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## DEPARTMENT OF AGING

*Choice, Independence and Dignity for Older Marylanders*

### MEMORANDUM

**TO:** CCRC Executive Directors and Continuing Care at Home Provider

**FROM:** Debra A. Roane, Chief, Continuing Care *Debra Roane*

**DATE:** July 9, 2009

**RE:** Follow-up to the 2009 Legislative Session –  
Chapter 750 (Continuing Care Agreements, effective July 1, 2009)  
Chapter 694 (Internal Grievance Procedure, effective October 1, 2009)

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The Maryland General Assembly at its 2009 Session enacted the above two chapter laws regarding continuing care. The Department hopes that this memo will be helpful to you as we move forward with these new laws.

Chapter 750, which enacted House Bill 952, deals with continuing care agreements. It does not require providers to make any changes in their continuing care agreements. However, in the event your provider elects to make changes in its continuing care agreement, you and your attorney may find the enclosed June 9, 2009 updated version of the Department's Contract Worksheet to be helpful. You will note that the amendments that took effect on July 1, 2009 are set forth at pages 18 to 20 of the Worksheet.

The rest of this memo deals with Chapter 694, which amended the continuing care laws related to internal grievances. These amendments will take effect on October 1, 2009, and will require most of you to make minor revisions to your disclosure statement and possibly to your continuing care agreement. What follows is a brief overview of the October 1, 2009 continuing care statutes related to internal grievances and sample wording you can use to comply with the new amendments.

#### **Overview of the Three Key Continuing Care Statutes Related to Internal Grievances**

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The three key continuing care statutes related to internal grievances are located at Human Services Article (“HSA”) §§10-425(a)(22), 10-428, 10-444(b)(16).<sup>1</sup>

Part I below discusses HSA §10-428 and its revised requirements as to what your provider’s internal grievance procedure must include, effective October 1, 2009.

Part II below discusses HSA §10-425(a)(22), which requires your provider’s disclosure statement to include a description of its internal grievance procedure. Part II also includes Department approved sample wording that may be inserted in your provider’s next disclosure statement, in order to satisfy the laws discussed in both Parts I and II.

Part III below discusses HSA §10-444(b)(16), which requires your provider’s continuing care agreement to state that there is an internal grievance procedure to address a subscriber’s grievance. As explained in Part III, some providers will need to change the wording in their form continuing care agreement(s) and some will not. To assist providers in complying with HSA §10-444(b)(16), Part III sets forth the same preapproved wording that the Department approved in its August 6, 2004 memo to Executive Directors, but also sets forth additional preapproved alternative wording.

However, if your provider needs to change its currently approved wording regarding grievances in its continuing care agreement due to the October 1, 2009 amendments and does not want to use the preapproved wording, as explained in Part III below, it needs to submit to the Department for approval the wording it proposes to use by September 1, 2009.

### **I. Changes to Your Provider’s Internal Grievance Procedure, Effective October 1, 2009**

As shown in the attached Chapter 694, effective October 1, 2009, HSA §10-428 will provide as follows (deleted wording in brackets, new wording in all capitals):

10-428.

(a) A provider shall establish an internal grievance procedure to address a subscriber’s grievance.

(b) The internal grievance procedure shall **AT LEAST**:

(1) allow a subscriber **OR GROUP OF SUBSCRIBERS COLLECTIVELY**

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<sup>1</sup> Note that there are also grievance related laws administered by the Department of Health and Mental Hygiene (“DHMH”) for assisted living and comprehensive care, which are not addressed by this memorandum. However, please note that the continuing care statutes do provide at HSA §10-425(c) that, if the continuing care agreement has a provision to provide assisted living services and the provider does not execute a separate assisted living agreement, the continuing care disclosure statement must include an explanation of the assisted living program’s complaint or grievance procedure (i.e. the DHMH administered assisted living complaint or grievance procedure).

to submit a written grievance to the provider;

(2) require the provider to send a written acknowledgment to the subscriber within 5 days after receipt of the written grievance;

**(3) REQUIRE THE PROVIDER TO ASSIGN PERSONNEL TO INVESTIGATE THE GRIEVANCE;**

~~[(3)]~~ (4) give a subscriber who files a written grievance the right to meet with management of the provider within ~~[45]~~ **30** days after receipt of the written grievance to present the subscriber's grievance; and

~~[(4)]~~ (5) require the provider to respond within 45 days after receipt of the written grievance regarding the investigation and resolution of the grievance.

**(C) (1) WITHIN 30 DAYS AFTER THE CONCLUSION OF AN INTERNAL GRIEVANCE PROCEDURE ESTABLISHED UNDER THIS SECTION, A SUBSCRIBER OR PROVIDER MAY SEEK MEDIATION THROUGH ONE OF THE COMMUNITY MEDIATION CENTERS IN THE STATE OR ANOTHER MEDIATION PROVIDER.**

**(2) IF A PROVIDER OR SUBSCRIBER SEEKS MEDIATION UNDER PARAGRAPH (1) OF THIS SUBSECTION:**

**(I) THE MEDIATION SHALL BE NONBINDING; AND**

**(II) THE PROVIDER AND SUBSCRIBER MAY NOT BE REPRESENTED BY COUNSEL.**

Note that providers are required to comply with these new amendments to the law beginning October 1, 2009. See Part II below for sample wording that providers can use to satisfy the requirements of both this statute and the statute that is discussed in Part II below.

## **II. Your Provider's Disclosure Statements Dated On or After October 1, 2009**

HSA §10-425(a)(22), which requires that the disclosure statement include "a description of the internal grievance procedure," is not being amended on October 1, 2009. However, given the statutory requirement explained in Part I above, it is almost certain that the description of your provider's grievance procedure in its disclosure statement will also need to change. Accordingly, the following is a sample grievance procedure that providers may establish in order to satisfy HSA §10-428 (discussed in Part I above) and include in the disclosure statement in order to satisfy HSA §10-425(a)(22) (discussed in this Part II):

[Insert name of Provider] has established an internal grievance procedure to address resident grievances. A resident or a group of residents collectively may submit a grievance in writing to [insert title of Provider representative or representatives to whom grievances are to be sent]. [Insert name of Provider] will send a written acknowledgment to the resident within five days after receipt of the written grievance. [Insert name of Provider] will assign personnel to investigate the grievance. A resident who files a

written grievance is entitled to a meeting with management of [insert name of Provider] within 30 days after receipt of the written grievance, in order to present the grievance. [Insert name of Provider] will provide a response within 45 days after receipt of the written grievance as to the investigation and resolution of the grievance.

Within 30 days after [insert name of Provider] provides its response to the grievance, a resident or [insert name of Provider] may seek mediation through one of the community mediation centers in the State or another mediation provider. If a resident or [insert name of Provider] seeks mediation under the preceding sentence, the mediation shall be nonbinding and neither the resident nor [insert name of Provider] may be represented by counsel.<sup>2</sup>

Please note that the Department will be checking disclosure statements dated on or after October 1, 2009 for compliance with the October 1, 2009 amendments.

### **III. Your Provider's Continuing Care Agreements Entered Into on or After October 1, 2009**

The following sample provision was set forth in the Department's August 6, 2004 memo to CCRC Executive Directors as a pre-approved provision for complying with HSA §10-444(b)(16):

#### **Continuing Care Agreement Department Approved Alternative #1**

There is an internal grievance procedure to investigate the grievances of [insert the term used in the continuing care agreement to refer to subscribers, which for most providers is the word Residents].

If your provider is already using this sample provision in its continuing care agreement, it does not need to change. However, for those providers that wish to inform consumers in the continuing care agreement as to where to find a copy of the internal grievance procedure, the Department is also hereby approving adding the following sentence as part of Department Approved Alternative #1:

A copy of [insert name of Provider]'s internal grievance procedure is set forth in its disclosure statement.

If your provider is currently using another approach (such as setting forth the entire grievance procedure in the continuing care agreement), especially given the added complexity of the

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<sup>2</sup> Note that, in order to conform to the terminology used in the disclosure statement, other appropriate terminology may be substituted for the terms "resident" and "residents."

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grievance procedure under the new law, it may want to consider switching to this simplified approach (i.e. Alternative #1, with or without the additional cross referencing sentence).

There are some providers that have elected to set forth their internal grievance procedure in the continuing care agreement. In order to assist such providers, the Department is also approving the use of the same wording in the continuing care agreement that it authorized for use in the disclosure statement in Part II above, i.e.:

### **Continuing Care Agreement Department Approved Alternative #2**

[Insert name of Provider] has established an internal grievance procedure to address resident grievances. A resident or a group of residents collectively may submit a grievance in writing to [insert title of Provider representative or representatives to whom grievances are to be sent]. [Insert name of Provider] will send a written acknowledgment to the resident within five days after receipt of the written grievance. [Insert name of Provider] will assign personnel to investigate the grievance. A resident who files a written grievance is entitled to a meeting with management of [insert name of Provider] within 30 days after receipt of the written grievance, in order to present the grievance. [Insert name of Provider] will provide a response within 45 days after receipt of the written grievance as to the investigation and resolution of the grievance.

Within 30 days after [insert name of Provider] provides its response to the grievance, a resident or [insert name of Provider] may seek mediation through one of the community mediation centers in the State or another mediation provider. If a resident or [insert name of Provider] seeks mediation under the preceding sentence, the mediation shall be nonbinding and neither the resident nor [insert name of Provider] may be represented by counsel.<sup>3</sup>

Accordingly, this confirms that the inclusion of the above Continuing Care Agreement Department Approved Alternative #1 (with or without the additional cross referencing sentence) or Department Approved Alternative #2 in the version(s) of your provider's continuing care agreement(s) most recently approved by the Department is hereby approved (along with a suitable heading, where appropriate) and need not be submitted to the Department for approval.

However, if the currently approved wording in your provider's continuing care agreement(s) needs to be changed due to the October 1, 2009 amendments and your provider wants to use wording other than that set forth above, please submit to the Department for approval by September 1, 2009 (i) clean copies of the proposed changed pages to your provider's approved continuing care agreement(s) and (ii) in order to clearly identify the proposed changes,

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<sup>3</sup> Note that, in order to conform to the terminology used in the continuing care agreement, other appropriate terminology may be substituted for the terms "resident" and "residents."

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redlined or blacklined copies of just the proposed changed pages against the last version of those pages approved by the Department.

**Conclusion**

We hope that this memo will make it easier for you to comply with the changes in the continuing care laws made by General Assembly at its 2009 Session. However, if you have any questions, please feel free to call me.

**Provider's Human Services Article Title 10, Subtitle 4**  
**Continuing Care Contract Worksheet**

**Community:** \_\_\_\_\_

**Date Submitted:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**I. ACCOMMODATIONS / SERVICES:**

**I.A. Description of Living Unit.**

“Identify the specific living unit initially assigned to the subscriber;” COMAR .28A(21).

*Where [section(s) and page(s)]:*

**I.B. Subscriber's Rights/Obligations Regarding Facility and Common Areas.**

“State the rights and obligations a subscriber has regarding the use of the facility, including common areas;” COMAR .28A(27).

*Where [section(s) and page(s)]:*

**I.C. Provider's Rights/Obligations Regarding Facility/Right of Entry.**

“State the rights and obligations a provider has regarding its use of the facility, including what, if any, rights the provider has to enter a subscriber's unit;” COMAR .28A(28).

(NOTE: COMAR 10.07.14.35 provides that a resident of an assisted living program has the right to “Privacy, including the right to have a staff member knock on the resident's door before entering unless the staff member knows that the resident is asleep;”.)

*Where [section(s) and page(s)]:*

**I.D. Respective Rights/Obligations Regarding Subscriber's Property.**

“State the subscriber's and provider's respective rights and obligations as to any real and personal property of the subscriber transferred to or placed in the custody of the provider;” COMAR .28A(26).

*Where [section(s) and page(s)]:*

**I.E. Description of Services/for Life.**

“Describe in detail all items of service to be provided to the subscriber, such as food, shelter, medical or nursing care, and other health-related services;” COMAR .28A(2).

“State whether the items described for §A(2) of this regulation are to be provided for a designated time period or for life;” COMAR .28A(3).

*Where [section(s) and page(s)]:*

**I.F. Priority Admission to Nursing Home.**

“If a subscriber is offered a priority for nursing home admission, state: (a) The name of the nursing home or homes with which the provider has a formal priority arrangement; (b) What provisions for care will be made if a nursing home bed is not available at a facility identified in §A(4)(a) of this regulation at the time the bed is needed; (c) What the payment provisions will be for care at a facility identified in §A(4)(a) of this regulation; and (d) That the provider shall promptly notify the subscriber and the Department of any

Article, §14-1315 restricts the amount of late fees that providers may charge and when they may be imposed.)

*Where [section(s) and page(s)]:*

**II.B. Fees Used for Purposes in Agreement Only.**

“State that fees collected by a provider under the terms of a continuing care agreement may not be used for purposes other than those set forth in the agreement;” COMAR .28A(37).

*Where [section(s) and page(s)]:*

**II.C. Entrance Fee Plans.**

“Designate the categories of subscribers at the facility according to the types of entrance fee plans offered;” COMAR .28A(5).

*Where [section(s) and page(s)]:*

**II.D. Rate Changes (bold type).**

“State in clear and understandable language, and in boldface type of the largest font used in the body of the agreement, whether or not periodic fees, if charged, will be subject to periodic increases;” COMAR .28A(17).

*Where [section(s) and page(s)]:*

**II.E. Rate Changes - Days Notice (bold/underline/CAPS).**

“If periodic fees are subject to increase, state in clear and understandable language, and in all capital, underlined, and bold letters of the largest type used in the body of the agreement, the number of days of notice that will be given by the provider before an increase becomes effective;” COMAR .28A(18). (NOTE: For rate changes in Assisted Living, **FORTY-FIVE (45) DAYS** notice must be provided, except if necessitated by a change in the subscriber’s medical condition. HSA §10-444(e)(2)(vii)5 and COMAR 10.07.14.25. There is also a 45-day notice requirement under Section 2.E of the DHMH comprehensive care agreement forms, which are referenced at Part VIII.B below.)

*Where [section(s) and page(s)]:*

**II.F. One Lump Sum?/No Increase Allowed.**

“State that the charges for prepaid care may not be increased, if the agreement provides that care is paid for in advance, in one lump sum;” COMAR .28A(19).

*Where [section(s) and page(s)]:*

**II.G. Absence from Unit.**

“State what fee adjustments, if any, will be made by the provider in the event of a subscriber's voluntary absence from the facility for an extended period of time;” COMAR .28A(31).

*Where [section(s) and page(s)]:*

**II.H. Multiple Subscribers - Increase/Decrease – Fee Impact.**

### **III.E. Temporary Emergency Transfer to Outside Facility Is Not Just Cause for Discharge.**

“An agreement may recognize that a subscriber may have to be moved in the event of an emergency. A move or transfer of a subscriber to an accommodation outside the facility because of an emergency may not, in and of itself, establish just cause for a dismissal or discharge.” COMAR .31B(4). See footnote 1 at Part V.A below.

*Where [page(s) and section(s)]:*

### **III.F. Right of Subscriber to Terminate.**

“A continuing care agreement shall allow a subscriber to terminate the agreement by giving a written termination notice to the provider.” HSA §10-449(a).

*Where [section(s) and page(s)]:*

## **IV. REFUNDS:**

### **IV.A. GENERAL.**

#### **1. Terms of Refund - Discharge, Termination/Cancellation (bold type).**

“State in clear and understandable language, and in boldface type of the largest font used in the body of the agreement, the terms governing the refund of any portion of the entrance fee in the event of: (a) Discharge by the provider; or (b) Termination by the subscriber;” COMAR .28A(14).

*Where [section(s) and page(s)]:*

#### **2. Non-Refundable Processing Fee.**

“A processing fee may only be assessed against a subscriber one time and may not exceed \$300 per individual.” COMAR .27C.

*Where [section(s) and page(s)]:*

#### **3. Termination by Subscriber after Occupancy - Agreement Controls.**

“If the subscriber elects to terminate the agreement after the date of occupancy, refund of the entrance fee is governed by the terms of the agreement.” COMAR .31A.

*Where [section(s) and page(s)]:*

#### **4. Multiple Subscribers - Refund upon decrease in unit.**

“State whether there will be a partial refund of an entrance fee, an additional fee, or any increase or decrease in a periodic fee in the event of an increase or decrease in the number of people occupying a unit;” COMAR .28A(12). (Also quoted at Part II.H above.)

*Where [section(s) and page(s)]:*

#### **5. Beneficiary Designation.**

“(23) allow a subscriber to designate a beneficiary to receive any refundable portion of the entrance fee that is owed due to the death of the subscriber on or after the date of occupancy, if the designation is: (i) in writing; (ii) witnessed by at least two competent witnesses; (iii) not contingent; and (iv) specified in percentages and accounts for 100% of the refund due;”

#### **IV.C. AFTER OCCUPANCY.**

##### **1. Contractual Refunds Upon Termination by Subscriber.**

“Include provisions governing contractual entrance fee refunds in accordance with the applicable requirements of Human Services Article, §10-449, Annotated Code of Maryland;” COMAR .28A(15).

###### **a. Within First 90 Days.**

“(b) If a continuing care agreement is terminated by the subscriber’s election or death within the first 90 days of occupancy, the provider shall pay any contractual entrance fee refund within 30 days after the earlier to occur of:

- (1) the recontracting of the subscriber’s unit by: (i) another subscriber for whom an entrance fee has been paid; or (ii) another party who is not a subscriber; or
- (2) the later to occur of: (i) the 90th day after the date the written termination notice is given or the date of death; or (ii) the day the independent living units at the facility have operated at 95% of capacity for the previous 6 months.” HSA §10-449(b).

*Where [section(s) and page(s)]:*

###### **b. After First 90 Days if Certain Conditions Exist.**

“(c) If a continuing care agreement is terminated by the subscriber’s election or death after the first 90 days of occupancy, the provider shall pay any contractual entrance fee refund within 60 days after the subscriber’s death or the effective date of termination, if on the date of death or at any time between the date the written termination notice is given and the effective date of termination: (1) the subscriber resides in a unit at a higher level of care than the level of care in which the subscriber resided on initially entering the facility; and (2) the last unit in which the subscriber resided at the initial level of care on entering the facility has been occupied by or reserved for another subscriber who has paid an entrance fee.” HSA §10-449(c). Note that under COMAR .28A(14), quoted at Part IV.A.1 above, provisions are also needed as to when the refund will be paid after the first 90 days in conditions other than those set forth in §10-449(c).

*Where [section(s) and page(s)]:*

###### **c. Requirement that Unit Be Vacated Before Refund Paid.**

“(d) This section does not prohibit a provider from requiring that a subscriber’s unit be vacated before any contractual entrance fee refund is paid as a result of the subscriber’s election to terminate a continuing care agreement.” HSA §10-449(d).

##### **2. Statutory Refund Required Upon Discharge by Provider.**

###### **a. Refund Upon Discharge by Provider after Occupancy.**

“In the event of a permissible dismissal or discharge, the provider shall pay to the discharged subscriber a refund equal to the subscriber's total entrance fee divided by the subscriber's years of expected life at admission multiplied by the subscriber's years of expected life at discharge or dismissal. Years of expected life at admission and at dismissal or discharge shall be computed at the time of discharge or dismissal. The computations shall be based upon the appropriate life tables in the most recently

*Where [section(s) and page(s)]:*

**V.B. Procedures for Temporary Change in Unit.**

“While recognizing the constraints of §A(6) of this regulation, describe the procedures the parties to the agreement are to follow in order to temporarily transfer a subscriber: (a) From the unit in which the subscriber resides to another unit within the facility; or (b) To an accommodation outside of the facility;” COMAR .28A(7)

*Where [section(s) and page(s)]:*

**V.C. Procedures for Return to Unit.**

“Describe the procedures the parties to the agreement are to follow in order to return a subscriber to the unit in which the subscriber resided before a temporary change;” COMAR .28(A)(8).

*Where [section(s) and page(s)]:*

**V.D. Procedures for Permanent Change in Unit.**

“While recognizing the constraints of §A(6) of this regulation, describe the procedures the parties to the agreement are to follow in order to permanently transfer a subscriber: (a) From the unit in which the subscriber resides to another unit within the facility; or (b) To an accommodation outside of the facility;” COMAR .28A(9)

*Where [section(s) and page(s)]:*

**V.E. Multiple Subscribers.**

“Describe how the procedures for changes, transfers, and returns, whether temporary or permanent, will operate if a unit is occupied by more than one subscriber;” COMAR .28A(11).

*Where [section(s) and page(s)]:*

**VI. CERTIFICATION ISSUES - STATE REQUIREMENTS:**

**VI.A. Financial Statement - Reviewed.**

“In a separate paragraph, signed by each subscriber, state: "I have received a copy of the provider's latest certified financial statement at least 2 weeks before signing this

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economic welfare of the other subscribers of the facility; and (2) the move is not to a higher level of care (e.g., moving a subscriber from one assisted living unit to another because extensive repair work is needed to the unit).

Note that the continuing care regulations do not define the term “emergency” used in COMAR 32.02.01.31B(4). Accordingly, a continuing care agreement may use the term pursuant to COMAR 32.02.01.31B(4) without defining it. However, for those providers wishing to include a definition in the agreement, either of the following definitions is acceptable to the Department: “‘Emergency’ means imminent danger of serious harm to the Resident or other residents.” “‘Emergency’ means a situation placing the Resident or other residents in imminent danger of serious harm.”

- (4) The provider has submitted documentation to the satisfaction of the Department that there is a commitment for permanent long-term financing;
- (5) The provider has submitted documentation which demonstrates to the satisfaction of the Department that closing on construction financing has taken place; and
- (6) The form and substance of all advertising and other promotional materials filed are not deceptive, misleading, or likely to mislead.”

*Where [section(s) and page(s)]:*

#### **VI.F. Conflicts.**

“State that if there are differences between the requirements for continuing care certification and the licensure requirements for assisted living and comprehensive care facilities, the applicable requirements most favorable to the subscriber will prevail while the subscriber is residing in an assisted living or comprehensive care unit.” COMAR .28A(42).

*Where [section(s) and page(s)]:*

#### **VI.G. Subscriber’s Legal Remedies.**

“State the legal remedies available to a subscriber in the event of injury caused by a provider's violation of the Act;” COMAR .28A(40).

1. “(d) (1) A subscriber may rescind a continuing care agreement at any time if a term of the agreement violates this subtitle and the subscriber is injured by the violation.

(2) The subscriber is entitled to treble damages for extensive injuries arising from a violation.” HSA §10-446(d).

2. “(a) (1) Any subscriber injured by a violation of this subtitle may bring an action for equitable relief or an action for damages in any court of general jurisdiction.

(2) In an action described in paragraph (1) of this subsection, the court may award reasonable attorney’s fees to a subscriber in whose favor a judgment is entered.” HSA §10-498(a).

NOTE: The following is a sample provision:

Under the continuing care laws set forth in Sections 10-401 through 10-499 of the Human Services Article of the Annotated Code of Maryland (the “Act”), Resident may rescind this Agreement at any time if its terms are in violation of the terms of the Act and Resident is injured by the violation. In such case, Resident will be entitled to treble damages for extensive injuries arising from the violations. In addition, under the Act, in the event Resident is injured by a violation of the Act, Resident may bring an appropriate action for equitable relief or an action for the recovery of damages in any court of general jurisdiction and, if a judgment is rendered in the Resident’s favor, the court may award reasonable attorney’s fees to Resident.”

*Where [section(s) and page(s)]:*

#### **VI.H. Amendments.**

“The provider shall request approval from the Department for any modification, addition, or deletion to the terms of a continuing care agreement, before the agreement is offered to

### VII.G. Provider's Written Rules.

“(10) state that the subscriber has received, at least two weeks before signing the agreement, the current version of the written rules of the provider;” HSA §10-444(b)(10).

NOTE: Please use the following model provision, *with or without either or both of the two parts of the model provision shown in italics*:

[Insert name of Provider] represents *and* [insert term used in the continuing care agreement to refer to the subscriber, typically “Resident”] acknowledges that [insert term used in the continuing care agreement to refer to the subscriber, typically “Resident”] has received at least two weeks before signing this [insert term used to refer to the continuing care agreement, typically “Agreement”] a copy of the current version of the written rules of [insert name of Provider], *which are subject to change by [insert name of Provider] from time to time.*

Where [section(s) and page(s)]:

### VIII. MISCELLANEOUS HUMAN SERVICES ARTICLE §§10-401—10-499

#### REQUIREMENTS APPLICABLE TO SOME CONTINUING CARE AGREEMENTS:

Some of the issues addressed in this Part VIII are more complex than those addressed in Parts I through VII above. It is beyond the scope of this Worksheet to thoroughly discuss these issues, but a limited amount of information is provided below with regard to them, in order to aid in identifying and addressing the issues.

#### VIII.A. Assisted Living Programs.<sup>2</sup>

Pursuant to HSA §10-444(e), in structuring its continuing care agreement for use with future residents, a provider that offers assisted living needs to decide whether to (i) offer a separate assisted living agreement (meaning that the provider is required to comply with COMAR 10.07.14.24 and .25, which are administered by DHMH) or (ii) not offer a separate assisted living agreement (meaning that the provider is required to comply with HSA §10-444(e)(2), which is administered by the Department of Aging). If the provider offers assisted living, please indicate whether the provider has chosen to offer a separate assisted living agreement pursuant to this continuing care agreement.

*Check one: Provider is    is not    offering a separate assisted living agreement pursuant to this continuing care agreement.*

**The information and checklist set forth below in this Part VIII.A are for use where the provider is not offering a separate assisted living agreement pursuant to this continuing care agreement.**

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<sup>2</sup>If the provider's form assisted living agreement/addendum is intended to also be entered into by individuals who are not continuing care subscribers, providers in drafting it need to take into account whether or not the provider is relying on a certificate of need exemption for its comprehensive care beds, which greatly limits the extent, if any, to which such individuals may use the comprehensive care beds. See Health - General Article, Sections 19-114(d), 19-123 and 19-124 and COMAR 10.24.01.03K.

4. identification of the persons responsible to pay all fees and charges and a clear indication of whether the person's responsibility is or is not limited to the extent of the subscriber's funds;
5. a provision for notice at least 45 days before any rate increase, except for an increase necessitated by a change in the subscriber's medical condition; and
6. fair and reasonable billing and payment policies." HSA §10-444(e)(2).

Where [section(s) and page(s)]:

The following is the "sample list of assisted living program services that the Department of Health and Mental Hygiene maintains," referenced in HSA §10-444(e)(2)(iv), which is quoted above:

**THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE'S**  
**Human Services Article §10-444(e)(2)(iv)**  
**Sample List of Assisted Living Program Services**<sup>4</sup>

- "1. Room

Where [section(s) and page(s)]:

2. Furniture for the subscriber's room (unless the subscriber brings personal furniture)

Where [section(s) and page(s)]:

3. Three well balanced meals and additional snacks each day

Where [section(s) and page(s)]:

4. Special diets

Where [section(s) and page(s)]:

5. Housekeeping

Where [section(s) and page(s)]:

6. Laundry

Where [section(s) and page(s)]:

7. Personal care services (consistent with subscriber's needs and service plan), including:

- \* Assistance with and/or supervision of activities of daily living, including: eating, personal hygiene, mobility, toileting, and dressing

Where [section(s) and page(s)]:

- \* Provision and/or facilitating access to appropriate health care and social services, including: social work services, rehabilitative services, home health services, hospice services, skilled nursing services, physician services, oral health care, dietary consultation and services, counseling, psychiatric services, and other specialty health and social work services.

Where [section(s) and page(s)]:

- \* Provision and/or facilitating access to social and recreational/services, including facilitating access to spiritual and religious activities consistent

<sup>4</sup> If an item on this DHMH list is located at the same section and page as the immediately preceding item on the list, please simply insert "Same" after "Where [section(s) and page(s)]."

### **VIII.B. Comprehensive Care Program.**

Many providers utilize a contract structure whereby certain subscribers enter into comprehensive care agreements based upon DHMH's two form comprehensive care agreements, which are entitled "Resident Admission Contract of [Name of Facility]" and "Resident's Agent Financial Agreement With [Name of Facility]". The Department has noted that, for most providers electing to use these two form DHMH agreements, the following two changes need to be made to conform them to the continuing care laws.

First, see the sixth paragraph of Section 3.B of the DHMH form Resident Admission Contract. This paragraph informs the resident that if the resident is no longer able to pay for care and is not eligible for Medical Assistance, the provider will notify the resident of its intention to discharge the resident for non-payment. For most providers, this provision is not in accord with the possibility of charitable care set forth in the continuing care agreement pursuant to COMAR .28A(13). If charitable care is a possibility in comprehensive care, this DHMH form agreement needs to be revised to reflect that fact. For example, a provider could insert the following at the end of the first sentence of the sixth paragraph " , unless we decide to wholly or partly subsidize you pursuant to the terms of your [insert title of continuing care agreement]." Note that a similar change would also be needed in the sixth paragraph of Section 3.B of the DHMH form Resident's Agent Financial Agreement.

*If applicable, where [section(s) and page(s)]:*

Second, see Section 4.F of the DHMH form Resident Admission Contract, which conflicts with the continuing care laws. The following is a suggested revision to the first paragraph of Section 4.F and the first sentence of the second paragraph of Section 4.F, which various communities have used and which the Department finds acceptable:

You have the right to remain here, and you may not be transferred or discharged against your will, unless both (i) the transfer or discharge is permitted under the terms of your [insert title of continuing care agreement] and (ii) one of the following reasons exists for the transfer or discharge: (a) your condition has improved so that you no longer need the services we provide in this comprehensive care facility; (b) the transfer or discharge is necessary for your welfare and your needs cannot be met by this comprehensive care facility; (c) the health or safety of an individual in the Facility is endangered; (d) you, after reasonable and appropriate notice, have failed to pay (or through your insurers have failed to pay) for a stay at the Facility; or (e) this comprehensive care facility ceases to operate.

If the Facility determines that the transfer or discharge is permitted under the terms of your [insert title of continuing care agreement] and identifies one of the reasons listed in (a) through (e) above for the transfer or discharge, we will (i) comply with the terms of your [insert title of continuing care agreement] with respect to the transfer or discharge and (ii) notify you and your family member, guardian, or representative by letter sixty (60) days in advance.

**WHETHER THE AGREEMENT COMPLIES WITH THE REQUIREMENTS OF THIS SUBTITLE.**

**(II) AT ANY TIME DURING THE REVIEW PROCESS, THE DEPARTMENT MAY SUBMIT COMMENTS TO OR REQUEST ADDITIONAL INFORMATION FROM THE PROVIDER TO DETERMINE WHETHER THE AGREEMENT COMPLIES WITH THE REQUIREMENTS OF THIS SUBTITLE.**

**(III) IF THE DEPARTMENT SUBMITS COMMENTS OR A REQUEST FOR ADDITIONAL INFORMATION UNDER SUBPARAGRAPH (II) OF THIS PARAGRAPH, THE 120-DAY REVIEW PERIOD UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH IS SUSPENDED.**

**(IV) ON RECEIPT OF ANY REQUESTED INFORMATION OR MODIFICATIONS TO THE AGREEMENT NECESSITATED BY THE DEPARTMENT'S COMMENTS UNDER SUBPARAGRAPH (III) OF THIS PARAGRAPH, THE DEPARTMENT, WITHIN THE NUMBER OF DAYS REMAINING IN THE 120-DAY REVIEW PERIOD, SHALL:**

- 1. COMPLETE ITS REVIEW TO DETERMINE WHETHER THE AGREEMENT MEETS THE REQUIREMENTS OF THIS SUBTITLE; AND**
- 2. APPROVE OR DISAPPROVE THE AGREEMENT.**

**(V) 1. IF THE DEPARTMENT DOES NOT APPROVE THE AGREEMENT, THE DEPARTMENT SHALL NOTIFY THE PROVIDER IN WRITING, INCLUDING CITATIONS TO THE SPECIFIC PROVISIONS OF LAW THAT THE DEPARTMENT DETERMINED WERE NOT COMPLIED WITH IN THE AGREEMENT.**

**2. A PROVIDER MAY APPEAL THE DISAPPROVAL OF AN AGREEMENT UNDER SUBPARAGRAPH (IV) OF THIS PARAGRAPH UNDER THE PROVISIONS OF TITLE 10, SUBTITLE 2 OF THE STATE GOVERNMENT ARTICLE.**

**(2) If the Department does not act within [180] 120 days, the agreement is deemed approved.**

**(b) The provider shall maintain the continuing care agreement at the facility and make it available for inspection by the Department of Health and Mental Hygiene under Title 19, Subtitle 18, of the Health – General Article AND TITLE 10, SUBTITLE 3 OF THE HEALTH – GENERAL ARTICLE.**

**(C) IF A PROVIDER IS SEEKING APPROVAL FOR A MODIFICATION TO AN APPROVED CONTINUING CARE AGREEMENT OR OTHER RELATED AGREEMENT, THE DEPARTMENT SHALL LIMIT ITS REVIEW TO:**

- (1) THE SECTION OF THE AGREEMENT BEING MODIFIED AND ANY SECTIONS DIRECTLY AFFECTED BY THE MODIFICATION; AND**
- (2) ANY SECTION OF THE AGREEMENT THAT MAY HAVE BEEN AFFECTED BY A CHANGE IN THE LAW OR A REGULATION THAT WAS ENACTED AFTER THE DEPARTMENT APPROVED THE AGREEMENT.**

**(D) IF THE PROVIDER EXECUTES A SEPARATE ASSISTED LIVING AGREEMENT OR COMPREHENSIVE CARE AGREEMENT, THE PROVIDER IS NOT REQUIRED TO SUBMIT THE ASSISTED LIVING AGREEMENT OR COMPREHENSIVE CARE AGREEMENT OR ANY REQUESTS FOR MODIFICATIONS TO THE**

## CHAPTER 694

(House Bill 843)

AN ACT concerning

### **Continuing Care Retirement Communities - ~~Subscriber Complaints and Investigations~~ Internal Grievance Procedure and Mediation**

FOR the purpose of adding to the requirements for a continuing care retirement community's internal grievance procedure; shortening the time frame within which certain subscribers have the right to meet with management of a provider; authorizing subscribers ~~to submit a certain request to the Long Term Care Ombudsman under certain circumstances; requiring the Long Term Care Ombudsman to provide certain written conclusions to certain individuals and to the Department of Aging and providers to seek certain mediation services~~ within a certain time after the conclusion of a certain internal grievance procedure; and generally relating to continuing care retirement communities and ~~subscriber complaints and investigations~~ internal grievance procedures and mediation.

BY repealing and reenacting, with amendments,  
Article - Human Services  
Section 10-428  
Annotated Code of Maryland  
(2007 Volume and 2008 Supplement)

~~BY adding to~~  
~~Article - Human Services~~  
~~Section 10-430~~  
~~Annotated Code of Maryland~~  
~~(2007 Volume and 2008 Supplement)~~

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

#### **Article - Human Services**

10-428.

(a) A provider shall establish an internal grievance procedure to address a subscriber's grievance.

(b) The internal grievance procedure shall **AT LEAST**:

(1) allow a subscriber **OR GROUP OF SUBSCRIBERS COLLECTIVELY** to submit a written grievance to the provider ~~IN ANY FORM;~~

~~(2) ALLOW FOR THE ESTABLISHMENT OF A PANEL CONSISTING OF AT LEAST THREE SUBSCRIBERS TO REVIEW AND PRESENT GRIEVANCES TO MANAGEMENT ON BEHALF OF A GRIEVANT WITHOUT FEAR OF REPRISAL;~~

~~[(2)](3)~~ require the provider to send a written acknowledgment to the subscriber within 5 days after receipt of the written grievance;

~~(4) (3) REQUIRE THE PROVIDER TO ASSIGN PERSONNEL TO INVESTIGATE THE GRIEVANCE AND ITS CAUSE IN A PROMPT MANNER;~~

~~[(3)](5)~~ (4) give a subscriber who files a written grievance the right to meet with management of the provider within [45] **30** days after receipt of the written grievance to present the subscriber's grievance; and

~~[(4)](6)~~ (5) require the provider to respond within 45 days after receipt of the written grievance regarding the investigation and resolution of the grievance.

**(C) (1) WITHIN 30 DAYS AFTER THE CONCLUSION OF AN INTERNAL GRIEVANCE PROCEDURE ESTABLISHED UNDER THIS SECTION, A SUBSCRIBER OR PROVIDER MAY SEEK MEDIATION THROUGH ONE OF THE COMMUNITY MEDIATION CENTERS IN THE STATE OR ANOTHER MEDIATION PROVIDER.**

**(2) IF A PROVIDER OR SUBSCRIBER SEEKS MEDIATION UNDER PARAGRAPH (1) OF THIS SUBSECTION:**

**(I) THE MEDIATION SHALL BE NONBINDING; AND**

**(II) THE PROVIDER AND SUBSCRIBER MAY NOT BE REPRESENTED BY COUNSEL.**

~~10-430.~~

~~(A) IF A SUBSCRIBER IS NOT SATISFIED WITH THE RESOLUTION OF A GRIEVANCE AS DECIDED BY A PROVIDER UNDER § 10-428 OF THIS SUBTITLE, THE SUBSCRIBER MAY SUBMIT A REQUEST TO THE LONG TERM CARE OMBUDSMAN TO INVESTIGATE AND REVIEW THE COMPLAINT.~~

~~(B) THE LONG TERM CARE OMBUDSMAN SHALL PROVIDE WRITTEN CONCLUSIONS RELATED TO THE INVESTIGATION AND REVIEW OF THE COMPLAINT TO THE GRIEVANT, THE MANAGEMENT OF THE RELEVANT CONTINUING CARE RETIREMENT COMMUNITY, AND THE DEPARTMENT.~~

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2009.

**Approved by the Governor, May 19, 2009.**