contact police in abuse cases.
106. See Teaster, supra note 4, at 112
107. United States Government Accountability Office, supra note 59, at 9
108. Id.
109. Id.
either not contacted at all, or were contacted in an untimely fashion, thus limiting their ability to conduct a thorough investigation.\textsuperscript{110}

Both CMS and the GAO advocate the notification of local police when sexual abuse is alleged.\textsuperscript{111} “Like any crime,” the GAO report states, “police should be summoned as soon as the [sexual abuse] incident is discovered.”\textsuperscript{112} However, long-term care staff and management, as well as residents and their families all have reasons for not wanting to involve the police. Staff members may fear “losing their jobs or facing recrimination from co-workers and nursing home management.”\textsuperscript{113} Management is often “reluctant to risk adverse publicity or sanctions from the state.”\textsuperscript{114} Residents may believe that the abuse will worsen if they involve the police and family members “are sometimes fearful that the resident will be asked to leave the home and are troubled by the prospect of finding a new place for the resident to live.”\textsuperscript{115}

The harm caused by not immediately reporting crimes to local law enforcement is evident when one examines the frequency with which abuse cases against long-term care residents are prosecuted. In the Teaster study, only 6\% of the cases examined were criminally prosecuted.\textsuperscript{116} The study found that the “most common reason noted for not prosecuting [sexual abuse] cases was insufficient evidence;” this was the situation in 60\% of the cases examined in the study.\textsuperscript{117} The GAO report also cites “lack of compelling evidence” as a major reason why long-term care sexual abuse cases are often not prosecuted.\textsuperscript{118} “Prosecutions of individuals accused of abusing nursing home residents,” the GAO report notes, “are often weakened by the time lapse between the incident and the trial.”\textsuperscript{119} The longer suspected abuse goes unreported to law enforcement, the longer it takes authorities to put together a solid case against an abuser. The amount of time that elapses between an incident and a trial,” the GAO found, “could ruin an otherwise successful case.”\textsuperscript{120} The passage of time can have a devastating effect on the ability of victims or witnesses to remember the details of the crime.\textsuperscript{121} According to the GAO, “nursing home residents may become incapable of testifying months after they were abused,” and often, given the advanced age and poor health of many long-term care residents, the victim or the witness may not live long enough to participate in a trial.\textsuperscript{122}

\begin{itemize}
\item[\textsuperscript{110}] Id.
\item[\textsuperscript{111}] See Edwards, supra note 33, United States Government Accountability Office, Id. at 9
\item[\textsuperscript{112}] United States Government Accountability Office, supra note 59, at 9
\item[\textsuperscript{113}] Id.
\item[\textsuperscript{114}] Id.
\item[\textsuperscript{115}] Id. at 11
\item[\textsuperscript{116}] Teaster, supra note 4, at 112
\item[\textsuperscript{117}] Id.
\item[\textsuperscript{118}] United States Government Accountability Office, supra note 59, at 16
\item[\textsuperscript{119}] Id.
\item[\textsuperscript{120}] Id.
\item[\textsuperscript{121}] Id.
\item[\textsuperscript{122}] Id. at 17
\end{itemize}
Federal law should follow the example of states such as Pennsylvania and Illinois and require long-term care facilities to involve local police in abuse investigations. If police are timely notified, they can better gather the evidence necessary to proceed with criminal prosecution. The sooner police can conduct their investigation, the sooner the case can be set for trial, thus increasing the chance that a victim’s health and memory will allow him or her to participate in trial. If more abusers were prosecuted, it would likely act as a further deterrent to committing this type of crime.

IV. CONCLUSION

Though traditionally under-recognized and underreported, sexual abuse of elders has now captured the attention of researchers and government officials alike. Strides have been made in identifying the most common classes of abusers, as well as the characteristics that can make certain elders the most vulnerable targets. Problems with adequately protecting potential victims, as well as possible solutions, have been brought to greater attention by private researchers and government studies. However, there is still a need for greater awareness of this problem. Only when long-term care personnel, families, and residents themselves are fully aware of the warning signs of abuse and how to properly report both alleged and actual abuse can this problem be effectively combated.

There have been many excellent suggestions posited, including stricter laws and more federal requirements, but they do the long-term care population little good until they are put into action. The proposed laws discussed in this paper, such as those regarding staff screening and training, and those that require the notification of local police in cases of suspected abuse, should be adopted. The long-term care population is highly vulnerable to abuse and should therefore be entitled to the best protection the law can afford.
CLOSING THE “ESTATE” LOOPHOLE: A UNIFORM, FEDERAL SOLUTION TO IMPROVE THE EFFECTIVENESS OF MEDICAID ESTATE RECOVERY

Korey L. Henson* 

I. INTRODUCTION ........................................................................................................153

II. THE MEDICAID PROGRAM ......................................................................................156
   A. State and Federal Medicaid Financing and Participation Requirements..... 157
   B. Individual Eligibility Requirements .............................................................. 158
   C. Spousal Protection .................................................................................. 158

III. THE MEDICAID ESTATE RECOVERY PROGRAM ....................................................159
   A. The History and Purpose of Estate Recovery ............................................. 159
   B. Spousal Recovery and the Definition of Estate .......................................... 160

IV. VARIATIONS IN SPOUSAL RECOVERY WITHIN STATE PROGRAMS........................162
   A. The Narrow Interpretation – States That Disallow Spousal Recovery ....... 162
   B. The Expansive Interpretation – States That Allow Spousal Recovery........ 165

V. ANALYSIS AND EVALUATION OF ESTATE RECOVERY APPLICATIONS...................168

IV. CONCLUSION.........................................................................................................173

I. INTRODUCTION

Imagine a situation in which an elderly married couple, Harold and Evelyn Stevenson, have come to you over the course of several years for estate planning services. Upon their initial visit in 2005, the Stevensons were specifically interested in figuring out how to pay for long term care in the event that either or both of them were forced to move into a nursing home. In the course of counseling the Stevensons you learned that they were ideal candidates for Medicaid planning.1

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1. Medicaid planning consists of the simultaneous practice of selling off or otherwise eliminating assets in an attempt to satisfy Medicaid eligibility requirements to qualify for Medicaid coverage for long term care and securing protection for such assets from Medicaid estate recovery efforts by the state Medicaid agency. Matthew Wilson, The Future of Medicaid Planning in Missouri, 62 J. Mo. B. 62, 62 (2006).
When the Stevensons visited in 2005, they had been married for 55 years and had three adult children: ages 40, 45, and 48. Harold Stevenson, age 85, retired from the local factory in 1985 after 42 years of service in the maintenance department. Although not the best paying of jobs, he never worried about job security, and the factory offered an excellent defined benefits program for its retirees. Evelyn Stevenson, age 80, retired from teaching at the local high school in 1995 after 35 years of service. Like the factory the school district offered an excellent defined benefits program for its retirees as well. Unfortunately due to recent economic troubles and corporate mismanagement, the income the Stevensons had counted on from the factory’s defined benefit plan was eliminated. As a result, the only source of income available to the Stevensons consisted of Evelyn’s small defined benefits plan from the school district and their combined Social Security income, totaling $1,800 per month. Luckily, the Stevensons had always tried to save money throughout their lives and had amassed $75,000 in a joint bank account. In addition, the Stevensons owned outright the home in which they had lived for more than 50 years. They owned the home as joint tenants with a right of survivorship and a recent appraisal valued the home at $100,000. After gathering all of this information, you were able to tell the Stevensons that they would be able to obtain Medicaid coverage without having to deal with the look-back period required by the Deficit Reduction Act of 2005 if either or both of them require nursing home care in the future despite the amount of their monthly income, the amount of their savings, and the value of their home.

In January 2007, Harold fell while working in the yard of their home and broke his hip. After surgery to repair the injury, he moved into a local nursing home for 19 days while his hip healed. Luckily, Medicare covered both the operation and the rehabilitation stay. Unfortunately, shortly after returning home Harold began to rapidly manifest symptoms of dementia. Although Evelyn remained in excellent health, she quickly realized that she could not care for Harold, whose condition was rapidly worsening, on her own. Even though Harold still had Medicare days

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3. Medicare covers care in a skilled nursing facility for up to one hundred days upon the satisfaction of certain specific conditions. Richard L. Kaplan, Honoring Our Parents: Applying the Biblical Imperative in the Context of Long-Term Care, 21 Notre Dame J.L. Ethics & Pub. Policy 493, 505 (2007). In order for the care to be covered, the nursing facility must be approved by Medicare, the individual must be admitted to the nursing facility within thirty days of discharge from a hospital stay of three days or more (not counting the day of discharge), and the individual must require skilled care that only a skilled nursing facility can provide. Id. at 505-506. If the individual’s care qualifies for Medicare, the cost of the first twenty days is reimbursed by Medicare in full, and the cost of the next eighty days is subject to a daily deductible. Id. at 506.
remaining after his previous rehabilitation stint, Medicare would not pay for any of this stay since Harold did not require skilled care. 4 With your assistance Evelyn successfully applied for Medicaid coverage for Harold’s nursing home care and promptly moved him into the local nursing home. Although not the fanciest of nursing homes, the nursing home that you helped Evelyn select for Harold was well known in the area for its quality of care and they always provided excellent care for Harold during his stay.

In January 2008, Harold suffered a massive myocardial infarction and died shortly thereafter from complications. Since all of the Stevenson’s assets were owned jointly with survivorship rights, no probate estate was opened for Harold; rather, Harold’s interests in the jointly owned assets passed to Evelyn by operation of law. In February 2008, Evelyn sustained a major fall in her home and suffered a severe head injury. She was rushed to the hospital and died the following day from her injuries. As both the attorney and the personal representative of Evelyn’s estate, you promptly initiated probate proceedings. Shortly thereafter, the state Medicaid office filed a claim as a creditor of Evelyn’s estate in the amount of $85,000. Since Evelyn never received Medicaid benefits, you inquired into the purpose of the claim and were told that the basis of the claim was to recover Medicaid expenditures made on behalf of Harold. The Medicaid office told you that under state and federal law, the state Medicaid office has authorization to seek reimbursement of Medicaid expenditures made for Harold by tracing Harold’s assets into Evelyn’s estate after Evelyn’s death. The woman on the phone then laughingly told you “it’s too bad your client didn’t live in a different state; the laws of some states don’t allow the Medicaid office to trace assets through the estate of a deceased surviving spouse!” 5 Not wanting to just take her word for it, you decided to do a little bit of research on the subject. Surprisingly, you found that a substantial divide exists between state Medicaid estate recovery programs with respect to the state’s ability to recover Medicaid nursing home expenditures from the estate of a surviving spouse of a Medicaid beneficiary. 6

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4. Medicare pays a maximum of one hundred days of skilled care provided in a skilled nursing facility and pays for long term care only if the long term care is incident to the skilled care. Alissa Halperin, Patricia Nemore, & Vicki Gottlich, What’s so Special About Medicare Advantage Special Needs Plans? Assessing Medicare Special Needs Plans for “Dual Eligibles”, 8 Marq. Elder’s Advisor 215, 225 (Spring 2007). Skilled care is defined as services that “are ordered by a physician; require the skills of technical or professional personnel…; and are furnished directly by, or under the supervision of, such personnel.” 42 C.F.R. § 409.31 (Westlaw current through Mar. 20, 2008).

5. *Infra* sec. IV(a) (discussing states rejecting spousal recovery under a narrow interpretation of the term “estate”).

6. *Infra* sec. IV (discussing the source of the divide between state estate recovery programs with respect to the definition of the term “estate”).
Known as tracing, some states allow their Medicaid agency to follow the assets of the beneficiary spouse into the estate of the surviving spouse, while others do not. As a result, similarly situated Medicaid recipients in different states could be treated considerably differently on the sole basis of the state in which their Medicaid nursing home benefits were received and similarly situated states could recover considerably different levels of their Medicaid nursing home expenditures. The source of this divide stems from the flexibility that the Medicaid Act affords to states when defining the term “estate.”

Part II of this note describes the basic operation of the federal Medicaid program as it pertains to an individual’s eligibility for Medicaid. Part III examines the operation of Medicaid estate recovery and discusses the flexibility afforded to each state in defining the term “estate.” Part IV evaluates the variations in state estate recovery programs and differentiates between the states electing a narrow interpretation of the term “estate” and those choosing a more expansive interpretation. Finally, Part V provides a general evaluation of the current operation of Medicaid estate recovery and a comparative evaluation of the estate recovery programs of two similarly situated states where one state has elected a narrow definition of the term “estate” and the other state has elected an expansive definition of the term “estate.” Part V also proposes that a consistent expansive definition of the term “estate” defined at the federal level would allow states to maximize the recovery of their Medicaid nursing home expenditures and would also allow individuals to effectively plan for the consequences of estate recovery regardless of the state in which they received benefits.

II. THE MEDICAID PROGRAM

Medicaid is the largest single source of financing for health care and long term care for eligible low income individuals in the United States. Signed into law in 1965 as Title XIX of the Social Security Act, and codified at 42 U.S.C. § 1396, et. seq., Medicaid is a means-tested welfare entitlement system originally designed to

7. Tracing is defined as “[t]he process of tracking property’s ownership or characteristics from the time of its origin to the present.” Black’s Law Dictionary 1529 (Bryan A. Garner ed., 8th ed., West 2004).
8. See e.g. In re Estate of Jobe, 590 N.W.2d 162, 166-167 (Minn. App. 1999); In re Estate of Thompson, 586 N.W.2d 847, 851 (N.D. 1998).
10. Infra sec. IV (discussing the source of the divide between state estate recovery programs with respect to the definition of the term “estate”).
12. Id.
provide health care to those who are too poor to access health care otherwise. Funding for Medicaid is derived from the general revenues of both state and federal governments.

A. State and Federal Medicaid Financing and Participation Requirements

Medicaid is jointly financed between individual states and the federal government and is designed to provide medical assistance benefits to individuals who are unable to financially satisfy the cost of their care. Although participation by individual states is voluntary, each state has elected to participate. While each state designs and manages its own Medicaid program, the program must meet certain specifications proscribed by federal law. Once a state elects to participate and as long as the state’s Medicaid plan remains consistent with the requirements of the Medicaid Act, the federal government shares the Medicaid costs with the state. This joint federal and state format is consistent with the concept of cooperative federalism in which the federal government leaves broad discretion to the states to achieve a specified policy goal.

14. AARP, Brief Overview, supra n. 11.
18. AARP, Brief Overview, supra n. 11.
20. AARP, Brief Overview, supra n. 11. For example, among listed requirements, state plans must contain provisions for notice and hearings, for establishing methods of administration, establishing an agency to oversee state Medicaid expenditures, establishing reporting requirements, and for providing application requirements for individuals. See 42 U.S.C. § 1396a (2000).
21. New Mexico Dept. of Health and Human Servs., 4 F.3d at 883.
22. Cooperative federalism is defined generally as the “[d]istribution of power between the federal government and the states in which each recognizes the powers of the other while jointly engaging in certain government functions.” Black’s Law Dictionary at 644. The operation of the concept has been described as that where:

[Programs set forth some uniform federal standards – as embodied in the statute, federal agency regulations, or both – but leave the state agencies with discretion to implement the federal law, supplement it with more stringent standards, and, in some cases, receive an exemption from federal requirements. This power allows states to experiment with different approaches and tailor federal law to local conditions.

Individuals may become eligible for Medicaid based on three considerations: categorical need, medical need, or optional categorical need. Federal law mandates that each state’s Medicaid program provide Medicaid coverage for individuals who fall into specific statutorily-defined categories. Individuals who fall into these categories are considered categorically needy and are automatically eligible for Medicaid. Additionally, states may choose to extend coverage to other individuals who meet specific requirements.

C. Spousal Protection

To qualify for Medicaid based on medical need, the original Medicaid Act required an applicant to spend down any income and resources that exceeded the statutorily defined income and resource levels. This spend-down requirement imposed a significant financial burden on married couples in instances where the non-applicant spouse remained in the community after the applicant spouse entered a long-term care facility. The spend-down requirement typically placed the community spouse in a situation in which all of their resources had been reduced to a point at which they retained little or no income or resources to live on. To remedy this situation and provide relief to community spouses, Congress enacted the Medicare Catastrophic Coverage Act of 1988 (MCCA), commonly referred to as the spousal impoverishment provisions to ensure that community spouses are able to continue to

25. Janel C. Frank, How Far Is Too Far? Tracing Assets in Medicaid Estate Recovery, 79 N.D. L. Rev. 111, 113 (2003). Defined categories of required coverage include coverage for those who are considered “aged, blind, disabled, or under the age of twenty-one; members of families with dependent children; and pregnant women.” Id.
26. Categorically needy individuals include those “eligible for cash benefits under the Aid to Families with Dependent Children (AFDC) program, the aged, blind, or disabled individuals who qualify for supplemental security income (SSI) benefits, and other low-income groups such as pregnant women and children entitled to poverty-related coverage.” Pharmaceutical Research and Mfrs. of Am. v. Walsh, 538 U.S. 644, 651 (2003).
29. Spend down is the process by which a Medicaid applicant who has income or resources above the levels proscribed for Medicaid eligibility depletes their income or resources down to the Medicaid eligibility levels in order to become eligible for Medicaid. Shawn Patrick Regan, Medicaid Estate Planning: Congress’ Ersatz Solution for Long-Term Health Care, 44 Cath. U. L. Rev. 1217, 1221 (1995). For example, if the Medicaid eligibility level for resources is $2,000 and a Medicaid applicant possesses $5,000 in assets, the applicant will be required to “spend down” to $2,000 (i.e. by spending $3,000) in order to become Medicaid eligible.
31. Frank, supra n. 25 at 116.
32. Shuh, 2008 WL 220642. See also Frank, supra n. 25 at 117.
live with independency and dignity. The spousal impoverishment provisions provide protection to the community spouse by altering the manner in which the income and resources of the couple are allocated to the recipient spouse. The spousal impoverishment provisions greatly increased the level of resources that the community spouse can retain without impacting the Medicaid eligibility of the recipient spouse. In addition, the community spouse’s income is now completely excluded from consideration of the recipient spouse’s Medicaid eligibility.

III. THE MEDICAID ESTATE RECOVERY PROGRAM

When applying for Medicaid eligibility, certain resources are exempt from consideration. As a result, a Medicaid recipient may qualify for Medicaid while retaining a significant estate. The purpose of estate recovery is to recover the amount expended for the benefit of the Medicaid beneficiary from those exempt assets that comprise the estate of the Medicaid beneficiary after their death. Therefore, with the implementation of estate recovery, Medicaid operates more like a loan than an entitlement program in that estate recovery in effect serves to provide a repayment mechanism from the estate of the Medicaid beneficiary to the state.

A. The History and Purpose of Estate Recovery

Estate recovery, codified at 42 U.S.C. § 1396p, has been a tool available to states for the purpose of recovering the cost of Medicaid benefits paid to individuals for long

35. Frank, supra n. 25 at 117.
36. Shuh, 2008 WL 220642. See 42 U.S.C. § 1396r-5(b) (2000). At the time of application for Medicaid, the couple’s resources are assessed jointly, regardless of ownership, to determine the spousal share. CMS, Spousal Impoverishment, supra n. 34. The spousal share is equal to one-half of the couple’s non-exempt resources. Id. Exempt assets consist generally of their home, the household goods contained therein, one automobile, and a burial plot. Id.
37. 42 U.S.C. § 1396r-5(b). For purposes of Medicaid eligibility, a married couple is not considered a couple for income eligibility considerations and the community spouse’s income is considered unavailable to the recipient spouse. CMS, Spousal Impoverishment, supra n. 34.
38. 42 U.S.C. § 1382b(a) (2000). Specifically excluded from consideration of income and resources are the applicant’s home, household goods, the applicant’s personal effects, one automobile, and a burial plot. 42 U.S.C. § 1382b(a).
40. Id.
term nursing care since the inception of the original Medicaid Act. The statutory framework for estate recovery is similar to that of Medicaid as a whole where federal law provides the framework and state law provides the specific details. As initially enacted, the Medicaid Act empowered states to employ estate recovery. However, initially the Medicaid Act did not mandate estate recovery, and as a result, barely half of the states had enacted an estate recovery program. To further complicate matters, the initial conception of estate recovery in the Medicaid Act did not provide a definition of the term “estate.” Instead, states were free to define the term “estate” for themselves, and state statutes typically either tied the term to their common law or statutory definition of probate estate or left the term undefined altogether. As a result, estate recovery did not provide a particularly effective or consistent method of revenue generation in its original form.

B. Spousal Recovery and the Definition of Estate

With the enactment of the Omnibus Budget Reconciliation Act of 1993 (OBRA), Congress intended to expand the portion of a beneficiary’s estate available to the states for estate recovery purposes. The purpose of which was to better provide for the medical care of those in need by providing a mechanism to achieve a greater rate of recovery, which in turn would provide more funding to the state for the provision of future services.

In effect, OBRA modified estate recovery in three substantial ways, only one of which is important to consider here. After OBRA, states were provided with a mandatory minimum definition of the term “estate” as well as the ability to utilize an

42. Frank, supra n. 25 at 117-118. The idea being that the government should be reimbursed for the expenses of care provided under Medicaid. Robyn O'Neill & Lee Beneze, A Guide to Medicaid’s Spousal Impoverishment Rules, 84 Ill. B.J. 22, 26 (1996).
43. Zieger, supra n. 39 at 367.
44. Frank, supra n. 25 at 117.
45. Oppenheim, supra n. 13 at 9.
46. Frank, supra n. 25 at 117. As of 1993, twenty eight states had implemented estate recovery programs. Id.
47. Oppenheim, supra n. 13 at 9.
48. Id.
49. Zieger, supra n. 39 at 370.
50. Id. at 367. For example, Florida’s estate recovery managed to collect an average of seventeen dollars from each Medicaid recipient to which Florida paid benefits for nursing home care. Id.
52. Oppenheim, supra n. 13 at 10.
54. Frank, supra n. 25 at 118. First, OBRA required that any state receiving federal funding for Medicaid must develop an estate recovery plan. Id. Second, OBRA mandated a reduction in the age at which states could initiate claims from sixty-five to fifty-five. Id. Third, OBRA provided a definition of “estate” and allowed that states could choose to expand the definition. Id.
expanded definition of the term “estate”. At the very least, a state now must define the term “estate” as including “all real and personal property and other assets included within the individual’s estate, as defined for purposes of State probate law.” In other words, at a minimum state estate recovery programs must recover against the probate estate. In addition, states have the option of expanding the definition of “estate” to include “any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement”. In other words, adoption of the expanded definition of “estate” allows states to more aggressively pursue recovery by exposing assets that fall outside of the probate estate to estate recovery.

55. Oppenheim, supra n. 13 at 10.
57. Id. The “probate estate” is defined generally as “a decedent’s property subject to administration by a personal representative. Black's Law Dictionary at 1239. The probate estate typically does not include: [p]roperty held in joint tenancy with right of survivorship; [l]ife insurance paid to a named beneficiary; [p]roperty held in a trust; [r]etirement plans payable to a named beneficiary; [p]ay-on-death bank accounts and trust arrangements on bank accounts payable to a named beneficiary at death; and [p]roperty in which in which the deceased held only a life estate, with the property going after death to a named beneficiary who holds the remainder interest in the property.

58. “Survivor” is generally defined as “one who outlives another. Black’s Law Dictionary at 1486.
59. “Heir” is generally defined as “a person who, under the laws of intestacy, is entitled to receive an intestate decedent’s property.” Id. at 740.
60. “Assign[ee]” is generally defined as “one to whom property rights or powers are transferred by another.” Id. at 127.
61. “Joint tenancy” is generally defined as “a tenancy with two or more coowners who take identical interests simultaneously by the same instrument and with the same right of possession.” Id. at 1505.
62. “Tenancy in common” is generally defined as “a tenancy by two or more persons, in equal or unequal undivided shares, each person having an equal right to possess the whole property but no right of survivorship.” Id. at 1506.
63. “Survivorship” is generally defined as “the right of a surviving party having a joint interest with others in an estate to take the whole.” Id. at 1486.
64. “Life estate” is generally defined as “an estate held only for the duration of a specified person’s life, usually the possessor’s.” Id. at 588.
65. “Living trust” or “inter vivos trust” is generally defined as “a trust that is created and takes effect during the settlor’s lifetime.” Id. at 1549.
66. 42 U.S.C. § 1396p(b)(4)(B) (2000). In is unclear exactly which types of conveyances Congress intended to include through the use of the term “other arrangement” and states have interpreted the term differently. Frank, supra n. 25 at 136.
67. Frank, supra n. 25 at 129.
The breadth of the expanded definition of “estate” is tempered by two important restrictions on the timeframe for the initiation of estate recovery. First, estate recovery may only be implemented following the death of a surviving spouse, if any, and only if there is no surviving child living in the home who is age 21 or younger or is blind or disabled. Second, the state is required to establish procedures through which estate recovery can be waived in the event that estate recovery would “work an undue hardship as determined on the basis of criteria established by the Secretary.”

IV. VARIATIONS IN SPOUSAL RECOVERY WITHIN STATE PROGRAMS

A jurisdictional divide exists between states that allow spousal recovery by tracing assets into the estate of the surviving spouse of a Medicaid beneficiary and those who do not. The source of this divide derives from the interpretation of the federal estate recovery guidelines that define “estate,” specifically the changes made following OBRA to 42 U.S.C. § 1396p(b)(4), which allow states to apply either a narrow or an expansive definition of “estate.” States that define “estate” narrowly protect the estate of the surviving spouse by utilizing a narrow interpretation of the language of 42 U.S.C. § 1396p(b), while states that define “estate” expansively allow invasion of the estate of the surviving spouse through the utilization of a broad interpretation of the entirety of the OBRA changes.

A. The Narrow Interpretation – States That Disallow Spousal Recovery

Several states restrict the use of spousal recovery by prohibiting the tracing of assets into the estate of the surviving spouse of a Medicaid beneficiary. These states accomplish this by narrowly interpreting the estate recovery provisions and the OBRA

68. Oppenheim, supra n. 13 at 10.
70. 42 U.S.C. § 1396p(b)(3) (2000). The term “undue hardship” is not defined in the Medicaid Act. West Virginia v. Thompson, 475 F.3d 204, 207 (4th Cir. 2007). Instead, criteria for determining undue hardship are established by the Secretary of the Department of Health and Human Services. Id. at 207-208. However, the Secretary has delegated the promulgation of criteria for defining the term “undue hardship” to the individual states subject to approval by the Secretary under the Secretary’s duty to ensure that state Medicaid plans satisfy the requirements set forth by federal law. Id.
71. Oppenehim, supra n. 13 at 12-13. Some states allow for tracing of assets that the beneficiary had title or interest in at death into the estate of their surviving spouse. For example: Idaho, e.g. In re Estate of Knaudson, 970 P.2d 6 (Idaho 1998); Minnesota, e.g. Jobe, 590 N.W.2d 162; and, North Dakota, e.g. Thompson, 586 N.W.2d 847. Other states do not allow for the tracing of assets that the beneficiary had title or interest in at death into the estate of their surviving spouse. For example: Missouri, e.g. Shuh, 2008 WL 220652; and, Wisconsin, e.g. Budney, 541 N.W.2d 245.
73. Id.
74. For example: Missouri, e.g. Shuh, 2008 WL 220652; and, Wisconsin, e.g. Budney, 541 N.W.2d 245; see also Oppenheim, supra n. 13 at 12-13.
changes in conjunction with each of their individual state definitions of “estate.” Specifically, these states narrowly interpret the language of 42 U.S.C. § 1396p(b)(1) and 42 U.S.C. § 1396p(b)(4) to restrict the ability of the state to recover Medicaid benefits paid for the benefit of a predeceased spouse from the estate of a surviving spouse.

Only two years after the enactment of OBRA, the Court of Appeals of Wisconsin prohibited the state from utilizing spousal recovery to recover Medicaid benefits paid for the benefit of a predeceased spouse. In In re Estate of Budney, the court held that the state statute allowing for spousal recovery exceeded the authority authorized under 42 U.S.C. § 1396p(b)(1). Budney originated from an objection made by the administrator of the estate of Paul Budney to a claim against his estate by the Wisconsin Department of Health and Human Services to recover Medicaid benefits paid for the nursing home care his predeceased spouse. The estate argued that Wisconsin Statutes § 49.496(3)(a), which authorized spousal recovery in Wisconsin, violated 42 U.S.C. § 1396p(b)(1). In finding in favor of the estate, the court based its decision on an interpretation of the language of 42 U.S.C. § 1396p(b)(1) prohibiting estate recovery except in certain instances. The court determined that none of the

75. E.g. Shuh, 2008 WL 220652; Budney, 541 N.W.2d at 246.
76. It should be noted that the term “restrict” contains variations in degree and source, as Wisconsin courts have determined that spousal recovery is restricted altogether by federal law, and thus in Wisconsin as well, Budney, 541 N.W.2d at 246, while Missouri has determined that spousal recovery is permitted by federal law under certain circumstances, but restricted in Missouri because Missouri law does not satisfy those requirements. Shuh, 2008 WL 220652.
77. E.g. Shuh, 2008 WL 220652; Budney, 541 N.W.2d at 246.
79. 541 N.W.2d 245 (Wis. App. 1995).
80. Id. at 246.
81. Id. at 245-246.
82. Wis. Stat. § 49.496(3)(a) stated in pertinent part: (a) Except as provided in par. (b), the department shall file a claim against the estate of a recipient or against the estate of the surviving spouse of a recipient for all of the following unless already recovered by the department under this section: 1. The amount of medical assistance paid on behalf of the recipient while the recipient resided in a nursing home or while the recipient was an inpatient in a medical institution and was required to contribute to the cost of care. Budney, 541 N.W.2d at 246 (Wis. App. 1995) (quoting Wis. Stat. § 49.496(3)(a) (1994)).
83. 42 U.S.C. § 1396p(b)(1) stated in pertinent part:
(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except that the State shall seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan in the case of the following individuals: (B) In the case of an individual who was 55 years of age or older when the individual received such medical assistance, the State shall seek adjustment or recovery from the individual’s estate...
(2) Any adjustment or recovery under paragraph (1) may be made only after the death of the individual’s surviving spouse, if any... Budney, 541 N.W.2d at 246 (quoting 42 U.S.C. § 1396(b)(1) (1994)).
84. Id.
specified instances authorized the recovery of Medicaid benefits paid to a predeceased spouse from the estate of their surviving spouse. Since 42 U.S.C. § 1396p(b)(1) provided for an initial general rule prohibiting estate recovery and did not specifically recognize spousal recovery as an exception to the general rule, the Wisconsin statute authorizing spousal recovery was held to exceed the authority granted by 42 U.S.C. § 1396p(b)(1).86

In a recent case, a Missouri Court of Appeals determined that Missouri law also restricts the state’s ability to recover Medicaid benefits paid for the benefit of a predeceased spouse from the estate of a surviving spouse. In Estate of Shuh, the court held that Missouri’s definition of “estate” does not allow for spousal recovery because the definition of “estate” provided in Missouri’s probate code was too narrow to coincide with the optional expanded definition of “estate” provided under 42 U.S.C. § 1396p(b)(4)(B). Shuh involved an appeal by the Missouri Department of Social Services, Mo Health Net Division from a trial court decision dismissing the state’s spousal recovery claim against the husband’s estate to recover Medicaid benefits paid on behalf of his predeceased wife. The court focused specifically on the language of 42 U.S.C. § 1396p(b)(1), which it interpreted as delineating a general rule prohibiting estate recovery except in three specific circumstances, all of which specify that recovery can only be obtained from the estate of an “individual’s estate.” The court evaluated the Medicaid Act and determined that it specifically allowed for recovery of benefits from the estate of a surviving spouse paid for the benefit of a predeceased spouse only when an expansive definition of “estate” consistent with 42 U.S.C. § 1396p(b)(4)(B) is employed in the

85. Id.
86. Id.
89. Id.
90. Id.
91. The three exceptions are:
(A) in the case of an individual described in subsection (a)(1)(B), the State shall seek adjustment or recovery from the individual’s estate or upon sale of the property subject to a lien imposed on account of medical assistance paid on behalf of the individual[;] (B) In the case of an individual who was 55 years of age or older when the individual received such medical assistance, the State shall seek adjustment or recovery from the individual’s estate, but only for medical assistance consisting of[:] (i) nursing facilities, home and community-based services, and related hospital and prescription drug services, or (ii) at the option of the State, any items or services under the State plan[; and,] (C) In the case of an individual who has received (or is entitled to receive) benefits under a long-term care insurance policy in connection with which assets or resources are disregarded in the manner described in clause (ii), except as provided in such clause, the State shall seek adjustment or recovery from the individual’s estate on account of medical assistance paid on behalf of the individual for nursing facility and other long-term care services.” 42 U.S.C. § 1396p(b)(1) (2000).
Closing the “Estate” Loophole

state’s probate code. The court then considered the applicable Missouri statues, and determined that Missouri’s definition of “estate,” as defined in Missouri’s probate code, does not contain all non-probate property. Thus the court determined that Missouri’s definition was narrower than the expansive definition of 42 U.S.C. § 1396p(b)(4)(B). As a result of this distinction, the court held that Missouri law does not allow for recovery actions against the estate of the surviving spouse of a predeceased spouse who had received Medicaid benefits.

States that have restricted the definition of “estate” to a limited definition of “estate” have done so through a narrow reading of 42 U.S.C. § 1396p(b)(4). In particular, these states restrict their definition to that provided under 42 U.S.C. § 1396p(b)(4)(A), which states that the definition of “estate” extend to the state’s definition of the probate estate. As a result, states following this approach have determined that spousal recovery cannot be utilized to recover Medicaid benefits paid on behalf of one spouse by tracing the assets into the estate of the surviving spouse.

B. The Expansive Interpretation – States That Allow Spousal Recovery

Several other states define “estate” expansively to allow invasion of the estate of the surviving spouse by utilizing a broad interpretation of the entirety of the OBRA changes. These states interpret the estate recovery provisions and the OBRA changes by applying rules of statutory construction and looking to the legislative intent of Congress in promulgating the OBRA changes.

The Supreme Court of North Dakota opted for an expansive interpretation of 42 U.S.C. § 1396p(b)(1) and allowed spousal recovery based on a reading of the plain meaning of the OBRA changes to 42 U.S.C. § 1396p(b)(1). In deciding In re Estate of Thompson, the court determined that in promulgating the OBRA changes to 42 U.S.C. §1396p(b) Congress intended to allow states to recover benefits paid to a

93. Id. This recovery may only occur from those assets that were either the assets of the individual predeceased spouse or were jointly owned by the surviving spouse and the predeceased spouse during their marriage. Id.
94. Id.
95. Mo. Rev. Stat. § 472.010 defines estate as “real and personal property of the decedent or ward, as from time to time changed in form by sale, reinvestment or otherwise, and augmented by any accretions and additions thereto and substitutions therefor[e], and diminished by any decreases and distributions therefrom[.]” Shuh, 2008 WL 220652 (quoting Mo. Rev. Stat. § 472.010 (2007)).
96. 42 U.S.C. § 1396p(b)(4)(B) includes “such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.” Shuh, 2008 WL 220652 (quoting 42 U.S.C. § 1396p(b)(4)(B) (2000)).
98. For example: Idaho, see Knudson, 970 P.2d 6; Minnesota, see Jobe, 590 N.W.2d 162; and, North Dakota, see Thompson, 586 N.W.2d 847. See also Oppenheim, supra n. 13 at 12.
99. E.g. Jobe, 590 N.W.2d at 166; Thompson, 586 N.W.2d at 848-849.
100. Thompson, 586 N.W.2d at 851.
Medicaid beneficiary from the estate of their surviving spouse through tracing.\footnote{Id. at 851.} Thompson involved an attempt by the North Dakota Department of Human Services to recover Medicaid benefits paid for the benefit of Nathaniel Thompson from the estate of his surviving spouse.\footnote{Id. at 848.} The estate argued that North Dakota’s estate recovery statute\footnote{N.D. Cent. Code § 50-24.1-07 (1997).} granted the state the ability to recover from the estate of a surviving spouse while the plain meaning of 42 U.S.C. § 1396p(b) did not.\footnote{Thompson, 586 N.W.2d at 848.} The court evaluated the plain meaning of 42 U.S.C. § 1396p(b) and Congress’ intent in enacting the estate recovery provisions and the OBRA changes thereto and determined that 42 U.S.C. § 1396p(b)(4) gave the state the ability to recover Medicaid benefits from the surviving spouse of the Medicaid recipient to the extent that the recipient held title or an interest in property conveyed to the surviving spouse.\footnote{Id. at 848-850.} The court determined that the 1995 amendments to North Dakota Century Code Section 50-24.1-07 which made the North Dakota estate recovery statutes consistent with the language of the OBRA changes allowed the state to pursue recovery from the estate of the surviving spouse.\footnote{Id. at 849-850.} Although North Dakota law did not explicitly identify spousal recovery as an option available to the state, the court interpreted the adoption of the OBRA changes into state law as an adoption of the broad definition of “estate” available under 42 U.S.C. § 1396p(b)(1).\footnote{Id. at 850.}

From this interpretation, the court held that the adoption of the expansive definition allowed the state to recover against any asset or property in which the Medicaid recipient held title or had an interest at the time of death, regardless of the method of conveyance.\footnote{Id. at 850.} The court reasoned that public policy supported an expansive interpretation since an expansive interpretation would allow states to recover a greater amount of their Medicaid expenditures and thereby have a greater ability to provide funding for future services.\footnote{Id. at 851.}

The Minnesota Court of Appeals interpreted 42 U.S.C. § 1396p(b) expansively to allow the state to pursue spousal recovery against non-probate assets in which the Medicaid beneficiary held an interest.\footnote{Jobe, 590 N.W.2d at 166. At the time at the Minnesota Court of Appeals decided Jobe, Minn. Stat. § 256B.15 allowed the state to recover against any asset that a married beneficiary held title or interest in at any point during their marriage. Id. In upholding spousal recovery in deciding Jobe, the Minnesota Court of Appeals approved the definition of Minn. Stat. § 256B.15 in its entirety. Id.} In deciding In re Estate of Jobe,\footnote{Id.} the court
determined that 42 U.S.C. § 1396p(b) should be read in its entirety, and in so doing found that Minnesota’s estate recovery statute allowing for spousal recovery conformed to the requirements of the OBRA changes to 42 U.S.C. § 1396p(b).114 Jobe involved an attempt by the Ottertail County Department of Social Services to recover Medicaid benefits paid for the benefit of Amos Jobe from the estate of his surviving spouse.115 The estate argued that federal law preempted the Minnesota statute authorizing spousal recovery since 42 U.S.C. § 1396p(b) did not authorize states to seek spousal recovery.116 The court disagreed with the estate’s argument and found that federal law did not preempt the Minnesota spousal recovery statute.117 The court reasoned that the narrow reading of 42 U.S.C. § 1396p(b) encouraged by the estate would impermissibly render portions of 42 U.S.C. § 1396p(b) meaningless in contradiction to fundamental statutory interpretation procedures.118 In addition, the court reasoned that public policy supported a finding in favor of allowing estate recovery, since a more expansive estate recovery program allows the state to provide funding for additional needy individuals in the future.119 As a result, the court held that the state could pursue spousal recovery since Minnesota had adopted the expansive definition of “estate” offered by OBRA.120

States that have expanded the definition of “estate” to a more broad definition of “estate” have done so through an expansive reading of 42 U.S.C. § 1396p(b)(4). In particular, these states expand their definition to that provided under 42 U.S.C. § 1396p(b)(4)(B), which provides that the definition of “estate” may extend to assets that would not normally fall within the probate estate. As a result, states following this approach have determined that Medicaid benefits paid on behalf of one spouse can be recovered through estate recovery by tracing the assets into the estate of the surviving spouse. This approach increases the resources available to the state that may be used to provide future coverage to eligible needy individuals.

preempted the particular provision in Minn. Stat. § 256B.15, but not the entire statute. In re Estate of Gullberg, 652 N.W.2d 709, 714 (Minn. App. 2002). In so deciding, the Minnesota Court of Appeals limited the reach of Minnesota’s estate recovery program to those assets in which the beneficiary had a legal interest at the time of their death. Id.
112. 590 N.W.2d 162 (Minn. App. 1999).
113. Minn. Stat. §256B.15 reads in pertinent part: Estates subject to claims. If a person receives any medical assistance hereunder, on the person’s death …or on the death of the survivor of a married couple, either or both of whom received medical assistance, the total amount paid for medical assistance rendered for the person and spouse shall be filed as a claim against the estate of the person or the estate of the surviving spouse in the court having jurisdiction to probate the estate. Jobe, 590 N.W.2d at 164 (quoting Minn. Stat. §256B.15 (1998)).
114. Jobe, 590 N.W.2d at 166-167.
115. Id. at 164.
116. Id.
117. Id. at 166.
118. Id.
119. Id.
120. Id. at 166-167.
V. Analysis and Evaluation of Estate Recovery Applications

Recall the Stevenson situation portrayed in the introduction. When the facts of the Stevenson situation are applied to the differing state approaches it becomes obvious that the Stevensons would face a dramatically different Medicaid estate recovery result depending on where they lived when Harold received his Medicaid benefits. If they had lived in a state such as Missouri or Wisconsin that interprets 42 U.S.C. § 1396p(b) narrowly, the state would not be able to recover against any of the assets in Evelyn’s estate due to the unavailability of spousal recovery in those states. Instead, the Stevensons lived in a state like Minnesota or North Dakota that interprets 42 U.S.C. § 1396p(b) broadly, and the state could recover against the assets in Evelyn’s estate through the availability of spousal recovery. The fact that the estates of similarly situated individuals are treated so drastically different begs one to ask what rationale supports allowing such a disparate result. Although Medicaid is a joint federal and state program, the changes to estate recovery authorized through OBRA by and large left determination of the reach of estate recovery to the individual states by allowing the states to determine the expansiveness of their own estate recovery programs. Even though the federal government provides over fifty percent of each state’s Medicaid financing, the federal government retains only minimal control over the extent to which states choose to recover expended funds. As a result, situations arise in which states that choose to impose narrow estate recovery programs disallowing the use of spousal recovery tend to recover less of their Medicaid benefits paid for the nursing home care of Medicaid beneficiaries than states that choose to impose broad estate recovery programs allowing spousal recovery. With the federal share of Medicaid expenditures as a percentage of gross domestic product expected by some estimates to increase in excess of 300 percent by 2080, the federal government must act to amend 42 U.S.C. § 1396p(b) to mandate a consistent expansive definition of the term “estate,” defined at the federal level. In so doing, state Medicaid programs would recover much needed funding for future Medicaid nursing home expenditures and individuals would be able to effectively plan for the consequences of estate recovery regardless of the state in which the benefits were received.

In promulgating the OBRA changes to estate recovery, Congress required the states to enact estate recovery provisions and provided the states with a minimum

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121. New Mexico Dept. of Health and Human Servs., 4 F.3d at 883.
123. AARP, Brief Overview, supra n. 11.
125. In 2004, Missouri and Wisconsin recovered 1.1% and 1.8% respectively, of their Medicaid expenditures for nursing home care, while Minnesota and North Dakota recovered 2.8% and 1.2% respectively. U.S. Dept. of Health & Human Servs., Medicaid Estate Recovery Collections, 8, http://aspe.hhs.gov/daltcp/Reports/estreccol.pdf (September 2005) [hereinafter HHS, Estate Recovery Collections].
definition of “estate” from which the states could opt to expand. Federal requirements prior to OBRA merely made estate recovery optional to the states, and provided no guidance to the states in determining the extent of an individual’s estate subject to estate recovery. In enacting the OBRA changes, Congress intended to provide a mechanism for the states to expand the available assets from which the states could recover Medicaid benefits paid. However, this intended purpose has not been particularly successful as some states continue to limit the available assets from which the state can recover Medicaid benefits and thereby exclude substantial assets from the reach of estate recovery. As a result, although the OBRA changes have provided states with a powerful tool to expand estate recovery, states have not utilized this tool with any particular degree of success as evidenced by the fact that in 2004 only three states collected more than 3 percent of the Medicaid benefits they expended for nursing home care. For a statute specifically designed to provide the Medicaid system with a source from which to recover expended funds, estate recovery has achieved particularly lackluster results.

The Medicaid statute operates under a cooperative federalism framework where the federal government sets the broad policy guidelines and the states provide the details. By implementing these changes to 42 U.S.C. § 1396p(b), Congress has demonstrated that the basic setting of the definition of “estate” for the purposes of 42 U.S.C. § 1396p(b) falls under Congress’s power to promulgate broad policy guidelines. As a result, Congress has the ability under its policymaking powers over Medicaid to amend 42 U.S.C. § 1396p(b) to mandate upon the states the most broad definition of “estate” possible.

127. Frank, supra n. 25 at 117-118.
128. Id. at 118.
129. Oppenheim, supra n. 13 at 9.
130. Id. at 10.
131. Frank, supra n. 25 at 118.
132. Andrew D. Wone, Don’t Want to Pay for Your Institutionalized Spouse? The Role of Spousal Refusal and Medicaid in Funding Long-Term Care, 14 Elder L.J. 485, 516 (2006).
133. In fact, some evidence exists tending to indicate that the OBRA changes may have had no effect at all in increasing the rate at which Medicaid nursing home expenditures recovered through the state estate recovery programs. In 2004, federal and state Medicaid programs expended $45,835,646,786 in Medicaid nursing home expenditures, compared with $361,766,396 collected through state estate recovery programs. HHS, Estate Recovery Collections, supra n. 125 at 8. In other words, estate recovery programs recaptured 0.8% of Medicaid nursing expenditures in 2004. Id. In 1985, federal and state Medicaid programs expended $3,408,300,000 in Medicaid nursing home expenditures, compared with $28,919,560 collected through state estate recovery programs. Dept. of Health & Human Servs., Medicaid Estate Recoveries: National Program Inspection, 37, http://oig.hhs.gov/oei/reports/oai-09-86-00078.pdf (June 1988). In other words, estate recovery efforts recaptured 0.85% of Medicaid nursing home expenditures in 1985, Id., while estate recovery efforts recaptured 0.8% of Medicaid nursing home expenditures in 2004. HHS, Estate Recovery Collections, supra n. 125 at 8.
134. Supra sec. II(a) and n. 22 (discussing the concept of cooperative federalism).
135. Lamore, 977 F.2d at 718.
When it comes to determining the proper definition of “estate,” Congress must be diligent in wording its definition in such a manner as to make the definition as broad as possible yet leave as little room for differing interpretation as possible. The current version of 42 U.S.C. § 1396p(b)(4)(B) allows for estate recovery against a wide array of assets by allowing states to recover against any asset in which the recipient had title or interest at the time of death, including “assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.” While the current optional definition allows for recovery against a substantially greater portion of the assets held by the Medicaid recipient at the time of death than the mandatory minimum definition, the optional definition provides ample room for divergent interpretation by the states. As a result, simply amending 42 U.S.C. § 1396p(b)(4) to modify the mandatory definition of “estate” to include both the language of the current mandatory minimum definition of “estate” and the permissive expansive definition of “estate” will provide an inadequate definition of “estate.” To establish a more effective estate recovery program, it is imperative that Congress draft a new, simplified definition of “estate.” Such a definition might read: the term “estate”, with respect to a deceased individual, shall include all real and personal property and other assets included within the individual’s estate, or within the estate of the individual’s surviving spouse, if any, held at the time of the death of the beneficiary. Such a definition would allow less room for interpretation by the states and would better satisfy the goal of the OBRA changes of increasing the recovery of Medicaid funding expended for nursing home care by further increasing the mandatory assets from which estate recovery programs must recover against.

The estate recovery program utilized by the State of Minnesota provides an excellent example of the type of fiscal benefits that could be derived if the federal government were to mandate a uniform broad definition of “estate” to be followed by the estate recovery programs of each state. Such an approach would eliminate state discretion in applying estate recovery in order to better achieve the Congressional intent expressed through the OBRA changes. Under Minnesota’s estate recovery program, “estate” is defined broadly, which allows the state to recover against any asset in which the Medicaid beneficiary held title or an interest in at the time of their death. In addition, this broad definition of “estate” allows the state to recover against assets from the estate of the Medicaid beneficiary’s surviving spouse to the extent that the Medicaid beneficiary held title or an interest in the assets at the time of the Medicaid beneficiary’s death. This approach has been extremely effective for

137. See Frank, supra n. 25 at 130-138 (providing discussion on the variability in defining transfers made by “joint tenancy,” “life estates,” “survivorship,” “trusts,” and “other arrangements” under the current optional definition of estate as provided under 42 U.S.C. § 1396p(b)(4)(B)).
138. Supra sec. IV(b) (discussing Minnesota’s estate recovery program).
139. Supra sec. IV(b) (discussing the allowance of spousal recovery under Minnesota’s estate recovery program).
Minnesota’s estate recovery efforts. 140 Wisconsin, which defines “estate” narrowly and does not allow for spousal recovery, on the other hand, has not been as successful as Minnesota. 141 Minnesota and Wisconsin 142 provide an excellent basis for comparison since their Medicaid nursing home expenditures have been virtually identical. 143 Further support for a comparison between Minnesota and Wisconsin arises from the fact that recent census data shows that the two states are similarly situated in terms of population demographics. 144 Minnesota and Wisconsin have a

140. In 2004, Minnesota ranked fifth out of all fifty states in terms of percentage of Medicaid nursing home expenditures recovered by recovering 2.8% of their Medicaid nursing home expenditures. HHS, Estate Recovery Collections, supra n. 125 at 9. Arizona ranked first at 10.4% of Medicaid nursing home expenditures recovered, however, Arizona’s recovery is not comparable because Arizona’s Medicaid program differs significantly from the Medicaid programs of all other states. Id. The national average of recovery of Medicaid nursing home expenditures in 2004 was 0.8%. Id. Oregon, Idaho, and Iowa are the only other states that ranked above Minnesota in terms of percentage of Medicaid nursing home expenditures recovered at 5.8%, 4.5% and 2.9%, respectively. Id. It is worth noting, however, that although Minnesota ranked behind Oregon, Idaho, and Iowa in terms of percentage of Medicaid nursing home expenditures recovered, Minnesota recovered a substantially greater dollar amount than any of the states that ranked ahead of Minnesota by percentage of Medicaid nursing home expenditures recovered. Id. at 8. Minnesota recovered $24,999,595, while Oregon, Idaho, and Iowa recovered $13,843,592, $5,695,851 and $12,194,616, respectively. Id. Minnesota’s recovery of Medicaid nursing home expenditures ranked third behind only California and New York, which recovered $44,668,847 and $29,953,334, respectively. Id.

141. In 2004, Wisconsin ranked ninth out of all fifty states in terms of percentage of Medicaid nursing home expenditures recovered by recovering 1.8% of their Medicaid nursing home expenditures. Id. at 9. It is worth noting, however, that while Wisconsin ranked only four places behind Minnesota based on percentage of Medicaid nursing home expenditures recovered, Wisconsin lagged far behind Minnesota in terms of actual amount recovered. Id. Wisconsin recovered $16,772,729, while Minnesota recovered $24,999,595. Id. at 8. In addition, this recovery comparison holds true over the course of several years, as Minnesota recovered on average $18,852,754 from 2002 through 2004, while Wisconsin recovered on average $15,011,160 from 2002 through 2004. Id. at 10-11.

142. In providing this comparison, it should be noted that both North Dakota and Missouri have been intentionally omitted. North Dakota, despite providing an excellent example of a broad interpretation of 42 U.S.C. § 1396p(b), has been excluded due to its relatively small amount of Medicaid nursing home expenditures. In 2004, North Dakota ranked 40th nationwide in Medicaid nursing home expenditures with $166,456,173 expended. Id. at 8. Missouri, on the other hand, despite providing an excellent example of a narrow interpretation of 42 U.S.C. § 1396p(b), has been excluded since the available data for Medicaid nursing home expenditures predates the decision narrowing Missouri’s estate recovery program in Shuh. Supra sec. IV(a) (discussing the recent disapproval of spousal recovery under the Missouri estate recovery program).

143. For example, in 2004 Wisconsin provided $917,421,595 in Medicaid nursing home expenditures and Minnesota provided $904,205,889 in Medicaid nursing home expenditures. HHS, Estate Recovery Collections, supra n. 125 at 8.

nearly identical population, and both states have a similar percentage of their population over age 65. Furthermore, both states have a percentage of population below the poverty line below the national average, and both states have populations with per capita income near the national average. Finally, both states have populations that are growing at a rate less than the national average.

While it has been argued that there is only a weak correlation between the definition of “estate” and the success of Medicaid estate recovery and that other factors have a more substantial effect on Medicaid estate recovery, such factors would largely disappear under the approach proposed herein. For example, almost all of these other factors would be eliminated since the scope of estate recovery would be set at the federal level and as a result states would no longer be able to use their discretion to manipulate these factors. Although these factors may have some effect in muddying the waters when it comes to assessing the impact of the definition of “estate” and the use of spousal recovery on the overall effectiveness of estate recovery, the comparison between the demographics, the estate recovery programs and the estate recovery results in Minnesota and Wisconsin provide strong evidence of a significant relationship between the expansiveness of the definition of “estate” and the success of the estate recovery program.


146. In 2006, the U.S. Census Bureau reported Wisconsin as having 13.0% of its population over age 65, U.S. Census, Wisconsin, supra n. 144, Minnesota having 12.1% of its population over age 65, U.S. Census, Minnesota, supra n. 144, and the nation as a whole having 12.4% over age 65, Census, Minnesota, supra n. 144.

147. In 2006, the U.S. Census Bureau reported both states to have populations living in poverty at rates below the national average of 12.7%, with Wisconsin having 10.9% of its population below the poverty level, U.S. Census, Wisconsin, supra n. 144, and Minnesota having 8.1% of its population below the poverty level, U.S. Census, Minnesota, supra n. 144.

148. In 2006, the U.S. Census Bureau reported both states to have populations with a per capita income near the national average of $21,587, with Wisconsin slightly below the national average at $21,271, U.S. Census, Wisconsin, supra n. 144, and Minnesota slightly above the national average at $23,198, U.S. Census, Minnesota, supra n. 144.

149. In 2006, the U.S. Census Bureau reported both states to have population growth at rates below the national average of 6.4%, with Wisconsin having population growth of 3.6%, U.S. Census, Wisconsin, supra n. 144, and Minnesota having population growth of 5.0%, U.S. Census, Minnesota, supra n. 144.

150. Other factors attributed to variations in Medicaid estate recovery rates include variations in: the allowance of certain assets as exempt from estate recovery; incentives provided by the amount of Federal Medicaid Matching Percentage (FMAP) funds received; state political considerations; the coordination between Medicaid and state probate law; state staffing levels; actions available to individuals to shelter assets; and the quality of the data set. HHS, Estate Recovery Collections, supra n. 125 at 4-6.

151. The factors that would be eliminated from influence by the individual states include: exemption of assets, incentives (or disincentives) created by the level of FMAP funds received, state political considerations, coordination with state probate law, and the available options to shelter assets.
IV. CONCLUSION

In enacting the OBRA changes to Medicaid estate recovery, Congress intended to provide a mechanism through which the states could opt to increase the amount of Medicaid nursing home expenditures eligible for recapture by each state. These changes have been met with lackluster results, largely due to variations in the application of 42 U.S.C. § 1396p(b)(4) by the states, and recent reporting data indicates that estate recovery nationwide recaptures less than one percent of Medicaid nursing home expenditures. The reasons for this lackluster result are exemplified by the Stevenson situation discussed throughout this note. If Harold had received his Medicaid benefits in Wisconsin, the state could recover virtually nothing from Evelyn’s estate since Wisconsin disallows the use of spousal recovery. However, if Harold had received his Medicaid benefits in neighboring Minnesota, the state could have recovered against almost all of Evelyn’s estate since Minnesota allows the use of spousal recovery. Such a result can hardly be considered a satisfactory effectuation of the Congressional intent behind the OBRA changes.

To provide an even playing field to all similarly situated individuals and allow estate recovery to more successfully effectuate the Congressional intent behind the OBRA changes to estate recovery, this note proposes a fundamental change to 42 U.S.C. § 1396p(b)(4) consisting of the enactment of a broad single, uniform definition of “estate” to be applied consistently amongst the several states in application of Medicaid estate recovery. In so doing, each state would be able to expansively apply estate recovery against all of the assets in which a recipient of Medicaid nursing home benefits held title or interest at the time of death, including by tracing any assets meeting this definition into the estate of a surviving spouse.

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152. In 2004, total Medicaid nursing home expenditures totaled $45,835,646,786 nationwide, while the total of the estate recovery efforts of each state totaled $361,766,396, or 0.8% of total Medicaid nursing home expenditures. HHS, Estate Recovery Collections, supra n. 125 at 4-6.