

- Recap of NALC2016
- Details for NALC2017!



# Bifocal

A Journal of the **ABA** Commission on Law and Aging  
Vol. 38, No. 1, September – October 2016

**Can My Advance Directives Travel Across State Lines?**  
*An Essay on Portability*

**How to Find  
Medicare Law**

**Three Low-Cost Ways  
to Do Outreach and  
Education on Elder Abuse**

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(202) 662-8690, or at:  
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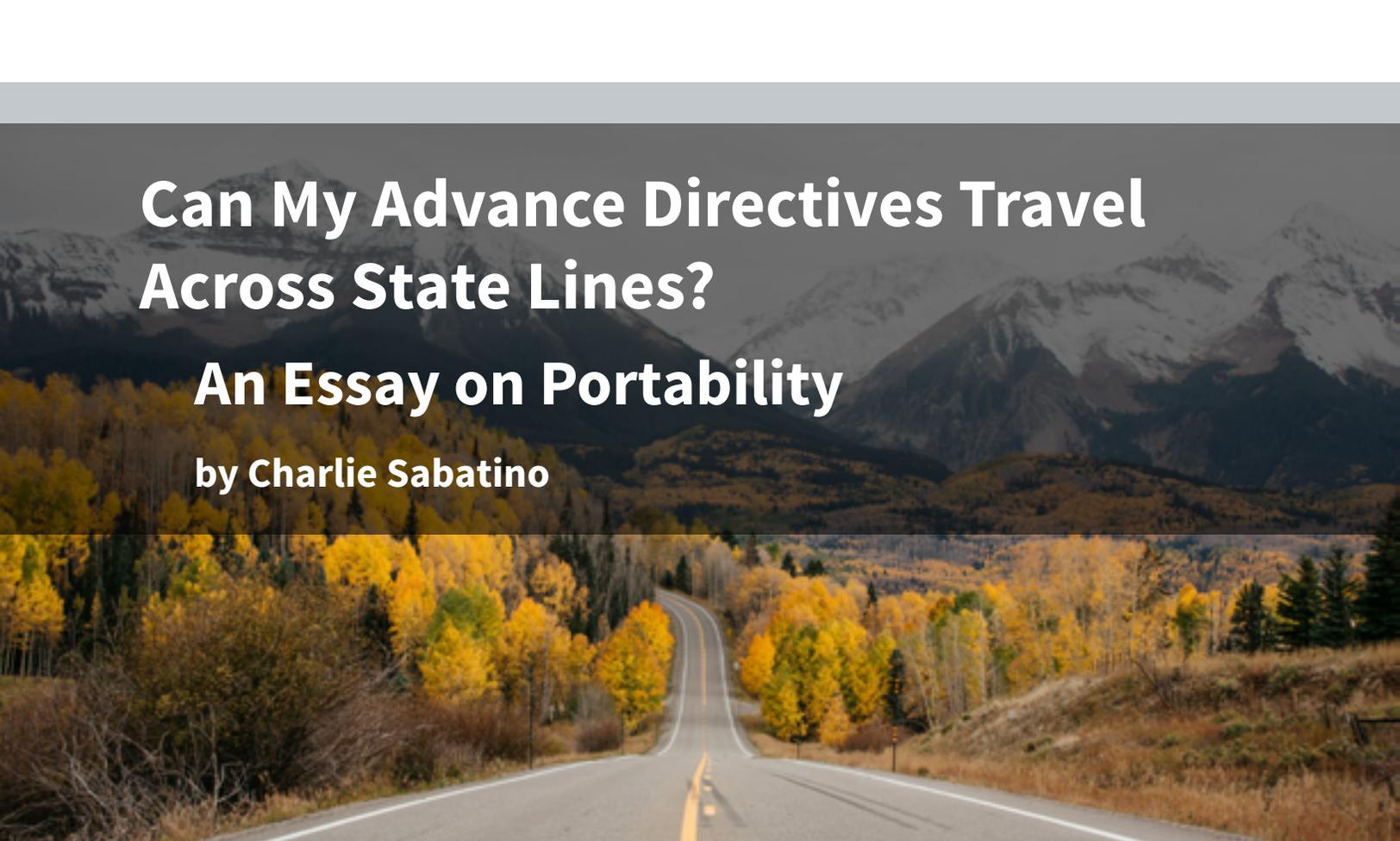
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# Can My Advance Directives Travel Across State Lines?

## An Essay on Portability

by Charlie Sabatino



America is a very mobile society. Not only do we move around a lot, many are willing to travel to get health care, especially for complex, specialty treatment. How well do our wishes travel with us across state lines and across health systems? The documentation of our health care wishes has come to be most associated with statutory advance directive documents, typically health care powers of attorney and living wills. These documents tend to be tethered to one's state of residence, because the content and formalities of execution of the documents are defined and regulated by state law. These laws are as varied as the geography of the states.

It's important to keep in mind that statutory advance directives are not the only game in town. There are any number of possible non-statutory modes of communication that can function as an advance directive. These may take the form of less formal writings by the individual such as a letter to family members, answers written in any of a growing number of advance care planning workbooks, statements recorded on video, or documented discussions with one's health care providers. Any expression of one's future wishes about health care is an advance directive in its broadest sense.

### Background on Statutory Advance Directives

Most state advance directive laws were intended to provide one clear pathway the public could use to document their wishes, not to eliminate all other avenues. These other avenues may be more valuable or less valuable as guidance than a formal advance directive, yet most policy and practice focuses almost exclusively on statutory directives. Statutory advance directives have the aura of state authority and provide a perk that physicians seem to value—statutory immunity for complying with their patients' directives. While immunity may have been an effective carrot for changing physician behavior in the 1970s and 80s, it should be irrelevant in today's world where advance care planning and person-directed care have become the expected standard of care. Given this legislative landscape, any discussion about the portability of advance care planning documents naturally starts with statutory directives.

Jane and Joe want to know if the advance directive they complete in their home state—let's pick one at random... Illinois—will be recognized and honored in other states. This question comes up with unceasing frequency. The usual answer is that it should be recognized and honored since most, but not all, states have provisions explicitly validating out-of-state

advance directives. Of course, every detail-conscious lawyer will add that it all depends on the state; and if one spends a good deal of time in a second state, the usual advice is to have a lawyer from the second state look at it.

In reality, there are no reported cases, virtually no research, and few word-of-mouth stories of refusals by health care providers to honor an advance directive from a different state. But, that fact doesn't mollify the concern that people have about the portability of their advance directives. Moreover, given the universal public policy in favor of advance care planning by all adults, it seems incongruous that states are so Balkanized in the mechanics of creating and implementing advance directives in the first place. As a lawyer, I would like to be able to assure a client that she can use any advance directive that resonates with her and it will be valid and honored in every state.

In 2005, I published an article that took one advance directive that sought to be used nationally—the *Five Wishes* advance directive—and held it up to the law of all 50 states and the District of Columbia to see if it could possibly work nationally.<sup>1</sup> If Jane and Joe used *Five Wishes* then, our conclusion was that it would probably be considered valid in 36 states and D.C. The other 14 states posed requirements that made it difficult, if not impossible, for *Five Wishes* or any other single form to work in all states as a statutorily recognized form. Interestingly, in the intervening years, some states have somewhat simplified their laws such that *Five Wishes* form now claims to be usable in 42 states and D.C. That's progress but not a state of universal friendliness to the concept of a national advance directive.

<sup>1</sup> Sabatino, Charles P., "National Advance Directives: One Attempt to Scale the Barriers," 1 NAELA Journal 131 (2005).

## Possible Policy Approaches to Portability

There are a number of possible policy pathways to portability of advance directives, each with its advantages and disadvantages. One is through the simplification and conforming of state law nationally, such that it becomes feasible to meet the requirements of all states in a single form. This is the route tested by the *Five Wishes* exercise. This is also the route promoted by the Uniform Law Commission which adopted a very simple Uniform Health-Care Decisions Act in 1993. Unfortunately, only seven states have adopted the act (Alaska, Delaware, Hawaii, Maine, Mississippi, New Mexico, and Wyoming), and even then, only with their own home-grown variations. Considering the politics of state law-making, sufficient uniformity across the states seems unlikely.

Another road to portability is the conventional path traveled by states, which relies on language in statute recognizing the validity of out-of-state directives if: (1) they are valid in the state where executed or (2) if they meet the requirements of the state where treatment is delivered. Two problems arise under this approach. One is that health providers cannot practically assess whether the directive meets the legal requirements of another state, unless a lawyer follows them around all day. If Jane and Joe spend winters in Arizona, what does Joe's cardiologist in Arizona know about Illinois law?

As a result, some states add a presumption of validity unless the provider has knowledge to the contrary. That certainly helps, but it doesn't solve a second problem. Even if legally recognized, the directive may not be interpreted in the way the maker of the document intended, because the definition of terms and rules for implementing the document vary across states. Jane and Joe's Illinois advance directives



name each other as primary health care agents with complete authority to make all health care decisions. In Illinois, health-care means “any care, treatment, service or procedure to maintain, diagnose, treat or provide for the patient’s physical or mental health or personal care.”<sup>2</sup>

If Jane and Joe go across the border to Wisconsin, a simple statement of authority to make “health-care” decisions comes with a couple caveats. In Wisconsin, it does not include authority to consent to the withholding or withdrawal of a feeding tube or long-term admission to a nursing home, unless the advance directive *explicitly* authorizes those decisions.<sup>3</sup> In other words, two things Jane and Joe could consent to in Illinois, they can’t in Wisconsin, even though their directives are valid there. They would have needed to comply with the special language requirements of Wisconsin law to have their wishes interpreted as they intended. Thus, the conventional approach of recognizing the validity of out-of-state documents falls short.

A third road to portability is through national legislation. A little known provision in federal law already makes one category of advance directives valid everywhere. In 1996, Congress enacted a federal advance directive option solely for military personnel that explicitly preempts state law.<sup>4</sup> Recommendations for a federally created national advance directive for the public at large have occasionally been pondered but have never been formally proposed in legislation. States’ rights concerns make this a long-shot, since health care decision-making has traditionally been seen as primarily the province of state law.

Given the barriers to a federally created national advance directive, proponents have pursued legislative strategies that seek only to address portability itself, but how to do this has its own challenges. The most obvious route is through Medicare and Medicaid, since in order to participate in those programs, providers must comply with federal standards. Federal law could replicate the conventional state approach by requiring providers to consider out-of-state directives valid if they are valid in the state where executed or if they meet the requirements of the state where treatment is delivered. A presumption of validity would be

important to include, also. This would be a very modest step forward but with the same limitations as described above.

If a federal provision went a step further to *require* compliance with an out-of-state directive, then difficult questions arise about the exact parameters of federal preemption. Suppose the law of the state where treatment is delivered provides for conscience objections by which providers can refuse to comply with an individual’s documented wishes as a matter of conscience. Would the federal portability provision override that? Delineating the exact parameters of preemption is more difficult than may be initially thought.

### **An Alternative: Focus on Respecting Individual Wishes, not on Validating Documentation**

A simpler way to approach portability may be to avoid the narrow focus on validating formal advance directives and to focus on honoring the wishes of Jane and Joe no matter how they express them. In 2005, the state of Idaho provided an example of one way to do this with one simple sentence in its advance directive law: “Any authentic expression of a person’s wishes with respect to health care should be honored.”<sup>5</sup> Under this provision, the inquiry moves away from determining the validity of the advance directive to determining the person’s wishes, regardless of how expressed.

Some will shudder at the prospect of possible argument over what is authentic or how to interpret vague expressions of wishes. But those concerns arise even with statutory advance directives. There are no cookbook instructions for end-of-life decisions. More importantly, the Idaho provision accurately affirms long-standing common law and constitutional principles of self-determination and liberty in the context of health care decision-making. We too easily forget that statutory advance directives were created as one way to effectuate those principles, not to box them in to a single pathway. Another advantage of the Idaho provision is that it makes no difference whether the person is out-of-state or in-state; their wishes, no matter how communicated, are strengthened. This does not eliminate differences in how a state may interpret particular words, such as in the Illinois-Wisconsin example above. But, it does make portability a non-issue.

<sup>2</sup> 755 Ill. Comp. Stat. Ann. 45/4-4.

<sup>3</sup> Wisc. Stat. Ann. § 155.20 (West 2016).

<sup>4</sup> 10 U.S. Code § 1044c.

<sup>5</sup> Idaho Code § 39-4508(3) (West 2016).

This approach has gained attention in at least one federal proposal in the 114<sup>th</sup> Congress. In 2016, representatives Earl Blumenauer (D-OR) and David Roe (R-TN) cosponsored the *Personalize Your Care Act 2.0* which addresses several aspects of advanced illness management and advance care planning.<sup>6</sup> Its portability language echoes Idaho's: "In the absence of a validly executed advance directive, any authentic expression of a person's wishes with respect to health care shall be honored."

One other state besides Idaho also chose this route in amending its advance directive law. A 2016 Maryland amendment to its health decisions law states: "Notwithstanding any other provision of law, in the absence of a validly executed or witnessed advance directive, any authentic expression made by an individual while competent of the individual's wishes regarding health care for the individual shall be considered." While the mandate to "consider" is less powerful than to "honor," it still turns the focus toward the goals, priorities, and wishes of the individual, rather than on the particular form used.

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<sup>6</sup> H.R. 5555.

## Conclusion

The value of this any-kind-of-expression approach is a freeing up of the process of advance care planning so that it can flow from the personal communication style, culture, and comfort level of each individual, ideally in dialog with loved ones and health care providers. In contrast, the legal paradigm, built upon precise formalities of execution, prescriptive language, and technical definitions, has been user-friendly only for a minority of the public. That is likely one of the reasons why, after over three decades of promoting advance directives, only about a third of adults have them today. Humans are a varied bunch. Jane and Joe are unique in biology, personal history, culture, education, and in a thousand other ways. Their preferred mode of communicating their wishes may be quite different from yours or mine or the one dictated in their state's advance directive law. That's why we need the flexibility to allow a thousand approaches to advance care planning.

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*Charles P. Sabatino is the Director of the ABA Commission on Law and Aging in Washington, DC. ■*

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## American Bar Endowment Opportunity Grants Program

The American Bar Endowment (ABE) has adopted an Opportunity Grants Program, to support smaller, innovative programs and projects by eligible grantees that fit within the mission of the ABE. The ABE is prepared to award up to \$200,000 in one or more grants. The Opportunity Grant is intended to be a one-time award to start or enhance a program of law-related research, education, or public service projects. The ABE will consider grant applications from 501(c)(3) entities for projects that meet the focus requirements set out in the Program Goal. It is expected that a program or project receiving an Opportunity Grant will become self-sustaining. The application process is streamlined to encourage proposals from a broad range of organizations.

### Program Goal

The goal of the Opportunity Grants program is to assist eligible grantees in the development or enhancement of innovative programs and projects that address issues of immediate and critical interest to the public and members of the legal profession. Examples

of areas of focus include: rule of law initiatives, access to justice initiatives, civics education on the American legal/justice system, and legal services initiatives.

### ABE Contact

To obtain an application form, visit: <http://www.abendowment.org/pdf/OppGrant-Application.pdf>. Additional guidance may be requested from the ABE at:

American Bar Endowment  
321 North Clark Street, 14th Floor  
Chicago, Illinois 60654-7648  
Attention: Opportunity Grants  
800-621-8981, ext. 6408 or 312-988-6408  
[jmartin@abendowment.org](mailto:jmartin@abendowment.org)

Grant applications must be submitted to the ABE by November 30, 2016, for consideration. To learn more, visit <http://www.abendowment.org/about/opportunity.asp>. ■



## New Commissioner Profiles

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, we have four new commissioners; you will find their short biographies below.



NEELUM AGGARWAL, MD, is a cognitive neurologist, clinical trialist and researcher in the field of population health and aging. She is Senior Neurologist for the federally funded Rush Alzheimer's Disease Center Clinical Core in Chicago; Director of Research and founder of the Cardiology Cognitive Clinic at the Rush Heart Center for Women; and an Associate Professor in the Department of Neurological Sciences and Rush Alzheimer's Disease Center at Rush University Medical Center. Dr. Aggarwal is a long-standing Steering Committee member and Site Principal Investigator for multiple NIA-funded clinical trials on aging and Alzheimer's Disease. Her clinical and population health research has focused on the predictors and outcomes of cognitive decline, mild cognitive impairment, and dementia in older adults, with a focus on underserved populations in Chicago. She is particularly interested in identifying how social determinants of health, cardiovascular disease, and other novel risk factors for cognitive impairment including sex and gender differences, may lead to strategies to prevent cognitive decline and dementia. A graduate of the Academy of Neurology - Palatucci Advocacy Leadership Forum, Dr. Aggarwal is a long-standing voice for community based research, clinical trial participation, and public health initiatives, locally and nationally. She is the Senior Advisor for Women's Health Issues, Research, Equity and Policy for the Health Equity, Leadership Exchange Network, was appointed as the first Chief Diversity and Inclusion Officer for the American Medical Women's Association, and serves as the Vice Chair of the Governing Council of the American Medical Association's Women's Physician Section. She recently was awarded the 2016 Woman in Science award from the American Medical Women's Association and is a fellow of the Institute of Medicine of Chicago.



TERESA CURTIN is an attorney with 28 years' experience and is entering into her tenth year of practice at the New York City office of Weitz & Luxenberg where she focuses on all stages of defective pharmaceutical drugs and medical devices litigations. While Ms. Curtin loves the intellectual challenge of complex multidistrict litigations, what motivates her is helping individuals, many of which whom are elderly, who suffering the devastating impact of unsafe drugs and medical devices. Ms. Curtin also maintains an active pro bono commitment to the deaf community and was involved in the seminal *Clarkson v. Coughlin* case related to the rights of deaf and hearing impaired persons in the state correctional facilities to have access to ADA accommodations in their prison settings. She is currently focusing on the lack of available mental health services for disabled individuals and individuals using American Sign Language. Ms. Curtin earned a B.A. from Princeton University in 1982, where she wrote her thesis on the Aging in America, and a J.D. from New York School of Law in 1988 where she was a Root-Tilden Public Interest Scholar. She clerked for the Honorable Justice Stewart Pollock of the New Jersey Supreme Court.



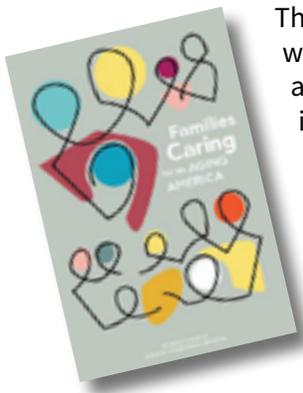
CARMEL BITONDO DYER is a graduate of Baylor College of Medicine, where she completed her Internal Medicine residency and Geriatrics Fellowship. She founded the geriatrics program at the Harris County Hospital District and the Texas Elder Abuse and Mistreatment Institute. Her research and publications have been in the area of elder mistreatment. She was a delegate to the 2005 White House Conference on Aging and has twice provided testimony at the U.S. Senate on behalf of vulnerable elders. She has received national and local recognition for her teaching abilities, research inroads and dedication to the health care of older persons. Dr. Dyer joined the UT Health faculty in January 2007 and is Professor of Geriatric and Palliative Medicine. She is currently the Chief of Staff for LBJ Hospital and Associate Dean of Harris County Programs. Dr. Dyer holds the Roy M. and Phyllis Gough Huffington Chair in Gerontology, the Nancy P. & Vincent F. Guinee, M.D. Distinguished Chair and is the executive director of the UT Health Consortium on Aging.



ELEANOR CROSBY LANIER is a full-time faculty member of the University of Georgia School of Law, teaching General Civil Mediation as well as Elder Law (entailing a pilot service learning project) and supervising students in a mediation clinic serving Athens-Clarke County. Ms. Lanier is also a registered mediator and arbitrator with the State of Georgia Office of Dispute Resolution and is qualified to mediate a wide range of disputes. Her teaching and mediation activities are informed by nearly 20 years' experience in providing and improving the delivery of legal services to older persons in Georgia, where she developed and managed the Georgia Senior Legal Hotline, and nationally. Similarly, she has been a pioneer in promoting the use of mediation in elder care disputes, providing training for mediators in several states and working with the Association for Conflict Resolution to develop training objectives for mediators in elder care, long-term care and adult guardianship cases. She has published law review articles on Adult Guardianship and the Ethics of Medicaid Estate

Planning, as well as numerous articles for the Georgia Bar Journal and for ABA publications including the Commission's *Bifocal* and the Senior Law Division's *Experience Magazine*. She is an active trainer at continuing legal education sessions and national conferences on topics ranging from ethics and professionalism to dual practice traps in mediation. A recipient of numerous honors for her work, including the State Bar of Georgia's Daniel Bradley Award, Ms. Lanier received her JD from Emory University School of Law. ■

## New Caregiving Report from the National Academy of Medicine: *Family Caring for an Aging America*



The demand for family caregivers for adults who are 65 or older is increasing significantly, and family caregivers need more recognition, information, and support to fulfill their responsibilities and maintain their own health, financial security, and well-being, says a new report from the National Academies of Sciences, Engineering, and Medicine. Although caregivers' individual circumstances vary, family caregiving can negatively affect caregivers' mental and physical health as well cause economic

harm, including loss of income and career opportunities. The report calls for health care delivery system reform that elevates family-centered care alongside person-centered care to better account for the roles of family caregivers and support their involvement in the care delivery process.

Download the report for free at: <http://www.nationalacademies.org/caregiving>.

For more information, contact: Jill Eden at [jeden@nas.edu](mailto:jeden@nas.edu). ■

## Commission Director Sabatino Named One of Next Avenue's 2016 Influencers in Aging

Next Avenue, public media's first and only digital publication dedicated to covering issues for older Americans, has named its 2016 Influencers in Aging. The list recognized 50 advocates, researchers, thought leaders, innovators, writers, and experts at the forefront of changing how we age and think about aging. "We've uncovered a range of leaders who have made exceptional contributions this year," said Susan Donley, Managing Director of Next Avenue. Learn more about the recognition and the other influencers at <http://nextavenue.org/influencers>.



### **Charlie Sabatino: Advocating for Legal Rights**

Director, American Bar Association Commission on Law and Aging

Sabatino has devoted more than three decades to his work at the American Bar Association, specializing in research and project development in health law, long-term care planning and access to legal services for older adults. He has also written and spoken widely on advance care planning. In addition, Sabatino has shared his expertise with students at Georgetown University Law Center as an adjunct professor in elder law since 1987.

Sabatino served as president of the National Academy of Elder Law Attorneys and has been active in the organization's public policy efforts. His work on elder law issues began at the ground level, when he joined Legal Services of Northern Virginia as senior citizens project counsel.

### **If you could change one thing about aging in America, what would it be?**

"My one change has a thousand facets — I would want to strengthen and secure the legal rights, dignity, autonomy, quality of life and quality of care of persons as they age, particularly low-income and vulnerable elders." ■



## The Commission's Fall 2016 Legal Externs



**Erica McCrea** is a second-year law student at The Catholic University of America, Columbus School of Law in Washington, D.C. Ms. McCrea received her B.A. in English from Charleston

Southern University in Charleston, S.C. Following her first year of law school, Ms. McCrea worked as an enforcement intern in the Washington Field Office of the EEOC. There she conducted intake and evaluation of charges under discrimination statutes including Title VII, the ADA, and the ADEA.

This fall she is working under the supervision of Erica Wood researching current privacy and confidentiality provisions in guardianship statutes. With that research, Ms. McCrea will create a chart of statutory provisions and draft a brief article discussing her findings.



**Sidney Zahabizadeh** is a second-year law student at the University of Maryland Francis King Carey School of Law where she is a Law & Healthcare Program Certificate Candidate and a Staff Editor on the Journal of Health Care Law & Policy. Prior to the

ABA, she interned for the Department of Health and Human Services, Office of General Counsel. Born and raised in Los Angeles, Ms. Zahabizadeh completed her undergraduate education at the University of Southern California where she discovered her interest in aging at the USC Davis School of Gerontology. This semester, she is working under the supervision of David Godfrey researching current durability provisions in power of attorney statutes. Using this research, she will create a state-wide chart of statutory provisions identifying key elements such as language required for durability, whether there is a statutory form, role of third parties, and more including where to locate these elements. ■

# Three Low-Cost Ways to Do Outreach and Education on Elder Abuse

by Keith Morris

Many of our senior legal hotline programs are starting new model approaches grants, all of them with some focus on addressing the problem of elder abuse. I thought it would be a good time to share some tips I have picked up over the years regarding doing low-cost or free outreach and education. (Let me say that I started this post with 7 low-cost ways, but had to cut it back so that the article wouldn't be so long. I'll share the others with you in an upcoming piece.)

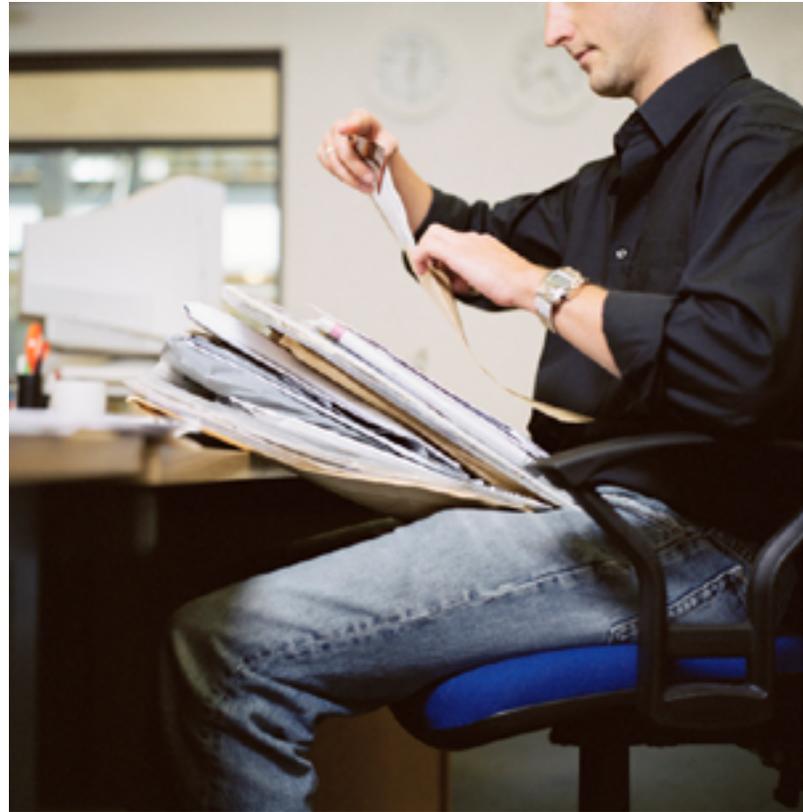
If you have any questions, would like some feedback on a program that you are working on, or have suggestions that you would like to share with others, please contact me at [kmorris@ceraresource.org](mailto:kmorris@ceraresource.org).

## 1. Use your existing correspondence efficiently

If you are already sending a closing letter, a satisfaction survey, or other information after you talk with your client on the phone, you should consider adding information about the problem of elder abuse. It could be a paragraph in your closing letter, a flyer that lists some of the facts about the problem, or an insert that tells the story of how your program helped a client who was a victim of elder abuse.

Make sure you have a clear reason for adding this to your mailing, and make sure the reader can figure that out as well. Do you want them to call your hotline for more information? Do you want them to know more about their rights, etc.? Often, narrowing the information to one specific topic makes it easier for the person to understand. For example, focusing on a particular scam and how to identify it.

It is important to pay attention to the language that you use in materials like this. Statements like "are you a victim of elder abuse?" may not work because often the older adult doesn't like to see themselves as victims. There are several approaches to take, such as focusing on the fact that many older adults are taken advantage of each year. Another approach is, "Are you or someone you love worried about how to deal with . . ."



Don't underestimate the importance of the correct graphic if you are adding an insert or a flyer to your mailing. For topics like elder abuse, it is difficult to decide on what emotion we want the reader to feel when looking at the information. I try to stay away from very sad images and very happy images. Perhaps you will find it easier to focus on the facts or situation and find an image to reflect that. For example, if your information is about a phone scam, using an image of a phone with a question mark or a caution sign might be what you need.

Here are some examples of flyers and inserts that have been used.

- Housing Outreach: <https://drive.google.com/file/d/0B7JFe258ss47SWFZNmtFa0gxLTA/view?usp=sharing>
- Debt Scams: [https://docs.google.com/document/d/1vWg\\_zqtjqe7PKtYTYZgKyeY-6swjykuuzKxBR9tZR8/edit?usp=sharing](https://docs.google.com/document/d/1vWg_zqtjqe7PKtYTYZgKyeY-6swjykuuzKxBR9tZR8/edit?usp=sharing)

Be sure to keep track of the number of clients that you provide this information to because you probably will want to include this activity in a grant report. It is a good idea to come up with a calendar of topics and include something in each client correspondence.

(Always make sure you know the number of pages that you can include in the envelope before the amount of postage required increases.)

Finally, if you have any questions or would like some ideas on how to use this to educate clients on relevant topics, the staff at CERA are always eager to help.

## **2. Educate service providers and professionals about the problem of elder abuse**

Over the years, I have found that providing education and resources to professionals that work with the older adult population was one of the most cost effective ways to do outreach to seniors. By doing a presentation on the problem of elder abuse or some related topic to senior housing service coordinators, law enforcement, nurses, in-home care service providers, etc., you can make an indirect connection to every person that they deal with.

Almost everyone at a presentation like this is grateful for the information you shared with them and for the resources that are available. Each person there wants to help the older adult they are working with, and wants to have as many tools at their disposal. Be sure to leave them with some flyers or cards that they can give to the older adult who may need your services.

Another way that you can accomplish this same goal is to write articles that can be included in the newsletter for the state chapter of the professional association. Also, most of these professionals have continuing education requirements, so try to get a webinar approved for credit and offer it for free.

I do want to mention a few groups of professionals that we often overlook:

- Hair Stylists. Whether someone at the beauty shop or barber shop, these professionals are great sources of information for their clients and can provide your information to their older adult clients.
- Postal Employees. They often see the older adult just about every day and could share information.
- Meter Readers, electric company or gas company. There are several great programs throughout the country where utility companies are checking in on older adults on a regular basis.

## **3. Use your clients**

Almost every hotline that keeps track of how a client found out about their services finds that a family member or friend told the client about the hotline. It is this unofficial endorsement of our services that gives the older adult the courage to call about a problem that they are having. So why don't we make it easier for people to be our ambassadors and tell others about the great work that we do?

Over the years, I have tried a variety of approaches for this. One of the ways to do this is to insert some pre-print business cards in the envelope with the client letter. The cards simply have the hotline logo, the phone number to call, and the hours that the hotline is open. In one campaign we did, at the end of the call, the attorney told the client that there would be some business cards in with the closing letter and encouraged the client to give a card to someone that they think might need our services. Another time, we encouraged the client to post our card at the grocery store or at their pharmacy.

But, one of the most effective ways that we found to do outreach about the hotline was to add something to the closing letter like this, "Even if you are unable to make a donation to support the work of the hotline, there is still something you can do. Tell a friend or family member who may need our services about us and how they can reach us." Of course, that was included after we asked for a donation, but it was a way for the client to feel like they were giving something back to the program that helped them.

I haven't used this method for outreach and education for addressing the problem of elder abuse, so I can only recommend it for general outreach. I would love to hear from others that have done something similar as a way to get the word out about the services available to combat elder abuse.

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*Keith Morris is the President of Elder Law of Michigan and Director of the Center for Elder Rights Advocacy. This article is reprinted from the CERA blog at <https://ceraresource.wordpress.com>. ■*

# How to Find Medicare Law

by Sidney Zahabizadeh



## The Medicare Program

Medicare provides health insurance for persons age 65 and older and persons eligible for Social Security Disability benefits for 24 months or more (with some exceptions for earlier coverage). The federal statutes creating the program can be found in 42 U.S.C. § 1395 *et seq.* and the federal regulations are located at 42 C.F.R. § 400 *et seq.* The program and policy operations manuals can be found at <https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms.html>.

The Medicare Program has four parts:

1. Medicare Part A covers hospital services, skilled nursing facilities, and home health services. The enabling law is found in 42 U.S. Code §§ 1395c–1395i-5 and the regulations are at 42 C.F.R. § 406. The program and policy manuals can be found at <https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912.html>.
2. Medicare Part B covers physician services, some preventative services, ambulance services, and durable medical equipment. The statutes can be found at 42 U.S.C. §§ 1395j–1395w-6 and the regulations are located at 42 C.F.R. Part 414. The policy manuals can also be found at <https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912.html>.

3. Medicare Part C, also known as Medicare Advantage, creates private insurance plans in the form of HMO, PPOs and such that replace Medicare Part A and B for beneficiaries who chose to enroll in them. The enabling law is found in 42 U.S. Code §§ 1395w-21–1395w-29 and the regulations are located at 42 C.F.R. Part 422. The policy manual is found at <https://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/downloads/mc86c11.pdf>.
4. Medicare Part D, creates private insurance plans that provide prescription drug coverage for Medicare beneficiaries. The enabling law is found in 42 U.S. Code §§ 1395w-101–1395w-154 and the regulations are located at 42 C.F.R. Part 423. The policy manual is found at <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Part-D-Benefits-Manual-Chapter-6.pdf>.

## Medicare Enrollment & Eligibility

Enrollment in Medicare is handled by the Social Security Administration (SSA). Eligible beneficiaries who are already receiving social security benefits are automatically enrolled in Medicare. There are three ways to be eligible for Medicare: (1) Age 65 or older; (2) Disability; or (3) ESRD (transplant or three months regular dialysis). Those who are not receiving Social Security benefits must actively enroll. The requirements for enrolling in the Medicare program can be found at 42 C.F.R. § 422.510.

The enabling statutes can be found in 42 U.S.C. 1395a(a), the regulations are found at 42 C.F.R. § 405 *et seq.*, and the program and policy operations manuals can be found at <https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms.html>. By statute, Medicare may only pay for items and services that are “reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,” unless there is another statutory authorization for payment. *See* 42 U.S.C. § 1395y(a) (1)(A).

### **Medigap**

Medigap insurance is meant to work in tandem with the original Medicare program by paying for beneficiary cost-sharing and some other services not usually covered by Medicare. An individual must have Parts A and B to buy a Medigap plan. Federal law provides rights to purchase policies at certain times and state law can expand such rights. The federal regulations can be found at 42 C.F.R. § 403.206. The program and policy operations manuals can be found at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c28.pdf>. More information can be found at <http://www.cgsmedicare.com/jc/pubs/pdf/chpt7.pdf>.

### **Medicare Savings Programs (MSPs)**

There are three Medicare Savings Programs:

- Qualified Medicare Beneficiary Program (QMB)
- Specified Low Income Medicare Beneficiary Program (SLMB)
- Qualified Individual Program (QI)

A useful chart for state-by-state MSPs Eligibility and Coverage in 2016 can be found at <https://www.ncoa.org/wp-content/uploads/medicare-savings-programs-coverage-and-eligibility.pdf>.

### **Medicaid**

Medicaid is a joint federal/state program that helps pay medical costs for some individuals with limited income and resources. State Medical Assistance office is responsible for determining eligibility and enrollment. Medicaid was created in the Social Security Act § 1902. The federal statutes creating

the program can be found in 42 U.S.C. § 1396a *et seq.*, the federal regulations are located at 42 C.F.R. § 435.121; 435.330; 435.631; 435.733. The State Medicaid Manual can be found at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>.

### **Medicare Advantage (MA)**

MA plans are another way to access Medicare benefits. A company offering an MA plan contracts with and is approved by CMS to administer Medicare benefits. The federal regulations can be found at 42 C.F.R. Part 422. The Medicare Managed Care Manual can be found at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html>.

### **Medicare Appeals**

The appeals process for Medicare Parts A and B can be found at <https://www.cms.gov/Outreach-and-Education/MedicareLearningNetworkMLN/MLNProducts/downloads/MedicareAppealsprocess.pdf>. The regulations for Determinations, Redeterminations, Reconsiderations, and Appeals under Medicare Parts A and B can be found at 42 C.F.R. Part 405, Subpart I. Additionally, Appeals under the Medicare Part B program specifically can be found at 42 C.F.R. Part 405, Subpart H. The Medicare Part C regulations for appeals can be found at 42 C.F.R. Part 422, Subpart M. The Medicare Part D regulations for grievances can be found at 42 C.F.R. Part 423, Subpart M.

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*Sidney Zahabizadeh is a legal intern for the ABA Commission on Law and Aging. Currently, Sidney is a second year law student at the University of Maryland Francis King Carey School of Law where she is a Law & Healthcare Program Certificate Candidate and a Staff Editor on the Journal of Health Care Law & Policy. Prior to the ABA, Sidney interned for the Department of Health and Human Services, Office of General Counsel. Born and raised in Los Angeles, Sidney completed her undergraduate education at the University of Southern California where she discovered her interest in aging at the USC Davis School of Gerontology. ■*

# 2016 National Aging and Law Conference:

*Conference highlights elder justice measures, progress yet to be made*



Edwin Walker, acting assistant secretary for aging and acting administrator of the Administration for Community Living in the U.S. Department of Health and Human Services.



Andy Mao, coordinator of the Elder Justice Initiative at the U.S. Department of Justice addresses the National Aging and Law Conference.

One in 23. That's the number of cases of elder abuse that are reported to the authorities, according to a 2011 study shared on the Centers for Disease Control and Prevention website. And the statistic makes clear that too many incidents of elder abuse remain unaddressed, leading organizers of the 2016 National Aging and Law Conference to theme their event: "Justice for elders."

The conference took place on Oct. 27-28 in Old Town Alexandria, Va., and was presented by several American Bar Association entities, including the Commission on Law and Aging; Commission on Homelessness and Poverty; Coordinating Committee on Veterans Benefits and Services; Section of Administrative Law and Regulatory Practice; Section of Civil Rights and Social Justice; Section of Real Property, Trust and Estate Law, Senior Lawyers Division; General Practice, Solo and Small Firm Division; and Standing Committee on Legal Aid and Indigent Defendants.

One of the more than 30 offered workshops and plenary sessions featured Edwin Walker, acting assistant secretary for aging and acting administrator of the Administration for Community Living in the U.S. Department of Health and Human Services, and Andy Mao, coordinator of the Elder Justice Initiative at the U.S. Department of Justice.

During the session "Justice for Elders Plenary," Walker and Mao discussed emerging trends in elder justice and initiatives at the federal, state and local level to prevent and mitigate the abuse of older Americans. Programs under the auspices of the ACL and DOJ that empower elders to maintain self-determination and avoid falling prey to abuse or exploitation were detailed. Attendees were instructed on connecting to evidence-based programs in their communities, while the efforts of the Elder Justice Coordinating Council to enhance interagency coordination were highlighted.

Prior to federal service, Walker served as director of the Missouri Division of Aging, responsible for administering a comprehensive set of human service programs for older persons and adults with disabilities. The programs of the ACL, which he now administers, work collaboratively to enhance access to health care and long-term services and supports, while also promoting inclusive community living policies.

Among the resources of Mao's Elder Justice Initiative is the DOJ Elder Justice Website. Information on the site includes how to report elder abuse and financial exploitation in all 50 states and territories, databases containing sample pleadings and statutes, and, for researchers, thousands of elder abuse and financial exploitation articles and reviews.

Previously, Mao was part of the team that led the federal government's health care fraud case against GlaxoSmithKline, in which the pharmaceutical company agreed in 2012 to plead guilty and pay \$3 billion related to the illegal promotion of certain drugs and other practices. Mao said he believes that providing greater education to law enforcement personnel, ombudsmen and the public on signs of elder abuse, neglect and exploitation can make a significant difference in preventing such crimes and bringing perpetrators to justice.

"The Department of Justice has taken a leadership role on ending international fraud targeting seniors," Mao said. He advocated that what is needed is a "great seamless collaborative effort to address elder justice," and that through the work of the Elder Justice Coordinating Council, "DOJ has taken to heart the need for collaboration; collaborative networks are the most effective way to address abuse."

Walker emphasized the importance of the Older Americans Act and said that data on its effectiveness is needed to get the law reauthorized. "The Older Americans Act was reauthorized for three years;

come spring it will be time to provide input for the next Older Americans Act reauthorization," he said. "In preparing for reauthorization, we are constantly asking, 'Where is the evidence? Where is the data?'"

Research shared at the conference reveal the uphill battle faced by advocates against abuse of older Americans. Elder abuse affects about 10% of people age 60 and over, and close to 50% of those with dementia. Without proper training, professionals working with older Americans often miss signs of abuse. Prosecutions in such cases are rare.

Presenter Ben Belton of the Social Security Administration challenged those in power to address unmet needs, quoting from Hubert Humphrey's last speech: ". . . The moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; those who are in the shadows of life, the sick, the needy and the handicapped."

Planning has begun for the 2017 National Aging and Law Conference to be held October 26-27 at the DoubleTree by Hilton in Silver Spring, Md. Check the website of the ABA Commission on Law and Aging for updates: <http://ambar.org/NALC>.

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*This ABA News Update was provided by the ABA Media Relations Department. Contact the Department at [abanews@americanbar.org](mailto:abanews@americanbar.org) or call (202) 662-1090. ■*



A packed room of attendees listens closely to Rapid-Fire Plenary panels. The crowd-favorite is a fast-paced session featuring multiple presentations in rapid succession.



Erica Wood, Assistant Director of the ABA's Commission on Law and Aging, speaking on the Rapid-Fire Plenary panel at NALC.

*Save the Date!*

# 2017 National Aging and Law Conference

DoubleTree by Hilton • Silver Spring, MD • October 26-27, 2017

Save the date for next year's National Aging and Law Conference in convenient Silver Spring, Maryland, a short 20-minute metro ride from downtown Washington, DC.

Stay up to date on details for the Conference by following the NALC twitter account or Facebook page!

**2016 Follow-Up: 2016 Meeting Materials are available for purchase.**

Please visit: <http://bit.ly/2eJgqLI> ■

 Conference website:  
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 Facebook:  
<http://t.co/fWDko0uL1R>

 Twitter:  
[@NtlAgingLawConf](https://twitter.com/NtlAgingLawConf)

 Staff contact: David Godfrey  
[David.Godfrey@Americanbar.org](mailto:David.Godfrey@Americanbar.org)

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### Discussion Lists

The Commission provides a forum for legal professionals to communicate and share ideas on two active discussion lists:

- *Elderbar*, an open discussion list for professionals in law and aging, and
- *Collaborate*, a discussion list on aging, disability, and dispute resolution.

Visit the [Commission's homepage](#) for more information on how to sign up.

### Media Requests

The Commission provides background to the media on a range of issues relating to law and aging, including:

- Guardianship and conservatorship
- 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](mailto:abanews@americanbar.org) or (202) 662-1090.