Message from the Chair...

Presumably all Elder Law Section members already know that the (now former) Medical Assistance eighteen day hospitalization bedhold was canceled by the Legislature and the Governor in one of the special sessions. The reason for canceling this benefit, that is of much importance to Maryland long term care Medical Assistance beneficiaries, was to save either five or six (both numbers have been used) million dollars in the DHMH budget. Reportedly legislators told themselves that this would not be a problem for Medical Assistance beneficiaries because the nursing homes would of course hold the beds without payment. Needless to say, that salve to their conscience was illusory. One nursing home reports that, although Medical Assistance was paying $75 per day for the bedhold, the nursing home is now "charging" $300 per day that must be paid by the Medical Assistance beneficiary or family members. This requirement flies in the face of the fact that Medical Assistance beneficiaries are impoverished as are many if not most of the families of Medical Assistance beneficiaries. In addition, one Long Term Care Ombudsman in the State reports that, nursing homes are changing the category of the bed of the Medical Assistance beneficiary who is hospitalized to be a non-Medical Assistance bed, so there is in fact no "available" bed when the Medical Assistance beneficiary is discharged from the hospital. This makes it extremely important to educate and advocate for our clients regarding Do Not Hospitalize orders, and is yet another reason to involve a good hospice as soon as possible for every Medical Assistance long term care beneficiary. If you have any clients who suffer adverse consequences from the change in the bed hold policy, please be sure to report the matter to the Long Term Care Ombudsman and to any member of the Elder Law Section Council. For other information on this topic of much importance and concern for our clients, please read the bedhold article in this newsletter.

On 17 October 2012 approximately two dozen Elder Law Section members, participated in a lively and information "Lunch and Learn" general Section meeting. Thanks to Council Member Wendy Little Schieke for her good work in arranging the successful event. Marjorie Corwin, an attorney in the Financial Services Practice Group at Gordon Feinblatt, and Mindy Lehman, Vice President of Government Affairs with the Maryland Bankers Association, led the meeting. The topics were the amendments to the Maryland Confidential Financial Records Act, and to the Maryland General and Limited Power of Attorney Act, all effective 01 October 2012. The Maryland

continued on page 2
General and Limited Power of Attorney Act is found at Estates and Trusts Title 17. The Maryland Confidential Financial Records Act is found at Financial Institution Title 1 Subtitle 3.

Materials kindly distributed by Marjorie Corwin and Mindy Lehman, include the "Gordon-Feinblatt LLC Maryland Laws Update 2012 Maryland Legislation Affecting Financial Services Providers" (the following URL: http://www.gfrlaw.com/pubs/Gordon-PubDetail.aspx?xpST=PubDetail&pub=989 has the text of this publication); the cover page and Table of Contents for the "Model Reference Manual for Financial Institution Employees" (the pdf for this entire publication can be found online by searching on that text); Sample Cover Memo to Accompany Written Elder Financial Abuse Reports" and "Sample Elder Financial Abuse Reporting Form" (which are Appendix D and Appendix E respectively of the "Model Reference Manual."

There was (no surprise) much discussion of the meaning of "substantially in the same form as" per § 17-101 (g). Interestingly, Marjorie Corwin stated that an attorney certification that the Power of Attorney of a client is "substantially in the same form as" would help her clients accept the Power of Attorney. This seems a good client service practice tip.

Perhaps the most obvious change to the Maryland General and Limited Power of Attorney Act is the revision of the statutory form documents to include specific text regarding coagents (see below). Be sure to note the major change in the statute that reverses the presumption regarding coagents. Before 01 October 2012, the "long form" document expressly stated that coagents were not required to act "unanimously." There was discussion at the meeting, that coagents are generally not a good idea in any case, which was agreed wholeheartedly by Mindy Lehman, because administering accounts with coagents is particularly difficult if not impossible for banks. At least one elder law firm in the State, completes all the blanks in the below fields with "NOT APPLICABLE" so that this is not an issue nor does it cause any problem for clients.

If you have any questions, concerns, comments, ideas, for your Elder Law Section, please call or send me an email. We want the Elder Law Section to be of maximum benefit to you in serving your clients.

Camilla McRory
Chair

Designation of Coagents (Optional)

This section of the form provides for designation of two or more coagents. Coagents are required to act together unanimously unless you otherwise provide in this form.

I, FULL FIRST MIDDLE LAST NAME OF PRINCIPAL~

(Name of Principal)

Name the following persons as Co-agents:

Name of Co-agent:
Co-agent Address:
Co-agent Telephone Number:
Name of Co-agent:
Co-agent Address:
Co-agent Telephone Number:
Special Instructions Regarding Co-Agents:
Estate and Liens 101:
The Medicaid Mystery

By Sharon Sirota Rubin, Esq.

Department of Health and Mental Hygiene, Division of Recoveries and Financial Services

Recovery of Maryland Medical Assistance Program (hereinafter “Medicaid”) expenditures is handled by the Department of Health and Mental Hygiene (“DHMH”) Division of Recoveries and Financial Services (“DRAFS”). Liens and estate claims are handled by the Estates, Liens & Trusts Unit of DHMH/DRAFS.

LIENS

When a person applies for Medicaid benefits, the eligibility rules generally limit assets to no more than $2500. However, the person may own real property and still qualify for Medicaid. In cases where the Medicaid recipient owns real property and is in a nursing home, DHMH will place a lien on the property, provided that no disabled child, living spouse, or child under 21 resides in the property, and that the recipient’s medical provider certifies that the recipient is not able to return to the residence. If those criteria are met, DHMH files a lien with land records in the county where the property is located.

If the property is sold, the lien must be satisfied. If the house is not sold, but rather goes to tax sale or foreclosure, DHMH recovers from any surplus from that sale. If the recipient passes away while still owning the property, DHMH recovers from the estate, pursuant to Health-General §15-121. If the recipient returns home for permanent residence from the nursing home, despite previous certification that he/she would not be able to do so, the lien is removed from the property.

If the property is sold, the lien must be satisfied. If the house is not sold, but rather goes to tax sale or foreclosure, DHMH recovers from any surplus from that sale. If the recipient passes away while still owning the property, DHMH recovers when the property transfers, or from the estate, pursuant to Health-General §15-121. If the recipient returns home for permanent residence from the nursing home, despite previous certification that he/she would not be able to do so, the lien is removed from the property.

ESTATES

DHMH has the right to recover medical benefits it paid on behalf of a Medicaid recipient pursuant to Health-General §15-121. DHMH recovers its entire claim amount, up to the value of the assets in the estate. Pursuant to Estates & Trusts §8-103, when the recipient dies, DHMH can file its claim by the earlier of: (1) 6 months from the date of publication of appointment of the personal representative or (2) 2 months after the PR mails/delivers notice to DHMH of the appointment of the PR.

DHMH files its claim with the Register of Wills in the county where the decedent resided. The claim includes the full amount of Medicaid expenses. If the claim for Medicaid expenses is not paid by the PR, DHMH will file a Petition to Require, which will generate a hearing in the Orphans’ Court for the judge to decide whether DHMH has a valid claim that must be paid by the PR.

If the PR files a Notice of Disallowance of some or all of DHMH’s claim, the Department will file a Petition for Allowance, which will generate a hearing in the Orphans’ Court for the judge to decide whether DHMH’s claim will be allowed. DHMH must file this Petition for Allowance within sixty (60) days of the certification of mailing of the Notice of Disallowance. If the Petition for Allowance is not filed within that time, DHMH’s claim is disallowed.

DHMH is entitled to recover its Medicaid expenses in accordance with §8-105 of the Estates & Trusts Article, which details Order of Payment. Generally, Medicaid expenses fall in the 11th category. However, if the Medicaid expenses were for the last illness of the decedent, those expenses fall in the 7th category.

In some instances, the PR is not able to pay the claim in full, despite the fact that the estate has assets to satisfy the DHMH claim. This usually happens when the primary asset is real estate which the family wants to keep rather than sell. In those cases, DHMH may agree to monthly payments for up to two (2) years. DHMH may also agree to allow the property to be transferred to the PR, so he/she can obtain a loan against the property to pay DHMH in full. These situations are reviewed and handled on a case-by-case basis.

When DHMH is paid in full, its claim and case are closed. If the amount paid to DHMH is the balance of the estate assets, but the claim is not paid in full, the Department will notify the Court that it has received the balance of the es-

continued on page 4
tate assets. This allows the Register of Wills to close its file. DHMH’s claim is still open, however, so it can recover from any newly discovered assets. If no new assets are discovered, there is nothing more due to DHMH.

Some PR’s make a claim for reduction or waiver of DHMH’s claim based on hardship. In those cases, the PR or family member must have lived in the decedent’s property on the date of death and for two (2) years prior to the date of death and have no ability to provide alternate housing. In those cases, which are reviewed on a case-by-case basis, DHMH may reduce or waive its claim. In some cases, DHMH may offer the PR a no-interest, no payment mortgage, so that the Department can be paid when the property is ultimately sold. However, this is an infrequent option. If the dependent living in the property is over 62 years of age, DHMH may deny a hardship request and recommend that the dependent pursue other payment arrangements, such as a reverse mortgage to pay the claim of DHMH.

**PAYMENTS**

All payments are to be made payable to “DHMH-MD” and sent to 201 W. Preston Street, 2nd Floor, Division of Recoveries, Baltimore, MD 21201. All checks should reference the recipient’s name and Medicaid number, and state whether it is an estate or lien case. While payments may be mailed, DHMH recommends having payments sent by messenger, certified mail, or overnight/priority mail for tracking purposes.

**CONCLUSION**

Each Estate and Lien case is handled by an assigned Recovery Officer, who is the primary point of contact for that case. If additional assistance is needed, the PR or the attorney can contact Sandra Schultz, Manager of the Estates, Liens & Trusts Unit, at 410-767-1776. If further assistance is required, the PR or the attorney can contact Sharon Sirota Rubin, Special Counsel to DHMH/DRAFS, at 410-767-1764.

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**Volunteer Opportunities: Law Day 2013**

“On Wednesday, May 1, 2013, the Elder Law Section of the Maryland State Bar Associate will once again sponsor statewide preparation of Maryland Advance Directives in Senior Centers throughout Maryland. In recent years, Law Day efforts have taken place in almost every county in the state, reaching several hundred senior citizens. In 2013, we hope to place at least one attorney in each of Maryland’s Senior Centers so that this important service can be provided. Our goal this year is to serve 800 seniors.

All attorneys are invited to participate, regardless of their area of practice. For those attorneys who are less familiar with Advance Directives, Coordinators for each county will strive to place such individuals with others who are more experienced. Furthermore, other training resources are available.

The suggested commitment on Law Day is 2.5 hours, comprising approximately 30 minutes per appointment. Volunteers will be directed to a specific Senior Center by their Coordinator. The various Senior Centers will be responsible for setting appointments with clients for the volunteer attorneys (again, in 30 minutes time slots).

If you are willing to be an attorney volunteer or to serve as a Coordinator, please contact this year’s program chair, Steve Elville, at 443-393-7696, or via email at steve@elvilleassociates.com. **Coordinators are still needed for Cecil and Harford Counties, and for Worcester County.**”
Written Mental Health Advance Directives

By Lawrence Adashek 1 and Randi Skullestad 2

1. An Introduction to Mental Health Advance Directives

Advance directives, health care powers of attorney and living wills enable clients to control decisions about end-of-life healthcare, to limit (or not) life-sustaining medical interventions that fail to provide a meaningful quality of life for terminally ill patients and (in the case of an advance directive and health care powers of attorney) to name health care surrogates to make decisions for an incapacitated client. However, these documents have limitations when applied in the context of mental health treatment for incapacitated psychiatric clients.

Given these limitations, states have adopted specific mental health advance directive (MHAD) statutes tailored for psychiatric patients who may experience fluctuating capacity to guide treatment decisions. MHADs allow psychiatric patients to document in advance, while competent, their acceptance or refusal of particular types of mental health treatment and intervention. Some of these documents also incorporate authorization of a health care agent.

There are three types of MHADs: instructional directives, proxy directives and hybrids. Instructional directives are similar to a living will in that they express the intent, viewpoint, values, and desires of a client to influence their course of care. Proxy directives are similar to a durable power of attorney for health care in that they appoint a representative to act on a client’s behalf. Hybrids combine instructive and proxy directives into a single form, allowing practitioners to combine the kind of material typically found in a durable power of attorney for health care and a living will in a single document put into the context of psychiatric care.

2. Maryland’s Approach to Mental Health Advance Directives

In 1993, the General Assembly passed and the Governor signed into Law the Health Care Decisions Act (“HCDA”). The intent of the HCDA was to preserve the patient’s right of autonomy in medical decision-making, while recognizing the interest of the state in the protection of human life.

When the General Assembly debated the HCDA, there was a consensus that the intent of the HCDA was to “honor both the individual’s right to make personal health care decisions, free of needless court or other intervention, and the community’s obligation to respect and protect the sanctity of human life.”

4 Id.
6 Id.
8 Michael W. Davis, Mindy A. Morrell, Guardianship Alternatives, Md. B.J., July/August 2005, at 42, 44
9 John Carroll Byrnes, The Health Care Decisions Act of 1993, 23 U. Balt. L. Rev. 1, 62 (1993). (When the General Assembly debated the HCDA, there was a consensus that the intent of the HCDA was to “honor both the individual's

continued on page 6
Maryland adopted a mental health advance directive statute under the HCDA in 2001. This statute is discretionary and instructive on what a client may want to include in a MHAD including appointing an agent and identifying preferences as to medications, facilities, and mental health professionals. However, procedurally, the statute follows the general medical advance directive under § 5-602.

Under § 5-602, there is commanding language as to how an advance directive becomes effective:

**Effectiveness of advance directive**

(e)(1) Unless otherwise provided in the document, an advance directive shall become effective when the declarant's attending physician and a second physician certify in writing that the patient is incapable of making an informed decision.

There are two alternatives to this language that may be written into a MHAD: (1) effective at the time of signature and (2) effective at the time of a triggering event.

Even though Maryland has carved out a MHAD statute, durable powers of attorney for health care, living wills and advance directives remain valid for mental health purposes. These documents may supplant or be used in lieu of a MHAD.

3. **Maryland Forms**

The Maryland Department of Health and Mental Hygiene (DHMH) has created a hybrid MHAD. The mental health community in Maryland often uses and recommends this form. The client or practitioner may add supplemental information. Also, the client can choose this form as instructional in nature or to only appoint a health care agent. A copy of this form can be found at the end of this document under Appendix A.

A new Maryland MHAD document was developed in 2009 by a consortium representing the Maryland Department of Health and Mental Hygiene, providers, and consumer and advocacy groups. This form has yet to be adopted by the DHMH. Similar to the standard form in format and effect, the form is much more detailed and clear, and allows greater specificity on types of treatment, visitors and medications. This form is available at the end of this document under Appendix B.

This form is helpful if a client has specific concerns about: side effects to medications that may be used during treatment, medication dosages, types of treatments that may be used (such as Electroconvulsive Therapy or Transcranial Magnetic Stimulation), experimental studies, drug trials, and visitors during psychiatric impatient care and treatment. This form is useful as a teaching tool for legal practitioners who may be unfamiliar with mental health treatment. This MHAD gives direction on issues that may arise for a client with a history of mental illness.

4. **Mental Health Professionals**

Pursuant the Federal Patient Self Determination Act, mental health care professionals have a responsibility to inform patients prior to treatment of their right to create an advance directive. In notifying a patient of their right to an advance directive, several mental health facilities indicated that it is normal practice to refer patients to the DHMH’s standard form found in Appendix A.

However, the mental health facilities polled also accept documents such as durable powers of attorney for health care, living wills and advance directives. The stated wish of these mental health professionals is clarity of the patient’s intent, contact information for a health care agent if one has been appointed, and whether the documents is effective upon signature or upon incapacity.

The emphasis on when a document comes into effect is a practical concern for mental health professionals. If a MHAD becomes effective at the time of signature, a client may bind themselves to a treatment plan that may become impractical or go against their wishes in the future. Even

14 This form can be found at: http://www.mhamd.org/_pdfs/mhamd_AdvanceDirective_09.pdf
15 42 U.S.C. 1395 cc (a) (1990)
16 The result of polling professionals at several mental health facilities in Baltimore and Baltimore County in October 2012.
17 Id.
though it is questionable whether such a provision would be enforceable, it raises an issue that has yet to be answered by a Maryland Court.

Similarly, springing MHAD provisions can be problematic for mental health professionals. Since such provisions are based on a future triggering event, there is an inherent uncertainty about them; an uncertainty that may undermine a patient’s wishes or the ability to treat a patient.19

5. Analysis of Various State’s Approaches to MHAD

All states have statutes that govern the use of advance directives. These can be applied generally to psychiatric care as well as medical care.20 How states approach MHAD can be categorized into three approaches: 1) specific MHAD, 2) advance directive that include mental health provisions and 3) advance directive without stand-alone mental health provisions. Maryland’s MHAD statute falls in the first approach.

States which do not have stand-alone mental health provisions either make no mention of mental health in their general advance directives, direct persons with mental illness to use documents such as durable powers of attorney for health care, or have the term “mental health care” sprinkled throughout their advance directive following “medical care”. No matter which approach a state takes, the client maintains a right to a MHAD.

Virginia is an example of a state that sporadically uses “mental health care” in their advance directive form. Even though Virginia has not carved out a MHAD statute or adopted a specific MHAD form, there has not been any case law to indicate that people with mental illness are unable to give treatment instructions. Rather, the Virginia advance directive allows for supplemental information where a person may clearly define their instructions on mental health treatment.

California’s approach combines a MHAD with medical advance directives. Paul M. Applebaum, M.D., a noted psychiatric scholar, argues that by combining a MHAD with a medical advance directive, the client’s mental health issues may be overshadowed by their medical needs21. However, such an approach may be convenient in practice by having a single document address appointment of a health care agent, mental health care instructions, and medical care instructions. If a client is hospitalized, a metaphorical line is not drawn between medical and mental treatment. The client must be treated as a whole. Having a single document contain all of the person’s treatment instructions may be more efficient to that end.

Various State Approaches to Written Mental Health Advance Directives 22
(See Chart Below)

19 Id.
21 Id.

<table>
<thead>
<tr>
<th>1. Health care agent + specific psychiatric advance instruction</th>
<th>2. Health care agent + generic health care advance instruction that may be used for (some) mental health decisions</th>
<th>3. Health care agent + instruction to agent, but no stand-alone instruction document for mental health decisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>HI ID IL KY LA MD ME MN NC NJ NM OH OK OR PA SD TN TX UT WA WY AZ IN (23)</td>
<td>AK CA DE MS ND (5)</td>
<td>AL AR CO CT FL GA IA KS MA MI MO MT NE NH NY NV RI SC VA VT WI WT (22)</td>
</tr>
</tbody>
</table>

continued on page 8
Advance Directives...
continued from page 7

6. A Small Survey of Several Court Holdings Regarding MHADs

In the unreported Maryland case, In re the Matter of Sophia E. Foley23, Mrs. Foley’s husband was her health care agent pursuant to her advance directive. Two years after being diagnosed with Alzheimer’s disease, Mrs. Foley was unable to make her own decisions. Mr. Foley then made decisions on her behalf in accordance with her wishes, if they could be ascertained, or her best interests.

Mrs. Foley’s sister doubted she had Alzheimer’s, but believed Sophia had Lyme disease that she claimed if left untreated would be deadly. Sophia tested negative for Lyme disease, but her sister persisted that more intensive testing was necessary and initiated a guardianship proceeding. Even though the sister did not allege that Mr. Foley was failing to follow Sophia’s wishes, the court allowed the case to proceed.

The HCDA has an express presumption that decisions of a health care agent are made in good faith24. However, the court used a reasonable health care agent standard for making decisions over the husband’s wishes. The court held that a “reasonable health care agent” would implement the intrusive testing Sophia’s sister sought.

In creating this reasonable health care agent standard, which was rejected by the same court in a later proceeding, the court attempted to ensure Mrs. Foley would get the “right” treatment. This case demonstrates a court’s willingness to dismiss an advance directive because of the possibility of two misdiagnoses that could be life-threatening.

In a New York case, In re Rosa M25, a patient revoked her consent to electroconvulsive therapy (ECT), directed that she not be given ECT in the future and requested that ECT only be discussed with her when her attorney was present. When the patient made these ECT requests her psychiatrist found her to be competent. When she was later deemed incompetent her psychiatrist petitioned the court to authorize ECT, arguing that it was the only effective treatment available.

The court dismissed the petition ruling that absent an overriding state interest, a hospital must respect the “fundamental rights of individuals to have the final say in respect to decisions regarding their medical treatment.”26 The holding of the case could be construed as granting an broad right to refuse treatment.

7. Arguments in Support and Against MHADs27

In Support

- Merely contemplating the possibility of mental illness may cause a person to take preventive measures
- Self-Determination and Autonomy; taking responsibility for treatment would empower a person and possibly counter resistance to treatment
- The very process of making advance decisions may prevent future incompetency
- The ability to prescribe future treatment reduces stress and anxiety over the possibility of future treatment
- The power to determine their own treatment allows for a more collaborative relationship with mental health professionals
- An efficient alternative to guardianship

Against

- People may use a MHAD as a tool to resist treatment, leaving facilities with patients that have been hospitalized but cannot be treated
- MHADs are not really necessary given other documents such as a durable power of attorney for health care, living will or general advance directive
- MHADs are inefficient since many times they are used along with documents such as a durable power of attorney for health care, living will or general advance directive
- Enforceability, Maryland law allows physicians under certain conditions to: give medication for the treatment of a mental disorder over a person’s expressed wishes, or place a person in restraints or seclusion against the person’s expressed wishes.28

7. What is the Practitioner to Do?

The goal of a continuing legal education course is to give the practitioner practical advice. For the normal drafting of powers of attorney in the absence of a known mental health condition, a carefully drafted advance directive or health care power of 27 Robert D. Miller, Advance Directives for Psychiatric Treatment: A View from the Trenches, 4 Psychol. Pub. Pol’y & L. 728, 735-36 (1998)
28Md. Code Ann., Health-Gen. § 10-708

continued on page 9
Advance Directives...
continued from page 8

attorney (see Exhibit C) should be sufficient for the surrogate to make decisions for an incapacitated client, including one suffering from mental health issues. Many knowledgeable estate planning and elder law attorneys add the following language to their documents: “this power of attorney for health care is effective for all areas of medical care including all areas of mental health care and psychiatric care.”

However, for a client with known mental health issues, the new consortium form MHAD may be quite useful to empower the client to make his or her wishes for mental health care known in detail and name an appropriate surrogate to make important mental health care decisions.

Finally, the issue of capacity to execute any powers of attorney or advance directives may always be raised by an objecting party. The best way to ensure the likelihood that an advance directive will withstand a competency challenge is for the client to obtain a physician’s determination of the client’s competency at the time of execution. While the common language used by physicians includes the fact that the client is oriented to time, place and person, the addition a general statement of intent and rationales for a particular decision may be most effective.

Mark Your Calendar!

MSBA ANNUAL MEETING
OCEAN CITY, MARYLAND

The MSBA annual meeting in Ocean City will be held from Wednesday, June 12 through Saturday, June 15, 2013.

SEA. YOU. THERE.
APPENDIX A: CURRENT MARYLAND MHAD FORM

**Advance Directive for Mental Health Treatment**

I (name) ________________________________ being an adult, and emotionally and mentally able to make this directive, willfully and freely complete this health care advance directive to be followed if it determined by two physicians that I am not able as a result of a psychiatric or physical illness to assist in my health care treatment. (The second physician may not be involved in my treatment). It is my intent that care will be carried out despite my inability to make choices on my own behalf. In the event that a guardian or other decision-maker is chosen by a court to make health care choices for me, I intend this document to take priority over all other means of discovering intent while able.

The usual symptoms of my identified mental disorder may be include:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

I direct my health care providers to follow my choices as set forth below:

**Medications for treatment of my mental illness:**

If I become unable to make informed choices for treatment of my mental illness, my wishes regarding medications are as follows:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

I may be allergic to the following medications:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Reaction</th>
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</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

The following medications have been helpful in the past and I would agree to them if prescribed:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

*Initial all that apply:*

_____ I agree to the performance of all tests and other means to identify or assess my mental health.

_____ I agree to the performance of all tests and other means to check how well the medications are working and their effect on my body, i.e. blood tests.

_____ I specifically do not agree with dispensing the following medications, or their own brand-name, trade name or generic equal.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Reasons for not agreeing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

_____ I agree with dispensing all medications prescribed by my treating psychiatrist, unless listed above.
Admission to and continuation of Mental Health Services from a facility other than an inpatient hospital.

Check one

_____ I do not have a preference about receiving mental health services from a facility or other provider than a psychiatric hospital, i.e., clinic, PRP, mobile treatment.

_____ I agree to receive services from a facility, which is not a hospital.

_____ I do not agree to receive mental health services from a provider or facility other than a hospital.

Conditions/ Limits:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Others Choices
If I am unable to make informed decisions about my mental health choices, my wishes regarding other information or options are listed below:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Release of Records
I authorize the release of (check one):
_____ any and all mental health records
_____ the following mental health record/ records of the following providers:
________________________________________________________________________
________________________________________________________________________

to:
________________________________________________________________________

(name of person records may be released to)

Appointment of Health Care Agent

I select the following person as my agent to make health care choices for me:

Name ________________________________________________________________

Address______________________________________________________________

Work Number _____________________ Home Number________________________

If this agent is unable, unwilling, or elsewhere engaged to act as my agent, then I select the following person to act in this role:

Name: ________________________________________________________________

Address ______________________________________________________________

Work Number _______________________ Home Number _______________________

My agent has full power and right to make health care choices for me:
_____ Just in regards to the instruction above.

_____ If my wishes are not expressed above, and my wishes are not otherwise known to my agent, or if my
wishes are unknown or unclear, my agent is to make health care choices for me with my best interest in mind, to
be determined by my agent after reviewing the benefits, burdens, risks that might result from a given treatment
of course of treatment, or from the withholding or withdrawal of a treatment or course of treatment.

The authority of my agent is subject to the following conditions and limits:

________________________________________________________________________
________________________________________________________________________

My agent has full power and right to:

1. Request, receive and review any information, oral or written, regarding my physical or mental
health, including, but not limited to, medical and hospital records, and the right to disclose this
information.

2. Employ and release my health care providers.

3. Approve my admission to or release from any facility (other than psychiatric hospital or unit),
nursing home, adult home or other supervised housing or medical care facility.

Circle One:
My agent **HAS HAS NOT** the power and authority to approve my admission to or release from a psychiatric
hospital or unit.

Check one:
My agent’s powers and rights become active:
_____ when my attending physician and a second physician decide that I am unable
to make well-versed choices regarding my health care;

**OR**

_____ When this document is signed.

My agent shall not be responsible for costs of care based just on this agreement.

________________________________________________________________________

Date     Signature

The above named person signed or acknowledged signing this advance directive in my company and based
upon my personal study appears to be a capable person.

Witness name     Witness signature

Witness name     Witness signature
APPENDIX B: NEW MARYLAND CONSORTIUM MHAD

ADVANCE DIRECTIVE FOR MENTAL HEALTH TREATMENT

Statement of Intent

I, __________________________________________, being an adult of sound mind, willfully and voluntarily complete this Psychiatric Advance Directive to ensure that, during periods in which I lack the capacity to make an informed decision about my mental health care, as certified in writing by two physicians, my choices regarding mental health care shall be carried out. It is my intent that my wishes expressed in this document be honored whether or not my agent dies or withdraws or if I have no agent appointed at the time this document is signed. In the event that a guardian or other decision maker is appointed by a court to make health care decisions for me, I intend that this document take priority over all other means of discovering my intent while competent.

The fact that I may have not completed certain sections of this Advance Directive should not affect its validity in any way. I intend that all completed sections be followed. If I have not expressed a choice, any agent or other decision-maker designated under this Advance Directive or by law should make the decision that he or she determines is the decision I would make if I were competent to do so.

It is my intention that each part of this Advance Directive stands alone and, therefore, if any part is invalid or ineffective, it does not affect the validity or effectiveness of any other part.

I further intend that this mental health Advance Directive take precedence over any and all living will documents and/or durable power of attorney for health care documents and/or other Advance Directives that I have previously executed, to the extent that they are inconsistent with this document.

SECTION I. INSTRUCTIONS REGARDING MENTAL HEALTH TREATMENT

[Place your initials in the box next to your choices and provide information where appropriate.]

A. Medications for mental health treatment (including medications to control side effects).

1. [ ] I consent to and authorize my agent to consent to the administration of the following medications and dosages:

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Not to exceed the following dosage:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

2. [ ] I consent to the medications and dosages deemed appropriate by

Dr. ___________________________ whose address and phone number are:

Address

Phone

3. [ ] I consent to the medications agreed to by my agent, after consultation with my treating physician and any other individuals my agent may think appropriate, with the restrictions, if any, described in 4 & 5 below.

4. [ ] I am concerned about the side effects of medications and do not consent or authorize my agent to consent to any medication that has any of the side effects I have checked below at a 1% or greater incidence (check all that apply):
5. [ ] I specifically do not consent and I do not authorize my agent to consent to the administration of the following medications or their respective brand name, trade-name or generic equivalents:

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Reason for refusal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

B. Electroconvulsive Therapy (ECT)

1. [ ] I do not consent to administration of ECT;

   OR

2. [ ] I consent, and authorize my agent to consent, to administration of ECT, but only:
   
a. [ ] with the number of treatments the attending psychiatrist deems appropriate;

   OR

b. [ ] with the number of treatments deemed appropriate by

Dr. _____________________________ whose phone number and address are:

Address
____________________________________________________________________

Phone
____________________________________________________________________

OR

C. Transcranial Magnetic Stimulation (TMS)

1. [ ] I do not consent to administration of TMS;

   OR

2. [ ] I consent, and authorize my agent to consent, to administration of TMS, but only:
   
a. [ ] with the number of treatments the attending psychiatrist deems appropriate;

   OR

b. [ ] with the number of treatments deemed appropriate by
Dr. _____________________________ whose phone number and address are:

Address

Phone

OR

c. [ ] for no more than the following number of treatments: _____________

3. [ ] Other instructions and wishes regarding the administration of TMS:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

D. Other forms of mental health treatment (e.g., individual psychotherapy, group therapy, self-help services, body-oriented treatments, etc.):

1. [ ] I consent to the following types of mental health treatment:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

2. [ ] I do not consent to following types of mental health treatment:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

E. Choice of hospital, facility, program and treating professional(s)

1. [ ] In the event that my mental health condition is serious enough to require 24-hour care and I have no physical conditions that require immediate access to emergency medical care, I would prefer to receive this care in a program/facility designed as an alternative to a psychiatric hospital.

2. [ ] In the event that I am to be admitted to a hospital for mental health treatment, I would prefer to receive care at the following hospitals:

___________________________________________________________________
___________________________________________________________________

3. [ ] I do not wish to be admitted/committed to the following hospitals or programs/facilities for mental health care for the reasons I have listed:

<table>
<thead>
<tr>
<th>Hospital/Program/Facility</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>_________________________</td>
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<td>_________________________</td>
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</tbody>
</table>

4. [ ] I do not wish to receive care/services from the following mental health professionals:

<table>
<thead>
<tr>
<th>Physician/Other Professional</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>___________________________</td>
<td>_____________________________</td>
</tr>
<tr>
<td>___________________________</td>
<td>_____________________________</td>
</tr>
</tbody>
</table>

F. Experimental Studies or Drug Trials

1. [ ] I do not wish to participate in any experimental drug studies or drug trials.

   OR

2. [ ] I authorize my agent to consent to my participation in experimental drug studies or drug trials if my agent, after consultation with my treating physician and any other individuals my agent may think appropriate, determines the potential benefits to me outweigh the possible risks of my participation and that other, non-experimental interventions are not likely to provide effective treatment.

G. Notification of Others, Visitors, and Consent to Release Information

1. [ ] If I am admitted to a psychiatric facility, I authorize staff to notify the following individuals (be sure to list your health care agent, if you have one).

   Name: ___________________________________________________________

   Contact info: _______________________________________________________

   Name: ___________________________________________________________

   Contact info: _______________________________________________________

   Name: ___________________________________________________________

   Contact info: _______________________________________________________

2. [ ] I agree that the following people may visit me while I am receiving care in a psychiatric facility (be sure to list your health care agent, if you have one).

3. [ ] I do not agree that the following people may visit me while I am receiving care in a psychiatric facility.

4. [ ] My health care agent is my “personal representative” as defined under the Health Insurance Portability and Accountability Act (HIPAA), and has the legal authority to view my mental health records, physical health records and to receive all protected health information about me.

   I authorize my health care agent to release the following records or other protected health information to the following individuals:

   a. [ ] any and all mental health records

   OR

   b. [ ] only the following Information (check those that apply):

      [ ] Diagnosis   [ ] Medications   [ ] Treatment Plan
      [ ] Discharge Plan   [ ] Progress/Status
      [ ] Other: _______________________________________________________

   ________________________________________________________________

16
c. | any and all physical health records

5. Individuals who may receive records and/or information from my health care agent (you may note any limitations you want applicable to a specific individual that you name. For example—"Joe Smith" may get all mental health and physical records, while "Jane Jones" may only get my diagnosis and discharge plan information.):

H. Approaches that help me when I'm having a hard time

If I am having a hard time, the following approaches have been helpful in the past. I would like staff to try to use these approaches with me: (Check all that apply)

- [ ] Voluntary time out in my room
- [ ] Voluntary time out in quiet room
- [ ] Calling my therapist
- [ ] Deep breathing exercises
- [ ] Having my hand held
- [ ] Pounding some clay
- [ ] Taking a shower
- [ ] Listening to music
- [ ] Talking with a peer
- [ ] Pacifying the halls
- [ ] Writing in a journal
- [ ] Exercising
- [ ] Talking with staff
- [ ] Pounding a pillow
- [ ] Writing in a journal
- [ ] Exercising

Other:

I. Special considerations regarding touch/body space: (Check all that apply)

- [ ] I do not wish to be touched
- [ ] I wish to be asked permission before being touched
- [ ] I wish to be told reasons why I am being touched
- [ ] I wish special attention to be given to allowing me extra personal body space
- [ ] I do not need special attention given to my body space.

J. Additional preferences regarding my mental health care and treatment:

________________________________________________________

K. Other existing co-occurring (physical and/or substance use) health related conditions, for example: diabetes, allergies, alcohol dependence, etc.)

________________________________________________________

SECTION II. APPOINTMENT OF AGENT FOR MENTAL HEALTH CARE

A. Designation of Mental Health Care Agent

I hereby designate and appoint the following person as my agent to make mental health care decisions for me as authorized in this document. This person is to be notified immediately upon my admission to a psychiatric hospital or crisis bed.

Name: _____________________________________________________________

Address: _____________________________________________________________

_____________________________________________________________

City        State        Zip Code

Phone Number: __________________________

Home        Cell        Work

B. Designation of Alternate Mental Health Care Agent
If the person named above is unavailable or unable to serve as my agent, I hereby appoint the following person to serve as my alternate agent. This person is to be notified immediately of my admission to a psychiatric hospital or crisis bed:

Name: ____________________________________________________________
Address: ____________________________________________________________
Phone Number: ____________________________________________________________

C. Agent Instructions

[ ] I authorize my agent to make decisions on my behalf only in accordance with my expressed wishes as stated in this document.

[ ] I authorize my agent to make decisions on my behalf in accordance with my expressed wishes, as stated in this document or as otherwise made known to my agent. If I have not expressed a choice about a certain proposed mental health treatment, I authorize my agent to make the decision he or she reasonably determines that I would make if I were competent to do so. If my agent is unable to reasonably determine what my decision would be, I authorize my agent to make a decision that is in my best interest after reviewing the benefits, burdens and risks that might result from a given treatment or course of treatment, or from the withholding or withdrawal of a treatment or course of treatment.

SECTION III. CANCELLATION OF ADVANCE DIRECTIVE

[ ] I intend that I may cancel any part or all of this Advance Directive, including my appointment of a health care agent, at any time, including during those periods when two physicians have documented in my medical record that I am not competent to make medical decisions. I understand that, under Maryland law at the time this Advance Directive is signed and dated, I have the legal right to cancel my Advance Directive at any time.

[ ] I intend that I may cancel any part or all of this Advance Directive, including my appointment of a health care agent, at any time, except for those periods when two physicians have documented in my medical record that I am not competent to make medical decisions. I understand that, under Maryland law at the time this Advance Directive is signed and dated, I have the legal right to revoke my Advance Directive at any time. However, I choose to freely waive this right and intend that the provisions regarding my mental health treatment contained in this Advance Directive and/or as authorized by my health care agent are implemented despite any verbal objection made by me while I am not competent.

SECTION IV. SIGNATURE

By signing here I indicate that I understand the purpose and effect of this document.

_______________________________________  ____________________________________
Signature        Date

The above named person signed or acknowledged signing this Advance Directive in my company, and based upon my personal judgment appears to be competent.

_______________________________________  Witness Signature
Witness Name

_______________________________________  Witness Signature
Witness Name
APPENDIX C: EXAMPLE DURABLE POWER OF ATTORNEY FOR HEALTH CARE

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, «name», hereby appoint «attyhealth», as my agent to make health care decisions for me as authorized in this document. In the event that «attyhealth» is unable or unwilling to serve as my agent, I hereby appoint «altattyhealth» to serve as my agent in her place.

The rights, power and authority to my attorney-in-fact that I now grant shall become effective as soon as I affix my signature to this document, and such rights, power and authority shall remain in force and effect until terminated by written notice given by me to my attorney-in-fact. The authority granted herein shall not terminate through disability, incompetence or incapacity on my part, and all acts done by my attorney-in-fact pursuant to this power during such disability, incompetence or incapacity shall bind me as fully as if I were not subject to such disability.

I hereby grant to my agent named above full power and authority to make health care decisions on my behalf, including, but not limited to the following:

(1) To request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and to consent to the disclosure of this information;

(2) To employ and/or discharge my health care providers;

(3) To consent to and authorize my admission to and discharge from any hospital or related health care institution, including transfer to another facility, hospice, nursing home, assisted living facility or adult home.

(4) To give consent for, or to withhold consent for, x-ray, anesthesia, medication, surgery and all other diagnostic and treatment procedures ordered by or under the direction of a licensed physician or dentist. This authorization specifically includes the power to consent to measures for relief of pain;

(5) To direct the withholding or withdrawal of life-sustaining procedures or measures when and if I am terminally ill, permanently unconscious, or in an end-state condition. Life-sustaining procedures or measures are those forms of medical care that only serve to artificially prolong the dying process, and may include mechanical ventilation, endotracheal intubation, cardiopulmonary resuscitation, pressors agents, dialysis, antibiotics, artificial nutrition and hydration, including, but not limited to, an NG tube, an OG tube, a gastrostomy, an IV, and other forms of medical treatment that stimulate or maintain vital bodily functions. Life-sustaining procedures do not include care necessary to alleviate pain;

(6) To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

(7) HIPAA

7.1. I intend that my Health Care Agent have the same authority that I would have regarding the access, use and disclosure of my individually identifiable health information or other health records, including mental health records, psychotherapy records and counseling records, whether or not associated with the treatment of a mental illness. Accordingly, my Health Care Agent shall be deemed to be my "Personal Representative" as that term is used in the Health Insurance Portability and Accountability Act of 1996, 42 USC 1320d ("HIPAA").

7.2. The authority granted to my Health Care Agent applies to the access, use and release of any and all information governed by HIPAA, the federal regulations relating thereto and Title 4, Subtitle 3 of the Health-General Article of the Maryland Statutes. The information disclosed or released will be used by my Health Care Agent in furtherance of the Agent's authority and responsibilities under this Health Care Power of Attorney.

7.3. I authorize any physician, health care professional, psychologist or other mental health professional, dentist hospital, clinic, laboratory, pharmacy, any insurance carrier or health plan and the Medical Information Bureau, Inc., or other health care clearinghouse, to give, disclose or release to my Health Care Agent or to anyone designated by the Health Care Agent without reduction, all of my individually identifiable health information and medical records relating to my past present or future physical, mental and emotional health, the provision of health care to me, including all information relating to the diagnosis and treatment of HIV/AIDS,
sexually transmitted diseases, mental, emotional or physiological diseases and conditions and drug or alcohol abuse and payment for such diagnosis and treatment.

7.4. The authority given to my Health Care Agent hereunder shall supersede any prior agreement I have made with any health care providers, health plans or health care clearinghouses to restrict access to or disclosure of my individually identifiable health information.

7.5. The authority given to my Health Care Agent hereunder shall expire only in the event that I revoke the authority in writing and deliver the revocation to the health care provider, health plan, hospital, clinic or health care clearinghouse from which my Health Care Agent seeks my individually identifiable health information.

7.6. In the event of a conflict between my Health Care Attorney-in-Fact under this document and any Living Will / Declaration / Advance Directive that I have executed, my Health Care Attorney-in-Fact shall control and his or her decision shall be final and binding.

This Power of Attorney shall not be affected by disability of the Principal, it being the intent of the maker hereof that all powers herein conferred shall remain in effect during any period of disability of the Principal herein and shall be fully exercisable by my said attorney notwithstanding any such disability.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this _________ day of ______________________, 20__.

______________________________

STATE OF MARYLAND
COUNTY OF BALTIMORE, to wit:

I hereby certify, that on this «Dateoftrust», before me, the subscriber, a Notary Public of the State of Maryland, in and for the aforesaid County, personally appeared «name», and he acknowledged the aforesgoing Durable Power of Attorney for Health Care to be his act and deed.

As witness my hand and Notarial Seal.

______________________________
Notary Public

QUOTE OF THE MONTH

They say that age is all in your mind. The trick is keeping it from creeping down into your body.

~Author Unknown
The General Assembly enacted the following bills relevant to the practice of elder law during the 2012 legislative session.

Notes: 1. For copies of state legislation, go to http://mlis.state.md.us/
2. The effective date of legislation was October 1, 2012 unless otherwise noted.

1. SB 711/HB 774 Maryland General and Limited Power of Attorney Act
(Chapter 84 Senate, Chapter 85 House)
Adds notices regarding change of retirement beneficiary. Adds option to list co-agents, presuming that co-agents must act unanimously unless specified otherwise in the document. Also corrects technical corrections concerning language used to appoint guardians of property and person.

2. SB 941 / HB1257 Fiduciary Institutions - Protection of Elder Adults from Financial Abuse - Reporting Requirements
(Chapter 293 Senate, Chapter 294 House)
Requiring banks to report suspected financial abuse of an elder adult under specified circumstances; requiring the report to be made to specified individuals and entities at specified times and by specified means; providing that a fiduciary institution is not required to investigate an allegation by an elder adult that financial abuse of the elder adult has occurred or to make a report if the same matter has already been reported; establishing specified civil penalties.

3. SB 1301 Budget Reconciliation and Financing Act of 2012 - Special Session (Senate Chapter 1)
Includes a provision amending Health General Code Sec. 15-117 eliminating Medicaid nursing home bed holds for hospital stays. Bed hold rule remains available for a leave of absence up to 18 days per calendar year for facilities that have a provider agreement with DHMH. Effective July 1, 2012
COMMENT: This was a “lesser evil” of options for DHMH to meet required budget reductions. It was hoped that nursing home vacancies were large enough that a resident would still be able to return after a hospital stay. DHMH has since opined that payment of bed hold is not a medical expense.

4. SB 353/ HB 318 Estates - Small Estate Administration - Eligibility Thresholds
(Chapter 62 Senate, Chapter 63 House)
Increasing the maximum value of property of specified decedents that may be eligible to be administered as a small estate to $100,000 (from $50,000) where the beneficiary is the spouse and $50,000 (from $30,000) for other beneficiaries; adjusting the fee schedule to a flat percentage of the estate for certain estates.

5. SB 397/HB 773 Estates and Trusts - Allowance for Funeral Expenses
(Chapter 226 Senate, Chapter 227 House)
Defining the term "funeral expenses" to include the cost of ceremony and food and beverages for purposes of payment from a decedent's estate; increasing from $5,000 to $10,000 the maximum amount that a court may allow for funeral expenses for a small estate.

6. SB71 / HB101 Posthumous Use of Donor Sperm and Eggs
HB101 signed into Law (Chapter 649)
Addresses various issues relating to posthumous use of sperm and eggs. The law changes the definition of "child" in E&T 1-205 to include "a child conceived from the genetic material of a person after the death of the person if (I) the person consented in a written record to use of the person's genetic material for posthumous conception in accordance with the requirements of section 20-111 of the Health - General Article and (II) the person consented in a written record to be the parent of a child posthumously conceived using the person's genetic material."

The legislation further states: “No other after-born relation may be considered as entitled to distribution in the relation’s own right unless: (1) the decedent had consented in a written record to use of the decedent’s genetic material for posthumous conception in accordance with the requirements of § 20–111 of the health – general article; (2) the

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person consented in a written record to be the parent of a child posthumously conceived using the person’s genetic material; and (3) the child posthumously conceived using the decedent’s genetic material is born within 2 years after the death of the decedent.”

COMMENT: This bill has the unintended consequence of potentially delaying the closing of estates until it is clear no posthumous beneficiaries exist. A fix is expected in the next legislative session.

7. SB 787/ HB 772 Estates and Trusts - Maryland Uniform Principal and Income Act - Certain Payments to and from Trusts (Chapter 301 Senate, Chapter 302 House)
Establishing specified requirements concerning allocation of principal and income for a distribution to a marital trust from an individual retirement account, qualified retirement plan account, or similar account or plan, or annuity; requiring a trustee of a marital trust to perform specified duties on request of a surviving spouse under specified circumstances; requiring a marital trust to increase receipts payable to a beneficiary under specified circumstances.

8. SB 294 / HB 444 Family Farm Preservation Act of 2012 (Chapter 448 Senate, Chapter 449 House)
Alter ing the determination of the Maryland estate tax under specified circumstances to exclude from the value of the gross estate up to $5,000,000 of the value of qualified agricultural property; providing that the Maryland estate tax on qualified agricultural property may not exceed 5% of the value of specified agricultural property exceeding $5,000,000; providing for the recapture of specified Maryland estate tax under specified circumstances; requiring the Comptroller to adopt specified regulations.
Applies to decedents who die after December 31, 2012

9. SB 485/ HB 556 Continuing Care Retirement Communities (Chapter 523 Senate, Chapter 524 House)
Requiring specified providers to set aside operating reserves that, before January 1, 2023, equal 15% of specified expenses of a facility; requiring specified providers to set aside operating reserves that, on or after January 1, 2023, equal 25% of specified expenses of a facility; beginning January 1, 2014, providing for the manner in which specified requirements relating to assets held by providers shall be met.
COMMENT: This is a watered-down version of legislation proposed in the 2011 session by various stakeholders.

10. SB 415 / HB 540 Handling Human Remains with Dignity Act of 2012
Requiring a funeral establishment or crematory, on taking custody of the body of a decedent, to maintain the body in a certain manner; requiring a funeral establishment or crematory to maintain the body of a decedent with refrigeration and at a certain temperature under specified circumstances; prohibiting the body of a decedent from being embalmed or artificially preserved except under specified circumstances.

11. SB 253 State Government - Administrative Procedure Act - Proposed Regulations (Chapter 201)
Requires an executive agency to post proposed rules on its web site within three business days of publication in the Maryland Register Effective June 1, 2012

12. SB 856/ HB 762 Maryland Mediation Confidentiality Act (Senate Chapter 309)
Establishing that specified communications made in the course of and relating to specified mediations may not be disclosed by the mediators, parties to the mediations, or specified persons who participate in or are present for the mediations, under specified circumstances; establishing specified exceptions for specified communications; providing for the application of the Act; defining specified terms; providing that the Act may be cited as the Maryland Mediation Confidentiality Act. Effective June 1, 2012

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Visit www.msba.org/sec_comm/sections/elder/ for all the latest updates!
Legislative Session Review...
continued from page 22

13. SB 231 Individuals with Disabilities - Attendant Care Program (Chapter 468)
Altering the method used by the Attendant Care Program in the Department of Disabilities to determine sliding payment scales for specified eligible individuals; altering the description of a specified category of eligible individuals at risk of nursing facility placement; authorizing the Secretary of Disabilities to waive specified proportional requirements under specified circumstances; authorizing the Secretary to adopt specified regulations. 
Effective July 1, 2012.

14. HB 596 Child with a Disability - Individualized Education Program Meeting - Document Access
Altering the period of time that appropriate school personnel must provide a copy of specified documents relating to the development of an individualized education program for a child with a disability to the parents of the child to at least 5 calendar days before a specified meeting.  
Effective July 1, 2012

15. SB 744 / HB 1055 Health Insurance - Habilitative Services - Required Coverage and Workgroup
Increases from 19 to 21 the age under which insurers, non-profit health service plans, and health maintenance organizations must provide coverage of habilitative services; adds certain disabilities to the list; specifying the format in which a notice about the coverage must be provided; requiring the Maryland Insurance Commissioner to establish a workgroup on access to habilitative services benefits.  
Effective July 1, 2012

Special Needs Law Study Group:

The next meeting of the Special Needs Law Study Group is scheduled for Friday, December 14, 2012, from 9-11 a.m. at the following location:

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

Lisa H. R. Hayes, Senior Wealth Planner/SVP, PNC Wealth Management, Brian F. Kennedy, Senior Trust & Fiduciary Specialist, Wells Fargo Private Bank, and William J. Gering, Vice President, Wealth Advisory Services, Wilmington Trust NA will be leading a panel discussion concerning the role of, and the services that can be provided by a corporate trustee. Please bring questions and be prepared to participate in the discussion.

Please RSVP directly to Edmund W. Law, Esq. @ ewlaw@erols.com if you definitely plan on attending the December 14th session, or are interested in being added to the mailing list and have not already done so.
Jimmo v. Sebalius and the Medicare Improvement Standard

By Leslie Fried
Director, Policy and Programs, National Council on Aging

In the proposed settlement of a significant Medicare case, the Centers for Medicare and Medicaid Services (CMS) agreed to eliminate the use of an “improvement standard” as a requirement for Medicare to cover skilled rehabilitation services. This federal class action case was brought by the Center for Medicare Advocacy on behalf of several individual Medicare beneficiaries, as well as numerous groups, including the Alzheimer’s Association, the National Multiple Sclerosis Society, the Parkinson’s Action Network, the Paralyzed Veterans of America and the National Committee to Preserve Social Security and Medicare. The lawsuit challenged the de facto denial of coverage for Medicare beneficiaries because their condition was not improving. Plaintiffs, and their constituents whom have chronic conditions, were denied medically necessary services despite their need for skilled care. CMS agreed to revise relevant provisions of its Medicare Benefit Policy Manual to provide that coverage standards for skilled nursing facility, home health and outpatient therapy benefits, and for inpatient rehabilitation facilities (IRF), do not include the individual’s potential to improve, but rather is based on the beneficiary’s need for skilled care. Once the provisions of the settlement are implemented, Medicare beneficiaries, including those individuals with chronic degenerative conditions such as Alzheimer’s disease, multiple sclerosis and Parkinson’s disease, should have greater access to physical, occupational and speech therapy based on their unique condition and individual needs.

The proposed settlement agreement has been submitted to the federal court for approval. Upon court approval, the terms of the settlement agreement will be implemented. For additional information about this lawsuit, go to the Center for Medicare Advocacy webpage at http://www.medicareadvocacy.org/hidden/highlight-improvement-standard/

Bedhold Changes in Maryland Medicaid

By Jennifer Goldberg
Assistant Director of Advocacy for Elder Law and Health Care, Legal Aid Bureau

As of July 1, 2012, the Maryland Medical Assistance Program is no longer paying to reserve a nursing home resident’s bed when the resident enters the hospital. Even without a bedhold payment, a Medical Assistance recipient has the right to return to the first available gender- and care-appropriate bed in a semi-private room. If a nursing home does not allow a Medicaid recipient to return when a bed is available, it is considered an involuntary discharge.

For more information about Maryland Medical Assistance’s new bedhold policy, see the following policy statements from the Department of Health and Mental Hygiene:


Clients and their families may have questions about the new bedhold policy. Maryland Legal Aid’s Long Term Care Assistance Project developed a flyer designed for nursing home residents and their friends and families to explain the changes. The flyer is included on the last two pages of the newsletter - you are welcome to distribute it widely, but please keep the flyer in its current form.
Bedhold for Nursing Home Residents: 
Know the Facts

*Maryland Medicaid has changed their bedhold policy. What does this mean for me if I receive Medicaid?*

1. What is a bedhold?
A bedhold is when a nursing home holds a bed for you when you go into the hospital. **Starting July 1, 2012, Maryland Medicaid is no longer paying for nursing homes to hold your bed if you are hospitalized.** All nursing homes must have a written bedhold policy. They must give it to you when you are admitted, before any transfer to the hospital, and when you transfer.

2. Can I still go back to the nursing home even if my bed was not held?
You have a right to return to the same nursing home IF there is an available bed. Even if someone has taken your old bed, you are entitled to return to the first available bed in a semi-private room. You may return to your old bed if it is empty, but the nursing home is not required by law to hold your old bed for you.

3. What if no beds are available at my previous nursing home when I am ready for discharge?
Very few nursing homes are so full that a bed would not be available. If this happens, the hospital must help you find another nursing home where beds are available. Then, if you choose to, you can later transfer back to the first nursing home when the first bed becomes available. If you try to stay at the hospital until a bed becomes available at the first nursing home, you could end up with a large bill owed to the hospital.
4. What if my previous nursing home says that they don’t have beds available, but they don’t seem full?

If you question whether a nursing home really has beds available, you can contact the Maryland Office of Health Care Quality at 1-877-402-8219.

If a nursing home doesn’t let you back in when a bed is available, that is called an involuntary discharge. You have a right to receive a 30-day involuntary discharge notice. You must be advised of your appeal rights in writing. You have a right to appeal an involuntary discharge by requesting a mediation and hearing with the Office of Administrative Hearings.

5. What questions should I ask about my bedhold rights when choosing a nursing home?

Ask the nursing home administrator about their bedhold policy. Some nursing homes may hold your bed for some time period while you are hospitalized, even though Maryland Medicaid will not pay the nursing home during your time away.

You can also ask the administrator about whether the nursing home usually has beds available. If the nursing home is typically almost full, tell them you are concerned about whether you will be able to go back to the nursing home if you are hospitalized. You can ask for a better bedhold policy when signing the admission contract.

6. Can a nursing home charge to hold a bed when I am hospitalized?

Yes, according to the Maryland Department of Health and Mental Hygiene, nursing homes may charge up to the private pay rate for a bed—sometimes as much as $300 per day. This charge has to be clearly stated in the nursing home’s bedhold policy. You or your family can choose whether to pay this daily fee. The nursing home is required to let you return to the first available bed but it may not be the bed that you left before you went into the hospital.

7. Who can I contact if I have questions or want help?

You can contact the Long Term Care Ombudsman’s office at 1-800-243-3425. The Ombudsman is a free advocate for nursing home residents. For legal advice, you can contact the Maryland Legal Aid Long Term Care Assistance Project at 1-800-367-7563. Legal Aid’s services are free for those who qualify.