

WHY NURSING HOMES WILL NOT WORK: CARING FOR THE NEEDS OF THE AGING MUSLIM AMERICAN POPULATION

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The growing Muslim American population has led to greater diversity within the elderly demographic. This change has created the need for culturally appropriate care for the elderly in the United States. Ms. Al-Heeti explores the current state of nursing home care through Medicaid and Medicare and illustrates its inadequacies in meeting the needs of the Muslim American elderly population. With Islam placing a strong emphasis on caring for one's parents in the home, along with cultural barriers, Medicaid and Medicare's focus on nursing homes is not a viable option for Muslim Americans. The author proposes modifying Medicaid and Medicare to allow elderly who have cultural or religious reservations against nursing homes, like Muslim Americans, to receive government support for home care or community-based services. Ms. Al-Heeti's resolution takes into consideration the growing ethnic and religious differences within the elderly population and proposes a solution that offers individualized choice and access to services that would allow Muslim Americans to receive proper medical care.

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I. Introduction

As the U.S. population increases in cultural multiplicity, it is becoming increasingly necessary to provide culturally appropriate care for an elderly population that is growing in size as well as in diversity.¹ One crucial cultural difference is the kind of respect and care the elderly expect of family, a difference that prevents many elderly Muslim Americans from receiving the care they need.²

As the elderly population grows in diversity,³ various cultural practices have made their way to the United States. Many immigrants have adapted their cultural practices to be in line with the practices and norms of the United States,⁴ but for some cultural practices there is no way to change without offending the culture and teachings of that society.

In particular, the religious and cultural background of Muslims and the teachings of Islamic scholars prevent many Muslims from sending their elders to nursing homes.⁵ But this religious tradition comes at a price. Medicaid and Medicare provide funds to cover nursing home stays for many families and elderly individuals, but these programs do not provide the same level of funding to individuals who live at home with family members, or at least not to all families who need the care.⁶

This note examines how to best provide for the needs of the elderly Muslim American population when federal funding focuses on nursing home care or limits its home care funding to the poor, and when requiring Muslim elders to live in nursing homes offends the religious and cultural practices of Muslims. Part II provides back-

1. U.S. CENSUS BUREAU, MAPPING CENSUS 2000: THE GEOGRAPHY OF U.S. DIVERSITY 26 (2000), available at <http://www.census.gov/population/cen2000/atlas/censr01-1.pdf> [hereinafter U.S. DIVERSITY].

2. See, e.g., Islam Online Team, *Parents*, ISLAM ONLINE, Aug. 14, 2003, <http://www.islamonline.net/english/introducingislam/family/Parenthood/article02.shtml> (“Nursing homes are almost unheard of in Muslim countries.”).

3. U.S. DIVERSITY, *supra* note 1.

4. E.g., Asian Community Nursing Home, <http://www.accsv.org/nh/index.php> (last visited Oct. 15, 2006) (discussing the creation of a nursing home for Asians by the Asian Community Center in Sacramento, Cal.).

5. E.g., Liaquat Ali Khan, *Taking Care of Old and Frail Parents*, PAKISTAN LINK, June 11, 2004, <http://www.pakistanlink.com/opinion/2004/june04/11/01.html> (“Muslim families living in America would hopefully resist the pressure of sending their elderly to nursing homes.”). However, this note does not attempt to speak on behalf of every single Muslim American.

6. See *infra* Part II.

ground by examining the stigma many Muslims associate with nursing homes and by exploring the basis of the stigma in culture, religious texts, and scholarly opinions. Part III analyzes the federal government's involvement in making nursing homes a financially viable option for America's elderly within the framework of Medicare and Medicaid. Part III also reveals why the status quo, the creation of Muslim nursing homes, or a change within the Muslim community are not viable options for the Muslim American community. Finally, Part IV explains that the only viable option for providing care in a manner that meets the needs of the growing Muslim elderly population in the United States is to provide the funds appropriated for nursing homes to people who care for their elders at home.

II. Background: Why Not Nursing Homes?

A. A Growing Population

Approximately six million Muslims reside within the United States.⁷ Of these Muslim Americans, 76% are immigrants from around the world.⁸ Within the Arab American population,⁹ Muslims are the fastest growing subgroup, and this group is more ethnically conscious than Arab Americans of other religions.¹⁰

As the size of the Muslim American population as a whole increases, so too does the size of the elderly Muslim American population. Although the U.S. Census Bureau does not collect or maintain records related to religion,¹¹ other sources indicate that the number of Muslims in the United States has indeed increased.¹² Muslims over the age of fifty-five comprise 5.25% of the Muslim American popula-

7. Sonia Salari, *Invisible in Aging Research: Arab-Americans, Middle Eastern Immigrations, and Muslims in the United States*, 42 GERONTOLOGICAL SOC'Y AM. 580, 584 (2002).

8. *Id.*

9. The Arab American population includes Muslims, but most Arab Americans are, in fact, Christian. Arab American Institute, <http://www.aaiusa.org/arab-americans/22/demographics>.

10. Salari, *supra* note 7, at 583.

11. See 13 U.S.C. § 221(c) (2006) (prohibiting the Census Bureau from compelling the disclosure of religious beliefs and affiliations).

12. Telephone Interview with Sayyid M. Syeed, Nat'l Dir., Islamic Soc'y of N. Am., in St. Louis, Mo. (Nov. 16, 2005).

tion, but “[t]his ratio . . . will be drastically changed in the next ten or so years by Muslim baby boomers.”¹³

The Muslim American elderly population is comprised of three groups: (1) aging Muslim immigrants, (2) parents of Muslim immigrants, and (3) American converts to Islam.¹⁴ First, the elderly Muslim population is comprised of aging Muslim immigrants.¹⁵ Most of the mosques and Islamic centers in the United States were founded by first generation Muslim immigrants who emigrated from around the world.¹⁶ As this first generation of immigrants age, they will become part of the elderly Muslim population.

Second, the elderly Muslim population is comprised of parents of Muslim immigrants.¹⁷ Many immigrants bring their parents to the United States. While their motivations for bringing their parents to the United States vary, some Muslim immigrants believe their parents can receive better care in the United States, and some Muslim immigrants would like their parents to help take care of their young children, as grandparents of all backgrounds do in the United States.¹⁸

The third group within the Muslim elderly population consists of American converts who have become Muslim at various stages in their lives.¹⁹ One ethnic group that has seen a rise in conversions to Islam is the Latino American population, with between 25,000 and 75,000 Latino Americans accepting Islam as their religion.²⁰ However, there are relatively few American Muslim converts relative to the size of the Muslim immigrant population in the United States.²¹ The issues that some American converts face in their old age differ from the issues facing immigrants and immigrants’ children because converts to

13. Zaheer Uddin, *Aging Muslim in America*, ISLAMIC HORIZONS, July/Aug. 2006, at 35, 36.

14. Samana Siddiqui, *Senior Citizens of Our Ummah*, MILLI GAZETTE, Jan. 15, 2005, available at <http://www.milligazette.com/Archives/2005/01-15Jan05-Print-Edition/011501200555.htm>.

15. *Id.*

16. Telephone Interview with Sayyid M. Syeed, *supra* note 12.

17. Siddiqui, *supra* note 14.

18. U.S. CENSUS BUREAU, WE THE PEOPLE: AGING IN THE UNITED STATES (2000), available at <http://www.census.gov/prod/2004pubs/cnsr-19.pdf> [hereinafter WE THE PEOPLE] (providing that more than a quarter of all grandparents older than sixty-five years of age were caregivers for their grandchildren).

19. Siddiqui, *supra* note 14.

20. ABBAS BARZEGAR, HARVARD UNIV. COMM. ON THE STUDY OF RELIGION, RESEARCH REPORT: THE EMERGING LATINO MUSLIM COMMUNITY IN AMERICA (2003), <http://www.pluralism.org/research/profiles/display.php?profile=72671>.

21. Siddiqui, *supra* note 14.

Islam do not always trace their immediate roots to a society that places a social stigma on institutionalized care for their elders.²² Although many American converts to Islam attempt to care for their parents at home in a manner consistent with Islamic religious and cultural beliefs, many parents of converts prefer to maintain their independence.²³

B. Exploring the Cultural and Religious Views of the Elderly Among Muslims

The Muslim religion requires all people to respect their elders and, in particular, requires children to take care of their aging parents. According to the Qur'an, the holiest of Muslim texts, revered as the word of God, "Your Lord has decreed that you worship none but Him, and that you be kind to parents. Whether one or both of them attain old age in your life, say not to them a word of contempt, nor repel them, but address them in terms of honor."²⁴ The chapter goes on, "And, out of kindness, lower to them the wing of humility, and say: 'My Lord! bestow on them Your Mercy even as they cherished me in childhood.'"²⁵ In a later chapter, the Qur'an instructs, "And We have enjoined on man (to be good) to his parents: in travail upon travail his mother bore him,[] and in two years was his weaning: (hear the command), 'Show gratitude to Me and to your parents: to Me is (your final) Goal.'"²⁶ These verses from the Qur'an teach Muslims to care for their parents as their parents cared for them when they were younger. The Qur'an equates showing gratitude to parents—in particular to the mother—with obedience to God.

In addition to the Qur'an, Muslims also seek guidance from Mohammad, the prophet of Islam, through his sayings and actions, known as *hadith*. There are many hadiths that address care for elderly parents. In one hadith, a man asked the prophet to whom the man should be good. "Your mother," Prophet Mohammad replied.²⁷ The

22. *Id.*

23. *Id.*

24. QUR'AN (17:23) (Yusuf Ali trans.).

25. *Id.* at (17:24).

26. *Id.* at (31:14).

27. MUHAMMAD IBN ISMAIL AL BUKHARI, IMAM BUKHARI'S BOOK OF MUSLIM MORALS AND MANNERS 2 (Yusaf Talal DeLorenzo trans., Al-Saadawi Publications 1997); see also Islam Online Team, *supra* note 2.

man asked, “Then who?” and the prophet had the same reply.²⁸ Finally, when the man asked “Then who?” again, the prophet replied, “Your father, then the next closest relative, and then the next.”²⁹ In other words, in a list of people about whom one should care, the first three spots should be occupied by one’s parents. Another hadith reports the saying “[t]he pleasure of the Lord is in the pleasure of the parent, and the wrath of the Lord is in the wrath of the parent.”³⁰

Many Muslims, including Muslim scholars and authors, interpret these religious texts to mean that adult children must care for their parents and other elderly family members at home.³¹ In many countries with a predominantly Muslim population, when parents age, the children move in with their parents, or the parents move in with their children.³²

Many American elders live in nursing homes³³ despite preferring not to do so.³⁴ For most Muslim families, however, allowing an aging parent to live in a nursing home is not a viable option because of the interpretation of religious texts, the decisions of religious scholars, and the cultural practices of countries with predominantly Muslim populations.

Evidence of the strength of this belief exists in many articles on caring for the elderly in Islam. Aneesah Nadir, Assistant Professor in the Department of Social Work at Arizona State University and the President of the Islamic Social Services Association-USA, wrote in an

28. AL BUKHARI, *supra* note 27, at 2–3; *see also* Islam Online Team, *supra* note 2.

29. AL BUKHARI, *supra* note 27, at 3.

30. *Id.* at 2.

31. *See, e.g.*, Islam Online Team, *supra* note 2.

32. *Id.*; Yahiya Emerick, *What Needs to Be Done for the Future?*, ISLAM FOR TODAY, <http://www.islamfortoday.com/emerrick13.htm> (last visited Oct. 15, 2006) (“In America, for example, it isn’t unusual for a person to lose contact with all their relatives when they strike out on their own. Contrast this with societies that still have some traditional basis to them. In places such as India, Nigeria or Malaysia, all you see are relatives. Relatives living in your house, relatives living down the road, relatives getting you a job in the local government[—]relatives coming out your ears! The ‘Tyranny of the Relatives’ is everywhere!”).

33. WE THE PEOPLE, *supra* note 18 (providing that 1.8% of people between the ages of sixty-five and seventy-four, 6% of people between the ages of seventy-five and eighty-four, and 21.9% of people over the age of eighty-five live in group quarters).

34. Richard L. Kaplan, *Federal Tax Policy and Family-Provided Care for Older Adults*, 25 VA. TAX REV. 509, 515 (2005).

article published by Soundvision, a media company that creates products for Muslims and publishes information on Islam:³⁵

We must also attend to the issues of our elderly members so that they may receive their right to be cared for and valued in the last stage of their life. . . .³⁶ Hospice and palliative care, and nursing home placement are services that Muslims will have to consider and determine the Islamically best way to deliver. Diseases like [A]lzheimer's and other problems of the frail elderly will require that families have professional assistance to appropriately care for elder relatives. . . .³⁷ In home personal care and adaptive equipment must be made available to assist families with caring for their elder relatives so that they are able to provide the best quality of care possible in the home setting for as long as possible.³⁸

In an article about care for elderly parents, Professor Liaquat Ali Khan of Washburn University School of Law implies that sending Muslim parents to nursing homes is a type of elderly abuse and neglect:³⁹ "Muslim families living in America would hopefully resist the pressure of sending their elderly to nursing homes."⁴⁰ A Saudi Arabian publication distributed by the University of Southern California's Muslim Students Association explains that "[i]n the Islamic world there are no old people's homes. The strain of caring for one's parents in this most difficult time of their lives is considered an honor and blessing, and an opportunity for great spiritual growth."⁴¹

35. SoundVision.com, About Sound Vision, <http://www.soundvision.com/about/> (last visited Oct. 15, 2006).

36. Aneesah Nadir, *Social Concerns: A Look Toward the Future*, SOUNDVISION.COM, <http://www.soundvision.com/info/socialservice/futureconcerns.asp> (last visited Oct. 15, 2006).

37. *Id.* ("While the elderly Muslim community over 65 is still very small, only .5% according to Ba-Yunus and Siddiqui (1998), we are an aging community. Those in our middle years will soon be among the elder population of Muslims with no means of care as we face old age.").

38. *Id.*

39. Khan, *supra* note 5 ("It cannot be assumed, however, that Muslim families are immune from elderly neglect and abuse. Even though Islam protects members of the extended family, elderly Muslims with no children or other relatives living in America are especially vulnerable.").

40. *Id.* ("Many old and frail parents are left out in the nursing homes; some live and die in loneliness; some are cursed, ridiculed, and physically abused by their own sons and daughters. Frightening stories of domestic and institutional elder abuse have forced Congress to study the problem, take action, and toughen the laws to punish and prevent such abuse.").

41. Univ. of S. Cal., Muslim Students Ass'n Compendium of Muslim Texts, Understanding Islam and the Muslims, <http://www.usc.edu/dept/MSA/introduction/understandingislam.html#Q22> (last visited Oct. 15, 2006).

The essence of the Muslim attitude toward caring for one's parents is captured in this passage from the online Muslim magazine, *Islam Online*:

Nursing homes are almost unheard of in Muslim countries. (And Alzheimer's disease is also rare.) In an Islamic society, parents are respected for their wisdom and experience. Adult children might move out in search of work, but they still turn to their parents for advice and visit or communicate with them as much as possible. It is a Muslim's honored duty to lovingly care for his or her parents in their old age. Parents sacrifice so much for their children when they are small; *a Muslim is happy to return that sacrifice when his or her parents can no longer care for themselves*. It is not a burden but a means of winning a great reward in Paradise.

In many Muslim societies, the extended family lives together. As parents become grandparents, they may help in looking after or educating young children. And even when they are no longer "productive," they continue to be loved and respected for their humanity, and for their wisdom and experience.⁴²

If, for a moment, the stigma associated with nursing homes were removed and the type of respect for the elderly that prevents many Muslims from admitting family members into long-term care facilities were ignored, several reasons explain why nursing homes would still not be an appropriate option for Muslim elders. First, medical services to family members should be provided discreetly to avoid embarrassment.⁴³ This is because "it is critical that the family is viewed as taking care of its own problems and needs,"⁴⁴ and keeping problems—even health problems—secret gives the appearance that this is the case. Second, the food served at many nursing homes does not comply with Islamic dietary restrictions against eating pork or meat

42. Islam Online Team, *supra* note 2 (emphasis added); *see also* Uddin, *supra* note 13, at 37 ("Senior citizens in Muslim countries and in many developing countries generally don't experience such neglect or loneliness. A joint or extended family social structure provides them with a pleasant, supportive environment replete with children, grandchildren, and sometimes peers of their age and gender.").

43. Salari, *supra* note 7 ("Sengstock (1996) urges professionals serving these populations to be more assertive advocates of services available, [because] the targeted recipients may be less likely to recognize their need for help or the availability of such help in the community. Providing services in a confidential and discrete manner would also prevent the Muslim families from becoming embarrassed in their community. This can be challenging, especially since social visiting by friends, neighbors, and family is quite common, and it is rare to find an individual alone. Culturally, it is critical that the family is viewed as taking care of its own problems and needs (Sengstock 1996).").

44. *Id.*

not slaughtered in a certain manner.⁴⁵ Third, a male patient may find it inappropriate for a female health professional to care for him.⁴⁶ Similarly, a female patient may find being alone with or being cared for by a male health professional inappropriate.⁴⁷ Male health professionals may be particularly inappropriate for women who wear hijab.⁴⁸ Fourth, the nursing home staff may view a family's frequent visits to be an inappropriate luxury or hindrance to the patient's care.⁴⁹ However, when a Muslim is not in good health or is institutionalized, the individual's family and friends have a religious and cultural duty to visit that person.⁵⁰ While frequent family visits may be seen as noncompliance of the visitation schedule by health professionals, limiting visits to prescribed times may be viewed by Muslims as a violation of basic needs.⁵¹ Finally, nursing homes do not provide a place where elderly Muslims can perform Islamic worship, socialize with other Muslims, or celebrate Muslim holidays.⁵²

In addition to these specific cultural barriers, many Muslims have a negative general opinion of nursing homes. In fact, the placement of elders in nursing homes, along with a high divorce rate, is evidence to many Muslims of the failing family structure in the United States.⁵³ Many Muslims experience guilt when they allow their parents to live in nursing homes, and many elders leave nursing homes within months of admittance because of the related guilt and stigma.⁵⁴

45. *Id.*

46. *Id.*

47. *Id.*

48. *Hijab* is the Arabic word used to describe the prescribed covering of Muslim women. A woman's hijab includes a scarf worn to cover her hair and long, loose clothing. *Id.*; see Anahita Rashidi & Shireen S. Rajaram, *Culture Care Conflicts Among Asian-Islamic Immigrant Women in US Hospitals*, 16 *HOLISTIC NURSING PRAC.* 55, 61 (2001).

49. Salari, *supra* note 7.

50. Rashidi & Rajaram, *supra* note 48.

51. Salari, *supra* note 7.

52. Siddiqui, *supra* note 14.

53. PBS.org, Global Connections: The Middle East, What Are Some Typical Misperceptions and Stereotypes Westerners Hold About Islam and the Middle East, and Vice Versa?, <http://www.pbs.org/wgbh/globalconnections/mideast/questions/types/> (last visited Oct. 15, 2005).

54. Siddiqui, *supra* note 14; Khalid Suleiman & Adrian Walter-Ginzburg, *A Nursing Home in Arab-Israeli Society: Targeting Utilization in a Changing Social and Economic Environment*, 53 *J. AM. GERIATRICS SOC'Y* 153, 153 (2005) ("Not only did the nursing home fail to achieve full occupancy after ten years of operation (in 2002 it was 87% occupied), but internal audits found that about one-fourth of residents who entered returned home within months of admission. The staff con-

C. Today's Muslim Elders in America

Muslim American leaders are beginning to express concern about the future of elderly Muslims in the United States as their numbers increase. Sayyid M. Syeed, Secretary General of the Islamic Society of North America, is one such leader. "Lots of Muslims came here in the '70s, and they are going to retire in the next few years," Syeed said.⁵⁵ "It will be a problem because Muslims have special requirements."⁵⁶ These requirements involve informing doctors of Muslims' home care needs. The needs of Muslim elders are not met in institutionalized care because the elders often cannot ask for what they need, and the staff do not know what those needs are.⁵⁷

Similarly, Mujahid Al-Fayadh, the former Imam of the Central Illinois Mosque and Islamic Center, said that although some of the Muslims in his congregation have trouble meeting the financial obligations of caring for parents at home, few of the Muslims he knows allow their parents to live in nursing homes.⁵⁸ In fact, three generations of the Al-Fayadh family live with the Imam at his home.⁵⁹ Caring for aging parents at home is something Muslims learn to do as children and know to expect as seniors, he said.⁶⁰ "I need my children today, and they will need their children tomorrow," Al-Fayadh said.⁶¹ "It's a mutual interest."⁶² But this sense of responsibility comes with a price for the family members. The medical equipment needed by an older person—such as a special bed—can be very costly for Muslims who choose to care for their parents at home.⁶³

Recent articles in Muslim media have even begun to discuss a "sandwich generation," consisting of people who must provide care and financial resources both to their young children and to their eld-

ducted a study to understand this phenomenon, and they found that the reasons the families themselves gave for leaving were not resident's improved health or functional condition but rather social norms, feelings of shame, and social pressure on the families to bring their elderly relatives home, revealing a cultural stigma associated with placing elderly relatives in nursing homes.").

55. Telephone Interview with Sayyid M. Syeed, *supra* note 12.

56. *Id.*

57. *Id.*

58. Interview with Mujahid Al-Fayadh, Imam, Cent. Ill. Mosque & Islamic Ctr., in Urbana, Ill. (Nov. 16, 2005).

59. *Id.*

60. *Id.*

61. *Id.*

62. *Id.*

63. *Id.*

erly parents.⁶⁴ The sandwich generation has not created the need for more nursing home care; it is merely in need of extra assistance.

A recent study of various ethnic groups found that Arab Americans⁶⁵ do not feel as if they burden their family members when they stay with them.⁶⁶ “The whole neighborhood is involved when someone is dying,” the study explains, citing Arab American attitudes.⁶⁷ The study found that “Arabs ‘try desperately not to go in a nursing home,’”⁶⁸ whereas other ethnic groups did not necessarily share these misgivings. For example, “black men in particular did not feel strongly about the importance of having family and friends take care of them and did not want to burden them.”⁶⁹ In addition, “whites indicated that they did not feel that it was the family’s responsibility to take care of them and were open to hospice and nursing homes.”⁷⁰

III. Analysis

A person’s need for medical attention increases with age.⁷¹ In the United States, many elderly people who need frequent medical assistance live in nursing homes. Other options for residential long-term care include congregate living arrangements⁷² that provide board and care (for example, personal care homes, rest homes, and foster homes), assisted living facilities (large complexes that house several hundred residents and offer such services as restaurant-style dining and individual apartments), and continuing care retirement communities that require up-front fees to cover a lifetime of nursing services.⁷³ Some of America’s elderly who need constant medical attention, how-

64. Siddiqui, *supra* note 14.

65. While not all Arab Americans are Muslims, many are. Even among those who are not Muslim, many Arab Americans share the same cultural values as immigrant and second-generation Muslims. In addition, many of the Arab Americans in this study were interviewed at a mosque, and the study makes reference to the fact that many of its Arab American subjects were indeed Muslim. See Sonia A. Duffy et al., *Racial/Ethnic Preferences, Sex Preferences, and Perceived Discrimination Related to End-of-Life Care*, 54 J. AM. GERIATRICS SOC’Y 150, 151 (2006).

66. *Id.* at 153.

67. *Id.*

68. *Id.*

69. *Id.*

70. *Id.* at 155.

71. LAWRENCE A. FROLIK & RICHARD L. KAPLAN, *ELDER LAW IN A NUT SHELL* 1 (3d ed. 2003).

72. Richard L. Kaplan, *Cracking the Conundrum: Toward a Rational Financing of Long-Term Care*, 2004 U. ILL. L. REV. 47, 47.

73. *Id.* at 53–55.

ever, stay home or live with relatives. These elders receive assistance in the form of nurses, aides, or volunteer family members.⁷⁴ The system of federal funding for elderly care—Medicaid and Medicare—is built around providing care in a manner that has suited most Americans. However, as the American population has changed, the federal programs have not kept up. Therefore, despite the need for home care, these programs continue to focus on nursing home care or, for a small number of people, home care.

A. Paying for Nursing Home Care

For many elderly people, at least some of their long-term care expenses are covered by one of two federal programs: Medicaid or Medicare. Medicaid provides federal and state funding for “families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services.”⁷⁵ Medicare is a federal program that provides funding for the health needs of people over the age of sixty-five.⁷⁶

1. MEDICAID

Medicaid funds medical care for the poor of all ages,⁷⁷ but a third of its funding goes toward helping older Americans.⁷⁸ Because Medicaid funding comes partly from the states, its coverage varies by state.⁷⁹ Medicaid covers a patient’s stay in “nursing facility services,” even when the patient has a chronic disease that does not require

74. FROLIK & KAPLAN, *supra* note 71, at 71; Kaplan, *supra* note 72, at 50.

75. 42 U.S.C.A. § 1396 (2006).

76. *Id.* § 1395(c).

77. *Id.* § 1396.

78. FROLIK & KAPLAN, *supra* note 71, at 105.

79. Kaplan, *supra* note 72, at 65; CTR. FOR MEDICAID & STATE OPERATIONS, U.S. DEP’T OF HEALTH & HUMAN SERVS., MEDICAID AT-A-GLANCE 1–5 (2005), *available at* <http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/maag2005.pdf> (explaining what some of the state programs include and how these programs are only available in certain states); *see, e.g.*, 42 U.S.C.A. § 1396d(a) (“The term ‘medical assistance’ means payment of part or all of the cost of the following care and services . . . for individuals, and, with respect to physicians’ or dentists’ services, *at the option of the State*, to individuals . . . not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter . . .”) (emphasis added).

skilled care.⁸⁰ Medicaid also provides “home and community care” coverage,⁸¹ which includes chore services, home health aide services, nursing care by or under the supervision of a nurse, and “such other home and community based services.”⁸² This level of home care is available to “functionally disabled elderly individual[s],”⁸³ the requirements of which include being over the age of sixty-five⁸⁴ and either having primary or secondary Alzheimer’s disease or being unable to eat, use the toilet, or transfer without help.⁸⁵

The breadth of Medicaid’s coverage, however, is curtailed by its financial eligibility requirements. Medicaid’s purpose, to provide care to those “whose income and resources are insufficient to meet the costs of necessary medical services,”⁸⁶ limits its ability to help all seniors.⁸⁷ In addition, Medicaid differentiates between the “medically” needy and the “categorically” needy.⁸⁸ The medically needy are financially ineligible for Social Security and state programs that provide aid to families with dependent children, whereas the categorically needy includes people “with dependent children, and the aged, blind, and disabled.”⁸⁹ States are required to extend Medicaid coverage only to the “categorically” needy; offering coverage to the “medically” needy is optional.⁹⁰

2. MEDICARE

All persons above the age of sixty-five who meet certain conditions qualify for Medicare coverage,⁹¹ and people who are eligible for

80. 42 U.S.C.A. § 1396d(a) (providing that Medicaid covers individuals “whose income and resources are insufficient to meet all of such cost” of “nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older”).

81. For the definition of “Home and Community Care,” see 42 U.S.C. § 1396t(a).

82. *Id.* § 1396t(a)(9).

83. *Id.* § 1396t(b) (defining “functionally disabled elderly individuals”).

84. *Id.* § 1396t(b)(1)(A).

85. *Id.* § 1396t(c).

86. *Id.* § 1396(d)(a).

87. Kaplan, *supra* note 72, at 64.

88. *Monmouth Med. Ctr. v. State*, 158 N.J. Super. 241, 247 (N.J. Super. Ct. App. Div. 1978); *CTR. FOR MEDICAID & STATE OPERATIONS*, *supra* note 79.

89. *Monmouth Med. Ctr.*, 158 N.J. Super. at 247; *see also* *CTR. FOR MEDICAID & STATE OPERATIONS*, *supra* note 79.

90. *Monmouth Med. Ctr.*, 158 N.J. Super. at 247; *CTR. FOR MEDICAID & STATE OPERATIONS*, *supra* note 79.

91. 42 U.S.C.A. § 1395c.

Social Security Title II benefits tend to also be eligible for Medicare.⁹² The conditions include being a federal employee eligible for retirement, being the spouse of someone who qualifies for Social Security Title II, or working for a certain length of time.⁹³ In addition, certain persons who are not at least sixty-five years old may qualify for Medicare because of disability or diseases such as end-stage renal disease.⁹⁴ In fact, “most older Americans are covered by Medicare.”⁹⁵

Despite Medicare’s broad eligibility standards, the coverage it provides is limited to “post-hospital *extended care services*”⁹⁶ that are “furnished pursuant to an admission to a *skilled nursing facility* occurring on or after January 1, 1989.”⁹⁷ *Extended care services* include “medical services provided by an intern or resident-in-training of a hospital,” nursing care by a registered nurse, care under the supervision of a registered nurse, “physical or occupational therapy or speech-language pathology services furnished by the skilled nursing facility or by others under arrangements with them made by the facility,” medicine provision, and medical social services.⁹⁸

92. *Id.* (“The insurance program for which entitlement is established by sections 426 and 426-1 of this title provides basic protection against the costs of hospital, related post-hospital, home health services, and hospice care in accordance with this part for (1) individuals who are age 65 or over and are eligible for retirement benefits under subchapter II of this chapter (or would be eligible for such benefits if certain government employment were covered employment under such subchapter) or under the railroad retirement system.”); Robert M. Hayes et al., *Medicare: Nuts and Bolts*, 143 PLI/NY 87, 92 (2004).

93. 42 U.S.C.A. § 1395c(1)–(3).

94. *Id.*; see also Hayes et al., *supra* note 92.

95. Kaplan, *supra* note 72, at 58.

96. 42 U.S.C.A. § 1395d(a)(2) (2006) (emphasis added).

97. Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, tit. I, subtit. A, § 104(a)(2), 102 Stat. 683, 688 (1988) (emphasis added).

98. 42 U.S.C.A. § 1395x(h) (“The term ‘extended care services’ means the following items and services furnished to an inpatient of a skilled nursing facility and (except as provided in paragraphs (3), (6), and (7)) by such skilled nursing facility—(1) nursing care provided by or under the supervision of a registered professional nurse; (2) bed and board in connection with the furnishing of such nursing care; (3) physical or occupational therapy or speech-language pathology services furnished by the skilled nursing facility or by others under arrangements with them made by the facility; (4) medical social services; (5) such drugs, biologicals, supplies, appliances, and equipment, furnished for use in the skilled nursing facility, as are ordinarily furnished by such facility for the care and treatment of inpatients; (6) medical services provided by an intern or resident-in-training of a hospital with which the facility has in effect a transfer agreement (meeting the requirements of subsection (l) of this section), under a teaching program of such hospital approved as provided in the last sentence of subsection (b) of this section, and other diagnostic or therapeutic services provided by a hospital with which the facility has such an agreement in effect; and (7) such other services necessary to the

A *skilled nursing facility* primarily provides “(A) skilled nursing care and related services for residents who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and is not primarily for the care and treatment of mental diseases.”⁹⁹

Medicare covers “(A) post-hospital extended care services for up to 100 days during any spell of illness, and (B) to the extent provided in subsection (f), extended care services that are not post-hospital extended care services.”¹⁰⁰ It covers in full the first twenty days of a stay in a skilled nursing facility.¹⁰¹ The following eighty days are covered in part through a co-payment arrangement¹⁰² that is set every year¹⁰³ and in 2004 required covered patients to pay \$109.50 for each day they remained in the skilled nursing facility.¹⁰⁴ However, this coverage is available only to Medicare patients who are admitted to a skilled nursing facility “within 30 days of being discharged from a hospital.”¹⁰⁵ In other words, a patient who enters a nursing home without first being discharged from a hospital or who was discharged from a hospital more than thirty days earlier will not qualify for coverage. In addition, the patient’s stay in the hospital must last at least three days.¹⁰⁶ “Thus, a trip to a hospital emergency room that does not require further hospital care fails to satisfy this requirement. Likewise, an overnight stay in the hospital for observation does not meet this requirement.”¹⁰⁷

The requirement that a patient be admitted to a “skilled nursing care” facility to receive Medicare coverage means that the care a patient receives at such a facility must not be available to the patient

health of the patients as are generally provided by skilled nursing facilities, or by others under arrangements with them made by the facility[.]”).

99. *Id.* § 1395i-3(a)(1).

100. *Id.* § 1395d(a)(2).

101. *Id.* § 1395e(a)(3) (“The amount payable for post-hospital extended care services furnished an individual during any spell of illness shall be reduced by a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day (before the 101st day) on which he is furnished such services after such services have been furnished to him for 20 days during such spell.”).

102. *Id.*

103. 42 C.F.R. § 409.85 (2006) (“For coinsurance days after December 31, 1981, the coinsurance amount is based on the deductible applicable for the calendar year in which the services were furnished”).

104. Hayes et al., *supra* note 92, at 96.

105. 42 U.S.C. § 1395x(i)(A).

106. *Id.*

107. Kaplan, *supra* note 72, at 60.

elsewhere.¹⁰⁸ This care can include the development, management, and evaluation of patient care, patient observation, patient assessment, and education services.¹⁰⁹ However, these services only qualify as “skilled nursing care” if the use of technical or professional personnel is necessary, as determined by a physician.¹¹⁰ In addition, “skilled nursing care” includes internal feedings that provide at least 26% of the patient’s daily calorie consumption, tracheostomy aspiration, treatment for widespread skin disorders, heat treatments ordered by a physician that require nurse observation, and “administration of medical gases.”¹¹¹

Medicare’s coverage for home stays is even more limited than its coverage of nursing home stays. Medicare does not provide funds to patients who receive help from family or other unpaid aides. To qualify for coverage, the Medicare patient must receive care from either a registered professional nurse or someone who is supervised by a reg-

108. *Id.* at 61.

109. 42 C.F.R. § 409.33 (2005).

110. *Id.* (“The development, management, and evaluation of a patient care plan based on the physician’s orders constitute skilled services when, because of the patient’s physical or mental condition, those activities require the involvement of technical or professional personnel in order to meet the patient’s needs, promote recovery, and ensure medical safety. . . . An aged patient with a history of diabetes mellitus and angina pectoris who is recovering from an open reduction of a fracture of the neck of the femur requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, an exercise program to preserve muscle tone and body condition, and observation to detect signs of deterioration in his or her condition or complications resulting from restricted, but increasing, mobility. Although any of the required services could be performed by a properly instructed person, such a person would not have the ability to understand the relationship between the services and evaluate the ultimate effect of one service on the other. Since the nature of the patient’s condition, age, and immobility create a high potential for serious complications, such an understanding is essential to ensure the patient’s recovery and safety. Under these circumstances, the management of the plan of care would require the skills of a nurse even though the individual services are not skilled. Skilled planning and management activities are not always specifically identified in the patient’s clinical record. Therefore, if the patient’s overall condition supports a finding that recovery and safety can be ensured only if the total care is planned, managed, and evaluated by technical or professional personnel, it is appropriate to infer that skilled services are being provided.”).

111. *Id.* (providing that “[s]ervices that qualify as skilled nursing services” include “[i]ntravenous or intramuscular injections and intravenous feeding[;] [e]nteral feeding that comprises at least [26%] of daily calorie requirements and provides at least 501 milliliters of fluid per day[;] [n]asopharyngeal and tracheostomy aspiration; [t]reatment of extensive decubitus ulcers or other widespread skin disorder[,] and [h]eat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by nurses to adequately evaluate the patient’s progress”).

istered professional nurse.¹¹² The patient's care must be under a physician-approved plan, the plan must be approved every sixty days, and the care must be "reasonable and necessary."¹¹³ In addition, Medicare covers only "part-time or intermittent" home care,¹¹⁴ which is defined as care that is provided fewer than seven days per week or fewer than eight hours per day for twenty-one days or fewer.¹¹⁵ By its construction, Medicare cannot cover home care that requires more than part-time care. In addition, to receive in-home care, the elderly patient must be "confined" to his or her home.¹¹⁶

Medicare's legislative history makes clear that the program is not intended for full-time home care: "The proposed post-hospital home care payment would meet the cost of part-time or intermittent nursing services, physical, occupational and speech therapy and other related home health services. . . . *More or less full-time nursing care would not be paid for under the home health benefits provision.*"¹¹⁷ The U.S. District Court for the District of Columbia confirmed the limitation in *Duggan v. Bowen*,¹¹⁸ finding "[t]he statute and the legislative history indicate Congress' intent to entitle beneficiaries to coverage if care is needed *either* part-time (i.e. less than eight hours per day) *or* on an intermittent basis."¹¹⁹ Thus, Medicare "utilizes primarily a medical approach that only incidentally strives to maintain a senior citizen in his or her home."¹²⁰

3. EFFICIENCY: THE ULTIMATE GOAL OF FEDERAL FUNDING

Despite the differences in eligibility and coverage between Medicare and Medicaid, both programs favor the efficiency of nursing homes, which place all medical services and the patients who need them in one location. In *Friedman v. Perales*,¹²¹ the U.S. Court of Appeals for the Second Circuit agreed with the lower court that Congress intended Medicaid to cover only efficient costs and that this goal lim-

112. 42 U.S.C.A. § 1395y(a)(14) (2003).

113. *Id.* § 1395y(a)(1).

114. *Id.* § 1395x(m)(1).

115. *Id.* § 1395x(m)(7); Hayes et al., *supra* note 92, at 96.

116. 42 U.S.C.A. § 1395a(2)(c).

117. S. REP. NO. 89-404, at 32 (1965), as reprinted in 1965 U.S.C.C.A.N. 1943, 1974 (emphasis added).

118. 691 F. Supp. 1487 (D.C. Cir. 1988).

119. *Id.* at 1511.

120. Kaplan, *supra* note 72, at 62.

121. 841 F.2d 47, 48 (2d. Cir. 1988).

ited which expenses Medicaid could cover: “[T]he efficient cost standard of the Medicaid provisions requires only that [Residential Health Care Facilities] be reimbursed for the efficient cost of their operation, not that every component of reimbursable cost be compensated at an efficient rate.”¹²² The *Duggan* court explained that the rationale behind limiting Medicare home coverage to part-time or intermittent care “was simple: full time care generally would be provided more humanely and economically in an institutional setting.”¹²³

B. Exploring Solutions to Muslim Elder Care

1. THE STATUS QUO

For all the reasons already discussed in this note, the status quo is no longer a viable solution. The demographics of America’s elderly population are changing, and this brings about a corresponding change in values, including views on elder care. Federal funds to the elderly exist only in the form of Medicare and Medicaid. Nursing homes are not an option for many Muslims, and while Medicaid provides extensive aid to those who choose home care, the eligibility criteria are strict. Even for the many elderly Muslims who qualify for Medicare, the funding for home care is limited to part-time help at home and does not assist families who care for their elderly family members on their own. Medicaid and Medicare are the only types of state aid available to the elderly, and neither is appropriate for Muslims.

2. ADOPTING WESTERN PRACTICES

The long-held system of admitting elders to nursing homes for efficient care is not a practice that can stand the test of cultural diversity. Some groups of people—specifically, the increasing Muslim population—need an affordable way to allow their parents and elders to live at home with their families.

Some Muslims have been forced to break the norms of Muslim culture and adapt to Westernized practices. In a recent study by Khalid Suleiman and Adrian Walter-Ginzburg, Arab Israeli families and individuals who could not care for their aging family members at

122. *Id.* at 48.

123. *Duggan*, 691 F. Supp. at 1511.

home turned to nursing homes for help.¹²⁴ The study found that “[t]hose who have large families follow social norms that encourage care of the disabled at home, but when the elderly need extensive nursing or develop cognitive deficits, the norm is violated and the family turns to the formal sector for care.”¹²⁵ When elder Arab Israelis in the study had little or no family support either because the family was small or because it lacked the necessary financial resources, the elder Arab Israelis themselves turned to nursing homes.¹²⁶

While some Muslims turn to nursing homes for help, most Muslims continue to find this type of care inappropriate. According to Suleiman and Walter-Ginzburg, “[c]ultural norms of Arab Israelis cannot be discounted as an influence on the low rate of utilization of formal sector services.”¹²⁷ The study found that in the Dabouriya Home for the Aged, located in the Arab village of Dabouriya, Israel, “fully one-fourth of residents admitted during the first 10 years of operation left the institution after an average of 5.4 months, most because of social norms, feelings of shame, and social pressure, not because of rehabilitation or improvement in health.”¹²⁸ The study also found that only 0.7% of Arab Israelis used nursing homes, despite the general availability of such care.¹²⁹ Although this nursing home was not in the United States, its rejection by Arabs speaks to the culture and beliefs that form, at a minimum, the backdrop to Muslim Americans’ attitudes toward nursing homes.

In the United States, it is possible that as the number of Muslims increases and as Muslim communities age, Muslim beliefs may change over time so that the economic efficiency of nursing homes becomes an appealing option to Muslims. This change would occur in much the same way that at least some of the Asian American community came to accept nursing homes as a means for caring for its elders.¹³⁰ In fact some Muslims have already spoken of a need to place

124. Suleiman & Walter-Ginzburg, *supra* note 54.

125. *Id.* at 155.

126. *Id.*

127. *Id.*

128. *Id.*

129. *Id.*

130. See, e.g., Asian Community Nursing Home, *supra* note 4 (explaining that the nursing home “provides cultural and socially sensitive [services] to help meet resident needs, including: specialized dietary services, including Asian [c]uisine . . .” and a “multi-lingual, multi-cultural staff [to] closely reflect the diverse community of residents”).

Muslim elderly in nursing homes.¹³¹ However, this change in perception, if it happens at all and becomes widespread, will not come rapidly enough to solve the short-term problem of how to care for the large population of today's first- and second-generation aging Muslims, for whom a change in attitudes may not be possible.

3. MUSLIM NURSING HOMES

Although there has yet to be an organized effort by Muslims in the United States to arrange for Muslim care, other cultural groups have found ways to care for their elderly in a manner consistent with their cultural ideals. For example, the Asian American elderly have faced some of the same issues as their Muslim American counterparts because a similar hesitancy over sending aging family members to nursing homes exists in both groups.¹³² Asian American groups with a long history in the United States, such as the Japanese American population, are less hesitant about caring for their elders in nursing homes than are groups with larger numbers of recent immigrants, such as Korean Americans.¹³³

In Sacramento, California, the Asian Community Center created the Asian Community Nursing Home to provide culturally appropriate care.¹³⁴ Its mission is "to provide compassionate and quality care that recognizes [Asian American] ethnic diversity and assures proactive clinical and social services."¹³⁵

The services provided at the Asian Community Nursing Home are tailored to meet patients' needs and include "specialized dietary services, including Asian Cuisine; rehabilitation services[,] physical therapy, occupational therapy, . . . speech pathology[,] family counsel-

131. See, e.g., Lynette Clemetson, *U.S. Muslims Confront Taboo on Nursing Homes*, N.Y. TIMES, June 13, 2006, <http://www.nytimes.com/2006/06/13/us/13muslim.htm/> (describing one Muslim leader's plans to build an assisted living and nursing home complex for elderly Muslims in Brooklyn Park, Minn.).

132. Kim EY & Kim CY, *Who Wants to Enter a Long-Term Care Facility in a Rapidly Aging Non-Western Society? Attitudes of Older Koreans Toward Long-Term Care Facilities*, 52 J. AM. GERIATRICS SOC'Y 2114, 2114-15 (2004) (on file with the Elder Law Journal) ("[C]ulture has a strong influence on the intention to use [long-term care] facilities. For example, in the United States, the attitude toward the use of [long-term care] facilities in traditionally family-centered groups—which tend to be nonwhite—is more negative than in whites.").

133. *Id.* at 2115 ("[I]t was found that Japanese Americans who had become acculturated into American society, and had never lived in Japan and could not speak Japanese, had high intentions to use [long-term care] facilities.").

134. Asian Community Nursing Home, *supra* note 4.

135. *Id.*

ing[,] multi-cultural activities for groups and individuals[,] art and craft activities[,] religious services[,] special entertainment, . . . laundry service, beauty salon, pharmacy [and] visiting hours.”¹³⁶ The members of the nursing home staff speak several languages, including English, Japanese, and Taiwanese.¹³⁷

One possible solution to the needs of the aging Muslim American population is to follow the example of the Asian Community Center by creating nursing homes for Muslims. Presumably, such facilities would avoid the problems Muslims face in traditional nursing home care, such as language barriers, isolation from other Muslims, dietary restrictions, and modesty concerns. However, this solution leaves one of the most important issues untouched: the creation of nursing homes for Muslims will not remove the stigma from institutionalized elder care and does not provide a system by which adult children can care for their parents in an Islamically acceptable manner. In fact, even though the Arab Israeli nursing home in the Suleiman and Walter-Ginzburg study discussed above addressed the very issues that a Muslim nursing home in the United States would solve, usage of the nursing home was still low among Muslims in that community.¹³⁸

In addition, case law regarding the operation of nursing homes for the exclusive benefit of a religious group provides conflicting guidance on how to proceed. In *Cabinet for Human Resources Kentucky Health Facilities v. Provincial Convent of Good Shepherd, Inc.*,¹³⁹ the Kentucky Court of Appeals found that imposing nursing homes statutes and regulations on a religious infirmary infringed upon the right to free exercise of religion by the sisters of the Good Shepherd.¹⁴⁰ “The Commonwealth may only infringe upon the free exercise of religion when it does so in pursuit of an overriding, compelling interest of the highest order, and only if it does so in the least restrictive manner possible.”¹⁴¹ The court found no such compelling state interest in this

136. *Id.*

137. *Id.*

138. Suleiman & Walter-Ginzburg, *supra* note 54 (“Although 44% of Arab Israelis and 26% of Jewish Israelis aged 65 and older are disabled, in 1999, 4.3% of the Jewish population but only 0.7% of the Arab-Israeli population aged 65 or older lived in long-term care institutions; disabled Arab-Israeli elderly were mainly cared for by families.”).

139. 701 S.W.2d 137 (Ky. Ct. App. 1985).

140. *Id.* at 138.

141. *Id.*

case because the sisters were properly taking care of the “aged, sick and infirm.”¹⁴² Finally, the court found that regulation of a religious home would potentially “create an excessive entanglement between the affairs of government and the church.”¹⁴³

Although the Kentucky Court of Appeals did not require a religious home to be subject to state nursing home regulations because doing so would be an invalid use of the state’s police power,¹⁴⁴ the California Court of Appeals, in *Universal Life Church, Inc. v. State*,¹⁴⁵ affirmed an injunction against an unlicensed community care facility even though the facility was for elderly church members.¹⁴⁶ In *Universal Life Church*, the court entered an injunction against the operation of the community care facility because it refused to comply with licensing restrictions.¹⁴⁷ The operators of the facility argued that it should be exempt from the license requirements as should “any well-recognized church or religious denomination for the purpose of providing facilities for the care or treatment [of the elderly].”¹⁴⁸ The court disagreed:

In affirming an injunction against unlicensed operation, the court said that by their own admission, the operators did not fall within the statutory exemption, and that since there was a question as to whether several residents required nursing care, doubt as to their safety should be resolved in favor of removing them from a potentially dangerous or unsafe environment.¹⁴⁹

In *Cabinet for Human Resources Kentucky Health Facilities*, any government interference with a religious home was an inappropriate use of police power,¹⁵⁰ but in *Universal Life Church*, the court affirmed an injunction on a religious home because it would not comply with government regulations.¹⁵¹ These opposing decisions provide little direction on how to operate a religious nursing home. Rather, they show the unique, unpredictable, and unresolved problems a religious nursing home would face.

142. *Id.* at 139.

143. *Cabinet for Human Res.*, 701 S.W.2d at 138.

144. John P. Ludington, Annotation, *Licensing and Regulation of Nursing or Rest Homes*, in 53 A.L.R. 4TH 689, § 9 (1987).

145. 205 Cal. Rptr. 11, 15 (Cal. Ct. App. 1984).

146. *Id.* at 12.

147. *Id.* at 15.

148. CAL. HEALTH & SAFETY CODE § 1505 (West 2000).

149. Ludington, *supra* note 143, § 6.

150. *Cabinet for Human Res. Ky. Health Facilities v. Provincial Convent of Good Shepherd, Inc.*, 701 S.W.2d 137, 139 (Ky. Ct. App. 1985).

151. *Universal Life Church*, 205 Cal. Rptr. at 15.

4. CREATING A NEW FEDERAL FUNDING PROGRAM

Another approach to solving the problems Medicare and Medicaid pose to elderly Muslims would be to create a separate system of funding. This new system would neither require poverty nor focus on the efficiency of institutional care. While Medicare and Medicaid would continue to exist, a new system would allow people in special circumstances to apply for supplemental funds when Medicare or Medicaid do not meet their needs. The program's purpose would be to meet the particular needs of families and individuals.

For Muslim families, this new program would provide funding for home care. To qualify, all the Muslim family would need to show is that Medicare and Medicaid do not meet the family's home care needs and that home care is essential to the elderly person in question because of the family's religious and cultural background. The program could be available to all people with special financial needs not addressed by Medicare or Medicaid, or the program could be limited to those with special needs who seek home care.

This new program would pose several problems, however. First, there are no objective criteria by which to judge a "special circumstance" because of its nature as special—by definition, a special circumstance does not fit into a pre-established mold. The respective situations of people applying for these funds could vary so much that many of them would not fit into easily identifiable categories. In addition, questions of degree would arise: how special must a situation be before it is dubbed a special circumstance? A second problem, similar to the argument about adopting western values,¹⁵² is that creating an entirely new federal or state system of funding for elder care would take too much time to meet the needs of today's elders. This program requires the lengthy process of creating a new fund and a new administrative agency before it could begin to serve the needs of the elderly.

As a long-term plan for meeting the needs of an increasingly diverse elderly population, the creation of a federal program may be a good solution, despite the foregoing problems. This federal plan would not discriminate against certain groups of people because it would allow people of all backgrounds to receive funds if they meet the qualifying criteria. As for the special circumstances requirement,

152. See *supra* Part III.B.2.

it is possible that many of the same types of circumstances would repeatedly arise over time, and those situations would help to develop a workable definition of a special circumstance.

5. CREATING INDIVIDUAL ELDERLY ACCOUNTS

One way to meet the needs of a diverse elderly population is to allow all elderly people—of every religion and ethnic background—to decide how to use their share of government funds. Creating individual accounts for elderly people to fund their long-term care, whether at home with family or in a nursing home, would provide this opportunity. Each account would contain the same amount of money to fund any type of long-term care. These accounts could be limited to the elderly by using the eligibility criteria of Medicare.¹⁵³ Individual accounts would not conflict with the Establishment Clause in the First Amendment because people of all faiths would have the freedom to decide how to spend the federal funds allocated to them, and the program would grant no special favors to people of one religion over another. Individual accounts would thus allow Muslims concerned with meeting their religious and cultural obligations to use federal money to fund home care.

However, this potential solution also poses several problems. First, not all elderly people need the same amount of care, and this allocation of funds gives every person the same amount of money regardless of the cost of their health care needs. For example, a relatively healthy elderly person who requires only limited additional funding for a home stay would receive the same amount of money as an Alzheimer's disease patient who needs extensive care. This problem could be overcome, however, by allocating funds on the basis of a person's health rather than giving each recipient the same amount of money. Second, this system could encourage inefficiency. Recipients of the individual accounts program would be concerned about how to best spend their allocated money to meet their own needs rather than thinking about how to spend the money in a manner that would be cost-effective for the program as a whole. On the other hand, people would be more inclined to use the money in a manner that is cheapest, favoring efficient solutions over costly ones, to receive the most gain from the money allocated to them. Finally, this program would re-

153. See *supra* Part III.A.2.

quire the creation of entirely new agencies and methods of dispersing funds. Although the ultimate gain of this program would be great once the infrastructure is created, the freedoms and options the program allows would not help today's elderly Muslims.

IV. Resolution: Federal Funds Should Cover the Costs of Elder Home Care for People Whose Backgrounds Prohibit the Traditional Nursing Home Stay

Medicare and Medicaid have provided funds to the elderly for more than thirty years. During this time, patients, caregivers, and attorneys alike have become familiar with how to use the programs and the services they provide. Change is necessary, but amending the existing federal programs is a more desirable option than creating an entirely new system for Americans with specific cultural or religious requirements.

Current federal allocation programs for home care are not sufficient for the increasing number of Muslim American elderly whose culture and religion make home care the only viable option. However, combining elements of Medicaid and Medicare would enable the government to serve the needs of the Muslim population without creating a whole new program of aid for the elderly.

A solution must take one of two forms: (1) expand Medicaid's eligibility standards to allow people of varying religions or cultures to qualify regardless of their economic status; or (2) expand Medicare's coverage needs to include the kinds of home care services that Medicaid provides while maintaining Medicare's eligibility criteria. Under the latter plan, the expansion of coverage can apply either to all people who qualify for Medicare or to people who qualify for Medicare and whose culture places great emphasis on providing home care for elders.

Each of these options requires a blending of different aspects of Medicare and Medicaid because the eligibility criteria for Medicaid and the list of covered expenses under Medicare are both too narrow. Therefore, a new federal program based on existing federal programs must include two elements. First, the eligibility requirements of Medicare should be used to determine which elderly individuals should receive federal funding. Applying Medicare's eligibility requirements, the federal funding available for home care would not be

limited to the poor,¹⁵⁴ but appropriately restricted to the elderly. Rather than create a new source of funding for a special population, modifying the programs already in place would allow eligible elderly to redirect the federal funds that are already available (typically for either limited home care or for nursing home care) and use that money in a manner that satisfies their home care needs.

Second, the list of covered home care services provided under Medicaid should be used to decide which care to provide. Medicaid enables eligible families to care for their elderly relatives in a manner consistent with Muslim traditions by allowing for all kinds of home care, including chore services, home health aide services, care under the supervision of a nurse, and any “such other home and community-based services.”¹⁵⁵ In addition, providing funding for home care avoids the constitutional issues raised in *Cabinet for Human Resources Kentucky Health Facilities*¹⁵⁶ because home care would not be directly regulated by religious institutions, therefore avoiding “excessive church/state entanglement.”¹⁵⁷

Combining the characteristics of Medicare eligibility with Medicaid services may be less efficient than Medicare because it favors home care over nursing home care and less efficient than Medicaid because it does not limit itself to helping the poor. However, this option is the only way to accommodate a culturally diverse elderly population. Rather than worry solely about the economics of the programs, Congress should be more concerned about whether federal programs meet its constituencies’ needs. Efficiency is important, but it should be an afterthought to the ultimate goal of both Medicare and Medicaid: providing medical assistance to the Americans who need it.

154. Kaplan, *supra* note 34, at 530–32 (“Medicaid is basically a poverty program. . . . As such, it is restricted to persons with few financial resources. . . . Accordingly, to access Medicaid, these older folks must use up all, or almost all, of their financial resources, including retirement accounts and principal residences. Only when they have ‘spent down’ their assets, in the peculiar argot of Medicaid, will they qualify for coverage of the more medicalized forms of long-term care, especially care in a nursing home. In many family situations, particularly when an eventual nursing home placement is likely, there is a tremendous temptation to have the older relative give away his or her financial assets, usually to family members, and to thereby hasten the day when that person becomes eligible for Medicaid’s long-term care coverage. Such transfers are extremely controversial and are often contrary to the best interests of the older people themselves.” (citations omitted)).

155. 42 U.S.C.A. § 1396t(a) (2003).

156. *Cabinet for Human Res.*, 701 S.W.2d 137.

157. *Id.*

V. Conclusion

Change is necessary in the federal programs that provide funds to our nation's elderly. While Medicare and Medicaid have been sufficient for some people, these programs fail to meet the U.S. population's changing needs and should be amended so that federal money can fund proper care for elderly citizens of all religions, nationalities, and ethnicities. The policies that aim to serve the American people should reflect the needs of a growing and increasingly diverse population. That said, an infrastructure already exists that successfully meets the needs of many of America's elderly. Medicare and Medicaid may not provide everything seniors need,¹⁵⁸ but both programs are ingrained in our legal system under a framework that has effectively provided funds for more than thirty years.¹⁵⁹ Therefore, combining the best elements of each program ensures that America's elderly will receive the best possible care.

158. See generally Kaplan, *supra* note 72, at 53.

159. See generally 42 U.S.C.A. § 1396 (referring to the 1965 version of the Social Security Act).