

# The Elder Law Extra

William Gering, *Chair*  
Elena S. Boisvert, *Editor*

## Message from the Chair...

Welcome to the 2011-2012 Newsletter. Your section council has been meeting monthly since August to address events occurring in the multi-faceted practice area we know as Elder Law. We are trying to be pro-active in supplying you with timely information on changes and events as they occur.

Ed Law has held two meetings of the Special Needs Study Group and has another meeting planned for December. These meetings are not just about "special needs trusts" as we commonly use the term. The December topic tentatively will be on SSI Applications and the Appeal Process.

Our first section meeting held on November 10th had Paul Ballard, Assistant Attorney General and Counsel to the Office of Health Care Quality of the Department of Health and Mental Hygiene speaking on the new MOLST form and how it will be used. We are working on plans for future section meetings which could include topics such as Accountable Care Organizations and a review of the proposed Maryland Trust Code if it is reintroduced in the General Assembly again this year. Every year, we have scheduled a section meeting in Annapolis during the General Assembly Session. We are open for suggestions as to how we can make this meeting more relevant for section members.

We are also open to considering any topics our members may feel are relevant for section members. We are also trying to provide video conferenc-

ing of our section meetings to reduce the travel time for members wishing to attend. If you have access to video conferencing please give me a call to see if we can connect with your location. My office has video conferencing capabilities but we have firewall concerns that must be addressed.

As you may be aware, my practice consists primarily of administering trusts and estates. However, I have been a member of the Elder Law section since its beginning. I feel that an understanding of the many issues that elder law involves allows me to better understand the problems that my clients face as they age.

We welcome your comments and suggestions.

*William J. Gering*  
Chair



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# New Legislation Increases Utility of Special Needs Trusts

By Jason Frank

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Many individuals with disabilities will ultimately have to qualify for Medical Assistance to pay for necessary long term support and services.<sup>1</sup> Medical Assistance is a means-tested program that pays the cost of medical care for individuals who meet the eligibility requirements.<sup>2</sup> An award from a personal injury case will likely cause an applicant/recipient (A/R) to exceed Medical Assistance's income and asset eligibility requirements.<sup>3</sup> The A/R, ineligible for Medical Assistance, will have to pay the private rate for nursing home care until they meet these eligibility requirements.<sup>4</sup> In many of these cases, the A/R will have to use the personal injury award to pay the exact facility that injured him or her in the first place.

In order to prevent the award from affecting the A/R's eligibility for Medical Assistance, the award may be placed in a 42 U.S.C. § 1396p(d)(4)(A) trust or a 42 U.S.C. § 1396p(d)(4)(C) pooled asset trust.<sup>5</sup> While federal regulations clearly define the (d)(4)(A) trust, some of the federal regulations concerning a (d)(4)(C) pooled asset trust are unclear. Maryland regulations do not impose requirements for pooled asset trusts beyond those specified under federal law and as a result, Maryland also provides ambiguous guidance on how a pooled asset trust affects Medical Assistance eligibility.<sup>6</sup>

The Maryland Department of Health and Mental Hygiene proposed regulations in January 2011 for the purpose of restructuring and clarifying special needs trust regulations.<sup>7</sup> In fact, the proposed regulations stripped special needs trusts of their utility and effectively barred individuals over the age of 65 from using special needs trusts.<sup>8</sup> Immediately, there was a ground swell of opposition to the regulations of tsunami proportions and the proposed regulations paved the way for a bill to bar their enactment.

In response to the proposed regulations, Senator Gladden sponsored Senate Bill 888 which opposed the proposed regulations and established how certain special needs trusts may be used in conjunction with Medical Assistance.<sup>9</sup> A broad spectrum of professionals in disability related fields including the Maryland Association of Justice supported

SB 888, including Delegate Smigiel who sponsored the same bill in the House of Delegates.<sup>10</sup> The Maryland legislature passed the bill in April 2011 and Governor O'Malley signed it into law on May 19, 2011.<sup>11</sup>

Attorneys with clients who have disabilities must understand how special needs trusts may be used to protect a client's assets, and how SB 888 will improve the utility of special needs trusts, especially when the client receives a personal injury award.

## I. Background on Special Needs Trusts

Individuals must meet several eligibility criteria in order to receive Medical Assistance.<sup>12</sup> One eligibility criterion requires an A/R to have assets below a certain limit.<sup>13</sup> If an A/R acquires assets in excess of the program limits, such as through a personal injury settlement or an inheritance, he or she may lose Medical Assistance eligibility until the assets are spent down or *placed in a special needs trust*.<sup>14</sup> An A/R who gives away or transfers assets below market value in order to meet the asset limit could be subject to a period of ineligibility.<sup>15</sup>

Generally, Medical Assistance counts a trust as an asset when calculating eligibility.<sup>16</sup> However, federal law governing Medicaid programs exempts certain special needs trusts from the asset calculation. There are four types of federal special needs trusts that can be created by or for an A/R.<sup>17</sup> The two relevant to this article are the 42 U.S.C. § 1396p(d)(4)(A) trust and the 42 U.S.C. § 1396p(d)(4)(C) trust. These trusts must be created to benefit an individual with a disability.<sup>18</sup> Under these statutes, an individual is considered disabled if he or she "is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months."<sup>19</sup> These trusts are distinguishable from other special needs trusts because the A/R funds the trust and is also the sole beneficiary of the trust.<sup>20</sup>

The (d)(4)(A) trust is a trust created by someone other

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## Special Needs Trust...

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than the A/R with the A/R's funds.<sup>21</sup> A parent, grandparent, legal guardian of the A/R, a court, or a person or administrative agency acting at the behest of the court creates the trust.<sup>22</sup> The trust is created with the A/R's funds and for the sole benefit of the A/R, who must be under 65 years of age and disabled.<sup>23</sup>

By comparison, the (d)(4)(C) trust, also known as the pooled asset trust, is a trust managed by a non-profit organization that collectively invests and manages funds of multiple individuals who are disabled, reducing the costs of trust administration.<sup>24</sup> The trust must be funded with the A/R's funds, and with a separate account maintained for each A/R who is a beneficiary of the trust.<sup>25</sup> The accounts are established by the A/R, a parent, grandparent, legal guardian of the A/R, or a court or administrative agency, and for the sole benefit of the A/R, who must be disabled at the time of the trust account's creation.<sup>26</sup>

Funds in an individual's account may be used for such things as travel, education, hobbies and health care not covered by Medical Assistance.<sup>27</sup> The trust may also pay for food and shelter under the Presumed Maximum Value rule, and private duty nursing, particularly when the nursing home causes problems. The pooled asset trust has complete discretion to make distributions from each beneficiary's individual account.<sup>28</sup> This discretionary power is an important part of why Medical Assistance treats the funds as unavailable and not countable for purposes of determining Medical Assistance eligibility.<sup>29</sup> Penn-Mar Human Services, Shared Horizons, Inc., ARC of Northern Virginia, and First Maryland Disability Trust, Inc ("FMDT") are pooled asset trusts available in Maryland.<sup>30</sup> Other regional and national trusts also offer services in Maryland.

### II. Ambiguities in Special Needs Trust Regulations

Although federal statute permits individuals with disabilities to create special needs trusts to hold assets, states vary in their interpretation and application of the federal regulations which govern special needs trusts. In particular, federal Medicaid policy is unclear in regards to whether assets may be transferred into a pooled asset trust established by an individual age 65 and older without penalty. Federal policy currently states that funds transferred to a pooled asset trust for an individual 65-years-or-older is a transfer

subject to penalty for SSI eligibility purposes.<sup>31</sup> Therefore, federal policy only suggests, and does not provide clear guidance, on how state *Medicaid* programs should treat a transfer of funds into a (d)(4)(C) pooled asset trust.<sup>32</sup> States vary in their interpretation and application of this federal law.<sup>33</sup>



Prior to the enactment of SB 888, Maryland also provided ambiguous guidance on this issue. Maryland regulations did not impose requirements for pooled asset special needs beyond those specified under federal law.<sup>34</sup> On May 11, 2010, the Assistant Attorney General responded to a query from the FMDT president and stated that, pursuant to federal and state law, there is no age limitation on who may transfer assets

into a pooled asset trust subaccount without penalty.<sup>35</sup> Therefore, a beneficiary with a disability, aged 65 years or older could transfer assets into a pooled asset trust without a Medical Assistance penalty.

However, in January 2011, the Department of Health and Mental Hygiene proposed new regulations concerning special needs trusts.<sup>36</sup> In contrast to the Assistant Attorney General's letter, the regulations stated that a transfer into a pooled asset trust after age 65 would be subject to a transfer penalty.<sup>37</sup> The proposed regulations included other provisions that also severely limited the use of special needs trusts. For example, the proposed regulations stated:

- Assets in a special needs trust may not be used to compensate family members of the trust beneficiary in any way, such as accompanying the beneficiary on travel or caring for the beneficiary.<sup>38</sup>
- A pooled asset trust may only accept individual accounts valued at less than \$100,000.<sup>39</sup>
- The trustee of a pooled asset trust must pay the Department of Health and Mental Hygiene all amounts remaining in a beneficiary's individual account upon the death of the beneficiary up to an amount equal to the total Medical Assistance benefits paid on behalf of the beneficiary.<sup>40</sup>

### III. Impact of Senate Bill 888

Governor O'Malley signed the estates and trusts Senate

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Visit [www.msba.org/sec\\_comm/sections/elder/](http://www.msba.org/sec_comm/sections/elder/) for all the latest updates!

## Special Needs Trust...

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Bill 888 into law on May 19, 2011 in order to clarify some of the issues regarding special needs trusts.<sup>41</sup> The bill maintains the “status quo” in Maryland regarding the use of special needs trusts and encourages the use of certain special needs trusts by individuals with disabilities.<sup>42</sup> The bill also effectively bars some of the provisions of the Department of Health and Mental Hygiene’s proposed regulations.<sup>43</sup>

Specifically, the bill states that it is the policy of Maryland to encourage individuals of any age with disabilities to use a special needs trust or a supplemental needs trust to preserve funds that will provide for the individual’s needs which are not met by public benefits.<sup>44</sup> In addition, the bill requires Medical Assistance and other public assistance programs to promulgate regulations consistent with following provisions.<sup>45</sup>

- An individual account in a pooled asset special needs trust may be funded without financial limit.<sup>46</sup> In contrast to a \$100,000 cap put forth in the proposed regulations, SB 888 permits an individual to fund an account with as much money as he has available. As a result, an individual can keep his or her entire personal injury award in a special needs trust, instead of retaining only \$100,000 and having to spend down the rest until he or she is eligible for Medical Assistance.
- A fund in a special needs trust, supplemental needs trust, or pooled asset special needs trust may be used for the sole benefit of the beneficiary including, at the discretion of the trustee, distributions for food, shelter, utilities, and transportation.<sup>47</sup>
- An individual may establish or fund an individual account in a pooled asset special needs trust without an age limit or a transfer penalty.<sup>48</sup> This provision is of particular importance because it clarifies Maryland’s regulations in regards to how Medical Assistance will treat a transfer into a pooled asset trust when determining eligibility. This provision explicitly allows individuals with disabilities of all ages, including 65-years-or-older, to transfer funds, such as from a personal injury award, into a pooled asset trust without a penalty.
- An individual may fund a special needs trust or supplemental needs trust for the individual’s child with disabilities without a transfer penalty and regardless of the child’s age.<sup>49</sup>
- All legally assignable income or resources may be assigned to a special needs trust, supplemental needs trust, or pooled asset special needs trust without limit.<sup>50</sup>

### Endnotes

<sup>1</sup> Nursing home care is expensive and paying for nursing home care out of pocket rapidly depletes an individual’s savings. A senior can anticipate spending more than \$90,000 dollars a year on nursing home care. GENWORTH, COST OF CARE SURVEY 2011 at 43, available at [http://www.genworth.com/content/products/long\\_term\\_care/long\\_term\\_care/cost\\_of\\_care.html](http://www.genworth.com/content/products/long_term_care/long_term_care/cost_of_care.html).

<sup>2</sup> DEP’T HEALTH AND MENTAL HYGIENE, MARYLAND MEDICAL CARE PROGRAMS, <http://www.dhmh.state.md.us/mma/mma-home.html> (last visited July 14, 2011).

<sup>3</sup> In 2011, the income limit is \$350 for an individual and \$392 for a couple. The asset limit is \$2,500 for an individual and \$3,000 for a couple sharing a room. BALTIMORE COUNTY BENEFITS ROSTER - 2011 ELIGIBILITY, <http://www.baltimore-countymd.gov/Agencies/aging/financial/benefits.html>.

<sup>4</sup> An individual with a disability may also exceed medical assistance eligibility if they receive an inheritance. In these situations a special needs trust may also be used to hold their assets so that they remain eligible for Medical Assistance.

<sup>5</sup> 42 U.S.C. § 1396p(d)(4)(A); 42 U.S.C. § 1396p(d)(4)(C).

<sup>6</sup> Fiscal and Policy Note, S. 888, 2011 Leg., 428<sup>th</sup> Sess. (Md. 2011); see also MD. CODE REGS.10.09.24.08-2 (2011).

<sup>7</sup> 38 Md. Reg. 185 (January 28, 2011) (to be codified at Md. CODE REGS. 10.09.24.08-2 through .08-5 (2011)).

<sup>8</sup> See id.

<sup>9</sup> S. 888, 2011 Leg., 428<sup>th</sup> Sess. (Md. 2011), codified at Md. CODE ANN. 14-114(A)-(D). This bill is effective October 1, 2011.

<sup>10</sup> H.D. 1277, Leg., 428<sup>th</sup> Sess. (Md. 2011), codified at Md. CODE ANN. 14-114(A)-(D).

<sup>11</sup> Id.

<sup>12</sup> Medical assistance requires an applicant to be a U.S. citizen or qualified alien, and Maryland resident. The applicant must also meet level of care requirements, and income and asset limits. Lastly, the applicant will have to address the program’s penalty provisions. See MD. CODE REGS.10.09.24 (2011).

<sup>13</sup> MD. CODE REGS.10.09.24.08 (2011). Medical Assistance counts such things as bank accounts, stocks, real property, and inter vivos trusts, as assets when determining eligibility. Id. In 2011, the income limit was \$350 for an individual and \$392 for a couple. The resource limit is \$2,500 for an individual and \$3,000 for a couple sharing a room. BALTIMORE COUNTY BENEFITS ROSTER - 2011 ELIGIBILITY, <http://>

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[www.baltimorecountymd.gov/Agencies/aging/financial/benefits.html](http://www.baltimorecountymd.gov/Agencies/aging/financial/benefits.html).

<sup>14</sup> See MD. CODE REGS.10.09.24.08 (2011).

<sup>15</sup> See MD. CODE REGS.10.09.24.08-1 (2011).

<sup>16</sup> See MD. CODE REGS.10.09.24.08 through .08-2 (2011).

<sup>17</sup> The four types of exempt federal statutory trusts are the 42 U.S.C. § 1396p(d)(4)(A) “exempt pay-back trust,” 42 U.S.C. § 1396p(d)(4)(C) “pooled asset trust,” and the 42 U.S.C. § 1396p(c)(2)(B)(iii) and 42 U.S.C. § 1396p(c)(2)(B)(iv) third-party trusts. For more information on these different types of trusts see JASON FRANK, *ELDER LAW IN MARYLAND* (Matthew Bender, 2009).

<sup>18</sup> See 42 U.S.C. § 1396p(d)(4)(A); 42 U.S.C. § 1396p(d)(4)(C).

<sup>19</sup> See 42 U.S.C. § 1382c(a)(3).

<sup>20</sup> See 42 U.S.C. § 1396p(d)(4)(A); 42 U.S.C. § 1396p(d)(4)(C).

<sup>21</sup> 42 U.S.C. § 1396p(d)(4)(A).

<sup>22</sup> *Id.*

<sup>23</sup> *Id.*

<sup>24</sup> 42 U.S.C. § 1396p(d)(4)(C).

<sup>25</sup> *Id.*

<sup>26</sup> *Id.*

<sup>27</sup> First Maryland Disability Trust, Inc., available at [www.firstmdtrust.org](http://www.firstmdtrust.org) (last visited July 14, 2011).

<sup>28</sup> *Id.*

<sup>29</sup> *Id.*

<sup>30</sup> For more information on each trust, visit the following websites, [www.penn-mar.org](http://www.penn-mar.org); [www.shared-horizons.org](http://www.shared-horizons.org); [www.thearcofnova.org](http://www.thearcofnova.org); and [www.firstmdtrust.org](http://www.firstmdtrust.org) (last visited July 14, 2011).

<sup>31</sup> Social Security Administration, POMS Manual, SI 01120.203B.2.a (stating that funds transferred to a pooled asset trust for an individual 65-years-or-older may be required to be treated as income for eligibility purposes, and that this addition income may cause the beneficiary to lose eligibility(emphasis added)); see also 42 U.S.C. § 1396p(d)(4)(C) (not establishing an age limit).

<sup>32</sup> On May 12, 2008, CMS failed to clarify Medicaid policy with respect to the transfer of assets penalty provision on pooled (d)(4)(C) trusts established by individual’s ages 65 or older. CMS reiterated that while a (d)(4)(C) trust may be established for a person of any age, any funds in a trust established for an individual 65 years or older may be subject to a penalty as a transfer of an asset for less than fair market value. CMS, STATE AGENCY REGIONAL BULLETIN, No. 2008-05, RE: MEDICAID ELIGIBILITY (May 12, 2008).

<sup>33</sup> Compare *Beach v. State of Tennessee Department of*

Human Services, No.09-21220-III (Tenn. Chan. Ct. Sept. 8, 2010) (holding that a 92-year-old Medicaid applicant may transfer funds into a pooled special needs trust without a penalty) with *Center for Special Needs Trust Administration, Inc. v. Olson*, No. 1:09-cv-072 (D.N.D. April 25, 2011) (holding that North Dakota may assess a transfer-of-assets penalty against a 78-year-old Medicaid applicant for funding a pooled trust account).

<sup>34</sup> Fiscal and Policy Note, S. 888, 2011 Leg., 428<sup>th</sup> Sess. (Md. 2011); see also MD. CODE REGS.10.09.24.08-2 (2011).

<sup>35</sup> Response letter from Meredith Borden, Assistant Attorney General, to Jason Frank, Esq. regarding pooled asset special needs trusts (May 11, 2010). See JASON FRANK, *ELDER LAW IN MARYLAND*, Appendix 4O (Matthew Bender, 2009) for a copy of the letter.

<sup>36</sup> 38 Md. Reg. 185 (January 28, 2011) (to be codified at MD. CODE REGS. 10.09.24.08-2 through .08-5 (2011)).

<sup>37</sup> 38 Md. Reg. 185 (January 28, 2011) (to be codified at MD. CODE REGS. 10.09.24.08-4G (2011)).

<sup>38</sup> *Id.* (to be codified at MD. CODE REGS. 10.09.24.08-5A(3)(h) (2011)).

<sup>39</sup> *Id.* (to be codified at MD. CODE REGS. 10.09.24.08-4B (2011)).

<sup>40</sup> *Id.* (to be codified at MD. CODE REGS. 10.09.24.08-4A(11) (2011)).

<sup>41</sup> H.D. 1277, S. 888, 2011 Leg., 428<sup>th</sup> Sess. (Md. 2011), codified at MD. CODE ANN. 14-114(A)-(D).

<sup>42</sup> *Id.*

<sup>43</sup> *Id.* For example, the proposed regulations restricted a pooled asset trust from accepting individual accounts valued at \$100,000 or more. By comparison, SB 888 requires that DHMH regulations allow an individual account in a pooled asset special needs trust to be funded without financial limit. MD. CODE ANN. 14-114(C)(2)(I).

<sup>44</sup> MD. CODE ANN. 14-114(B).

<sup>45</sup> MD. CODE ANN. 14-114(C)(1).

<sup>46</sup> MD. CODE ANN. 14-114(C)(2)(I).

<sup>47</sup> MD. CODE ANN. 14-114(C)(2)(II).

<sup>48</sup> MD. CODE ANN. 14-114(C)(2)(III).

<sup>49</sup> MD. CODE ANN. 14-114(C)(2)(IV).

<sup>50</sup> MD. CODE ANN. 14-114(C)(2)(V).

# VOLUNTEER OPPORTUNITY!

The Legal Services to the Elderly program of the Bar Association of Baltimore City needs volunteer attorneys to prepare simple estate planning documents for seniors over the age of 60 living in Baltimore City. The Program is eligible for fee waiver and offers comprehensive malpractice insurance covering all *pro bono* services. If you are able to volunteer your experience and time to assist a vulnerable part of our population, please contact Jackie Jones at (410) 396-5605 or at [jjones@baltimorebar.org](mailto:jjones@baltimorebar.org).

Thank you for taking the time out of your busy schedule to review this information and post our need to your membership on the MSBA List Service.

Your cooperation in this matter has been greatly appreciated!

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# SAVE THE DATE

## MSBA ANNUAL MEETING OCEAN CITY, MARYLAND



*It is never too early to start planning.*

The MSBA annual meeting in Ocean City will be held from  
Wednesday, June 13 through Saturday, June 16, 2012.



# SEA. YOU. THERE.

# MOLST: MEDICAL ORDERS FOR LIFE SUSTAINING TREATMENT. YOUR CLIENT'S END OF LIFE HEALTH CARE WISHES CARRIED OUT.

By Lawrence Adashek

## OVERVIEW

This past legislative session, the Maryland Legislature has passed and the Governor has approved the MOLST, an evolutionary step forward (perhaps even a revolutionary step forward) giving hospitals and other medical institutions a most powerful tool to carry out our client's wishes for end of life medical care.

Over the past several decades, the state, the medical communities and the legal communities have joined together to provide powerful tools to empower our clients to have their wishes for end of life care enacted. However, these tools, including "living wills", "advance directives", "health care powers of attorney", the "Instructions on Current Life-Sustaining Treatment Options" form, and the "EMS DNR and Medical Care Order" form, all have substantial limitations that hinder and delay medical staff from implementing our client's end of life health care wishes. Medical staff cannot act on the provisions of living wills and advance directives without medical orders implementing the provisions. Health care agents may be unavailable in emergency situations to make health care decisions for the client. The EMS DNR form is not widely used and when used must be available in emergencies.

Following a trend (called the "POLST: Physician's Orders for Life Sustaining Treatment") that began in Oregon in 1995, Maryland has enacted the MOLST Form Statute (effective 10/1/11). Maryland has taken extensive efforts to educate and inform all members of the medical community (including hospitals, nursing homes, assisted living facilities, doctors and EMS personnel) involved in end of life medical matters regarding the MOLST form.

Both physicians and nurse practitioners may complete the MOLST form in active consultation with the patient and the patient's surrogate. The MOLST form includes numerous choices for end of life care including: CPR options, ventilation options, transfusion options, hospitalization options, antibiotic options, artificial feeding and hydration options and dialysis options. Most importantly, the MOLST form is a medical order that hospitals, nursing homes, medical staff and EMS must follow.

The MOLST form must follow the patient. For example,

if a patient in a nursing home is emergently transferred to a hospital, the MOLST form must accompany the patient and must be followed by EMS and hospital emergency staff. The MOLST form will be a single form used by the entire medical community to carry out the patient's wishes for end of life care. The MOLST form is voluntary to the patient. While a very valuable tool, and while a nursing home's physician or nurse practitioner, for example, must offer to complete the form for a patient, the patient can choose not to participate in the MOLST.

Welcome to MOLST: a new opportunity for estate planning attorneys to educate and empower our clients for end of life medical care options.

## HISTORY

- October 1, 1993: The Health Care Decisions Act, which set the stage for MOLST, went into effect. It applied in all health care settings in Maryland and in the community.
- Early 1990s: The POLST (Physician Orders for Life-Sustaining Treatment) Protocol began in Oregon. The first POLST form was implemented in Oregon in 1995, and has served as a model across the country. By February 2011, 12 states implemented POLST, 24 states were developing POLST programs, and 9 states were working to develop a program.
- 1996: The first POLST work group began in Maryland.
- 2004: The "Patient Plan of Care" form became effective. The form documents conversations and established care goals between the health care provider and the patient or authorized decision maker about life-sustaining treatments. This form was not an advance directive and was mandated only to be offered in nursing homes.
- April 2008: The name of the "Patient Plan of Care form" changed to "Instructions on Current Life-Sustaining Treatment Options." This form was only used by nursing homes, and not consistently honored by other health care providers.

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## MOLST..

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•2009: MOLST work began in Maryland led by the State Advisory Council on Quality Care at the End of Life along with the POLST subcommittee. Through research and collaboration with other states, input from 52 stakeholders and their constituents and hundreds of individuals, the MOLST form was developed.

•2011 Legislative Session: Health Care Decisions Act – “Medical Orders for Life Sustaining Treatment” Form: House Bill 82, Senate Bill 203 was passed by both houses and signed by the Governor on May 19, 2011. Effective date October 1, 2011. The following Sections of the Health General Code are affected: 5-602 , 5-608, 5-608.1, 5-608.1 , 5-609 , 5-617 , 5-619 , 19-344. See [mlis.state.md.us/2011rs/bills/hb/hb0082e.pdf](http://mlis.state.md.us/2011rs/bills/hb/hb0082e.pdf) for the full statute.

•September 23, 2011: DHMH proposed regulations including an official MOLST form to implement MOLST are published in the Maryland Register. Although in proposed form with comments due 10/24/11, it applies to persons admitted beginning 10/1/11. These proposed regulations were “emergency” regulations so implementation would begin before comments were reviewed. After some feedback from the community, the proposed regulations were converted to “non-emergency” proposed regulations so that comments would be reviewed prior to implementation. The MOLST form remains valid as of 10/1/11, but the provisions requiring institutions to execute the MOLST form for their patients will be postponed until the regulations become effective.

### PRE-MOLST TOOLS AND PROBLEMS

#### 1. Living Wills or Declarations

1.1. Allow a client to state their intentions for how their final illness (end of life care) will proceed.

1.2. Include such provisions as CPR, artificial respiration, and artificial nutrition.

1.3. Problems include:

1.3.1. health care providers not having notice of the document.

1.3.2. health care providers not implementing the living will provisions through doctor’s orders. Health care staff other than doctors cannot interpret a living will but must wait for a doctor to make orders after reviewing the provisions of a living will.

1.3.3. living wills not following a patient after transport to a new facility such as from a nursing

home to a hospital.

#### 2. Health Care Powers of Attorney

2.1. Allow a client to name an attorney-in-fact to speak for the client regarding medical decisions if the client cannot speak for themselves.

2.2. Includes most or all health care decisions including end of life decisions.

2.3. Problems include:

2.3.1. the named attorney-in-fact being unavailable through illness, disability, distance or death.

2.3.2. health care providers not implementing the decisions of the attorney-in-fact through doctor’s orders.

2.3.3. Joint attorneys-in-fact failing to come to an agreement regarding care.

#### 3. Advance Directives

3.1. Combine the provisions of a living will and a health care power of attorney into one document.

3.2. See [dhmh.maryland.gov/yourrights/pdf/advdirform.pdf](http://dhmh.maryland.gov/yourrights/pdf/advdirform.pdf).

3.3. For mental health, see [dhmh.maryland.gov/mha/Advance%20Directive%20for%20Mental%20Health%20Treatment%20july%202008.pdf](http://dhmh.maryland.gov/mha/Advance%20Directive%20for%20Mental%20Health%20Treatment%20july%202008.pdf).

3.4. Problems include

3.4.1. made for a client to fill out themselves without education. Does your average client know who a “declarant” is?

3.4.2. binds the hands of the health care agent.

3.4.3. is better than nothing really better than nothing?

#### 4. Health Care Decisions Act

4.1. Allows a health care surrogate to act on behalf of a client when no prior planning (such as the above) has been done. Same statute implements the Advance Directive form noted in Section 3 above. See [www.oag.state.md.us/Healthpol/HCDAtext.pdf](http://www.oag.state.md.us/Healthpol/HCDAtext.pdf).

4.2. May prevent the need for a guardianship.

4.3. Problems include:

4.3.1. surrogate may not be a person who the client would choose.

4.3.2. surrogates within a permitted class may be oppositional.

#### 5. Instructions on Current Life–Sustaining Treatment Options Form

5.1. Used by nursing homes to document a patient’s wishes for life sustaining treatment options.

5.2. See the following for a detailed explanation [www.oag.state.md.us/Healthpol/LST%20Options\\_explanatory\\_professionals.pdf](http://www.oag.state.md.us/Healthpol/LST%20Options_explanatory_professionals.pdf).

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5.3. See the following form [www.oag.state.md.us/Healthpol/LST%20Options%20Draft1%202007.pdf](http://www.oag.state.md.us/Healthpol/LST%20Options%20Draft1%202007.pdf).

5.4. Problems include:

5.4.1. not widely used.

5.4.2. not follow a patient to hospitals and other institutions.

5.4.3 .not widely known in the medical community.

6. Emergency Medical Services (“EMS”) Do Not Resuscitate (“DNR”) and Medical Care Order Form.

6.1. Until now, the only form that EMS (e.g. ambulance) would accept for not performing CPR. Without this form, if the patient cannot speak for themselves, EMS was required to perform CPR and other extraordinary measures to resuscitate a patient.

6.2. See the following form: [www.miemss.org/home/Portals/0/Docs/OtherPDFs/DNRorder\\_form.pdf](http://www.miemss.org/home/Portals/0/Docs/OtherPDFs/DNRorder_form.pdf).

6.3. Problems include:

6.3.1. not widely used.

6.3.2. only used for EMS.

6.3.3. must be available in emergency.

## HOW MOLST WORKS

1. A physician or a nurse practitioner, in consultation with the patient or their surrogate, fills out and signs the MOLST form. The MOLST then becomes a valid medical order that must be complied with by any medical facility. Health General Code Annotated, § 5-608.1(f) (supp. 2011). A health care facility must consult and involve the patient or their surrogate as follows:

1.1. [the health care facility] shall: (i) Offer the patient, health care agent, or surrogate decision maker the opportunity to participate in updating or completing the form; § 5-608.1(c)(2)(i).

1.2. [the health care facility] shall: (ii) Note in the medical record when a patient, health care agent, or surrogate decision maker declines to participate in updating or completing the form, indicating the date and with whom the form was discussed; § 5-608.1(c)(2)(ii)

1.3. [the health care facility] shall (iii) On request of the patient, offer any physician or nurse practitioner selected by the patient the opportunity to participate in updating or completing the form; and § 5-608.1(c)(2)(iii)

1.4. [the health care facility] shall:(iv) Inform the patient, health care agent, or surrogate decision maker that the form will become a part of the patient's medical record and can be accessed through the procedures used to access a medical record. § 5-608.1(c)(2)(iv).

2. The provisions of the MOLST must be consistent with:

2.1. The known decisions of: 1. The patient if the patient is a competent individual; or 2. A health care agent or surrogate decision maker as authorized by statute; and § 5-608.1(c)(3)(i)

2.2. Any known advance directive of the patient if the patient is incapable of making an informed decision. § 5-608.1(c)(3)(ii).

3. Medical facilities must complete a MOLST for a patient as follows:

3.1. Nursing homes, assisted living facilities, hospices, home health agencies, kidney dialysis centers upon new admission. § 5-608.1(c)(1)(ii)1.

3.2. Hospitals upon discharge of patient to another medical facility. § 5-608.1(c)(1)(ii)2.

4. Upon completion of the MOLST, the health care provider must:

4.1. keep the MOLST in the patient's medical record; § 5-608.1(e)(1)

4.2. have the MOST physically accompany the patient or transmit the MOLST to the new health care facility when the patient is transferred to a health care facility; and § 5-608.1(e)(2)

4.3. give a copy of the MOLST to the patient, health care agent, or surrogate decision maker within 48 hours of completion of the form or sooner if the patient is transferred or discharged. § 5-608.1(e)(3).

5. A health care facility shall comply with all medical orders contained in a MOLST regardless of whether the physician or nurse practitioner who signed the form has admitting privileges or is otherwise credentialed at the health care facility. § 5-608.1(f).

6. In the event of conflicting forms, the most recent MOLST shall be followed. § 5-608.1(g).

## THE PROVISIONS OF THE MOLST FORM

1. Notice provision (top of form): gives instructions to the medical officer filling out the form and notice that the form includes valid medical orders for EMS and all Maryland health care facilities:

This form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation and other life-sustaining treatment options for a specific patient. It is valid in all health care facilities and programs through-

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**MOLST..**

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out Maryland. This order form shall be kept with other active medical orders in the patient's medical record. The physician or nurse practitioner must accurately and legibly complete the form and then sign and date it. Blank order forms shall not be signed. The physician or nurse practitioner shall select only 1 choice in Section 1 and only 1 choice in any of the other Sections that apply to this patient. If any of Sections 2-9 do not apply, leave them blank. A copy or the original of every completed MOLST form must be given to the patient or authorized decision maker within 48 hours of completion of the form or sooner if the patient is discharged or transferred.

2. Certification provisions: certifies if the patient or the patient's surrogate was consulted and if the patient gave informed consent to the medical orders in the form. Also identifies if the form is based on a patient's advance directive or determination by two (2) physicians that specific treatments will be medically ineffective. Also notes if a patient or surrogate does not participate in the preparation of the MOLST. Finally, the provision notes that if the patient or surrogate has not limited care, CPR will be attempted and other treatments will be given: (see page 11).

3. CPR options: offers the choice to attempt CPR and if not, whether intubation should be initiated: (see form on page 11).

4. Ventilation options: offers the choice for indefinite or time limited ventilation, external ventilation or no assistance:

2a. \_\_\_\_\_ May use intubation and artificial ventilation indefinitely, if medically indicated.

2b. \_\_\_\_\_ May use intubation and artificial ventilation as a limited therapeutic trial.

Time limit \_\_\_\_\_

2c. \_\_\_\_\_ May use only CPAP or BiPAP for artificial ventilation, as medically indicated.

Time limit \_\_\_\_\_

2d. \_\_\_\_\_ Do not use any artificial ventilation (no intubation, CPAP or BiPAP).

5. Blood Transfusion options:

3a. \_\_\_\_\_ May give any blood product (whole blood, packed red blood cells, plasma or platelets) that is medically indicated.

3b. \_\_\_\_\_ Do not give any blood products.

6. Hospital Transfer options: note the three options here:

4a. \_\_\_\_\_ Transfer to hospital for any situation requiring hospital-level care.

4b. \_\_\_\_\_ Transfer to hospital for severe pain or severe symptoms that cannot be controlled otherwise.

4c. \_\_\_\_\_ Do not transfer to hospital, but treat with options available outside the hospital.

7. Medical Workup options:

5a. \_\_\_\_\_ May perform any medical tests indicated to diagnose and/or treat a medical condition.

5b. \_\_\_\_\_ Only perform limited medical tests necessary for symptomatic treatment or comfort.

5c. \_\_\_\_\_ Do not perform any medical tests for diagnosis or treatment.

8. Antibiotic options. note the various options:

6a. \_\_\_\_\_ May use antibiotics (oral, intravenous or intramuscular) as medically indicated.

6b. \_\_\_\_\_ May use oral antibiotics when medically indicated, but do not give intravenous or intramuscular antibiotics.

6c. \_\_\_\_\_ May use oral antibiotics only when indicated for symptom relief or comfort.

6d. \_\_\_\_\_ Do not treat with antibiotics.

9. Artificial Administered Fluids and Nutrition options:

7a. \_\_\_\_\_ May give artificially administered fluids and nutrition, even indefinitely, if medically indicated.

7b. \_\_\_\_\_ May give artificially administered fluids and nutrition, if medically indicated, as a trial. Time limit \_\_\_\_\_

7c. \_\_\_\_\_ May give fluids for artificial hydration as a therapeutic trial, but do not give artificially administered nutrition. Time limit \_\_\_\_\_.

7d. \_\_\_\_\_ Do not provide artificially administered fluids or nutrition.

10. Dialysis options:

8a. \_\_\_\_\_ May give chronic dialysis for end-stage kidney disease if medically indicated.

8b. \_\_\_\_\_ May give dialysis for a limited period. Time limit \_\_\_\_\_

8c. \_\_\_\_\_ Do not provide acute or chronic dialysis.

11. Other orders: leaves space for additional Medical Orders.

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## CERTIFICATION PROVISIONS

Part of Question 2.

### CERTIFICATION FOR THE BASIS OF THESE ORDERS

Mark any and all that apply. Otherwise, leave this section blank.

I hereby certify that these orders are entered as a result of a discussion with and the informed consent of:

- the patient; or  
 the patient's health care agent as named in the patient's advance directive; or  
 the patient's guardian of the person; or  
 the patient's surrogate; or  
 if the patient is a minor, the patient's legal guardian or another legally authorized adult.

Or, I hereby certify that these orders are based on:

- instructions in the patient's advance directive; or  
 certification by two physicians that CPR and/or other specific treatments will be medically ineffective.

Mark this line if the patient or authorized decision maker declines to discuss or is unable to make a decision about these treatments. The patient's or authorized decision maker's participation in the preparation of the MOLST form is always voluntary. If the patient or authorized decision maker has not limited care, except as otherwise provided by law, CPR will be attempted and other treatments will be given.

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## CPR OPTIONS

Part of Question 3.

CPR (RESUSCITATION) STATUS: EMS providers must follow the Maryland Medical Protocols for EMS Providers.

Attempt CPR: If cardiac and/or pulmonary arrest occurs, attempt cardiopulmonary resuscitation (CPR). This will include any and all medical efforts that are indicated during arrest, including artificial ventilation and efforts to restore and/or stabilize cardiopulmonary function.

[If the patient or authorized decision maker does not or cannot make any selection regarding CPR status, mark this option. Exceptions: If a valid advance directive declines CPR, CPR is medically ineffective, or there is some other legal basis for not attempting CPR, mark one of the "No CPR" options below.]

No CPR, Option A, Comprehensive Efforts to Prevent Arrest: Prior to arrest, administer all medications needed to stabilize the patient. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally.

Option A-1, Intubate: Comprehensive efforts may include intubation and artificial ventilation.

Option A-2, Do Not Intubate (DNI): Comprehensive efforts may include limited ventilatory support by CPAP or BiPAP, but do not intubate.

No CPR, Option B, Palliative and Supportive Care: Prior to arrest, provide passive oxygen for comfort and control any external bleeding. Prior to arrest, provide medications for pain relief as needed, but no other medications. Do not intubate or use CPAP or BiPAP. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally.

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### FINAL THOUGHTS ON WHAT MOLST DOES DO, DOES NOT DO AND POSSIBLE CONCERNS.

#### 1. A MOLST DOES:

- 1.1. Allow a patient or their surrogate health care decision maker to be actively involved in end of life medical decisions.
- 1.2. Encourage the discussion between patient (or surrogate) and physician or nurse practitioner regarding end of life medical decisions.
- 1.3. Convert a patient's stated decisions, either oral or included in an advance directive, into a medical order that medical facilities must honor.
- 1.4. Become a medical order that must be transported (or electronically sent) with a patient to the patient's next medical facility.
- 1.5. Become a medical order that must be honored by every Maryland medical facility and EMS.
- 1.6. Become a single form that is used throughout Maryland (and by other States accepting out of state POLST forms) for end of life medical decisions.
- 1.7. Require the medical facilities most involved in end of life medical decisions to actively create and revise a patient's MOLST form.
- 1.8. Remain voluntary on the part of the patient.

#### 2. A MOLST DOES NOT

- 2.1. Replace a patient's intentions for end of life medical decisions with those of the medical staff, medical professionals or medical facilities.
- 2.2. Force a patient to give up end of life medical care.
- 2.3. Replace a patient's living will, advance directive or health care power of attorney.
- 2.4. Work out of state unless that state accepts an out of state MOLST.
- 2.5. Authorize a medical facility or provider to make decisions for a patient. Although certain medical facilities are required to fill out a MOLST, if a patient or their surrogate does not wish to participate or limit care, the facility will check the MOLST form's Section 1 "Attempt CPR" selection and the rest of the form will be blank. Under the statute, this will qualify as a completed MOLST form.

#### 3. POSSIBLE CONCERNS ABOUT MOLST

- 3.1. Medical facilities and medical providers (including

physicians and nurse practitioners) will, because of haste, lack of resources, lack of education and paternalism, make a MOLST not in true consultation with the patient or their surrogates.

3.2. The patient or their surrogate will not understand the voluntariness of the MOLST.

3.3. Resource limitations or other causes will prevent medical facilities and medical providers from getting the education and training that is imperative for MOLST to be successful.

3.4. Politics will hijack the true benefit of the MOLST.

#### RESOURCES FOR YOUR CLIENTS:

The following resources may be helpful for your clients or their families in understanding their options for health care and end of life decision-making.

**Maryland Medical Orders for Life-Sustaining Treatment (MOLST) Form and Instructions.** The actual form that is to be filled out by the physician or medical professional in consultation with the patient or their surrogate. It can be downloaded at: [dhmh.maryland.gov/marylandmolst/docs/Maryland%20MOLST%20Form%20and%20Instructions%20Final.pdf](http://dhmh.maryland.gov/marylandmolst/docs/Maryland%20MOLST%20Form%20and%20Instructions%20Final.pdf).

**Information Sheet for Consumers: Ten Facts Consumers Should Know About Maryland MOLST.** A one (1) page sheet that informs the consumer about the MOLST form. It can be downloaded at: [dhmh.maryland.gov/marylandmolst/docs/Information%20Sheet%20for%20Consumers.pdf](http://dhmh.maryland.gov/marylandmolst/docs/Information%20Sheet%20for%20Consumers.pdf).

#### UNDERSTANDING YOUR CHOICES FOR MEDICAL TREATMENTS:

**Maryland MOLST Training Task Force, May 2011.** An ten (10) page handout accompanying a power point presentation that explains in detail and defines the terminology and options used in the MOLST form. The pamphlet can be downloaded at: [dhmh.maryland.gov/marylandmolst/docs/handouts/Understanding%20Your%20Choices%20for%20Medical%20Treatments\\_HO.pdf](http://dhmh.maryland.gov/marylandmolst/docs/handouts/Understanding%20Your%20Choices%20for%20Medical%20Treatments_HO.pdf).

**Maryland MOLST; Guide for Patients.** Maryland MOLST Training Task Force, June 2011. A thirty-five

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(35) page detailed pamphlet that assists your client in understanding how the MOLST form is used and reviews and explains the available options. The pamphlet can be downloaded at: [dhhm.maryland.gov/marylandmolst/docs/Guide%20for%20Patients%20and%20Caregivers.pdf](http://dhhm.maryland.gov/marylandmolst/docs/Guide%20for%20Patients%20and%20Caregivers.pdf).

**Health Care Decision Making Worksheet.** This worksheet can prepare your client in advance for a discussion with her physician or medical professional regarding the MOLST form. It can be downloaded at: [dhhm.maryland.gov/marylandmolst/docs/Health%20Care%20Decision%20Making%20Worksheet.pdf](http://dhhm.maryland.gov/marylandmolst/docs/Health%20Care%20Decision%20Making%20Worksheet.pdf).

### RESOURCES FOR YOU AS ADVISOR:

The following resources may aid you in learning about the MOLST and health care decision options for your client.

**Information Sheet for Health Care Professionals: Ten Things Health Care Professionals Should Know About Maryland MOLST.** A one (1) page sheet that informs the professional about the MOLST. It can be downloaded at: [dhhm.maryland.gov/marylandmolst/docs/Information%20Sheet%20for%20Healthcare%20Professionals.pdf](http://dhhm.maryland.gov/marylandmolst/docs/Information%20Sheet%20for%20Healthcare%20Professionals.pdf).

**Maryland's Health Care Decisions Act: Handouts for the PowerPoint presentation by Maryland MOLST Training Task Force. May 2011.** A nine (9) page handout of the training presentation for advance directives and health care decision making. The presentation can be viewed and downloaded at: [dhhm.maryland.gov/marylandmolst/docs/handouts/Health%20Care%20Decisions%20Act\\_HO.pdf](http://dhhm.maryland.gov/marylandmolst/docs/handouts/Health%20Care%20Decisions%20Act_HO.pdf). Maryland Emergency Medical Services (EMS) Do Not Resuscitate (DNR) and Medical Care Order form. This form is still valid and although the MOLST form will replace this form (as of 10/1/11), it remains a valuable tool. It is included in your materials and can be downloaded at: [www.miemss.org/home/Portals/0/Docs/OtherPDFs/DNRorder\\_form.pdf](http://www.miemss.org/home/Portals/0/Docs/OtherPDFs/DNRorder_form.pdf).

Instructions on Current Life-Sustaining Treatment Options form. This form will be replaced (superseded) by the MOLST form as of 10/1/11. It can be downloaded at: [www.oag.state.md.us/Healthpol/LST%20Options%20Draft1%202007.pdf](http://www.oag.state.md.us/Healthpol/LST%20Options%20Draft1%202007.pdf).

For more information about MOLST, visit [dhhm.maryland.gov/marylandmolst/](http://dhhm.maryland.gov/marylandmolst/). Or email [MarylandMOLST@dhhm.state.md.us](mailto:MarylandMOLST@dhhm.state.md.us).

## Upcoming Section Events:

**The next meeting of the Special Needs Law Study Group is scheduled for Thursday, December 15, 2011, from 9-11 a.m. at the following new location:**

**The Meeting House (The Quad Room)  
Oakland Mills Interfaith Center  
5885 Robert Oliver Place  
Columbia, Maryland 21045-3786  
[www.themeetinghouse.org](http://www.themeetinghouse.org)**

**Thomas G. Slater, Esq., of the Frederick law firm of Slater & Slater, P.C., will lead a discussion concerning the SSI/SSD application process, and the handling of any follow-on appeal. Please bring questions and be prepared to participate in the discussion.**

**Please RSVP to Edmund W. Law, Esq. at [ewlaw@erols.com](mailto:ewlaw@erols.com) if you are interested in attending th December 15th session, or are interested in being added to the mailing list and have not already done so.**



# Law Day 2012



The Elder Law Section Council of the Maryland State Bar Association will once again sponsor a statewide free preparation of Health Care Powers of Attorney and Living Wills /Advance Directives in Senior Centers throughout Maryland on TUESDAY, MAY 1, 2012.

In 2011 Law Day efforts took place in nearly every county in the state, reaching several hundred seniors. In 2012 we will strive to place at least one attorney in each of Maryland's 122 Senior Centers to provide this service.

We hope that attorneys involved last year, those who served either as county coordinators or volunteer attorneys in senior centers, will once again offer their time for this valuable pro bono opportunity.

All attorneys, regardless of areas of practice, are invited to participate in this pro bono event. For those attorneys less familiar with the documents being prepared, coordinators strive to pair them with others who have more experience. Helpful information is also available on the Internet

The suggested commitment on Law Day is at least 2.5 hours, with approximately 1/2 hour per appointment. Coordinators match their volunteers with centers. Senior Centers handle time slot bookings for the volunteer attorney, generally one-half hour per client.

Law Day information will be distributed through the Elder Law Section newsletter, State and Local Bar Association publications, through the Maryland Disability Law Center and through the Maryland Association of Senior Centers. The Senior Center Association's e-mail list includes the Area Agency on Aging Directors in each county and Baltimore City, along with 200 staff working in Senior Centers across the state.

For general information about Law Day, contact Joyce Demmitt, Assistant to Lawrence Adashek, P.A., 410-415-5880, or e-mail [joyce@adasheklaw.com](mailto:joyce@adasheklaw.com).

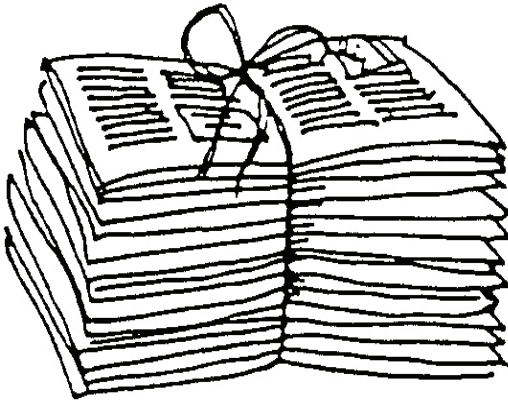
**"INSIDE EVERY OLDER PERSON IS A YOUNGER PERSON WONDERING WHAT HAPPENED."**

--Jennifer Yane

# SECTION NEWS

## Long Term Care Work Group

By Anne Haffner Hurley, Legal Aid Bureau, and Nomiki B. Weitzel, Law Office of Nomiki Bouloubassis Weitzel & Assoc.



Since early February of this year, the Long Term Care Work Group has convened every other week to collaborate on possible solutions to the Medical Assistance, Long Term Care (MALTC) delay problem. Sec. Ted Dallas of DHR leads the Work Group, which consists of advocates for the elderly from The Legal Aid Bureau, the Elder Law Section of the MSBA, and the National Academy of Elder Law Attorneys (NAELA), representatives from DHMH, DSS and DHR, and representatives from the nursing home industry.

Each month, Sec. Dallas is required to report the progress of the group to the Joint Chairmen of the Senate Budget & Taxation and House Appropriations Committees, and the Senate Finance and House Health and Government Operations Committees.

The July 15, 2011 report addressed the following four matters:

“...(1) initiating all annual redeterminations of existing cases to improve cash flow to providers; (2) implementing a new technology; (3) streamlining policy concerning the 60 month look back period; and (4) simplifying application forms for both new applications and redeterminations in order to make them more user-friendly.”

### Transmittal #11-26

The most significant development to come out of the Work Group has been Action Transmittal #11-26, which changes documentation requirements for evaluating an applicant's financial transactions during the look-back period. The Transmittal #11-26 link is <http://dhr.maryland.gov/manuals/action/11-26.pdf>. The hope is that this change will reduce the burden on both applicants and caseworkers and have the effect of improving application processing times.

Previously, applicants were required to provide 60 months of financial statements for themselves and their community spouse to DSS.

Under the new rules, the following financial information is required of the applicant and community spouse upon application:

- Exact copies of tax returns for the current tax year and the past four years (including all attached forms and schedules), and
- Bank and financial statements for:
  - the month of application.
  - the month prior to the month of application.
  - the last five years of the anniversary month of application.

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PLEASE CONTACT THE EDITOR, ELENA S. BOISVERT, [MEBOISVERT@COMCAST.NET](mailto:MEBOISVERT@COMCAST.NET) FOR ARTICLE SUGGESTIONS AND MEMBER NEWS FOR THE NEXT NEWSLETTER.



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Some questions have frequently come up about the new policy:

What if the applicant doesn't have copies of the tax returns that she filed?

That's ok. You can request a Record of Account from the IRS for the missing years. A Record of Account shows what an applicant reported on their tax return, plus any adjustments that were later made. The quickest way to request a Record of Account from the IRS is to call 1-800-908-9946. Early estimates indicate that a Record of Account is usually received about two weeks after a request is made.

What if the applicant didn't file taxes for one or all of the past five years?

That's also ok, and the documentation requirements are still less than under the previous policy. In lieu of tax returns or a Record of Account, an applicant can provide monthly statements from each quarter of the year. For example, monthly statements from December, October, July and April of 2011 would satisfy the requirement if no taxes were filed for 2011.

Should an applicant hold off on filing an MALTC application until they have a chance to file their tax returns?

No, unless that is easier for the applicant. This change in policy was developed to make the process easier for applicants and case workers. If it is easier for an applicant to produce quarterly bank statements, then the applicant should do that. In other words, the filing of taxes for the past five years is not a pre-requisite to MALTC eligibility. There is no requirement that an applicant show an inability to produce tax returns in order to have the option of producing quarterly bank statements.

What does the Transmittal mean by "anniversary month"? The anniversary month is the month that you applied for MALTC. So, if an applicant applied in March, 2011, March statements for the every year back to 2006 would need to be provided to DSS.

### Other Developments:

The Bureau of Long Term Care has established a triage unit, effective October, 2011, which will assess applica-

tions upon submission. If an application is determined to be complete, that application will be sent to a caseworker for eligibility determination. If an application is determined to be incomplete, the applicant would receive 1052 Request for Information forms from a worker in the triage unit until the application is complete. The goal of this new process is to reduce processing delays by having applicants know right away when more information is needed, and ensuring that caseworkers are making assessments based upon complete applications. The triage unit will be formed from a re-organization of existing staff.

A new Medical Assistance application and redetermination application was developed. See Transmittal [dhr.maryland.gov/manuals/action/12-02.pdf](http://dhr.maryland.gov/manuals/action/12-02.pdf) and the new fillable Medical Assistance applications and Redetermination applications can now be found at the DHR website. For the fillable Medicaid application (which is printed on bright yellow paper) see: [dhr.maryland.gov/manuals/doc/Fillable.pdf](http://dhr.maryland.gov/manuals/doc/Fillable.pdf).

For the fillable Redetermination application(which is printed on mint green paper) see [dhr.maryland.gov/manuals/doc/Redetermination.pdf](http://dhr.maryland.gov/manuals/doc/Redetermination.pdf).

A new fillable form 1052 is also being developed for the caseworkers to use.

Finally, the Work Group has also been actively attempting to address other issues that are affecting MALTC eligibility processing, including:

- Lost applicant information at the Bureau of Long Term Care Eligibility
- Outstanding pre- and post-eligibility expense deductions
- Waiver participants being erroneously required to submit a new MALTC application if they require institutionalization
- Erroneous automatic denials being sent to applicants