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BIFOCAL, ISSN 0888-1537, is published six times a year by the ABA Commission on Law and Aging, 1050 Connecticut Ave. NW, Ste. 400, Washington, DC 20036.

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New Commission on Law and Aging Chair and Members

Each September 1, a new roster of Law and Aging Commissioners is appointed by the ABA president. Most Commissioners serve for multiple years with a handful of new faces starting in any given year. This year, we have a new Chair and six new Commissioners; you will find them to be a diverse and highly expert group in their individual disciplines.

Below, you will find short biographies of our incoming Chair and our six new Commissioners.

HON. PATRICIA BANKS, Chair, serves on the Executive Committee of the Circuit Court of Cook County and is Presiding Judge of the Elder Law and Miscellaneous Remedies Division of the Circuit Court. She served as a trial judge in the Domestic Relations and Law Divisions prior to her current assignment. Immediately prior to her judicial career, Judge Banks practiced extensively in the areas of probate and family law. Other employment included a position with Sears Roebuck & Company as its first African American Attorney specializing in advertisement and employment law from 1974-78, and staff attorney with the Leadership Council for Metropolitan Open Communities and the United States Department of Labor. Judge Banks has several certifications in mediation, including advanced training in Adult Guardianship and Eldercare mediation. Additionally, she has held various leadership positions, including Chairperson of the Illinois Supreme Court Alternative Dispute Resolution Coordinating Committee, Chairperson of the Judicial Council of the National Bar Association and member of the Chicago Bar Association Board of Managers. Currently, Judge Banks is a member of the National Council of Juvenile and Family Court Judges’ Family Violence Advisory Committee and the Center for Conflict Resolution Board of Directors. She is a 1972 graduate of the University of Wisconsin Law School.

IVÁN CHANIS BARAHONA currently serves as the Legal and Political Counselor of the Mission of Panama to the Organization of American States (OAS). He is the current Vice President of the working group in charge of drafting an Inter-American Convention on the Human Rights of Older Persons. Mr. Chanis is in charge not only of negotiating international conventions, but also producing opinions about projects on education, human rights, competitiveness, and science and technology, among other topics. He is also part of the team in charge of representing Panama in Pan American Health Organization (PAHO) and has worked closely with the AARP Office of Gender, Diversity and Human Rights, considering the health perspective in the negotiation of different international treaties in the Inter-American system. The past few years he has been involved in specific themes for the Americas Agenda, such as: non-discrimination, the rights of Elderly, Indigenous, and LGBT. Mr. Chanis’ academic background includes studies in Panama and the United States, but also for shorter periods in Spain, Italy, England, and Brazil; these experiences provide a broad international perspective. He has an LL.M. in General Studies, focused on International Law, from New York University, and has studied Law and Political Sciences in Catholic University in his home country Panama, although he is not a licensed lawyer in the U.S. His background, experience, and his current focus on an international aging treaty make him a superb addition to the Commission’s expertise.
JEAN CALLAHAN is the Director of the Brookdale Center on Healthy Aging at Hunter College. Brookdale is one of the country's leading academic gerontology centers and seeks to improve the lives of older adults through research, policy and professional development. She presents frequently on elder abuse, financial exploitation, guardianship, and access to health care for older adults. Jean also coordinates the Westchester County Elder Abuse Multi-disciplinary Team (MDT). Prior to joining Brookdale, Jean was the founding Director of the Guardianship Project at the Vera Institute of Justice. A model program that provides high quality Article 81 guardianship services for incapacitated elderly New Yorkers regardless of their ability to pay for services. In 1998-99 Jean served as a White House Fellow with Secretary of Health and Human Services Donna E. Shalala. Earlier in her career as a staff attorney for the Legal Aid Society, Jean represented elderly and homebound New Yorkers in areas such as housing, health care, home care, consumer law, financial exploitation and entitlements. A graduate of New York University, Jean received her law degree from Rutgers University and her Masters in Social Work from the Hunter College School of Social Work.

RICKER HAMILTON is Deputy Commissioner of Programs for the Maine Department of Health and Human Services. He oversees programs and services in the Offices of Aging and Disability Services, Child and Family Services, Multicultural Affairs, Substance Abuse and Mental Health Services, Violence Prevention (Domestic Violence and Sexual Assault Services); and Maine's two psychiatric hospitals, Dorothea Dix Psychiatric Center and Riverview Psychiatric Center. He has over three decades of experience in social work specializing in adult protective services and services for adults, older persons and person with disabilities. Mr. Hamilton was founder of the Maine Elder Death Analysis Review Team. He has served on various Boards including the Elder Abuse Institute of Maine, the Attorney General’s Elder Fraud Task Force and the Maine Medical Center Clinical Ethics Committee. Mr. Hamilton is an Instructor at the Maine Criminal Justice Academy and has served as an Advisory Board member for the Community Counseling Center, Elder Advisory Council; the American Bar Association’s Elder Abuse Project; curriculum advisor and trainer for the FBI and is a guest lecturer for the Department of Justice, Office on Violence Against Women; National Clearinghouse on Abuse in Later Life; National Institute on the Prosecution of Elder Abuse; and the Federal Law Enforcement Training Center. Mr. Hamilton has a B.A. degree from St. Anselm College, M.S.W. degree from Boston College Graduate School of Social Work and Certified by the Maine Criminal Justice Academy as a Reserve Law Enforcement Officer.

BRUCE ROSS has over 40 years’ experience litigating trust, estate, and conservatorship matters and is the chair of Holland and Knight's national Private Wealth Services Dispute Resolution Team. Mr. Ross is a Certified Specialist in Estate Planning, Trust and Probate Law (California Board of Legal Specialization). He is a past president and regent emeritus of the American College of Trust and Estate Counsel. Mr. Ross and colleagues successfully negotiated a $2.8 million judgment on behalf of Hollywood legend Mickey Rooney and his court-appointed conservator in an elder abuse lawsuit against a Rooney family member. The lawsuit alleged that the family member and his wife had financially and verbally abused Rooney for more than 10 years, leaving the famed entertainer powerless over his assets and personal life. Mr. Ross is a consultant to and expert witness for plaintiffs and defense attorneys, accountants, and malpractice insurance carriers in the areas of estate planning, probate, fiduciary litigation, and professional responsibility.
HON. KATHERINE TENNYSON is a Circuit Court Judge in Multnomah County, Oregon. Judge Tennyson is a member of the Family Law Department, which is a unified family court. Since July 2002, Judge Tennyson’s docket has included cases involving probate and protective proceedings, dissolution, custody, parenting time, support enforcement, domestic violence, juvenile delinquency and dependency and termination of parental rights. Judge Tennyson became the Chief Probate Judge for the county in January 2007. Judge Tennyson is the Secretary of the National Council of Juvenile and Family Court Judges. Prior to her election as Secretary, Judge Tennyson chaired the Family Violence and Domestic Relations Advisory Committee for the Council for three years. Judge Tennyson has served as faculty for NCJFCJ national judicial training including the Child Abuse and Neglect Institute, Enhancing Judicial Skills in Elder Abuse Cases and the Institute for New Family Law Judges. She is a 1981 graduate of Duke University and a 1984 graduate of Lewis and Clark College Law School and was admitted to practice law in both Oregon and Washington in 1984.

CAROLE WORTHINGTON is a solo practitioner in Knoxville, Tennessee, with nearly 30 years’ experience in estate planning and administration, non-profit organizations, real estate, equine and elder law. She earned her J.D. and B.S. with honors at the University of Tennessee where she was a member of the Tennessee Law Review. She has served as Chair of the Alumni Advisory Council of the U.T. College of Law and as a member of the Dean’s Circle. Ms. Worthington has served as a member of the Board of Governors of the Tennessee Bar Association, President of the Chattanooga Bar Association, and on committees for the American, Tennessee, Knoxville and Chattanooga Bar Associations. She served on the TYLC Commission on Women and Minorities. Nationally, Ms. Worthington was selected as President of the National Conference of Bar Presidents and has been selected to sit on the National Conference of Bar Presidents Nominating Committee which will meet to recommend five Executive Council members and the future President of the NCBP. She has been elected to three terms as a national Delegate-at-Large to the American Bar Association House of Delegates and has served on committees and commissions of the American Bar Association and House of Delegates. Her current memberships include the American Conference of Bar Presidents, the American and Tennessee Bar Foundations, and the American, Tennessee, and the Chattanooga and Knoxville Bar Associations.

Upcoming Commission Webinar

VA Pension: Income Security for Veterans and Their Family

- Register and learn more at: http://bit.ly/1IGENlC
- November 17, 2015
- This webinar will cover eligibility of veterans and their dependents for VA pension.

Panelists will discuss how to get the best results for a client looking to obtain a VA pension. Practical pointers on obtaining the highest amount for pension will be discussed, as well as how a client can keep that amount each year. Practice tips on dealing with a VA debt—due to an overpayment issue related to a VA pension—will also be provided. This presentation will give practitioners an understanding of the law and provide practical tips on how to work within the confines of the VA.
Top Ten Myths and Facts About Health Care Advance Directives
by Charles P. Sabatino

Last refreshed in 2011, this resource from our Director was in need of an update. You’ll find below a current version of this informative article.

Terms to Know

• **Advance Care Planning** – A process for setting goals and plans with respect to medical care and treatments. It requires conversations between the individual and his or her family, key health care providers, and anyone else who may be involved in decision-making. It can begin at any point in a person’s life, regardless of his or her current health state and, ideally, is documented in an advance directive or recorded in your medical record, revisited periodically, and becomes more specific as your health status changes.

• **Health Care Advance Directive** – The general term for any document in which you provide instructions about your health care wishes or appoint someone to make medical treatment decisions for you when you are no longer able to make them for yourself. Living wills and durable powers of attorney for health care are both types of health care advance directives.

• **Living Will** – A type of advance directive in which you state your wishes about care and treatment you want or don’t want if you are no longer able to speak for yourself. Normally, living wills address one’s preferences about end-of-life medical treatments, but they can also communicate your wishes, values, or goals about any other aspect of your care and treatment.

• **Durable Power of Attorney for Health Care (or Health Care Proxy)** – A type of advance directive in which you appoint someone else to make all medical treatment decisions for you if you cannot make them for yourself. The person you name is called your agent, proxy, representative, or surrogate. You can also include instructions or guidelines for decision-making.

• **POLST/MOLST/POST** – “Physician Orders for Life-Sustaining Treatment” (also referred to by other terms, such as “Medical Orders for Life-Sustaining Treatment” or “Provider Orders for Scope of Treatment”). A set of medical orders in standardized format that addresses key critical care decisions consistent with the patient’s goals of care and results from a clinical process, designed to facilitate shared, informed medical decision making and communication between health care professionals and patients with advanced, progressive illness or frailty.
<table>
<thead>
<tr>
<th>Myth 1</th>
<th>You must have a living will to stop treatment near the end of life.</th>
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<tr>
<td><strong>False.</strong> Treatment that is no longer helping can be stopped without a living will. Physicians will generally consult with your health care agent or close family when you cannot speak for yourself. The goal is to make the decision you would make if you had the capacity to speak for yourself. However, having an advance directive can make the right decision easier and help avoid family disputes.</td>
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<tr>
<td>• The durable power of attorney for health care is the more useful and versatile advance directive, because it applies to all health care decisions and empowers the person you name to make decisions for you in the way you want them made.</td>
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<td>• Two-thirds of all adults have no living will or other advance directive.</td>
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<th>Myth 2</th>
<th>You have to use your state's statutory form for your advance directive to be valid.</th>
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<td><strong>False.</strong> Most states do not require a particular form, but they do have witnessing requirements or other special signing formalities that should be followed.</td>
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<tr>
<td>• Even if your state requires a specific form, doctors have a legal obligation to respect your clearly communicated treatment wishes in any manner or form expressed, as long as the wishes are medically appropriate.</td>
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<td>• Most official state forms are either worded too generally or include multiple choice options that may not adequately address the complex clinical circumstances you face in the future.</td>
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<tr>
<td>• The critical task in advance care planning is to clarify your values, goals, and wishes that you want others to follow if they must make decisions for you, rather than trying to address every possible medical treatment. Workbooks such as The Tool Kit for Health Care Advance Planning can help you: <a href="http://www.ambar.org/agingtoolkit">www.ambar.org/agingtoolkit</a>.</td>
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<th>Myth 3</th>
<th>Advance directives are legally binding, so doctors have to follow them.</th>
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<tr>
<td><strong>False.</strong> Advance directives are legally recognized documents and doctors must respect your known wishes, but doctors can always refuse to comply with your wishes if they have an objection of conscience or consider your wishes medically inappropriate. Then, they have an obligation to help transfer you to another health care provider who will comply.</td>
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<tr>
<td>• Advance directive laws give doctors and others immunity if they follow your valid advance directive. This is the “carrot” the law provides to them.</td>
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<tr>
<td>• The only reliable strategy is to discuss your values and wishes with your health care providers ahead of time, to make sure they are clear about what you want, are willing to support your wishes, and they document your wishes.</td>
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### Myth 4

**An advance directive means “Do not treat.”**

**False.** No one should ever presume it simply means “Do not treat.” An advance directive can express both what you want and what you don’t want.

- Even if you do not want further curative treatment, you should always be given “palliative care” which is care and treatment to keep you pain free and comfortable by addressing your medical, emotional, social, and spiritual needs.

### Myth 5

**If I name a health care proxy, I give up the right to make my own decisions.**

**False.** Naming a health care agent proxy does not take away any of your authority. You always have the right, while you are still competent, to override the decision of your proxy or revoke the directive.

- If you do not name a proxy or agent, the likelihood of needing a court-appointed guardian grows greater, especially if there is disagreement regarding your treatment among your family or between family and doctors.
- Choosing a health care proxy is the most important decision you will make. It should be someone who knows you very well, with whom you have discussed your values, goals, and preferences, and who is capable of handling the decision-making responsibility as your spokesperson and advocate.

### Myth 6

**I should wait until I am sure about what I want before signing an advance directive.**

**False.** Most of us have some uncertainty or ambivalence about what we would want, and our goals of care change over time. A young adult may not be ready to contemplate end of life but that individual can think about and appoint a health care agent in case of serious accident or illness.

- As one matures and faces new health conditions and family experiences, values, goals and priorities change and need to be communicated to your agent and family, and they may lead to a decision to name a new agent.
- When one enters a stage of advanced illness, goals of care change again and as end of life approaches, greater specificity about what one wants or doesn’t want becomes a greater focus of advance planning.

### Myth 7

**Just talking to my doctor and family about what I want is not legally effective.**

**False.** Meaningful discussion with your doctor and family is actually the most important step.

- The question of what is “legally effective” is misleading, because even a legally effective document does not automatically carry out your wishes.
- The best strategy is to combine talking and documenting. Use a good health decisions workbook or guide to help you clarify your wishes; talk with your physician, health care agent, and family about your wishes; put those wishes in writing in an advance directive; and make sure everyone has a copy.
Myth 8  Once I give my doctor a signed copy of my directive, my task is done!

**False.** You have just started.

- First, make sure your doctor understands and supports your wishes, and you understand your health state, likely futures, and options.
- Second, there is no guarantee that your directive will follow you in your medical record, especially if you are transferred from one facility to another. You or your proxy should always double-check to be sure your providers are aware of your directive and have a copy.
- Advance planning is an ongoing, evolving process. Review your wishes whenever any of the Five D’s occur: (1) you reach a new **decade** in age; (2) you experience the **death** of a loved one; (3) you **divorce**; (4) you are given a **diagnosis** of a significant medical condition; (5) you suffer a **decline** in your medical condition or functioning.

Myth 9  If I am living at home and my advance directive says I don’t want to be resuscitated, EMS will not resuscitate me if I go into cardiac arrest.

**Usually False.** Your advance directive will usually not help in this situation. If someone dials 911, EMS must attempt to resuscitate you and transport you to a hospital, UNLESS you have an out-of-hospital Do-Not-Resuscitate (DNR) Order.

- A majority of states have now incorporated instructions about whether or not to attempt resuscitation in a special set of portable medical orders called POLST, MOLST, or similar name. See the definition at the beginning.
- In states with POLST programs, health care providers should initiate discussions of goals of care and care options with patients facing advanced, progressive illness or frailty.
  - They should then offer to translate those wishes into a set of medical orders (i.e., POLST) addressing key critical care decisions the patient is most likely to face, such as resuscitation, hospitalization, and artificial nutrition and hydration.
  - Your health care providers are then obligated to make sure these portable orders travel with you across care setting and are regularly reviewed to ensure they conform to your wishes.

Myth 10  Advance directives are only for old people.

**False.** It is true that more older, rather than younger, people use advance directives, but every adult needs one.

- Younger adults actually have more at stake, because, if stricken by serious disease or accident, medical technology may keep them alive in a vegetative state for decades. Young adults should at least appoint a proxy decision-maker.

*Charles P. Sabatino is the Director of the ABA Commission on Law and Aging in Washington, DC.*
You are a physician in a busy urban hospital when a 95-year-old man arrives in the emergency room, non-responsive, after collapsing at home. You need to make a decision about his code status. While no medical records have accompanied him, soon his two daughters arrive. You determine from talking with them that there is no guardian and no advance directive—and also that one daughter favors a do not resuscitate order and the other daughter opposes it.

Rising Role of Surrogates in Medical Decisions

Scenarios like this are increasing in frequency. Converging demographic trends increasingly make the question of who decides if the patient cannot central to medical practice. The boomers are aging; the “old old” population is swelling; the number of Americans with Alzheimer’s disease is markedly escalating; the number of people with intellectual disabilities living into old age is rising; and a significant number of individuals each year suffer a traumatic brain injury. A recent landmark study by the Institute of Medicine found that:

Most people nearing the end of life are not physically, mentally, or cognitively able to make their own decisions about care. Approximately 40 percent of adult medical inpatients, 44-69 percent of nursing home residents, and 70 percent of older adults facing treatment decisions are incapable of making those decisions themselves.¹

Moreover, increasingly older patients in need of decisions about end of life care will be seen by physicians who do not know them. Hospital medicine is an emergent medical specialty dedicated to the delivery of comprehensive medical care to hospitalized patients. Hospitalists are on the front line every day. They work under pressure—sometimes with incomplete records or delayed records, and little or no knowledge of a patient’s background. They frequently encounter incapacitated patients with no advance directive or guardian, sometimes with discord among relatives or no apparent relatives, and must determine quickly how a decision is to be made. Hospitalists have no pre-existing relationship with the patient or family—thus increasing the challenge of identifying a surrogate who knows about the patient’s wishes.

In situations in which the patient is not able to give informed consent for treatment, and there is no guardian and no advance directive, some 44 states² have “default surrogate consent laws”—formerly commonly known as “family consent laws.” These laws generally provide a hierarchy of authorized family decision-makers who in descending order starting with the spouse can make medical treatment decisions on someone’s behalf. Over 20 of these statutes now specify that a “close friend” familiar with the person’s values can make the decision if none of the listed family members exist or are available—and approximately 11 states have developed a mechanism for “unbefriended” patients, usually involving choices by designated physicians often in conjunction with other physicians or ethics committees.

Because less than 30% of Americans have an advance directive in place,3 these surrogate consent laws cover the vast majority of decisions for patients unable to give informed consent. Indeed, “default surrogates are the most numerous type of surrogate. Therefore, the sequence and manner in which they are designated . . . has great significance.”4 Yet there has been no research on their use and implementation. For example, it would be important to know how often the need for surrogate decision-making in the medical context occurs; whether physicians look to the state law in determining who is to make choices; and whether hospitals have policies aligned with the surrogate laws.

ABA Commission Focus Group

Because questions about surrogate decisions are so grave and the existing knowledge so scant, in the Spring of 2015, the ABA Commission on Law and Aging conducted a focus group of physicians at the March meeting of the Society of Hospital Medicine. The group included 22 hospitalists from 13 states, with a medical experience range of from five to 32 years. While small and not conclusive for research purposes, the focus group began to shed light on how the laws are perceived and used on the ground in hospital settings (although other clinicians may have different perspectives).

We asked the physicians how frequently they face situations in which there is no guardian and no advance directive, and there is a need for a decision by family members. They reported a range of frequency from “four or five times a year” to “several times a week.” Of those who gave specific numbers, the average was 40 times in the past year. For cases in which there was no family but a close friend, the average was 28 times per year. For cases in which surrogates are in conflict over treatment, the average was 21 times in the past year. For “unbefriended” cases, the average was 12 times in the past year.

Concerning unbefriended patients, some of the focus group attendees pointed out that performing a due diligence search for contacts often results in finding someone who knows the person, however attenuated.

A majority of physicians, but not all, said they were aware of a state law on surrogate decision-makers. Interestingly, the responses did not always correlate with the actual state statute. Less than half the physicians in the group were fully knowledgeable about their state provisions. Additionally, 12 participants said they were aware of a hospital policy that would affect their identification of a surrogate decision-maker.

We asked the physicians to name the two top medical treatment decisions in which issues of surrogacy come up. By far, the top issue was life sustaining treatment decisions, followed by code status decisions, surgery and discharge.

Perhaps most interesting was the perspective of the hospitalists on the decision-making process. During the focus group, many stated that the process to identify the patient’s values and preferences was more important than the legal identification of the proper decision-maker. Participants talked about initiating family meetings, bringing all parties together to make a decision, and being guided by what people who know the patient best think he or she would want. Many indicated they wanted to find the decision that most closely approximates what the person would choose (i.e., “substituted judgment”5). In other words, getting the decision right (i.e., what the patient would have wanted) was more important than identifying the right

Because questions about surrogate decisions are so grave and the existing knowledge so scant, in the Spring of 2015, the ABA Commission on Law and Aging conducted a focus group of physicians at the March meeting of the Society of Hospital Medicine.

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surrogate under state surrogacy laws. Here is what they said about how surrogate decisions are made on the hospital floor:

- “You find out who [the patient is] closest to, even outside the borders of law, and ask that person what do you think their wishes would be.”
- “We ask who she would want to speak on her behalf, and then we accept that, if they are willing to perform that role.”
- “In conflict, you’re in a tough spot, but almost always you try to get the family to agree.”
- “If there is a conflict, you bring as many people in so when the people leave they are not upset. People are emotionally invested. You can’t throw laws at someone and say ‘the law says you are the decision-maker.’”
- “Get all the siblings in a room and focus on what would be his or her decision. Often it takes multiple family meetings. When they’re together, it’s easier.”

The focus group results thus call into question whether the 44 state surrogate consent laws on the books have any substantial association with real life hospital practices—and also suggest that the surrogate issue will continue to arise with compelling frequency.

Moreover, the group’s discussion alluded to but did not directly explore related issues of surrogacy. To what extent do the surrogates named by law or selected by the physicians accurately reflect the values of the patient? What hospital practices encourage and support involvement of the surrogates? To what extent do the physicians and hospital staff take action to support the patient so perhaps the patient could make his or her own decisions rather than or in conjunction with the surrogates.

Finally, what guidance is available to surrogates to perform their often anguishing role? As to guidance for surrogates, see the ABA Commission’s booklet on *Making Medical Decisions for Someone Else* (available on the Commission’s Health Care Decision-Making website at http://ambar.org/healthdecisions), and consider adapting this guide for your state.

**Erica Wood is the Assistant Director of the ABA Commission on Law and Aging in Washington, DC.**

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**ABA Urges HHS to Strengthen Resident Protections in Proposed Nursing Home Rule**

On September 30, the ABA submitted comments to the Department of Health and Human Services’ Centers for Medicare & Medicaid Services (HHS CMS) urging it to modify its proposed rule establishing new requirements for long-term care facilities. The ABA identified several areas in which the proposed nursing home rule should be strengthened or clarified, including new language supporting residents’ right to vote, encouraging advance care planning, and expressly prohibiting pre-dispute agreements to arbitrate disputes between nursing homes and residents.

Read the comment letter here: http://bit.ly/1OThN76.

**Attorneys Currently Testing New Guardianship Practice Tool**

The Commission is happy to report that it has over 100 volunteer attorneys signed up to help test a new lawyer practice tool. It is called the PRACTICAL tool, and includes a checklist and background resource guide to lead lawyers through practical and legal options less restrictive than guardianship. PRACTICAL is an acronym for nine steps to examine options and explore resources for supported decision-making.

The ABA Commission on Law and Aging is a partner collaborating on this project, along with three other ABA groups – the Section on Real Property, Trust and Estate Law, Commission on Disability Rights, and the Section on Civil Rights and Social Justice.

Learn more at http://ambar.org/guardianship.
Medicaid helps low-income beneficiaries stay home by providing funding for home and community-based services (HCBS). This care is vital but not without flaws. In 2014, the Centers for Medicare & Medicaid Services (CMS) issued new rules on person-centered planning, designed to ensure that the services provided are tailored to individuals' needs plus their goals and preferences. States vary in their implementation of these rules, but even where they are fully in effect, sometimes the important voices of family caregivers are left out of the conversation. This hypothetical scenario, focused on long-term services and supports (LTSS) and compiled from Justice in Aging’s experiences working with advocates on managed care, illustrates some of the issues facing caregivers today.

Christina's Story:
When Managed Care Ignores the Family Caregiver

Christina is a 51-year-old grandmother. Her mother, Maria, is 83 and is receiving care in her home after a stroke that left her partially paralyzed and in a wheelchair. Christina works full time, provides child care for her grandchildren, and also spends several hours a day providing care and companionship for her mother who also receives paid care funded by her Medicaid coverage.

Since her stroke, Maria has struggled with speech issues and hearing loss. When Maria’s managed care organization (MCO) did an assessment of Maria’s needs, they never spoke to Christina. The assessment was done over the telephone and at a time when Christina was at work. Despite her attempts to contact the MCO to make sure they understood all of Maria’s preferences and needs, Christina never has her concerns taken into account.

Maria’s care plan does not include sufficient hours, but when Christina alerts the MCO that some of Maria’s goals are not being met, she is told that hours cannot be added just for her convenience. It is her responsibility to cover any missing care.

Christina starts skipping as much sleep as she can to spend more time with her mother. She asks for a reduction of hours at work, and her employer suggests

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she might need to look for a new job if she cannot be reliable. Exhausted, she turns to her doctor who diagnoses her with anxiety and arrhythmia and places her on medication for both.

**Strengthening LTSS by Supporting Family Caregivers**

Understandably, much of the focus of Medicaid LTSS is on paid caregivers. But most LTSS consumers like Maria rely on family caregivers, usually adult daughters like Christina, to meet many of their service needs.

In 2013, unpaid caregivers provided an estimated 470 billion dollars and 37 billion hours of care.\(^2\) In 2009, the average family caregiver provided nearly 20 hours per week of care for nearly five years.\(^3\)

As a nation, we already rely on family members to make the system work, and that reliance is likely to increase as our population ages. But the current toll on family caregivers is devastating. They often suffer physical, mental, and emotional impacts, lost wages and benefits, job insecurity, and long-term financial insecurity.\(^4\)

These stresses on the caregivers’ time and health, exacerbated by care plans that over-rely on family, can eventually force them to give up the role. This in turn leads to a decline in the available care for loved ones and possible institutionalization.

**Medicaid’s Role in Protecting Family Caregivers**

The person-centered planning rules in the new HCBS regulations raise two important issues for family caregiving: voluntariness and the need for assessments.

**Voluntariness**

Written service plans for Medicaid LTSS should clearly identify all services and supports the consumer will receive on a regular basis and indicate specifically who will provide those services.\(^5\) This includes both paid and unpaid care.

The rules are clear that unpaid care must be voluntary. But this voluntariness is in jeopardy when states reduce paid Medicaid services because of the presumed availability of unpaid care. In practice, some states or managed care plans offset paid Medicaid services—services that reflect needs that have been identified through the assessment process—with unpaid services, without regard to the caregivers’ availability, ability, or willingness. In such states, these allotments are defended with claims that consumers are just requesting paid services for the caregiver’s “convenience.”\(^6\) But a caregiver being coerced into care is not simply “inconvenient,” it is dangerous, antithetical to personal autonomy, and against the rules.

**Caregiver Assessments**

While assessments of need are the norm for LTSS consumers, they commonly leave out the vital voice of family caregivers. Identifying and incorporating the caregivers’ needs into the plan is a necessity whenever unpaid caregivers will be relied upon to implement any elements of the person-centered service plan.\(^7\)

Only one HCBS rule—for 1915(i) State Plan Services—requires caregiver assessments during the planning process.\(^8\) This leaves the bulk of HCBS recipients without this important safeguard. But several states have gone beyond the regulations to include caregiver assessments even where they are not strictly required.

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\(^5\) 42 C.F.R §441.301(c) (1915(c) HCBS waivers); 42 C.F.R. §441.540(b) (1915(k) Community First Choice waivers); 42 C.F.R. §441.725(b) (1915(i) State Plan Services).


\(^7\) For more information on caregiver assessments, see Kathleen Kelly, et al., *Listening to Family Caregivers: The Need to Include Family Caregiver Assessment in Medicaid Home-and Community-Based Service Waiver Programs*, AARP PUBLIC POLICY INSTITUTE (December 2013), available at http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/the-need-to-include-family-caregiver-assessment-medicaid-hcbs-waiver-programs-report-AARP-ppi-ltc.pdf.

\(^8\) 42 C.F.R. § 441.720(a)(4).
For example, Minnesota uses a Caregiver Questionnaire which allows the assessor to understand the informal caregiver’s needs, to inform the planning process, to create back-up plans, and to identify resources that may be available to ease caregiver stressors or better allow caregivers to flourish. The Questionnaire asks about the caregiver’s health, stress levels, employment, supports, and many other aspects of their lives that can impact their ability to provide care. The questionnaire includes follow-up referrals to assistance, if the caregiver is interested.9

Similarly, Tennessee’s managed care contracts require caregiver assessments as part of a certain face-to-face visit intake visits. This includes an overall assessment of the family caregiver’s willingness and ability to contribute effectively to the LTSS consumer’s needs.10

As with voluntariness, caregiver assessments help keep consumers safe with willing, responsible, and capable care. While there is no current national consensus for what a caregiver assessment should include, the author knows of one taskforce that is working with CMS to draft potential guidance for necessary or expected components.

**Supporting Caregivers Going Forward**

Dedicated family caregivers are necessary to keep many in the aging and disability communities in their homes rather than confined in institutional settings. We simply need to do more to give these caregivers the support, information, and protection they need to provide their ever-more-necessary care.

There are several ongoing efforts to support family caregivers at the national level. The Assisting Caregivers Today (ACT) Caucus is a bipartisan, bicameral Congressional caucus focused on elevating family caregiver’s needs.11 The “Recognize, Assist, Include, Support, and Engage (RAISE) Family Caregivers Act” (S. 1719/H.R. 3099) would require the Department of Health and Human Services to develop a national strategy to support family caregivers.

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9 Caregiver Questionnaire: DHS-6914-ENG, MINNESOTA DEPARTMENT OF HUMAN SERVICES, available at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6914-ENG.


Additional clarity in federal guidance, state rules, and MCO contracts will help ensure LTSS consumers and their caregivers are not forced into damaging, unsafe, or uncertain care situations. Family caregivers must be volunteers and should not be the only thing standing between a consumer and institutionalization. Care plans should realistically offer enough paid hours for the health, safety, and security of consumers without the over-reliance on family that exacerbates already difficult situations.

“Convenience” statutes should not be used as a weapon against caregivers to force them to provide more care than they are willing, capable, or comfortable providing. Reducing caregiver concerns to mere convenience is an attempt to belittle and delegitimize them. Caregivers are not Medicaid’s enemy.

For assessments, it is imperative that the caregiver assessment requirement be extended to all HCBS regulations covering all Medicaid consumers, not just 1915(i) State Plan Services consumers. As caregiver assessments are implemented, they should be used to gauge the employment status and other caregiving responsibilities of family caregivers as well as their stress level, health, and need for knowledge or skills training. CMS should provide states with more guidance in doing assessments well. Further, states should not just identify what caregivers need but take positive steps to provide the services and supports necessary to keep caregivers in their vital roles.

As with every Medicaid rule or regulation, the challenge is to make they are implemented in a way that truly benefits LTSS consumers. All HCBS rules are intended to keep consumers in their homes or in the community. The goal of person-centered planning is greater independence and a better quality of life for seniors and people with disabilities and their families.

To accomplish any of these changes, it is time to embrace and celebrate the role of family caregivers as a loving, vital, and heroic choice. Let’s not squander this precious resource. For every hypothetical Christina or Maria, there are millions of real ones, and they need our support.

Justice in Aging is a national nonprofit with a mission of fighting senior poverty through law.

Julie Carter is an Irmas and Health and Aging Policy Fellow whose work focuses on person-centered planning and managed care. This article is the second in a series on the legal and practical realities of person-centered planning.

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12 While the legislation undergirding 1915(i) State Plan Services (42 USC 1396n(i)) includes more references to assessments than the 1915(c) or (k) language (1396n(c) and (k), respectively), the requirement of an explicit caregiver assessment is regulatory rather than legislative. See 79 FR 2985 for CMS discussion of the inclusion of a caregiver assessment provision, available at https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider#p-601.

President George H.W. Bush signed the Americans with Disabilities Act (ADA) into law on July 26, 1990.\(^1\) Fashioned with the Civil Rights Act of 1964\(^2\) as a guide, the ADA provides comprehensive legislation on the equal protection of individuals with disabilities.\(^3\) The purpose of the ADA is to allow the full participation of individuals with disabilities in society through independence in their living arrangements and finances.\(^4\) With this aim, the ADA addresses the four critical topics of employment, state and local government activities, public accommodations, and telecommunications.

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\(^2\) See id. (noting that the Civil Rights Act of 1964 proscribes any discrimination on the basis of race, color, national origin, sex, or religion).

\(^3\) The ADA defines a disability as “a physical or mental impairment that substantially limits one or more major life activities . . . [and] a record of such an impairment.” 42 U.S.C.A. § 12102 (2008). The ADA has included “caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working” as major life activities. *Id.* (clarifying that the impairment of major bodily functions amounted to a major life activity).

\(^4\) See *Americans with Disabilities Act (ADA) 25th Anniversary*, Ctr. for Disease Control and Prevention, http://www.cdc.gov/features/ada-anniversary/ (last updated July 20, 2015) (“The ADA has made a positive difference in the lives of those who have disabilities by providing better access to buildings, transportation, and employment.”).

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Title I addresses employment issues that may arise in cases where an employee has a disability. Generally, Title I prohibits discrimination in the employer’s decision-making process throughout all stages of a potential or actual employee’s position, unless the employer can demonstrate an undue hardship.\(^5\) Similarly, Title II requires all state and local governments to provide individuals with disabilities equal protection in accessing the rights and privileges guaranteed to others in that community, such as public transportation.\(^6\) Title III concentrates on public accommodations (e.g., movie theaters, hotels, and restaurants), and underscores the requirement for accessibility.\(^7\) Lastly, Title IV requires the telecommunication industry to ensure that individuals with disabilities will be able to

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\(^6\) Access to public schools, public transportation, public structures, and public services are all examples of areas where a government must provide equal opportunity. *See id.* (pointing out that governments have an obligation unless an undue hardship is proven or it is proven that the application of equal opportunity would dramatically alter the nature of the governmental right or privilege).

\(^7\) *See id.* (ensuring that equal opportunity may be accomplished, for example, by creating wheelchair ramps).
communicate with others using the most appropriate technology available at the time.  

A 2012 report by the United States Census Bureau found that an estimated 57 million individuals in the United States have a disability. To put that into perspective, 19% of the American population has a disability of some sort that prevents them from enjoying their rights and privileges in the same fashion as Americans without a disability. While the ADA protects individuals with disabilities in the form of equal opportunity legislation, the reality emphasizes that work still needs to be done.

The Census Bureau noted that only 41% of individuals between the ages of 21 and 64, and with a disability, were employed. Conversely, 79% of the individuals in the same age range and with no disabilities had employment. Accordingly, nearly 11% of individuals between the ages of 15 and 64, who have severe disabilities, are subjected to persistent poverty while only about four percent of non-disabled individuals were subjected to the same condition.

The 25th anniversary of the Americans with Disabilities Act should be a day of celebration and a day of reflection. Although the nation has shed light on those it previously kept in its shadow, many still need the warmth of that light. The next 25 years of the ADA must continue the work of the last quarter century and ensure that the promise of the ADA is fulfilled.

Dara Valanejad is a rising second-year law student at American University Washington College of Law in Washington, DC, and was a 2015 summer intern at the ABA Commission on Law and Aging. Mr. Valanejad is currently a junior staff member of the American University Law Review and will be a Writing Fellow with the school’s Legal Rhetoric program this coming year. Prior to attending law school, Mr. Valanejad was an undergraduate at San Francisco State University, where he graduated cum laude with a B.A. in Philosophy and B.A. in History.

Update on Fair Labor Standards Act (FLSA) Home Care Rule

On October 6, 2015, Chief Justice John Roberts of the US Supreme Court denied an emergency request to stay the effective date of the Fair Labor Standards Act (FLSA) Home Care Rule.

The Home Care Rule will therefore go into effect as scheduled, with enforcement dates as follows:

- October 13, 2015: The Home Care Rule takes effect, although the Department of Labor (DOL) enforcement will not begin for another month. However, workers could still pursue private litigation for back wages owed for time worked on and after October 13.
- November 13, 2015: DOL begins "selective enforcement" of the Home Care Rule. From November 13 until December 31, 2015, DOL will exercise prosecutorial discretion in determining whether to bring enforcement actions. An entity’s good faith efforts to come into compliance will factor strongly into DOL’s decision to prosecute or not. Entities who have made little or no good faith effort to comply with the Home Care Rule are at highest risk of prosecution by DOL during this time period.
- January 1, 2016: Full enforcement of the Home Care Rule begins.

On October 30, 2105, the Centers for Medicare and Medicaid Services (CMS) released its final physician fee schedule for 2016 [CMS-1631-FC], approving two reimbursement codes for advanced care planning (ACP). While the rule is final and effective January 1, CMS invites further comments on the rule by December 29, 2015.

Below is a summary of the details of the rule, paraphrasing CMS’s explanation of what the rule means in practice and its responses to several issues that were raised in some 725 public comments they received during the comment period.

1. New Codes
   - CPT code 99497 (Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate);
   - An add-on CPT code 99498 (Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; each additional 30 minutes (List separately in addition to code for primary procedure)).

The services could be paid on the same day or a different day as other evaluation and management (E/M) services. Physicians’ services are covered and paid by Medicare would be reported when the described service is reasonable and necessary for the diagnosis or treatment of illness or injury.

2. Valuation
   - We believe the recommendation of the American Medical Association/Specialty Society Relative Value Update Committee (RUC) accurately reflects the resource costs involved in furnishing the services described by CPT codes 99497 and 99498, and therefore, are finalizing our proposal to adopt the RUC-recommended values for both codes.
   - [NOTE: Our understanding of the above is that this means CMS proposes a payment of approximately $86 for the initial consultation.

Summary of Center for Medicare and Medicaid Services (CMS) Rule for Covering Cost of Advance Care Planning Services

by Charles P. Sabatino
(code 99497) and $75 for any 30-minute add-on conversation (code 99498). The relative value units (RVUs) for these codes are estimated at 1.5 and 1.4, respectively. RVUs are a measure of value used to calculate Medicare reimbursement for physician services in various settings.]

3. **No National Coverage Decision**  
   (which would avoid any local variation in coverage)

   - We believe it may be advantageous to allow time for implementation and experience with ACP services. Third party contractors (i.e., the insurance companies who handle payment for Medicare) can use their discretion to determine the utilization of these codes. By including ACP services as an optional element of the Annual Wellness Visit (AWV), for both the first visit and subsequent visits, this rule creates an annual opportunity for beneficiaries to access ACP services should they elect to do so.

4. **Cost Sharing**

   - When a beneficiary elects to receive ACP services, we encourage practitioners to notify the beneficiary that Part B cost sharing will apply as it does for other physicians’ services (except when ACP is furnished as part of the AWV). We plan to monitor utilization of the new CPT codes over time to ensure that they are used appropriately.

5. **Intersection with Other Services**

   Whether and how the ACP codes could be billed in conjunction with evaluation and management (E/M) visits or services that span a given time period, such as 10- or 90-day global codes or Transitional Care Management (TCM) and Chronic Care Management (CCM) services.

   - In this case, CPT instructs that CPT codes 99497 and 99498 may be billed on the same day or a different day as other E/M services, and during the same service period as TCM or CCM services and within global surgical periods. We are also adopting the CPT guidance prohibiting the reporting of CPT codes 99497 and 99498 on the same date of service as certain critical care services including neonatal and pediatric critical care.

6. **Who Can Furnish**

   - We note that the CPT code descriptors describe the services as furnished by physicians or other qualified health professionals, which for Medicare purposes is consistent with allowing these codes to be billed by the physicians and non-physician practitioners (NPPs) whose scope of practice and Medicare benefit category include the services described by the CPT codes and who are authorized to independently bill Medicare for those services.

   - We expect the billing physician or NPP to manage, **participate and meaningfully contribute to the provision of the services, in addition to providing a minimum of direct supervision.** We also note that the usual PFS payment rules regarding “incident to” services apply, so that all applicable state law and scope of practice requirements must be met in order to bill ACP services.

   - We do not believe it would be appropriate to create an exception to allow these services to be furnished incident to a physician or NPP’s professional services under less than direct supervision because the billing practitioner must participate and meaningfully contribute to the provision of these face-to-face services.

7. **Settings of Care**

   - We agree with commenters that ACP services are appropriately furnished in a variety of settings, depending on the condition of the patient. These codes will be separately payable to the billing physician or practitioner in both facility and non-facility settings and are not limited to particular physician specialties.

8. **Payment for ACP Along the Entire Health Continuum**

   - We are adding ACP as a **voluntary, separately payable element of the AWV.** We are instructing that when ACP is furnished as an optional element of AWV as part of the same visit with the same date of service, CPT codes 99497 and 99498 should be reported and will be payable in full in addition to payment that is made for the AWV. Under these circumstances, ACP should be reported with modifier -33 and there will be no Part B coinsurance or deductible, consistent with the AWV.
9. **How it Applies to Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) that Furnish Medicare Part B Services**
(since they are paid in accordance with the RHC all-inclusive rate system or the FQHC prospective payment system)

- Beginning on January 1, 2016, ACP will be a stand-alone billable visit in a RHC or FQHC, when furnished by a RHC or FQHC practitioner and all other program requirements are met.

10. **Standards/Training**

- We will continue to consider whether additional standards, special training or quality measures may be appropriate in the future as a condition of Medicare payment for ACP services.

11. **Telehealth**

- We note that we did not propose to add ACP services to the list of Medicare telehealth services, so the face-to-face services described by the codes need to be furnished in-person in order to be reported to Medicare.

12. **Potential for Bias**
(i.e., against choosing treatment options involving living with disability, requiring physicians to discuss questionable treatment options (such as physician assisted suicide or other patient choices that might violate individual physician ethics) and similar issues.)

- We believe the services described by the new codes are appropriately provided by physicians or using a team-based approach where ACP is provided by physicians, NPPs, and other staff under the order and medical management of the treating physician. Since the ACP services are by definition voluntary, we believe Medicare beneficiaries should be given a clear opportunity to decline to receive them. We note that beneficiaries may receive assistance for completing legal documents from other non-clinical assisters outside the scope of the Medicare program. Nothing in this final rule with comment period prohibits beneficiaries from seeking independent counseling from other individuals outside the Medicare program—either in addition to, or separately from, their physician or NPP.

13. **Beneficiary Considerations**

Several commenters suggested that CMS pursue waivers of cost sharing for ACP services or that cost sharing should vary by the condition of the patient.

- We lack statutory authority to waive beneficiary cost sharing for ACP services generally because they are not preventive services assigned a grade of A or B by the United States Preventive Services Task Force (USPSTF); nor may CMS vary cost sharing according to the patient’s diagnosis. Under current law, the Part B cost sharing (deductible and coinsurance) will be waived when ACP is provided as part of the AWV, but we lack authority to waive cost sharing in other circumstances.

**American Bar Association Policy**

Related Commission-supported policy is online at: [http://www.americanbar.org/groups/law_aging/policy.html](http://www.americanbar.org/groups/law_aging/policy.html).

- **Advanced Care, February 2015, 100**
  Urges federal, state, local, territorial, and tribal governments to enact legislation and regulation that will promote six enumerated components in the provision of care to persons with advanced illness.

- **Medical Decision-Making, August 2012, 106A**
  Amendments to the Patient Self Determination Act, calling for strengthening advance care planning rights and procedures for health care decisions.

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*Charles P. Sabatino is the Director of the ABA Commission on Law and Aging in Washington, DC.*
Helping Financial Caregivers in Every State
by Naomi Karp

Millions of Americans are managing money or property for a family member or friend who is unable to pay bills or make financial decisions. We’ve heard from these financial caregivers about how tough it can be.

Kristin in Virginia had to take over financial management for her 35-year-old brother when he suffered a traumatic brain injury in a devastating car wreck. “Taking over financial caregiving for my brother was especially challenging when coupled with the physical and emotional trauma of his accident. Even though I’m a financially savvy individual, I had no idea where to get help…. Unfortunately, there was no guide, no checklist, or a book of best practices to refer to.”

In Florida, Hector stepped in to help his elderly mother after a niece stole nearly $100,000 from her. Despite his own severe disability, he works every day to make sure her nursing home bills are paid and her accounts are in order. “When you have to take care of someone else’s finances, you feel more responsible for their affairs than you do for your own. It’s overwhelming.”

Managing Someone Else’s Money

We listened to consumers about the need for easy-to-understand tools to help manage a loved one’s money. Two years ago we released the Managing Someone Else’s Money guides for financial caregivers all over the country, and we’ve distributed over 600,000 printed copies so far. The guides are for:

- Agents under a power of attorney
- Court-appointed guardians of property and conservators
- Trustees
- Government-benefit fiduciaries (Social Security representative payees and VA fiduciaries).

The guides help financial caregivers in three ways: they walk them through their duties, they tell them about protecting their loved ones from financial exploitation and scams, and they tell them where to go for help.

But, because people’s powers and duties overseeing another person’s finances vary from state to state, we’ve learned that people need more than a one-size-fits-all guide. That’s why we are releasing specially adapted guides for six states. We’ve already launched guides for Florida and Virginia, and soon will release guides to help financial caregivers in Arizona, Georgia, Illinois and Oregon.

But, what about the other 44 states and the territories?

On October 19th, 2015, we released new tools to help experts in other states adapt the CFPB’s guides. These tips and templates are meant for key state professionals to develop guides for states that don’t have them. (If you are wondering who a key state professional is, check out tip 2, in the tips document.) Our tips and templates will make it easy for experts to create state guides with specific information that financial caregivers need to know. The tips tool explains how to
adapt the guides in ten easy steps. The templates highlight the parts of our guides where experts can add information about your state’s laws, practices and resources.

The tips and templates are available for download on http://consumerfinance.gov/managing-someone-elses-money. If you would like free print copies of the tips document, you can order single copies or place bulk orders.

Let’s work together to meet the needs of people like Kristin and Hector in your community.

Naomi Karp is Senior Policy Analyst at the Office for Older Americans of the Consumer Financial Protection Bureau.

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• Elder abuse, neglect, and exploitation
• Mental capacity, aging, and surrogate decision-making
• Health care decision-making and advance directives
• Medicare, Medicaid, and long-term care
• Elder Law and the delivery of legal assistance to older persons

Contact the Division for Media Relations and Communication Services for expert contacts at abanews@americanbar.org or (202) 662-1090.
Each year, public service employers report difficulty in recruiting and retaining talented staff, leaving many Americans without critically needed services. According to the Bureau of Labor Statistics, despite steady growth in private sector employment figures, there are still 500,000 fewer public sector positions than before the recession, and the U.S. population relying on such services has grown.

The public sector includes a broad range of occupations, including first responders, teachers, health professionals, and lawyers. For example, prosecutors and public defenders promote public safety and the administration of justice. Legal aid lawyers and others at nonprofits help low-income elderly, veterans, and families remain stably housed, employed, and receiving due benefits and services, whether they live in urban or rural communities, including on tribal lands.

The reasons for the difficulty in recruiting and retaining these professionals can be complex, but the greatest common obstacle in the legal community has been the substantial student debt that borrowers incur to pursue a law degree. In 2014, the average law student graduating from a private law school accumulated $122,000 in student loan debt, and the average public law school graduate had accumulated $84,000. This does not include an average of $30,000 in student debt for undergraduate studies. By contrast, according to a 2014 survey by the National Association for Law Placement, the starting salary for a legal aid lawyer was $44,600, and for prosecutors and public defenders, starting salaries for each were approximately $50,000.

In 2007, Congress bolstered the public sector by creating the Public Service Loan Forgiveness program (PSLF). Under PSLF, those who make 120 monthly payments on their federal loans while employed full-time in qualified public service jobs are eligible to have their remaining balance forgiven. Congress is on the verge of eliminating the program.
tie monthly repayment obligations to a percentage of actual income, PSLF provides a critical tool for employers to fill necessary positions with motivated persons who make a lasting commitment.

Congress, however, has recently enrolled a budget resolution for FY2016 that calls for the repeal of PSLF. This proposal comes without hard data or any assessment of the projected impact that repeal would have on an already-lagging public sector. Repeal would return the country to where we were prior to 2007—circumstances sufficiently challenging as to warrant the creation of PSLF.

The American Bar Association urges Congress to preserve the federal Public Service Loan Forgiveness Program.

• Repeal of PSLF will undermine a vital source of support to state and local communities and leave many American people vulnerable at times of crisis.

• PSLF helps fill laudable public service jobs in every state and territory amid lagging employment in the public sector and increasing public need.

• Restricting or eliminating PSLF will harm rural, tribal or other under-resourced communities where recruitment and retention are the most difficult.

Learn more at: https://www.americanbar.org/advocacy/governmental_legislative_work/loan4giveness.html.

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The mission of the ABA Commission on Law and Aging is to serve as a collaborative, interdisciplinary leader of the Association’s work to strengthen and secure the legal rights, dignity, autonomy, quality of life and quality of care of aging persons.

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