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Medicare, Medicaid, guardianship, elder abuse, legal ethics, consumer law and income security—and the important roles lawyers play regarding them—were highlighted at this year’s National Aging and Law Conference sponsored by the American Bar Association Commission on Law and Aging.

A sold-out audience of 150 law, policy, and legal service development and delivery practitioners from across the country attended 19 workshops and four plenary sessions offering a wide array of programming, with a focus on practical information for front-line law and aging service providers. Among the session subjects were “Using the ADA to Take on the Government: Accessing Essential Benefits and Services for Seniors,” “Gaps, Bumps and Glitches: Smoothing out ACA Transitions to Medicare and Medicaid,” and “After Windsor: How the Demise of DOMA Affects LGBT Seniors.”


"Recent research finds that one in 10 people 60-plus are victims of elder abuse,” said Connolly. “Civil attorneys have a critical role to play in preventing and responding to this serious problem, both on behalf of individual clients and with impact litigation designed to improve the systemic responses.”

Nora Dowd Eisenhower, Assistant Director, Office for Older Americans, addresses the sold-out Conference in Washington, DC.
Other statistics cited by Connolly were that:

- 43 million people care for someone age 50 or older
- 47 percent of those with dementia and cared for at home were abused or neglected
- Two-thirds of elder abuse victims are women (due in part to women’s greater longevity)

“While advocacy has focused on criminal responses to elder abuse, civil attorneys offer extraordinary resources to combat abuse on both the individual and systemic levels,” said Hirschel. “They can educate older adults and families to prevent victimization. If abuse and exploitation occur, they can recover assets, obtain protection, and help clients access the benefits and services they need to regain safety, security, dignity and autonomy. In addition, they can work with multi-disciplinary teams, serve as legal resources for advocates and service providers, and help develop systemic reforms. Elder law attorneys may be the greatest unrecognized resource in the fight against elder abuse.”

One of the slides presented during the Connolly-Hirschel presentation offered their reasons why criminal cases in the elder abuse area are not enough:

- Such cases are pursued after the harm has occurred.
- They punish perpetrators but rarely help victims.
- Criminal cases apply to only a fraction of elder abuse situations.
- Many victims do not want prosecution.
- Such cases do not educate the citizenry about prevention.
- Criminal prosecutions do not help implement protections.

“We are not going to prosecute our way out of this problem. … We are letting our legislatures off easy in criminalizing more acts of elder abuse without any decrease in the activity,” said Connolly.

Also included in the conference programming, held at the AARP headquarters in Washington, D.C., on Oct. 16-17, was a “listening session” for planning the 2015 White House Conference on Aging, featuring the conference’s executive director, Nora Super, and Kathy Greenlee, assistant secretary for aging at the Department of Health and Human Services. Suggestions for conference subjects included obtaining data about guardianships, a legal infrastructure for elder rights, lawyers screening for signs of capacity while doing transactional work, and the needs of LGBT older adults.

The Commission spearheaded organizing and executing the Conference this year, after it was clear that, due to lack of a lead organizer, the long-standing event might not be continued.

The National Aging and Law Conference will return on October 29-30, 2015, to Washington, D.C., with a focus on legal issues impacting low- to moderate-income Americans age 60 and over.

“By doing this work there are tremendous rewards. And I think that’s why most of us became lawyers,” said Hirschel.


Commission Director Charlie Sabatino's article in the Gerontological Society of America’s Public Policy & Aging Report is available for free online. To read Advance Care Planning Tools That Educate, Engage, and Empower, please visit: http://bit.ly/1wCHa1q
2014-2015 Commission on Law and Aging

Each September 1, a new roster of 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, there are four new commissioners. The next page provides a short biography of our new additions; you will find them to be a diverse and highly expert group in their individual disciplines.

The full roster of this year’s Commission is below.

Chair:
Prof. David M. English
University of Missouri
Columbia Law School
Columbia, MO

Commissioners:
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Organization of American States
Washington, DC

Rawle Andrews, Jr.
AARP
Washington, DC

Hon. Patricia Banks
Circuit Court of Cook County
Chicago, IL

Richard Browdie
Benjamin Rose Institute on Aging
Cleveland, OH

XinQi Dong
Rush University Senior Care
Chicago, IL

William E. Hopkins
Husch Blackwell LLP
Austin, TX

Jason Karlawish
Institute on Aging
Philadelphia, PA

Prof. Nina Adams Kohn
Syracuse University College of Law
Syracuse, NY

Keith L. Morris
Elder Law of Michigan
Lansing, MI

Kerry R. Peck
Peck Bloom LLC
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Stephen B. Rosales
Rosales & Rosales LLC
Belmont, MA

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Drinker Biddle & Reath LLP
Milwaukee, WI

Susan P. Shapiro
American Bar Foundation
Chicago, IL

Patricia D. Struck
DFI Division of Securities
Madison, WI

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Madison, WI

Help us continue to improve the lives of older Americans.

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Rawle Andrews Jr. is the regional vice president for AARP’s State and National Group, and a member of the Association’s Enterprise Strategy Leadership Team. His duties include providing leadership and oversight of AARP’s operations and activities in eight states. Previously, Mr. Andrews was the senior state director for AARP in Maryland and, before that, managing attorney of AARP’s Legal Counsel for the Elderly. He was in private practice for 16 years before joining AARP in January 2007.

A frequent lecturer on consumer protection and elder law issues, Mr. Andrews holds adjunct professorships at Georgetown University and Howard University School of Law.

Richard Browdie is President/CEO of the Benjamin Rose Institute on Aging, a nationally recognized leader in service, research, and advocacy addressing issues of aging. Prior to his position with Benjamin Rose, he served as Pennsylvania’s Secretary of Aging from 1995-2002. Mr. Browdie also served as Executive Director of the National Association of Area Agencies on Aging from 1993-1995. Mr. Browdie served as President of the American Society on Aging from 1998-2000. He was elected Chairman of the Board of the National Council on Aging in September 2011. Effective November 2013, he is Chairman of the Generations Editorial Board.

He earned his Bachelor of Arts degree in sociology from Allegheny College, Meadville, Pennsylvania and his Master of Business Administration degree from Gannon University in Erie, Pennsylvania.

Keith Morris is the President of Elder Law of Michigan, a nonprofit charitable organization that promotes and protects the rights, health, and economic well-being of older adults and people with disabilities by providing information, advocacy, legal advice and professional services. Prior to August 2013, Mr. Morris served in various positions of growing responsibility since joining the organization in 2001 as a volunteer while in law school. In 2007, Keith became the Project Director for the Center for Elder Rights Advocacy, which was established to provide technical assistance to senior legal hotlines throughout the nation. Mr. Morris was instrumental in designing and implementing Michigan’s Legal Services Information System, a statewide reporting system for senior legal services. He also worked on the development of senior legal helpline standards for reporting.

Mr. Morris attended Thomas M. Cooley Law School, where he graduated magna cum laude in 2003. He completed his Masters in Public Administration from Western Michigan University, with a focus on non-profit administration, in 2008.

Stephen B. Rosales is the managing member of Rosales & Rosales LLC, a small firm in Belmont, MA, where he runs a general practice concentrating in estate planning, elder law, real estate, probate administration, and litigation.

He is a 1977 graduate of Boston College and earned his JD from Suffolk University Law School in 1980. He has been active for over twenty years in and is the current Chair-Elect of the American Bar Association’s Solo, Small Firm and General Practice Division. Stephen has achieved the prestigious AV rating from Martindale Hubbell and has been named a Massachusetts SuperLawyer by Thomson Reuters.

He resides in Belmont, MA, with his wife Debi, enjoys golf, plays a reasonable guitar, roots for his Boston College Eagles and is a passionate member of Red Sox and Patriot Nations.
The way “Without Regrets: A Nurse’s Advice about Aging and Dying” is organized speaks volumes about the philosophy of the author on the issues of aging and dying. Author and registered nurse (RN) Helen Emmott starts with how families, relationships, family dynamics, and individual values and beliefs should shape care in later life and end-of-life decisions. The book uses a very modern person-centered approach that looks to the individual first, and then at how medicine and law can support the wishes and needs of the person.

Person-centered care focuses on the individual, or their surrogate—informing them of multiple care and treatment options so that they may make choices based on their beliefs and values in consultation with health care professionals. The real shift is in offering more treatment options, including options of not treating and empowering the individual to make their own health choices. The essence of this book is to explore person-centered care from the point of view of the individual and family.

It all starts with a person’s values, Emmott asserts, and throughout the book the author urges her readers to have meaningful discussions about values, hopes, and goals as people age and approach the end of life. The book provides an intimate view of the complex personal and family dynamics that shape decision-making about care in later life and about dying. The issues are richly illustrated by narrative drawn from the author’s decades of personal and professional experience as an RN, medical ethicist, and family caregiver. The book explores selecting a surrogate and empowering intra-family communication.

This is not a book about the medicine or the legal issues of aging and dying. It is about how beliefs, values, and goals should guide the life of an older person. The author explores the tension between honoring the values and wishes of a frail adult and the caregiving capacity and needs of family members and other caregivers.

The book is a worthwhile read for aging professionals seeking a deeper understanding of person-centered care and the interpersonal dynamics of aging and dying. The text is clear and easy to read. The subject is not always easy; there is a lot of discussion of end-of-life issues and dying. The book helps readers to develop understanding and skills that will make us better advocates for our clients, their families, and ourselves.

David M. Godfrey is a Senior Attorney at the ABA Commission on Law and Aging in Washington, DC.
All too often the end of life care wishes of a person in good health differ drastically from those facing a terminal illness. POLST (Physician Ordered Life-Sustaining Treatment) is a highly effective option for conveying the fluidity of one’s end of life care wishes and goals for persons with advanced, progressive illness. The essence of POLST is to translate patients’ goals for end-of-life care in to medical orders that are placed into the patients’ medical records, which is tremendously beneficial.

Advance directives and living wills are necessary legal instruments to convey a person’s wishes in case of illness. POLST is medical instrument that should be used in conjunction with advance care directives and living wills to supplement a patient’s end-of-life care wishes. Although the process varies from jurisdiction to jurisdiction, patients must have a candid and honest conversation with their physician. The fruits of that discussion become a set of medical orders that are then placed into the patients’ medical record. POLST forms are typically revisited whenever the patient’s condition, site of care, or wishes change. POLST program participants have the unique ability to have their most recent wishes elicited, recognized, and honored.

In 2014, two new states—Connecticut and Mississippi—joined twenty other states in codifying regulation of a clinical program based on the POLST paradigm. In Connecticut, MOLST (Medical Orders for Life Sustaining Treatment) allows physicians, advanced practice registered nurses, and physician assistants to sign the MOLST form. In Mississippi, only physicians can sign POST (Physician Orders for Sustaining Treatment) forms. In both states, the patient or the patient’s authorized surrogate must sign the form.

**Connecticut MOLST Summary**

Connecticut enacted legislation (2014 Conn. Legisl. Serv. P.A. No. 14-231) that established a two-year pilot program in two locations, one rural and
one urban. As in other states, participation in the MOLST program is voluntary. Notably, the statute explicitly limits the use of the form to only to individuals who are approaching the end stage of a serious, life-limiting illness or is in a condition of advance, chronic progressive illness.

Medical staff participating in the MOLST program must attend training courses, and clinicians signing MOLST forms must also receive training; this is a mandate missing in most states. The training includes recognizing the significance of discussing with a patient’s personal treatment goals as well as methods for the unbiased outlining of choices for end-of-life care to elicit patient preferences. Additionally, the MOLST program requires that a copy of the form be given to patients and to their surrogates.

The legislature purposefully created a broad statute that defers the details of the form and protocol to the health department, with the assistance of an advisory committee consisting of an array of medical professionals. Participation in the pilot program is voluntary for patients and health care providers. MOLST is transferrable among, and recognized by, various types of health care institutions creating some flexibility for patients, incentivizing their participation. Conversely, the statute does not address provider immunity, which could disincentivize provider participation.

**Mississippi POST Summary**

Mississippi enacted legislation (Miss. Code. Ann. §§ 41 -41 -302 – 303 (2014)) that governs the Physician Orders for Sustaining Treatment (POST) program. The legislation allows emancipated minors, guardians of minors, and adults alike to participate in the program. The legislature specified in unusually great detail the language and elements of the form and procedures. The State Board of Medical Licensure is responsible for creating and approving POST forms. By law, the Board must consult with various professional and advocacy organizations in developing the POST form, including the Mississippi Hospital Association and others.

While there is provider immunity for completing and honoring POST, it does not require that a provider participate in the program stipulating that a provider must not impede the transfer of a patient to another provider or facility willing to implement an order. This statutory limitation could present an unforeseen problem in practice as it applies to enforcing the program.

According to the National POLST Paradigm website at www.POLST.org, twenty-nine states, including Florida, Arizona, and North Dakota are developing programs based on the POSLT paradigm. POLST and other similar programs provide the opportunity for providers to communicate with patients and to clarify their treatment goals and wishes. It is truly a unique opportunity for patients to remain in control of their end-of-life care wishes.

Kelly Richardson is a second-year law student at American University Washington College of Law in Washington, D.C. She is currently an intern at the Commission, researching the statutory implementation of Physician Orders for Life Sustaining Treatment (POLST) programs nationwide.

For more information, please download the updated POLST chart from the Commission's Medical Decision-Making Resources page at: http://ambar.org/healthdecisions.
Decisions
by Surrogates
An Overview
of Surrogate Consent Laws in the United States
by Shana Wynn

The greying of America has become a concern for medical professionals and health care planning advocates. According to current demographic trends, there is a growing aging population and an increase in the prevalence of chronic disease among adults 44 years or older.1 Thus, it is vital that families and physicians engage in meaningful communication regarding a patient’s health care and end-of-life care wishes. However, 27% of Americans say they have thought very little about how they would like medical professionals to handle end-of-life medical decisions. In the absence of advance care directives, most individuals unknowingly rely heavily on their state’s default surrogate consent statutes. These statutes grant a person or particular class of people, usually in kinship priority, the default authority to make health care decisions for a loved one when that loved one loses decisional capacity. This article provides a brief overview of state statutory provisions in the U.S. which directly address health care decision-making on behalf of patients lacking advance directives.

Default Surrogate Consent Statutes
Default surrogate consent statutes were enacted to provide legal authority for health care decision-making through a non-judicial rule of law when no guardian or agent had been appointed. States which have adopted these provisions recognize the importance of alternative means of consent to health care in the absence of advance directives. Instead of forcing families and incapacitated individuals into judicial guardianship proceedings for their failure to execute advance directives, surrogate consent laws allow physicians to consult a designated individual or group of individuals who can presumably convey the incapacitated or incompetent patient’s health care wishes and provide informed consent or refusal to proposed health care interventions. Currently, 44 states have enacted surrogate consent laws.

Generally, two types of surrogate consent laws are recognized: hierarchy surrogate consent laws and consensus surrogate consent laws. In four of the states with surrogate consent laws, the law is only applicable to consent for medical research and certain facility admissions.2 Currently, there are seven states with no surrogate consent laws (Massachusetts, Minnesota, Missouri, Nebraska, New Hampshire,3 Rhode Island, and Vermont). In states that have adopted hierarchy surrogate consent laws, family members and the people closest to the patient by kinship usually become the designated surrogate. In Colorado and Hawaii, consensus statutes require that all reasonably available “interested persons” come to a consensus about who should act as the decision-maker. Most state provisions address four key areas of surrogate decision-making:

a) the priority of surrogates who may legally act in the absence of an appointed agent or guardian with health care powers;

1 Jaya K. Rao et al., Completion of Advance Directives Among U.S. Consumers, 46 NAT’L. J. OF PREVENTIVE MED. 65, 65 (2014) (The data collected from this survey was collected from 2009 and 2010 Porter Novelli Healthstyles surveys. There were a total of 7,946 respondents included in the population-based end-of-life care data).

2 In California, Kansas, New Jersey, and Oklahoma the law only applies to consent for medical research. The surrogate consent statute in Wisconsin only applies to certain facility admissions.

3 New Hampshire enacted a surrogacy law in 2014, effective 1/1/15. The statute is not included in this analysis.
b) limitations on the types of decisions the surrogate is empowered to make;

c) the standards for decision-making; and

d) the process for resolving disputes among equal priority surrogates.

Potential Surrogates and Priority

Statutory provisions addressing who may act as surrogate for decisionally incapacitated adults vary, but a majority of states have adopted hierarchy surrogate consent laws. Under the hierarchy scheme for decision-making, members of the patient’s family fall within a priority list of potential surrogates who may act as surrogate. In most states, the following persons are designated to serve as surrogates, in descending order: the spouse (unless divorced or legally separated); an adult child; a parent; and an adult sibling. Some also include class designations for other adult relatives including: grandchildren; nieces and nephews; and aunts and uncles. Twenty-one go as far as to include virtually any living adult relative.\(^4\)

Currently, about half of states include recognition of authority to persons considered to be a “close friend” of the incapacitated patient, although close friend usually falls at the bottom of the priority list.\(^5\)

Colorado and Hawaii have chosen an alternative to reliance on a priority list by creating a single class of “interested persons.” In Hawaii, “interested persons” includes the patient’s spouse (unless legally separated or estranged), a reciprocal beneficiary,\(^6\) any adult child, either parent of the patient, an adult sibling or adult grandchild of the patient, or any adult who has exhibited special care and concern for the patient and who is familiar with the patient’s personal values.\(^7\)

Fourteen states have enacted provisions for decisionally incapable patients who have no living relative or friend who can be involved in decision-making. Commentators have called this class of patients “unbefriended.”\(^8\) The total unbefriended population includes “persons who are decisionally incapacitated and made up of two main groups: (1) those who had capacity and lost it, including frail elders in nursing homes and hospitals; and (2) those who never had capacity, including persons with mental retardation or developmental disabilities.”\(^9\)

In nine states, attending and primary physicians have been placed on surrogate priority lists for Patients with no family or friend surrogates. These states typically seek to prevent unilateral decision-making by requiring physicians to consult an ethics committee or have the concurrence of a second physician before health care decisions are made for the unbefriended.

Limitations on Decision-Making

To protect against the potential misuse and abuse of incapacitated adults, some states have placed limitations on surrogate decision-making. The District of Columbia has adopted a procedural limitation requiring that at least one witness be present whenever a surrogate grants, refuses, or withdraws consent on behalf of the patient.\(^10\)

About a dozen states permit surrogates to withhold life-sustaining treatment only if the patient has been certified to be in a terminal or permanently unconscious condition. In a few states, special

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\(^4\)There are 21 states and the District of Columbia which list “other adult relatives” as another broad category of decision makers.

\(^5\)Currently, 22 states list “close friend” where relatives are not available to serve as surrogates.

\(^6\)Reciprocal beneficiaries include two adults who are parties to a valid reciprocal beneficiary relationship. Hawaii Rev. Stat. §572-C-4. Under HRS § 572C-3, a valid reciprocal beneficiary relationship is established where: (a) each party is at least eighteen years old; (b) neither party is married, a partner to another reciprocal beneficiary relationship, or a partner in a civil union; (c) the parties are legally prohibited from marrying one another; (d) consent of either party to the relationship has not been obtained by force, duress, or fraud; and (d) each party has signed a declaration of reciprocal beneficiary relationship.


\(^9\)Id. at 15.

\(^10\)DC Code § 21-2210.
conditions apply to the withholding of artificial nutrition and hydration. Ohio goes as far as prohibiting it without a court order.\textsuperscript{11}

\textbf{Standards for Decision-Making}

In a majority of states, surrogates must make decisions in accordance with a substituted judgment standard. Under this approach, the surrogate makes decisions according to the patient’s wishes even if such wishes may not have been expressly conveyed. Instead, with as much accuracy as possible, the surrogate must make an inference based on the patient’s statements and conduct. Where the patient’s values and wishes are unknown, surrogates must take an objective approach in determining the patient’s best interests. The \textit{best interest standard} seeks to implement one’s best interests by reflecting upon the welfare or wellbeing of the individual.\textsuperscript{12}

\textbf{Resolving Disagreement Among Surrogates}

Lastly, most states provide avenues for resolution of differences when equal priority surrogates are unable to reach a consensus regarding health care decisions or when some interested party objects to the process or decision. First, the designation of a hierarchy is the primary strategy states use to avoid disputes, because those lower in the hierarchy cannot overrule the authorized surrogate without resorting to judicial proceedings. The most common provision for dispute resolution among multiple surrogates at the same level of authority (typically adult children) is to allow providers to rely on a majority of the equally authorized surrogates. About 18 states follow that principle, although whether such democratic principles succeed for families under stress in a clinical setting may be in doubt. Currently, 39 states and the District of Columbia expressly address some form of judicial recourse for disagreements. Even without an express provision for resolving disagreements, judicial intervention through the initiation of a guardianship or conservatorship is always available as a possible intervention by any interested party.

\textbf{The Future of Surrogate Consent}

Despite the many statutory improvements and changes in the law, significant challenges remain to be resolved by legislatures and policy makers. Generally, surrogate consent statutes may need further evaluation in three areas: (a) whether specifying a priority order of surrogates can accurately reflect today’s family and cultural diversity; (b) whether surrogate decisions accurately reflect patients’ values and priorities, considering the resources available to support surrogate decision makers; and (c) how to devise more meaningful decision-making processes for unbefriended patients.

\textit{Addressing the Realities of Family and Cultural Diversity}

The hierarchical model of surrogate appointment applied in most states may not appropriately address the needs of patients in non-traditional family settings. Family differences in culture, religious tradition, ethnic and racial background all affect the decision-making process. Decisions may be a group obligation, or may be driven by communitarian concerns rather than individual preferences, or may involve certain mandates or prohibitions relating to ill health and the dying process. Even in traditional family structures, the legal hierarchy may not reflect reality where families are geographically far flung or complicated by divorce and remarriage, or where a friend has become the closest confidant and supporter.

Under the hierarchical model of surrogate appointment, there is very little focus on collaborative decision-making. In contrast, the consensus model expands the decision-making process to include

\textsuperscript{11}Ohio Rev. Code Ann. § 2133.09.

individuals with some personal tie to the patient.\textsuperscript{13} In order to better support surrogates, this model acknowledges that a single person may be ill equipped to make health care decisions for the patient. Instead, collaborative decision-making among family surrogates is employed and the health care facility may provide support to surrogates by providing a consultation by the facility’s ethics committee and input from various members of the patient’s treatment team.

Further, the rigid structure of the priority list also denies legal authority to non-traditional families and persons who may be best suited to make decisions for the patient. Currently, 19 states and the District of Columbia allow same-sex marriage.\textsuperscript{14} In these states, same-sex spouses are given statutory priority to serve as surrogates just as opposite-sex spouses are. As more states with hierarchy surrogate consent laws allow same-sex marriage, and as more same-sex couples marry, same-sex spouses will not be prevented from making health care decisions due to their inferior status on the priority list.

\textit{Providing Greater Support for Surrogate Decision-Makers}

The most difficult issue facing family surrogates is how to understand the unique health care issues and treatment options, and how to make an informed decision that reflects their loved one’s values, goals, and preferences. It is not a familiar role. There is a tremendous need for health care providers to provide more support to family surrogates. Under the hierarchical model of surrogate appointment, there is very little focus on collaborative decision-making. In contrast, the consensus model expands the decision-making process to include individuals with some personal tie to the patient.\textsuperscript{15} This model acknowledges that a single person may be ill equipped to make health care decisions for the patient. Both models are needed to accommodate the cultural diversity of families.

\textit{Dignity driven decision-making} is an important emerging concept. Defined as “a process in which decisions about the patient’s care emerge from a collaborative relationship developed over multiple encounters,” this method also favors patient autonomy and greater support for surrogate decision-makers.\textsuperscript{16}

Further, care featuring dignity-driven decision-making involves balancing medical care with supportive services.\textsuperscript{17} There are limitations surrounding the amount of time and resources individual clinicians can devote to the dignity-driven decision-making process. However, hospitals and health plans using this model have invested in additional resources, such as trained social workers to manage parts of the process.\textsuperscript{18} Undoubtedly, surrogates and patients could benefit greatly from a process that requires a team of clinicians and other staff to work collaboratively throughout the process.

\textit{Meaningful Processes for Unbefriended Patients}

There is a great need to devise respectful and dignified ways to make health care decisions for unbefriended individuals. Although judicial processes such as guardianship proceedings may be available, more timely and respectful non-judicial processes can be more appropriate. Because all patients deserve the same quality of health care treatment, meaningful


\textsuperscript{17}Id.

\textsuperscript{18}Id. at 1273.
processes can help engender a clear focus on the interests and well-being of unbefriended patients.

One approach allows physicians to serve as ad hoc surrogates and with other physicians and/or ethics committees make decisions for an unbefriended patient. Another is to allow employees of the health care facility where the patient receives treatment to serve as surrogates. Institutional committees at the health care facilities where the patient receives treatment can also play an important role in the decision-making process. Scholars have proposed that this group include a pre-established subcommittee of the hospital ethics committee. While routinely relying on judicial procedures does not serve best serve unbefriended patients in need of immediate care, a less extensive judicial intervention may serve as a last resort. Health care institutions have opted for the temporary guardianship process as an expedited, value-neutral way of making treatments decisions for unrepresented patients.

In conclusion, default surrogate consent statutes are far from ideal solutions to decisionmaking in the absence of an advance directive. There is a great need for all Americans to communicate personal health care and end-of-life care wishes effectively. As a result, advocates and health care professionals are encouraged to increase awareness about options for advance care planning. Equipped with a better understanding of the history and current progress of advance directives, individuals may be more inclined to complete the documents. Nonetheless, until culture change leads to execution of advance directives by the majority of Americans, default surrogate consent statutes will remain all the more important.

Shana Wynn is a third-year law student at North Carolina Central University School of Law in Durham, NC. Ms. Wynn received her B.A. from Winston-Salem State University in Winston-Salem, NC. She was a Summer 2014 intern with the Commission on Law and Aging in Washington, DC.

19 Supra, note 12 at 270.
20 Pope & Sellars, at 271.

For more information, please download the Surrogate Consent Law chart from the Commission’s Medical Decision-Making Resources page at: http://ambar.org/healthdecisions.


National Legal Resource Center
2014 User Needs Survey

Once a year, we invite users of the NLRC, visitors to the NLRC website at www.NLRC.ACL.gov, attendees of our webinars and trainings, and people who read our publications to communicate resource needs and priorities. Please take a few minutes and complete the brief survey at http://bit.ly/1tA0cDW.

Your input will be used to help shape the expectations and work plans of the NLRC partners for the coming year and beyond. Please take a few minutes and tell us how we can support you in providing services to your clients.

The survey will close on November 30, 2014.
Fall 2014 Commission Intern

The Commission’s robust internship program hosts students year-round in Washington, DC. To learn more, contact David Godfrey, Senior Attorney, at David.Godfrey@americanbar.org.

Kelly Richardson is a second year law student at American University Washington College of Law in Washington, D.C. Ms. Richardson graduated from Clark University in Worcester, Massachusetts, where she majored in Philosophy and Psychology.

After college, Ms. Richardson worked in the New York City’s Office of the Public Advocate for the current Mayor Bill de Blasio. Most recently, Ms. Richardson interned for the Office of the Public Defender in Broward County, Florida.

Currently an intern at the Commission, Ms. Richardson is researching the statutory implementation of Physician Orders for Life Sustaining Treatment (POLST) programs nationwide.

New CFPB Resources in Spanish that could help thousands of older Hispanics spot financial exploitation and scams

by Nora Dowd Eisenhower

Elder financial exploitation crosses all social, economic and cultural boundaries. Older Hispanics, like other older adults, increasingly are targets of financial abuse and scams by a broad spectrum of perpetrators. A 2012 study found that 17% of Hispanic seniors are victims of financial exploitation, and that limited English proficiency is a factor that contributes to the vulnerability of older Hispanics.

Nearly 1.5 million—or two-in-five—older Hispanics have limited English language proficiency and speak Spanish only. Their limited access to trusted information and resources in Spanish hampers their ability to detect, respond to and report abuse.

There are Spanish versions of two resources that can help Spanish-speaking seniors, their family members and other caregivers, and the professionals and organizations that work with them:

- **Money Smart para Adultos Mayores** (Money Smart for Older Adults)
  An educational program with the FDIC that teaches older adults and their caregivers how to spot scams and frauds, and prevent financial exploitation. The translated guide can be used as a self-study guide or delivered as a training in a group setting.

- **Cómo Administrar el Dinero de Otras Personas** (Managing Someone Else’s Money)
  A set of four guides for financial caregivers—government fiduciaries, agents under power of attorney, guardians of property and trustees—to help them understand their duties, and how to prevent and respond to financial exploitation.

These resources are available in English and Spanish for download and free print copies are also available at: http://www.consumerfinance.gov/.

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Nora Dowd Eisenhower is Assistant Director for the Office for Older Americans at the Consumer Financial Protection Bureau in Washington, DC.
"Congratulations! You've won a million dollars!"

Finding Justice for a Victim of Elder Financial Exploitation

by Paul Greenwood

This story originally appeared in a post to the National Center on Elder Abuse (NCEA) listserv. Learn more about subscribing to the list by visiting the NCEA Listserv webpage at www.ncea.aoa.gov/About/StayInTouch/Listserve/.

Paul Greenwood is Deputy DA and Head of Elder Abuse Prosecutions in San Diego, CA.

We all have seen or heard this. We all know of victims who have handed over their life savings via Moneygram, Green Dot, Western Union, or through a wire transfer.

Most times the victims are too embarrassed to tell anyone. And very rarely do we ever hear of a perpetrator being identified and prosecuted.

An often-repeated response from law enforcement is “Sorry for your loss, but there is nothing we can do. Besides, the suspect is out of state and beyond our jurisdiction.”

Well, here is a good Friday afternoon story to end your busy week. Thanks to you all out there for what you have accomplished in trying to pursue justice on behalf of older adults.

A few months ago I received an e-mail from an 85 year-old retired Catholic priest who had been encouraged to contact me. Somewhat reluctantly, he described how he had been scammed with the promise of having won a million dollars in a sweepstakes. The victim’s imagination took hold and he already was planning several charitable projects once he got his hands on the prize money.

He was told to wire the “taxes” of $41,000 via a bank transfer to a Wells Fargo account. He did so.

Eventually, he realized that he had been scammed and a sickening feeling took hold of him. He confided in a close friend and then reached out to the San Diego County District Attorney's office.
Instead of directing the victim to file a police report, my office agreed that we could investigate. I am blessed to work among a group of dedicated former police officers who are as hungry as I am to catch a scammer. After interviewing the victim, a search warrant was served on our local Wells Fargo Bank branch. We had no clue whose account it was.

I e-mailed Ron Long who is based in St. Louis, Missouri, and is Director of Regulatory Affairs for Wells Fargo Advisors and explained the situation. Within 24 hours—thanks to Ron’s intervention—we had details of the account into which our victim’s money had been transferred in South Carolina and a photo of our suspect at that branch! Naturally, the suspect had opened up an account using bogus information.

My investigators then worked with local law enforcement in South Carolina and within a couple of weeks a detective called us to say that he recognized our suspect from the bank photo. Now we had the suspect’s real name. We discovered that the suspect had recently been arrested in South Carolina while at another bank. But he had bailed out and failed to appear at his first court appearance. So my investigators drafted an arrest warrant and I filed a case charging the suspect with elder financial exploitation and identity theft. Weeks passed.

In mid-September, Roberts pled guilty to felony elder financial abuse; he will be sentenced on October 9th, 2014. Kudos to everyone involved: to our victim being courageous enough to reach out, to our dedicated investigators in San Diego, to law enforcement in South Carolina, to Wells Fargo, and to the unknown officer in Atlanta, Georgia, doing his job on that Sunday.

Then on June 15th, 2014—appropriately, World Elder Abuse Awareness Day—our suspect was pulled over in Atlanta, Georgia, on a routine traffic stop. The officer ran the suspect’s details and came across our warrant. The suspect ended up in a Georgia jail on that Sunday, unable to raise the bail on a $250,000 warrant that our judge had set. In late August, our investigators flew to Georgia to pick up Mr. Earl Roberts.
Older people are often generous with their children, making gifts willingly, free from inappropriate influence. Reasons for doing so may include the following: to assist a family member with a particular need (such as funding a grandchild’s college savings plan or providing a child with a down payment on a house); to transfer responsibility for maintenance and expense on a piece of real estate such as a cottage; to give a family member acreage on which to build a home; to transfer a farm or a family business to a younger relative who works in the business; or as compensation for a person’s caregiving services.

However, the clients LSE was seeing (and still sees) came to the organization in great distress, having given up assets before they were ready, leaving themselves in precarious financial circumstances. Some were left destitute and had even been evicted from their homes after transferring title to family members.

Social and Economic Forces

One of the driving factors behind such transfers was, and continues to be, the high cost of long-term care. Almost all the LSE clients involved in these problematic transfers had a relative, friend, or neighbor who had spent everything on nursing home care. Stories circulated about families having to sell a nursing home resident's house to pay the state of Maine’s estate recovery claim. Thus, some older people became increasingly susceptible to suggestions that they impoverish themselves in order to qualify for government assistance; and some family members eager to receive an inheritance or to keep the family homestead put increasing pressure on elders to do so.

Where transfers for less than fair market value were made without the advice of an attorney knowledgeable about Medicaid planning, elders were frequently in for a rude surprise. They had not been aware that where such gifts were made within five years before applying for Medicaid long-term care coverage, the state would penalize them by declining coverage for a period of months proportional to the value of the assets transferred. These elders were caught between a rock and a hard place: in need of long-term care, with neither the funds to pay for it nor coverage available through government programs.

Attorneys at LSE found such cases almost impossible to litigate. Elders faced a very high burden of proof.
going forward with civil suits based on common law causes of action such as undue influence.

**Legislative Proposal**

These forces sparked the idea of shifting the burden of proof from the transferor to the transferee by creating a presumption of undue influence under a limited set of circumstances:

1. Transferor was “elderly” (age 60 or older);
2. Transferor was “dependent” on others;
3. Transferor was in a “confidential or fiduciary relationship” with the transferee;
4. Transferor did not have “independent counsel”;
5. Transfer was made for less than full consideration; and
6. Transfer of assets was “major” (ten percent or more of the elder’s estate).

(For the statutory definitions of these terms, see 33 M.R.S.A. Section 1021 and 1022.)

The proposal also included these legal remedies: rescission or reformation of a deed or other instrument, the imposition of a constructive trust on property, and injunctive relief. Moreover, it provided that the presumption could be used as a defense against a transferee’s action to enforce a contract for the transfer or guaranty of an asset.

**Initial Opposition to the Bill**

Sponsors were found for the bill and it was introduced in the 1988 legislative session. The bill faced opposition from several quarters: (1) various sectors of the bar, concerned that the Act would interfere with the orderly transfer of title and create ambiguity and litigation in ordinary transactions; (2) those who claimed it was a “lawyers’ bill,” designed to create business and drive up fees; and (3) even some advocates for elders, claiming it was paternalistic and ageist.

The critical elder advocates correctly pointed out that some elders who had decision-making capacity would be covered by the Act. A standard hypothetical used to demonstrate the issue was the following: Following a ski injury, a 60-year old competent, prosperous professional gives money to a child who is providing assistance while the parent recovers. Indeed this 60-year old would meet all the criteria of an elderly, dependent person in a confidential or fiduciary relationship, but would be clearly in control of his or her own destiny and would not need special protection. Legal Services for the Elderly’s rejoinder was that such elders, operating on a level playing field, would simply not avail themselves of the law, and thus would be happily unaffected by its ageism. The presumption would instead be there for use by elders who did need its protection.

Another objection to the bill was that the proposed law would aid manipulative elders who voluntarily transferred assets without having been unduly influenced, and who then sought to rescind the transfer purely based on a change of heart. These critics argued that this was unfair to the transferee. The proponents of the Act responded that the prevailing social problem (significant numbers of elders unduly influenced to give away substantial assets) outweighed these rarer incidences of “buyer’s remorse.” Moreover, any transferee who wanted to ensure that the gift would not be subject to rescission could make sure that the elder had consulted with independent counsel.

In spite of these objections, the bill was favorably received in the Legislature, and it passed in 1988.

**Amendments**

For a period of time, the bill continued to be unpopular with some sectors of the bar. This was ameliorated to some extent by elder law attorneys collaborating with real property lawyers to successfully propose a number of appropriate amendments related to transfers of real estate: (1) a provision which states that nothing in the Act affects the right, title, and interest of good faith purchasers, mortgagees, holders of security interests, or other third parties who obtain an interest in the transferred property for value after its transfer from the elderly dependent person; and (2) provisions affecting title practices, stating that title examiners were not required to inquire as to the age of the transferor and whether he or she had independent representation.

**Current Support of the Act**

Most elder advocates, after seeing the legislation in action, became ardent supporters of it. Property lawyers learned to live with it and some even grew to appreciate it. Attorneys are now generally aware through continuing legal education and practical
experience that the best practice in any intra-family real estate transaction involving a transferor age 60 or older is to ensure that the transferor has independent counsel. Moreover, most attorneys in private practice, including those whose practices are purely transactional, have seen egregious instances of financial exploitation and have come to appreciate the possibility of getting redress for elders. And, from a client-relationship standpoint, the legislation has allowed attorneys to avoid the awkward and possibly unethical situation of being asked by families to represent all parties to the transaction. Even if family members argue that family representation would keep the process simple and less expensive, the attorney can simply respond that the law requires separate counsel for each party.

**Conclusion: What has the Law Accomplished?**

Twenty-six years after the passage of the Act, plaintiffs’ lawyers say that it continues to be an uphill battle to litigate elder exploitation cases. There are several reasons why these cases are challenging, including:

- Litigation is, of course, expensive. Financial exploitation victims lack resources to pay private lawyers and agencies such as Legal Services for the Elderly have limited resources.
- Elderly, unwell clients frequently cannot take the pressures of litigation. Some drop their cases because they are reluctant to alienate family members, or because they are embarrassed about having been taken advantage of.
- Frequently these clients make poor witnesses, due to cognitive issues.
- Finally, because litigation can drag on, clients often die before obtaining redress.

However, in spite of these difficulties, the presumption and burden-shift under the ITTA may offer a negotiating advantage and lead to settlement. Moreover, the Act may have a deterrent effect. Knowledgeable attorneys now refer elders to outside counsel before assisting with a gift to family or others with whom the elder has a close relationship. Some elders may, having received this advice, nevertheless forge ahead with an unwise transaction—but others may hesitate. And unscrupulous family and friends, as more eyes focus on the transaction, may back off and cease pressuring the elder for fear of being sued. (Worth noting, however, is the counter-argument that an elder’s visit to a separate attorney who provides minimal advice may effectively give an inappropriate transaction the “Good Housekeeping Seal of Approval,” thereby making the case harder to litigate.)

Maine’s ITTA represents a creative statutory approach, seemingly unique in the U.S., to attempting to level the playing field for older people in property transactions. While representing vulnerable elders continues to be challenging, the law has, at the very least, created awareness within the legal profession of the need for caution in facilitating these transactions.

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**Sally M. Wagley is an elder law attorney in Winthrop, Maine, and one of the authors of Maine’s Improvident Transfers of Title Act. She has worked in the field of law and aging for 27 years, in the government, nonprofit and private sectors.**

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**Related Reading from the Bifocal Archives...**

Readers may also be interested in another Maine-focused article on elder financial exploitation: *No Higher Calling — Representing Victims of Financial Exploitation* (Bifocal, Volume: 34 Issue: 5) by Denis Culley and Jaye Martin.


Elder abuse cases often highlight the reality that the same frailties and vulnerabilities that make older clients easy victims also make them imperfect witnesses and poor advocates for their cause. Despite the difficulties and resource demands that financial exploitation cases involving the elderly present, there are no cases where a legal aid provider such as ours, Legal Services for the Elderly (LSE) in Maine, believes we are more clearly discharging our duties as advocates for our vulnerable elderly clients. Dogged pursuit of, and repeated success in, these civil cases is just one among the many actions that must be taken to rid our society of elder abuse.
As we gear up for the second year of Affordable Care Act (ACA) enrollment, it is easy to overlook the law’s quiet transformation of the long-term services and supports (LTSS) delivery system. LTSS are services and supports that help older adults and individuals with disabilities with activities of daily living. In 2015, several states will finalize significant structural changes to their Medicaid long-term care programs. Part of the structural change is an enhanced focus in all states on eliminating conflict of interest from case management services.

The push toward conflict-free case management poses interesting questions for elder lawyers. First, how does any system regulate and monitor conflict of interest? And second, for clients, what does this mean for LTSS service delivery?

Model Rules for Professional Responsibility, the ethics guidance for lawyers, focus on protecting clients by eliminating conflict of interest in representation. The rules are pretty straightforward—don’t represent a client if representation will directly harm another client—with specific details for different situations. In a legal system rooted in the belief that the lawyer’s primary role is to provide a client with competent, diligent and prompt representation, it’s generally clear when a situation presents a conflict.

In LTSS delivery, roles are not as direct as client and counselor. Often, the assessor, the coordinator, and the provider of services roles overlap. In these situations, when one agent serves as both the gatekeeper and provider of services, there is a clear potential for conflict. This conflict of interest may not be a conscious decision on the part of the agent, but may be the result of incentives and disincentives built in the system. In guidance, the federal Centers for Medicare and Medicaid Services (CMS) offer an example of conflict in the assessment process: if the agent is both the assessor of need and the provider of services, the assessor may have an incentive to assess for more or less services than the consumer needs.

In an effort to eliminate the potential for conflict, the ACA includes a requirement that certain states develop conflict-free case management systems. The requirement pertains to states that receive enhanced funding to provide home and

1 States participating in the Balancing Incentive Payment program are required to make LTSS structural changes by September 30, 2015. More information: Section 10202 of the Patient Protection and Affordable Care Act; 42 U.S.C. 1396n(i)(1)(H)(2).
2 Model Rules of Professional Conduct 1.1: Competence.
3 Model Rules of Professional Conduct 1.3: Diligence.
4 For more CMS guidance on the Balancing Incentive Program, see: http://www.balancingincentiveprogram.org/sites/default/files/Balancing_Incentive_Program_Manual_2.0.pdf.
community based services under the Balancing Incentive Payment program. Participating states⁵ must make significant LTSS structural changes, including implementing a conflict-free case management system, by September 30, 2015.

The focus on conflict-free case management complements the goal of improving person-centered care planning: if the case manager is free from conflict, the case manager can appropriately enable and assist the consumer in identifying and developing a plan to access services. Eliminating conflict of interest in the assessment, case management, and care delivery process is an important component of that goal.

States are working toward this goal in earnest through state workgroups⁶ that are assessing the LTSS delivery system and working to design a structure that eliminates conflict of interest. As states work toward this goal, they are forced to grapple with a core LTSS delivery tension: how does a state deliver services to an individual in a manner that facilitates ultimate choice and consumer direction, while ensuring the overall care system is coordinated and free from conflict? Further, how does a state develop this system to work both with the existing aging and disability services infrastructure and in the rapidly changing health care delivery landscape?

Over the next year, it will be interesting to observe structural changes to better understand how states monitor and regulate conflict of interest. To help the aging and disability network understand different state approaches, NSCLC developed an issue brief, Conflict-Free Case Management: Themes in States Working to Implement New Systems, available at www.nsclc.org.

New ABA Standards Available

Standards for Programs Providing Civil Pro Bono Legal Services to Persons of Limited Means

Organized Pro Bono programs have existed in the United States for over a century, and provide options for those who may not have access to legal services. The number of pro bono programs is continually increasing however, not all pro bono programs succeed and are effective. Due the changing nature and the multiple types of Pro Bono programs the Standards for Programs Providing Civil Pro Bono Legal Services to Persons of Limited Means provides guidance on the necessary elements of an effective pro bono program. This includes becoming effective and efficient in finding volunteers, meeting the clients’ needs, and providing high quality service for volunteer lawyers and clients.

The Standards have been crafted specifically for programs and components of programs which provide free civil legal services to persons of limited means through the use of volunteers. Even though this book is based on civil pro bono legal services, many other pro bono models can benefit from the guidance this resource provides. This publication offers the “black letter” Standards adopted by the ABA House of Delegates in 2013 as well as updated commentary and practical resources for implementing the Standards.

Whether your program is new or already established, the Standards for Programs Providing Civil Pro Bono Legal Services to Persons of Limited Means provides the necessary tools to create a successful, effective, and efficient program.

To order the print copy or to download an e-pub file, please visit the ABA webstore: http://bit.ly/1wDBrcK.

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⁵ For a list of states participating in the Balancing Incentive Program, see: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Balancing/Balancing-Incentive-Program.html.

⁶ For a list of state structural change workplans, see: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Balancing/Balancing-Incentive-Program.html.
Update on
Jimmo v. Sebelius
Medicare Standards for Skilled Nursing Care
by Morris Klein

Jimmo v. Sebelius challenged the legality of the “improvement” standard.

One of the few Medicare benefits available for long-term services and supports is payment for up to 100 days of skilled care in a nursing home. Medicare pays the entire amount for the first 20 days and the excess of $152 per day ($157.50 effective January 1, 2015) for the remaining 80 days.

Medicare does not guarantee the entire 100 days of coverage, however, and the patient’s need for skilled care services is under constant review. Until recently, the criteria for continued skilled care have been based on informal Medicare policy guidelines asserting that a patient must demonstrate “improvement” from receiving skilled care services. This policy resulted in many Medicare beneficiaries losing their benefit far short of the full eligibility period.

In Jimmo v. Sebelius, No. 11-CV-17 (D. Vt.), various individuals and organizations challenged the legality of the “improvement” standard by filing a class-action lawsuit against the U.S. Department of Health and Human Services.

Plaintiffs argued that the “improvement” standard was not based on federal Medicare law and regulations.

The government settled the lawsuit after it failed to win its motion to dismiss. The government agreed to clarify in its manuals and directives to providers to say that the eligibility for the continuation of skilled care services should be based not on the beneficiary’s “improvement” but on whether the beneficiary requires skilled care and whether such services themselves are reasonable and necessary. The federal district court judge presiding over the litigation approved the settlement on January 24, 2013, and CMS agreed to make the necessary changes within one year.

On December 9, 2013, CMS revised its Medicare Benefit Policy Manuals. It also started its promised educational campaign. The manuals and educational campaign now make it clear that improvement is not necessary for coverage of skilled nursing and therapy services. The fact a patient has a chronic condition or lacks “improvement” or “restoration potential” should not be deciding factors for access to continued coverage. Such skilled therapy services are covered when an individualized assessment of the patient’s

1 Medicare also will pay for physician-authorized skilled care to a home-bound beneficiary on an intermittent basis, or for inpatient care in a rehabilitation facility. Skilled care includes physical, occupational and speech therapy, wound therapy, and observation of changing conditions.

2 The nursing home stay must commence within 30 days of discharge from a hospital where the patient had been admitted for at least three days.

clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are necessary for the performance of a safe and effective maintenance program. Other skilled nursing services would be covered when necessary to maintain the patient’s current condition or prevent or slow further deterioration as long as the beneficiary requires skilled care for the services to be safely and effectively provided.

The Center for Medicare Advocacy, the lead counsel in Jimmo, reports that beneficiaries and providers are still reporting denials based on the old “improvement” standard. It also notes there are more denials for services that are “not skilled” or “not medically necessary.”

The lead plaintiff in the original Jimmo settlement did not automatically receive Medicare benefits as a result of the litigation. Glenda Jimmo, who is legally blind and has a partially amputated leg, initially appealed her original denial of coverage, as per the terms of the settlement agreement. Last April, the Medicare Appeals Council, the last step in the Medicare administrative appeals system, affirmed her denial on the grounds that she was not improving. She responded by filing a second lawsuit in federal court, and on October 29, 2014, twenty-one months after the original settlement, Medicare agreed to cover her care.

Advocates need to scrutinize Medicare skilled care denials with care to determine if the beneficiary still qualifies for skilled care, and, if necessary to appeal.4

Separately, the settlement also permits Medicare beneficiaries whose denial of coverage became final and nonappealable after January 18, 2011, because of the improvement standard, to have their claims re-reviewed under the revised manual provisions. The review process is not automatic, and a beneficiary must fill out and submit a Request for Re-Review form. If the claim became “final and non-appealable” from January 18, 2011 through January 24, 2013, the deadline for filing is July 23, 2014. If it became “final and non-appealable” from January 25, 2013, through January 23, 2014, the deadline is January 23, 2015. Claims that became final and nonappealable after January 23, 2014, are not eligible for re-review.

The Center for Medicare Advocacy has posted self-help packets online5 to help patients and advocates determine whether the basis for the denial is appealable and how to prosecute the appeal.

Note that the settlement affects only the standard to receive skilled care. Other Medicare eligibility rules remain the same. The 100-day limit on skilled nursing care rule has not changed. Also, skilled care services will continue to be provided only when such care is reasonable and necessary. Moreover, someone whom the hospital did not formally admit for at least three days but instead classified as at the hospital only for “observation” does not qualify for any skilled care subsidy.6

The Jimmo settlement represents affirmation of what the law has always required Medicare to provide in benefits and a step forward in the quest by patients to remain as healthy as possible for as long as possible. It is now up to advocates to continue to make sure the settlement is followed.

Morris Klein, CELA, CAP, practices law in Bethesda, Maryland. He is a member of the NAELA Public Policy Steering Committee.


5 The link is http://www.medicareadvocacy.org/medicare-info/improvement-standard/.
6 In Bagnall v. Sebelius (No. 3:11cv01703, D. Conn), advocates challenged the use of the observation status, but the court dismissed the lawsuit.
“… Pass It On”
New Scam Awareness and Education Materials from the Federal Trade Commission
by Lisa Weintraub Schifferle

Chances are good that someone you know has been scammed. They may not talk about it, but the statistics do. The truth is that sharing what you know can help protect someone who you know from a scam. People listen to you because they trust you. You’re a friend, a neighbor, a relative, maybe even an elder care advocate or attorney.

That’s why the Federal Trade Commission (FTC) created “Pass It On”—to help you start a conversation about scams and pass on information that could help someone you know.

What is “Pass It On”? It’s the FTC’s newest education effort. It includes articles, presentations, bookmarks, activities, and a video—all designed to get you talking about scams and how to prevent them.

“Pass It On” is aimed at active older adults, ages 65 and older—a huge group with life experience and a social network. “Pass It On” sees older adults as part of the solution, not simply victims of the actions of others. In short, older adults have knowledge and can pass it on to others.

This article describes the “Pass It On” materials, what the FTC’s newest campaign involves, and how you can get involved.

“Pass It On” Materials
“Pass It On” reinforces what older adults already know about scams. The materials cover six scams that older adults may be likely to confront:

- Imposter Scams—what to do when someone calls or emails you, pretending to be someone you know, and asks for money or personal information.
- Identity Theft—what to do when someone gets your personal information and runs up bills in your name.
- Charity Fraud—what to do when someone contacts you and asks for donations to a fake charity.
- Health Care Scams—what to do when someone lies to you about medical discount cards or changes to Medicare, in order to get your medical information.
- “Paying Too Much”—what to do when unexpected charges appear on your bill for fees or services that you didn’t order.
- “You’ve Won” Scams—what to do when someone tells you that you’ve won a prize or sweepstakes, then asks for money in order to claim your prize.

For each topic, “Pass It On” includes a one-page article, a bookmark, and an activity.

- Article: The article is divided into two parts: (1) “Here’s how they work”—this part describes how the particular scam happens; and (2) “Here’s what you can do”—this part lists two steps that you can take to try to prevent the particular scam. The article invites you to pass the information on to someone you...
know. The back of the article explains how to report scams to the FTC through 1-877-FTC-HELP or www.ftc.gov/complaint.

- Bookmarks: The bookmarks offer quick reminders on how to prevent each type of scam. They offer quick tips like “if you have to pay, it’s no prize” and “never donate by wiring money.” The back of each bookmark explains how to report scams to the FTC at 1-877-382-4357.

- Activities: For each scam, there is an activity to reinforce knowledge and have fun. The activities include an “imposter scams” word scramble, a “paying too much” word find, a secret message decoder on “you’ve won” scams, and more. The activities could be used at a senior center, library, or scam jam—to make talking about scams entertaining.

In addition, there is a three-minute video, which introduces the “Pass it On” materials and how you can use them.

Sample “Pass It On” Article

Wondering what these materials look like? Here’s an example of what you’ll find on the “You’ve Won” Scams one-pager:

Here’s how they work:

You get a card, a call, or an email telling you that you won! Maybe it’s a trip or a prize, a lottery or a sweepstakes. The person calling is so excited and can’t wait for you to get your winnings.

But here’s what happens next: they tell you there’s a fee, some taxes, or customs duties to pay. And then they ask for your credit card number or bank account information, or they ask you to wire money.

Either way, you lose money instead of winning it. You don’t ever get that big prize. Instead, you for more requests for money, and more promises that you won big.

Here’s what you can do:

1. Keep your money—and your information—to yourself. Never share your financial information with someone who contacts you and claims to need it. And never wire money to anyone who asks you to.

2. Pass this information on to a friend. You probably throw away these kinds of scams or hang up when you get these calls. But you probably know someone who could use a friendly reminder.

The reverse side of the one-pager explains how to report a scam to the FTC, as well as how to sign up for scam alerts at www.ftc.gov/subscribe.

“Pass It On” Outreach

“Pass It On” is more than just materials. It is also outreach. The FTC is reaching out to older adults through the places they get together or live: libraries, social and civic clubs, senior centers, adult living communities, and veterans’ facilities.

There is clearly a demand for this approach. Within the first two weeks it was public, the FTC received orders for 150,000 copies of “Pass It On” materials, from 43 states. Within the first month, we received requests for almost 200,000 copies, from 49 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. To date, we have received over 400,000 orders from all 50 states.

We’re also working with other government agencies and non-profit organizations to get these materials to as many older adults as possible.

“Pass It On” sees older adults as part of the solution, not simply victims of the actions of others.
How You Can Be Involved

You, too, can pass it on. Like all FTC materials, “Pass It On” is free and in the public domain. That means you can use the materials and even put your own logo on them. Copies are available in print and online.

- **Print:** You can order print copies at [www.ftc.gov/bulkorder](http://www.ftc.gov/bulkorder). You’ll receive folders with all six fact sheets and bookmarks. Copies are available in English and Spanish.

- **Online:** All of the materials are also available on the “Pass It On” websites—[www.ftc.gov/passiton](http://www.ftc.gov/passiton) (in English) and [www.ftc.gov/pasalo](http://www.ftc.gov/pasalo) (in Spanish). The websites include the articles and bookmarks, plus the activities and video.

There are many ways that you or your organization can use the “Pass It On” materials. Here are some possibilities:

- Link to “Pass It On” on your website.
- Write a blog about “Pass It On.”
- Host a Twitter chat or webinar.
- Sponsor a scam jam event, using “Pass It On” materials.
- Offer print copies of “Pass It On” in your office’s lobby or waiting room.
- Put copies of “Pass It On” in your local library or senior center.
- Hand it to your friend, neighbor, or family member.

We hope that you’ll use the materials and take a minute to let us know how they are working or what else you need. Please also reach out to us if you have ideas on distribution channels and strategies. You can email us at: PassItOn@ftc.gov in English, or Pasalo@ftc.gov in Spanish. Pass it on!

*Lisa Weintraub Schifferle is an Attorney in the Bureau of Consumer Protection at the Federal Trade Commission in Washington, D.C.*
The White House has held a Conference on Aging each decade since the 1960s to identify and advance actions to improve the quality of life of older Americans. The 2015 White House Conference on Aging (WHCoA) is an opportunity to look ahead to the issues that will help shape the landscape for older Americans for the next decade.

The White House Conference on Aging will be held in 2015—next year that marks the 50th anniversary of Medicare, Medicaid, and the Older Americans Act, as well as the 80th anniversary of Social Security. The 2015 White House Conference on Aging is an opportunity to recognize the importance of these key programs as well as to look ahead to the next decade.

Conference Structure

In the past, conference processes were determined by statute with the form and structure directed by Congress through legislation, as part of the authorization of the Older Americans Act.

At this point in time, Congress has not reauthorized the Older Americans Act, and the pending bill does not include a statutory requirement or framework for the Conference.

However, the White House is committed to convening the 2015 conference and we will seek broad public engagement and work closely with stakeholders in the lead-up to the conference. We also plan to use web tools and social media to encourage as many older Americans as possible to participate.

The Conference Web site provides regular updates on Conference activities. The website also provides opportunities for older Americans and leaders in the field of aging to provide their input and personal stories.

Issue Selection

The White House is engaging with stakeholders and members of the public about the issues most important to older individuals, their caregivers, and families. To listen and learn from key aging leaders and older Americans, the Administration is participating in listening sessions with older Americans and advocates across the country. These listening sessions began in July 2014 and will continue up to and during the Conference.

Some of the common themes voiced so far by aging leaders and older Americans include the following:

- **Retirement security** is a vitally important issue. Financial security in retirement provides essential peace of mind for older Americans, but requires attention during our working lives to ensure that we are well prepared for retirement.

- **Healthy aging** will be all the more important as baby boomers age. As medical advances progress, the opportunities for older Americans to maintain their health and vitality should progress as well and community supports, including housing, are important tools to promote this vitality.

- **Long-term services and supports** remain a priority. Older Americans overwhelmingly prefer to remain independent in the community as they age. They need supports to do so, including a caregiving network and well-supported workforce.

- **Elder justice** is important given that seniors, particularly the oldest older Americans, can be vulnerable to financial exploitation, abuse, and neglect. The Elder Justice Act was enacted as part of the Affordable Care Act, and we need to realize its vision of protecting seniors from scam artists and others seeking to take advantage of them.

More Information

For additional questions or to provide specific input, please visit: www.WhiteHouseConferenceOnAging.gov.
The Association for Conflict Resolution has unanimously approved guidelines for an “eldercaring coordination” process. The process targets adult guardianship and related cases in which high conflict family dynamics may interfere with the well being and safety of an older person and with adherence to court orders.

Since “parenting coordination” has been established as a viable dispute resolution option for high conflict cases involving parents and children in court actions, an ACR Task Force on Eldercaring Coordination used parenting coordination as a model to develop a similar dispute resolution process specific to the unique needs of elders.

The new ACR Guidelines for Eldercaring Coordination are posted on the ACR Elder Decision-Making Section website at: http://bit.ly/1x0H3Q3.

The Guidelines also are posted on the National Center for State Courts’ Elders and the Courts website at: http://bit.ly/1wuQoOC.

The ACR Task force is now looking for possible court pilot project sites.

For more information, contact Task Force co-chairs Linda Fieldstone (lfieldstone@jud11l.courts.org) and Sue Bronson (sbrinson@wi.rr.com).

Interested in NALC 2014’s conference materials?

Materials are available for order: http://bit.ly/1DqliYx

Nonprofit, government employees, and academics may use the coupon code: ALCCOR60.

Staff contact:
David Godfrey
David.Godfrey@Americanbar.org

Save the Date!
NALC 2015 will be held October 29-30
Representing a client with diminished capacity entails several competing ethical considerations. Don’t fall into one of the traps.

Attend this webinar to learn:

• How to maintain a "normal" attorney-client relationship with a client with diminished capacity
• How to determine when a lawyer may seek decision-making assistance for a client with diminished capacity from a family member or third-party without violating the duty of confidentiality
• How to represent a client with diminished capacity in court

What do you do when you suspect your client suffers from diminished capacity? When can you seek outside guidance to help a client with diminished capacity? What can you say to whom without violating the duty of confidentiality to the client?

This ethics webinar will cover the parameters set out in Rule 1.14 directing an attorney to maintain a "normal" attorney-client relationship with a client with diminished capacity to the extent possible, and explore how to enter into an attorney-client relationship with a client with less than full capacity, what to do when a client’s capacity declines during representation, and how to represent a client with diminished capacity in court.

Faculty:

• **Hon. Patricia Banks**, serves on the Executive Committee of the Circuit Court of Cook County in Illinois, and is Presiding Judge of the Elder Law and Miscellaneous Remedies Division of the Circuit Court

• **Prof. Rebecca C. Morgan**, is the Boston Asset Management Chair in Elder Law, the director of the Center for Excellence in Elder Law at Stetson University College of Law in Gulfport, FL, and the director of Stetson's online LL.M. in Elder Law

• **Kerry R. Peck**, is managing partner of Peck Bloom, LLC in Chicago, IL, and author of *Alzheimer's and the Practice of Law*

• **David M. Godfrey (moderator)**, Senior Attorney, ABA Commission on Law and Aging

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