

The Elder Law Extra

Robin L. Weisse, *Chair*

Catherine E. Stavely, *Vice-Chair*

Nicole Livingston, *Editor*

Message from the Chair..

Welcome to the Spring Edition of our Newsletter. Thanks to the hard work of our members, we are pleased to be able to share information on a wealth of topics. Never in my recollection have things moved so swiftly in areas impacting our clients and their families, and not necessarily in a good way. Our contributors graciously share their expertise to educate Section members on important changes at the federal and state levels, recent litigation and court decisions.

The Deficit Reduction Act of 2005 was signed by President Bush on February 8, 2006. The ramifications of these regulatory changes on Medical Assistance qualification for "middle" America are far-reaching. I'm not sure why impoverishing the very citizens who for a lifetime have unselfishly supported this country with their money and hard work is good public policy. Long term care is often the "one and only time" the average American needs help. Clearly, without public outcry and advocacy, these new regulations will play a role in eroding the quality of care our seniors receive and will make the job of caregivers more onerous and potentially abusive. Many families will simply try to make do in an effort to not lose everything it took a generation to build, simply because Mom got sick.

On a more upbeat note, it is my hope that some of our members will have seen Maryland Public Television's airing of "Almost Home" on April 20th which shows the transformation of a nursing home. The dialogue needs to begin in earnest in Maryland to recognize that nursing homes are just that, "homes" for many of our residents. We need to provide long term care in settings that recognize the resident's humanity, preserve dignity and provide an opportunity to continue contributing to society, if possible. After all, many of us will some day be residing in these "homes."

Legislatively, the 2006 Session is coming to a close as I write this and everyone will need to review the new Advance Directive forms approved this year. For the future, the Section is working on the possible introduction of the Uniform Power of Attorney Act next year. By

the time this publication reaches you, a meeting with representatives from Elder Law, Estates & Trust, Real Property and the Maryland Bankers Association will have met with Professor Linda Whitton from Valparaiso University and Senator Dolores Kelley to comment on the proposed legislation.

In closing, please note our upcoming programs. The Section Meeting on May 2nd is titled "Helping Our Caregiver Clients Avoid Insanity" and will be most appropriately held at Sheppard Pratt Hospital Center. Further, if you are completely confused, like most of us, as to how to advise clients in light of the implementation of the Deficit Reduction Act, the MICPEL programs coming up in May and June will definitely help. And finally, mark your calendar for the Annual Meeting in Ocean City. Our Section is sponsoring two programs this year. We are co-sponsoring with the Health Law Section on the changes to Advance Directives and with the ADR Section on the Maryland Senior Mediation Project.

It has been an extremely busy year. In preparing the Elder Law Section's Annual Report to the Bar Association, I certainly realized and appreciated the tireless efforts of our Section Council Members and wish to formally thank each and every one for all they have done.

Kindest regards,

Robin L. Weisse, Chair

MSBA

ELDER LAW
Meetings

❖ *May 2, 2006*

**HELPING OUR CAREGIVER CLIENTS
AVOID INSANITY (11:30 a.m.)
Sheppard Pratt Hospital
6501 N. Charles Street
Baltimore, Maryland 21204**



Assessing a Client's Mental Capacity: What's an Attorney to do?

by Benjamin J. Woolery, Esq.
McGill & Woolery

A handbook of 72 pages published in 2005 by the American Bar Association's Commission on Law and Aging in cooperation with the American Psychological Association is available (for \$25.00) to its intended audiences: elder law attorneys, trusts and estates lawyers, family lawyers, and general practitioners. There is no mention of the handbook being useful in the criminal law context.

Not "meant to outline compulsory standards," it instead sets forth "16 key questions" and "offers ideas for effective practices and makes suggestions for attorneys who wish to balance the competing goals of autonomy and protection..."

Currently, most of us who confront these issues can usually get over this threshold question without a second thought (even if that first thought is "This person has no idea what's going on – I can't work for them"). On those occasions when we ask ourselves about the new or existing Client "Does this person understand what's going on?", a cover letter from the Client with the Retainer Agreement can get that Client's written direction to us 'into the file' while simultaneously compelling the Client to focus on the task at hand and make choices. This handbook is intended to help us in that narrower set of situations that the ABA expects to occur with increasing frequency as our society continues to gray: "If my client cannot give me written instructions on what task(s) I am to carry out, can I take my marching orders merely from a conversation?"

A tool many lawyers have used for years is the physicians' Mini-Mental Status Exam. The MMSE (a/k/a the "Mini Mental") uses a series of simple and varied markers as the client/patient works toward a perfect score of 30, which is very easy for an intelligent and competent person to score; a score of 26 is still passing, and 23 or below compels the practitioner to get a medical work-up of "competent" if an attorney-client relationship is going to be established or maintained. The handbook terms it "a quick but blunt assessment of overall

cognitive mental status," and concludes "for a variety of reasons ... it is generally not appropriate for attorneys to use more formal clinical assessment instruments, such as the MMSE."

The handbook correctly states "Lawyers generally do not have the education and training needed to administer these tests." With that being said, the practicing attorney needs something readily available for the threshold question "Do I have a Client here?" Certainly a full work-up by a medical professional can be called for by the circumstances of a given case. Yet, if the lawyer does his or her evaluation with the MMSE as one tool in a given Client's case, it should still be useful.

Personally, in the time I've had the handbook, no occasion has presented itself for using the handbook's "Capacity Worksheet for Lawyers" with a Client. I may find it useful in practice, but for the moment, it seems more complicated to use than the Mini Mental – I don't say this because of the practitioner's usual aversion to change, but from the absence of a straight-forward "score" at the end of the testing.

We must all make decisions for our clients on a case-by-case basis, and the economics of any Client's situation will play a role to one degree or another. For cases involving substantial questions (revoking a prior Will, disinherit a child, lifetime gifting) and a potential challenge, a 30 on the Mini Mental with a letter of "competent" from the treating physician can still be enough; absent a Mini Mental 30 or similar positive conclusions from the "Capacity Worksheet for Lawyers," cases with substantial questions and a lot at stake will call for an assessment by one of more medical professionals at any expense commensurate with the circumstances.

To be ready for that case, call the ABA at 202-662-8690 about Product Code #4280025, "Assessment of Older Adults with Diminished Capacity: a Handbook for Lawyers" (\$25.00).

Please contact the editor, Nicole Livingston, at Nicole@sinclairprosserlaw.com for article suggestions and member news for the Fall 2006 newsletter.



The Deficit Reduction Act of 2005

Estate Planners Beware The Pitfalls of Gift Giving

by Laurie S. Frank, Esq.

Do any of your clients make gifts to charities, family members, friends, or religious institutions? Are they helping to pay for their grandchildren's education, helping their children buy homes or making the annual gifts of \$12,000 per person per year? If the answer to any of these questions is **yes** then you must read on. The legal landscape for gift giving by the affluent – but not super-rich – older American is different than it was at the start of the year, not because of a change in gift or estate tax law, but because of the Deficit Reduction Act of 2005 (DRA).¹

While the nominal purpose of the DRA is to reduce the costs of a number of governmental programs, it seeks to do so by making much harsher and more stringent the rules that govern the Medicaid (properly called Medical Assistance) program, the main source of assistance for long term care costs other than private long term care insurance. The new rules will affect those who cannot afford to pay \$300,000 to \$600,000 (\$5,000 - \$10,000 per month) for long term care on their own for five years. At that rate almost everyone afflicted with an illness necessitating nursing home care will become impoverished within a relatively short time period.

The biggest change is Congress' reach to discourage gift giving. Gifts made on or after **February 8, 2006**, will be subject to review for anyone seeking Medicaid Long Term Care (MALTC) within the next five years. The person who waits until s/he is out of funds seek MALTC, may then be told that the well-intentioned gifts made up to five years earlier result in a denial of benefits for many months (or years) more.² To be sure, there may be ways to get such denials over-turned – if the person can hire a lawyer to appeal. These provisions will apply to anyone who makes a gift within five years of needing MALTC benefits regardless of how wealthy and healthy they were when the gift was made. Many provisions of the DRA are effective as of the date of its enactment, **February 8, 2006**.³ Those with the broadest scope are the change in the start date of the penalty period and the increase in the look-back period for penalizing transfers from three to five years. Other provisions most significant in Maryland are those restricting the use of immediate annuities, limiting the equity an individual may have in his or her home, limiting the use of loans or promissory notes and life estates, and changing the treatment of entrance fees at

continuing care retirement communities. On the positive side, the DRA also re-institutes the “long term care partnership” act. These key provisions are summarized here.

The Look-Back Period

When a person applies for MALTC benefits, the Medicaid program “looks back” in time from the month of application for a specified number of years to see if the individual and/or his or her spouse has transferred any assets for less than fair market value, *i.e.*, made any gifts. Before the DRA, this time period was three years for assets owned by the individual and/or his or her spouse and five years for assets titled in trust. For gifts that occurred prior to February 8, 2006 this is still the case. For all gifts occurring on or after February 8, 2006 the look-back period increases to five years.⁴

Part of the problem with this longer look-back period is simply procedural: applicants face a denial of benefits if they cannot provide statements and records on all accounts in existence for the five years prior to the month of application.

The Penalty Start Date

If a gift occurs during the look-back period, Medicaid penalizes the individual by denying him or her benefits for a period of time. The length of the penalty is calculated by dividing the amount gifted by the average monthly cost of nursing home care. Maryland uses \$4,300 as the average cost of care, although the actual average cost in Maryland is greater than this.⁵ The penalty is one month of ineligibility for every \$4,300 given away.

The DRA made significant changes to the start date. Under the old rule, the penalty start date was the first day of month in which the gift was made.⁶ Under DRA, the start date for transfers occurring on or after the date of enactment, February 8, 2006, occurs when the person is in a nursing home,⁷ requires that level of care, and is approved for benefits⁸ “but for the application of the penalty period.” Thus, the penalty does not start until the person is a nursing home resident and otherwise eligible, *e.g.*, has not retained other countable assets to spend during the period of ineligibility.

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Deficit Reduction . . .

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The new rule may be more understandable if seen as it was designed, to eliminate use of the so-called “half-a-loaf” strategy. Under the old rule, a person entering a nursing home could give away about half of his or her assets while using the remaining assets to pay for his or her care during the waiting period resulting from the transfer. A transfer in advance of nursing home admission would preserve even more in assets. The requirement that the person otherwise be eligible does not allow him or her to retain countable assets while a transfer penalty period is running.

Home Equity

The DRA limits the equity an individual applicant may have in his or her home and still qualify for MALTC. An individual applicant may have no more than \$500,000⁹ in home equity. This limitation does not apply if there is a spouse or a minor or disabled child living in the home. Home equity may be reduced via a reverse mortgage or home equity loan. Note that this provision of the DRA is **effective January 1, 2006**.

Annuities

Immediate payment annuities have been used in both individual and spousal cases to spend down. The DRA discourages the use of annuities as a spend down vehicle by requiring that the State be named the primary beneficiary upon the annuitant’s death up to the amount of benefits paid on behalf of the Medicaid recipient. While this is clearly required in the case of an individual applicant or recipient, it is unclear at this juncture whether, if the community spouse is the owner and the annuitant, the State must be named the beneficiary upon the community spouse’s death to the extent of benefits paid for the institutionalized spouse’s care.

Annuities that are funded with monies from individual retirement plans are generally excluded from this provision.

The DRA also prohibits the use of balloon annuities, **e.g.**, an immediate annuity that pays interest only for the specified term of the annuity and then the principal balance at the end. Under the DRA if this type of annuity is purchased, it will be treated as a transfer subject to penalty.

Life Estates

The purchase of a life estate interest without power of sale in a home property will be treated as a transfer subject to penalty unless the purchaser resided in the home for a period of at least one year after the date of the purchase.

Promissory Notes

The DRA provides that certain notes and loans will be deemed to be countable assets unless they have repayment terms that are actuarially sound, have equal payments during the term of the note, and prohibit cancellation of the principal balance upon the death of the lender. If the note does not comply with these provisions its value will be the outstanding principal balance as of the date of the Medicaid application.¹⁰ This suggests that the inverse is also true, if the note meets these requirements, then it is an income stream and not a countable asset, but whether Maryland will recognize such consistent treatment is unresolved.

Continuing Care Retirement Communities (CCRCs)

Effective January 1, 2006, the rules regarding the treatment of entrance fees at CCRCs changed in Maryland. If certain conditions are met the entrance fee at the CCRC will be deemed a countable asset by Medicaid even though the CCRC may still retain control of the asset.¹¹ The DRA goes even further and provides that entrance fee shall be considered a countable asset if the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care if other income or assets are insufficient to cover the cost. It also allows the CCRC to require residents to spend on their care all of the resources that they declared at the time they were admitted to the CCRC before applying for Medicaid.

Long-Term Care Partnerships

The State Long-Term Care Partnership Program has been resurrected. This program encourages the purchase of long-term care insurance by allowing owners of such policies to increase exempt assets, on a dollar-for-dollar basis, to an amount equal to the benefits paid out by the policy. Maryland enacted such a program in 1993,¹² but the Maryland program was in effect barred by the estate recovery provisions of the Omnibus Reconciliation Act of 1993. The DRA provides that the protected funds are not subject to estate recovery.

So what do we tell our clients? Whenever there is a major change in the law, there will be a period of uncertainty and we are in the midst of it now. There are still ways to gift funds and protect assets without having a disastrous result if your client needs long term care within five years of the transaction(s). It will be more difficult than before. The consequences of poor planning or a failure to plan will be more severe. The

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Deficit Reduction . . .

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result of misinformed action could well be disastrous. The current administration has justified cuts to the estate tax by asserting the need of multi-millionaires to “leave a legacy” to their children. The DRA challenges attorneys to find ways in which less than multi-millionaires can do the same for their families.

With special thanks to Jason A. Frank, Esq. and Ron M. Landsman, Esq. for their assistance.

Footnotes

¹ A law suit has been filed in Alabama alleging that the DRA is unconstitutional because the versions which passed the House and the Senate and signed by President Bush were not identical. At issue is a provision concerning the period of time that the Medicare program will pay for oxygen, the version which passed the House provided for three years and the one the President signed into law provided for thirteen months.

² Both Federal and, necessarily, Maryland law excludes from these penalties gifts made exclusively for a purpose other than to qualify for Medicaid. COMAR 10.09.24.08-1B(8)(f). But the burden is on the applicant to do so by “convincing evidence,” *id.*, and the Maryland Medical Assistance *Eligibility Manual* has a rebuttable presumption that gifts by a person aged 60 or older are for the purpose of establishing Medicaid eligibility. *id.*, p. 800-97.

The DRA does provide that a nursing facility, with the individual or their representative’s consent, may apply for a hardship waiver, but nursing homes will likely begin taking steps to avoid putting themselves in the position of having to incur that additional expense.

³ The DRA requires that states come into compliance as of the enactment date. However, if State legislation is needed to implement its provisions, the State must implement the Act’s provisions no later than the first day of the first calendar quarter following the close of the next legislative session. At this time it is not clear what the effective date will be in Maryland. The Elder Law Section of the Maryland State Bar Association and the Maryland/ DC Chapter of the National Academy of Elder Law Attorneys have written to the Department of Health and Mental Hygiene regarding this provision (and many others) and are awaiting clarification from the Department.

⁴ When the look-back period was increased from 30 months to 36 months in August 1993, the increase was phased in beginning with the 31st month after August 1993. Assuming the same phase in process is utilized beginning March 8, 2009 an additional month will be added to the look-back period until the full five year look-back is in place in February 2011.

Another way to look at it is that the three year look-back applies for applications now, while the five year look back applies to prospective planning. To put it another way, there continues to be a three year look-back. From February 2009 through February 2011 the look-back will be to February 2006. From February 2011 onward, there will be a five year look-back.

The one further complication is that for the next three years, two different penalty rules apply, one for pre-DRA gifts, and a different, more harsh one for post-DRA gifts.

⁵ Maryland has a history of decennial adjustment. It first set the average cost of private pay care at \$3,000 in 1988, when this amount was first used for determining penalty periods. It increased it to \$4,300 in September 1998.

⁶ For example if an individual who gifted \$43,000 in March 2005 would not be eligible for benefits for ten months, from March 1, 2005 through December 31, 2005. If he or she applied for benefits in March 2006, benefits would be approved if the person were otherwise eligible. The penalty start date goes back in time to the month in which the gift was made, so it has no impact on eligibility for the program in March 2006.

⁷ This would also apply to an individual applying for one of the Medicaid Home and Community Based Services Waivers.

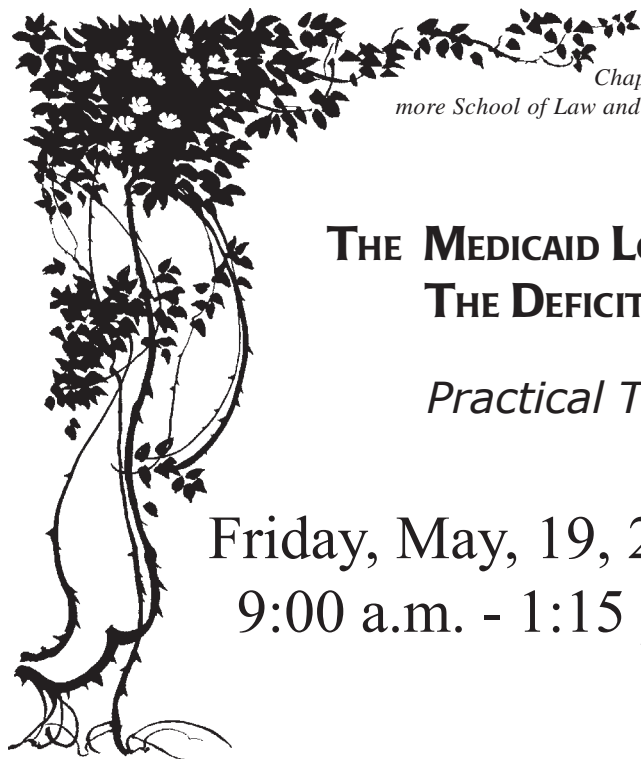
⁸ For an individual applicant the countable asset limit is \$2,500 (\$2,000 if the individual is receiving SSI and/or applying for a Home and Community Based Services Waiver). In the case of a husband and wife, the spouse at home can keep the house and one half of the countable assets that existed as of the first day of the month of a more than 30 day nursing home placement up to a maximum of \$99,540 and a minimum of \$19,908 (these amounts are adjusted annually). The institutionalized spouse is allowed to keep up to an additional \$2,500.

⁹ If the State elects, this figure can be increased to \$750,000. The Elder Law Section of the Maryland State Bar Association and the Maryland/DC Chapter of the National Academy of Elder Law Attorneys has requested that the State make this election.

¹⁰ Current Maryland Medicaid policy treats the principal balance of any promissory note as a countable asset.

¹¹ In this regulatory change, the Department of Health and Mental Hygiene attempted to ensure that the special protections under the Medicaid law for individuals with disabilities and spouses would not be thwarted.

¹² See Md. Health General Code Section 15-401 et seq



MICPEL, the MSBA Sections of Elder Law, Estate & Trust Law, and Health Law & the Maryland/Washington D.C. Chapter of NAELA, in cooperation with the University of Baltimore School of Law and the University of Maryland School of Law, present:

THE MEDICAID LONG TERM CARE PROGRAM AFTER THE DEFICIT REDUCTION ACT OF 2005:

Practical Tips and Potential Pitfalls

Friday, May, 19, 2006 | Ecker Business Training Center
9:00 a.m. - 1:15 p.m. | 6751 Columbia Gateway Drive
Columbia, MD

WHAT YOU WILL LEARN AND WHY YOU SHOULD ATTEND... Effective February 8, 2006, Medicaid long-term care benefits financial eligibility rules have dramatically changed. While these benefits are still available for home and community based settings (Medicaid Waiver) as well as nursing homes, the Deficit Reduction Act of 2005 (DRA) has significantly altered the eligibility rules of the program. Join our outstanding faculty and you will learn the new Medicaid financial eligibility rules as well as other important changes made by the DRA. Additionally, the faculty will address the limited availability of the Medicaid Waiver for Older Adults Program, rules applicable when the resident has a spouse in the community, the application process and rules establishing medical eligibility. This program is intended as a practical look at the new law with a view toward bringing the most significant changes to the attention of the elder law practitioner.

Gain a practical understanding of how to help your clients by learning the necessary strategies as well as which trusts to use. Attend **The Medicaid Long Term Care Program After the Deficit Reduction Act of 2005: Practical Tips and Potential.**

Watch your mail for details, or check the MICPEL website at www.micpel.edu.

FACULTY:

- ♦ **Jason A. Frank, Esq.**
Frank, Frank and Scherr, LLC
Program Chair
- ♦ **Laurie S. Frank, Esq.**
Frank, Frank and Scherr, LLC
- ♦ **Morris Klein, Esq.**
Law Office of MorrisKlein
- ♦ **Lisa M. Kulishek, Esq.**
Chief, Beneficiary Services Administration,
Medicaid Policy Administration,
Department of Health and Mental Hygiene
- ♦ **Ron M. Landsman, Esq.**
Ron M. Landsman, P.A.
- ♦ **Michael D. Levine, Esq.**
Division of Recoveries and Financial Services,
Department of Health and Mental Hygiene
- ♦ **Sarah Lenz Lock, Esq.**
AARP Foundation Litigation

Nursing Home Contracts

by Benjamin J. Woolery, Esq.

On March 14, 2006, the Court of Appeals of Maryland filed its Opinion in *Audrey Walton, et al. v. Mariner Health of Maryland, Inc.*, Case Number 33 of the Court's 2005 September Term. The holding of the case impacts all persons who sign Nursing Home Contracts in Maryland as 'agent' for the 'resident.' The Court phrased the basic question as follows: "We must determine whether a contract between an agent, on behalf of a nursing home resident, and a nursing home facility, entitles the nursing home to a private cause of action against an agent for the cost of the resident's care."

The Court's conclusion suggests a sweeping rule to protect all 'agents' who sign these contracts, stating "In summary, an agent's responsibility is limited to the administration and management of the resident's funds." With that being said, we need to keep in mind the facts of the case as distilled and recited by the Court.

Upon her mother being transferred from Southern Maryland Hospital Center to Mariner Health of Southern Maryland, Patricia Walton as agent for her mother Audrey Walton signed the "Resident's Agent Financial Agreement," indicating therein that "the only methods of payment would be Medicare and Medical Assistance. In the agreement, Patricia expressly denied any personal responsibility for Audrey's bill. When Audrey was admitted to the facility, Medicare paid for Audrey's nursing home bill, however, at the end of February, 2001, Medicare stopped paying for Audrey's nursing home care. Patricia, as agent, was required, as stipulated in the agreement . . . to reapply for eligibility or Medical Assistance. There was testimony that Audrey would have been a successful candidate for Medical Assistance and, most likely, Medicare. The bill accumulated to a balance of \$86,235.91 for eighteen months.

"On July 6, 2004, Patricia testified at trial that she was not aware that Medicare ceased paying for her mother's care . . . Patricia stated that she would have applied for medical benefits for her mother had she been aware that Medicare stopped paying for Audrey's nursing home bill. Patricia testified that she was not given notice of the outstanding monetary obligation until after Mariner Health sold the facility to another group. Mariner Health offered no explanation or evidence as to why it failed to notify Audrey or Patricia that Medicare had ceased paying or that a debt had been incrementally tallied for eighteen months."

With that factual background, the Court of Appeals undertook an analysis of the contract as offered into evidence before the circuit court – which contracts, as we practitioners know, routinely exceed two dozen pages.

Looking to the law, the Court's analysis covered agency law, the contract itself, and then Section 19-344 (c) of Maryland's Health-General Article before reaching the question of "Statutory Remedies":

'There were several statutory remedies that Mariner Health chose not to pursue...

'Section 19-344(c) does not expressly state that a private cause of action against a resident's agent is authorized or prohibited under the statute... "A frequently stated principal of statutory construction is that when legislation expressly provides a remedy or remedies, courts should not expand the coverage of the statute to subsume other remedies." *Sugarloaf*... 78 Md.App. 550... (1989), *aff'd* 319 Md. 558 . . . (1990)...

'In *Sugarloaf*, the statute provided for criminal penalties, administrative punishments, injunctive relief, and taxpayer suits under limited circumstances. It did not provide, however, for private causes of action...

'The intermediate appellate court . . . relied upon the principal that "it is an elemental canon of statutory construction that where a statute expressly provides a particular remedy or remedies, a court must be chary of reading others into it." *Sugarloaf*, 78 Md.App. at 559 . . . '

The *Walton* Court held that since Section 19-344 contained certain sanctions against an agent, including but not limited to "a civil penalty not exceeding \$10,000.00," a facility must first pursue those remedies:

A nursing home facility **may** choose to obtain a court order to compel an agent to either apply or request a determination for Medical Assistance. It **must**, however, report any violation of § 19-344(c)(4) and (5) to the Attorney General because, "[t]he Attorney General is responsible for the enforcement and prosecution of violations of paragraphs (4) and (5) of this subsection." See § 19-344(c)(6)(iii).

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Sleepless in Temple Hills

Maryland's Response to Foreclosure Rescue Scams

by Karren Pope-Onwukwe, Esq.
Law Office of Karren Pope-Onwukwe

"The Defendant, Mr. Abell's tortuous conduct in this case constitutes the most reprehensible actions this Court has ever observed in his 28 years on the Orphan's Court, the District Court, and the Circuit Court save only the physical violence and death routinely visited on the Court's conscious in criminal cases. If the Defendant sleeps at night, the Court can't help but wonder how."

Judge Steven I. Platt of the Circuit Court for Prince George's County wrote these words in the Opinion and Order of Court that he issued on February 7, 2006 (see, Rachel M. Dollar, Wednesday, March 1, 2006 www.mortgagefraudblog.com). The "reprehensible actions" discussed in Judge Platt's opinion are what have become known as foreclosure rescue scams or deed theft. Historically, more than 50% of the victims of this and other forms of predatory lending are the elderly of all ethnic groups, followed by African-Americans and Hispanics. (see, Melissa A. Huelsman, "A Brief Primer on Fighting Predatory Lending Practices" American Bar Association's Law Trends & News Business Law, September 2005).

Generally, foreclosure rescue scams prey on people that are faced with the foreclosure of a family home. In the case before Judge Platt a mother and daughter bought a home in Temple Hills, Prince George's County, Maryland on July 8, 1993. Ten years later, the daughter died on April 3, 2003, within a year the mortgage was in default. The mother was now responsible for a monthly mortgage payment of \$1,655.22. The mother's total monthly income was \$1,314.00 consisting of income of \$1,197.00 per month from Social Security and \$117 monthly spousal death benefit. The mother was seventy (70) years old suffering from severe diabetes and loss of hearing.

The mother probably spent many sleepless, anxious nights, worried that she would lose her home. On April 3, 2004 a man arrived on the mother's doorstep offering help. For countless other homeowners that fall prey to this particular scam the reason they are in default on their mortgage varies, but they are all in the same position. They have no money and are normally not creditworthy, a swift legal foreclosure process begins that can only be stopped with money. Many of the homeowners actually initiate contact with the con art-

ists by calling for assistance when they start to notice signs that say, "WE STOP FORECLOSURES CALL NOW!"

The homeowner can not discern that the signs are not miraculously posted by angels with an altruistic desire to help, but by an unscrupulous "rescuer", who has poured over the foreclosure filings at the courthouse and targeted communities with a high rate of foreclosures. The lure for the scam artist is the substantial equity in the houses being foreclosed, not a desire to help.

The National Consumer Law Center ("NCLC") released a report in June 2005 entitled, "Dreams Foreclosed: The Rampant Theft of Americans' Homes through Equity-Stripping Foreclosure 'Rescue' Scams" (www.consumerlaw.org/news/ForeclosureReportFinal.pdf) wherein they identified the three most common forms of rescue fraud:

Phantom Help Scams

The anxious homeowner is told not to contact the mortgage company or attorneys and to talk with and trust the rescuer. The homeowner then pays outrageous fees for little or no work and eventually loses her home.

False Bailouts

The anxious homeowner is told by the rescuer that there are investors that will help if the homeowner signs over the title to her home. The homeowner enters into a "lease/buyback scheme" wherein she pays rent to the investor. Under the egregious terms of the lease the homeowner/renter, unable to make the hefty rental payments or repurchase her home at the end of the lease/buyback period, is evicted.

Bait-And-Switch

The anxious homeowner agrees to a plan to bring her mortgage current. The rescuer engages in fraud and sometimes forgery to execute documents changing the title on the property.

On May 26, 2005 Maryland fought back when Governor Robert Ehrlich signed into law the "Protection of Homeowners in Foreclosure Act" found in the Real Property Article, Title 7, Subtitle 3 ("the Act"). The Act was introduced as emergency legislation in the Maryland General Assembly by Delegate Doyle Niemann and

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Rescue Scams . . .

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Senator Brian Frosh. The Act focuses on three activities: (i) promises made to assist a homeowner facing foreclosure; (ii) transfers of interest in real property with a promise that the homeowner may remain or repurchase the property and (iii) agreements wherein a homeowner waives her right to any foreclosure surplus.

Maryland homeowners may now bring action for damages suffered as a result of foreclosure rescue scams. The homeowner may file in either District Court or Circuit Court alleging violations of the Act. If found guilty of this misdemeanor, a defendant may be imprisoned up to three years and/or face a fine of up to \$10,000. The Act allows for reasonable attorney fees and if the defendant is found to have willfully and knowingly vio-

Nursing Home Contracts . . .

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(*Walton* Slip Op. at p. 32, **emphasis in original**).

In order to further explore the meaning of the Court's *Walton* holding, clear your calendar so that you can attend the Elder Law Section's 'brown bag' meeting on Tuesday, May 2nd – we hope to spend a few minutes on this topic after our principal speaker and, at a minimum, have a hand-out if the decision is not under reconsideration.

lated the statute, a court may award triple damages. The Act has no statute of limitation. Maryland homeowners can all sleep a little easier tonight.

Health Care Agents and Admission to a Mental Health Facility: The View of the Attorney General

by Jack Schwartz
Attorney General's Office

Are there any circumstances under which a facility that provides treatment for mental disorders may accept a patient for voluntary admission at the request of the patient's health care agent? Traditionally, the answer to this question has been "No." In a recent opinion, however, Attorney General J. Joseph Curran, Jr., identified limited circumstances under which such a request may be acted upon.

The voluntary admission statute, § 10-609 of the Health-General Article, Maryland Code, sets various prerequisites. Among them is that the individual to be admitted "understands the nature of the request for admission, ... is able to give continuous assent to retention by the facility, and ... is able to ask for release." When the predecessor of this law was enacted in 1910, and for decades afterwards, an individual who lacked capacity to meet these prerequisites could not be admitted to a facility voluntarily, and consequently could not be admitted at all unless the stringent "danger to self or others" standard for involuntary admission was met.

The Attorney General's opinion, however, considered that the voluntary admission statute was neither the only relevant law nor the last word. The opinion reviewed the effect of the Health Care Decisions Act of 1993, with its provision for advance directives capable of broadly empowering health care agents, and 2001 leg-

islation encouraging planning for future mental health care by means of advance directives. Reading all of the provisions together, the Attorney General concluded that the term "individual" in § 10-609 "should be construed to mean not only the individual acting personally but also the individual acting through an appropriately empowered health care agent."

The Attorney General cautioned that a voluntary admission at the behest of a health care agent would be permissible only if the action is within the scope of the agent's authority under the advance directive, the agent will monitor the patient's well being and progress during the course of treatment, and the patient does not express disagreement with the voluntary admission. As to the last point, some have observed that allowing an incapacitated patient's objection to block voluntary admission may effectively undermine the agent's authority. Nevertheless, the opinion gave effect in this context to § 5-611(e)(2) of the Health-General Article, which disallows reliance on authority under the Health Care Decisions Act "if the health care provider is aware that the patient for whom the health care is provided has expressed disagreement with the action."

The Attorney General's opinion is 91 Op. Att'y Gen. 3 (2006). It is available online at: <http://www.oag.state.md.us/Opinions/2006/06index.htm>

How Senior Mediation Can Help Your Clients

by Robert J. Rhudy

A Maryland family is facing difficult decisions regarding how to care for their aging mother needing assistance with daily care, finances, and health. One daughter has just moved in with her mother, and her siblings are threatening to file for guardianship.

Grandparents want to maintain relations with their grandchildren after their son and daughter-in-law divorce.

Mr. and Mrs. Smith are encountering disagreements with the management of their continuing care community regarding issues that are not clearly addressed in their original agreement.

Your client wants to know how to develop an estate plan and advance health care directives that do not set off warfare within his family when they need to be implemented.

Each of these situations raise the kind of issues that elder law attorneys routinely encounter. They also illustrate opportunities where mediation might help parties come together to present their concerns, listen to each other, explore possible alternatives, and develop agreements. The use of mediation and related approaches has expanded very substantially in Maryland since creation of the Maryland Alternative Dispute Resolution Task Force by Chief Judge Robert Bell in 1998 and its successor agency, the Maryland Mediation and Conflict Resolution Office (MACRO), by the Maryland Judiciary in 1999. These approaches have not been used to any extent, however, to help prevent or resolve problems confronting Maryland's growing senior population.

In February 2005 MACRO made a grant to the Maryland Department of Aging (MdoA) to promote senior mediation services in our state. The Maryland Senior Mediation Project is being developed in collaboration with mediators, local departments of aging, attorneys, courts, senior organizations, and others. The project has been actively supported by numerous Maryland organizations and agencies, as well as the American Bar Association's Commission on Law and Aging, AARP, and The Center for Social Gerontology (Ann Arbor, MI).

From some experience in Maryland and around the country, we know that mediation and other facilitated decision-making approaches can be used to help seniors and their families make difficult decisions regarding care and living arrangements, and to prevent or

resolve conflicts involving estate planning, health care, insurance, housing, nursing homes, public agencies, neighbors, and consumer issues. Mediation is being used in some instances as an alternative or supplemental approach to guardianship proceedings. The Baltimore County Circuit Court will begin using mediation in contested adult guardianship cases this summer, and is working with local elder law attorneys, department of aging, this writer, and others to help establish the new program. Other courts are also beginning to implement this approach in such cases.

Mediation is conducted in a safe setting where the mediator acts as a neutral party to help the parties arrive at their own voluntary agreement. Except as otherwise agreed by the parties or required by law (e.g., concerning physical abuse or threats of violence), all matters discussed in mediation are confidential. If the parties have legal counsel, they can decide whether their lawyers will participate in the mediation or advise them before going into mediation or signing an agreement. Mediation is generally less expensive and can provide a faster resolution than litigation. Mediation can be especially useful in cases where parties wish to maintain relations after the conflict has been resolved. State and national studies confirm that parties comply with mediated agreements better than court-ordered resolutions. If the parties do not come to an agreement, they can take whatever other legal action desired.

MDoA is seeking to assure that all persons regardless of income have access to high quality mediation services for senior needs, while striving to help develop alternative mediation choices. The project coordinator has been working with private mediators, community mediation centers (now located in most parts of the state and providing services without charge or on a sliding fee) and court staff mediators for the provision of senior mediation services. The project has been providing training for mediators on the particular aspects of working with seniors, as well as promoting local collaborations between mediators, elder law attorneys, and other aging professionals and service providers around the state.

The MSBA Elder Law Section and ADR Section are co-sponsoring a workshop entitled, "Coming of Age: Senior Mediation in Maryland" on June 16, 2006, at

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THE NEW MEDICARE PART D PRESCRIPTION DRUG PROGRAM

by Vicki Gottlich

Senior Policy Attorney

Center for Medicare Advocacy, Inc.

On January 1, 2006, Medicare began covering out-patient prescription drugs for all Medicare beneficiaries through a new, voluntary and privately-administered Part D program. To obtain Part D coverage, Medicare beneficiaries must take the affirmative step of enrolling in either a free-standing prescription drug plan (PDP) or a Medicare Advantage (managed care) prescription drug plan (MA-PD). Medicare beneficiaries who do not enroll by May 15, the end of the initial enrollment period, will pay a late penalty on their premiums if they choose to enroll during a subsequent open enrollment period, to be held from November 15-December 31 each year.

Although enrollment in a Medicare Part D plan is supposed to be voluntary, beneficiaries who are also eligible for Medicaid (the "dual-eligibles") have virtually no choice about participation. Medicaid coverage for prescription drugs for dual-eligibles ended on January 1, 2006. To avoid a gap in drug coverage, dual-eligibles were automatically enrolled in a randomly-selected Part D plan in the Fall of 2005. The process of random assignment created numerous difficulties for dual-eligibles. Some were overlooked and not enrolled in any plan. Others were enrolled in a drug plan that did not cover their drugs or that placed onerous restrictions on access to their medicines.

The statutory standard prescription drug benefit includes a \$250 deductible, 25% co-insurance, and a gap in coverage or "doughnut hole" during which the enrollee pays the full cost of her drugs until a catastrophic limit is reached. The majority of the PDPs and MA took the option of offering, instead, an actuarially equivalent version of the benefit package. Some plans offer an enhanced benefit, for an additional price, that covers generics or some brand-name drugs in the doughnut hole. The differences in the benefit packages offered by the numerous PDPs and MA plans have made choosing a plan complicated and confusing for many beneficiaries. Additionally, the most complete source of information about Part D plan choices is on the Internet, which is not used extensively by older people and people with low-incomes.

PDPs and MA-PDs also have broad discretion to decide which specific drugs to include in their formularies, the strengths and dosage forms of covered drugs to include, and the types of "utilization management processes" to use. Under utilization management, plans

may establish different co-payments for different drugs; "tiered pricing" distinguishes among preferred drugs, non-preferred drugs, and generic drugs. Plans may also require that beneficiaries request prior authorization for covered prescription drugs or that they try particular medications included in the plan's formulary before those prescribed by the physician ("step therapy"). The processes for establishing prior authorization or for seeking an "exception" to get coverage for a non-formulary drug vary from plan to plan. The onerous requirements established by plans and the failure of plans to meet the regulatory time frames for completing exceptions and appeals processes have created barriers to the receipt of medically necessary drugs for some beneficiaries.

Part D was intended to provide prescription drug coverage to Medicare beneficiaries who, because of age and/or disability, utilize more prescriptions than the general population. Instead, many dual eligibles find themselves without access to drugs previously covered under their Medicaid program. Other beneficiaries are finding that their plans will not pay for the drugs they need, or that the cost-sharing requirements are greater than anticipated. Still others, exasperated by the complexities caused by the number of plan choices and the variable benefit packages, have decided not to enroll in a drug plan. These and other problems in the first three months of the program raise questions about the design and the true purpose of the Medicare Part D program.

Senior Mediation . . .

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the Maryland State Bar Association's Annual Conference in Ocean City. Interested persons can also obtain more information on the project from the Maryland Association for Community Mediation Centers' website, www.mdmediation.org, by clicking "Senior Mediation" and "Senior Training" on the home page, or by contacting the project coordinator (below).

Robert J. Rhudy, an attorney and mediator, is a consultant coordinating the Maryland Department of Aging's Senior Mediation Program. He was formerly executive director of the Maryland Legal Services Corporation, a member of the Maryland Alternative Dispute Resolution Task Force, and on the advisory committee to the Maryland Mediation and Conflict Resolution Office. Rhudy can be reached at bobrhudy@yahoo.com.

Maryland State Bar Association
Annual Meeting in Ocean City, Maryland
June 14 – 17, 2006

What's So Hard About Advance Directives?

Thursday, June 15, 2006 8:00 a.m. – 10:30 a.m.

It's a document every adult in the state may have need of. But call them "living wills", "durable powers of attorney for health care" or the statutory term, more than two decades after their inception relatively few Marylanders ever complete them – and those that are executed often fail in their essential goals when needed. The recent Schiavo case taught us all the stakes when the individual's wishes are not clearly known. Come learn from an elder law attorney, a hospital counsel and one of the authors of the HCDA about the latest legislative developments in this area, interviewing clients about their wishes and how to draft effective Advance Directives that will work when they need to.

Program Chair: Martha Ann Knutson, Esq.

Sponsored By: Health Law Section & Elder Law Section

Speakers: Mary O'Byrne, Esq., Frank, Frank & Scherr, LLC; Martha Ann Knutson, Esq., General Counsel, Upper Chesapeake Health; Jack Schwartz, Esq., Director for Health Policy Development, Office of the Attorney General

Coming of Age -

Maryland's New Senior Mediation Program

Friday, June 16, 2006 11:00 a.m. – 1:00 p.m.

In February 2005, the Maryland Judiciary's Mediation and Conflict Resolution Office (MACRO) made a grant to the Maryland Department of Aging to promote the development and use of mediation and related dispute resolution approaches in issues confronting senior and their families. The Baltimore County Circuit Court will begin using mediation in contested adult guardianship cases this summer, and other courts around the state are considering this service. This workshop will present what is happening in Maryland and around the country in senior mediation, review plans for future development, and promote a discussion regarding the potential benefits of such services for mediators, courts, agencies, elder law attorneys, and their clients in our state.

Program Chairs: Angela B. Grau, Esquire; Catherine Stavely, Esquire; Jonathan S. Rosenthal, Esquire

Sponsored by: Elder Law Section/Alternative Dispute Resolution Section

Speakers: Robert Rhudy, Esq.; Consultant and Developer, Maryland Senior Mediation Project, Maryland Department of Aging; Erica Wood, Esq., Deputy Director, Commission on Law and Aging, American Bar Association; Wendy Sawyer, Director, Office of Family Mediation, Baltimore County Circuit Court

NAELA NEWS

Thirty-five Maryland elder law attorneys enjoyed the second annual "Ask the Experts" fund raiser on March 28, 2006 at the Florence Bain Senior Center in Columbia.

Panelists Kevin F. Bress, Michael G. Day, Anne DeNovo, Jason A. Frank, Laurie S. Frank, Morris Klein and Ron M. Landsman answered written questions organized and asked by moderator Camilla O. McRory. Follow up questions from the floor contributed to the liveliness of the afternoon. The Maryland/DC Chapter provided a good lunch, and everyone left at least a bit more educated than they were when they arrived. Don't miss it next year!

The next regular meeting of the Maryland/DC Chapter of the National Academy of Elder Law Attorneys (NAELA) will be held May 18, 2006 at 8:30 A.M. at the Waterside Restaurant, Sheraton Hotel, Columbia, Maryland. As a general rule, chapter meetings are held the third Thursday of every other month. Everyone orders and pays for the breakfast they may desire.

Meetings sometimes include a study group, with members able to ask practice questions and receive the views and thoughts of attendees. Anyone interested in having their case discussed should e-mail Laurie Frank, lfrank@frankelderlaw, at least a week in advance of the meeting.