TASK FORCE ON PREVENTING AND COUNTERING ELDER ABUSE

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FINAL REPORT

December 23, 2024

The Honorable Wes Moore
Governor, State of Maryland
State Circle
Annapolis, Maryland, 21401

Dear Governor Moore,

We want to thank you as stakeholders and colleagues for the opportunity to come together to focus on the epidemic of elder abuse in our state. The Task Force on Preventing and Countering Elder Abuse (Task Force) was authorized by Chapters 706 & 707, Acts of 2023, and is comprised of four multisector subcommittees. Together, the Task Force compiled extensive information on current laws and administrative practices and identified legislative and regulatory gaps associated with the abuse, neglect, and exploitation of Older Adults in Maryland. Please find attached the final report of the Task Force.

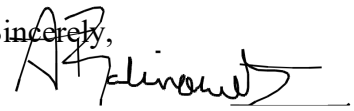
The population of Maryland residents aged 60 years and older is rapidly growing. By the year 2034, there will be more Older Adults residing in Maryland than there will be children and youth. This is an unprecedented time in the history of our state. Reliable data shows that 1 in 10

community-residing people aged 60 and older reports being abused. [1] As the percentage of the Older Adult population increases, so does the likelihood that abuse, neglect, and exploitation will also increase.

The Task Force aims for this report to be utilized for developing statutes, regulations, policies, and procedures that have an effective and lasting impact on the systemic prevention and response to the abuse, neglect, and/or exploitation of Older Adults. Due to the vast scope of this topic, combined with limited time, the Task Force was unable to address all essential needed system changes. This work is just beginning. It is recommended that the Task Force continue its work with further efforts to improve statutes and processes, as well as to address gaps in services and resources for victims aged 60 and older.

We look forward to working with you to implement the recommendations contained in the report.

Sincerely,



Andrew Rabinowitz, Esq.
Chair

[1] 27 Acierno, R., Hernandez, M. A., Amstadter, A. B., Resnick, H. S., Steve, K., Muzzy, W., & Kilpatrick, D. G. (2010). Prevalence and correlates of emotional, physical, sexual, and financial abuse and potential neglect in the United States: The National Elder Mistreatment Study. American journal of public health, 100(2), 292-297.
28 Rosay, A. B., & Mulford, C. F. (2017). Prevalence estimates and correlates of elder abuse in the United States: The national intimate partner and sexual violence survey. Journal of elder abuse & neglect, 29(1), 1-14.

Executive Summary

The Moore-Miller Administration took office on January 18, 2023. From its inception, the Administration has been resolute in its efforts to ensure that Older Adult Marylanders receive the essential services and support they need, and are protected from abuse, neglect and exploitation. It was nearly 40 years ago that these issues were last addressed in a comprehensive endeavor, and as such, it was clear that Maryland's laws relating to elder abuse required review, updating, and expansion, to better protect Maryland's Older Adult population. To accomplish that objective, this task force was created and charged with examining the most urgent needs surrounding abuse, vulnerability, and exploitation of the Maryland Older Adult population. The Task Force on Preventing and Countering Elder Abuse (Task Force) focused on the following four, principal areas: the Study of Maryland and Other States' Laws, Guardianship, Enhancing Accountability and Oversight over Transitions in Care, and Fraud and Scams and Financial Exploitation.

As a result of examining these four areas of focus, the Task Force formulated the following primary recommendations which are summarized as follows:

List of Recommendations

Establish a comprehensive statutory scheme, including modernizing important definitions, in order that the various community supports work together to investigate and protect Older Adult victims of abuse

Enact legislation to establish an Older Adult criminal trafficking statute

Assess Alternatives to Guardianship and Contract Attorneys Skilled in Medical Assistance Planning to Serve as Guardian of Property

Enhance Oversight of Private and Public Guardianships

Establish a formal process to request a hearing for involuntary discharge or evictions from assisted living programs so that residents in assisted living programs are able to benefit from the same protections as residents in other settings

Establish an interagency committee to study the issues and challenges associated with safe, well-coordinated, and appropriate transitions of care for Older Adults across the three provider settings

Ensure accountability and adequate support are in place to prevent any delays in the application process for Maryland Medicaid and its programs to promote continuity of care for community-based services, to improve coordination among programs, and to make available to beneficiaries accurate and timely information about their benefits

Increase oversight of Power of Attorneys and Representative Payees

Increase oversight in Reporting Banking Fraud and Exploitation

Establish a Public Awareness Campaign Supported by a Comprehensive Inventory of Services & Programs to Prevent Abuse of Older Adults

A centralized data repository is necessary to understand the full scope of abuse, neglect and financial exploitation experienced by Older Adults in Maryland

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Introduction

The abuse, neglect, and exploitation of adults aged 60 and older is a pervasive and insidious problem the State of Maryland currently faces. The statistics show this problem will only continue to increase. People in Maryland are living longer than ever before. In 2000, the 60 and older population represented 15% of all Marylanders. By 2020, that population grew to approximately 23%. Projecting to 2030, Marylanders aged 60 or older can expect to represent about 26% of the population.[2]

Background on Maryland's history addressing Abuse and Neglect

In September 1985, under the leadership of Governor Hughes, a statewide Elder Abuse Task Force was enacted to study the issues of elder abuse and neglect identified by House Joint Resolution 48 of the 1985 Maryland General Assembly. Over the course of the last 38 years, the recommendations of that Task Force have not been adequately implemented.

Due to insufficient laws, resource shortages, and multiple gaps in policies and practices, organizations and advocates face numerous barriers when trying to assist adults over the age of 60 who are being abused, neglected, and/or exploited. In July 2023, the Governor's Task Force on Preventing and Countering Elder Abuse (Task Force) was authorized by the Maryland General Assembly (Chapters 706 & 707, Acts of 2023). The Task Force was charged with studying existing laws, policies, and practices relating to elder abuse and crimes committed against Older Adults, and then making recommendations regarding changes to State laws, policy, and practice that would help prevent elder abuse.

The Task Force members include representatives from the following state and local entities and organizations:

> One member of the Senate of Maryland; one member of the House of Delegates; the Attorney General of Maryland or the Attorney General's designee; the Secretary of Aging or the Secretary's designee; the Chief of the Baltimore City Fire Department or the Chief's

[2] Maryland Department of Aging. *State Plan on Aging FY 2022-2025*. Accessed November 25, 2024. https://aging.maryland.gov
Maryland Department of Aging. "Demographics and Projections of Maryland's Older Adult Population." *Maryland State Plan FY 2022-2025*. Accessed November 25, 2024. https://aging.maryland.gov

designee; the Executive Director of CHANA or the Executive Director's designee; the Maryland Chief Medical Examiner or the Chief Medical Examiner's designee; the Director of the Office of Adult Services or the Director's designee; the Executive Director of 2-1-1 Maryland or the Executive Director's designee; the Director of Forensic Nursing at Baltimore Mercy Medical Center or the Director's designee; and Maryland's Long-Term Care Ombudsman or the Ombudsman's designee, Additional members of the Task Force appointed by the Governor comprise a representative from each of the following entities: the Maryland Office of Health Care Quality; the Baltimore City Circuit Court Guardianship program; Maryland Legal Aid, Baltimore Senior Legal Services; the Montgomery County Department of Health and Human Services; the Maryland State Police; the Maryland Health Care Commission; the Maryland Children's Alliance; the Maryland Banker's Association; the (Vacant/did not participate) Montgomery County Department of Health and Human Services Representative (Vacant/did not participate, Maryland Human Trafficking Task Force Representative

The Task Force began meeting in the summer of 2024 and held regular meetings and work sessions to review existing Maryland statutes, regulations, policies and procedures related to reporting, preventing and responding to abuse, neglect and exploitation of Older Adults. The Task Force divided into subcommittees: the Study of Maryland and Other States' Laws, Guardianship, Enhancing Oversight and Accountability over Transitions in Care, and Fraud and Scams, and Financial Exploitation. Each was charged with conducting a comprehensive review of Maryland statutes and current practices. The Study of Maryland and Other States' Laws subcommittee reviewed and compared Maryland statutes with existing statutes in other states including California, Georgia, and Pennsylvania.

The recommendations of the Task Force, as contained in this report, are directed to the Governor, Maryland Legislature, State organizations and agencies, the Courts, and advocates to more effectively safeguard older Marylanders experiencing abuse, neglect and/or exploitation, and to enhance the ability for the prosecution of bad actors.

Despite the existence of these statutes, more comprehensive legislation is needed. With the creation of this Task Force and through a new administration leading Maryland, now is the opportune time to create crucial safeguards for the fast-growing population of older Marylanders who are being abused, neglected, and/or exploited.

The Task Force aims for this report to be utilized for developing statutes, regulations, policies, and procedures that have an effective and lasting impact on the systemic prevention and response to the abuse, neglect, and/or exploitation of Older Adults.

Recommendations

Due to the vast scope of this topic, combined with limited time, the Task Force was unable to address all essential needed system changes. This work is not finished and it is recommended that the Task Force continue its work with further efforts to improve statutes and processes, as well as to address gaps in services and resources for victims aged 60 and older.

The Collaborative Study of Maryland and Other States' Laws

The Task Force recommends that an all-inclusive "Older Adult Abuse and Neglect Act" be enacted into a comprehensive statutory scheme that addresses abuse, neglect, trafficking, and financial exploitation of adults in later life. When proscribing actionable conduct, the more expansive term "Older Adult," meaning aged 60 and older, should be used rather than the more limiting term "vulnerable adult."[3] The latest Maryland State Plan on Aging (2022 – 2026)[4] and Governor Moore's policy statement on Older Adults[5] both concentrate on individuals aged 60 and older. The Task Force herein recommends that the term "Older Adult" be defined as an individual 60 years of age or older.

The current abuse and neglect laws are only applicable to "vulnerable adults" and in the case of financial abuse, individuals aged 68 and older. This disregards a substantial portion of Older Adult abuse, neglect and exploitation victims. The abuse, neglect and exploitation laws should not be limited exclusively to someone defined as a 1) vulnerable adult (limited in physical or mental capacity), or 2) a person who is aged 68 or older.[6] Currently a large portion of victims of abuse in later life are left out of investigation and support services.

In comparison to the abuse, neglect, and financial exploitation laws in other states, Maryland lacks a comprehensive scheme of protections for Older Adults. The Task Force compared California, Georgia, and Pennsylvania, all of which do have comprehensive schemes. As a result, we make the following recommendation:

> *Establish a comprehensive statutory scheme, including modernizing important definitions, in order that the various community supports work together to investigate and protect Older Adult victims of abuse*

Specifically, the Task Force recommends that an all-inclusive Older Adult Abuse and Neglect Act be enacted that would house all of the civil and criminal abuse, neglect, trafficking, and financial exploitation statutes. Establishing a comprehensive statutory scheme and implementing comprehensive definitions are crucial components of a robust and effective statutory framework. The Task Force proposes the comprehensive Older Adult Abuse and Neglect Act include:

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[3] The term "vulnerable adult" is defined as "an adult who lacks the physical or mental capacity to provide for [their] daily needs. Md. Code Ann. Crim § 3-604(8)(a)(10) and Md. Code Ann. Family Law 14-101(q).
[4] https://aging.maryland.gov/SiteAssets/Pages/StatePlanonAging/MD%20State%20Plan%202022-2025.pdf
[5] https://wesmoore.com/issues/supporting-seniors/
[6] Current financial exploitation law is defined as domination against an individual age 68 and above. Md. Code Ann, Crim Law § 8-801(a)(6)(i).

ABUSE

RECOMMENDED MARYLAND DEFINITION: **Abuse** means or includes actual or attempted:

(1) Infliction or threat of physical pain or injury of an Older Adult; or

(2) Infliction of psychological, emotional, verbal abuse or mental anguish of an Older Adult; or

(3) Sexual violence or the threat thereof of an Older Adult; or

(4) Confinement or deprivation of goods or services necessary to maintain an Older Adult's physical, emotional, or mental health; or

(5) Stalking of an Older Adult by a person of trust, or through misappropriation, deception, intimidation or undue influence; or

(7) "Abuse" does not include an accepted medical or behavioral procedure ordered by a health care provider; or

(8) Organizations, institutions, and businesses can be held to the abuse standard.

Pennsylvania defines abuse as injury, confinement, intimidation, punishment that results in physical harm, pain, or mental anguish, or a caretaker's willful deprivation of goods or services necessary to maintain physical or mental health. This includes sexual harassment, rape, and abuse.

Georgia defines abuse as willful infliction of physical pain or injury, mental anguish, confinement, willful deprivation of essential services, or sexual abuse.

California defines abuse of an elder or dependent adult as physical abuse, neglect, abandonment, isolation, abduction, acts that result in physical harm or mental suffering, deprivation of goods or services necessary to avoid physical harm or mental suffering, or financial abuse. Physical abuse is assault, battery, unreasonable physical constraint, continual deprivation of food or water, sexual assault, or medically unauthorized use of physical or chemical restraints or psychotropic medications. Sexual assault is defined as sexual battery, rape, incest, sodomy, oral copulation, sexual penetration, and lewd or lascivious acts.

SEXUAL ABUSE

RECOMMENDED MARYLAND DEFINITION: **Sexual Abuse** means or includes:

(1) Sexual violence or the threat thereof of an Older Adult; or

(2) Any act that involves sexual molestation or sexual exploitation of an Older Adult; or

(3) Any sexual coercive act against an Older Adult for the purpose of self-gratification.

Pennsylvania defines sexual abuse as rape, sexual assault, indecent assault, incest, or involuntary deviant sexual intercourse.

Georgia defines sexual abuse as coercion of a disabled or elderly person by a caretaker for the purpose of self-gratification, to engage in: lewd display of genitals, physical restraint or torture by or upon partially unclothed person, sexual stimulation through physical contact of unclothed genitals with a woman's unclothed chest, defecation or urination for the purpose of sexual stimulation, and penetration of the vagina or rectum. Physical restraint and penetration of the vagina or rectum are not considered sexual abuse if medically necessary.

NEGLECT

RECOMMENDED MARYLAND DEFINITION: **Neglect** means or includes:

(1) The deprivation of adequate food, clothing, medical or mental health treatment, shelter, or supervision; or

(2) Isolation or abandonment; or

(3) The absence or omission of essential services such that it harms or threatens to harm physical, psychological, or mental health.

Pennsylvania defines neglect as the failure of a caretaker, or oneself, to provide goods or services essential to avoid clear and serious threats to physical or mental health. Neglect does not include environmental factors beyond the control of the Older Adult or caretaker, such as housing, furnishings, income, clothing, or medical care.

Georgia defines neglect as the omission of essential services which harms or threatens the physical or emotional health of a disabled or elderly person.

California defines neglect as the failure of a caretaker, or an elder adult, to exercise a standard of care according to a reasonable person in a similar position. Neglect includes failure to assist in personal hygiene, provide food, clothing, or shelter, provide medical care, protect from health and safety hazards, or prevent malnutrition or dehydration. Neglect also includes the substantial inability or failure of an elder adult to manage their own finances, or satisfy their aforementioned needs, as a result of poor cognitive functioning, substance abuse, poor health, or homelessness.

FINANCIAL ABUSE OR EXPLOITATION

RECOMMENDED MARYLAND DEFINITION: **Financial Abuse or Exploitation** means:

(1) The wrongful or unauthorized taking or attempt thereof by any person (or anyone assisting in these acts), including a person of trust, in withholding, appropriating, concealing or using the money, assets, or property of an Older Adult, by any act or failure to act; or

(2) The wrongful or unauthorized obtaining or attempting to obtain control over the money, assets, or property of an Older Adult through deception, intimidation, undue influence, harassment, duress, false pretense, false representation, or other means of improper profit or advantage by any person (or anyone assisting in these acts), including a person of trust; or

(3) The converting or attempting to convert money, assets or property of an Older Adult to deprive the Older Adult of the ownership, use, benefit or possession of the Older Adult's money, assets or property [7].

Pennsylvania defines financial exploitation as the wrongful or unauthorized withholding, appropriation, concealment, conversion, use, or control of an Older Adult's money, assets, or property through deception, intimidation, or undue influence. This includes any act or omission through a power of attorney, or by a guardian, custodian, trustee, personal representative, conservator, or person who stands in a position of trust and confidence with an Older Adult.

Georgia defines exploitation as the illegal or improper use of a disabled or elder adult's resources through undue influence, harassment, duress, false representation, false pretense, or other means of profit or advantage.

California defines financial abuse of an elder adult as taking, secreting, appropriating, obtaining, or retaining (or assisting in these acts) property for wrongful use or with intent to defraud, including through undue influence. This includes deprivation of property right by agreement, donative transfer, or testamentary bequest, regardless of whether the property is held by the elder adult or a representative. These acts are deemed to occur if the taking party knew or should have known that their conduct was likely to be harmful to the elder adult.

[7] The financial exploitation of vulnerable adults statute in Maryland (MD Code, Criminal Law, § 8-801) requires obtaining the property of a vulnerable adult, "by deception, intimidation, or undue influence." Without this element, a prosecutor can only charge theft. So, for example, if a nurse's aide says, "loan me your debit card and I'll order you a pizza," but then proceeds to drain the resident's account, that is financial exploitation and theft. But if she simply comes into the room in the middle of the night, takes the resident's debit card, and drains the account, that is exclusively theft. What the Task Force is recommending is a change in the statute recognizing that people in a position of trust who violate that trust are guilty of exploitation.

Enact legislation to establish an Older Adult criminal trafficking statute

TRAFFICKING

Maryland has two trafficking statutes which only relate to trafficking of sex workers, sex crimes and labor. Maryland does not have a criminal trafficking statute that is exclusively applicable to Older Adults. The Task Force strongly urges the Maryland legislature to create and enact legislation that specifically establishes an Older Adult criminal trafficking statute.

RECOMMENDED MARYLAND DEFINITION: **Trafficking of an Older Adult** means[8]:

A person, through deception, coercion, human trafficking, forced labor, domestic servitude, sexual or non-sexual exploitation, debt-bondage, isolation, who:

- Knowingly recruits, harbors, or transports an Older Adult for any purpose, including but not limited to:
  - Forced labor; or
  - Sexual conduct; or
  - Appropriation of resources or assets; and/or
  - Benefits (pensions, public, social security, veteran's, retirement).

Georgia defines trafficking as using deception, coercion, exploitation, or isolation to knowingly recruit, harbor, transport, provide, or obtain a disabled or elder adult for the purpose of appropriating their resources for benefit.

SUMMARY

In summary, the Task Force recommends that an all-inclusive Older Adult Abuse and Neglect Act be enacted into a comprehensive statutory scheme that addresses abuse, neglect, trafficking, and financial exploitation of adults aged 60 or older. In consonance with the Maryland State Plan on Aging (2022 – 2026)[9] and Governor Moore's policy statement on Older Adults,[10] the Task Force herein recommends that the term "Older Adult" be defined as an individual 60 years of age or older in a comprehensive statutory scheme.

There is insufficient legal protection for Older Adults in Maryland because the law focuses on a "vulnerable adult" standard that constricts both the prosecution of abusers and the protection of the victims. Far too many persons who are being abused, neglected, trafficked, or financially exploited do not meet the "vulnerable adult" standard due to their age or physical/mental prowess. The Task Force recommends that the proposed comprehensive statutory scheme include an expanded definition of identified subject areas: abuse, sexual abuse, neglect, financial

[8] The Task Force notes that one organization raised concerns about creating an older adult criminal trafficking statute.
[9] https://aging.maryland.gov/SiteAssets/Pages/StatePlanonAging/MD%20State%20Plan%202022-2025.pdf
[10] https://wesmoore.com/issues/supporting-seniors/

abuse or exploitation, and trafficking. These expanded definitions are based on a review of the Older Adult statutory schemes in California, Georgia, and Pennsylvania.

Maryland's Older Adults are at risk. Adoption of an all-inclusive Older Adult Abuse and Neglect Act will establish a comprehensive statutory scheme that reflects an all-inclusive location for statutes relating to Older Adult civil and criminal abuse, neglect, trafficking and financial exploitation. This all-inclusive Act will enable next steps, including processes for increased reports, investigations, victim advocacy, safety and prosecution. This will move Maryland forward with the Governor's plan for Older Adults to age comfortably and with dignity, while honoring their lives and contributions to our state.

Preserving the Rights of the Person and Property and Utility of Guardianship

Guardianship involves the removal of a person's fundamental rights and liberties. "The typical ward [person subject to guardianship] has fewer rights than the typical convicted felon – they can no longer receive or manage their money or pay their own bills. They cannot marry or divorce. By appointing a guardian, the court entrusts to someone else the power to choose where they will live, what medical treatment they will get and, in rare cases, when they will die. It is, in one short sentence, the most punitive civil penalty that can be levied against an American citizen, with the exception, of course, of the death penalty." -Former Congressman Claude Pepper (FL)

People with disabilities are more at-risk for abuse, neglect, and exploitation generally. Guardianship itself can operate as a form of abuse when it is misused as a tool to control someone or their assets or isolate them from others. When a plenary guardianship is put into place without assessing alternatives to guardianship and limiting the guardianship to meet a person's demonstrated needs, the result may lead to negative health consequences, loss of sense of self and self-determination, deterioration, and poorer life outcomes. It is imperative that guardianship be utilized as a last resort, and when guardianship is unavoidable, the powers of a guardian should be limited to what is necessary to meet a disabled person's unmet needs. What's more, adequate monitoring of both private and public guardianships must be in place to help prevent abuse of Older Adults under guardianships.

The following are issues critical to ensuring the safety of Older Adults subject to guardianship across the State of Maryland: 1) Assessing Alternatives to Guardianship and Contracting Attorneys Skilled in Medical Assistance Planning to Serve as Guardian of Property and 2) Enhancing Oversight of Private and Public Guardianships.

Assessing Alternatives to Guardianship and Contracting Attorneys Skilled in Medical Assistance Planning to Serve as Guardian of Property

Guardianship is intended to be the option of last resort. It is not a discharge plan. It is not the answer in all cases that are filed. Even if an alleged disabled person is experiencing diminished capacity, that does not mean guardianship is the only option. Each case needs to be addressed

with an individualized approach to ensure decisions are being made based on the alleged disabled person's demonstrated needs. There is no one-size-fits-all solution. When a guardianship is used for purposes of consenting to medical treatment or discharge or transfer from a hospital, the resulting guardianship is usually plenary in nature. The guardianship often remains in place despite the disabled person having recovered from the disability leading to the appointment of a guardian. It is far easier to be put under guardianship than it is to get out of one. Appointing a guardian without assessing all alternatives and appropriate limitations stands to exploit vulnerability.

Many less restrictive alternatives to guardianship exist, and Maryland law requires that all less restrictive forms of intervention be explored and exhausted before a court can appoint a guardian. A valid healthcare or financial power of attorney or advanced directive; the existence and availability of a surrogate decision maker pursuant to Md. Code Ann., Health-General §5-605; and the ability of an alleged disabled person to designate an authorized representative for purposes of medical assistance planning pursuant to COMAR 10.09.24.04(F)(1) are a few examples of less restrictive alternatives to guardianship.[11] Examination of the alleged disabled person's specific needs can also aid in determining whether there is a more suitable, less restrictive alternative to guardianship. For instance, if a guardianship of the property is requested in order to gain access to the alleged disabled person's financial institution records—or for some other defined action involving the property of an alleged disabled person which cannot be accomplished without a court order—then a specific transaction without the appointment of a guardian pursuant to Md. Code Ann., Estates and Trusts §13-204 may be the more appropriate option. An order authorizing a specific transaction may be a means to meet an alleged disabled person's demonstrated needs without having to implement a guardianship, thereby limiting a court's interference in a person's property rights. When a guardianship is shown to be the least restrictive alternative, a determination must follow as to who shall be appointed as guardian. Although the appointment of a guardian may be unavoidable, the inquiry cannot end without considering appropriate limitations on a guardian's powers.

Petitions for guardianship of person frequently include a request for appointment of guardian of property. Often, these cases are not merely about consent to medical treatment or discharge or transfer from a hospital or facility. There is a financial piece. Many guardianship cases involve low-income persons that require an application for medical assistance for discharge to a long-term care facility. If a person does not have capacity or a legal representative such as power of attorney, a guardian of property may be needed to complete a medical assistance application in order to secure long-term care benefits to cover the cost of the disabled person's care.

For guardianship of person, Maryland has a strong public guardianship system. There is no similar system for guardianship of property. Courts must turn to attorneys to serve as guardian of property when no one with a higher statutory priority is willing or eligible. Medical assistance planning is complex and attorneys skilled in this area are few and far between. The attorneys are

[11] We did not make preliminary recommendations about oversight of surrogate decision making under Md. Code, Health-Gen. § 5-605, and a later section describes recommendations for preventing fraud, scams, and financial exploitation.

expected to serve on a *low bono* or *pro bono* basis. There is no source of funding to pay them,[12] and attorneys are not lined up at the courthouse to provide this service. Courts across the state are at crisis points because there are not enough attorney guardians to do this work. The reality is that if a guardian of property is needed, until someone is willing to serve in that role, the person who no longer requires acute care is forced to languish in a hospital. Resources continue to be expended for the person, which in effect limits access to services for those who require acute care. This financial piece is often the crux of the issues presented in guardianship matters. It is vital that it be addressed.

MDH is the single state agency designated to administer the Medical Assistance Program. COMAR 10.09.24.02(B)(16). An application for Long-Term Care Medical Assistance may be filed online through MDThink, in person at or by mail to a local department of social services, or the Bureau of Long-Term Care for certain jurisdictions. COMAR 10.09.24.04(A) requires MDH or its designee to determine initial and continuing eligibility for the Medical Assistance Program. The Division of Long-Term Services and Supports is the designee that reviews and determines eligibility for Long-Term Care Medical Assistance applications.

The priority need is to allocate resources for long-term care medical assistance planning for low-income disabled persons, which must include an appropriation to pay court-appointed attorney guardians to do this work. The Department of Human Services (DHS) has an infrastructure in place, i.e., its Maryland Legal Services Program legal services contracts [with attorneys who are appointed as counsel pursuant to Md. Code Ann., Estates and Trusts § 13-211(b)(3)] that may be adapted for court-appointed attorney guardians. It follows then that DHS would be the suitable agency to manage any appropriation for these services. A separate procurement process would be needed, and establishing a new DHS unit would be necessary, including attorneys to serve as guardian and contract monitors, auditors, investigators, etc. to oversee the contract. Although Estates and Trusts § 13-211(b) provides the framework for DHS to be a contract administrator for court-appointed attorney guardians, the Statute needs to be amended accordingly.

Enhancing Oversight of Private and Public Guardianships

Enhancing current monitoring practices will serve to prevent occurrences of abuse of persons under guardianship. A focus on the following key areas will help to improve oversight of at-risk adults under guardianship in Maryland.

1. Monitoring - Evaluation of systems currently in place for private and public guardianships, including Adult Public Guardianship Review Boards. Maryland's Administrative Office of the Courts is the current recipient of a federal Elder Justice Innovation Grant, part of which involves evaluation of and strategies for providing adequate monitoring for persons under guardianship.

[12] If assets are later discovered that would make a disabled person ineligible for long-term care medical assistance, or assets are available to pay an attorney guardian as part of a medical assistance spenddown, then the attorney guardian would be paid from the guardianship estate. *See* Md. Code Ann., Estates and Trusts §§ 13-218 and 14.5-708.

Reappointment of counsel for disabled persons and the appointment of independent investigators are monitoring tools to ensure the safety of a disabled person and gather more information regarding the circumstances of a person under guardianship.

2. Information sharing - Public agencies currently collect and store information on clients they serve. The courts are exploring a similar system for data management in guardianship cases, in addition to MDEC. Information sharing between the courts and public agencies when a person is subject to a guardianship proceeding will help to protect Older Adults under guardianship. Court access to NICS to better screen proposed guardians, receipt of notifications when a person under guardianship or a guardian is subject to an Adult Protective Services (APS) investigation, or when a guardian is convicted of a disqualifying offense post-appointment. Court access to vital records will help determine whether a guardianship should continue or a substitution proceeding should be initiated, or when a disabled person or their guardian is missing or has been reported deceased would all trigger court intervention.

3. Access to counsel post-appointment for indigent persons under private guardianship - There appears to be a disparity in access to counsel for indigent persons under private guardianship versus indigent persons under public guardianship. It is necessary to obtain clarification from DHS to determine whether attorneys contracted to serve as court-appointed counsel for indigent persons in guardianship of person and/or property proceedings may be reappointed in post-appointment proceedings for indigent persons under private and public guardianships alike.

4. Training - Enhanced training of the judiciary and guardians will improve monitoring and compliance. It is important to be mindful not to create unnecessary barriers for persons serving as private guardians.[13] The courts currently offer orientation and training programs and assistance for private guardians and persons wishing to become guardian of person and property.

Enhancing Accountability and Oversight of Transitions in Care

Transitions in care refers to the movement of patients between various levels of care or settings within our healthcare system including hospitals, skilled nursing facilities, and assisted living facilities. Much work has been done over the years to standardize and improve these transitions and to ensure patient safety and effective continuity of care. Effective care transitions are particularly crucial for Older Adults and other at-risk individuals. Hospitals employ discharge planners, care navigators, and social workers who collaborate with other health care providers, family members, and support services providers to address the post-acute care needs of the patient. Skilled nursing homes are required by Maryland law to have discharge planning policies in place to ensure the patient receives the care needed and remains safe and free from harm.

[13] Financial institutions often create barriers to accessing account records by requiring documentation that is inconsistent with Maryland law. The development of a guidance document for financial institutions that sets forth Maryland law as it pertains to guardianship and its alternatives may prove to be a useful tool to enhance communication with financial institutions.

Assisted living programs, although also regulated by the State of Maryland, have fewer protections regarding the overall discharge process. All these settings are required to comply with state laws and regulations, but unfortunately, our most at-risk residents are still unnecessarily harmed in these settings.

The core recommendations of the Task Force as it pertains to Enhancing Accountability and Oversight of Transitions in Care were developed to strengthen the protections established through current Maryland law and to advocate for new ways to ensure safe transitions of care.

Planning challenges in transitions of care are common experiences faced by consumers of hospitals, skilled nursing facilities, and assisted living programs. For example, the decision-making capacity of Older Adults is often undermined, and support is not adequately considered, or surrogate decision making is very broadly implemented. For profit service providers, particularly in skilled nursing facilities and assisted living programs, where residency is often more prolonged, can pressure and take advantage of residents who rely on their support. Despite the continuum of housing and health stability that each environment provides, the regulations operate specific to each setting. As a result, the Task Force recommends a further study focusing on ensuring safe and appropriate discharges involving these settings.

<u>Enhancing Accountability and Oversight of Transitions in Care recommendations:</u>

1) Establish a formal process to request a hearing for involuntary discharge or evictions from assisted living programs so that residents in assisted living programs have the same protections as residents in other settings.

2) Establish an interagency committee to study the issues and challenges associated with safe, well-coordinated and appropriate transitions of care for Older Adults across the three provider settings.

3) Ensure accountability and adequate support are in place to prevent any delays in the application process for Maryland Medicaid and its programs to promote continuity of care for community-based services, to improve coordination among programs, and to make available to beneficiaries accurate and timely information about their benefits.

> *Establish a formal process to request a hearing for involuntary discharge or evictions from assisted living programs so that residents in assisted living programs are able to benefit from the same protections as residents in other settings*

Assisted living programs can play a significant role in preserving independence, dignity, and the ability to participate in the community. However, residents in assisted living programs have fewer protections when compared to other health care settings such as nursing homes and hospitals. To augment the statutory protections, during last year's legislative session, the Maryland Attorney General's Office advocated for additional protections. Those efforts resulted in the Maryland legislature's enacting Md. Health Gen. § 1805.1 "Injunctive relief to prevent irreparable harm," which became law effective July 1, 2024. The purpose of this provision is to prevent irreparable harm to residents in an assisted living program and allows the Attorney General to seek injunctive relief on behalf of the State on the basis of an imminent or ongoing violation of one of the basic,

enumerated rights of assisted living program residents. The law codifies minimum basic rights of residents in assisted living programs, to include the right to participate in decision making regarding transitions in care, including a transfer or discharge.[14]

However, additional protections are necessary, and in particular, there should be an appeals process for assisted living residents such as that which exists for residents of skilled nursing facilities. Without an appeals process to contest an involuntary discharge or process (including the reoccurring practice of assisted living programs surrendering their license), residents are left vulnerable and often lack the appropriate supports to navigate our complex health care delivery system such that their medical, social, and financial needs are addressed.

A Comparison of Maryland to Other States:

Of particular concern is that an eviction or involuntary discharge of a resident from an assisted living facility is based entirely on the resident agreement, without an opportunity to appeal before a court or administrative body, and without a safe discharge requirement. Often, the eviction or displacement of a resident occurs when an assisted living facility closes. The State Long-Term Care Ombudsman is usually one of the first entities to be notified when a skilled nursing facility or assisted living facility closes and has played a critical role in assisting with relocating residents. However, a more structured process with greater enforcement in statute and regulation would be helpful in preventing potential harm and unwarranted disruptions to residents.[15]

Other states have implemented protocols limiting the reasons for an assisted living program eviction and providing for appeal procedures. In California, an eviction notice is required to contain: 1) proposed date of eviction, 2) resources for finding alternative housing, 3) information to file a complaint to the state, and 4) obligation of the facility to file an unlawful detainer action and right to request a hearing.[16]

In Utah, there are five delineated reasons a resident of an assisted living facility may be discharged, transferred, or evicted: 1) the resident poses a threat to the health or safety to self or others, or the resident's required medical treatment is no longer able to be provided, 2) the resident fails to pay for services, 3) the resident fails to comply with written policies or rules of the facility, 4) the resident wishes to transfer, or 5) the facility ceases to operate.[17]

In Oregon, limited reasons for discharge are delineated with supporting documentation required and any notice of involuntary discharge must contain the rights to request an administrative hearing.[18]

The Maryland Department of Health and the Long-Term Care Ombudsman Program should implement a process by which any resident in an assisted living facility (regardless of their

[14] Md. Code, Health-Gen. § 19-1805(a)(8)(v) & (vI)
[15] See recommendation on pgs. 18-19 re: the establishment of an interagency committee and adopting 42 CFR 441.530(a)(1)(vi)(A) into Maryland Law.
[16] Cal. Health & Safety Code §1569.683.
[17] Utah Admin. Code 432-270-12
[18] Or. Admin. R. 411-054-0080

Medicaid eligibility) may request a hearing after being served with an eviction or involuntary discharge notice that is facilitated and coordinated by the Office of Administrative Hearings (OAH).

Further, the criteria upon which an involuntary discharge or eviction may be invoked should be limited to the following: *(See Appendix pgs.117-118 for specifically recommended statutory language)*

- An eviction may be necessary for the resident's welfare;
- An eviction may be a result of endangerment to the health and safety of others;
- An eviction may be the result of non-payment;
- An eviction may be the result of the facility ceasing to operate.

Establish an interagency committee to study the issues and challenges associated with safe, well-coordinated, and appropriate transitions of care for Older Adults across the three provider settings

Regardless of health care setting, discharging patients or residents without proper care and planning can lead to repeated hospitalization and unnecessary suffering. For example, hospitals are intended to provide acute, short-term care, and ideally, discharge planning is established at the early stages of hospitalization, with the patient's input. If post-acute care services are required, patients are often discharged to a skilled nursing facility, where Medicare-eligible patients receive coverage for a transitional period of care. Once Medicare coverage ends, residents must decide what resources and coverage will facilitate ongoing recovery and stabilization. Many Older Adults remain in skilled nursing care for the rest of their lives. Many elect to apply for coverage for services they could receive in an assisted living program or other setting in the community.

Transitioning Older Adults from one health care setting to another is an ongoing concern and is sometimes the reason for complaints filed with OHCQ against providers. In its 2024 Annual Report and Staffing Analysis for 2023, OHCQ noted there were 4,692 complaints and facility reported complaints from skilled nursing facilities, comprising 225 facilities. In addition, 1,349 complaints and facility reported incidents from assisted living program, comprising 1,721 facilities.[19] Only 661 of 1,349 complaints, comprising 49%, were investigated in assisted living facilities. Only 2,855 of 4,692 complaints comprising 61%, were investigated in skilled nursing homes, and only 19% of those 225 facilities had an annual survey completed to monitor compliance.

2024 Report Data

Type of Program	*Number of facilities*	*# of complaints*	*# of investigations*
Assisted Living Program	*1,721*	*1,349*	*661*
Skilled Nursing Facility	*225**	*4,692*	*2,855*

**Of note, only 42 facilities had an annual full survey to monitor compliance*

[19] Office of Health Care Quality, Annual Report and Staffing Analysis, Fiscal Year 2024, p. 9 https://health.maryland.gov/ohcq/docs/Reports/Office%20of%20Health%20Care%20Quality%20Annual%20Report%20FY%202023%20-%20Letter%20and%20Report%20-%20Jan.%202024.pdf. In the Report, the Maryland Department of Health states that 2024 concludes the FY 2018 seven-year staffing plan, and that the Department is developing a staffing plan for FY2025-2029.

Many residents in each setting rely on OHCQ to address their complaints and concerns. They cannot withhold payment for poor care because they would be discharged or evicted. Rather, the state is charged to provide oversight to a) ensure residents do not develop severe pressure ulcer wounds and infections from remaining in soiled incontinence briefs, b) ensure administration and proper monitoring of correct medication, c) ensure that facilities receiving money from the state and federal government are providing quality care. The backlog of investigations and annual surveys is a significant concern to the Task Force, despite the approval by the legislature of increased staffing over a seven-year period from FY2019 to FY2025.

Since our Preliminary Report was filed, the organizations Justice in Aging and Public Justice Center filed a complaint in federal court against MDH, which elevates this subcommittee's concerns regarding the backlog of complaints to be investigated and surveys to be completed. [20] MDH is continuing to address the backlog with increased staffing and survey teams. However, more resources are needed to meet the demand.

Across all settings, information on the availability of licensed providers and federal and state resources for financial support for those services is lacking. Residents are often not informed about HCBO Waiver services or other support available.[21] For instance, a patient may have a case manager in the community or a housing application pending, but if information about those activities is not communicated in a timely manner among all parties involved in the patient's care, poor coordination, duplication of effort or ineffective utilization of services occurs.

Currently, a process that ensures greater protections can be found in the federal regulatory framework. Those who participate in Maryland's Home and Community Based Services Waiver ("Waiver") and Community First Choice Medicaid Programs, designed to keep residents needing nursing home level of care from institutionalization by providing services in the community, are currently entitled, under federal law, to receive the same protections as tenants.[22] Under what is referred to as the Community Settings Rule, referring to assisted living programs, "[t]he unit or dwelling is a specific physical place that can be owned, rented or occupied under a legally enforceable agreement by the individual receiving services, and *the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law of the State, county, city or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law."*42 CFR 441.530(a)(1)(vi)(A). The Task Force believes the protections that the federal regulations provide should be adopted into Maryland law. Currently, the Maryland Health Code does not contemplate whether the protections in the Real Property Code outlining the processes and protections under landlord-tenant law apply.

[20] *Connor v. Maryland Department of Health*, 1:24-cv-01423, (D. Maryland)
[21] We also recommend expanding the HCBS Waiver program.
[22] 42 CFR 441.530(a)(1)(vi)(A)

In hospitals, case managers, nurses and licensed social workers are often responsible for discharge planning and work as an interdisciplinary team to ensure there is no confusion or disruption of viable community placements.

In assisted living facilities, staffing resources available to transition patients to the most appropriate level of care are more limited than in hospital settings. The assisted living manager and delegating nurse are key staff who perform discharge planning and sometimes, the same person performs both roles. With minimal guidance in the regulations protecting residents in assisted living programs, these residents are particularly susceptible to the cycle of displacement caused by inadequate discharge planning.

There is a critical role for the state to play in facilitating safe and effective transitions of care. The Task Force recommends an interagency committee be established to bring state agency representatives together with representatives from the provider community to share information and ideas on how to create a well-trained workforce that is equipped with timely and accurate information to better serve our at-risk population. An interagency committee could facilitate a more holistic approach to addressing the medical, social and financial components of promoting and sustaining safe and effective placements. That committee should include the state agencies that influence our healthcare delivery system for older Marylanders including, but not limited to Maryland Health Care Commission (MHCC), The Office of HealthCare Quality (OHCQ) under the Maryland Department of the Health (MDH), Maryland Department of Aging (DoA), the State Long- Term Care Ombudsman program, Maryland Office of the Attorney General (OAG), and the Medicaid divisions under the Department of Human Services (DHS) and Maryland Department Of Health (MDH) to facilitate collective understanding of the current programs and services across state government. The committee should also include stakeholder advocates such as Maryland Legal Aid, representatives from the Maryland Patient Safety Center (MPSC), the provider community including the Maryland Hospital Association (MHAA), Health Facilities Association of Maryland, Lifespan, the National Association of Social Workers (NASW), the Board of Social Work, as well as other stakeholder and legal advocacy organizations.

Specifically, the goals of the interagency committee should be:

1. Ensure the implementation of training and education to recognize and timely report suspected instances of abuse and neglect in the hospital setting;

2. Ensure the implementation of training and education for safe and effective discharge planning in all provider settings;

3. Ensure the availability of timely and accurate information on the licensure status and performance measures of providers before placement is made. This must include timely information sharing across agencies to monitor provider performance and strengthen safe transitions of care;

4. Ensure that information on reimbursement options is a component of the training provided and appropriate resources for discharge planning and placement;

5. Work with the designated patient safety center for the state of Maryland to initiate training and education programs for all staff involved in implementing safe transitions of care and implement an evaluation and monitoring component to promote adherence to best practices.

Ensure accountability and adequate support are in place to prevent any delays in the application process for Maryland Medicaid and its programs to promote continuity of care for community-based services, to improve coordination among programs, and to make available to beneficiaries accurate and timely information about their benefits

To contextualize this recommendation, many low-income Marylanders cycle through institutionalization. Once discharged from a hospital to a skilled nursing facility, Medicare only fully covers the first 20 days of care, and if approved, 80% of the cost of care for days 21 through 100. Maryland provides coverage under Long Term Care Medical Assistance for eligible individuals for the duration of care. Importantly, (CMS) proscribes skilled nursing facilities from discharging individuals while an application for Medicaid coverage is pending.[23] However, delays in obtaining five years of financial statements and confusion about the coverage often result in Notices of Involuntary Discharges for residents or Petitions for Guardianship that are untimely and inappropriate. These concerns underscore why discharge planning is so important.

Many Marylanders want to receive services in their home to prevent institutionalization, and have a home to return to after hospitalization and rehabilitation. As the fiscal note in the 2019 study of changes to MD Code, Health - General, § 15-137 (a)(2) confirmed, care in the community is less expensive than institutionalized settings.[24] Services are available in the community to prevent institutionalization and from the institutionalized setting to help people return to the community. In both settings, timely review and approval are necessary to avoid unnecessary institutionalized care.

Residents in skilled nursing facilities who continue to need skilled nursing care but would like to return to the community are often eligible for Home and Community Based Services (HCBS) through the Home and Community Based Options (HCBO) Waiver program. [25] Too often, residents wait months for approval.[26]

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[23] Centers for Medicare and Medicaid Services Guidance https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf ("A resident cannot be discharged for nonpayment while their Medicaid eligibility is pending.")

[24] See Maryland Fiscal Note, 2019 Sess. S.B. 699: *For example, to the extent the bill reduces the number of individuals who lose CFC coverage from entering a nursing home, Medicaid expenditures of approximately $79,000 per person per year are avoided.*

[25] The Waiver program is which is authorized by §1915(c) of the Social Security Act and is limited to people with income as high as three times the max Supplemental Security Income amount. In 2024, that amount is 3x$943=$2,829. In addition, a person cannot have over $2,000 in resources.

[26] During this approval process, residents are expected to pay their "cost of care," which is often all of their income excluding a small personal needs allowance. When a resident identifies their "Intent to Return Home," Maryland permits a "Resident Maintenance Allowance" to be provided, but the amount of the resident allowance is not identified and is limited to six months. In effect, because residents cannot afford to pay both the rent or mortgage in the community that they intend to return to, and at the same time pay all income except the personal needs allowance for care provided in a skilled nursing facility, many residents lose their home in the community. The loss

People in the community seek to avoid institutionalization in the first place. Maryland Medical Assistance provides health coverage and services for care in the community that is vital for care in the community. Community First Choice (CFC)[27] is a service offered through Medical Assistance that provides personal assistance services in the home; no waitlist exists for the services.[28] The income limit for obtaining Medical Assistance is $350 for people who are over age 65 and on Medicare due the Affordable Care Act's limited expansion.[29] Because the income limit is so low, people receiving services under CFC were kicked out of in-home services once they became eligible for Medicare. As a result, in 2019, MD Code, Health - General, § 15-137 (a)(2) was added.[30] This statute created a pathway for people who are ineligible for CFC after enrollment in Medicare such that they can obtain in home services through the Home and Community Based Options Waiver program, a program with a higher income limit. However, the statute does not contemplate people being approved for Title II benefits based on disability, including Social Security Disability Insurance (SSDI) and auxiliary benefits, which have a two year wait period before becoming eligible for Medicare. In essence, they are currently kicked out of in-home care through CFC once they receive Social Security benefits that exceed the Medicaid income limit. As a result, we recommend that MD Code, Health - General, § 15-137 (a)(2)(iii) be amended to include people who received services through CFC but who became approved for Title II benefits based on disability and are *awaiting* Medicare eligibility. This would to preserve the continuity of their in-home care, and the expansion would close the gap in ensuring many low-income and medically eligible individuals who received in-home care under CFC are able to maintain services through HCBO Waiver. [31] In addition, because preserving in-home care is vital to preventing institutionalization, we recommend increasing the Medically Needy income limit to increase access to Medical Assistance and services offered under this insurance. We also recommend expanding the Waiver Program. From a fiscal perspective, in-

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of their community home forces institutionalization. *See* Maryland Medicaid Manual Section 1000.1(i) : https://health.maryland.gov/mmcp/Medicaid%20Manual/Section%201000-Eligibility%20for%20Institutionalized%20Persons.Final%205-15-14.pdf. Other allowances, for spouses and dependents are also considered.

[27] CFC is authorized under §1915(k) of the Social Security Act

[28] Md. Code Regs. 10.09.84.04(A)(2)

[29] Medically Needy income limit for Maryland Medical Assistance is $350 unless "spend down" is established or the person specifically receives SSA Supplemental Security Income benefits, which off all 50 states, only exceeds Kentucky's $235 limit. (https://www.medicaidplanningassistance.org/medicaid-eligibility-income-chart/) . Increasing this limit, as many states have done to match at least the SSI maximum benefit, would expand access to home and community based services through Community First Choice. Maryland has not increased its Medically Needy income limits since before 2009 and is grossly behind well-established cost of living increases. (See appendix).

[30] Of note, according to the state's application for Waiver services the state reported 23 of 1,103 people were enrolled from CFC to Waiver services. https://health.maryland.gov/mmcp/longtermcare/SiteAssets/SitePages/Community%20First%20Choice/Home%20and%20Community-Based%20Options%20Waiver%20Renewal%20Application%20effective%2001.01.2023%20-%2012.31.2027.pdf (see pg 28 of 162)

[31] MD Code, Health - General, § 15-137 (a)(2) is explicit in its application to individuals who have been entitled to or enrolled in Medicare, but does not address those who become approved for Social Security benefits and therefore ineligible for community Medical Assistance but for the HCBO Waiver pending Medicare eligibility.

home services and support is more cost effective than institutionalization, often owned and operated by corporations and private equity outside of Maryland.

Finally, people can apply for HCBO Waiver services from the community as well as from nursing homes. There can be significant delays in both methods such that prospective beneficiaries can be faced with costly and often traumatic institutionalized care. MDH has delegated much of the process to support planners at Support Planning Agencies, which are contracted by the state. There have been challenges with contracted agencies. Therefore, there should be enhanced oversight of contracted agencies and streamlining of the entire process to effectuate the purpose of the program with coordination of care.

Preventing Fraud, Scams and Financial Exploitation

According to the World Health Organization, the current population of individuals aged 60 years and older will double from 1 billion in 2020 to 2.1 billion by 2050. As the quantity of Older Adults increases, so will the need for support.[32] However, this supports that Older Adults need makes them particularly at risk for exploitation. Older Adults are especially vulnerable to fraud and scams. Losing money or possessions to scams, fraud, and exploitation can be especially devastating to Older Adults, and Older Adults may be targeted at rates that outpace the services available to help the growing number of victims. Financial exploitation of Older Adults is costly, widespread, and results in a loss of billions of dollars each year. The mistreatment of Older Adults can also be by family members, strangers, health care providers, caregivers, or friends, and often takes one of the following forms: physical abuse, psychological or emotional abuse, sexual abuse, stalking, abandonment, human trafficking, spiritual abuse, financial abuse, and neglect. The abuse of an Older Adult not only impacts the individual but also communities on many levels, including personal relationships, community engagement, public health, and economic domains.

Fraud, scams, and exploitation often go unreported and can be difficult to prosecute. One in ten community dwelling Americans aged 60 and older has experienced abuse, and one of the most frequent forms of abuse of Older Adults is financial exploitation. Older Adults are more susceptible to financial abuse and exploitation and are perceived to be easy victims due to a variety of reasons, including cognitive and/or physical decline, an accumulated wealth in savings and asset accounts, and a greater reliance on family, friends, neighbors, and even strangers who can take advantage of them via the telephone, internet, or email to gain access to their personal information. These types of crimes leave Older Adults in vulnerable positions with limited ability to ever recover their losses in full.

To prevent Older Adults from becoming victims of fraud, scams and financial exploitation across the state of Maryland, the Task Force determined prioritizing its focus on these two critical areas to be paramount:

1) Preventing financial abuse and exploitation by Powers of Attorney and Representative Payees,
2) Implementing Follow-up and Partnership on Reporting Banking Fraud and Exploitation.

[32] "Representative Payees: A Call to Action" Social Security Advisory Board. March 3, 2016, available at https://www.ssab.gov/research/representative-payees-a-call-to-action/

Increase oversight of Power of Attorneys and Representative Payees

Power of Attorney and Representative Payee are important tools, but without regulations, they provide a mechanism for exploitation.

Power of Attorney

A Power of Attorney (POA) is a document authorized by Md. Code, Est. & Trusts § 17-101 etc., that gives someone legal authority to act on another person's behalf. Through the document, a person, known as an "Agent" (also sometimes called "Attorney-in Fact"), is assigned to manage the affairs of the person granting the authority, known as the "Principal." POAs are a helpful tool for Principals to facilitate powers. There is a Personal and Financial Power of Attorney and Limited Power of Attorney Forms, and the powers can go into effect at the Principal's discretion so long as the Principal has capacity when the document is executed.

The POA defines the limits of the power the Principal gives to the Agent. The Principal retains authority to act and make decisions and only gives the Agent the power to act for the Principal under defined circumstances. For the POA to be valid, the Principal must grant the power to the Agent of their own free will before a notary and witnesses. The Principal determines who is named as their Agent, and how much power is given to the Agent. If a Principal is subject to undue influence, is pressured or coerced, or is not of sound mind, the POA may be found invalid in a court of law. The Principal can revoke the POA at any time so long as the Principal has capacity.

Maryland has a statutory form for both Personal and Financial Power of Attorney and Limited Power of Attorney. However, the forms are often underutilized and that leads to a wide variety of POA documents that vary in content, quality, and terms, and calls into question the validity of the document. The Task Force recommends that Maryland Code explicitly provide that a POA statutory form be required moving forward. In the alternative, the Task Force recommends state clarify the provision regarding allowing acceptance of "substantially in the same form" POA so that it unambiguously includes the duties of the Agent in both the Personal and Financial Power of Attorney and Limited Power of Attorney Forms.[33] Specifically, Maryland Code permits utilization of POA forms that do not conform with the statutory form so long as the form is "substantially similar."[34] The Task Force recommends that *all* Maryland statutory POA forms contain the duties of the agent.[35] These duties of the Agent are not currently contained at all in the Limited Power of Attorney form.[36] Without specifically requiring the duties and responsibilities of the Agent within all of the statutory forms, older versions of POA forms can continue to be implemented depriving Agents of understanding their fiduciary obligations.

Moreover, educating Agents about the duties and responsibilities included with the Power of Attorney would reduce the chance of exploitation. While Maryland has acknowledged the

[33] Md. Code, Est. & Trusts § 17-101 (p)(1)
[34] Underscoring the need for clarity is that fact that receivers are required to accept the form, without exception. Md. Code, Est. & Trusts § 17-104
[35] See Md. Code, Est. & Trusts § 17-101(p), § 17-201, § 17-110
[36] Md. Code, Est. & Trusts § 17-203

importance of training when a person is designated and appointed by a court to serve as Guardian of the person, similar training for Agents designated in a power of attorney is lacking. Specifically, Maryland does not require that Agents acknowledge any duties or responsibilities that are contained in Md. Code, Est. & Trusts § 17-113. A brief section of the Personal and Financial Power of Attorney contains "Important Information for Agent," but does not require the Agent to sign or acknowledge or otherwise agree to the designation or responsibilities.[37] Acknowledgement of the Agent's responsibilities in both the Personal and Financial Power of Attorney and Limited Power of Attorney Forms is important.[38] In other words, while responsibilities of the Agent are codified, an Agent should be required to sign and acknowledge those duties and responsibilities to ensure they are meaningful. Absent such a requirement, bad acting Agents will continue to have plausible deniability and feel more empowered to engage in or enable acts that constitute fraud and/or financial exploitation. Because this opportunity for education and acknowledgement is so critical, we believe that each Agent must be required to sign the certification to effectuate their authority.[39]

We also request additional provisions to make the POA more robust, including establishing Agent liability if the fiduciary duties are broken. Other states require an agent to restore or reimburse property when the Agent has failed to act in accordance with their duties and responsibilities on behalf of the Principal.[40] Maryland has no similar requirement and without prescribed remedies, victims are limited to the prolonged tort claim process when the duties are breached. By codifying the obligation of the breaching Agent to restore or reimburse the Principal, Agents will be more motivated to contemplate their fiduciary duties.

In addition, we recommend that an avenue be created for registering Power of Attorney. In Maryland, a person may register a Power of Attorney for tax purposes through the Comptroller through a tax form 548.[41] A person may also record a Power of Attorney within the Department of Land Records in the county Circuit Court for land transactions.[42] However, outside of tax and land sales, there is not an avenue available for people to register Power of Attorney instruments if they would like to have that option.[43] Such a registry would help not only the Principal and Agent safely retain the document, but it also could allow other entities, such as courts, attorneys,

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[37] Md. Code, Est. & Trusts § 17-202

[38] Maryland implemented an "Agent certification," but this certification is optional and does not describe any duties or responsibilities. Md. Code, Est. & Trusts § 17-204

[39] The legislature should explore and consider whether the POA would be effective absent a signed acknowledgment of the designee.

[40] GA code provides that an Agent: "(1) Restore the value of the principal's property to what it would have been had the violation not occurred" Ga. Code § 10-6B-17(1)
CA: "(a) If the attorney-in-fact breaches a duty pursuant to this division, the attorney-in-fact is chargeable with any of the following, as appropriate under the circumstances:(1) Any loss or depreciation in value of the principal's property resulting from the breach of duty, with interest." Cal. Prob. Code § 4231.5(a)(1)
ME: "1.Restore property. Restore the value of the principal's property to what it would have been had the violation not occurred" Me. Stat. tit. 18-C § 5-917(1)

[41] Comptroller of Maryland, Revenue Administration Division, P.O. Box 1829, Attn: POA, Annapolis, Maryland 21404-1829

[42]https://www.mdcourts.gov/legalhelp/landrecords#:~:text=The%20Department%20of%20Land%20Records,of%20attorney%2C%20and%20certain%20leases.&text=What%20is%20a%20deed?,Give%20you%20legal%20advice

[43] States like North Carolina require Principal's to register POAs. *See* North Carolina: https://www.ncleg.gov/EnactedLegislation/Statutes/PDF/BySection/Chapter_47/GS_47-28.pdf , N.C. Gen. Stat. § 47-115

government agencies and financial institutions to confirm the validity of the current POA document and whether the document has been revoked.

Representative Payee

A Representative Payee (Rep Payee) is an individual or organization nominated by the Beneficiary and appointed by a government agency to receive benefits for a Beneficiary who cannot manage or instruct someone else to manage their income. In contrast to a Power Of Attorney, a Rep Payee[44] receives Beneficiary's funds directly from the Social Security Administration, Department of Veterans Affairs, or Office of Personnel Management. The Rep Payee has a fiduciary duty to manage the Beneficiary's funds, which must be placed into a dedicated account, and provide an accounting of expenditures.[45]

Organizations can also serve as Rep Payee, and are known as Institutional Rep Payees. Long term care facilities are some of these organizations Older Adults rely upon. When a direct care organization serves as an Institutional Rep Payee, the organization is entitled to pay itself rent and other charges.[46] However, while Federal law prohibits long term care facilities from conditioning admissions based on assignment of Rep Payee,[47] frequently these organizations require it despite it being illegal.

Even with accounting, there is an apparent conflict of interest:

> "Appointment of a residential care facility [as rep payee], however, is disfavored because it creates a conflict of interest for the representative payee: on one hand, the care facility has a duty as payee to expend Social Security funds in a manner with the beneficiary's best interests; on the other hand, the care facility has a financial incentive to maximize its compensation for services provided to the beneficiary, and that compensation can be drawn directly from the beneficiary's monthly Social Security benefit check."[48]

Rep Payee programs can be advantageous for the Beneficiary by enhancing their ability to maintain independence, meet basic needs, and mitigate risks such as hospitalization, homelessness, and victimization. These programs also contribute to an improved quality of life and can have positive economic implications for communities by reducing the need for costly institutional care. However, the appointment of a Rep Payee carries inherent risks. Foremost among these is the loss of financial autonomy, which can have profound psychological effects, including diminished self-esteem, heightened anxiety, increased dependency, and compromised

[44] In this letter, we are using the term "representative payee" to describe a person or entity appointed to receive and manage an individual's governmental benefits.
[45] Social Security Administration, Representative Payee Report of Benefits and Dedicated Account (available at https://secure.ssa.gov/apps10/public/pomsimages.nsf/gfx_num/G-SSA-6233-BK-1/$File/G-SSA-6233-BK-1.pdf) (commonly referred to as Form 623).
[46] *Id.*
[47] *See* 42 CFR §483.10(f)(10), which provides "The facility may not require residents to deposit their personal funds with the facility although a resident can if he or she so desires." Note: Facilities similarly use resident trust accounts. Maryland does not distinctly regulate resident trust funds in ALPs, of note, Texas requires assisted living facilities to keep funds received from or on behalf of a client a separate bank account from the facility's operating funds and outlines the types of accounts that may be used. 40 Tex. Admin. Code § 46.63(a), (b).
[48] Reid K. *Weisbord, Social Security Representative Payee Misuse*, 117 PENN ST. L. REV. 1257, 1257 (2013).

autonomy. Moreover, entrusting another individual with control over the disbursement of funds exposes beneficiaries to potential mismanagement, misuse, or outright financial exploitation. Specifically, while a Beneficiary may elect to use a Rep Payee on their own, it can often be a requirement set forth by SSA in the disability determination process. This highlights the exploitation risk because when this requirement to have a Rep Payee is imposed on a Beneficiary, in order for a Beneficiary to access benefits at all, they must designate someone to be their Rep Payee, even if that designated individual isn't well known or trusted by the Beneficiary.[49] SSA does not extensively vet the designated individual to confirm they are an appropriate candidate for the role of Rep Payee, and minimal education takes place regarding fiduciary duties. This can make the Beneficiary extremely vulnerable and at the mercy of their Rep Payee financially. Thus, while Rep Payee programs offer crucial support, it's essential to address and mitigate these risks to safeguard the well-being and financial security of at-risk individuals.

Importantly, facilities do not have to become representative payees in order to secure control of residents' funds. In lieu of becoming a Rep Payee, SSA permits a facility to create a "resident trust account" through Resident Fund Management System (RFMS) for a Beneficiary, into which the resident's social security benefits are deposited.[50] The facility owns the account, and while the beneficiary is supposed to have access to the account, the facility deducts amounts it claims are owed to it.[51] This creates a gap in oversight because RFMS bypasses the Rep Payee approval process, yet involves the direct receipt and management of resident benefits.[52] Maryland should work more closely with the Social Security Administration (and other government agencies using Representative Payees) to address Rep Payee and RFMS issues of financial abuse and exploitation.

A Representative Payee Investigations Program (RPI) currently exists. In Maryland, this is housed at Disability Rights Maryland (DRM). There, federally funded SSA-trained investigators receive referrals from SSA to investigate potential bad actor Rep Payees. There is a thorough investigative process that includes screening, site visits, records requests, Rep Payee re-education, and reporting of findings and recommendations that may or may not yield restrictions of Rep Payees or potentially referral to the Office of Inspector General (OIG). DRM can also receive community referrals about potential bad Rep Payees, refer them to SSA, and have SSA

[49] To change the Rep Payee, the beneficiary would need to indicate who they want to serve as Rep Payee, and that person would need to apply. To remove the Rep Payee, the beneficiary would need to present evidence of their ability to care for themselves. https://www.ssa.gov/payee/advance_designation.htm, https://www.ssa.gov/payee/faqbene.htm?tl=12

[50] While Maryland does not distinctly regulate resident trust funds in ALPs, of note, Texas requires assisted living facilities to keep funds received from or on behalf of a client a separate bank account from the facility's operating funds and outlines the types of accounts that may be used. 40 Tex. Admin. Code § 46.63(a), (b).

[51] POMS GN 00603.020 Collective Checking and Savings Accounts Managed by Representative Payees available at https://secure.ssa.gov/poms.nsf/lnx/0200603020; JUSTICE IN AGING, *Skilled Nursing Facilities and Other Creditors Acting as Rep payees* (January 2018), at 7, available at https://www.justiceinaging.org/wp-content/uploads/2018/01/Skilled-Nursing-Facilities-and-Other-Creditors-Acting-As-Representative-Payees.pdf.

[52] Of note, facilities are not allowed to require such accounts as a condition of stay, but some do anyway. Facilities are not allowed to continue to receive benefit funds after a resident leaves and is no longer receiving care from the facility, but some residents have difficulty terminating the RFMS. Some residents have expressed concern about the administration of the residents' "personal needs allowance" including the ability to access those funds.

essentially approve it and send it back to DRM to proceed with the investigation. We recommend the RPI Program include more vendors, modeled after the program housed at DRM.

One example of nefarious acting has occurred when a bad acting institution closes and reemerges under a different name. When this happens, the bad actor is able to engage in the same conduct that existed before, exploiting more at-risk adults with the same practices. The Task Force recommends a cohort to include DRM and other non-profits, relevant government agencies, law enforcement, and other stakeholders that can collaborate to identify problematic individual and institutionalized Rep Payees, and explore possible legal avenues for recourse. The State could also bolster accountability measures and prevent bad actors from evading consequences and liability by simply changing business names and reemerging as new Rep payees. Even specific requirements based in state law for skilled nursing facilities and assisted living programs serving as Rep Payee would be a critical step in ensuring monetary benefits used in good faith for the intended beneficiary.

The Task Force's recommendations below will serve to help mitigate some occurrences of financial abuse and exploitation of persons who have a Rep Payee in place:

- Increase oversight of long term care facilities utilizing RFMS accounts.
- Expand the "Representative Payee Investigations Program" to include more vendors, modeled after the program housed at Disability Rights Maryland (DRM).
- Coordinate a collaborative cohort of stakeholders and relevant government agencies to identify and track bad acting facilities and programs and explore existing and potential legal avenues for recourse.

Increase oversight in Reporting Banking Fraud and Exploitation

Fraud in banking is a type of financial crime that involves the use of deceptive or illegal practices to gain an unfair or unlawful financial advantage. It is a serious crime that can cost banks and customers significant amounts of money. Bank fraud can come in many forms, from small-scale scams to large-scale operations that involve millions of dollars. It can occur in many ways and can involve any type of banking activity, including deposits, withdrawals, transfers, loan applications and investments. One of the most common types of banking fraud is identity theft and another form of banking fraud is phishing.

The responsibility for banking fraud lies with both the bank and the customer. The responsibility of the banks is to ensure the security of customer's financial data and accounts. There are strong protocols in place to protect customers' accounts from fraud and theft. Banks should ensure that their staff is adequately trained in detecting and preventing banking fraud as required by federal regulation. (16 CFR 681.1.)

On the flip side, customers have a responsibility to protect their accounts from fraud. They should ensure that their passwords are secure and not easily guessed. Customers should also be alerted of any suspicious activity in their accounts and should immediately report it to the bank.[53]

Maryland law requires fiduciary institutions to submit reports of suspected abuse. Md. Code, Fin. Inst. § 1-306. When addressing suspected financial abuse and exploitation of Older Adults, the reporting party does not receive follow-up after a claim is submitted. The reporter might be left not knowing if their referrals were dismissed or investigated, and if so, what was the result of the investigation. Some form of follow-up would validate screening and empower the reporter to take appropriate protective action.

In addition, Maryland does not currently allow for online reporting of suspected financial exploitation and exploring this possibility would improve reporting.

The Task Force's recommendations below wills serve to help bridge the gap in sharing of information:

- Develop a methodology for agencies and reporters to legally share information to close the loop on reporting.
- Suggest financial institutions (to include digital banks and social payment apps) provide educational information about financial exploitation to customers.

Public Awareness

Establish a Public Awareness Campaign Supported by a Comprehensive Inventory of Services & Programs to Prevent Abuse of Older Adults

A public awareness campaign is needed to educate the public on the issue of abuse and neglect of Older Adults and the availability of resources and options for prevention and elimination of this growing problem. Through education, advocacy, and community engagement and assessment of existing resources, the state can empower individuals and communities to recognize, report, and stop abuse and neglect of Older Adults in all its forms and across various settings.

The Task Force recommends the following strategies to promote Public Awareness:

1. *Community Engagement:* The state should lead in the following activities in order to engage the Older Adult community:
    - Organize workshops, seminars, and town hall meetings to educate the public about the prevention of the abuse and neglect of Older Adults.
    - Collaborate with local senior centers, libraries, and community organizations to reach a wider audience.

[53] The Task Force recognizes that exploitation may occur such that a perpetrator of exploitation withholds access to bank statements that would ordinarily be the customer's responsibility to track and review and that significant consequences result when this information is withheld from the customer and so this issue should be further explored.

- Partner with law enforcement agencies, healthcare providers, legal organizations, and social service agencies to coordinate efforts in preventing elder abuse.
- Seek support from influential figures and community leaders to amplify the campaign's message.
- Seek collaboration and funding from financial institutions to raise awareness of common scams and strategies that contribute to financial abuse.
- Create and launch an Elder Abuse Marketing Campaign that includes billboards, posters, as well as radio and television PSAs.
- Engage in live Q&A sessions and social media platforms

2. *Education:* The state should review and update existing educational materials, including the utilization of brochures, posters, and pamphlets outlining signs of the abuse and neglect of Older Adults and how to report it, how to talk with a healthcare provider and other mandated reporters, and services available to empower choice to prevent abuse, such as financial planning and establishing a POA when appropriate.

3. *Training Programs:* The state should lead in offering accessible training sessions for staff of state agencies, care providers, healthcare professionals, and community members on identifying and addressing the abuse and neglect of Older Adults engaging professional speakers. Elder abuse should be included in onboarding training for all state agency staff serving Older Adults and there should be elder abuse training for mandated reporters statewide. In addition, the state should offer training modules for law enforcement personnel and legal professionals in order to improve the response and support for cases involving abuse and neglect of Older Adults and implement elder abuse training for medical examiners who take calls from police after the death of an Older Adult. Finally, the state should develop (or promote awareness of) short online videos on how to identify deceptive practices/scams that lead to financial abuse, including training for appropriate utilization of tools such a Representative Payee and how to report misuse and change the person serving as Representative Payee. These trainings should include and address the impact on elder abuse victims involving adult children with mental illness.

4. *Create Connection with Federal Agencies:* Establish awareness campaigns with the local Social Security Offices and Department of Veterans Affairs, and more robust education for both Rep Payees and SSA benefit recipients in general about financial exploitation, resources, reporting, prevention, etc.

Comprehensive Inventory of Services and Programs

The abuse and neglect of Older Adults often occurs where there are gaps in resources, resulting in unwanted institutionalization and other harms. The Task Force recommends that the state engage in an inventory of resources and work toward expanding services that promote the health

and dignity of Older Adults and the bridge and facilitating connections where greater efficiency would be beneficial. Many programs and resources exist but operate in isolation. A state agency must be designated and resourced to maintain and update the inventory of programs and services and to sustain this enhanced and collaborative communication strategy, leveraging opportunities to expand the support available.

- *Home and Community Based Services Waiver Expansion:* Increasing access to care in the community empowers Older Adults to respond when care needs fail to be met in institutionalized settings. The state should assess expanding the Waiver program, including the utilization of the supports planners in facilitating the plan of service.
- *Helplines:* Providing direct access to services greatly increases the prospects of a timely response. This Task Force wishes to explore existing helplines, active shelters, legal service providers, and other entry ways for assistance and make recommendations about how such resources can be accessed and utilized.
- *Designate Abuse Expert in State Agencies:* 17 state agencies receive reports of abuse. Those state agencies should identify a staff member who would be trained in the abuse and neglect of Older Adults in to appropriately address and coordinate response and follow-up to the issue. If a report is made, there must be follow-up with the reporter and collaboration with the agencies involved.

Data Collection

A centralized repository is necessary to understand the full scope of abuse, neglect and financial exploitation experienced by Older Adults in Maryland.

No central data repository exists for the collection of reports on abuse, neglect and financial exploitation of Older Adults.[54] Consequently, no central method currently exists for analyzing data on Older Adult abuse in the State. It is unknown how many people are being harmed. Experts believe the numbers are vastly undercounted.[55] A centralized repository is necessary to understand the full scope of abuse, neglect and financial exploitation experienced by Older Adults in Maryland, in order to determine appropriate and timely responses and to allocate necessary resources. Confidentiality can be protected by an alpha-numeric or other system.

A central repository of data that includes the number and type of victims, abusers, and the locations and types of abuse, is necessary to understand the full scope of abuse, neglect,

[54] The Department of Human Services maintains a database through the various Departments of Social Services, but it is not comprehensive to the 17 agencies identified above.

[55] National Center on Elder Abuse, https://ncea.acl.gov/prevalenceofeldermistreatment#gsc.tab=0
" Studies have recognized that projections of abuse likely underestimate the actual population prevalence." …
"For every incident of abuse reported to authorities, nearly 24 additional cases remain undetected." Pillemer, K., Burnes, D., Riffin, C., & Lachs, M. S. (2016). Elder abuse: global situation, risk factors, and prevention strategies. The Gerontologist, 56(Suppl_2), S194-S205;
Storey, J. E. (2020). Risk factors for elder abuse and neglect: A review of the literature. Aggression and Violent Behavior, 50, 101339.

trafficking and financial exploitation experienced by Older Adults in Maryland. This is needed to determine appropriate and timely responses and to allocate resources.

Once Maryland has consistent, reliable data, appropriate funding can be determined so that safety barriers can be removed and timely service delivery be provided. Without knowing the number of people being harmed, what interventions have been applied and the results, Maryland remains unaware of how much money, staff and resources are needed to provide intervention, safety and/or criminal prosecution.[56]

Analysis of Data Collection and Coordination

It is essential to collect comprehensive data from the array of state and local agencies who receive reports of abuse, neglect and exploitation. Collection of data is needed to identify the total number of reports and types of abuse that occur in Maryland. Thereafter, appropriate funding needs can be determined so that barriers to safety can be removed, and that timely response and necessary resources are delivered. Without knowing the number of people being harmed, the interventions applied and the results of the interventions, we cannot know how much money, staff and resources are needed to provide appropriate response for safety and/or criminal prosecution.

The common types of abuse data that should be collected include psychological/emotional, verbal, sexual, physical, stalking, abandonment, neglect, self-neglect, as well as financial exploitation and trafficking. The Task Force highly recommends that Maryland also collect data on sex, age, gender, sexual orientation, location of the alleged abuse, perpetrator type, and process outcomes.

Currently, many officials and reporters believe that APS is the only repository of reports of abuse. In fact, there are 17 different state and local agencies that receive reports of abuse, neglect and financial exploitation that serve as points of entry into the social services and criminal justice systems. They include:

1. Maryland Department of Aging, State Long Term Care Ombudsman
2. Local Long-Term Care Ombudsman Programs
3. Local Area Agencies on Aging (including Baltimore City Department of Health, Division of Aging and CARE Services), Maryland Access Point
4. Maryland Department of Human Services
5. Local Departments of Social Services, Adult Protective Services
6. Maryland Department of Health
7. Local Health Departments
8. Office of the Chief Medical Examiner
9. Office of Health Care Quality
10. Local Police Departments, 911

[56] "Agencies report challenges with sharing data related to elder abuse. A uniform older abuse and neglect reporting form accepted by all Maryland agencies that serve as points of entry and receive reports of abuse and neglect that is authorized by statute could help facilitate sharing information. Statutory authority clarifying when an investigation should commence, when a preliminary finding should be reported, and how agencies should share information.

11. 211 Maryland Hotline
12. Local Fire Departments, EMS
13. Maryland Department of State Police, Office of the State Fire Marshal
14. Local Offices of the Fire Marshall
15. Hospitals
16. Office of the Attorney General, including but not limited to Medicaid Fraud and Vulnerable Victims Unit, Financial Exploitation Unit, and Civil Rights Division
17. Local Offices of the States Attorney

Coordination of reports from *all settings* is needed. For example, community-dwellings, congregant settings, hospitals, skilled nursing facilities (nursing homes), assisted living programs, drug and alcohol rehabilitation programs, and adult daycare programs all have data that should also be included.

Department of Social Services and those state and local agencies that receive reports of abuse, neglect or financial exploitation of Older Adults should have annual training as to any law and policy changes applicable to the delivery of services to Older Adults.

Additional Recommendations

There is an urgency in the state of Maryland to continue this effort, acknowledging that additional areas also require attention. Due to the vast scope of this topic, combined with limited time, the Task Force was unable to address all essential system changes. It is recommended that the Task Force continues to work, with further efforts to improve statutes and processes, as well as to address gaps in services and resources for victims.

1. **Establish the Maryland Office of Elder Abuse Response**
    - The Task Force recommends Governor Moore replicate the model established by the Maryland Office of Overdose Response. Maryland would be the first state in the country to institute such an office.
        - The office will coordinate and promote efforts across Maryland state agencies to address the elder abuse crisis.
        - In his address about the establishment of the Maryland Office of Overdose Response, Governor Moore highlighted how he is focused on broadening pathways to care for individuals who are being abused, neglected, or financially exploited, and focused on developing and growing communities that ensure all Marylanders can access the support they require. This philosophy should also guide the Maryland Office of Elder Abuse Response, as it will address similar challenges in protecting at-risk populations.

- A Special Secretary will lead the office, and a Maryland Elder Abuse Response Advisory Council will be established.
- Governor Moore will appoint the Council Chair.
- The Council will involve state and local agencies to enhance data sharing, collaboration, and access to resources.
    - Elder abuse affects individuals, families, and communities, impacting public health, safety, and education. Therefore, everyone should have a seat at the table in addressing this issue.
- The Moore-Miller Administration's elder abuse approach is guided by five policy pillars: *prevention, harm reduction, treatment, recovery, and public safety.*
- The Maryland Office of Elder Abuse Response will:
    - Create a comprehensive strategic plan to develop and implement policies and programs addressing elder abuse.
    - Gather input from Older Adults, experts, state, local, and nonprofit agencies, community partners and the public.
- The Maryland Office of Elder Abuse Response will help fulfill the administration's commitment to:
    - Providing essential services to at-risk individuals.
    - Strengthening inter-agency cooperation for better outcomes.

2. **Proactive and Preventative Regulatory Oversight**
    - Enact regulations to effectuate complete transparency of private equity investment in acquiring, managing, and selling skilled nursing facilities, assisted living programs, adult day care programs, home health programs, and hospice programs.
    - Increase regulatory oversight in assisted living facilities and licensed adult daycare programs.
    - Develop regulatory oversight in drug and alcohol detox and rehabilitation facilities, and in homeless shelters where Older Adults are served.
3. **Access to Healthcare**
    - Increase Aged Blind Disabled Medical Assistance eligibility to the SSI income limit so that Older Adults can more easily establish dual eligibility and have coverage for essential services and care.
    - Expand Home and Community Based Options Waiver program and coverage for in-home care.
4. **Increase Screening for Elder Abuse**
    - Implement elder abuse screening in all intake processes in agencies that serve Older Adults.
5. **Elder Abuse Lethality Assessment**

- Develop an Elder Abuse Lethality Assessment for police responding to domestic calls.

6. **Capacity Evaluation**
   - Standardize tools and procedures for assessing "capacity" in Older Adults.
   - Increase and train the number of Capacity Evaluators across the state.
7. **Social Workers and Care Resources**
   - Increase the number of professional social workers who serve Older Adults by incentivizing work in the field of aging and caring for Older Adults in all life domains.
   - Develop a long-term professional care resource partner system that pairs professional social workers and other resource partners with individuals when they turn age 60 and older.
8. **Civil and Legal Remedies**
   - Establish pro bono emergency legal services and Mobile Protective Orders for Older Adults.
   - Extend the duration of protective orders for Older Adults.
   - Develop methods for enhancing accountability for abusers.
9. **Financial Protection and Institutions**
   - Increase the Homestead Exemption in Maryland to prevent predatory bankruptcies from being filed. [57]
10. **Affordable, Safe, Housing and Shelters**
    - Develop and provide more affordable licensed assisted living options for low-income Older Adults.
    - Explore legislation that could aid in surveillance in skilled nursing and assisted living facilities in order to promote and improve safety.[58]
    - Establish elder abuse shelters and transitional housing for victims needing a safe space.

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[57] Currently, the Maryland homestead exemption is limited to $27,900.00. The process of filing bankruptcy has been exploited in Maryland to the detriment of Maryland residents. Specifically, if a Maryland resident falls behind in medical debt arising from nursing home stay, and they are sued, the medical provider can sell that home to enforce the judgment that they have against them. The limited exemption means that the resident is only able to retain a small portion of the equity. This means that a homeowner who is in a nursing home is essentially forced to liquidate their home to pay off the debt to medical provider, which means that property is no longer an alternative location for care. If the homestead exemption was much larger, it would allow a homeowner to file Chapter 7 bankruptcy, discharge the medical home debt, and protect the home as an alternative location for discharge. The Task Force believes that Older Adult Marylanders, including those in nursing homes, may be the biggest beneficiaries of increasing the exemption.

[58] Maryland passed a law in 2003 regarding recordings. The law required Maryland Department of Health to establish guidelines for recording in skilled nursing facilities. The guidelines are contained in this report: https://health.maryland.gov/ohcq/docs/Reports/149report.pdf. Of note, in 2010, there was an attempt to update the law to require SNFs to allow electronic monitoring that did not pass (https://mgaleg.maryland.gov/2010rs/bills/hb/hb1019f.pdf).

11. Elder Fatality Review Team

- Establish a multisector Elder Fatality Review Team to include Adult Protective Services, local law enforcement, local state's attorney's office, Office of the Chief Medical Examiner, and the Long-Term Care Ombudsman Program.

Conclusion

Maryland is home to nearly 1.4 million people over the age of 60, and according to the Governors recent State Plan on Aging, Maryland is expected to see considerable growth in the Older Adult population in the next two decades. In fact, this age group is expected to grow to 1.7 million by 2040. Additionally, the population of Marylanders over the age of 85 will more than double in the same time period. This means Maryland must be prepared now to support its senior population, by protecting them from identifiable and preventable forms of elder abuse.

This task force aims to publicize the issues of elderly abuse and neglect and promote the implementation of legal, administrative, service provision, and educational responses. As stated above Maryland's elderly population is expanding, with the oldest group growing most rapidly. These individuals are more likely to be ill, have conditions that affect Older Adults such as Alzheimer's and Dementia, or be dependent on family or community caregivers, making them vulnerable to abuse and neglect. Maryland must mobilize its resources now to prevent a parallel increase in abuse and neglect with the projected growth in the oldest population members.

This Task Force believes it has identified the most prevalent areas of preventable abuse to Maryland's aging population. This Task Force is committed to continuing its research and investigation into the study of these areas and issues.

The goal of this Task Force is to provide the Governor, his aids, and the General Assembly with a comprehensive approach to addressing the four areas of study and to create a path to provide sustained change through recommendations that can be adapted into legislation.

Appendix

List of Acronyms

APS= Adult Protective Services

CFC= Community First Choice (a Medicaid Service)

DHS=Department of Human Services

HCBO Waiver=Home and Community Based Options Waiver (a Medicaid Program)

MDH=Maryland Department of Health

OHCQ= Office of Health Care Quality

POA=Power of Attorney

Rep Payee=Representative Payee

RFMS=Resident Fund Management Service

Statutes

MD Code Ann., Fam. Law §14-101(b) defines abuse as "the sustaining of any physical injury by a vulnerable adult as a result of cruel or inhumane treatment or as a result of a malicious act by any person."

MD Code Ann., Crim. Law §3-604(a)(2)(i) and (ii) defines abuse as "the sustaining of physical pain or injury by a vulnerable adult as a result of cruel or inhumane treatment or as a result of malicious act under circumstances that indicate that the vulnerable adult's health or welfare is harmed or threatened" and that "'abuse' includes the sexual abuse of a vulnerable adult."

MD. Code Ann., Crim. Law §3-604(a)(10), defines "vulnerable adult" as "an adult who lacks the physical or mental capacity to provide for the adult's daily needs."

MD Code Ann., Fam. Law §14-101(q) also defines "vulnerable adult" as "an adult who lacks the physical or mental capacity to provide for the adult's daily needs."

MD Code Ann., Crim. Law § 8-801(a)(6)(i) "Undue influence" means domination and influence amounting to force and coercion exercised by another person to such an extent that a vulnerable adult or an individual at least 68 years old was prevented from exercising free judgment and choice.

MD Code Ann., Crim. Law § 8-801(b)(1) A person may not knowingly and willfully obtain by deception, intimidation, or undue influence the property of an individual that the person knows or reasonably should know is a vulnerable adult with intent to deprive the vulnerable adult of the vulnerable adult's property.

Md. Code Ann., Health-Gen. § 19-347 (a)(2)(i) "Abuse" means the non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce or resulting in mental or emotional distress. (ii) "Abuse" does not include the performance of an accepted medical procedure that a physician orders.

Md. Code Ann., Fam. Law § 14-101: (l) (1) "Neglect" means the willful deprivation of a vulnerable adult of adequate food, clothing, essential medical treatment or habilitative therapy, shelter, or supervision. (2) "Neglect" does not include the providing of nonmedical remedial care and treatment for the healing of injury or disease, with the consent of the vulnerable adult, recognized by State law instead of medical treatment.

Md. Code Ann., Fam. Law § 14-101 (q) "Vulnerable adult" means an adult who lacks the physical or mental capacity to provide for the adult's daily needs.

Md. Code, Crim. Law § 3-604 (b)(1): Prohibits a caregiver, parent, or other person supervising a vulnerable adult from causing abuse or neglect that results in death, serious physical injury, or involves sexual abuse of the vulnerable adult.(b)(2): Prohibits a household or family member from causing abuse or neglect that results in death, serious physical injury, or involves sexual abuse of the vulnerable adult.

Md. Code, Crim. Law § 3-605 (b): Prohibits the abuse or neglect of, or the intentional and malicious infliction of severe emotional distress on, a vulnerable adult by a caregiver, parent, household or family member, or other person with supervisory responsibility.

Md. Code, Crim. Law § 8-801: Prohibits a person from knowingly and willfully obtaining by deception, intimidation, or undue influence the property of a vulnerable or Older Adult with intent to deprive the vulnerable adult of that property.

Md. Code, Est. & Trusts § 13-601(e) (1) "**Financial exploitation**" means an act taken by a person who:

(i) Stands in a position of trust and confidence with a susceptible adult or Older Adult and who knowingly obtains or uses, or endeavors to obtain or use, a susceptible adult's or Older Adult's funds, assets, or property with the intent to temporarily or permanently deprive the susceptible adult or Older Adult of the use, benefit, or possession of the funds, assets, or property for the benefit of someone other than the susceptible adult or Older Adult, in such a manner that is not fair and reasonable;

(ii) By deception, false pretenses, false promises, larceny, embezzlement, misapplication, conversion, intimidation, coercion, isolation, excessive persuasion, or similar actions and tactics, obtains or uses, or endeavors to obtain or use, a susceptible adult's or Older Adult's funds, assets, or property with the intent to temporarily or permanently deprive the susceptible adult or Older Adult of the use, benefit, or possession of the funds, assets, or property for the benefit of someone other than the susceptible adult or Older Adult; or

(iii) Knows or should know that a susceptible adult or Older Adult lacks capacity to consent and who obtains or uses, or endeavors to obtain or use, the susceptible adult's or Older Adult's funds, assets, or property with the intent to temporarily or permanently deprive the susceptible adult or Older Adult of the use, benefit, or possession of the funds, assets, or property for the benefit of someone other than the susceptible adult or Older Adult.

(e)(2) "**Financial exploitation**" includes:

(i) Breach of a fiduciary relationship resulting in the unauthorized appropriation, sale, or transfer of property.

(ii) Unauthorized taking of personal assets.

(iii) Misappropriation, misuse, or transfer of assets belonging to a susceptible adult or Older Adult from a personal or joint account; and

(iv) Intentional failure to effectively use a susceptible adult's or Older Adult's income and assets for the necessities required for the susceptible adult's or Older Adult's support and maintenance.

(e)(3) "Financial exploitation" does not include an individual's good-faith use of a susceptible adult's or Older Adult's assets, including for the purposes of establishing and implementing an estate plan intended to reduce taxes or to maximize eligibility for public benefits in order to preserve assets for an identified or identifiable person.

(k) "**Susceptible adult**" means an adult who is unable to perform, without prompting or assistance, one or more activities of daily living, is unable to protect the adult's rights, or has diminished executive functioning, due to:

(1) Advanced age.
(2) Mental, emotional, sensory, or physical disability or disease.
(3) Impaired mobility.
(4) Habitual drunkenness.
(5) Addiction to drugs; or
(6) Hospitalization.

Md. Code, Est. & Trusts § 13-604: Provides cause of action for damages and other appropriate relief to susceptible or Older Adult subjected to financial exploitation in the State, or to a person acting on their behalf, against a person who has committed financial exploitation.

Md. Code, Fam. Law § 14-302: Provides requirements for mandatory reporting and report contents.

Md. Code, Fam. Law § 14-303: Provides the timeline for investigation of received reports and the sharing of investigation information.

Md. Code, Health-Gen. § 19-407: Provides for inspections of the operations of home health agencies at least every three (3) years.

Md. Code, Health-Gen. § 19-903: Provides regulations for the standards and practices of Hospice centers.

Md. Code, Health-Gen. § 19-1401(d) "**Deficiency**" means a condition existing in a nursing home or an action or inaction by the nursing home staff that results in potential for more than minimal harm, actual harm, or serious and immediate threat to one or more residents.(f) "**Ongoing pattern**" means the occurrence of any potential for more than minimal harm or greater deficiency on two consecutive on-site visits as a result of annual surveys, follow-up visits, any unscheduled visits, or complaint investigations.

Md. Code, Health-Gen. § 19-1801– Assisted Living Programs

Md. Code, Fin. Inst. § 1-306: Abuse Report Requirements

(3) "**Elder adult**" means an individual who is believed to be: (i) At least 65 years old; and(ii) Residing in the State.

(4) "**Financial abuse**" means to take, appropriate, obtain, or retain, or assist in taking, appropriating, obtaining, or retaining, real or personal property of an elder adult by any means, including undue influence, for a wrongful purpose or with intent to defraud the elder adult.

(5) "**Financial exploitation**" means any action which involves the misuse of a customer's funds or property.

Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

January 24, 2024

The Honorable Bill Ferguson
President of the Senate
100 State Circle
Annapolis, MD 21401-1991

The Honorable Adrienne Jones
Speaker of the House
100 State Circle
Annapolis, MD 21401-1991

Re: Health General-Article §19–308 (b)(4) – Office of Health Care Quality FY 23 Annual Report, MSAR # 5624

Dear President Ferguson and Speaker Jones:

Pursuant to the requirements Health General-Article §19–308 (b)(4), the Maryland Department of Health (MDH) respectfully submits the Office of Health Care Quality FY 23 Annual Report.

If you have any questions or comments concerning the report, please contact Sarah Case-Herron, Office of Governmental Affairs, at sarah.case-herron@maryland.gov.

Sincerely,

Laura Herrera Scott, M.D., M.P.H.
Secretary

cc: Marie Grant, JD, Assistant Secretary for Health Policy, Office of the Secretary
Nilesh Kalyanaraman, MD, Deputy Secretary of Public Health Services
Sarah Case-Herron, JD, Director, Office of Governmental Affairs
Sarah Albert, Department of Legislative Services (5 copies), MSAR # 5624

MARYLAND DEPARTMENT OF HEALTH
Office of Health Care Quality

Maryland Department of Health
Office of Health Care Quality

Annual Report and Staffing Analysis
Fiscal Year 2023

Health-General Article § 19-308(b)(4)
Health-General Article § 19-1409(e)

Wes Moore, Governor
Aruna Miller, Lt. Governor
Laura Herrera Scott, MD, MPH, Secretary
Nilesh Kalyanaraman, MD, FACP, Deputy Secretary for Public Health Services
Patricia Tomsko Nay, MD, CHCQM, FAAFP, FABQAURP, FAAHPM, Executive Director

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Executive Summary

On behalf of the Office of Health Care Quality (OHCQ), it is my privilege to submit the FY 23 Annual Report and Staffing Analysis. This document is submitted pursuant to Health-General Article § 19-308(b)(4) and Health-General Article § 19-1409(e). OHCQ is the agency within the Maryland Department of Health (the "Department") that determines compliance and non-compliance with State licensure and/or federal certification requirements in health care facilities and community-based programs. As of July 1, 2023, OHCQ oversees 21,221 providers in 47 industries, an increase of 6.7 percent from the number of providers on July 1, 2022.

On behalf of the Maryland Secretary of Health, OHCQ issues State licenses that authorize the operation of certain health care facilities or programs in Maryland, such as nursing homes or assisted living programs. The State licensure requirements establish the minimum health and safety requirements to obtain and maintain a license to operate in Maryland.

On behalf of the Secretary of the U.S. Department of Health & Human Services, OHCQ conducts certification, recertification, and CLIA activities. The Social Security Act mandates the establishment of minimum federal health and safety and Clinical Laboratory Improvement Amendments ("CLIA") standards that must be met by providers and suppliers to participate in the Medicare and Medicaid programs. Based on outcomes from certification surveys, OHCQ makes recommendations regarding certification of a provider or supplier to the Centers of Medicare & Medicaid Services ("CMS"). Once certified, a provider or supplier may participate in and seek reimbursement from Medicare and Medicaid for services rendered to beneficiaries.

In FY 18, the Department developed and implemented a seven-year staffing plan for OHCQ. As anticipated, this controlled growth in the agency's workforce is progressively improving compliance with federal and State mandates. FY 24 marks the final year of this staffing plan. The Department is developing a staffing plan for OHCQ for FY 25 through FY 29.

Every day, OHCQ staff conduct or support licensure and certification activities that protect the health and safety of Marylanders across the health care continuum. It is an honor and a privilege to lead this group of dedicated staff. OHCQ appreciates the ongoing support of the Secretary, the Deputy Secretary, the Administration, members of the General Assembly, and all of our stakeholders.

Patricia Tomsko Nay, MD

Patricia Tomsko Nay, MD, CHCQM, FAAFP, FABQAURP, FAAHPM
Executive Director
Office of Health Care Quality

Roles of the Office of Health Care Quality

The Office of Health Care Quality ("OHCQ") is the agency within the Maryland Department of Health that determines compliance and non-compliance with State licensure and/or federal certification requirements in health care facilities and community-based programs in 47 industries.

On behalf of the Maryland Secretary of Health, OHCQ issues State licenses that authorize the operation of certain health care facilities or programs in Maryland, such as nursing homes or assisted living programs. The State licensure requirements establish the minimum health and safety requirements to obtain and maintain a license to operate in Maryland.

The Social Security Act mandates the establishment of minimum federal health and safety and Clinical Laboratory Improvement Amendments ("CLIA") standards that must be met by providers and suppliers to participate in the Medicare and Medicaid programs. In this context, providers are patient care institutions, such as hospitals, hospices, nursing homes, and home health agencies. Suppliers are agencies for diagnosis and therapy rather than sustained patient care, such as laboratories and ambulatory surgery centers.

The agreement between the U.S. Department of Health & Human Services ("HHS") and the Maryland Department of Health ("MDH") relates to the provisions of Sections 1864, 1874, and related provisions of the Social Security Act (the "1864 Agreement"). The 1864 Agreement specifies the functions to be performed by Maryland's state survey agency. MDH has designated OHCQ as the state survey agency. In accordance with the 1864 Agreement, OHCQ conducts certification, recertification, and CLIA activities for the purpose of certifying to the HHS Secretary the compliance or non-compliance of providers and suppliers. OHCQ makes recommendations regarding certification of a provider or supplier to CMS. A certified provider or supplier may participate in and seek reimbursement from Medicare and Medicaid for services rendered to beneficiaries.

It is through licensure and certification activities that OHCQ fulfills its mission to protect the health and safety of Marylanders and to ensure that there is public confidence in the health care and community delivery systems. OHCQ's vision is that all those receiving care in Maryland can trust that their health care facility or program is licensed and has met the regulatory standards for the services that they offer.

Licensed and/or Certified Providers

As of July 1, 2023, OHCQ oversees 21,221 providers in 47 industries, an increase of 6.7 percent in the total number of providers overseen by OHCQ since July 1, 2022. The increase in providers occurred primarily in residential service agencies, health care staff agencies, the number of sites serving individuals with developmental disabilities, and clinical laboratories.

Table 1 lists the number of licensees per provider types as of July 1st of 2021, 2022, and 2023.

Table 1: Number of Licensees per Provider Type as of July 1, 2021, 2022, and 2023

Provider Type	Number of Licensees		
	July 1, 2021	July 1, 2022	July 1, 2023
Adult Medical Day Care Centers	122	116	120
Assisted Living Programs	1,672	1,691	1,721
Assisted Living Referrers	41	73	100
Birthing Centers	2	1	0
Cholesterol Testing Sites	0	0	0
Community Mental Health Centers	3	3	3
Comprehensive Outpatient Rehabilitation Facilities	1	1	0
Cosmetic Surgery Facilities	5	5	9
Developmental Disabilities Sites (365 in 2023)	3,008	3,383	3,631
Employer Drug Testing Facilities	250	259	272
Federally Qualified Health Centers	77	77	84
Federally Waived Laboratories	3,894	3,982	4,011
Forensic Laboratories	45	45	46
Forensic Residential Centers	1	1	1
Freestanding Ambulatory Surgical Centers	340	338	360
Freestanding Medical Facilities	5	7	7
Freestanding Renal Dialysis Centers	175	175	170
Health Awareness Testing Sites	60	55	51
Health Care Staff Agencies	593	848	1,179
Health Maintenance Organizations	7	7	7
Home Health Agencies	56	56	56
Hospices	26	26	26
Hospice Houses	16	16	13
Hospitals	63	60	61
Hospital Laboratories	91	99	99
Hospitals within Correctional Facilities	10	10	10
Independent Reference Laboratories	148	165	145
Intermediate Care Facilities for Individuals with Intellectual Disabilities	2	2	2
Limited Hospice Care Programs	1	1	1
Limited Private Inpatient Facilities	7	7	7
Long Term Care Facilities	226	225	225
Major Medical Equipment Providers	201	205	209
Nursing Referral Service Agencies	158	168	243
Outpatient Physical Therapy Providers	67	66	66
Physician Office Laboratories	3,749	3,564	3,675
Point-of-Care Laboratories	1,804	1,766	1,861
Portable X-Ray Providers	10	11	10
Public Health Testing Sites	34	25	28
Rare Disease Testing Laboratories	1	1	1
Residential Service Agencies	1,605	1,874	2,209
Residential Treatment Centers	6	6	6
Rural Health Clinics	1	1	1
Surgical Abortion Facilities	11	11	12
Tissue Banks	438	451	481
Transplant Centers	2	2	2
Total Number of Providers	**19,034**	**19,885**	**21,221**
Percent of Growth of Total Number of Licensed Providers	**7.7%**	**4.5%**	**6.7%**

Surveyor Staffing Analysis

The surveyor staffing analysis in Appendix A calculates the number of surveyors needed in FY 24 to complete the projected number of mandated licensure and certification activities in FY 24. These projections consider historical information as well as anticipated upcoming changes in federal or State oversight of an industry. The activities include the duties performed by surveyors, but not those duties performed by managers and administrative staff.

The number of hours required for each activity is multiplied by the projected number of required activities in FY 24. The total is divided by 1,500, which is the industry standard for the number of hours that the average surveyor spends conducting surveys in a year. The 1,500 hours considers time taken for holidays, vacation, personal days, sick leave, training, meetings, and travel. The number of full-time equivalents of surveyors required for each activity is calculated and then totaled by unit based on its specific mandates. The surveyor staffing deficit (number needed – current positions) for each unit is calculated. The sum of all units' surveyor staffing deficit is OHCQ's surveyor staffing deficit.

Table 2 summarizes the projected surveyor staffing deficit by unit, with an overall deficit of 21 surveyor positions. Appendix A details this analysis by unit, provider type, and activity. Note that this year, certain activities that require less than 0.05 FTE surveyors were combined in other rows.

Table 2: Surveyor Staffing Deficit Projected for FY 24

Unit	Current Number of Surveyor Positions	Number of Surveyor Positions Needed	Surveyor Deficit
Long Term Care	64	75	11
Federal	20	20	0
Assisted Living	34	37	3
Developmental Disabilities	54	59	5
Laboratories	5	7	2
Totals	**177**	**198**	**21**

OHCQ Staffing Plan for FY 18 through FY 24

Through the seven-year staffing plan, the Department continues to make significant progress towards meeting OHCQ's overall staffing needs. The plan includes the need for surveyors, managers, and other positions. The plan considers historical data as well as anticipated changes in federal and State oversight and industry trends. A controlled growth of 5 to 6 percent increase in workforce annually can be accommodated. OHCQ's mandated activities include licensure, certification, and survey activities, including the investigation of complaints and facility-reported incidents. As predicted, compliance with federal and State mandates is progressively improving as additional surveyors are hired and trained. The FY 18 through FY 23 staffing plans were fully implemented.

In FY 24, OHCQ received 10 new merit positions, including 5 nurse surveyors in the long term care unit; 1 nurse surveyor in the assisted living unit; and 2 nurse surveyors, 1 administrative officer surveyor, and 1 coordinator (supervisor) in the developmental disabilities unit. Table 3 provides additional details about the allocation of positions from FY 18 through FY 24.

Table 3: OHCQ Staffing for FY 18 through FY 24

OHCQ Unit	Position	FY 18	FY 19	FY 20	FY 21	FY 22	FY 23	FY 24	Total
Long term care	Coordinator	2	1	1	0	0	0	0	**4**
Long term care	Nurse surveyor	1	4	3	5	1	3	5	**22**
Long term care	Physician surveyor	0	1	0	0	0	0	0	**1**
Long term care	Nurse trainer surveyor	1	0	0	0	0	0	0	**1**
Assisted living	Coordinator	1	0	0	1	0	0	0	**2**
Assisted living	Nurse surveyor	0	2	1	0	2	1	1	**7**
DD	Coordinator	1	1	1	0	1	1	1	**6**
DD	Nurse surveyor	1	2	2	2	0	2	2	**11**
DD	Coordinator special program surveyor	0	1	1	1	0	0	0	**3**
DD	Administrative officer III surveyor	0	0	0	0	4	2	1	**7**
DD	Office secretary II	1	0	0	0	0	0	0	**1**
Federal	Coordinator	1	0	1	0	0	0	0	**2**
Federal	Nurse surveyor	0	0	0	1	1	1	0	**3**
Federal	Triage specialist	0	0	0	0	1	0	0	**1**
Federal	Assistant deputy director	1	0	0	0	0	0	0	**1**
Federal	Health policy analyst	1	0	0	0	0	0	0	**1**
State	Health policy analyst	1	0	0	0	0	0	0	**1**
Positions per fiscal year		**12**	**12**	**10**	**10**	**10**	**10**	**10**	**74**

The Department is developing a long-term staffing plan for OHCQ that will be implemented in FY 25. In conjunction with staffing plans, OHCQ continues to develop and implement initiatives to enhance regulatory efficiency and effectiveness.

Long Term Care Unit

The long term care unit conducts surveys to determine if nursing homes are compliant with federal health and safety standards, certification requirements, State licensure requirements, and local requirements through unannounced on-site surveys, follow-up surveys, complaint investigations, and administrative reviews.

Table 4: Nursing Homes

Units of Measurement	FY21	FY22	FY23
Number of licensed nursing homes	226	225	225
Initial surveys	0	0	0
Annual full surveys	27	28	42
Follow-up surveys (onsite)	33	41	41
Follow-up surveys (offsite)	277	144	54
Complaints and facility reported incidents (FRI)	4,067	4,414	4,692
Complaints and FRI investigations	2,281	1,549	2,855
Life safety code surveys	79	82	132
Resident fund surveys	31	59	64

Assisted Living Unit

The assisted living unit is responsible for the oversight of all assisted living programs in Maryland, including those that participate in the Medicaid waiver program. The unit completes surveys for prelicensure, licensure, inspection of care, change of ownership, change of the level of care, follow-up, and to investigate complaints and facility-reported incidents. Allegations of unlicensed assisted living programs are investigated by this unit. The unit is also responsible for registering assisted living referrers.

The unit oversees adult medical day care centers, including surveys for prelicensure, licensure, biannual, change of ownership, follow-up, and investigates complaints and facility-reported incidents.

Table 5: Assisted Living Programs

Units of Measurement	FY21	FY22	FY23
Number of licensed assisted living programs	1,672	1,691	1,721
Initial surveys	164	102	146
Renewal surveys	817	543	298
Other surveys	100	33	114
Complaints and facility reported incidents (FRI)	1,079	1,010	1,349
Complaints and FRI investigated	1,192	474	661
Investigations of alleged unlicensed programs	116	138	80

Table 6: Assisted Living Referrers

Units of Measurement	FY21	FY22	FY23
Number of referrers	41	73	100
Complaints investigated	0	0	0

Table 7: Adult Medical Day Care Centers

Units of Measurement	FY21	FY22	FY23
Number of licensed adult medical day care centers	122	117	120
Initial surveys	7	13	9
Full surveys	3	55	46
Follow-up surveys	0	5	30
Complaints investigated	10	27	49

Developmental Disabilities Unit

The developmental disabilities unit is the licensing and monitoring agent for the Developmental Disabilities Administration ("DDA"). Through periodic surveys, the unit oversees community-based providers serving individuals with developmental disabilities. The unit completes on-site surveys and administrative reviews of complaints and facility reported incidents.

This unit also licenses health care staff agencies and nurse referral agencies and investigates complaints in these industries.

Table 8: Developmental Disabilities Unit

Units of Measurement	FY21	FY22	FY23
Licensed developmental disability agencies	304	333	365
Number of sites	3,008	3,383	3,631
New agencies	31	26*	58
Initial site surveys	164	349	379
Agencies surveyed	90	112	112
Complaints and FRI	4,253	3,695	4,864
Complaints and FRI, administrative reviews	2,363	3,494	2,919
Complaints and FRI, on-site investigations	1,434	1,353	1,585

*Corrected FY22 number of new agencies from 9 to 26

Table 9: Developmental Disabilities Mortality Unit

Units of Measurement	FY21	FY22	FY23
Developmental disabilities deaths	313	293	254
On-site investigations	102	93	99
Administrative reviews	133	306	197

Table 10: Health Care Staff Agencies

Units of Measurement	FY21	FY22	FY23
Health care staff agencies	593	848	1,179
Initial licensure administrative surveys	94	287	332
Complaint investigations	2	0	4

Table 11: Nursing Referral Service Agencies

Units of Measurement	FY21	FY22	FY23
Nursing referral service agencies	158	168	243
Initial licensure administrative surveys	12	27	55
Complaint investigations	0	0	1

Federal Unit

As applicable to the provider type, under State and/or federal authority the federal unit conducts various types of surveys, investigates complaints and facility-reported incidents, and reviews reports from accreditation organizations. It is responsible for the State licensure and/or federal certification of all non-long term care facilities as well as certain providers under State oversight only.

Table 12: Birthing Centers

Units of Measurement	FY21	FY22	FY23
Licensed birthing centers	2	1	0
Initial surveys	0	0	0
Full surveys	2	1	0
Follow-up surveys	0	0	0
Complaint investigations	0	0	0

Table 13: Community Mental Health Centers

Units of Measurement	FY21	FY22	FY23
Community mental health centers	3	3	3
Complaint investigations	0	0	0

Table 14: Comprehensive Outpatient Rehabilitation Facilities

Units of Measurement	FY21	FY22	FY23
Licensed comprehensive outpatient rehab facilities	1	1	0
Initial surveys	0	0	0
Full surveys	0	0	0
Follow-up surveys	0	0	0
Complaint investigations	0	0	0

Table 15: Cosmetic Surgical Facilities

Units of Measurement	FY21	FY22	FY23
Licensed cosmetic survey facilities	5	7	9
Initial surveys	0	2	2
Full surveys	0	0	0
Follow-up surveys	0	0	0
Complaint investigations	0	0	0

Table 16: Federally Qualified Health Centers

Units of Measurement	FY21	FY22	FY23
Federally qualified health centers	77	77	84
Complaint investigations	0	0	0

Table 17: Forensic Residential Centers

Units of Measurement	FY21	FY22	FY23
Number of licensed forensic residential centers	1	1	1
Renewal surveys	1	1	1
Complaints investigated	11	12	41

Table 18: Freestanding Ambulatory Surgery Centers

Units of Measurement	FY21	FY22	FY23
Licensed freestanding ambulatory surgical centers	340	355	360
Initial surveys	10	28	15
Full surveys	90	97	98
Follow-up surveys	9	12	4
Complaint investigations	9	3	3

Table 19: Freestanding Medical Facilities

Units of Measurement	FY21	FY22	FY23
Licensed freestanding medical facilities	5	7	7
Initial, full and follow-up surveys	0	1	1
Complaints investigated	0	0	1

Table 20: Freestanding Renal Dialysis Centers

Units of Measurement	FY21	FY22	FY23
Licensed freestanding renal dialysis centers	175	175	170
Initial surveys	1	2	0
Full surveys	45	58	28
Follow-up surveys	3	3	16
Complaint investigations	32	36	39

Table 21: Health Maintenance Organizations

Units of Measurement	FY21	FY22	FY23
Health maintenance organizations	7	7	7
Full surveys	0	0	0
Follow-up surveys	0	0	0
Complaint investigations	1	0	0

Table 22: Home Health Agencies

Units of Measurement	FY21	FY22	FY23
Licensed home health agencies	56	56	56
Initial surveys	0	0	0
Full surveys	14	6	8
Follow-up surveys	0	1	0
Complaint investigations	6	3	2

Table 23: Hospices and Hospice Houses

Units of Measurement	FY21	FY22	FY23
Licensed hospices	26	26	26
Initial surveys	0	1	0
Full surveys	2	3	1
Follow-up surveys	1	0	0
Complaint investigations	11	0	2
Licensed hospice houses	16	15	13
Initial surveys	0	0	0
Complaint investigations in hospice houses	0	0	0

Table 24: Hospitals

Units of Measurement	FY21	FY22	FY23
Licensed or certified hospitals	63	60	61
Validation surveys of accredited hospitals	0	0	0
Complaints investigated on-site	44	10	14
Administrative reviews	207	73	121
Follow-up surveys	9	3	5

Table 25: Hospitals within Correctional Facilities

Units of Measurement	FY21	FY22	FY23
Licensed hospitals within correctional facilities	10	10	10
Initial surveys	0	0	0
Full surveys	0	0	6
Complaint investigations	0	0	0

Table 26: Intermediate Care Facilities for Individuals with Intellectual Disabilities

Unit of Measurement	FY21	FY22	FY23
Number of licensed ICF IIDs	2	2	2
Renewal surveys	2	2	1
Follow-up surveys	0	0	0
Complaints and facility reported incidents, investigated	21	27	39

Table 27: Limited Private Inpatient Facilities

Units of Measurement	FY21	FY22	FY23
Licensed limited private inpatient facilities	7	7	7
Initial, full and follow up surveys	7	3	1
Complaint investigations	2	1	1

Table 28: Major Medical Equipment Providers

Units of Measurement	FY21	FY22	FY23
Licensed major medical equipment providers	201	204	209
Initial administrative licensure surveys	0	0	7
Full or follow-up surveys	0	0	0
Complaint investigations	3	0	1

Table 29: Outpatient Physical Therapy Providers

Units of Measurement	FY21	FY22	FY23
Licensed outpatient physical therapy providers	67	67	66
Initial surveys	2	1	0
Full surveys	9	1	0
Follow-up surveys	1	0	0
Complaint investigations	0	0	0

Table 30: Portable X-ray Providers

Units of Measurement	FY21	FY22	FY23
Licensed portable x-ray providers	10	12	10
Initial surveys	0	1	1
Full surveys	1	0	2
Follow-up surveys	0	0	0
Complaint investigations	0	0	0

Table 31: Residential Service Agencies

Units of Measurement	FY21	FY22	FY23
Licensed residential service agencies	1,605	1,874	2,209
Initial licensure administrative surveys	155	105	387
Full surveys	14	0	20
Follow-up surveys	18	17	10
Complaint investigations	99	47	73

Table 32: Residential Treatment Centers

Units of Measurement	FY21	FY22	FY23
Licensed residential treatment centers	6	6	6
Follow-up surveys	0	1	2
Validation surveys, seclusion or restraint investigation	0	0	0
Complaint investigations	7	13	22

Table 33: Rural Health Clinics

Units of Measurement	FY21	FY22	FY23
Licensed rural health clinics	1	1	1
Follow-up surveys	0	0	0
Complaint investigations	0	0	0

Table 34: Surgical Abortion Facilities

Units of Measurement	FY21	FY22	FY23
Licensed surgical abortion facilities	11	11	12
Initial surveys	0	0	1
Renewal surveys	1	4	0
Complaints investigated	2	1	1

Table 35: Transplant Centers

Units of Measurement	FY21	FY22	FY23
Licensed transplant centers	2	2	2
Follow-up surveys	0	0	0
Complaint investigations	0	0	0

Clinical and Forensic Laboratories Unit

The Clinical and Forensic Laboratories Unit is the agent for federal certification in the CLIA program, which is required for all clinical laboratory testing sites. The unit is also responsible for State licensure of all laboratories that perform tests on specimens obtained from Marylanders. The programs include tissue banks, blood banks, hospitals, independent reference, physician office and point-of-care laboratories, public health awareness screening, pre-employment related toxicology testing for controlled dangerous substances, and public health testing programs that offer rapid HIV-1 and rapid Hepatitis C antibody testing to the public. This unit conducts surveys to ensure compliance with applicable federal and State requirements.

This unit also provides oversight for accredited and non-accredited laboratories that perform forensic analyses.

Table 36: Cholesterol Testing Sites

Units of Measurement	FY21	FY22	FY23
Cholesterol testing sites	0	0	0
Initial surveys	0	0	0
Full surveys	0	0	0
Complaint surveys	0	0	0

Table 37: Employer Drug Testing Facilities

Units of Measurement	FY21	FY22	FY23
Employer drug testing facilities	250	259	272
Initial surveys	2	9	13
Full surveys	27	16	38
Follow-up surveys	0	0	0
Complaint surveys	0	0	0

Table 38: Forensic Laboratories

Units of Measurement	FY21	FY22	FY23
Forensic laboratories	45	45	46
Full surveys	15	23	36
Follow-up surveys	0	0	0
Surveillance surveys	0	0	0
Complaint investigations	0	0	0

Table 39: Health Awareness Testing Sites

Units of Measurement	FY21	FY22	FY23
Health awareness test sites	60	55	51
Initial surveys	6	3	9
Full surveys	11	16	31
Follow-up surveys	0	0	1
Site approvals	403	772	868
Complaints surveys	0	0	2

Table 40: Hospital Laboratories

Units of Measurement	FY21	FY22	FY23
Hospital laboratories	91	99	99
Initial surveys	0	0	0
Full surveys	0	0	0
Follow-up surveys	0	0	4
Validation surveys	0	0	4
Complaint surveys	1	0	2

Table 41: Independent Reference Laboratories

Units of Measurement	FY21	FY22	FY23
Independent reference laboratories	148	165	145
Initial surveys	2	5	21
Full surveys	12	50	78
Follow-up surveys	0	0	13
Validation surveys	0	0	5
Complaint surveys	4	0	0

Table 42: Physician Office and Point of Care Laboratories, State Only Surveys

Units of Measurement	FY21	FY22	FY23
Physician office and point of care labs, State only	475	566	597
Initial surveys	12	33	21
Full surveys	87	219	250
Follow-up surveys	0	33	90
Complaint surveys	8	2	4

Table 43: Physician Office and Point of Care Laboratories, Federal CLIA Surveys

Units of Measurement	FY21	FY22	FY23
Physician office, point of care labs, CLIA surveys	475	566	597
Initial surveys	12	33	21
Renewal surveys	72	186	229
Full surveys	84	219	250

Table 44: Public Health Testing Sites

Units of Measurement	FY21	FY22	FY23
Public health testing	34	25	28
Initial surveys	0	0	3
Full surveys	0	0	12
Follow-up surveys	0	0	0
Complaint surveys	0	0	0

Table 45: Rare Disease Testing Laboratories

Units of Measurement	FY21	FY22	FY23
Licensed rare disease testing laboratories	1	1	1
Initial surveys	0	0	0
Complaint surveys	0	0	0

Table 46: Tissue Banks

Units of Measurement	FY21	FY22	FY23
Tissue banks	438	451	481
Initial surveys	2	0	4
Full surveys	0	9	77
Follow-up surveys	0	0	1
Validation surveys	0	0	0
Complaint surveys	0	0	0

Appendix A: OHCQ Projected Surveyor Staffing Analysis for FY 24

Mandates	A. Number of activities required in 2024	B. Hours required per activity	C. Hours required for activities (A x B)	D. # of surveyors required (C/1500)	E. Current # of surveyors	F. # of additional surveyors needed
Long Term Care Unit						
Long Term Care Facilities (Nursing Homes)						
Initial surveys	0	240	0	0.00		
Annual surveys	225	232	52,200	34.80		
CHOW initial surveys	32	240	7,680	5.12		
CHOW follow-up surveys	32	45	1,440	0.96		
Complaint investigations	3,830	10	38,300	25.53		
Follow-up surveys onsite	50	32	1,600	1.07		
Follow-up surveys offsite	72	16	1,152	0.77		
State resident funds surveys, all activities	N/A	N/A	N/A	2.00		
Life safety code surveys, all activities	N/A	N/A	N/A	3.50		
Informal dispute resolutions	50	16	800	0.53		
Testifying in hearings	9	120	1,080	0.72		
Long Term Care Unit				**75.00**	**64**	**11.00**
Assisted Living Unit						
Adult Medical Day Care Centers						
Initial surveys	6	24	144	0.10		
Renewal surveys	74	16	1,184	0.79		
Complaints and facility reported incidents	70	8	560	0.37		
Assisted Living Programs						
Initial surveys	154	40	6,160	4.11		
Annual surveys	1,506	16	24,096	16.06		
Complaints and facility reported incidents	1,146	16	18,336	12.22		
Follow-up surveys	82	16	1,312	0.87		
Informal dispute resolutions	14	16	224	0.15		
Testifying in hearings for unit	5	80	400	0.27		
Investigations of alleged unlicensed programs	96	32	3,072	2.05		
Assisted Living Referrers						
All activities	N/A	N/A	N/A	0.01		
Assisted Living Unit				**37.00**	**34**	**3.00**

Mandates	A. Number of activities required in 2024	B. Hours required per activity	C. Hours required for activities (A x B)	D. # of surveyors required (C/1500)	E. Current # of surveyors	F. # of additional surveyors needed
Developmental Disabilities Unit						
Developmental Disabilities Programs						
Initial site openings	409	6	2,454	1.64		
Annual surveys of providers	365	120	43,800	29.20		
Complaint and FRI, on-site	1,428	16	22,848	15.23		
Complaint and FRI, administrative	2,968	4	11,872	7.91		
Death investigations, on-site	94	28	2,632	1.75		
Death investigations, administrative	173	4	692	0.46		
Children's providers, all activities	N/A	N/A	N/A	2.00		
Informal dispute resolutions	8	12	96	0..06		
Settlements and hearings	5	80	400	0.27		
Health Care Staff Agencies						
Initial licensure administrative surveys	130	4	520	0.35		
Complaint investigations	3	8	24	0.02		
Nurse Referral Agencies						
Initial licensure administrative surveys	40	4	160	0.11		
Complaint investigations	1	8	8	0.01		
Developmental Disabilities Unit				**59.00**	**54**	**5.00**
Federal Unit						
Birthing Centers						
All activities	N/A	N/A	N/A	0.1		
Community Mental Health Centers						
All activities	N/A	N/A	N/A	0.2		
Comprehensive Outpatient Rehabilitation Facilities						
All activities	N/A	N/A	N/A	0.1		
Correctional Health Care Facilities						
All activities	N/A	N/A	N/A	0.30		
Cosmetic Surgery Facilities						
All activities	N/A	N/A	N/A	0.1		
Federally Qualified Health Centers						
Complaint investigations	4	24	96	0.1		

Mandates	A. Number of activities required in 2024	B. Hours required per activity	C. Hours required for activities (A x B)	D. # of surveyors required (C/1500)	E. Current # of surveyors	F. # of additional surveyors needed
Federal Unit						
Forensic Residential Centers						
Annual surveys	1	160	160	0.11		
Complaints and facility reported incidents	32	8	256	0.17		
Freestanding Ambulatory Surgical Centers						
Initial surveys	16	48	768	0.51		
Renewal surveys	90	48	4,320	2.88		
Follow-up surveys	8	16	128	0.09		
Complaint investigations	12	16	192	0.13		
Freestanding Medical Facilities						
All activities	N/A	N/A	N/A	0.10		
Freestanding Renal Dialysis Centers						
Initial surveys	4	48	192	0.13		
Renewal surveys	55	48	2,640	1.76		
Follow-up surveys	10	16	160	0.11		
Complaint investigations	45	16	720	0.48		
Health Maintenance Organizations						
All activities	N/A	N/A	N/A	0.15		
Home Health Agencies						
Initial surveys	1	40	40	0.03		
Renewal surveys	14	40	560	0.37		
Complaint investigations	8	24	192	0.13		
Hospice Care Programs						
Initial surveys	1	40	40	0.03		
Renewal surveys	9	40	360	0.24		
Complaint investigations	10	16	160	0.11		
Hospitals						
Initial surveys	1	210	210	0.14		
Validation surveys	2	210	420	0.28		
Complaint investigations, on-site	70	48	3,360	2.24		
Complaint investigations, administrative	250	6	1,500	1.00		
Follow-up surveys	12	16	192	0.13		
Transplant surveys	2	210	420	0.28		
Mortality review, psychiatric hospitals	36	24	864	0.58		

Mandates	A. Number of activities required in 2024	B. Hours required per activity	C. Hours required for activities (A x B)	D. # of surveyors required (C/1500)	E. Current # of surveyors	F. # of additional surveyors needed
Federal Unit						
Intermediate Care Facilities for Individuals with Intellectual Disabilities						
Annual surveys	2	160	320	0.21		
Complaints and self-reports	60	8	480	0.32		
Limited Private Inpatient Facilities						
All activities	N/A	N/A	N/A	0.15		
Major Medical Equipment Providers						
All activities	N/A	N/A	N/A	0.10		
Outpatient Physical Therapy Providers						
All activities	N/A	N/A	N/A	0.25		
Portable X-ray Providers						
All activities	N/A	N/A	N/A	0.15		
Residential Service Agencies						
Initial on-site surveys	12	32	384	0.26		
Initial administrative surveys	288	4	1,152	0.77		
Follow-up surveys	14	16	224	0.16		
Complaint investigations	170	16	2,720	1.81		
Residential Treatment Centers						
Initial surveys	2	80	160	0.11		
Complaint investigations, on-site	36	32	1,152	0.77		
Complaint investigations, administrative	55	4	220	0.15		
Validation surveys	6	80	480	0.32		
Follow-up surveys	3	16	48	0.03		
Surgical Abortion Facilities						
All activities	N/A	N/A	N/A	0.40		
All provider types in the unit						
Life safety code activities	N/A	N/A	N/A	0.50		
Informal dispute resolutions and hearings	N/A	N/A	N/A	0.50		
Federal Unit				**20.00**	**20**	**0.00**

Mandates	A. Number of activities required in 2024	B. Hours required per activity	C. Hours required for activities (A x B)	D. # of surveyors required (C/1500)	E. Current # of surveyors	F. # of additional surveyors needed
Clinical and Forensic Laboratories Unit						
Cholesterol Testing Sites						
Cholesterol testing	0	4	0	0.00		
Employer Drug Testing Facilities						
Initial surveys	8	8	64	0.04		
Full surveys	125	8	1,000	0.67		
Forensic Laboratories						
Initial surveys	1	40	40	0.03		
Renewal surveys	23	40	920	0.61		
Complaints and self-reports	3	24	72	0.05		
Health Awareness Testing Sites						
Health awareness testing surveys	55	8	440	0.29		
Health awareness site approval	1,750	0.5	875	0.58		
Full surveys	50	8	400	0.27		
Hospital Laboratories						
Initial surveys	1	40	40	0.03		
Independent Reference Laboratories						
Initial surveys	6	8	48	0.03		
Full surveys	34	8	272	0.18		
Physician Offices and Point-of-Care Laboratories						
Initial surveys	20	6	120	0.08		
Full surveys	130	6	780	0.52		
Follow-up surveys	95	4	380	0.25		
Validation surveys	6	16	96	0.06		
Public Health Testing Sites						
Full surveys	25	6	150	0.10		
Tissue Banks						
Initial surveys	6	8	48	0.03		
Full surveys	178	8	1,424	0.95		
Forensic Genetic Genealogical Laboratories						
All activities	N/A	N/A	N/A	2		
Clinical and Forensic Laboratories				**7.00**	**5.00**	**2.00**
All units				**198.00**	**177**	**21.00**

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND
NORTHERN DIVISION

IRENE CONNOR, MICHAEL NEVIN, ALEX NOONAN, HERMAN DRESSEL, and ELEANOR HOLLMAN on behalf of RICHARD HOLLMAN, for themselves and those similarly situated, Plaintiffs, v. MARYLAND DEPARTMENT OF HEALTH, and SECRETARY LAURA HERRERA SCOTT, in her official Capacity as Secretary of Maryland Department of Health, Defendants.	**Civil Action No. ___** **CLASS ACTION COMPLAINT** **REDACTED VERSION PUBLIC**

I. INTRODUCTION

1. Plaintiffs,[1] and the class they seek to represent, are nursing facility residents with mobility impairments living in Medicaid- and Medicare-participating facilities ("Plaintiffs"). Plaintiffs surrendered life in their community in favor of placement in an institutional care setting to ensure that they receive the

[1] Plaintiffs are concurrently filing a Motion to File under Seal and Proceed under Pseudonyms, due to the sensitive and highly personal nature of the details in this complaint, and concerns of retaliation for filing this suit from the nursing facilities in which they reside. The Memorandum of Law filed in support of that motion explains these reasons more fully. The publicly filed case caption states their pseudonyms.

round-the-clock medical care and assistance with toileting, hygiene, mobility, and other activities of daily living that they need to maintain their health, safety, and dignity. The Maryland Department of Health (MDH) is the government entity charged with regularly entering Maryland's nursing facilities to assess their operations and to ensure compliance with federal and state quality of care standards. Despite the importance of its oversight responsibilities, MDH has allowed more than 100 nursing facilities to go four years without an annual inspection (known as a "survey"),[2] with many more facilities overdue for an annual survey, and has allowed a backlog of thousands of uninvestigated complaints[3] from nursing facility residents to pile up. When MDH fails to carry out its oversight responsibilities, dangerously poor-quality care within nursing facilities goes undetected and uncorrected.

2. For years, MDH has failed to conduct statutorily-mandated annual surveys or act on Plaintiffs' complaints within statutorily-prescribed time frames. As a result, Maryland's nursing facilities have not been held accountable when

[2] "Annual survey," as used in this case, is intended to include the full process of inspection, identification of deficiencies, and resolution of any deficiencies found in a given nursing facility, pursuant to 42 U.S.C. § 1396r(g)(1)(A), (h).
[3] "Complaint investigation," as used in this case, is intended to include the full process of investigation, identification of deficiencies, and resolution of any deficiencies related to the complaint, pursuant to 42 U.S.C. § 1396r(g)(4), § 1396r(h).

they fail to meet mandated federal and state standards related to resident rights, quality of care, and staffing. Because of Plaintiffs' mobility impairments, this lack of accountability leaves Plaintiffs in situations where they are vulnerable to neglect and mistreatment, which lead to pressure ulcers, falls, and unnecessary seclusion. Plaintiffs have suffered and continue to suffer personal degradation and significant physical and psychosocial harm as a result of Defendants' failures.

3. MDH operates its mandated program of nursing facility oversight and enforcement to ensure that covered nursing facilities recognize and honor the rights of residents. 42 U.S.C. § 1396r(g); Md. Code Ann., Health – Gen. § 19-1408. Through this oversight role, MDH acts as the State's designated eyes and ears to assess quality of care in nursing facilities. MDH's program of annual surveys and complaint investigations in nursing facilities, related plans of correction to cure any deficiencies, and enforcement through appropriate remedial action are designed to ensure that conditions violative of residents' rights are effectively addressed.

4. MDH's performance in timely completing annual surveys is among the worst among the states. Its failure has left the residents of a vast majority of the state's nursing facilities without the benefit of annual surveys designed to protect their rights.

5. Similarly, MDH has failed to investigate Plaintiffs' complaints within mandated time frames. Many serious complaints alleging harm go uninvestigated for months or years, leaving the residents across nursing facilities without an independent governmental review of allegations related to neglect and other violations of resident rights.

6. Plaintiffs do not receive the benefit of state oversight when the survey and complaint investigation processes and corrective action process called for in federal and state law do not occur, leaving nursing facilities to violate Plaintiffs' rights with impunity.

7. Plaintiffs are uniquely impacted by this vicious cycle. Due to their mobility impairments, Plaintiffs rely to a greater extent than other residents on the nursing facility to provide essential care. For example, Plaintiffs must rely on nursing staff assistance on a daily basis to leave their rooms and interact with others, to take a shower, for toileting and incontinence care, to receive needed pain medicine, and even to have a drink of water. Where that care is lacking, Plaintiffs experience higher levels of harm, including skin problems such as skin breakdown and pressure sores, falls, and seclusion relative to residents without mobility impairments. They experience personal loss of dignity when their hygiene and incontinence needs are not met by the nursing facility.

8. The heightened nature of Plaintiffs' care needs stem from their mobility impairments and result in increased demand for the time of facility staff. When the facility is short-staffed, Plaintiffs are uniquely vulnerable to neglect when those care needs are not met.

9. Many of Maryland's nursing facilities have a record of repeated poor performance over numerous review cycles. This is particularly true of nursing facilities located in Black communities.

10. MDH's methods of administering its nursing facility oversight program deny Plaintiffs meaningful enforcement of their federal rights delineated in the Nursing Home Reform Act (NHRA), 42 U.S.C. § 1396r(g)(1)(A), and their state rights found in the Resident Bill of Rights Act, Md. Code Ann., Health – Gen., § 19-343, because of their disability. MDH's disability discrimination results in a failure to detect and address violations within nursing facilities, and as a result Plaintiffs suffer unique and unaddressed harm due to the nature of their disability. As such, MDH's administration of the program defeats the purpose of or substantially impairs the accomplishment of nursing facility oversight and enforcement of federal and state protections for Plaintiffs.

II. JURISDICTION AND VENUE

11. This action is brought pursuant to Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. § 12132, and Section 504 of the Rehabilitation

Act (Section 504), 29 U.S.C. § 794. Defendants are public entities subject to Title II of the ADA. Defendants are recipients of federal financial assistance subject to Section 504. This Court has jurisdiction over the claims under the ADA pursuant to 28 U.S.C. § 1331, 42 U.S.C. § 12133, and 29 U.S.C. § 794a.

12. Injunctive relief is authorized by 28 U.S.C. § 2202, 42 U.S.C. § 1983, and Federal Rule of Civil Procedure 65.

13. Venue is proper in the District of Maryland pursuant to 28 U.S.C. § 1391(b).

III. PARTIES

a. Individually Named Plaintiffs

14. Plaintiff Irene Connor is a fifty-four-year-old Black woman with a disability involving mobility impairment, who resides in a Medicaid- and Medicare-participating nursing facility licensed by MDH. The nursing facility is located at [redacted].

15. Plaintiff Michael Nevin is a sixty-one-year-old Black man with a disability involving mobility impairment, who resides in a Medicaid- and Medicare-participating nursing facility licensed by MDH. The nursing facility is located at [redacted].

16. Plaintiff Alex Noonan is an eighty-five-year-old white man with a disability involving mobility impairment, who resides in a Medicare- and Medicaid-participating nursing facility licensed by MDH. The nursing facility is located at [redacted].

17. Plaintiff Herman Dressel is a seventy-five-year-old white man with a disability involving mobility impairment, who resides in a Medicaid- and Medicare-participating nursing facility licensed by MDH. The nursing facility at [redacted].

18. Plaintiff Richard Hollman is a fifty-seven-year-old white man with a disability involving mobility impairment, who resides in a Medicaid- and Medicare-participating nursing facility licensed by MDH. The nursing facility is located at [redacted].

b. Defendants

19. Defendant MDH is a recipient of federal financial assistance that is responsible for ensuring that annual survey and complaint investigation activities are conducted pursuant to state and federal law.

20. Defendant Laura Herrera Scott, in her official capacity as Secretary of the Maryland Department of Health, is responsible for the administration of MDH's program of nursing facility oversight and enforcement.

IV. STATUTORY FRAMEWORK

a. MDH's Duty to Enforce the Rights of Residents under Federal and State Law

i. Federal Law

21. MDH is the designated state survey agency charged with specific oversight and enforcement functions of the NHRA, including annual surveys and complaint investigations. 42 U.S.C. § 1395aa(a); 42 C.F.R. § 488.11.

22. MDH is required by federal law to conduct an annual survey of each Medicaid- and Medicare-participating nursing facility in Maryland to certify each facility's compliance with federal standards, including standards related to resident rights, quality of care, and minimum staffing standards. 42 U.S.C. § 1396r(g)(1)(A) (referencing 42 U.S.C. § 1396r(b), (c), and (d)).

23. Federal law requires also MDH to investigate complaints relating to nursing facility services. 42 U.S.C. § 1396r(g)(1)(C), (g)(4).

24. The central purpose of the federal annual surveys and complaint investigation requirements is to "improve the quality of care for Medicaid-eligible nursing home residents, and either to bring substandard facilities into compliance with Medicaid quality of care requirements or to exclude them from the program." Staff of Subcomm. on Health and the Env't of the H.R. Comm. on Energy and Com., 100th Cong., 1st Sess., Rep. on Medicare and Medicaid Health Budget Reconciliation Amendments of 1987, 77 (Comm. Print 1987).

25. The focus of these federal protections is to ensure that residents receive quality care: "The purpose of the unannounced 'annual' standard survey is not to determine whether every nursing facility is in compliance with every requirement of participation. Instead, its purpose is to detect facilities where residents are not receiving quality care." *Id* at 93. This focus on ensuring that nursing facilities meet the needs of residents became part of the implementing regulations. "The survey process uses resident and patient outcomes as the primary means to establish . . . compliance . . . . Specifically, surveyors will directly observe the actual provision of care and services to residents . . . , and the effects of that care, to assess whether the care provided meets the needs of the individual residents . . . ." 42 C.F.R. § 488.26(c)(2).

26. There are three objectives for the complaint investigatory process. The first is protective oversight to identify and respond to allegations that appear to pose the greatest potential for harming residents. The second is prevention in cases where serious harm has not been alleged, to identify and correct less serious complaints and prevent escalation of those problems and potential for future harm. The third is promotion of efficiency and quality within the health care delivery system. Center for Medicare and Medicaid Services (CMS), Ch. 5 - Complaint Procedures, State Operations Manual (SOM) 6 (Rev. 212, Feb. 10, 2023) [hereinafter SOM, Ch. 5].

27. Complaints are triaged as "Immediate Jeopardy" when they allege that the facility has failed to meet one or more federal health, safety, and/or quality regulations; and where as a result, serious injury, serious harm, serious impairment, or death has occurred, is occurring, or is likely to occur to one or more identified residents-at-risk; and where there is a need for immediate corrective action to prevent such harms from occurring or recurring. *Id.* at 15. Under federal guidance, MDH is required to initiate an onsite investigation of a complaint alleging Immediate Jeopardy within three business days. *Id.* at 23.

28. Complaints alleging a provider's noncompliance that "may have caused harm that negatively impacts [a resident]'s mental, physical and/or psychosocial status and are of such consequence to the [resident]'s well-being that a rapid response by the SA [survey agency] is indicated" are triaged as "Non-Immediate Jeopardy – High" or "high priority." *Id.* at 17. For such high priority complaints, MDH "must initiate an onsite survey within an annual average of 15 business days of receipt of the initial report, not to exceed 18 business days." *Id.*

29. The facts available when the complaint is triaged by MDH determine whether a complaint alleging harm is characterized as Immediate Jeopardy or high priority. Where there continues to be an immediate risk of serious harm or death, the complaint should be triaged as Immediate Jeopardy, and an investigation must be initiated within three business days. Where there is no longer on-going risk of

further harm necessitating immediate action, the complaint is to be identified as high priority and must be investigated within fifteen days under federal law.

30. Federal law requires MDH to establish procedures and maintain adequate staff to investigate complaints of violations. 42 C.F.R. § 488.332(a)(1). Further, MDH must review all allegations of resident neglect and abuse or misappropriation of resident property and follow procedures specified in 42 C.F.R. § 488.332. 42 C.F.R. § 488.335(a)(3); *see also* SOM, Ch. 5, at 7. While federal law provides the "maximum time frames" to investigate complaints from nursing facility residents, when a state's "time frames for the investigation of a complaint/incident are more stringent than the Federal time frames, the intake is prioritized using the State's timeframes [sic]." SOM, Ch. 5, at 7.

ii. State Law

31. In addition to federal law requirements, Maryland state law also requires oversight of all licensed nursing facilities, including annual surveys and complaint investigations.

32. Maryland law requires MDH to conduct a full survey of each licensed nursing facility at least once per calendar year. Md. Code Ann., Health – Gen. § 19-1408(a)(1).

33. MDH is also charged with conducting investigations stemming from nursing facility complaints. Md. Code Ann., Health – Gen. § 19-1408(b).

34. Under state law, MDH has specific time frames within which it must initiate an on-site investigation, depending on the severity of the allegations in the complaint. For the most serious allegations involving immediate jeopardy to a resident, MDH must initiate its investigation within 48 hours of receipt of the complaint, but must make "every effort" to investigate within 24 hours of receipt. Md. Code Ann., Health – Gen. § 19-1408(b)(2)(i), (ii).

35. Maryland law further requires that complaints which allege that a resident experienced actual harm that do not involve immediate jeopardy concerns, MDH "shall initiate an investigation . . . within 10 business days after receiving the complaint." Md. Code Ann., Health – Gen. § 19-1408(b)(1).

36. When MDH determines that the nursing facility has failed to ensure that resident rights are protected or that it has failed to meet quality care standards, among other potential failures, it cites the nursing facility with a deficiency. When citing a deficiency, MDH determines whether a resident experienced harm (the level of severity), as well as the number of residents impacted or potentially impacted (the scope).

37. MDH has many tools available under state and federal law to remedy deficiencies and enforce resident rights. Nursing facilities can face the potential loss of Medicaid funds during the period that they are out of compliance. 42 U.S.C. § 1396r(h)(1). Depending on the seriousness of the deficiencies, nursing facilities

also can be subject to Sanction or Corrective Enforcement Actions, including fines, installation of temporary outside management for the facility, state monitoring, transfer of residents, a directed plan of correction, termination of the facility's provider agreement, and closure of the facility. 42 U.S.C. § 1396r(h)(2); 42 C.F.R. § 488.406; Md. Code Ann., Health – Gen. § 19-1402(a).

38. The annual surveys form one of the three foundations for assessing a nursing facility's performance rating, ranging from one (1) to five (5) stars, which are posted publicly and on the CMS Care Compare website. Centers for Medicare & Medicaid Services, Design for *Care Compare* Nursing Home Five-Star Quality Rating System: Technical Users' Guide 1 (Apr. 2024) [hereinafter Five-Star Rating Guide]; 42 U.S.C. § 1396r(g)(5)(A), (i)(1)(A)(ii).

39. Each facility's star-rating is based on facility-reported information on quality, on staffing data based on payroll reporting, and on the results of the facility's annual survey, with the results from the annual survey weighted the most heavily. Five-Star Rating Guide at 1.

40. The star rating is intended to be a resource to the public in deciding where to receive long-term care for themselves or their family members. *Id.*

b. <u>MDH's Oversight and Enforcement Activities Must Be in Compliance with the ADA and Section 504</u>

41. Title II of the ADA prohibits discrimination against people with disabilities, stating that "no qualified individual with a disability shall, by reason of

such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such public entity." 42 U.S.C. § 12132.

42. Section 504 of the Rehabilitation Act prohibits discrimination on the basis of disability by recipients of federal financial assistance, stating "[n]o otherwise qualified individual with a disability . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity." 29 U.S.C. § 794(a).

43. Courts have recognized that protections afforded disabled people under the ADA and Section 504 mirror one another. Legal claims brought under both the ADA and Section 504 based upon the same set of facts are generally considered in tandem.

44. The ADA and Section 504 prohibit programs from discriminating against individuals with disabilities, and similarly prohibit discrimination against classes of individuals with disabilities, with respect to the opportunity to access the full range of benefits or services provided by the program. *See* 28 C.F.R. § 35.130(b); 45 C.F.R. § 84.4(b).

45. Congress's express purpose in enacting the ADA was "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities," 42 U.S.C. § 12101(b)(1), including

discrimination related to institutionalization and discrimination in health services, 42 U.S.C. § 12101(a)(3). Congress found that discrimination against individuals with disabilities includes the failure to make modifications to existing facilities and practices, and relegation to lesser services and programs. 42 U.S.C. § 12101(a)(5).

46. Both the ADA's implementing regulations and Section 504's implementing regulations prohibit discriminatory methods of administering public programs. Specifically, a "public entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration: . . . (ii) That have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities." 28 C.F.R. § 35.130(b)(3)(ii); *see also id.* § 35.130(b)(3)(i); 45 C.F.R. § 84.4(b)(4).

47. MDH's duties under the ADA are proactive. State programs and those that receive federal financial assistance must not only remedy discrimination once it has occurred; they also have an affirmative duty to modify "policies, practices, or procedures" to "avoid discrimination on the basis of disability." 28 C.F.R. § 35.130(b)(7); *see also* 45 C.F.R. § 84.4(a).

V. STATEMENT OF FACTS

a. Overview of Maryland's Nursing Facility Population

48. Maryland has 225 licensed nursing facilities that participate in Medicaid or Medicare. MDH is charged with certifying annually that each of these facilities is in compliance with federal requirements and therefore eligible to participate in the Medicaid and Medicare programs.

49. Nursing facilities in Maryland provide care to residents requiring "maximal nursing care." Md. Code Ann. Health – Gen. § 19-1401(e).

50. According to CMS data, there are at least 9,056 people with mobility impairment residing in nursing facilities in Maryland. *See* CMS, *Minimum Data Set Frequency, Q1 2024*, Data.CMS.gov, https://data.cms.gov/quality-of-care/minimum-data-set-frequency/data (last visited May 13, 2024) (the number of persons requiring "Extensive assistance" or "Total dependence" for MDS Item Question/Description "G0110B1: Functional Status - Activities of Daily Living (ADL) Assistance - Transfer - Self Performance"). Many Maryland nursing facility residents with mobility limitations need assistance with numerous care tasks: 86% require help from one or more staff members to get into or out of bed, 54% require the help of another to eat a meal, and 94% require help from one or more staff members to toilet. *Id.* These care needs reflect the heightened reliance that Plaintiffs have on staff assistance.

51. In fiscal year 2022, there were 51,656 residents in nursing facilities in Maryland; statewide, 35.7% of them were identified as Black residents. Center for Quality Measurement and Reporting, Maryland Health Care Commission, Nursing Home Utilization 2022, at 2 (Feb. 2023), https://mhcc.maryland.gov/mhcc/pages/apcd/apcd_quality/documents/CQM_LTC_NH_CY2021_Utilization_TABLES_20230228.pdf (last visited May 13, 2024).

52. The percentage of Black residents varies by county or region. In Baltimore City, 62.9% of nursing facility residents are Black. *Id.* at 2. Meanwhile, Baltimore City has just six nursing facilities that provide care to ventilator-dependent people. *Maryland Quality Reporting: Nursing Homes*, Maryland Health Care Commission, https://healthcarequality.mhcc.maryland.gov/NursingHome/List?searchBy=name&sCol=name&sDir=ASC&countyCode=510&hasVentilatorSvc=true (last visited May 14, 2024). All of these facilities have majority Black resident populations and are low-performing 1- or 2-star facilities.

53. Many 1- and 2-star facilities have a poor record of ensuring residents receive care in accord with their federal and state rights, and Black nursing facility residents are often in 1- or 2-star facilities.

b. MDH Has Not Conducted Annual Surveys in a Vast Majority of Nursing Facilities

54. According to CMS data, MDH has not completed an annual survey in 181 of Maryland's 225 licensed nursing facilities in the last sixteen (16) months. These uninspected facilities account for 81.5% of nursing facilities in Maryland. *See Overdue Recertification Surveys Report*, Quality, Certification and Oversight Reports (QCOR), Centers for Medicare and Medicaid Services, https://qcor.cms.gov/main.jsp (last visited May 13, 2024).

55. Maryland is one of only four states in the country that have failed to conduct annual surveys in over 70% of their nursing facilities; in this regard, only one other state (Kentucky) is more delinquent than Maryland. *Id.*

56. Many facilities have not had an annual certification survey for years. As of May 13, 2024, over 100 nursing facilities have not been surveyed by MDH during the past four years. *Id*.

57. MDH's failure to conduct annual surveys is concerning where facilities with a prior history of numerous deficiencies, a history of resident abuse and neglect, patterns of failures to provide residents with quality care, and violations of residents' rights are not regularly monitored. Without annual surveys, any new rights violations in these troubled facilities may never come to MDH's attention, unless a complaint is made.

c. Plaintiffs' Complaints Are Uninvestigated and Unaddressed

58. MDH has a backlog of complaints that have not been investigated. Over the past three fiscal years, MDH reported approximately 13,173 complaints and facility-reported incidents, including serious allegations of harm to residents, of which fewer than half have been investigated. Maryland Department of Health Office of Health Care Quality, Annual Report and Staffing Analysis Fiscal Year 2023, at 9 (2024).

59. Rather than following state and federal maximum time frames for initiating a complaint investigation, MDH regularly allows all but those complaints triaged as immediate jeopardy to await investigation until the facility's next annual survey. This results in nursing facility residents waiting months, or even years, for their complaints that they were harmed by abuse, neglect, poor-quality care, or rights violations, to be investigated.

60. Plaintiffs are harmed by these delayed complaint investigations. Delays between the incident and the investigation often result in a finding of no violations and no citations due only to difficulties locating documents, staff turnover, or the subsequent discharge or death of the resident.

d. MDH Surveys Are Designed to Address Violations of Plaintiffs' Rights

61. When MDH surveyors conduct their annual reviews, they look at resident rights, quality of life, medication management, skin care, the resident assessments, and other compliance areas.

62. In doing so, MDH can identify rights violations including, but not limited to, the failure to treat residents with respect and dignity (28 C.F.R. § 483.10; Md. Code Ann., Health – Gen. § 19-343(b)(2)(i)), insufficient nursing staff (28 C.F.R. § 483.35; COMAR 10.07.02.19), physical, sexual, and verbal abuse (28 C.F.R. § 483.12; Md. Code Ann., Health – Gen. § 19-343(b)(2)(iv)), failure to provide care pursuant to the plan of care (28 C.F.R. 483.10(c)(2)(vi); Md. Code Ann., Health – Gen. § 19-343(b)(2)(ii)), and failure to provide assistance completing activities of daily living, such as bathing, toileting, transferring, and ambulation (28 C.F.R. § 483.24; Md. Code Ann., Health – Gen. § 19-343(b)(2)(ii)).

63. Plaintiffs' mobility impairment can impact their ability to move from a lying position or turn from side to side in bed. Their Plans of Care regularly require periodic repositioning, assistance with getting into or out of their bed, and help using the bathroom or attending to incontinence care. Plans of Care also address any assistance needed in leaving their room to socialize and engage with the community in or outside the facility.

64. Plaintiffs' reliance on facility staff to meet daily care needs leaves them feeling uniquely vulnerable to retaliation for grievances and complaints. MDH surveyors are charged with ensuring that nursing facilities "tak[e] immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated." 42 C.F.R. § 483.10(j)(4)(iii).

e. MDH Fails to Ensure Plaintiffs' Rights Are Honored

65. The nursing facilities where the Named Plaintiffs reside have failed to protect their rights or ensure the implementation of their Plans of Care.

66. Had MDH complied with its oversight obligations through annual inspections and timely complaint investigations, it would have reviewed records, met with personnel, and spoken with residents. The failure to engage in this process means that MDH is unaware of these violations in facilities. The discovery of such violations would mandate MDH's implementation of corrective action, including the implementation and enforcement of a facility plan of correction.

Irene Connor

67. Ms. Connor is a fifty-four-year-old Black woman who is diagnosed with a wedge compression of her first lumbar vertebra and muscular dystrophy. She relies upon a wheelchair for mobility. She also has diagnoses of acute and chronic respiratory failure, dysphagia, generalized anxiety disorder, post-traumatic

stress disorder, and asthma. She depends upon a ventilator for respiration for a portion of the day and has a tracheostomy.

68. Ms. Connor resides in a nursing facility located in [redacted].

69. Ms. Connor is a mother to two adult children, including a developmentally disabled son. Ms. Connor acted as her son's primary caregiver until she was no longer able due to her disabilities.

70. Before her disability, Ms. Connor worked as a nursing assistant in a nursing facility before earning a college degree in chemical dependence with a concentration in drug and alcohol counseling. Ms. Connor worked as a drug and alcohol counselor until she became too disabled to work in 2013 due to muscular dystrophy.

71. While Ms. Connor's disabilities prevent her from working, she has continued to serve nursing facility residents and use her education and experience as a volunteer. In 2014, Ms. Connor began volunteering to assist nursing facility residents to return to the community. In 2015, Ms. Connor began volunteering with an organization which assists nursing facility residents to return to the community.

72. Born and raised in [redacted], Ms. Connor thrived on community and family life prior to entering the nursing facility. She attended church, the movies, and events at her local community center, such as comedy shows. Ms. Connor spent time with family at gatherings large and small.

73. Ms. Connor entered the nursing facility on January 4, 2023, for rehabilitation following a fall in her apartment. Ms. Connor hopes to discharge from the nursing facility into a subsidized apartment.

74. Defendant MDH last conducted an annual survey at the nursing facility on August 8, 2022.

75. Ms. Connor is unable to meet her own basic care needs due to her disability and mobility impairment. She is incontinent of bladder and bowel. She relies upon facility staff to transfer her into and out of bed, to assist her with tracheostomy care, to assist her to reposition in bed to prevent pressure ulcers and maintain skin integrity, as outlined in her Plan of Care.

76. The nursing facility often fails to meet Ms. Connor's documented care needs, increasing her risk of developing pressure ulcers, complications related to her ventilator and tracheostomy, and falls.

77. Ms. Connor has waited hours for the facility to provide her with incontinence care. When facility staff do not change Ms. Connor's incontinence briefs, she experiences a loss of dignity and humiliation. She has at times been provided with a fresh incontinence brief placed over the soiled one.

78. Due to her mobility impairment, Ms. Connor relies on the facility to respond to a call bell to assist her with transferring out of her bed into a wheelchair, attending to her incontinence and respiratory needs, and other daily

care tasks. Ms. Connor often waits from thirty minutes to two hours for staff to respond to her call bell. For the past several months, the facility has failed to keep Ms. Connor's call bell in working order.

79. The nursing facility is often without hot water. On or around September 26, 2023, Ms. Connor filed a complaint with MDH after the facility failed to provide hot water, because all personal care or cleaning of the environment was being done with cold water.

80. MDH has not yet investigated Ms. Connor's September 26, 2023, complaint, and the facility's problems maintaining adequate hot water continue.

Michael Nevin

81. Mr. Nevin is a sixty-one-year-old Black man who is diagnosed with quadriplegia following a cerebral infarction, epilepsy, diabetes, anxiety disorder, major depressive disorder, obstructive sleep apnea, generalized muscular weakness, rosacea, gastro-esophageal reflux disease, high blood pressure, and cataracts, among other conditions.

82. Mr. Nevin was admitted to the nursing facility located in [redacted], on December 14, 2012. He has resided there ever since.

83. MDH last conducted an annual survey of the facility on November 20, 2020.

84. Before entering the nursing facility, Mr. Nevin worked as a journalist and in technology. He attended his church and enjoyed visiting with loved ones while participating in family gatherings.

85. Mr. Nevin struggles to maintain his social network and relationships while living in the facility due to a lack of privacy for verbal and video conversations, and due to the facility's failure to provide Mr. Nevin with the support he needs to attend events in the community.

86. The nursing facility similarly fails to provide Mr. Nevin the support he needs to create new social relationships. The nursing facility does not provide staff to assist Mr. Nevin to go to common areas of the facility to interact with other residents.

87. Mr. Nevin is unable to meet his own basic care needs due to his disability and mobility impairment. Mr. Nevin relies on the facility to assist him with bathing, dressing, personal hygiene, medication management, repositioning in bed, transitioning into and out of bed, and for general mobility, as outlined in his Plan of Care.

88. Mr. Nevin has been unnecessarily secluded in his room, away from everyone other than his roommate, against his wishes and without medical justification. For more than a year, the facility has failed to provide him with the transition and mobility assistance required by his Plan of Care. It has failed to

provide him with a wheelchair so that he can transition out of his bed and engage with other residents or leave the facility. It has denied his requests for using the facility's Geri-chair to leave his room.

89. As a result, he has been confined to his bed in his shared room in the nursing facility since March 2023, with the exception of some medical appointments.

90. The nursing facility's failure to provide Mr. Nevin with transfer and mobility assistance has kept him from important family events and meaningful community activities. For example, Mr. Nevin was recently honored by a leading long-term care advocacy organization with its Leadership Award for his advocacy on behalf of his fellow nursing facility residents. Mr. Nevin secured transportation to take him to the award ceremony, but he was unable to attend because the facility did not provide him with a wheelchair.

91. The nursing facility assigned Mr. Nevin a roommate with apparent cognitive disorder who was physically aggressive with other residents. Because of his disability, Mr. Nevin is unable to defend himself against any assault and was traumatized by having an aggressive roommate in his room.

92. While missing out on social and community events and relationships due to the facility's failure to provide him with transfer and mobility assistance,

Mr. Nevin is confined to his bed, unable to leave the facility to breathe fresh air and feel sunlight.

93. Mr. Nevin is considered at risk for falling, and he has experienced several falls at the nursing facility.

94. Due to his immobility and to reduce his fall risk, Mr. Nevin's Plan of Care requires that staff anticipate his care needs and respond promptly to his requests for assistance, including incontinence care, and that his call bell be kept reachable and in working order.

95. The nursing facility frequently fails to provide "prompt response to all requests for assistance," including incontinence care. Mr. Nevin often goes an entire eight (8) hour shift or longer without incontinence care.

96. At any given time, particularly during night shifts and on weekends, a single staff member is often responsible for the care of many residents. Mr. Nevin often waits an hour or more for a response to his call bell during these shifts.

97. Mr. Nevin filed a complaint with MDH on April 30, 2024, regarding lack of notice as to roommate changes and failure to accommodate his technology-dependent communication needs, specifically the lack of privacy required by that means of communication. He also noted the prolonged denial of sunlight he has experienced because the privacy curtain is continuously closed across the window

in his room and he cannot independently adjust it. Mr. Nevin's complaint has not yet been investigated.

98. Based on his experience, Mr. Nevin is very afraid that if he were to have another stroke or medical emergency, staff would not respond to his call bell in time to provide him with life-sustaining care.

Alex Noonan

99. Mr. Noonan is an eight-five year old Navy veteran who is diagnosed with Parkinson's disease, anxiety disorder, major depressive disorder, claustrophobia, post-traumatic stress disorder, a spine condition, mild cognitive impairment, osteoporosis, vision impairment, and muscle wasting/atrophy, among other conditions.

100. Before his retirement, Mr. Noonan worked for a municipal finance department for 35 years. A lifelong athlete, Mr. Noonan loved to run cross-country and exercise. Even into his 80s, Mr. Noonan maintained a strict daily regimen of pushups and calisthenics to maintain his strength and physical conditioning.

101. Following a surgery in 2020, Mr. Noonan was admitted for rehabilitation to the nursing facility in [redacted]. He has resided there since March 21, 2020.

102. Defendant MDH last conducted an annual survey at the nursing facility on June 30, 2021.

103. Mr. Noonan is unable to meet his own basic care needs due to his disability and mobility impairment. He relies upon the nursing facility to help him transfer into and out of bed; reposition in bed to prevent pressure ulcers and provide him with incontinence care at least every two hours (as he cannot walk to the toilet), to maintain his skin integrity and prevent infection; and assist him with mobility, personal hygiene, support for socialization, nutrition, and medication administration, as outlined in his Plan of Care.

104. Mr. Noonan is unable to walk on his own. He uses a wheelchair and relies on staff to navigate the wheelchair.

105. Mr. Noonan is reliant on the facility to safely transfer into and out of bed. According to his Plan of Care, two staff are required to use a mechanical lift in order to safely transfer him into and out of bed.

106. Mr. Noonan has frequently been told by nursing facility staff that there was insufficient staff available to help him transfer out of his bed and into the common areas of the facility. Many days, Mr. Noonan does not leave his bed at all. He rarely leaves his room. When Mr. Noonan is transferred out of bed, the nursing facility often fails to provide two staff to transfer him, instead subjecting him to a one-person transfer.

107. Because Mr. Noonan rarely leaves his bed and even more rarely leaves his room, Mr. Noonan is seldom able to breathe fresh air and feel sunlight.

108. Mr. Noonan is unnecessarily secluded in his room when staff fail to transfer him out of his bed.

109. Mr. Noonan's personal hygiene and appearance are very important to him, especially his hair, which he keeps long. Mr. Noonan's Plan of Care requires that he be "clean, well-groomed and appropriately dressed daily with staff assistance." However, the nursing facility often fails to provide Mr. Noonan with this required care.

110. Mr. Noonan's Plan of Care requires staff to offer him a shower no fewer than twice per week. Despite this requirement, Mr. Noonan reports that he wants to be showered twice a week, but he is not regularly showered.

111. Because Mr. Noonan is not showered regularly, he is not able to maintain his personal hygiene and hair cleanliness as he prefers.

112. Mr. Noonan currently has multiple pressure ulcers and has a history of fungal skin infections and developing pressure ulcers.

113. Mr. Noonan's Plan of Care requires that staff assist him to reposition in bed at least every two hours to prevent the development of pressure ulcers. He requires the assistance of two facility staff to be safely repositioned.

114. The facility often fails to reposition Mr. Noonan in bed every two hours as required by his Plan of Care.

115. Mr. Noonan's Plan of Care requires that staff provide him with incontinence care, including application of a barrier cream, at least every two hours to prevent the development of pressure ulcers.

116. The nursing facility often fails to provide Mr. Noonan with required incontinence care, leaving him on at least one occasion in incontinence briefs soiled with urine and feces for more than twelve hours.

117. In addition to the risk of developing pressure ulcers, Mr. Noonan experiences psychosocial harm, emotional distress, and a loss of dignity due to having been left in soiled clothing and linens.

118. Mr. Noonan's Plan of Care requires that his call bell be kept within reach at all times. However, when Mr. Noonan uses the call bell to request assistance, he often waits more than an hour for help.

119. Mr. Noonan believes that the facility does not have enough staff to respond promptly to his call bell, so he limits himself to using his call bell only once or twice per day when he requires incontinence care.

120. Mr. Noonan's Plan of Care recognizes that he should be evaluated for physical therapy to help treat his Parkinson's disease. Mr. Noonan has not been evaluated for or received any physical therapy to treat his Parkinson's disease, contractures, and other conditions related to his immobility.

Herman Dressel

121. Mr. Dressel is a fifty-seven-year-old white man who is diagnosed with left-side weakness due to a stroke, ambulatory dysfunction, hand contracture, diabetes, deep vein thrombosis, urinary incontinence, bowel incontinence, chronic kidney disease, dizziness, sleep apnea, obesity, generalized anxiety disorder, and insomnia.

122. Before his disability, Mr. Dressel worked in sales for a paper goods company. His real passions, though, were community service and sports. Mr. Dressel was an active member of his church and a local fraternal organization, where he led youth activities. Throughout the 1990's, Mr. Dressel served as the volunteer chairman of the local recreation department's soccer and baseball leagues. Mr. Dressel was a fixture of his local recreational sports leagues, participating in the same bowling league for 25 years.

123. On November 30, 2021, Mr. Dressel was admitted to the nursing facility located in [redacted] following a hospitalization for kidney failure. He has resided in the facility ever since.

124. Defendant MDH last conducted an annual survey at the nursing facility on November 15, 2022.

125. Mr. Dressel is unable to meet his own basic care needs due to his medical conditions and mobility impairments. His Plan of Care requires staff to

assist him with bathing, dressing, transferring into and out of bed, mobility, personal hygiene, and medication management.

126. Mr. Dressel's Plan of Care requires that he get out of bed every day with the assistance of two staff and a mechanical lift. Mr. Dressel often does not receive the assistance that he needs to transfer safely into and out of bed. Two to three times a month he is left in his bed for the entire day.

127. On those occasions when Mr. Dressel is left in his bed for the day, he is unnecessarily secluded in his room when staff fail to transfer him out of his bed.

128. Mr. Dressel has a history of falls. On March 2, 2023, Mr. Dressel was injured when the nursing facility attempted an inappropriate one-person transfer using a mechanical lift, contrary to his Plan of Care. During the botched lift, Mr. Dressel struck his head and experienced dizziness and nausea. His injuries were so significant that Mr. Dressel was sent to the hospital for treatment, where he was admitted.

129. MDH has not yet investigated the circumstances which led to Mr. Dressel's March 2, 2023, injuries.

130. On or about May, 2023, Mr. Dressel's wife filed a complaint on his behalf with MDH concerning the poor care that Mr. Dressel was receiving at the facility. The complaint alleged that on April 16, 2023, Mr. Dressel did not receive incontinence care for more than 15 hours, and that facility staff did not timely

respond to Mr. Dressel's call bell. The complaint further alleged several additional instances where facility staff did not respond to his call bell for prolonged periods of time, and that Mr. Dressel did not have access to the hoyer lift he needs to transfer out of bed.

131. MDH has not yet investigated the May 2023 complaint.

132. According to Mr. Dressel's Plan of Care, he must receive specialized incontinence care and repositioning to reduce his risk of developing pressure ulcers. Mr. Dressel often goes entire shifts or longer without incontinence care.

133. On a regular basis, Mr. Dressel often waits 30 minutes to an hour for a response to a call bell, and often, when facility staff arrive, they ask what he needs and say they will come back, but they never do.

134. When Mr. Dressel requests facility staff assistance to change his incontinence brief, he is frequently told that if staff assist him into his bed for the change, he will have to remain in bed for the rest of the day. Because he does not want to be stuck in bed for the day, he now puts a towel inside his brief to capture urine during the day and avoid the need to change the brief. This means that he must tolerate the urine-soaked towel all day instead.

135. Mr. Dressel is scheduled for a shower twice a week, on Mondays and Thursdays. Despite the fact that Mr. Dressel's Plan of Care requires staff assistance

with showering, facility records show that the facility often fails to shower Mr. Dressel twice a week.

136. Despite the fact that Mr. Dressel's Plan of Care requires staff assistance with personal hygiene, the facility does not ensure that staff regularly assist him to brush his teeth, despite the contractures in his hands and weakness in his arms. Facility staff have told him that they do not have time to assist him with dental care. As a result, his dental health has deteriorated significantly.

137. Mr. Dressel has requested, but not received, therapy to increase muscle strength so that he can be more independent, for many months. His muscle strength has continued to deteriorate.

Richard Hollman

138. Mr. Hollman is a fifty-seven-year-old white man who experienced a devastating traumatic brain injury during a boating accident in 2002. As a result of his brain injuries, Mr. Hollman is diagnosed as living in a "persistent vegetative state" and experiences seizures. He is non-verbal and unable to communicate his wants and needs. Mr. Hollman is incontinent of bladder and bowel. He uses a urinary condom catheter.

139. Eleanor Hollman, Mr. Hollman's mother, is his legal guardian.

140. Mr. Hollman has resided at the nursing facility since 2003.

141. MDH last conducted an annual survey at the facility in October 2022.

142. Before becoming disabled, Mr. Hollman lived for boating and time in the sun and on the water. Mr. Hollman performed maintenance and repairs on his boat and his two jet skis. Mr. Hollman was in his second year of studying to become a marine electrician at the time of the accident.

143. When Mr. Hollman was not spending time on the water, he enjoyed watching NASCAR races, football, and baseball, his beloved Chevrolet, and collecting Budweiser beer memorabilia.

144. Due to his disabilities, Mr. Hollman relies on the facility to anticipate and meet all of his care needs, including mobility, transfers into and out of bed, incontinence and catheter care, personal hygiene, socialization, mental stimulation, nutrition, and medication administration, as outlined in his Plan of Care.

145. Mr. Hollman is unable to walk. He is reliant upon the nursing facility to help him move from place to place using a wheelchair. He is unable to support himself while sitting in the wheelchair and relies on staff to use straps to secure him in place.

146. Mr. Hollman has a history of pressure ulcers.

147. Mr. Hollman's Plan of Care requires that specific care be provided to prevent new pressure ulcers from developing: that he be repositioned in bed at least every two hours (other than during overnight hours), that he receives incontinence care every two hours, that he receives daily skin checks by qualified staff, that he

receives weekly skin checks by a nurse, and that nursing staff employ pressure relieving devices on his bed and wheelchair.

148. Mr. Hollman's records indicate that the nursing facility often fails to ensure that he receives this required care, placing him at greater risk of developing pressure ulcers.

149. Most recently, in January 2024, Mr. Hollman developed a new stage 2 pressure ulcer.

f. MDH's Administration of Facility Oversight Discriminates Against Residents with Mobility Impairments.

150. MDH abdicates its duty to ensure that Plaintiffs' rights are honored in nursing facilities when it fails to conduct the survey and complaint investigations.

151. MDH's failure to timely investigate complaints is a chronic and well-documented problem. The U.S. Department of Health and Human Services Office of Inspector General found that Maryland was one of only ten (10) states that failed to meet CMS performance "timeliness threshold" requirements for nursing facility complaint investigations each year from 2011 through 2018.

152. The pattern of failed oversight has continued in the most recent CMS report on state agency performance. *See* Center for Clinical Standards and Quality, CMS, Admin Info: 23-10-ALL: Fiscal Year 2022 (FY22) State Performance Standards System (SPSS) Findings 7 (July 20, 2023). CMS found that MDH did

not meet four of the five measures relating to effective nursing facility survey and complaint process administration. *Id.*

153. In 2018, the Maryland Legislature enacted legislation to mandate increased staffing in the MDH unit responsible for surveys and complaints, the Office of Health Care Quality (OHCQ). In doing so, the Legislature cited "[t]he lack of commitment to investigating complaints regarding nursing homes and other facilities by the State [which] is evident in the longstanding understaffing of nurse surveyors in the Maryland Office of Health Care Quality," and stated that "[t]here appears to be no commitment to change the deficient and dangerous conditions in terms of the timeliness of investigating nursing home complaints, which affects the health and well-being of vulnerable Marylanders who reside in nursing homes." Maryland Nursing Home Resident Protection Act of 2018, S.B. 386, 2018 Reg. Sess. (Md. 2018).

154. In response to the legislation, MDH instituted a "7-Year Staffing Plan" beginning in fiscal year 2018, under which the Long Term Care Unit would receive twenty (20) new, full-time surveyor positions between fiscal years 2020 and 2024. Office of Health Care Quality, Maryland Department of Health, Analysis of the FY 2024 Maryland Executive Budget, 2023, at 14 [hereinafter FY 2024 Md. Exec. Budget]. Despite MDH's "7-Year Staffing Plan," the nursing facility survey unit has been understaffed, with many nursing facilities not

surveyed. *See id.* at 15; Office of Health Care Quality, Maryland Department of Health, Analysis of the FY 2025 Maryland Executive Budget, 2024, at 5 [hereinafter FY 2025 Md. Exec. Budget].

155. In fiscal year 2023, state legislative reports estimated that MDH retained an unspent $3.2 million, which had been budgeted for unfilled surveyor position salaries and benefits. FY 2024 Md. Exec. Budget at 8.

156. Over the years, MDH has exacerbated the backlog in annual surveys, complaint investigations, and related enforcement activities by permitting surveyors to transfer out of the Long Term Care Unit without replacement, and not requesting the full funding from the Legislature needed to fully staff the Long Term Care Unit so that all annual surveys are completed each year and all complaints are timely investigated. *See id.* at 14-15.

157. Further reducing its ability to timely conduct annual surveys and complaint investigations, MDH canceled its memorandum of understanding with Montgomery County Commission on Aging on or about March 2021, eliminating 10 county-based surveyors who operated under the agreement, and replacing them with only 4 state nursing facility surveyors. *See* Chitra Kalyandurg & Kaitlyn Simmons, Office of Legislative Oversight, Nursing Homes in Montgomery County: Regulatory Framework and Issues Impacting the Quality of Care 82, 98 (July 25, 2023); Letter from Barbara Seller, Montgomery County Commission on

Aging, to Dr. Patricia Tomsko Nay, Executive Director, Office of Health Care Quality 1 (Mar. 29, 2021).

158. According to the most recent publicly available data, the Long-Term Care Unit remains significantly understaffed. *See* FY 2025 Md. Exec. Budget at 5.

VI. CLASS ALLEGATIONS

159. This action is properly maintained as a class action pursuant to Federal Rules of Civil Procedure 23(a) and 23(b)(2).

160. Plaintiffs seek certification of a class of similarly situated individuals who are:

> Residents of nursing facilities, who have disabilities with mobility impairment, and who live in nursing facilities that operate under the oversight authority of MDH.

161. The class is sufficiently numerous to make joinder impracticable. According to CMS data, there are at least 9,056 people with mobility impairment residing in nursing facilities in Maryland. *See* CMS, *Minimum Data Set Frequency, Q1 2024*, Data.CMS.gov, https://data.cms.gov/quality-of-care/minimum-data-set-frequency/data (last visited May 13, 2024); *see also supra* at Paragraph 50 and accompanying text. The questions of law and fact are common to and typical of those of members of the putative class they seek to represent.

162. The Plaintiffs and the putative class members rely on Defendants for oversight and enforcement of their federal and state rights relating to the provision of nursing facility services.

163. Defendants' long-standing and well-documented failure to conduct annual surveys and timely complaint investigations departs from their state and federally mandated duties and violates the legal rights of Plaintiffs and the putative class members they seek to represent.

164. Questions of fact common to the class include:

a. Does MDH substantially deny the plaintiff class enforcement of their resident rights and quality of life standards under state and federal law by failing to conduct annual surveys of nursing facilities?

b. Does MDH substantially deny the plaintiff class their resident rights and quality of life standards under state and federal law by failing to timely investigate complaints in nursing facilities?

c. Does MDH's failure to conduct timely annual surveys and investigations of complaints have a disparate impact on the plaintiff class of nursing facility residents with mobility impairments?

165. Questions of law common to the class include:

a. Does Defendants' administration of MDH's nursing facility oversight and corrective enforcement program violate the ADA's requirement that

"[a] public entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration . . . [t]hat have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities"? 28 C.F.R. § 35.130 (b)(3)(ii).

b. Does Defendants' administration of MDH's program of oversight and enforcement of nursing facilities fail to protect Plaintiffs' right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility?

c. Does Defendants' administration of MDH's program of oversight and enforcement fail to protect Plaintiffs' rights and ensure compliance with quality of care standards under the NHRA?

d. Does Defendants' administration of MDH's program of oversight and enforcement fail to protect Plaintiffs' rights and ensure compliance with quality of care standards under the Maryland Resident Bill of Rights Act, Md. Code Ann., Health – Gen., § 19-343?

166. The violations of law and resulting types of harm and risks of harm alleged by Plaintiffs are typical of the legal violations and types of harms and risks of harm experienced by all members of the proposed class.

167. The Plaintiffs will fairly and adequately protect the interests of the class that they seek to represent.

168. There is no conflict between the interests of the Plaintiffs and the class they seek to represent.

169. The Plaintiffs are represented by attorneys who are competent and experienced in class action litigation, the Americans with Disabilities Act, nursing facility law, and complex civil litigation.

170. Defendants have acted or failed to act on grounds applicable to the class, necessitating class-wide declaratory and injunctive relief.

VII. LEGAL CLAIMS

Count I
Americans with Disabilities Act, 42 U.S.C. § 12131 *et seq.*
(Methods of Administration Violation)

171. Plaintiffs reallege and incorporate the allegations in Paragraphs 1 through 170 above as if fully set forth herein.

172. Title II of the ADA prohibits discrimination against people with disabilities: "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132.

173. Plaintiffs are qualified individuals with disabilities within the meaning of the ADA due to their physical, mental, or cognitive disabilities. 42 U.S.C. § 12131(2).

174. The regulation implementing the ADA prohibits Defendants from "directly or through contractual or other arrangements, utiliz[ing] criteria or methods of administration . . . [t]hat have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities." 28 C.F.R. § 35.130(b)(3)(ii).

175. As residents of Medicaid-funded nursing facilities, Plaintiffs meet the essential eligibility requirements as qualified individuals with disabilities to receive and benefit from the oversight and corrective enforcement activities and programs of MDH. *See* 42 U.S.C. § 12131(2).

176. Defendants are a public entity under the ADA, charged under federal and state law with protecting the health and safety of Maryland's nursing facility residents.

177. As a result of MDH's conduct, Plaintiffs are denied meaningful access to and the benefit of MDH's nursing facility oversight and enforcement activities. Defendants' methods of administration of its oversight and enforcement duties have the effect of defeating or substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with mobility-

related disabilities, and thereby subject Plaintiffs to discrimination on the basis of disability. Such methods of administration include the failure to conduct annual surveys and the failure to timely investigate many complaints. Taken together or separately, these failures defeat or substantially impair the purpose of MDH's oversight program, *i.e.*, to protect the rights of nursing facility residents and to ensure that nursing facility residents receive quality care.

Count II
Section 504 of the Rehabilitation Act, 29 U.S.C. § 794 *et seq*.
(Methods of Administration Violation)

178. Plaintiffs re-allege and incorporate the allegations in Paragraphs 1 through 170 above as if fully set forth herein.

179. Plaintiffs are individuals with disabilities under Section 504 of the Rehabilitation Act. 29 U.S.C. § 794(a).

180. As residents of nursing facilities subject to Defendants' oversight, Plaintiffs are otherwise qualified to receive and benefit from the oversight and corrective enforcement activities and programs of MDH. 29 U.S.C. § 794(a).

181. Defendants are recipients of federal financial assistance subject to the requirements of Section 504. *Id.*

182. The regulations implementing Section 504 of the Rehabilitation Act prohibit recipients of federal financial assistance from "utiliz[ing] criteria or methods of administration (i) that have the effect of subjecting qualified

handicapped persons to discrimination on the basis of handicap, [or] (ii) that have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the recipient's program or activity with respect to handicapped persons." 45 C.F.R. § 84.4(b)(4)(i), (ii).

183. As a result of MDH's conduct, Plaintiffs are denied meaningful access to and the benefit of MDH's nursing facility oversight and enforcement activities. Defendants' methods of administration of its oversight and enforcement duties have the effect of defeating or substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with mobility-related disabilities, and thereby subject Plaintiffs to discrimination on the basis of disability. Such methods of administration include the failure to conduct annual surveys and the failure to timely investigate many complaints. Taken together or separately, these failures defeat or substantially impair the purpose of MDH's oversight program, *i.e.*, to protect the rights of nursing facility residents and to ensure that nursing facility residents receive quality care.

RELIEF SOUGHT

Plaintiffs, on behalf of themselves and the Plaintiff Class, request that the Court:

a. Assume jurisdiction over this action and maintain continuing jurisdiction until the Defendants are in full compliance with the order of this Court;

b. Certify the Plaintiff Class as defined in Paragraph 160 pursuant to Rule 23(b)(2) of the Federal Rules of Civil Procedure;

c. Declare that Defendants' policies, practices, acts, and omissions, as set forth above in Paragraphs 1 through 158, violate Plaintiffs' rights under the Americans with Disabilities Act;

d. Grant preliminary and permanent injunctive relief, requiring Defendants to:

(1) Completely and accurately conduct annual surveys of nursing facilities on a twelve-month cycle, and complete related enforcement activities of nursing facilities relating to compliance with the requirements of the Nursing Home Reform Act, 42 U.S.C. § 1396r(g) (referencing 42 U.S.C. § 1396r(b), (c), and (d)). Such surveys and enforcement activities are to be conducted to ensure that nursing facilities that have resident populations which are majority Black are subject to enforcement activities to ensure compliance with nursing facility requirements.

(2) Timely, completely, and accurately investigate complaints (including, as required by Md. Code Ann., Health – Gen. § 19-1408(b), initiating within 48 hours for Immediate Jeopardy, and within 10 days for other serious allegations) and complete related enforcement activities regarding nursing facility care, such investigations to include complaints where physical or psychosocial

harm is alleged. Such complaint investigation and enforcement activities are to be conducted to ensure that nursing facilities serving Plaintiffs that have resident populations which are majority Black are subject to enforcement activities to ensure compliance with nursing facility requirements.

(3) Conduct timely, complete, annual surveys, and related enforcement activities to ensure that nursing facilities are in compliance with state licensing standards under Md. Code Ann., Health – Gen. § 19-1408(a), including compliance with the protections afforded nursing facility residents in the Maryland Resident Bill of Rights Act, Md. Code Ann., Health – Gen. § 19-343. Such enforcement activities are to use all available remedies necessary to ensure nursing facility compliance, including nursing facilities serving Plaintiffs that have resident populations which are majority Black.

(4) Conduct timely, complete investigations of complaints and related enforcement activities to ensure that nursing facilities are in compliance with state licensing standards under Md. Code Ann., Health – Gen. § 19-1408(b), and include complaints related to the protections afforded nursing facility residents in the Maryland Resident Bill of Rights Act, Md. Code Ann., Health – Gen. § 19-343. Such enforcement activities are to use all available remedies necessary to ensure nursing facility compliance, including nursing facilities that have resident populations which are majority Black.

(5) Timely make available to the public information respecting all nursing facility surveys, complaint investigations, and certifications made with respect to nursing facilities, including facility sanctions and corrective enforcement actions.

e. Award the Plaintiffs the costs of this action and reasonable attorneys' fees pursuant to 29 U.S.C. § 794a and 42 U.S.C. § 12133 and as otherwise permitted by law.

f. Grant such other relief that this Court deems appropriate.

Dated: May 15, 2024

/s/ Debra Lynn Gardner

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*Applications for Admission *Pro Hac Vice* pending

Proposed Language for Assisted Living Facility Eviction Limitations and Request for Hearing:

Md. Code Health-Gen §19-1805.2-Notice of eviction or transfer in an assisted living facility and right to hearing

(a) A resident of a facility may not be transferred or evicted from the facility involuntarily except for the following reasons:**(1)** The transfer or eviction is necessary for the resident's welfare and the resident's needs cannot be met in the facility **(2)** The health or safety of an individual in a facility is endangered;**(3)** The resident has failed, after reasonable and appropriate notice, to pay for, or under Medicaid or otherwise, to have paid for a stay at the facility; or **(4)** The facility ceases to operate

(b) A facility shall provide the resident with written notice of: **(1)** Any proposed eviction or transfer; and **(2)** The opportunity for a hearing in accordance with the provisions of this section before the discharge or transfer.

(c) The Department shall prepare and provide each facility with a standardized form that provides, in clear and simple language, at least the following information:**(1)** Notice of the intended eviction or transfer of the resident, including the proposed date of the intended discharge or transfer, which may change as a result of an appeal or the discharge planning process;**(2)** Each reason for the discharge or transfer;**(3)** The location, including the physical address, to which the resident will be evicted or transferred, which may change as a result of an appeal or the discharge planning process;**(4)** The name of the staff, which may change during the discharge planning process, who:**(i)** Is designated to provide discharge planning services to the resident in connection with the eviction or transfer; and**(ii)** Will be responsible for the development of the post discharge plan of care under subsection (h) of this section;**(5)** A proposed date within 10 days after the date of the notice for a meeting between the resident, the resident's representative, and facility staff to develop the post discharge plan of care under subsection (g) of this section;**(6)** The right of the resident to request a hearing;**(7)** The right of the resident to consult with any lawyer the resident chooses;**(8)** The availability of the services of the Legal Aid Bureau, the Older American Act Senior Legal Assistance Programs, and other agencies that may provide assistance to individuals who need legal counsel;**(9)** The availability of the Long-Term Care Ombudsman Program to assist the resident; and**(10)** The provisions of this section.

(d) Except as otherwise provided in this section, at least 30 days before the facility involuntarily transfers or evictions a resident, the facility shall:**(1)** Provide to the resident the written notice required under subsection (a) of this section; and**(2)** Provide the written notice required under subsection (a) of this section to:**(i)** The resident;**(ii)** The next of kin, guardian, or any other individual known to have acted as the resident's representative, if any;**(iii)** The Long-Term Care Ombudsman; and**(iv)** The Department.

(e)(1)(i) In accordance with regulations adopted by the Secretary, the facility shall provide the resident with an opportunity for a hearing on the proposed transfer or eviction. **(2)** Except as otherwise provided in this subsection, hearings on proposed transfers or evictions shall be

conducted in accordance with the provisions of Title 10, Subtitle 2 of the State Government Article and the Medicaid Fair Hearing Procedures.**(3)** Any hearing on a proposed eviction or transfer of a resident:**(i)** Is not a contested case as defined in § 10-202 of the State Government Article; and**(ii)** May not include the Secretary as a party.**(4)** A decision by an administrative law judge on a proposed eviction or transfer of a resident:**(i)** Is not a decision of the Secretary;**(ii)** Unless appealed, is final and binding on the parties; and**(iii)** May be appealed in accordance with § 10-222 of the State Government Article as if it were a contested case but the appeal does not automatically stay the decision of the administrative law judge.

(f) The facility shall provide the written notice required in subsection (a) of this section as soon as practicable before eviction or transfer if:**(1)** An emergency exists and health or safety of the resident or other residents would be placed in imminent and serious jeopardy if the resident were not transferred or eviction from the facility as soon as possible; or**(2)** The resident has not resided in the facility for 30 days.

(g) If the information in the notice provided under subsection (d) of this section changes before the eviction or transfer, the facility shall provide the changes to the recipients of the notice as soon as practicable after the new information becomes available.

(h)(1) Before any eviction or transfer and subject to paragraphs (4) and (5) of this subsection, a facility shall develop a post discharge plan of care for the resident to assist the resident with adjusting to the resident's new living environment and that:**(i)** Addresses the resident's post discharge goals of care and treatment preferences; and**(ii)** Identifies each of the resident's reasonably anticipated medical and basic needs after eviction or transfer and establishes a plan for meeting those needs.**(2)** The facility shall, if possible, meet with the resident and, with the resident's consent, the resident's representative within 10 days after providing the notice required under subsection (a) of this section to discuss the post discharge plan of care for the resident.**(3)(i)** The resident's post discharge plan of care shall be developed with the participation of the resident and, with the resident's consent, the resident's representative

Kaiser Family Foundation Report regarding Medical Assistance supporting the recommendation to increase the Maryland income limit for this insurance:

kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

ISSUE PAPER

December 2012

The Medicaid Medically Needy Program: Spending and Enrollment Update

The medically needy program provides states the option to extend Medicaid eligibility to individuals with high medical expenses whose income exceeds the maximum threshold, but who would otherwise be eligible for Medicaid. The program accounts for a small share of Medicaid enrollment, it is difficult for individuals to navigate, and it is cumbersome for states to administer. However, the medically needy program remains an important and consequential pathway to Medicaid eligibility, acting as a last-resort to Medicaid eligibility for those whose medical expenses overwhelm their income. Elderly living in nursing homes and children and adults with disabilities who live in the community and incur high health care costs comprise a large portion of spending in the medically needy program.

This brief provides updated enrollment and spending figures on the medically needy using data through federal fiscal year 2009. It then explains how individuals become eligible for the medically needy program. Finally, it provides key considerations for policy discussions, especially pertinent in light of the optional Medicaid expansion that states are now considering. The data in this brief comes from the 2009 Medicaid Statistical Information System (MSIS) maintained by the Centers for Medicare and Medicaid Services (CMS), with spending adjusted to align with CMS Form 64 levels. Among the findings from this work are:

- In federal fiscal year 2009, there were 2.8 million medically needy enrollees who spent a total of $36.7 billion. The medically needy accounted for 5 percent of total Medicaid enrollment, but 11 percent of total Medicaid spending.
- Among the 34 states with medically needy programs, there is variation between states. New York and California each provide Medicaid coverage to over 700,000 medically needy individuals - one quarter of the total medically needy population. Sixteen states do not offer medically needy coverage.
- The elderly and individuals with disabilities comprise 41 percent of medically needy enrollment, but make up nearly 88 percent of total medically needy spending. In contrast, non-disabled children and adults comprise the majority (59%) of medically needy enrollment, but only account for 12 percent of total medically needy spending.
- Dual eligible beneficiaries account for 28 percent of medically needy enrollees, but 68 percent of medically needy spending.

As financial eligibility for Medicaid and CHIP has expanded over the past decade, enrollment in medically needy programs has declined, most notably among children. However, the medically needy program continues to act as a safety net to those who are among the most vulnerable in our population. Medicaid expansion and the exchanges will provide medical insurance to some of the medically needy population. As states discuss implementing the Medicaid expansion, in addition to other policy decisions, they will undoubtedly take into consideration the great need of this population, as well as the efficiency and expense of providing care under the various options.

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Introduction

The medically needy program offers states the option to extend Medicaid coverage to individuals with high medical expenses, who would otherwise be ineligible for Medicaid because their incomes exceed eligibility limits. By subtracting incurred health care expenses from their income, individuals are permitted to "spend down" to Medicaid eligibility. The medically needy option is complicated for beneficiaries to understand and for state Medicaid programs to administer, but the opportunity to spend down is very important to elderly individuals residing in nursing facilities and children and adults with disabilities who live in the community and incur high health care expenses. As of 2009, 33 states and the District of Columbia had Medicaid medically needy programs that covered 2.8 million people. The medically needy population represented 5 percent of the total Medicaid population and accounted for 11 percent of Medicaid spending in 2009. The most expensive among the medically needy population are those who are dually eligible for both Medicaid and Medicare. This brief provides an overview of the medically needy program; describes how it works for persons with disabilities, the elderly, and low-income families; and highlights some key issues surrounding the program as states consider new Medicaid coverage options included in the Affordable Care Act (ACA).

How Do the Medically Needy Qualify for Medicaid?

The medically needy option enables states to provide Medicaid coverage to individuals who meet the categorically needy pathway eligibility requirements,[1] but exceed the income standards. In general, there are two ways individuals can become eligible for medically needy Medicaid coverage: 1) individuals with income below medically needy levels, but above categorically needy income levels are eligible under the medically needy option. This includes children up to age 21 in states where the medically needy program is either the only eligibility category for these individuals or where the medically needy program has the highest maximum allowable income for Medicaid eligibility; and 2) persons who spend down by incurring medical expenses so that, after medical expenses, their income falls below a state-established medically needy income limit (MNIL). The option does not permit states to provide Medicaid to individuals who are not categorically-related (e.g., non-disabled, non-pregnant adults age 19 to 64 without dependent children), regardless of how poor they are or how extensive their medical needs.

Financial eligibility standards for the medically needy program vary considerably across states, but are typically well below poverty. State MNILs are low because they remain tied to AFDC levels that were in place in 1996. Federal rules require MNILs to be no higher than 133 percent of the maximum state Aid to Families and Dependent Children (AFDC) level, as of July 16, 1996, for a family of two without income or resources.[2] Although AFDC was replaced in 1996 by the Temporary Assistance to Needy Families (TANF) program, Medicaid MNILs remain linked to the old AFDC standards. States can raise their MNIL if they increase their TANF income standards. States can also increase the MNIL as family size increases, but they are not allowed to decrease it as family size increases. States can also have different MNILs for urban and rural areas, taking into consideration differences in housing costs.[3]

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[1] For more information on the categorically needy pathway see Appendix A.
[2] 42 CFR § 435.1007.
[3] CMS State Medicaid Manual, § 3621.

State Medically Needy Eligibility Levels

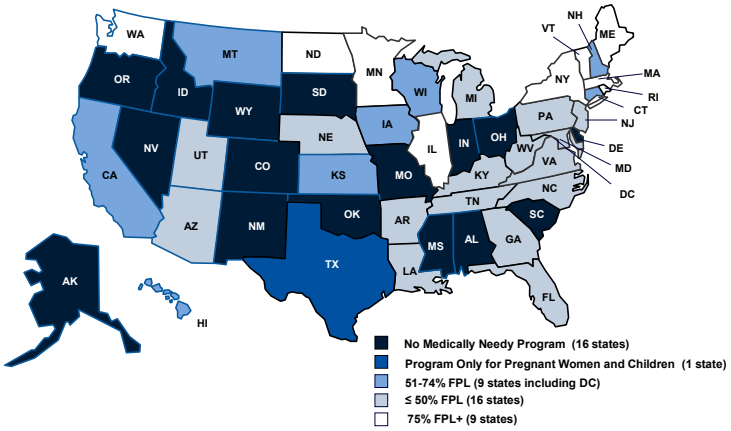
In 2009, the median MNIL for a single individual was $447 per month, or about 50 percent of the FPL (Figure 1 and Table 1).[4] In 16 states, the MNIL was below 50 percent of the FPL for non-institutionalized people with disabilities. In 25 states, the MNIL was below the SSI income level of $674 per month in 2009.

Resource limits are often the same as those used in the Supplemental Security Income (SSI) program, with 19 states setting resource limits at $2,000 for individuals and $3,000 for couples. States are permitted to use less restrictive methodologies in counting resources under the medically needy program than under the SSI program, but they may not be more restrictive (see Appendix B for further explanation).

In 11 states, known as 209(b) states, Medicaid eligibility rules for people with disabilities and the elderly are different from those under the federal SSI program—and some people who receive SSI do not qualify for Medicaid. When the Congress enacted the SSI program in 1972, it allowed states to use their 1972 state assistance eligibility rules for determining Medicaid eligibility in place of the federal SSI eligibility rules.[5] In 209(b) states, both the financial and non-financial eligibility criteria can be more restrictive than the federal standard, as long as they are no more restrictive than the rules they had in place in 1972. The states with 209(b) programs in 2012 are: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia. In these states, people with disabilities and the elderly must be given the opportunity to spend down to the state's income standard for mandatory eligibility, whether or not the state permits spend-down through a medically needy program.[6] In 209(b) states that also have medically needy programs (all 209(b) states except Indiana, Missouri, Ohio, and Oklahoma), an individual must only spend down to the 209(b) income standard if they meet the SSI financial requirements (such as by receiving SSI or a state supplement).[7] All persons who do

Figure 1

Medically Needy Income Levels by State, 2009



SOURCE: *Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities*, Kaiser Commission on Medicaid and the Uninsured analysis of data collected by Medicare Rights Center, 2009, February 2010.

[4] Kaiser Commission on Medicaid and the Uninsured and the Medicare Rights Center, "Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities," Kaiser Commission on Medicaid and the Uninsured, February 2010, available at http://www.kff.org/medicaid/8048.cfm.

[5] Kaiser Commission on Medicaid and the Uninsured, "The Medicaid Resource Book," July 2002, available at http://www.kff.org/medicaid/2236-index.cfm.

[6] House Ways and Means Committee, "The Green Book, October 2000, (See p. 897).

[7] State Medicaid Manual, § 3613.3 (A). Individuals are also considered to be meet the financial requirements for SSI if they would be eligible for SSI or a state supplement with Old Age and Survivors Disability Insurance (OASDI) cost-of-living disregards applied under 42 CFR 214.134 and 435.13.

not meet the SSI income eligibility requirements must spend down to the state's MNIL in order to qualify for Medicaid as a medically needy individual.

The following examples illustrate the types of individuals who would benefit from a Medicaid medically needy spend-down program:

Family with recurring medical expenses – Sean, an 11 year-old boy with a behavioral health diagnosis, has been receiving outpatient therapy at a community health center. His symptoms are worsening, however, and he is exhibiting self-injurious behaviors and becoming violent toward family members. His doctor recommends a stay in a residential treatment center where he can receive more intensive services, but his family is uninsured, and the residential treatment center costs approximately $333 per day, or $10,000 per month. The social worker at the residential treatment center helps Sean's parents apply for Medicaid coverage for him.

In Sean's state, children qualify for Medicaid if their family income is less than 100 percent of the federal poverty level ($1,921 per month for a family of four in 2012). Sean's family earns $2,500 per month -- too much to qualify for Medicaid coverage-- but they live in a state that includes the medically needy spend-down option in its Medicaid program with a one month spend-down period. Sean has a spend-down amount of $579, the difference between his family's income of $2,500 and the $1,921 limit for Medicaid eligibility. Sean meets his spend-down amount after incurring $579 in medical bills, the cost of less than two days of his 30-day stay in the residential treatment center. After meeting his spend-down amount, Sean is eligible for Medicaid for the rest of the month, and the remainder of his inpatient stay is covered.

Adult with cancer diagnosis – 55-year-old Cynthia has metastasized colon cancer. She has been told she has less than six months to live. After her illness made it impossible for her to continue to work, Cynthia qualified for Social Security Disability Insurance (SSDI) benefits based on her work history and medical condition. After becoming eligible for SSDI, there is a 24-month waiting period before receiving Medicare, and Cynthia has no other health insurance. She needs chemotherapy, scans, and a hospital bed at home. She also needs prescription drugs for pain, depression and a blood clot. Her SSDI benefits are $1,100 per month, and her state provides Medicaid coverage to people with disabilities with incomes up to 100 percent of the federal poverty level, or $930 per month for an individual in 2012. Her treatments cost hundreds of dollars every month, much more than she can afford with her limited income. Her prescription drugs alone cost over $500 per month, and the hospital is allowing her to receive chemotherapy on a payment plan.

The Medicaid program in Cynthia's state includes the medically needy spend-down option with a six-month spend-down period. Cynthia's spend-down amount is $1,020 over a six month period, the difference between her monthly income of $1,100 and the financial eligibility limit for an individual of $930 over six months. Cynthia is able to meet her spend-down amount in the first week of her six month spend-down period because she gets all of her prescriptions filled and incurs a bill for chemotherapy – together her out-of-pocket medical costs exceed her $1,020 spend-down amount. After this point, Cynthia is eligible for Medicaid for the remainder of the six-month spend-down period. At the end of the six months, she will have to incur another $1,020 of expenses before becoming eligible for Medicaid again.

Table 1: Medically Needy Eligibility, 2009

State	Medically Needy or Comparable	Monthly Income Limit		Monthly Income Limit as a Percentage of Federal Poverty Level[1]		Asset Limit	
		Single	*Couple*	*Single*	*Couple*	*Single*	*Couple*
Alabama	No program	NA	NA	NA	NA	NA	NA
Alaska	No program	NA	NA	NA	NA	NA	NA
Arizona[2]	Comparable	$360	$485	40%	40%	May not exceed total of $100,000 including home, & no more than $5,000 can be liquid	May not exceed total of $100,000 including home, & no more than $5,000 can be liquid
Arkansas	Medically Needy	$108	$217	12%	18%	$2,000	$3,000
California	Medically Needy	$600	$750	66%	62%	$2,000	$3,000
Colorado	No program	NA	NA	NA	NA	NA	NA
Connecticut*[3]	Medically Needy	Depending on region $476 or $576	Ranges from $633 to $734	53% or 64%	52% to 60%	$1,600	$2,000
Delaware	No program	NA	NA	NA	NA	NA	NA
District of Columbia	Medically Needy	$577	$607	64%	50%	$4,000	$6,000
Florida	Medically Needy	$180	$241	20%	20%	$5,000	$6,000
Georgia	Medically Needy	$317	$375	35%	31%	$2,000	$4,000
Hawaii*	Medically Needy	$469	$632	45%	45%	$2,000	$3,000
Idaho	No program	NA	NA	NA	NA	NA	NA
Illinois*	Medically Needy	$903	$1,215	100%	100%	$2,000	$3,000
Indiana*	No program	NA	NA	NA	NA	NA	NA
Iowa	Medically Needy	$483	$483	54%	40%	$10,000	$10,000
Kansas	Medically Needy	$495	$495	55%	41%	$2,000	$3,000
Kentucky	Medically Needy	$217	$267	24%	22%	$2,000	$4,000
Louisiana[3]	Medically Needy	Urban counties: $100 Rural counties: $92	Urban counties: $192 Rural counties: $167	10% to 11%	14% to 16%	$2,000	$3,000
Maine	Medically Needy	$903	$1,215	100%	100%	$2,000	$3,000
Maryland	Medically Needy	$350	$392	39%	32%	$2,500	$3,000
Massachusetts	Medically Needy	$903; $1,200 those with Professional Care Assistance	$1,215; $1,615 for those with Professional Care Assistance	100% or 133%	100% or 179%	$2,000	$3,000
Michigan[3]	Medically Needy	Ranges from $341 to $408	Ranges from $458 to $541	38% to 45%	38% to 45%	$2,000	$3,000
Minnesota*	Medically Needy	$677	$911	75%	75%	$3,000	$6,000
Mississippi	No program	NA	NA	NA	NA	NA	NA
Missouri*	No program	NA	NA	NA	NA	NA	NA
Montana	Medically Needy	$625	$625	69%	51%	$2,000	$3,000
Nebraska	Medically Needy	$392	$392	43%	32%	$4,000	$6,000
Nevada	No program	NA	NA	NA	NA	NA	NA
New Hampshire*	Medically Needy	$591	$675	65%	56%	$2,500	$4,000
New Jersey	Medically Needy	$367	$434	41%	36%	$4,000	$6,000
New Mexico	No program	NA	NA	NA	NA	NA	NA
New York	Medically Needy	$767	$1,117	85%	92%	$2,000	$3,000
North Carolina	Medically Needy	$242	$317	27%	26%	$2,000	$3,000
North Dakota*	Medically Needy	$750	$1,008	83%	83%	$3,000	$6,000
Ohio*	No program	NA	NA	NA	NA	NA	NA
Oklahoma*	No program	NA	NA	NA	NA	NA	NA
Oregon	No program	NA	NA	NA	NA	NA	NA
Pennsylvania	Medically Needy	$425	$442	47%	36%	$2,400	$3,200
Rhode Island	Medically Needy	$800	$842	89%	69%	$4,000	$6,000
South Carolina	No program	NA	NA	NA	NA	NA	NA
South Dakota	No program	NA	NA	NA	NA	NA	NA
Tennessee	Medically Needy	$241	$258	27%	21%	$2,000	$3,000
Texas	Medically Needy for Pregnant Women and Children	NA	NA	NA	NA	NA	NA
Utah	Medically Needy	$370	$498	41%	41%	$2,000	$3,000
Vermont[4]	Medically Needy	$916 ($991 for Chittenden)	$916 ($991 for Chittenden)	101% or 110%	75% or 82%	$2,000	$3,000
Virginia*[3]	Medically Needy	Ranges from $281 to $421	Ranges from $358 to $508	31% to 47%	29% to 42%	$2,000	$3,000
Washington	Medically Needy	$674	$674	75%	56%	$2,000	$3,000
West Virginia	Medically Needy	$200	$275	22%	23%	$2,000	$3,000
Wisconsin	Medically Needy	$592	$592	66%	49%	$2,000	$3,000
Wyoming	No program	NA	NA	NA	NA	NA	NA

Source: *Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities* , Kaiser Commission on Medicaid and the Uninsured analysis of data collected by Medicare Rights Center, 2009, February 2010.

* 209(b) eligibility states: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia.

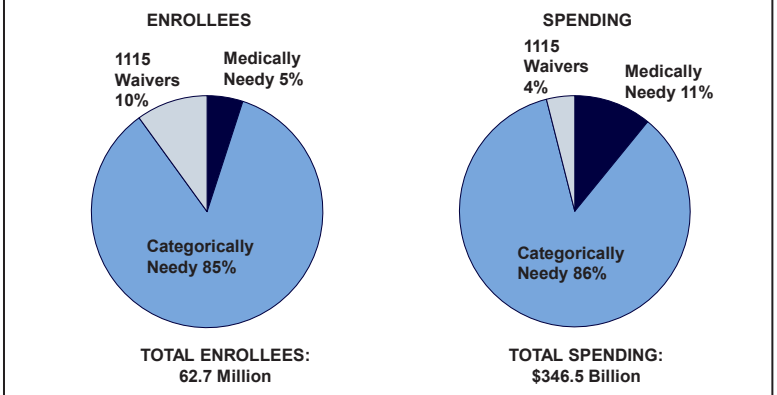
1. In 2009 the federal poverty level (FPL) equaled $10,830 for 1-person families and $14,570 for 2-person families in the 48 contiguous states and D.C. It equaled $12,460 for 1-person families and $16,760 for 2-person families in Hawaii.
2. Comparable program - Arizona's Medical Expense Deduction program allows for an individual whose income exceeds 100% FPL and who does not qualify for any other category of Medicaid, to qualify for Medicaid if they have a family income that does not exceed 40% FPL after deducting for allowable medical expenses. Please see http://law.justia.com/arizona/codes/title36/02901-04.html.
3. Income standards are based on the region in which the individual is living.
4. Vermont uses a higher income standard for Chittenden County only.

Enrollment and Spending in the Medically Needy Program

In federal fiscal year 2009, 2.8 million Medicaid beneficiaries were enrolled as medically needy at a total (federal and state) cost of $36.7 billion. Medically needy beneficiaries represent 5 percent of the entire Medicaid population and account for 11 percent of total spending (Figure 2). A 2001 analysis of the medically needy program found 3.6 million medically needy enrollees.[8] Over time, as financial eligibility for Medicaid and CHIP has expanded, enrollment in medically needy programs has declined, particularly among children.

Figure 2

Medically Needy as a Percentage of Medicaid Enrollment and Spending, 2009

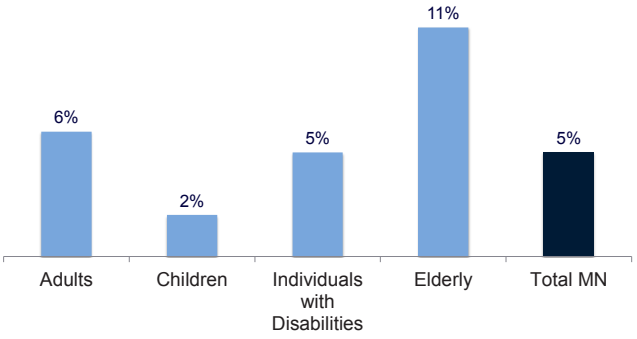


SOURCE: KCMU and Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64 reports, 2012. Because 2009 data was unavailable, 2008 MSIS data was used for Pennsylvania, Utah, and Wisconsin. Spending for these states was adjusted to 2009 CMS-64 spending levels.

While the medically needy account for just 5 percent of all Medicaid enrollees nationally (Figure 3), there is significant variation in their share of each state's Medicaid enrollment and spending (Table 2). The medically needy option accounts for 11 percent of overall elderly enrollment, reflecting the program's critical role in helping elderly individuals pay for nursing facility expenses. Medically needy coverage also is important to people with disabilities. It provides Medicaid coverage to poor and moderate-income beneficiaries who are ineligible for categorically needy Medicaid because their income (for example Social Security Disability Insurance (SSDI) payments or private pensions) is too high. The program plays a different role for non-disabled children and adults, who may qualify based on having health care costs related to an accident or severe illness.

Figure 3

Medically Needy Beneficiaries as a Percentage of Total Medicaid Enrollment, by Group, 2009



SOURCE: KCMU and Urban Institute estimates based on data from FFY 2009 MSIS. Because 2009 data was unavailable, 2008 MSIS data was used for Pennsylvania, Utah, and Wisconsin.

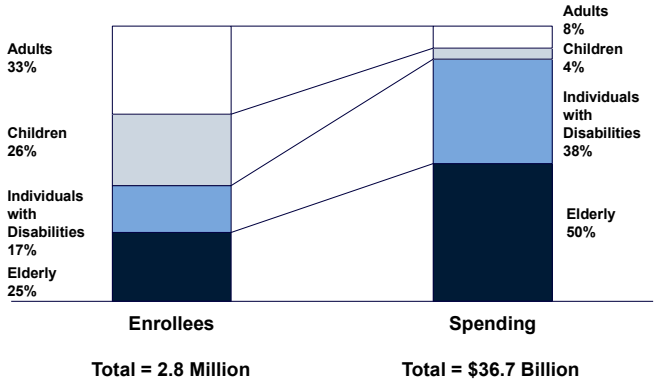
Within the medically needy population, non-disabled children and adults made up the majority of enrollees (59%) but accounted for just 12 percent of total spending. In contrast, the elderly and persons with disabilities made up 42 percent of enrollment and accounted for the vast majority of spending (88%) (Figure 4).

[8] Jeff Crowley, "Medically Needy Programs: An Important Source of Medicaid Coverage," Kaiser Commission on Medicaid and the Uninsured, January 2003, available at http://www.kff.org/medicaid/4096-index.cfm.

The distribution of medically needy enrollees varies across states. States with the highest medically needy enrollment include New York, California, and Illinois. These three states make up 68 percent of enrollment and nearly three-quarters of all spending on the medically needy. In states that offer the medically needy option, Hawaii, Montana, and Kansas had the fewest number of individuals enrolled, covering a combined 14,000 individuals. These variations reflect a state's demographic profile as well as state policy choices affecting the extent of Medicaid medically needy coverage they provide to the elderly and persons with disabilities versus other adults and children. As shown in Figure 1, 16 states do not cover any medically needy populations.

Figure 4

Medically Needy Enrollment and Spending, 2009



SOURCE: KCMU and Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64 reports, 2012. Because 2009 data was unavailable, 2008 MSIS data was used for Pennsylvania, Utah, and Wisconsin. Spending for these states was adjusted to 2009 CMS-64 spending levels.

Table 2: Medically Needy Enrollment and Spending, by State, 2009

State	Elderly		Individuals with Disabilities		Adults		Children		TOTAL	
	Enrollees (rounded to nearest 100)	$ (thousands)	Enrollees (rounded to nearest 100)	$ (thousands)	Enrollees (rounded to nearest 100)	$ (thousands)	Enrollees (rounded to nearest 100)	$ (thousands)	Enrollees (rounded to nearest 100)	$ (thousands)
TOTAL	696,800	$18,378,428	469,800	$13,771,388	929,300	$3,052,867	740,100	$1,452,001	2,836,000	$36,654,684
Alabama										
Alaska										
Arizona										
Arkansas	300	$1,830	2,400	$23,785	3,300	$10,703	600	$1,264	6,700	$37,582
California	204,600	$3,965,140	77,400	$2,554,291	112,600	$219,560	322,700	$518,325	717,200	$7,257,317
Colorado										
Connecticut	8,200	$178,901	11,200	$146,785	900	$2,634	2,500	$7,021	22,900	$335,341
Delaware										
District of Columbia	1,000	$56,398	7,700	$170,430	13,700	$45,121	22,800	$55,147	45,200	$327,097
Florida	6,000	$11,309	15,800	$161,524	109,400	$223,599	27,400	$44,347	158,600	$440,778
Georgia	2,800	$9,053	5,800	$66,633			200	$712	8,800	$76,398
Hawaii	2,700	$121,432	500	$20,712					3,100	$142,143
Idaho										
Illinois	73,600	$1,221,509	80,300	$1,833,708	267,100	$915,696	4,900	$5,870	425,900	$3,976,783
Indiana										
Iowa	600	$1,663	600	$8,852	4,900	$18,818	700	$1,329	6,700	$30,662
Kansas	1,000	$4,019	3,600	$42,352	500	$628	400	$750	5,500	$47,748
Kentucky	1,300	$10,964	3,700	$49,530	15,000	$73,748	7,600	$20,534	27,500	$154,776
Louisiana	1,600	$23,828	2,500	$47,322	5,900	$26,326	400	$984	10,400	$98,459
Maine	3,900	$134,018	900	$45,191	500	$885	700	$946	5,900	$181,040
Maryland	20,700	$900,441	19,500	$573,592	4,400	$14,576	2,400	$74,750	47,000	$1,563,359
Massachusetts	29,700	$1,182,586	8,200	$282,890					37,900	$1,465,476
Michigan	8,000	$149,015	8,900	$100,749	62,800	$224,728	40,200	$65,103	120,000	$539,595
Minnesota	15,900	$431,091	9,700	$310,873	6,800	$21,753	2,000	$2,434	34,500	$766,150
Mississippi										
Missouri										
Montana	3,000	$66,847	2,100	$40,659					5,100	$107,505
Nebraska	9,800	$285,520	2,300	$128,227	14,300	$44,282	500	$6,592	26,800	$464,621
Nevada										
New Hampshire	1,700	$34,892	3,700	$39,980	2,400	$8,184	1,400	$5,876	9,200	$88,932
New Jersey	4,700	$164,872	1,100	$18,945					5,800	$183,817
New Mexico										
New York	240,000	$8,130,854	145,900	$6,211,759	163,000	$681,509	228,900	$446,601	777,900	$15,470,724
North Carolina	21,500	$566,965	10,100	$281,897	18,900	$103,672	3,600	$10,626	54,100	$963,160
North Dakota	5,400	$174,058	2,500	$101,530	2,600	$8,688	400	$2,058	10,900	$286,334
Ohio										
Oklahoma										
Oregon										
Pennsylvania	8,200	$302,375	3,900	$47,699	34,500	$84,574	24,500	$55,181	71,000	$489,829
Rhode Island										
South Carolina										
South Dakota										
Tennessee	400	$2,206	500	$3,424	13,100	$36,819	36,000	$86,313	50,000	$128,763
Texas	100	$595	300	$2,574	52,900	$217,515	1,800	$12,979	55,100	$233,663
Utah	1,900	$17,342	3,100	$38,918	1,000	$4,964	1,100	$8,080	7,100	$69,304
Vermont	3,500	$11,972	4,500	$22,852	6,600	$20,031	2,600	$12,539	17,100	$67,394
Virginia	3,100	$38,915	5,600	$118,610	100	$174	100	$1,207	8,900	$158,906
Washington	5,500	$65,056	7,800	$87,345	100	$448	500	$1,151	13,900	$153,999
West Virginia	1,600	$33,295	15,000	$138,193	11,900	$42,914			28,400	$214,403
Wisconsin	4,500	$79,466	2,800	$49,557	100	$319	3,500	$3,282	10,900	$132,624
Wyoming										

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64 reports, 2012. Because 2009 data was unavailable, 2008 data was used for Pennsylvania, Utah, and Wisconsin. Spending for these states was then adjusted to 2009 CMS-64 spending levels.

Note: Due to data security measures, the values of cells with fewer than 50 enrollees are neither reported nor included in the final totals. Without these exclusions total national enrollment rises to 2,836,100 and total national spending rises to $36,655,010,000.
The FFY 2009 MSIS data did not report any medically needy enrollees in Rhode Island, although at the time, there was a medically needy program in place. There were 4,400 medically needy enrollees in Rhode Island in FFY 2008.

Table 3: Medically Needy Enrollment as a Share of Total Enrollment, by State, 2009

State	Elderly	Disabled	Adults	Children	TOTAL
TOTAL	11.4%	5.1%	5.6%	2.4%	4.5%
Alabama					
Alaska					
Arizona					
Arkansas	0.5%	1.8%	2.9%	0.2%	1.0%
California	20.5%	7.6%	2.5%	7.3%	6.5%
Colorado					
Connecticut	11.9%	15.4%	0.7%	0.8%	3.9%
Delaware					
District of Columbia	6.4%	20.9%	34.2%	29.4%	26.6%
Florida	1.3%	2.8%	16.3%	1.6%	4.6%
Georgia	1.7%	2.0%		0.0%	0.5%
Hawaii	10.9%	1.7%			1.3%
Idaho					
Illinois	35.1%	25.2%	38.1%	0.3%	15.8%
Indiana					
Iowa	1.4%	0.7%	3.2%	0.3%	1.3%
Kansas	2.7%	4.9%	0.9%	0.2%	1.5%
Kentucky	1.4%	1.6%	10.8%	1.8%	3.1%
Louisiana	1.4%	1.2%	2.8%	0.1%	0.9%
Maine	6.5%	1.3%	0.5%	0.5%	1.7%
Maryland	28.3%	14.6%	2.0%	0.6%	5.4%
Massachusetts	17.4%	3.2%			2.3%
Michigan	5.8%	2.7%	14.3%	3.6%	5.9%
Minnesota	16.6%	7.7%	2.9%	0.5%	3.9%
Mississippi					
Missouri					
Montana	27.9%	10.2%			4.4%
Nebraska	40.8%	6.4%	35.9%	0.3%	10.6%
Nevada					
New Hampshire	10.9%	13.4%	11.2%	1.5%	5.8%
New Jersey	3.2%	0.6%			0.6%
New Mexico					
New York	40.5%	21.8%	8.4%	11.4%	14.9%
North Carolina	11.8%	3.3%	5.3%	0.4%	3.0%
North Dakota	58.6%	22.3%	16.6%	1.1%	14.4%
Ohio					
Oklahoma					
Oregon					
Pennsylvania	3.5%	0.7%	8.1%	2.5%	3.2%
Rhode Island					
South Carolina					
South Dakota					
Tennessee	0.3%	0.1%	4.6%	4.7%	3.3%
Texas	0.0%	0.1%	9.0%	0.1%	1.2%
Utah	12.1%	8.4%	1.3%	0.7%	2.4%
Vermont	17.4%	19.3%	9.2%	3.8%	9.4%
Virginia	3.0%	3.3%	0.0%	0.0%	0.9%
Washington	6.3%	4.3%	0.0%	0.1%	1.2%
West Virginia	3.7%	13.0%	19.7%		6.8%
Wisconsin	3.1%	1.9%	0.0%	0.8%	1.1%
Wyoming					

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FFY 2009 MSIS, 2012. Because 2009 data was unavailable, 2008 MSIS data was used for Pennsylvania, Utah, and Wisconsin. Spending for these states was then adjusted to 2009 CMS-64 spending levels.

Note: Due to data security measures, the values of cells with fewer than 50 enrollees are neither reported nor included in the final totals. The FFY 2009 MSIS data did not report any medically needy enrollees in Rhode Island, although at the time, there was a medically needy program in place. Two percent of the total Rhode Island Medicaid population was medically needy in FFY 2008.

Children and Families. In federal fiscal year 2009, over 929,000 non-disabled adults and 740,000 non-disabled children were enrolled in a state medically needy program. California enrolled the highest number of medically needy children (322,700), representing 44 percent of all medically needy child enrollment, 36 percent of spending on medically needy children, and 7 percent of all Californian non-disabled children enrolled in Medicaid. California uses a higher income eligibility threshold than other states to determine financial eligibility which translates into greater opportunities for children with large medical bills to spend-down to Medicaid eligibility. Illinois had the largest adult medically needy population (267,100) followed by New York (163,000). Spending on medically needy adults in these two states represented half of all adult medically needy spending.

For non-disabled children, the medically needy program provides a pathway to Medicaid for those who exceed categorically needy income eligibility levels. Federal rules require that states provide Medicaid to children under age 6 up to 133 percent of the Federal Poverty Level ($30,656 for a family of 4 in 2012) and for those ages 6 to 18 up to 100 percent of the FPL ($23,050 for a family of 4 in 2012). Most states have expanded eligibility for children above the minimum levels. As of January 2012, half of the states (26, including DC) cover children in families with incomes up to at least 250 percent FPL.[9] Children in families with higher incomes can qualify for the Children's Health Insurance Program (CHIP). States that cover children under CHIP receive a higher FMAP than under Medicaid, so children in this higher income range are not likely to be enrolled in a medically needy option. Children with incomes above the CHIP income range could potentially spend down to Medicaid medically needy eligibility. Together Medicaid and CHIP function as key sources of coverage for low- and moderate-income children.

The federal minimum level at which states must cover parents through Medicaid is below poverty in every state and below half of poverty in nearly all states. Most states have expanded parent eligibility above this minimum through optional Medicaid authority or waiver or state-funded programs but often with more limited benefits and higher cost sharing than Medicaid. Parents can qualify for Medicaid medically needy coverage by having income below the state's MNIL or by incurring out-of-pocket health expenses that would reduce their income below the applicable MNIL.

The Elderly and People with Disabilities. In federal fiscal year 2009, the elderly accounted for one-quarter (696,800) of total medically needy beneficiaries and people with disabilities accounted for 17 percent (469,800) of total medically needy enrollment. Overall, the elderly were responsible for half of medically needy spending and non-elderly people with disabilities were responsible for 38 percent of total medically needy spending. New York and California enrolled the largest number of elderly medically needy individuals, representing 64 percent of all medically needy elderly enrollment and 66 percent of total spending on elderly medically needy beneficiaries. New York also enrolled the largest number of individuals with disabilities in a medically needy program (145,900).

The medically needy program is an important source of coverage for some elderly and persons with disabilities who are ineligible for SSI because their income is too high. For these

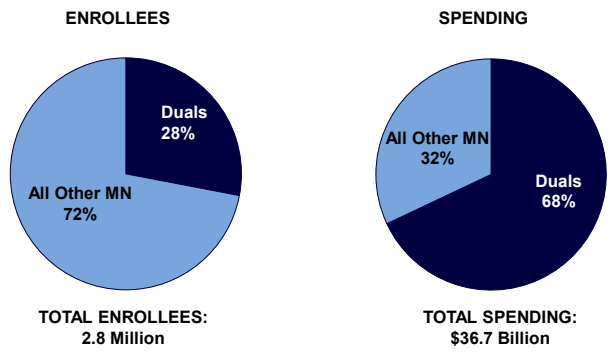
[9] Kaiser Commission on Medicaid and the Uninsured, "Where are States Today? Medicaid and CHIP Eligibility Levels for Children and Non-disabled Adults," March 2012, available at http://www.kff.org/medicaid/7993.cfm.

individuals, the medically needy pathway may be the only way they can qualify for Medicaid. States also have the option to cover persons with disabilities and the elderly up to 100 percent FPL with resources at the SSI level. Most people with disabilities, who qualify under the medically needy option, receive services in the community (85%) compared to 58 percent of elderly medically needy who live in the community. For elderly and persons with disabilities living in the community, Medicaid coverage is often the only way they are able to pay for personal care, prescription drugs, or other medical services. While Medicare assists the elderly and some people with disabilities, it leaves many expenses uncovered, including long-term institutional or community-based services and supports.

For people living in nursing facilities, the medically needy program is particularly important because the cost of care is expensive and many people do not have sufficient income or assets to pay for this care. In states without a medically needy program, an individual with $1 of income more than the 300 percent of SSI limit is ineligible for Medicaid, regardless of the cost of nursing home care.[10] Institutionalized individuals whose income exceeds the state's MNIL or categorically needy must spend-down to the state's MNIL to qualify for Medicaid. Depending on the state, the income limit for institutionalized individuals could be either the SSI-related income standard or a higher income eligibility level permitted under the "300 percent rule." Thirty-eight states allow people needing nursing home care to qualify for Medicaid with income up to 300 percent of the benefit amount payable to an individual with no income or resources ($2,094/month in 2012).[11] Once an institutionalized individual has established Medicaid eligibility, most of the income that the individual receives is applied to the cost of the institutional care,[12] with the exception of a small "personal needs allowance," typically $50 or less per month. Individuals are also

Figure 5

Medically Needy as a Percentage of Medicaid Enrollment and Spending, by Dual Status, 2009



SOURCE: KCMU and Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64 reports, 2012. Because 2009 data was unavailable, 2008 MSIS data was used for Pennsylvania, Utah, and Wisconsin. Spending for these states was adjusted to 2009 CMS-64 spending levels.

[10] In a 209(b) state, spend-down is mandatory as a condition for maintaining more restrictive eligibility standards than SSI. Individuals may spend down to the 209(b) income level to qualify for Medicaid. Another exception occurs in a state that recognizes Miller Trusts – a trust used specifically to meet the state's income threshold for Medicaid eligibility. In Miller Trust states, individuals with income that exceeds the Special Income Limit may assign the "excess" to the Trust. Monies in the trust may be used only to pay for specific costs, such as the support of a community spouse.

[11] Kaiser Commission on Medicaid and the Uninsured and the Medicare Rights Center, "Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities," Kaiser Commission on Medicaid and the Uninsured, February 2010, available at http://www.kff.org/medicaid/8048.cfm. This is an optional categorically needy group that some states cover as an alternative to covering the medically needy because it bounds their financial exposure for the costs of institutional and home and community-based services.

[12] An exception to this occurs within the context of spousal impoverishment protections that allow states to disregard the income of the community spouse and allow the community spouse to keep half of the couple's joint assets subject to minimum and maximum thresholds.

required to meet the medically needy resource requirements, typically those used in the SSI program.

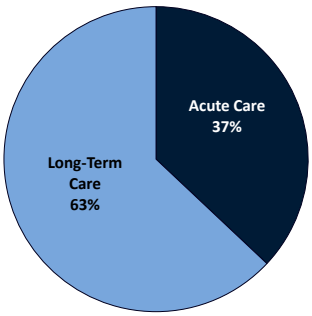
Dual Eligible Beneficiaries. People who are dually eligible for both Medicare and Medicaid accounted for about one-quarter of the medically needy population but two-thirds of medically needy spending (Figure 5), reflecting their more intensive need for services. Medicaid provides coverage to more than 9 million Medicare beneficiaries helping them with Medicare's premiums and cost sharing requirements, and paying for the services that are not covered by Medicare, such as long-term services and supports. Many states have efforts underway to improve integration of care for individuals dually eligible for Medicare and Medicaid, including providing more community-based options for beneficiaries who are in need of long-term services and supports.[13]

What Services Do Medically Needy Enrollees Rely On?

Medically needy beneficiaries rely on a range of Medicaid services to meet their acute and long-term services and supports needs. In federal fiscal year 2009, total federal and state Medicaid spending on services was $36.7 billion (Figure 6). Spending on acute care services, including payments to managed care, inpatient, outpatient/physician services and prescription drugs, totaled $13.5 billion. In contrast, spending on long-term services and supports was nearly double, totaling $23.2 billion. Within long-term care services, the vast majority of spending went toward the cost of providing institutional services (81%), including nursing facility, ICF/MR, and inpatient psychiatric services (Figure 7). The remainder of long-term services spending went toward home and community-based services. Payment of Medicare premiums and DSH payments were excluded from this analysis.

Figure 6

Medically Needy Spending by Service, 2009

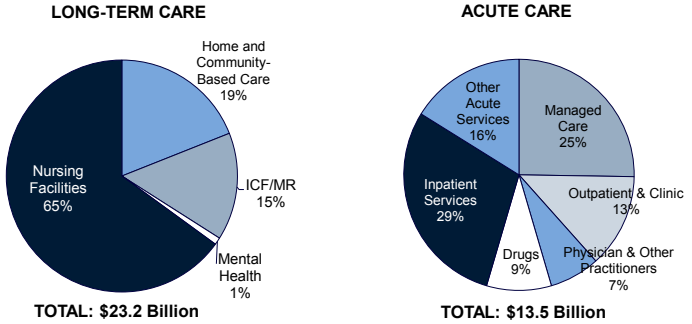


TOTAL: $36.7 Billion

SOURCE: KCMU and Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64 reports, 2012. Because 2009 data was unavailable, 2008 MSIS data was used for Pennsylvania, Utah, and Wisconsin. Spending for these states was adjusted to 2009 CMS-64 spending levels.

Figure 7

Medically Needy Spending by Service, 2009



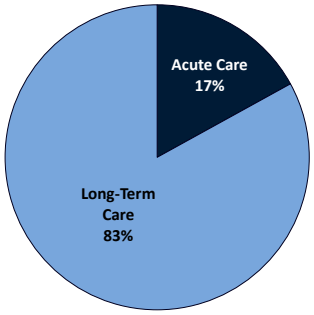
TOTAL: $23.2 Billion **TOTAL: $13.5 Billion**

NOTE: The Managed Care grouping includes HMO, PHP, and PCCM.
SOURCE: KCMU and Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64 reports, 2012. Because 2009 data was unavailable, 2008 MSIS data was used for Pennsylvania, Utah, and Wisconsin. Spending for these states was adjusted to 2009 CMS-64 spending levels.

[13]MaryBeth Musumeci, "State Demonstrations to Integrate Care and Align Financing for Dual Eligible Beneficiaries: A Review of the 26 Proposals Submitted to CMS," Kaiser Commission on Medicaid and the Uninsured, October 2012, available at http://www.kff.org/medicaid/8369.cfm

Figure 8

Medically Needy Spending by Service for Dual Eligible Beneficiaries, 2009



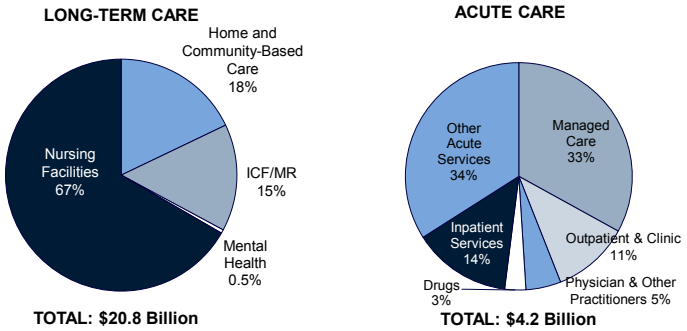
TOTAL: $25.0 Billion

SOURCE: KCMU and Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64 reports, 2012. Because 2009 data was unavailable, 2008 MSIS data was used for Pennsylvania, Utah, and Wisconsin. Spending for these states was adjusted to 2009 CMS-64 spending levels.

Medically needy beneficiaries who are dually eligible for Medicare and Medicaid accounted for $25 billion (or 68%) of total Medicaid medically needy spending (Figure 8). When Medicare premiums are excluded, 83 percent of Medicaid expenditures for medically needy dual eligible beneficiaries are for long-term services and supports. Amongst dual eligible beneficiaries, Medicaid coverage is supplemental to Medicare, which is the primary payer for acute care, resulting in only 17 percent of Medicaid expenditures for medically needy dual eligible beneficiaries going to acute care. Sixty-seven percent of long-term services and supports spending for dually eligible medically needy beneficiaries went toward nursing facilities (Figure 9). Most of the remaining long-term services and supports spending was on home and personal care services, which are composed of home and community-based services, home health, and personal care. Only 3 percent of 2009 acute care expenditures for medically needy dual eligible beneficiaries were for prescription drugs, as nearly all prescription drug spending for dual eligible beneficiaries was absorbed into Medicare in January 2006 with the implementation of Medicare Part D. However, states are required to make a substantial contribution towards this benefit through monthly "clawback" payments to the federal treasury. The remaining acute care spending on medically needy dual eligible beneficiaries went toward payments to managed care, Medicaid's financing of Medicare-covered acute care services (e.g., hospital, physician, and lab/x-ray services) and other acute care services that are not covered by Medicare, such as dental care, vision, and hearing services.

Figure 9

Medically Needy Spending by Service for Dual Eligible Beneficiaries, 2009



TOTAL: $20.8 Billion

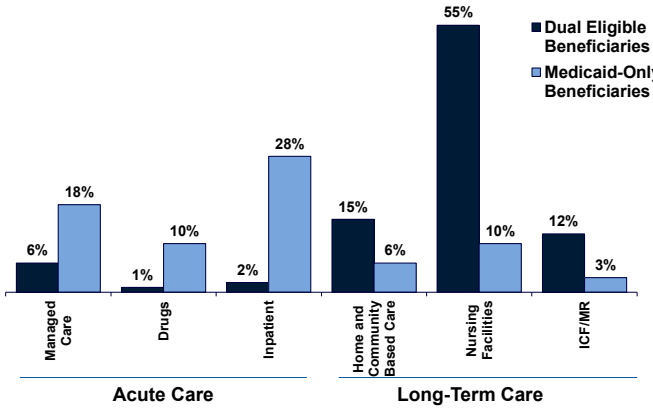
TOTAL: $4.2 Billion

NOTE: The Managed Care grouping includes HMO, PHP, and PCCM.
SOURCE: KCMU and Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64 reports, 2012. Because 2009 data was unavailable, 2008 MSIS data was used for Pennsylvania, Utah, and Wisconsin. Spending for these states was adjusted to 2009 CMS-64 spending levels.

Compared to all other medically needy beneficiaries, medically needy beneficiaries who are dually eligible for Medicare and Medicaid had a higher percentage of spending on long-term services and supports (Figure 10). Notably, the duals had a higher percentage of spending on nursing facility services (55% versus 10%), all home and community-based services including HCBS, home health and personal care (15% versus 6%), and ICFs/MR (12% versus 3%).

Figure 10

Medically Needy Spending by Service for Dual Eligible and Medicaid-Only Beneficiaries, 2009



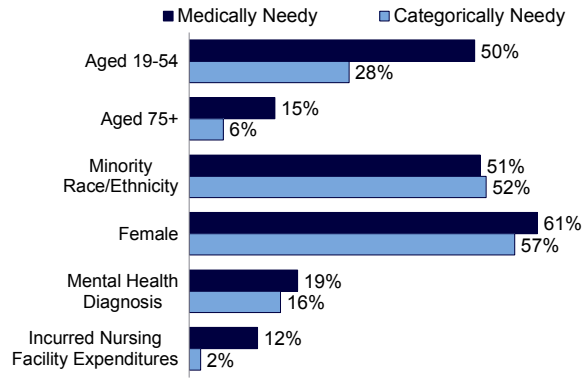
NOTE: The Managed Care grouping includes HMO, PHP, and PCCM.
SOURCE: KCMU and Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64 reports, 2012. Because 2009 data was unavailable, 2008 MSIS data was used for Pennsylvania, Utah, and Wisconsin. Spending for these states was adjusted to 2009 CMS-64 spending levels.

How Do Medically Needy Enrollees Compare to Categorically Needy Enrollees?

Individuals who qualify for Medicaid through the medically needy option differ from others on Medicaid who qualify through categorically needy pathways in their age and nursing facility spending. By definition, the medically needy have more income than the categorically needy. In general, the medically needy incur medical expenses in order to qualify and, to remain eligible, repeatedly incur medical expenses. The medically needy option plays a large role for elderly Medicaid beneficiaries. With 15 percent of the medically needy age 75 or older, the medically needy population is generally more aged than the categorically needy, of whom only 6 percent are age 75 or older. In addition, 12 percent of the medically needy incurred nursing home expenditures, while only 2 percent of the categorically needy did (Figure 11). In other ways, such as race and ethnicity, gender, and mental health diagnoses, the composition of the medically needy is similar to the categorically needy, with the exception of income.

Figure 11

Comparison of Medically Needy and Categorically Needy, 2009

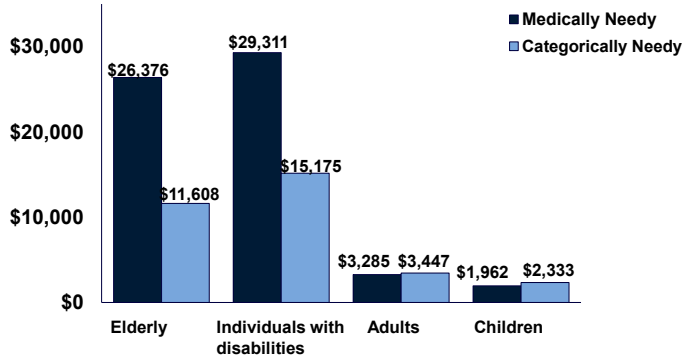


SOURCE: KCMU and Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64 reports, 2012. Because 2009 data was unavailable, 2008 MSIS data was used for Pennsylvania, Utah, and Wisconsin. Spending for these states was adjusted to 2009 CMS-64 spending levels.

Spending per medically needy enrollee varied by eligibility group and differed from spending for categorically needy enrollees. Among medically needy enrollees, individuals with disabilities and elderly individuals had the highest average annual per capita spending (at $29,311 and $26,376, respectively) compared to significantly lower costs for adults and children ($3,285 and $1,962) (Figure 12). Moreover, for elderly individuals and individuals with disabilities, medically needy enrollees had significantly higher spending compared to categorically needy individuals. In contrast, spending for adults and children was similar for both medically needy and categorically needy enrollees. Higher per capita expenditures for the elderly and individuals with disabilities, relative to adults and children, reflect their intensive use of both acute and long-term services and supports.

Figure 12

Medicaid Expenditures Per Enrollee, 2009



SOURCE: KCMU and Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64 reports, 2012. Because 2009 data was unavailable, 2008 MSIS data was used for Pennsylvania, Utah, and Wisconsin. Spending for these states was adjusted to 2009 CMS-64 spending levels.

Policy Implications

The medically needy option is complicated for individuals to navigate and for states to administer; however, it provides an important safety net for people whose medical costs overwhelm their income. The opportunity to spend down is very important to elderly individuals residing in nursing facilities and children and adults with disabilities who live in the community and incur high health care expenses. Still, the process of accounting for incurred expenses during a specific budget time period (one to six months) and paying claims after the spend-down has been met adds administrative complexity for states and can make medically needy coverage less consistent for individuals, especially for those who do not have high, recurring medical expenses. Presumably, a number of individuals cycle in and out of medically needy eligibility, depending on whether or not their expenses are sufficient to meet the spend-down obligation for a specific budget period. For example, if an individual has a $400 monthly spend-down obligation, but she resides in a state with a six-month budget period, she must incur $2,400 of expenses before her Medicaid coverage begins. Her medically needy eligibility would extend only during the portion of the 6-month budget window after she had met her spend-down obligation, and then the $400 per month spend-down obligation would reset. In contrast, in a state that redetermines eligibility for children (or any other group) once every 12 months, an individual who is determined eligible would remain eligible until redetermination unless there is a change in circumstances that may affect his or her eligibility.[14]

States have tools to simplify medically needy eligibility with authority to offer income deductions beyond those offered by SSI in order to loosen eligibility standards for potential medically needy beneficiaries, commonly referred to as the 1902(r)(2) regulations.[15] These regulations also allow states to increase the allowable resource limit. Iowa, for example, has an asset limit of $10,000 for an individual or couple. This flexibility, however, is not unlimited. Guidance from the Centers for Medicare and Medicaid Services (CMS) states that a state may not limit deductions only to waiver beneficiaries, or only to persons in institutions. Targeting can only be based on eligibility groups such as the medically needy aged or medically needy disabled persons or a combination of both groups.[16] At least initially, these targeting rules appear to significantly limit the viability of income deductions due to the potential financial burden on states.[17] However, CMS has stated that a state can choose to disregard specific kinds of income – examples include Social Security Disability Income, interest from savings accounts, income put into a medical savings account, or used to maintain or repair a home.[18] These types of income disregards may be particularly important for elderly and disabled individuals who wish to avoid entering a nursing home and remain living in the community by having to incur fewer expenses before they gain Medicaid eligibility.

[14] 42 CFR 435.916
[15] 42 CFR 435.601
[16] CMS, Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources: Questions and Answers (May 11, 2001).
[17] National Senior Citizens Law Center, "Medicaid Payment for Assisted Living, Overview of Medically Needy Eligibility: A Resource for Advocacy and Policy Development," February 2011, available at http://medicaidalseries.org/wp-content/uploads/White-Paper-Medically-Needy-Feb-2011-FINAL1.pdf.
[18] CMS, Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources: Questions and Answers (May 11, 2001).

Despite tight budget conditions, states have maintained medically needy programs over the past several years. During the most recent recession, states experienced strong enrollment and spending growth along with diminished state revenues. As a result, many sought to reduce Medicaid costs by restricting provider rates and benefits and implementing new controls on prescription drug spending.[19] However, eligibility for Medicaid has remained stable due to the maintenance of eligibility (MOE) requirement included in ARRA and extended in the ACA.[20] Moreover, several states made positive changes to their medically needy programs over the last several years ranging from increases in the MNILs (North Dakota raised its MNIL from 58% to 83% of FPL)[21] to increases in asset levels (New York raised its asset levels from $3,000 to $13,000 for a family of one with the asset limit further rising with household size). Montana increased the general income deduction to $100 for the medically needy population.[22]

Experience with severe budget shortfalls over the past decade, however, demonstrates that without the MOE requirement, Medicaid medically needy programs can be vulnerable during tight budget years. In 2003, Oklahoma and Oregon both eliminated their programs due to shortfalls in their state budgets. When Oregon's program was discontinued, 8,750 people lost coverage.[23] When Oklahoma eliminated its medically needy program a few months later, an estimated 800 children, 6,500 parents, and 1,000 seniors lost coverage.[24] Reducing medically needy coverage could result in greater financial burden on these individuals, in these individuals going without necessary care, and in providers absorbing costs of uncompensated care.

The medically needy option helps facilitate access to Medicaid home and community-based services. The vast majority of medically needy people with disabilities use community-based services (85%) and over half (58%) of the medically needy elderly access care in the community. Community-based care is an important option for dual eligible beneficiaries, who account for over a quarter of medically needy enrollment and 68 percent of medically needy spending. States utilize HCBS waivers in order to provide services in the community as an alternative to institutional care provided in a nursing facility, ICF/MR or hospital. These waiver programs permit Medicaid beneficiaries who meet requirements for admission to an institutional setting (or

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[19] Vern Smith et al, "Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends," Kaiser Commission on Medicaid and the Uninsured, October 2011, available at http://www.kff.org/medicaid/8248.cfm.

[20] As a condition of accepting additional federal fiscal relief through the ARRA, states were required to ensure that the eligibility standards, methodologies, or procedures under their Medicaid State Plan as well as under any waivers or demonstration programs were not more restrictive than those in effect on July 1, 2008. The ARRA enhanced funding and MOE requirements expired on June 30, 2011, but the ACA extended MOE requirements. Under the ACA, states must maintain eligibility standards and enrollment and renewal procedures that were in place on March 23, 2010 until 2014 for adults and until 2019 for children with some limited exceptions. Ibid.

[21] Vern Smith et al., "Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends," Kaiser Commission on Medicaid and the Uninsured, available at http://www.kff.org/medicaid/8105.cfm.

[22] Vern Smith et al., "The Crunch Continues: Medicaid Spending, Coverage and Policy in the Midst of a Recession," Kaiser Commission on Medicaid and the Uninsured, September 2009, available at http://www.kff.org/medicaid/7985.cfm.

[23] Judy Zerzan. "Oregon's Medically Needy Program Survey," Office for Oregon Health Policy and Research, February 2004.

[24] Leighton Ku and Sashi Nimalendran. "Losing Out: States are cutting 1.2 to 1.6 Million Low-Income people from Medicaid, SCHIP and Other State Health Insurance programs." Center on Budget and Policy Priorities, December 22, 2003.

who would meet these requirements absent the HCBS waiver services) to receive appropriate services and supports in their homes or a community-based setting and maintain both their independence and ties to family and friends. States may impose a special income disregard for Medicaid HCBS waiver applicants whose incomes are above waiver limits. Louisiana has adopted this authority with an income disregard equal to the state's average monthly cost of nursing facility care for individuals who do not qualify under the 300 percent of SSI category. Without this authority, individuals not categorically eligible would have to meet spend-down requirements each month to maintain Medicaid waiver eligibility.[25]

Conclusion

In 2009, 2.8 million Medicaid beneficiaries received coverage through the medically needy option at a federal and state cost of nearly $37 billion per year. These individuals represent a small but costly segment of the Medicaid population. Medicaid medically needy programs have always been complicated for individuals to navigate and for states to administer, but these programs have provided an important safety net for many whose medical costs overwhelm their income. Many states have successfully used medically needy programs to expand benefits to individuals with high-cost conditions who would otherwise be ineligible for Medicaid coverage. Through medically needy programs, states also have a vehicle to expand Medicaid coverage to populations that may otherwise be ineligible for Medicaid.

It will be important to consider what happens to Medicaid medically needy programs and to the individuals who currently receive coverage under the medically needy option post-2014. The ACA did not change any current requirements for medically needy eligibility under section 1902(a)(10)(C) of the Act. However, under the ACA as interpreted by the Supreme Court, states have the option to expand Medicaid coverage to non-disabled adults under age 65 with incomes at or below 138 percent FPL ($15,415 per year for an individual in 2012), beginning in January 2014.[26] States also will have the option to cover non-elderly individuals who are not otherwise eligible for Medicaid with incomes above 138 percent FPL, up to a maximum income limit set by the state.[27] In addition, the Exchanges will provide a new coverage option for millions of currently uninsured individuals with advance premium tax credits (APTC) available to individuals up to 400 percent FPL to help offset the costs of coverage. These new optional coverage expansions have the potential to reach individuals who currently qualify for Medicaid through the medically needy option.

Looking forward, since the elderly are not affected by the ACA coverage expansion, the medically needy option remains an important source of coverage for this population, by providing access to care for individuals with long-term services and supports needs in both community and institutional settings. States may continue to offer medically needy coverage to this population post-2014 but would still be required to extend coverage to children and pregnant women. The medically needy option would also continue to help children such as Sean, an 11-

[25] Gene Coffey, "Helping Medicaid's Medically Needy Stay at Home," presentation to NASUAD's 2011 HCBS Conference, National Senior Citizens Law Center, September 13, 2011.
[26] MaryBeth Musumeci, "A Guide to the Supreme Court's Decision on the ACA's Medicaid Expansion," Kaiser Commission on Medicaid and the Uninsured, August 2012, available at http://www.kff.org/healthreform/8347.cfm.
[27] 42 C.F.R. § 435.218.

year old boy with behavioral health problems, afford the cost of a $10,000 per month residential treatment center. Ultimately, states that elect the ACA's Medicaid expansion will have to decide if covering an individual through the Medicaid expansion or the Exchange can substitute for medically needy coverage. States will likely consider whether they can save money and reduce administrative burden by covering some medically needy individuals under other eligibility pathways, without compromising on scope of services and affordability.

This brief was prepared by Molly O'Malley Watts, Principal of Watts Health Policy Consulting and Katherine Young of the Kaiser Commission on Medicaid and the Uninsured. The authors wish to thank Andy Schneider, Samantha Artiga and MaryBeth Musumeci for their helpful comments and review of the brief.

Appendix A

BACKGROUND ON MEDICALLY NEEDY ELIGIBILITY

The medically needy option provides a pathway to Medicaid coverage for people who have extensive health care needs, yet start out with too much income to qualify for cash assistance and therefore, Medicaid. The role of the medically needy option is unique in that it provides a last chance opportunity for becoming eligible for Medicaid for individuals not eligible as categorically needy. Under current law, in exchange for receiving federal Medicaid matching funds, states are required to cover certain federal core groups, listed in Appendix Table 1. States also have flexibility to expand Medicaid eligibility beyond federal minimum standards to cover additional "optional" groups and receive federal Medicaid matching funds for the costs of their services.

The term "medically needy" was used by the architects of the Medicaid program in 1965 to distinguish this population from other populations eligible for Medicaid known as the "categorically needy." At that time, in order to qualify for Medicaid, it was not sufficient for an individual to be poor. An individual also had to fit into a certain category – i.e., aged, blind, disabled, a dependent child, or a parent or caretaker relative of a dependent children. These categories reflected cash assistance policy of the day, to which Medicaid eligibility was closely linked. (Poor working-age adults without disabilities who did not have dependent children could not qualify for Medicaid because they were not categorically eligible). Within the categorically needy, there were some populations that, as a condition of participating in Medicaid, states were required to cover – e.g., individuals receiving cash assistance through the Aid to Families with Dependent Children (AFDC) program. States also had the option of covering other categorically needy populations, such as children aged 20, 19, or 18 who were no longer receiving AFDC benefits (because cash assistance eligibility ended at age 18) but who still met the income and resource requirements of the state AFDC program. Both mandatory and optional categorically needy groups have income and resource eligibility thresholds tied to specific dollar amounts; an individual with countable income or resources even one dollar above those amounts cannot qualify. As with the optional categorically needy populations, coverage of the "medically needy" is also optional. This option allows states to receive federal Medicaid matching funds for the costs of health and long-term care services for individuals who meet categorical eligibility requirements but whose incomes exceed the income eligibility thresholds for coverage as a categorically needy individual.

States may choose to provide medically needy coverage to one or more groups: the elderly, individuals with disabilities, parents and caretaker relatives, and certain other financially eligible children up to age 21. However, states which elect to implement the medically needy option are required to include certain children under age 19 and pregnant women who, except for income and resources, would be eligible as categorically needy. Moreover, income standards under the medically needy option must be the same for all covered groups, including low-income families, the elderly, and people with disabilities.

Appendix Table 1:
Medicaid Eligibility Groups, 2011

Federal Core Enrollees	State Expansion Enrollees
• Pre-school children ≤133% FPL ($24,645 per year for a family of three) • School-age children ≤100% FPL ($18,530 per year for a family of three) • Pregnant women ≤133% FPL • Parents <state's AFDC limit as of July 1996 (median = 64% FPL or $11,859 for a family of three) • Elderly and disabled individuals receiving SSI (<75% FPL $8,168 per year for an individual) • Certain working people with disabilities • Medicare buy-in groups (QMB, SLMB, QI)	• Low-income children above federal core minimum income thresholds • Low-income parents >1996 AFDC limits • Pregnant women >133% FPL • Adults ≤133% FPL* • Disabled and elderly individuals above SSI level, but <100% FPL ($10,890 for an individual) • Nursing home residents above SSI level, but below 300% of SSI ($2,022 per month) • Individuals at risk of needing nursing facility or ICF-MR care (HCBS waiver enrollees) • Certain working people with disabilities above SSI levels • Section 1115 waiver enrollees (including family planning waiver enrollees) • Medically needy

* Effective April 2010, the ACA provides states with a new option to receive federal funds to cover, non-pregnant, non-disabled adults age 19 to 64 without dependent children with incomes up to 133% FPL.
Source: Courtot, Lawton, and Artiga, *Medicaid Enrollment and Expenditures by Federal Core Requirements and State Options*, Kaiser Commission on Medicaid and the Uninsured, January 2012.

Most states offer the full Medicaid benefit package to medically needy individuals, but states are permitted to offer a more limited benefit package than for categorically needy beneficiaries.[28] States are also permitted to place different limitations on covered services for the medically needy and charge higher cost sharing for medically needy beneficiaries. Services furnished to the medically needy are matched at a state's regular federal medical assistance percentage (FMAP).

Federal requirements for medically needy programs are:

- If a state covers institutional services for any medically needy individual, it must also cover ambulatory services for that individual;
- States must provide ambulatory services to medically needy children age 18 and under;
- States must cover prenatal care and delivery services for medically needy pregnant women; and
- If a state provides medically needy coverage for services in Institutions for Mental Diseases (IMDs) or Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) (or

[28] Barbara Edwards, Sandy Kramer and Linda Elam, "The Impact of Part D on Dual Eligibles Who Spend-Down to Medicaid," Kaiser Commission on Medicaid and the Uninsured, April 2007, available at http://www.kff.org/medicaid/7629.cfm.

both), then it must provide to all medically needy beneficiaries either (1) all required services for the categorically needy (except nurse practitioner services and free-standing birth center services) or (2) the following services: inpatient hospital services, outpatient hospital services, laboratory and x-ray services, nursing facility services, physician services, and nurse-midwife services.[29]

[29] Jeff Crowley, "Medically Needy Programs: An Important Source of Medicaid Coverage," Kaiser Commission on Medicaid and the Uninsured, January 2003, available at http://www.kff.org/medicaid/4096-index.cfm.

Appendix B

HOW TO CALCULATE SPEND-DOWN

States may choose to provide medically needy coverage to one or more groups: the elderly, individuals with disabilities, parents and caretaker relatives, and certain other financially eligible children up to age 21. States must use a single income eligibility standard for all medically needy recipients (regardless of whether they are families or SSI-related) that takes into account the number of persons in the assistance unit.[30] This single income standard is called the "medically needy income level" (MNIL). By federal law, the MNIL may not exceed 133 percent of the maximum payment for a similar family under the state's AFDC program in place on July 16, 1996. Individuals who have incomes above the state's MNIL, but who fall below that level once their medical expenses are deducted, can qualify for Medicaid coverage as medically needy through spend-down.

To spend down, an individual must incur (but not necessarily pay) medical and remedial care expenses that bring their countable income below the MNIL. Federal rules identify expenses that count toward the spend-down requirements including expenses for Medicare and other health insurance premiums, deductibles and coinsurance; expenses for necessary medical and remedial services recognized under state law but not included in the Medicaid state plan; and, expenses for necessary medical and remedial services that are included in the Medicaid state plan, including those that exceed limitations on amount, duration or scope of services. Several factors affect the determination of Medicaid eligibility through spend-down, including:

- Income eligibility
- Budget period
- Pay-in spend-down

Income Eligibility
There are two components to determining income eligibility, the income standard and the income methodology. The standard is the maximum amount of countable monthly income an individual can have and still be eligible for Medicaid. The methodology is used to determine how much of a person's income is counted toward the income standard.

In most circumstances, federal regulations require a state to use a single income standard for all medically needy beneficiaries. States have broad discretion in setting the income standard, although they can only receive federal matching payments for individuals whose income is below a maximum of 133 percent of the state's 1996 AFDC payment level. States can adjust this level for inflation, but adjustments cannot exceed increases in the consumer price index. The MNIL can also vary between urban and rural areas based on differences in housing costs. States are permitted, but not required, to increase the MNIL as family size increases, but they are prohibited from decreasing MNIL as family size increases. In most states, the income standard must be set at an amount no lower than the lowest income standard used to determine eligibility under the related cash assistance programs. The 209(b) states are allowed an exception to

[30] 42 CFR 435.811

establish a more restrictive income standard for medically needy blind and disabled individuals than for medically needy families with children.

States have flexibility in establishing income methodology, and the rules that each state chooses to apply can vary dramatically. Elements of the methodology include: definitions of income, exclusions or disregards of income, composition and number of persons included in the budgetary unit, deeming of income from spouses and parents, treatment of regular and periodic income, and ownership of income. Except for 209(b) states, the methodology that a state uses to count income can be no more restrictive than those that are used in the most closely related cash assistance program. Therefore, a state may have a single income standard for all groups, but use a different methodology for determining whether income falls below the standard for children, parents, people with disabilities, and the elderly. However, states are still bound by the 133 percent of AFDC payment standard constraint.

Budget Period

In determining eligibility, the state selects a budget period of between one and six months, during which time an applicant will be assessed to determine whether they meet their spend-down obligation.[31] If, after deducting medical costs, the individual's income is below the state established MNIL, the individual will qualify for Medicaid coverage for the remainder of the period. There is no Medicaid coverage until the point in the spend-down period that the individual has hit the MNIL and continues through the last day of the states spend-down period.

Depending on an individual's circumstance, and whether or not his or her medical expenses are incurred on an ongoing basis, the length of the budget period can make it easier or harder for an individual to meet the spend-down requirement. States are permitted to use more than one budget period. For example, the state could establish one budget period for institutionalized individuals and another for non-institutionalized individuals. Further, the state could establish two budget periods for non-institutionalized individuals. In this case, however, the state must allow the applicant to select which budget period will be applied.

The length of the budget period can pose a significant barrier to Medicaid coverage for people in certain circumstances, including persons in need of home and community based services or persons desiring to live in an assisted living center. This is because the full spend-down for the length of the budget period must be incurred before Medicaid coverage begins. In this case, either the individual needs to pay the full spend-down with his or her own funds or the provider must be willing to wait for payment until Medicaid coverage begins. Institutional providers and larger providers may be more willing to begin caring for an individual before they are determined to be eligible for Medicaid, something that smaller, community based providers are unable to do.

There are advantages to both a short and a long budget period. Presumably, a long budget period is administratively preferable. However, for many beneficiaries, a shorter budget period makes it easier to qualify for Medicaid because they only need to meet the spend-down requirement one month at a time. For some individuals, however, a longer budget period may be preferable if they have recurring high-cost health conditions. In this case, they may prefer to meet their

[31] 42 CFR 435.831

spend-down and then have a longer period of Medicaid coverage before having to spend down once again.

Appendix Table 2 shows an example of how the spend-down amount is calculated. Assume a state has a 6-month spend-down period. The applicant has a monthly income of $650 and the eligibility standard is $450 a month. To meet the eligibility level, the applicant must incur health-related expenses of $1,200 ($200 x 6) before she is eligible for Medicaid. To remain qualified, the applicant must incur enough health expenses to reduce her income to the eligibility standard each month.

Appendix Table 2: Spend Down Example for the Medically Needy

Individual's Countable Monthly Income	$650
State's Medically Needy Monthly Income Limit	$450
Income Over State Limit	$200
State Spend-Down Period	6 months (Varies by state from 1 - 6 months)
Individual's Spend-Down Amount	$1,200 Income over state's limit times spend down period ($200 x 6 months)

Pay-In Spend-down

States can also provide an alternative method for individuals to meet the spend-down requirement, called Pay-in Spend-down. This involves individuals making a cash payment to the state to satisfy the spend-down requirement. For example, if an individual has a spend-down obligation of $500, which is partially satisfied through incurring $300 of medical expenses, the state can accept a cash lump sum or installment payment of $200 for the balance. It can be beneficial to allow individuals to use a pay-in spend-down. For example, if an individual pays in, then they can be eligible for Medicaid before any medical expenses are incurred. This would mean that all expenses are billable at Medicaid payment rates. If an individual must incur expenses before they are eligible, then the services would not be billed at Medicaid rates or they would not be eligible for discounts and rebates negotiated by Medicaid. The following states utilize the pay-in option: Illinois, Minnesota, Missouri, Montana, New York, Ohio and Utah.

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

American Council on Aging

Medicaid Eligibility Income Chart by State (Updated Nov. 2024)

Last updated: November 24, 2024

The table below shows Medicaid's monthly income limits by state for seniors. Income is not the only eligibility factor for Medicaid long-term care; there is also an asset limit and level of care requirement. Additionally, there are state-specific details. Click on the state name below to see that state's complete Medicaid eligibility criteria.

✱ A free, non-binding Medicaid Eligibility Test is available here. This test takes approximately 3 minutes to complete.

The maximum income limits change dependent on the marital status of the applicant, whether a spouse is also applying for Medicaid, and the type of Medicaid for which they are applying. Nursing Home Medicaid may have a different income limit than Medicaid Home and Community Based Services, and both of those may differ from the Aged, Blind and Disabled Medicaid income limits.

Exceeding the income limit does not mean an individual cannot qualify for Medicaid. Most states have multiple pathways to Medicaid eligibility, such as a Medically Needy Pathway. Furthermore, many states allow the use of Miller Trusts or Qualified Income Trusts to help persons who cannot afford their care costs to become income-eligible for Medicaid. There are also Medicaid Planning Professionals that employ other complicated techniques to help persons become eligible.

What Happens to One's Income When They Enter a Nursing Home

While persons residing in Medicaid-funded nursing homes are permitted to have monthly income as high as $2,901 in 2025 (in most states), they are not permitted to keep all of it. Instead, nearly all of their income except for a Personal Needs Allowance (which ranges for $30 – $200 / month), must go towards paying for their cost of care. Often, the nursing home coordinates directly with Social Security so the income they would have otherwise received goes straight to the nursing home.

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What Happens to One's Income When They Qualify for a Medicaid HCBS Waiver

When persons receive Medicaid long-term care at home or "in the community" (outside of a nursing home) through a Medicaid Waiver, they still have expenses that must be paid. Rent, food, and utilities, as an example, are expenses that end when one is in a nursing home, but continue when one receives Medicaid at home. Therefore, Medicaid beneficiaries that receive assistance through a Medicaid HCBS Waiver are permitted to keep their monthly income (up to a certain amount) to pay those expenses.

❗ Should one's income exceed the limits in the table below, it may still be possible to qualify for Medicaid through working with a Certified Medicaid Planner. Find a Planner that provides services in your area.

2025 Medicaid Eligibility Income Chart – Updated Nov. 2024

State	Type of Medicaid	Single	Married (both spouses applying)	Married (one spouse applying)
Alabama	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Alabama	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Alabama	Regular Medicaid / Medicaid for Elderly and Disabled	$987 / month	$1,470 / month	$1,470 / month
Alaska	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Alaska	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Alaska	Regular Medicaid / Aged Blind and Disabled	$1,751 / month (eff. 1/24 – 12/24)	$2,593 / month (eff. 1/24 – 12/24)	$2,593 / month (eff. 1/24 – 12/24)

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2025 Medicaid Eligibility Income Chart – Updated Nov. 2024

State	Type of Medicaid	Single	Married (both spouses applying)	Married (one spouse applying)
Arizona	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Arizona	Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Arizona	Regular Medicaid / Aged Blind and Disabled	$1,255 / month (eff. 2/24 – 1/25)	$1,704 / month (eff. 2/24 – 1/25)	$1,704 / month (eff. 2/24 – 1/25)
Arkansas	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Arkansas	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Arkansas	Regular Medicaid / Aged Blind and Disabled	$1,004 / month (eff. 4/24 – 3/25)	$1,362.67 / month (eff. 4/24 – 3/25)	$1,362.67 / month (eff. 4/24 – 3/25)
California	Institutional / Nursing Home Medicaid	No income limit, but resident is only permitted to keep $35 / month.	No income limit, but resident is only permitted to keep $35 / month.	No income limit, but resident is only permitted to keep $35 / month.
California	Medicaid Waivers / Home and Community Based Services	$1,732 / month (eff. 4/24 – 3/25)	$2,352 / month (eff. 4/24 – 3/25)	$1,732 / month for applicant (eff. 4/24 – 3/25)
California	Regular Medicaid / Aged Blind and Disabled	$1,732 / month (eff. 4/24 – 3/25)	$2,352 / month (eff. 4/24 – 3/25)	$2,332 / month (eff. 4/24 – 3/25)
Colorado	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant

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2025 Medicaid Eligibility Income Chart – Updated Nov. 2024

State	Type of Medicaid	Single	Married (both spouses applying)	Married (one spouse applying)
Colorado	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Colorado	Regular Medicaid / Aged Blind and Disabled	$967 / month	$1,450 / month	$1,450 / month
Connecticut	Institutional / Nursing Home Medicaid	Income must be less than the cost of nursing home	Income must be less than the cost of nursing home	Income must be less than the cost of nursing home
Connecticut	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Connecticut	Regular Medicaid / Aged Blind and Disabled	$1,314 / month (eff. 10/1/24)	$2,112 / month (eff. 10/1/24)	$1,601 / month (eff. 10/1/24)
Delaware	Institutional / Nursing Home Medicaid	$2,417.50 / month	$4,835 / month ($2,417.50 / month per spouse)	$2,417.50 / month for the applicant
Delaware	Home and Community Based Services / Long Term Care Community Services	$2,417.50 / month	$4,835 / month ($2,417.50 / month per spouse)	$2,417.50 / month for the applicant
Delaware	Regular Medicaid / Aged Blind and Disabled	$967 / month	$1,450 / month	$1,450 / month
Florida	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Florida	Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant

2025 Medicaid Eligibility Income Chart – Updated Nov. 2024

State	Type of Medicaid	Single	Married (both spouses applying)	Married (one spouse applying)
Florida	Regular Medicaid / Medicaid for Aged and Disabled	$1,105 / month (eff. 4/24 – 3/25)	$1,499 / month (eff. 4/24 – 3/25)	$1,499 / month (eff. 4/24 – 3/25)
Georgia	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Georgia	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Georgia	Regular Medicaid / Aged Blind and Disabled	$967 / month	$1,450 / month	$1,450 / month
Hawaii	Institutional / Nursing Home Medicaid	No hard income limit. One's entire income except for $50 / month must go towards cost of care.	No hard income limit. Each spouse's entire income except for $50 / month must go towards cost of care.	No hard income limit. Applicant's entire income except for $50 / month must go towards cost of care.
Hawaii	Home and Community Based Services	If one lives at home $1,443 / month (eff. 2/4/24)	Each spouse is considered separately. If they are living at home, each spouse can have up to $1,443 / month. (eff. 2/4/24)	If one lives at home, applicant income limit of $1,443 / month (eff. 2/4/24)
Hawaii	Regular Medicaid / Aged Blind and Disabled	$1,443 / month (eff. 2/4/24)	$1,958 / month (eff. 2/4/24)	$1,958 / month (eff. 2/4/24)
Idaho	Institutional / Nursing Home Medicaid	$2,921 / month	$5,822 / month	$2,921 / month for applicant
Idaho	Medicaid Waivers / Home and	$2,921 / month	$5,822 / month	$2,921 / month for applicant

2025 Medicaid Eligibility Income Chart – Updated Nov. 2024

State	Type of Medicaid	Single	Married (both spouses applying)	Married (one spouse applying)
	Community Based Services			
Idaho	Regular Medicaid / Aged Blind and Disabled	$1,020 / month	$1,470 / month	$1,470 / month
Illinois	Institutional / Nursing Home Medicaid	$1,255 / month (eff. 4/24 – 3/25)	$1,703 / month (eff. 4/24 – 3/25)	$1,255 / month for applicant (eff. 4/24 – 3/25)
Illinois	Medicaid Waivers / Home and Community Based Services	$1,255 / month (eff. 4/24 – 3/25)	$1,703 / month (eff. 4/24 – 3/25)	$1,255 / month for applicant (eff. 4/24 – 3/25)
Illinois	Regular Medicaid / Aid to Aged Blind and Disabled	$1,255 / month (eff. 4/24 – 3/25)	$1,703 / month (eff. 4/24 – 3/25)	$1,703 / month (eff. 4/24 – 3/25)
Indiana	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Indiana	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Indiana	Traditional Medicaid / Aged Blind and Disabled	$1,255 / month (eff. 3/24 – 2/25)	$1,704 / month (eff. 3/24 – 2/25)	$1,704 / month (eff. 3/24 – 2/25)
Iowa	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Iowa	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant

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2025 Medicaid Eligibility Income Chart – Updated Nov. 2024

State	Type of Medicaid	Single	Married (both spouses applying)	Married (one spouse applying)
Iowa	Regular Medicaid / Aged Blind and Disabled	$967 / month	$1,450 / month	$1,450 / month
Kansas	Institutional / Nursing Home Medicaid	No set income limit. Income over $62 / month must go towards one's cost of care.	No set income limit. Income over $62 / month (per spouse) must go towards one's cost of care.	No set income limit. Applicant's income over $62 / month must go towards one's cost of care.
Kansas	Medicaid Waivers / Home and Community Based Services	No set income limit. Income over $2,901 / month must be paid towards one's cost of care.	No set income limit. Income over $2,901 / month (per spouse) must be paid towards one's cost of care.	No set income limit. Applicant's income over $2,901 / month must be paid towards one's cost of care.
Kansas	Regular Medicaid / Aged Blind and Disabled	$475 / month	$475 / month	$475 / month
Kentucky	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Kentucky	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Kentucky	Regular Medicaid / Aged Blind and Disabled	$235 / month	$291 / month	$291 / month
Louisiana	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Louisiana	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Louisiana	Regular Medicaid / Aged Blind and	$967 / month	$1,450 / month	$1,450 / month

2025 Medicaid Eligibility Income Chart – Updated Nov. 2024

State	Type of Medicaid	Single	Married (both spouses applying)	Married (one spouse applying)
	Disabled			
Maine	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Maine	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Maine	Regular Medicaid / Aged Blind and Disabled	$1,255 / month (eff. 1/24 – 12/24)	$1,704 / month (eff. 1/24 – 12/24)	$1,704 / month (eff. 1/24 – 12/24)
Maryland	Institutional / Nursing Home Medicaid	Cannot exceed the cost of nursing home care	Cannot exceed the cost of nursing home care	Applicant's income cannot exceed the cost of nursing home care
Maryland	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Maryland	Regular Medicaid / Aged Blind and Disabled	$350 / month	$392 / month	$392 / month
Massachusetts	Institutional / Nursing Home Medicaid	No hard limit. Income over $72.80 / month must go towards care costs.	No hard limit. Income over $72.80 / month (per spouse) must go towards care costs.	No hard limit. Income over $72.80 / month must go towards care costs.
Massachusetts	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Massachusetts	Regular Medicaid / Aged Blind and Disabled	$1,255 / month (eff. 3/24 – 2/25)	$1,704 / month (eff. 3/24 – 2/25)	$1,704 / month (eff. 3/24 – 2/25)

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2025 Medicaid Eligibility Income Chart – Updated Nov. 2024

State	Type of Medicaid	Single	Married (both spouses applying)	Married (one spouse applying)
Michigan	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Michigan	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Michigan	Regular Medicaid / Aged Blind and Disabled	$1,255 / month (eff. 1/24 – 12/24)	$1,703 / month (eff. 1/24 – 12/24)	$1,703 / month (eff. 1/24 – 12/24)
Minnesota	Institutional / Nursing Home Medicaid	$1,255 / month (eff. 7/24-6/25)	$1,704 / month (eff. 7/24-6/25)	$1,255 / month for applicant
Minnesota	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Minnesota	Regular Medicaid / Elderly Blind and Disabled	$1,255 / month (eff. 7/24 –6/25)	$1,704 / month (eff. 7/24 –6/25)	$1,704 / month (eff. 7/24 –6/25)
Mississippi	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Mississippi	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Mississippi	Regular Medicaid / Aged Blind and Disabled	$967 / month	$1,450 / month	$1,450 / month
Missouri	Institutional / Nursing Home Medicaid	All available income except for $50 / month must be paid towards care	All available income except for $50 / month (per spouse) must be paid towards care	All applicant's available income except for $50 / month must be paid towards care

2025 Medicaid Eligibility Income Chart – Updated Nov. 2024

State	Type of Medicaid	Single	Married (both spouses applying)	Married (one spouse applying)
Missouri	Medicaid Waivers / Home and Community Based Services	Structured Family Caregiving Waiver ($1,067 / month – eff. 4/24 – 3/25) Aged & Disabled Waiver ($1,649 / month – eff. 1/24 – 12/24)	Structured Family Caregiving Waiver ($1,067 / month per spouse – eff. 4/24 – 3/25) Aged & Disabled Waiver ($1,649 / month per spouse – eff. 1/24 – 12/24)	Structured Family Caregiving Waiver ($1,067 / month for applicant – eff. 4/24 – 3/25) Aged & Disabled Waiver ($1,649 / month for applicant – eff. 1/24 – 12/24)
Missouri	Regular Medicaid / Aged Blind and Disabled	$1,067 / month for Aged & Disabled (eff 4/24 – 3/25). $1,255 / month for Blind (eff 4/24 – 3/25).	$1,448 / month for Aged & Disabled (eff 4/24 – 3/25). $1,704 / month for Blind (eff 4/24 – 3/25).	$1,448 / month for Aged & Disabled (eff 4/24 – 3/25). $1,704 / month for Blind (eff 4/24 – 3/25).
Montana	Institutional / Nursing Home Medicaid	Income must be equal or less than the cost of nursing home care	Income must be equal or less than the cost of nursing home care	Applicant's income must be equal or less than the cost of nursing home care
Montana	Medicaid Waivers / Home and Community Based Services	$967 / month	$1,934 / month ($967 / month per spouse)	$967 / month for applicant
Montana	Regular Medicaid / Aged Blind and Disabled	$967 / month	$1,450 / month	$1,450 / month
Nebraska	Institutional / Nursing Home Medicaid	$1,255 / month (eff. 1/24 – 12/24)	$1,255 / month per spouse (eff. 1/24 – 12/24)	$1,255 / month for applicant (eff. 1/24 – 12/24)
Nebraska	Medicaid Waivers / Home and Community Based Services	$1,255 / month (eff. 1/24 – 12/24)	$1,255 / month per spouse (eff. 1/24 – 12/24)	$1,255 / month for applicant (eff. 1/24 – 12/24)

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2025 Medicaid Eligibility Income Chart – Updated Nov. 2024

State	Type of Medicaid	Single	Married (both spouses applying)	Married (one spouse applying)
Nebraska	Regular Medicaid / Aged Blind and Disabled	$1,255 / month (eff. 1/24 – 12/24)	$1,703 / month (eff. 1/24 – 12/24)	$1,703 / month (eff. 1/24 – 12/24)
Nevada	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Nevada	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Nevada	Regular Medicaid / Aged Blind and Disabled	$967 / month	$1,450 / month	$1,450 / month
New Hampshire	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
New Hampshire	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
New Hampshire	Regular Medicaid / Old Age Assistance	$957 / month (eff. 1/24 – 12/24)	$1,416 / month (eff. 1/24 – 12/24)	$1,416 / month (eff. 1/24 – 12/24)
New Jersey	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
New Jersey	Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
New Jersey	Regular Medicaid / Aged Blind and Disabled	$1,255 / month (eff. 1/24 – 12/24)	$1,704 / month (eff. 1/24 – 12/24)	$1,704 / month (eff. 1/24 – 12/24)

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2025 Medicaid Eligibility Income Chart – Updated Nov. 2024

State	Type of Medicaid	Single	Married (both spouses applying)	Married (one spouse applying)
New Mexico	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
New Mexico	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
New Mexico	Regular Medicaid / Aged Blind and Disabled	$967 / month	$1,450 / month	$1,450 / month
New York	Institutional / Nursing Home Medicaid	$1,732 / month (eff. 1/24 – 12/24)	$2,351 / month (eff. 1/24 – 12/24)	$1,732 / month for applicant (eff. 1/24 – 12/24)
New York	Medicaid Waivers / Home and Community Based Services	$1,732 / month (eff. 1/24 – 12/24)	$2,351 / month (eff. 1/24 – 12/24)	$1,732 / month for applicant (eff. 1/24 – 12/24)
New York	Regular Medicaid / Aged Blind and Disabled	$1,732 / month (eff. 1/24 – 12/24)	$2,351 / month (eff. 1/24 – 12/24)	$2,351 / month (eff. 1/24 – 12/24)
North Carolina	Institutional / Nursing Home Medicaid	Must be less than the amount Medicaid pays for nursing home care (est. $8,004 – $11,093 / mo.)	Must be less than the amount Medicaid pays for nursing home care (est. $8,004 – $11,093 / mo.)	Applicant's income must be less than the amount Medicaid pays for nursing home care (est. $8,004 – $11,093 / mo.)
North Carolina	Medicaid Waivers / Home and Community Based Services	$1,255 / month (eff. 4/24 – 3/25)	$1,704 / month (eff. 4/24 – 3/25)	$1,255 / month (eff. 4/24 – 3/25)
North Carolina	Regular Medicaid / Aged Blind and Disabled	$1,255 / month (eff. 4/24 – 3/25)	$1,704 / month (eff. 4/24 – 3/25)	$1,704 / month (eff. 4/24 – 3/25)
North Dakota	Institutional / Nursing Home	No set limit. Applicant is allowed	No set limit. Couple is allowed $200 for	No set limit. Applicant is allowed

2025 Medicaid Eligibility Income Chart – Updated Nov. 2024

State	Type of Medicaid	Single	Married (both spouses applying)	Married (one spouse applying)
	Medicaid	$100 for personal needs and the remaining income goes towards the cost of care.	personal needs. The remaining income goes towards the cost of care.	$100 for personal needs and the remaining income goes towards the cost of care
North Dakota	Medicaid Waivers / Home and Community Based Services	$1,130 / month (eff. 4/24 – 3/25)	$1,533 / month (eff. 4/24 – 3/25)	$1,130 / month for applicant (eff. 4/24 – 3/25)
North Dakota	Regular Medicaid / Aged Blind and Disabled	$1,130 / month (eff. 4/24 – 3/25)	$1,533 / month (eff. 4/24 – 3/25)	$1,533 / month (eff. 4/24 – 3/25)
Ohio	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Ohio	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Ohio	Regular Medicaid / Aged Blind and Disabled	$967 / month	$1,450 / month	$1,450 / month
Oklahoma	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Oklahoma	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Oklahoma	Regular Medicaid / Aged Blind and Disabled	$1,255 / month (eff. 4/24 – 3/25)	$1,704 / month (eff. 4/24 – 3/25)	$1,704 / month (eff. 4/24 – 3/25)
Oregon	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant

2025 Medicaid Eligibility Income Chart – Updated Nov. 2024

State	Type of Medicaid	Single	Married (both spouses applying)	Married (one spouse applying)
Oregon	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Oregon	Regular Medicaid / Aged Blind and Disabled	$967 / month	$1,450 / month	$1,450 / month
Pennsylvania	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Pennsylvania	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Pennsylvania	Regular Medicaid / Aged Blind and Disabled	$965.10 / month (eff. 1/24 – 12/24)	$1,448.30 / month (eff. 1/24 – 12/24)	$1,448.30 / month (eff. 1/24 – 12/24)
Rhode Island	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Rhode Island	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Rhode Island	Regular Medicaid / Elders and Adults with Disabilities (EAD)	$1,255 / month (eff. 1/24 – 12/24)	$1,703 / month (eff. 1/24 – 12/24)	$1,703 / month (eff. 1/24 – 12/24)
South Carolina	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
South Carolina	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant

2025 Medicaid Eligibility Income Chart – Updated Nov. 2024

State	Type of Medicaid	Single	Married (both spouses applying)	Married (one spouse applying)
South Carolina	Regular Medicaid / Aged Blind or Disabled	$1,255 / month (eff 3/24 – 2/25)	$1,704 / month (eff 3/24 – 2/25)	$1,704 / month (eff 3/24 – 2/25)
South Dakota	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
South Dakota	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
South Dakota	Regular Medicaid / Aged Blind and Disabled	$967 / month	$1,450 / month	$1,450 / month
Tennessee	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Tennessee	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Tennessee	Regular Medicaid / Aged Blind and Disabled	$967 / month	$1,450 / month	$1,450 / month
Texas	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Texas	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Texas	Regular Medicaid / Aged Blind and Disabled	$967 / month	$1,450 / month	$1,450 / month
Utah	Institutional / Nursing Home	No income limit. One's monthly	No income limit. Each spouse's	No income limit. Applicant's monthly

2025 Medicaid Eligibility Income Chart – Updated Nov. 2024

State	Type of Medicaid	Single	Married (both spouses applying)	Married (one spouse applying)
	Medicaid	income determines how much one must pay towards the cost of care.	monthly income determines how much each spouse must pay towards the cost of care.	income determines how much one must pay towards the cost of care.
Utah	Medicaid Waivers / Home and Community Based Services	Aging Waiver ($1,255 / month – eff. 3/24 – 2/25) New Choices Waiver ($2,901 / month – eff. 1/25 – 12/25)	Aging Waiver (Each spouse is allowed up to $1,255 / month – eff. 3/24 – 2/25) New Choices Waiver (Each spouse is allowed up to $2,901 / month – eff. 1/25 – 12/25)	Aging Waiver ($1,255 / month for applicant – eff. 3/24 – 2/25) New Choices Waiver ($2,901 / month for applicant month – eff. 1/25 – 12/25)
Utah	Regular Medicaid / Aged Blind and Disabled	$1,255 / month (eff. 3/24 – 2/25)	$1,703 / month (eff. 3/24 – 2/25)	$1,703 / month (eff. 3/24 – 2/25)
Vermont	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Vermont	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Vermont	Regular Medicaid / Aged Blind and Disabled (outside Chittenden County)	$1,300 / month (eff. 1/24 – 12/24)	$1,300 / month (eff. 1/24 – 12/24)	$1,300 / month (eff. 1/24 – 12/24)
Vermont	Regular Medicaid / Aged Blind and Disabled (inside Chittenden County)	$1,408 / month (eff. 1/24 – 12/24)	$1,408 / month (eff. 1/24 – 12/24)	$1,408 / month (eff. 1/24 – 12/24)

2025 Medicaid Eligibility Income Chart – Updated Nov. 2024

State	Type of Medicaid	Single	Married (both spouses applying)	Married (one spouse applying)
Virginia	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Virginia	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Virginia	Regular Medicaid / Aged Blind and Disabled	$1,004 / month (eff. 1/24 – 12/24)	$1,363 / month (eff. 1/24 – 12/24)	$1,363 / month (eff. 1/24 – 12/24)
Washington	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Washington	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Washington	Regular Medicaid / Aged Blind and Disabled	$967 / month	$1,450 / month	$1,450 / month
Washington, DC	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Washington, DC	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Washington, DC	Regular Medicaid / Aged Blind and Disabled	$1,255 / month (eff. 1/24 – 12/24)	$1,703 / month (eff. 1/24 – 12/24)	$1,703 / month (eff. 1/24 – 12/24)
West Virginia	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,829 / month per spouse)	$2,901 / month for applicant

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2025 Medicaid Eligibility Income Chart – Updated Nov. 2024

State	Type of Medicaid	Single	Married (both spouses applying)	Married (one spouse applying)
West Virginia	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,829 / month per spouse)	$2,901 / month for applicant
West Virginia	Regular Medicaid / Aged Blind and Disabled	$967 / month	$1,450 / month	$1,450 / month
Wisconsin	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Wisconsin	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Wisconsin	Regular Medicaid / Elderly Blind and Disabled (EBD)	$1,026.78 / month (eff. 1/24 – 12/24)	$1,547.05 / month (eff. 1/24 – 12/24)	$1,547.05 / month (eff. 1/24 – 12/24)
Wyoming	Institutional / Nursing Home Medicaid	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Wyoming	Medicaid Waivers / Home and Community Based Services	$2,901 / month	$5,802 / month ($2,901 / month per spouse)	$2,901 / month for applicant
Wyoming	Regular Medicaid / Aged Blind and Disabled	$967 / month	$1,450 / month	$1,450 / month

Financial Industry Regulatory Authority (FINRA) Sections

FINRA

2165. Financial Exploitation of Specified Adults

(a) Definitions

(1) For purposes of this Rule, the term "Specified Adult" shall mean: (A) a natural person age 65 and older; or (B) a natural person age 18 and older who the member reasonably believes has a mental or physical impairment that renders the individual unable to protect his or her own interests.

(2) For purposes of this Rule, the term "Account" shall mean any account of a member for which a Specified Adult has the authority to transact business.

(3) For purposes of this Rule, the term "Trusted Contact Person" shall mean the person who may be contacted about the Specified Adult's Account in accordance with Rule 4512.

(4) For purposes of this Rule, the term "financial exploitation" means:

(A) the wrongful or unauthorized taking, withholding, appropriation, or use of a Specified Adult's funds or securities; or

(B) any act or omission by a person, including through the use of a power of attorney, guardianship, or any other authority regarding a Specified Adult, to:

(i) obtain control, through deception, intimidation or undue influence, over the Specified Adult's money, assets or property; or

(ii) convert the Specified Adult's money, assets or property.

(b) Temporary Hold on Disbursements or Transactions

(1) A member may place a temporary hold on a disbursement of funds or securities from the Account of a Specified Adult or a transaction in securities in the Account of a Specified Adult if:

(A) The member reasonably believes that financial exploitation of the Specified Adult has occurred, is occurring, has been attempted, or will be attempted; and

(B) The member, not later than two business days after the date that the member first placed the temporary hold on the disbursement of funds or securities or the transaction in securities, provides notification orally or in writing, which may be electronic, of the temporary hold and the reason for the temporary hold to:

(i) all parties authorized to transact business on the Account, unless a party is unavailable or the member reasonably believes that the party has engaged, is engaged, or will engage in the financial exploitation of the Specified Adult; and

(ii) the Trusted Contact Person(s), unless the Trusted Contact Person is unavailable or the member reasonably believes that the Trusted Contact Person(s) has engaged, is engaged, or will engage in the financial exploitation of the Specified Adult; and

(C) The member immediately initiates an internal review of the facts and circumstances that caused the member to reasonably believe that the financial exploitation of the Specified Adult has occurred, is occurring, has been attempted, or will be attempted.

(2) The temporary hold authorized by this Rule will expire not later than 15 business days after the date that the member first placed the temporary hold on the disbursement of funds or securities or the transaction in securities, unless otherwise terminated or extended by a state regulator or agency of competent jurisdiction or a court of competent jurisdiction, or extended pursuant to paragraph (b)(3) of this Rule.

(3) Provided that the member's internal review of the facts and circumstances under paragraph (b)(1)(C) of this Rule supports the member's reasonable belief that the financial exploitation of the Specified Adult has occurred, is occurring, has been attempted, or will be attempted, the temporary hold authorized by this Rule may be extended by the member for no longer than 10 business days following the date authorized by paragraph (b)(2) of this Rule, unless otherwise terminated or extended by a state regulator or agency of competent jurisdiction or a court of competent jurisdiction, or extended pursuant to paragraph (b)(4) of this Rule.

(4) Provided that the member's internal review of the facts and circumstances under paragraph (b)(1)(C) of this Rule supports the member's reasonable belief that the financial exploitation of the Specified Adult has occurred, is occurring, has been attempted, or will be attempted and the member has reported or provided notification of the member's reasonable belief to a state regulator or agency of competent jurisdiction or a court of competent jurisdiction, the temporary hold authorized by this Rule may be extended by the member for

no longer than 30 business days following the date authorized by paragraph (b)(3) of this Rule, unless otherwise terminated or extended by a state regulator or agency of competent jurisdiction or a court of competent jurisdiction.

(c) Supervision

(1) In addition to the general supervisory and recordkeeping requirements of Rules 3110, 3120, 3130, 3150, and Rule 4510 Series, a member relying on this Rule shall establish and maintain written supervisory procedures reasonably designed to achieve compliance with this Rule, including, but not limited to, procedures related to the identification, escalation and reporting of matters related to the financial exploitation of Specified Adults.

(2) A member's written supervisory procedures also shall identify the title of each person authorized to place, terminate or extend a temporary hold on behalf of the member pursuant to this Rule. Any such person shall be an associated person of the member who serves in a supervisory, compliance or legal capacity for the member.

(d) Record Retention

Members shall retain records related to compliance with this Rule, which shall be readily available to FINRA, upon request. The retained records shall include records of: (1) request(s) for disbursement or transaction that may constitute financial exploitation of a Specified Adult and the resulting temporary hold; (2) the finding of a reasonable belief that financial exploitation has occurred, is occurring, has been attempted, or will be attempted underlying the decision to place a temporary hold on a disbursement or transaction; (3) the name and title of the associated person that authorized the temporary hold on a disbursement or transaction; (4) notification(s) to the relevant parties pursuant to paragraph (b)(1)(B) of this Rule; (5) the internal review of the facts and circumstances pursuant to paragraph (b)(1)(C) of this Rule; and (6) the reason and support for any extension of a temporary hold, including information regarding any communications with or by a state regulator or agency of competent jurisdiction or a court of competent jurisdiction.

• • • Supplementary Material: ----------

.01 Applicability of Rule. This Rule provides members and their associated persons with a safe harbor from FINRA Rules 2010, 2150 and 11870 when members exercise discretion in placing temporary holds on disbursements of funds or securities from the Accounts of Specified Adults or transactions in securities in the Accounts of Specified Adults consistent with the requirements of this Rule. This Rule does not require members to place temporary holds on disbursements of funds or securities from the Accounts of Specified Adults or transactions in securities in the Accounts of Specified Adults.

.02 Training. A member relying on this Rule must develop and document training policies or programs reasonably designed to ensure that associated persons comply with the requirements of this Rule.

.03 Reasonable Belief of Mental or Physical Impairment. A member's reasonable belief that a natural person age 18 and older has a mental or physical impairment that renders the individual unable to protect his or her own interests may be based on the facts and circumstances observed in the member's business relationship with the natural person.

Amended by SR-FINRA-2021-016 eff. March 17, 2022.
Adopted by SR-FINRA-2016-039 eff. Feb. 5, 2018.

Selected Notice: 17-11, 22-05.

‹ 2150. IMPROPER USE OF CUSTOMERS' SECURITIES OR FUNDS; PROHIBITION AGAINST GUARANTEES AND SHARING IN ACCOUNTS UP 2200. COMMUNICATIONS AND DISCLOSURES ›

VERSIONS

Mar 17, 2022 onwards

FINRA

4512. Customer Account Information

(a) Each member shall maintain the following information:

(1) for each account:

(A) customer's name and residence;

(B) whether customer is of legal age;

(C) name(s) of the associated person(s), if any, responsible for the account, and if multiple individuals are assigned responsibility for the account, a record indicating the scope of their responsibilities with respect to the account, provided, however, that this requirement shall not apply to an institutional account;

(D) signature of the partner, officer or manager denoting that the account has been accepted in accordance with the member's policies and procedures for acceptance of accounts;

(E) if the customer is a corporation, partnership or other legal entity, the names of any persons authorized to transact business on behalf of the entity; and

(F) subject to Supplementary Material .06, name of and contact information for a trusted contact person age 18 or older who may be contacted about the customer's account; provided, however, that this requirement shall not apply to an institutional account.

(2) for each account other than an institutional account, and accounts in which investments are limited to transactions in open-end investment company shares that are not recommended by the member or its associated persons, each member shall also make reasonable efforts to obtain, prior to the settlement of the initial transaction in the account, the following information to the extent it is applicable to the account:

(A) customer's tax identification or Social Security number;

(B) occupation of customer and name and address of employer; and

(C) whether customer is an associated person of another member; and

(3) for discretionary accounts maintained by a member, in addition to compliance with subparagraph (1) and, to the extent applicable, subparagraph (2) above, and Rule 3260, the member shall maintain a record of the dated, signature of each named, associated person of the member authorized to exercise discretion in the account. This recordkeeping requirement shall not apply to investment discretion granted by a customer as to the price at which or the time to execute an order given by a customer for the purchase or sale of a definite dollar amount or quantity of a specified security. Nothing in this Rule shall be construed as allowing members to maintain discretionary accounts or exercise discretion in such accounts except to the extent permitted under the federal securities laws.

(b) A member need not meet the requirements of this Rule with respect to any account that was opened pursuant to a prior FINRA rule until such time as the member updates the information for the account either in the course of the member's routine and customary business or as otherwise required by applicable laws or rules.

(c) For purposes of this Rule, the term "institutional account" shall mean the account of:

(1) a bank, savings and loan association, insurance company or registered investment company;

(2) an investment adviser registered either with the SEC under Section 203 of the Investment Advisers Act or with a state securities commission (or any agency or office performing like functions); or

(3) any other person (whether a natural person, corporation, partnership, trust or otherwise) with total assets of at least $50 million.

• • • Supplementary Material: ----------

.01 Customer Account Information Retention Periods. For purposes of this Rule, members shall preserve a record of any customer account information that subsequently is updated for at least six years after the date that such information is updated. Members shall preserve a record of the last update to any customer account information, or the original account information if there are no updates to the account information, for at least six years after the date the account is closed.

.02 Additional Customer Account Records Under the Exchange Act. Members should be aware that they may be required to make and preserve additional customer account records as required under Section 17(a) of the Exchange Act and the applicable associated Exchange Act rules.

.03 Compliance With Rule 2070. With respect to paragraph (a)(2)(B) of this Rule, members should be aware that they have an obligation to comply with the requirements of Rule 2070(a) if they have actual notice that a customer having a financial interest in, or controlling trading in, an account is an employee of FINRA.

.04 "Maintain" and "Preserve." For purposes of Rule 4512 only, as a general matter, the term "maintain" is used to reflect customer account information that is current or in use. The term "preserve" is used to reflect customer account information that is no longer current or in use.

.05 Supervision of Accounts. Nothing in paragraph (a)(1)(C) of this Rule obviates a member's obligation to supervise an account that it services, including determining the associated persons responsible for the account and ensuring that such persons are appropriately qualified and registered, and to comply with the requirements of Rule 2090 (effective July 9, 2012). With respect to a member's obligation to supervise an account, it is incumbent upon the member to design appropriate mechanisms to determine the associated persons responsible for the account, ensure that such persons are appropriately qualified and registered, and have the ability to provide such information to FINRA or SEC staff upon request.

.06 Trusted Contact Person

(a) With respect to paragraph (a)(1)(F) of this Rule, at the time of account opening a member shall disclose in writing, which may be electronic, to the customer that the member or an associated person of the member is authorized to contact the trusted contact person and disclose information about the customer's account to address possible financial exploitation, to confirm the specifics of the customer's current contact information, health status, or the identity of any legal guardian, executor, trustee or holder of a power of attorney, or as otherwise permitted by Rule 2165. With respect to any account that was opened pursuant to a prior FINRA rule, a member shall provide this disclosure in writing, which may be electronic, when updating the information for the account pursuant to paragraph (b) of this Rule either in the course of the member's routine and customary business or as otherwise required by applicable laws or rules.

(b) The absence of the name of or contact information for a trusted contact person shall not prevent a member from opening or maintaining an account for a customer, provided that the member makes reasonable efforts to obtain the name of and contact information for a trusted contact person.

(c) With respect to any account subject to the requirements of SEA Rule 17a- 3(a)(17) to periodically update customer records, a member shall make reasonable efforts to obtain or, if previously obtained, to update where appropriate the name of and contact information for a trusted contact person consistent with the requirements of SEA Rule 17a-3(a)(17).

Amended by SR-FINRA-2019-009 eff. May 8, 2019.
Amended by SR-FINRA-2018-040 eff. May 6, 2019.
Amended by SR-FINRA-2016-039 eff. Feb. 5, 2018.
Amended by SR-FINRA-2011-070 eff. Dec. 5, 2011.
Adopted by SR-FINRA-2010-052 eff. Dec. 5, 2011.

Selected Notices: 11-19, 17-11, 19-13.

‹ 4511. GENERAL REQUIREMENTS UP 4513. RECORDS OF WRITTEN CUSTOMER COMPLAINTS ›

VERSIONS

May 08, 2019 onwards