IN THE SUPREME COURT OF MARYLAND

IN THE MATTER OF THE
TWO HUNDRED AND TWENTY-NINTH REPORT
OF THE STANDING COMMITTEE ON
RULES OF PRACTICE AND PROCEDURE

229th Report
Category Fifteen — Proposed Amendment to Rule 19-301.15

COMMENTS OF THE MARYLAND/DC CHAPTER OF THE NATIONAL ACADEMY OF ELDER LAW ATTORNEYS

In Support of Version A of the Proposed Amendment
to Maryland Rule 19-301.15

Submitted by the Maryland/DC Chapter
National Academy of Elder Law Attorneys

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Introduction

Access to justice requires that vulnerable people be able to obtain the legal representation necessary to secure essential benefits. For older adults and people with disabilities seeking Medicaid coverage for long-term care, Maryland Rule 19-301.15 can impede that access by requiring advance legal fees to remain in trust when the client's continuing interest in those funds can interfere with financial eligibility. The Maryland/DC Chapter of the National Academy of Elder Law Attorneys[1] therefore urges the Court to adopt Version A, which addresses this conflict through a limited exception with meaningful client protections.

Medicaid planning applies eligibility rules and family protections deliberately established by Congress and recognized by the courts. Representation involves both establishing eligibility and obtaining the agency's recognition of it. Although substantial services have been delivered when an eligible client's application is filed, processing delays, repeated information requests, and improper denials can require extensive additional work. Historically, transferring the remaining agreed fee from trust before filing allowed clients to complete their spend-down[2] while securing counsel for that continuing representation. The current rule disrupts that arrangement precisely when applicants have exhausted the resources available to pay for assistance.

[1] The Maryland/DC Chapter of the National Academy of Elder Law Attorneys has 78 members, including Jason Frank (joined in 1988), Camilla McRory (1988), and Morris Klein (1993), who, with the late Ron Landsman, have shaped elder law in Maryland and nationally. For over 15 years, the Chapter has advocated to expand Maryland's Home and Community-Based Options Waiver, eliminate its waitlist, and clarify applications, helping secure passage of S.B. 28 and H.B. 80 (2022). The Chapter also offers monthly programs preparing members to become Certified Elder Law Attorneys (CELAs). More information about the Chapter is available at mdcela.org.

[2] Throughout these comments, "spend-down" is used in its ordinary, broad sense to encompass income and resources in establishing Medicaid eligibility. *See, e.g.*, Md. Rule 10-304.2(b)(2) committee note (referring to "a spend down of known income and resources").

Version A advances the rule's protective purpose by accounting for these circumstances. Its targeted exception, signed agreement, prominent disclosures, and continuing termination and refund rights preserve safeguards while enabling clients to secure necessary representation. The following discussion explains the lawful foundation of Medicaid planning, the practical conflict created by the current rule, and why adopting Version A would promote access to justice.

I. Elder Law Attorneys Engage in Medicaid Planning

Medicaid planning is the process of arranging a person's income, assets, and payment for long-term care within the eligibility rules established by federal and state law. It helps older adults, people with disabilities, and their families obtain needed care while preserving resources the law permits them to retain. This work involves applying the protections Congress established alongside the program's disclosure requirements and restrictions.[3]

A. Congress Has Carefully Legislated Medicaid Planning

Congress has carefully and intentionally developed the statutory framework that makes Medicaid planning possible. Over more than six decades, Congress has established, expanded, and refined specific protections that allow individuals and families to arrange their financial affairs while qualifying for Medicaid long-term care benefits. These provisions are not accidental loopholes or unintended consequences of the law. Rather, they reflect deliberate legislative choices to balance Medicaid eligibility requirements with the protection of spouses, individuals with disabilities, and other vulnerable family members.

[3] *See* 42 U.S.C. § 1396p (asset transfers, trusts, and estate recovery); 42 U.S.C. § 1396r-5 (spousal protections).

Medicaid planning has its origins in Title XIX of the Social Security Act, enacted by Congress in 1965 as part of the Social Security Amendments of 1965[4]. Congress established Medicaid as a means-tested program providing medical assistance to eligible individuals with limited income and resources. From its inception, Medicaid eligibility depended on statutory rules governing income, resources, and financial need. Lawful planning developed within this framework, including the expenditure of available resources on care, housing, debts, and other legitimate needs to satisfy eligibility requirements.

In 1988, Congress enacted the spousal impoverishment protections through the Medicare Catastrophic Coverage Act.[5] Recognizing that the cost of institutional care could impoverish a spouse remaining at home, Congress established protections allowing the community spouse to retain specified income and resources. These provisions created an express statutory framework for protecting a married couple's financial security while allowing the spouse requiring long-term care to qualify for Medicaid.[6]

Congress further refined Medicaid planning through the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993).[7] Although Congress strengthened restrictions on transfers for less than fair market value, it expressly preserved exceptions for certain transfers to spouses, disabled children, and other protected recipients, including qualifying transfers of a home to specified

[4] Pub. L. No. 89-97.

[5] Pub. L. No. 100-360, § 303, codified at 42 U.S.C. § 1396r-5.

[6] *See Wisconsin Department of Health & Family Services v. Blumer*, 534 U.S. 473, 480 (2002) (citing H.R. Rep. No. 100-105, pt. 2, at 65 (1987)).

[7] Pub. L. No. 103-66, § 13611.

family members. These exceptions[8] recognize circumstances in which transfers of assets do not result in Medicaid transfer penalties.

OBRA 1993 also established express statutory exceptions for special needs trusts and pooled special needs trusts.[9] These provisions allow qualifying assets to be held in trusts for individuals with disabilities without automatically disqualifying them from Medicaid, subject to statutory conditions, including applicable Medicaid reimbursement requirements.

Congress subsequently tightened Medicaid eligibility rules through the Deficit Reduction Act of 2005, extending the asset-transfer look-back period, delaying the commencement of transfer penalties, and restricting certain transactions designed to shelter assets.[10] Significantly, Congress left in place the principal planning strategies employed by elder law attorneys, including:

- Lawful spend-down of assets, allowing individuals to use their resources for care, housing, debts, and other legitimate expenditures for fair market value.
- Spousal impoverishment protections, allowing the community spouse to retain protected income and resources.
- Exempt transfers, including qualifying transfers to spouses, disabled children, and certain other family members.
- Special needs trusts and pooled special needs trusts, preserving resources for individuals with disabilities while maintaining eligibility under applicable statutory conditions.

These continuing statutory protections demonstrate that Medicaid planning operates within a framework Congress has intentionally established and preserved, rather than through unintended

[8] 42 U.S.C. § 1396p(c)(2).

[9] 42 U.S.C. § 1396p(d)(4)(A) and (C).

[10] Pub. L. No. 109-171, §§ 6011–6016.

loopholes in federal law. Accordingly, planning that properly uses these statutory protections carries out choices Congress deliberately made.

B. Courts Answer Medicaid Planning Critics

Courts have had to remind critics of Medicaid planning that it "is legally permissible under federal and state Medicaid law" and have compared lawful planning to using tax deductions to preserve family resources.[11] Similarly, the New York Court of Appeals recognized that individuals may arrange their financial affairs to qualify for Medicaid and that incapacity should not deprive them of that opportunity.[12] Another New York court rejected the characterization of lawful asset transfers as fraud, observing that "current law rewards prudent 'Medicaid planning.'"[13]

This Court likewise rejected a nursing facility's attempt to contractually prevent a resident from obtaining Medicaid coverage through lawful financial planning, explaining that objections to the resulting financial consequences were matters for the legislature.[14] And in *Matter of Kamp*,[15] a New York court recognized that preserving assets through a supplemental needs trust can serve a disabled beneficiary's best interests by supplementing public benefits.

Together, these decisions establish that Medicaid planning is not inherently improper or fraudulent. Rather, courts have recognized that individuals may lawfully arrange their affairs within the eligibility rules established by Congress and state legislatures, including through

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[11] *See In re Keri*, 181 N.J. 50, 69–70, 853 A.2d 909 (2004).

[12] *Matter of Shah*, 95 N.Y.2d 148, 162–63 (2000).

[13] *Matter of John XX*, 226 A.D.2d 79, 83–84 (3d Dep't 1996).

[14] *Oak Crest Village, Inc. v. Murphy*, 379 Md. 229, 248–49, 841 A.2d 816 (2004).

[15] *Matter of Kamp*, 7 Misc. 3d 615 (Sur. Ct. 2005).

authorized representatives when appropriate. The permissibility of any particular strategy remains subject to applicable law and safeguards.

C. The Recognized Need for Medicaid Planning Is Even Greater Today

The need for Medicaid planning becomes more pressing as long-term care costs rise and Maryland's population ages. Families must confront the expense of care at home, in assisted living, or in a nursing facility, often without sufficient insurance or private resources to sustain it. Medicaid provides essential coverage for eligible individuals in both institutional and community settings, but obtaining that coverage requires careful attention to the program's requirements. The following discussion describes Maryland's care costs and Medicaid coverage, explaining why access to knowledgeable legal assistance matters to families seeking necessary care.

1. Long-Term Care Costs in Maryland

Long-term care costs in Maryland can rapidly exhaust a lifetime of savings. CareScout's 2025 Cost of Care Survey, released in March 2026, reports the following statewide median costs:[16]

Type of care	Median rate	Annual cost
Non-medical home caregiver	$35 per hour	$80,080 for 44 hours per week
Adult day health care	$117 per day	$30,313 for five days per week
Assisted living	$7,173 per month	$86,070
Nursing home, semi-private room	$425 per day	$155,125
Nursing home, private room	$475 per day	$173,375

Annual figures reflect the survey's underlying rates and assumptions; displayed rates are rounded or approximated.

[16] CareScout, Cost of Care Survey 2025: Median Cost Data Tables, at 2–3, 6–8, Maryland entries (released Mar. 2, 2026) ("Care Costs"), available at https://assets.carescout.com/x/8fcb50422f/282102.pdf (last checked Nov. 17, 2026).

These figures demonstrate that receiving care at home does not eliminate the financial burden.

- The $80,080 annual home-care figure purchases only 44 hours of assistance per week.[17]
- At the same $35 hourly rate, eight hours of assistance every day would cost $102,200 annually, while continuous, round-the-clock assistance would cost $306,600.[18]

These calculations illustrate how the amount of assistance required can make home care as expensive as, or more expensive than, institutional care. Sustained expenses of this magnitude can consume retirement savings, undermine a spouse's financial security, and force family members to reduce or leave paid employment to provide care.[19]

The financial pressure will likely intensify as Maryland's population ages and demand for care grows. The Maryland Department of Aging projects that the population age 85 and older will increase by approximately 158 percent between 2020 and 2045, reaching more than 315,000 people.[20] That growth signals increasing demand for the services that help older adults remain safe and independent.[21]

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[17] Care Costs at 2–3.

[18] Care Costs at 8 (author's calculations using the $35 hourly rate for 365 days).

[19] Reed Abelson & Jordan Rau, Facing Financial Ruin as Costs Soar for Elder Care, The New York Times & KFF Health News (Nov. 14, 2023) ("Financial Ruin"), available at https://kffhealthnews.org/aging/dying-broke-facing-financial-ruin-as-costs-soar-for-elder-care/ (last checked Nov. 17, 2026).

[20] Maryland Department of Aging, Paving the Way for a Longevity Ready Maryland, at 6 (July 2025) ("Longevity Plan"), available at https://aging.maryland.gov/media/96/download?inline= (last checked Nov. 17, 2026).

[21] Longevity Plan at 6. Maryland's August 2026 community-care report also identifies shortages of direct service professionals and nurses as a significant challenge to expanding services. Maryland Department of Health, Community First Choice Program and Community Options Waiver Financial and Registry Data, at 19–20 (Aug. 2026) ("Community Care Report"), available at https://health.maryland.gov/mmcp/Documents/CFCcommunityoptionswaiverJCRfinal8-26.pdf (last checked Nov. 17, 2026).

Even moderate annual price increases would substantially enlarge the burden. Using the 2025 Maryland medians as a starting point and assuming 3 percent annual increases, the annual cost of a semi-private nursing home room would reach approximately $208,475 in 2035 and $280,173 in 2045.[22] Assisted living would reach approximately $115,671 and $155,452, respectively.[23] These are illustrative calculations, rather than predictions of actual future prices. They show how sustained increases can compound an already severe affordability problem.

2. Medicaid Long-Term Care Coverage in Maryland

Medicaid is a lifeline for Maryland residents who cannot afford the sustained care they need. Medicare and most health insurance do not cover ongoing assistance with activities such as bathing, dressing, eating, and using the bathroom when that assistance constitutes long-term custodial care.[24]

For families without adequate long-term care insurance or sufficient private resources, Medicaid provides essential access to services that would otherwise be financially out of reach.

a) Medicaid Coverage in Care Facilities

Maryland Medicaid covers nursing facility services for individuals who meet its medical and financial eligibility requirements.[25] Its central role is evident in the payer data: Medicaid was the primary payer for 62 percent of Maryland's certified nursing facility residents in 2025.[26]

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[22] Care Costs at 2 (author's calculations, assuming 3% annual increases for 10 and 20 years).

[23] Care Costs at 2 (author's calculations using the same assumptions).

[24] Medicare.gov, Long-term care ("Medicare Coverage"), available at https://www.medicare.gov/coverage/long-term-care (last checked Nov. 17, 2026).

[25] Maryland Department of Health, Nursing Facility Resident Information ("Nursing Facility Information"), available at https://health.maryland.gov/mmcp/longtermcare/Pages/Nursing-Facility-Residents,-Recipients-and-Family-Members.aspx (last checked Nov. 17, 2026).

[26] KFF, Distribution of Certified Nursing Facility Residents by Primary Payer Source, 2025 data ("KFF Payer Data"), available at https://www.kff.org/state-health-policy-data/state-

Maryland's Office of Health Care Quality reported 220 licensed nursing homes in fiscal year 2025.[27]

b) Medicaid Coverage of Community-Based Programs

Medicaid also finances services that allow eligible individuals to remain at home and in their communities. Community First Choice services include personal assistance, nurse monitoring, home-delivered meals, accessibility adaptations, assistive technology, emergency response systems, supports planning, and transition services.[28] The Community Options Waiver provides access to additional services, including assisted living services, medical day care, case management, nutritional services, behavior consultation, and family training.[29] Together, these programs help make living safely in the community possible for people who need substantial care.

The Department's August 2026 report documents both the scale of community services and continuing demand for access. Community First Choice served 18,585 individuals in March 2026, the latest month reported.[30] Separately, 20,778 individuals were on the Community Options registry as of June 30, 2026, including 13,493 people age 65 or older.[31] Registry participation did not establish eligibility, and 4,071 registrants were already receiving other home and community-

indicator/distribution-of-certified-nursing-facilities-by-primary-payer-source/ (last checked Nov. 17, 2026).

[27] Maryland Department of Health, Office of Health Care Quality Annual Report FY2025, at 9, Table 2 (Jan. 15, 2026) ("OHCQ Report"), available at https://health.maryland.gov/ohcq/docs/Reports/Archived-Annual-Report/MDH-Office-of-Health-Care-Quality-Annual-Report-FY-2025.pdf (last checked Nov. 17, 2026).

[28] Maryland Department of Health, Community First Choice Program ("Community First Choice"), available at https://health.maryland.gov/mmcp/ltss/Pages/Community-First-Choice.aspx (last checked Nov. 17, 2026).

[29] Maryland Department of Health, Community Options Waiver ("Community Options"), available at https://health.maryland.gov/mmcp/ltss/Pages/Community-Options-Waiver.aspx (last checked Nov. 17, 2026).

[30] Community Care Report, *supra* note 21, at 4, Table 2.

[31] Community Care Report at 17, Table 19.

based services while awaiting an invitation to apply.[32] Community Options participants may also receive Community First Choice benefits, so the programs' participation figures should not be added together.[33]

For families confronting these costs, obtaining Medicaid coverage requires navigating a complex system of federal and state regulations, agency interpretations, and case law. An elder law attorney helps connect access to essential care with the lawful preservation of resources for a spouse or certain family members and the retention of funds to supplement the recipient's care and quality of life. That need extends beyond nursing home admission to securing and maintaining the services that allow a person to remain at home.

D. Medicaid Planning Requires Expertise

Medicaid planning is highly technical, requiring careful application of interlocking federal and state laws. Medicaid is established under Title XIX of the Social Security Act, which the U.S. Supreme Court described as having a "Byzantine construction" that makes it "almost unintelligible to the uninitiated."[34] The Fourth Circuit similarly described the Medicare and Medicaid statutes as "dense reading of the most tortuous kind."[35] Effective planning requires understanding how these provisions interact with state eligibility rules, transfer penalties, spousal protections, trusts, annuities, and estate recovery.

[32] Community Care Report at 17.

[33] Community Care Report at 5.

[34] *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981).

[35] *Rehabilitation Association of Virginia, Inc. v. Kozlowski*, 42 F.3d 1444, 1450 (4th Cir. 1994).

E. NAELA Promotes Professional Competence in Elder Law

The National Academy of Elder Law Attorneys (NAELA) is dedicated to improving the quality of legal services provided to older adults and people with disabilities.[36] Through education, advocacy, and professional collaboration, NAELA equips attorneys to address the complex legal, financial, and long-term care issues these individuals and their families face. Its members must support NAELA's Aspirational Standards,[37] reinforcing the organization's commitment to serving clients with competence and care.

To further strengthen professional competence and help the public identify qualified counsel, NAELA's Board of Directors founded the National Elder Law Foundation (NELF) in 1993.[38] NELF administers an American Bar Association-accredited certification program recognizing attorneys who demonstrate enhanced knowledge, skills, experience, and proficiency in elder law. The Certified Elder Law Attorney (CELA) designation provides older adults, people with disabilities, and their families with a meaningful credential to consider when seeking assistance with these highly technical and consequential legal matters.[39]

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[36] NAELA, Who We Are, available at https://www.naela.org/Web/Web/Who-We-Are-Template.aspx.

[37] NAELA, Aspirational Standards, available at https://www.naela.org/Web/Web/Who-We-Are/History_and_Standards/Aspirational_Standards.aspx ("The NAELA Aspirational Standards are designed to assist attorneys in providing high-quality counsel, advocacy, and guidance to clients in this unique and specialized area of law.").

[38] NELF, About, Mission, available at https://www.nelf.org/mission.

[39] *Id.* ("The [ABA] accreditation standards were developed to provide both lawyers and clients with a way to identify those certification programs that employ adequate methods and criteria to reliably recognize experienced legal specialists.").

II. Medicaid Regulations Create Specific Challenges to Providing Medicaid Planning Services

Medicaid's financial eligibility requirements create a practical conflict for clients who must spend down their resources while securing continuing legal representation. Counsel may complete the planning and transactions necessary to establish eligibility before filing the application, yet substantial and unpredictable work remains to obtain the agency's recognition of that eligibility. Historically, fee arrangements allowed clients to complete their spend-down while providing for that continuing representation. Requiring the remaining unearned fee to stay in trust disrupts those arrangements because the client's continuing interest in the refundable balance can interfere with eligibility. The following sections explain the stages of Medicaid representation, the financial rules underlying the historical fee practice, and the continuing need for counsel through agency processing, reconsideration, and appeal.

A. Medicaid Representation

Medicaid representation commonly involves a continuing process that extends from initial planning through resolution of the application. Counsel assesses the applicant's care needs, income, assets, family circumstances, and eligibility category; develops a lawful eligibility plan; implements the necessary transactions and spend-down; and prepares and files the application and supporting documents. Filing completes one stage of that process, but substantial work may remain before the applicant receives a correct eligibility determination.

Medicaid planning services proceed through several distinct stages:

1. **Assess the client's circumstances and develop the plan.** Review care needs, income, assets, prior transactions, and legal documents; apply the eligibility rules; and identify the steps necessary to qualify for benefits while protecting resources as permitted by law.

2. **Prepare documents and implement the plan.** Complete the legal documents and transactions necessary to establish eligibility, coordinate with financial institutions and other professionals, and document the work performed.
3. **Prepare and submit the application once eligibility is established.** At this point, the client satisfies the applicable eligibility requirements. The application presents and documents that eligibility as of the relevant date. Submission therefore marks a significant milestone: the planning and implementation needed to make the client eligible have been completed, although the agency has not yet confirmed that eligibility.
4. **Respond to agency requests and pursue approval.** After submission, counsel monitors processing, supplies additional documentation, explains the legal treatment of transactions and assets, addresses agency errors or misunderstandings, and presses for a timely and correct determination.
5. **Pursue reconsideration or appeal when necessary.** If the agency issues an adverse determination, counsel evaluates its basis and challenges it through the appropriate review or appeal process.

This sequence is central to the discussion of attorney fees for Medicaid planning. Establishing the client's eligibility and obtaining the agency's recognition of that eligibility are distinct stages. Substantial legal services have already been completed—and their benefit delivered—when an eligible client's application is submitted. Agency approval follows later, and the time and effort required to obtain it may depend on processing delays, requests for information, or disputed interpretations.

B. Medicaid Eligibility Rules Dictate Depositing Funds into Operating Accounts

Historically, funds paid toward the fee were first deposited into the attorney's IOLTA account. The attorney billed against those funds as work was performed, transferring earned fees to the attorney's operating account. On the eve of filing the Medicaid application, any remaining fee balance held in IOLTA was transferred to the operating account as payment for the remaining services, so those funds would be spent down and would not interfere with the client's eligibility at the time of application.

This practice was driven by Medicaid's financial eligibility rules. If the remaining funds stayed in IOLTA and remained attributable to the client, they could count toward the client's resource limit and prevent eligibility.

A client seeking Medicaid eligibility ordinarily must satisfy the applicable resource standard when eligibility is determined. Maryland's resource regulation for applicants considers legal and equitable interests in property and makes the applicant ineligible when countable resources exceed the applicable standard.[40] The federal Supplemental Security Income resource methodology likewise looks to ownership and the individual's right, authority, or power to liquidate property for support and maintenance.[41] These principles make the client's continuing interest in an unearned, refundable legal fee relevant to the eligibility determination.

The requirement to hold an advance fee in trust therefore creates tension with the client's eligibility objective. Maryland Rule 19-301.15 requires an advance fee to remain in trust until earned and cross-references the obligation to refund unearned fees.[42] If the unearned portion

[40] COMAR 10.09.24.08.

[41] 20 C.F.R. § 416.1201(a).

[42] Maryland Rule 19-301.15.

remains the client's refundable property when eligibility is determined, the client's continuing interest in those funds presents a countable-resource problem.

For example, assume a client has $2,000 in a bank account and his attorney holds $5,000 in the attorney's IOLTA account to complete the work. If the $5,000 remains refundable and unspent, the client's continuing interest in those funds constitutes a countable resource. The client would therefore have $7,000 in countable resources—well above an assumed $2,500 limit—even though the bank balance alone falls below that limit. Paying the fee before filing was intended to remove those funds from the client's available resources and thereby complete the spend-down.

C. Attorney Representation Continues After Medicaid Application Submission

The Medicaid application framework requires ongoing representation of the client well after the application is submitted. This framework requires agency processing and permits appeals. However, the burden of seeing the application successfully adjudicated or appealing a wrongful denial must be borne by the applicant and counsel. And while the applicant and attorney can in most cases anticipate when an appeal could arise, no one can predict how long processing will take or how much effort representation will require. The dysfunction of the Department of Health has made it impossible to expect timely processing of even the most ordinary and routine cases.

1. Agency Processing Requirements

Federal verification requirements help explain why representation may continue after filing. When information supplied by an applicant conflicts with electronically obtained information, the agency must seek an explanation or additional information, subject to limits on unnecessary documentation requests and a requirement to allow a reasonable response period.[43]

[43] 42 C.F.R. § 435.952(c).

The agency also must satisfy applicable information-request, notice, and hearing requirements before denying or terminating eligibility or reducing benefits on the basis of that information.[44] Counsel's continuing work may therefore include answering requests, replacing documents that were lost or not associated with the application, correcting agency errors, and pursuing delayed decisions.

An improper denial may require representation through reconsideration or a fair hearing. Federal regulations require the agency to inform applicants of their hearing rights, how to obtain a hearing, and their right to represent themselves or use legal counsel or another representative, both when they apply and when specified adverse actions occur.[45] These protections support the practical conclusion that substantial work may remain after the date for which eligibility is sought.

2. Dysfunction in Application Processing Requires Continuing Representation

The Department of Health's own reporting demonstrates why filing a Medicaid application does not end the need for legal representation. Its August 2026 report shows that, of 2,183 Community Options Waiver applications received through registry outreach, 1,673—approximately 77 percent—remained pending, while only 128 applicants had enrolled. Unresolved cases included 98 of 182 applications from the July 2025 invitation cohort and 103 of 173 from the August 2025 cohort.[46] These figures illustrate the prolonged uncertainty applicants face after submitting an application, when they need assistance obtaining an eligibility determination and access to care.

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[44] 42 C.F.R. § 435.952(d).

[45] 42 C.F.R. § 431.206(b)–(c).

[46] Community Care Report, *supra* note 21, at 7, Table 6.

The frequency of denials further demonstrates the importance of securing counsel for the work that follows submission. Across Community Options Waiver applications, the Department reported 1,914 denials out of 2,590 submissions—a denial rate of 73.9 percent—including 645 procedural denials.[47] Although these figures do not establish that particular denials were improper, they show that a substantial number of applications fail for procedural reasons rather than substantive ineligibility. Continuing representation allows counsel to address documentation requirements, determine the basis for an adverse decision, and pursue reconsideration or appeal when warranted.

The Department also acknowledges administrative bottlenecks and substantial staffing shortages affecting financial eligibility determinations. Its report lists 11 filled positions and seven vacancies for Community Options Waiver financial eligibility work and describes plans to recruit staff and establish a unit devoted to complex financial eligibility cases without providing concrete implementation dates or processing-time targets.[48] Meanwhile, reconsideration remains confined to the applicant's original six-month application window; after a second denial, an applicant seeking to reapply must register again and await another invitation.[49] These conditions make timely and effective follow-through consequential, while leaving the duration and extent of the necessary legal work uncertain.

This processing environment makes the conflict created by the advance-fee rule especially acute. Counsel may have completed the planning, transactions, and spend-down necessary to establish eligibility before filing, yet substantial work may remain to obtain the agency's

[47] *Id.* at 16, Table 17.

[48] *Id.* at 14–15, Table 14.

[49] *Id.* at 8–9.

recognition of that eligibility. The client must therefore provide for continuing representation at the same time that financial eligibility requires the expenditure of available resources. Version A addresses that practical conflict by allowing a protected fee arrangement that enables the client to complete the spend-down while securing counsel for the uncertain course of agency processing, reconsideration, and appeal.

D. Rule 19-301.15 Exacerbates Medicaid Applicants' Circumstances

Rule 19-301.15 now disrupts the historical arrangement Medicaid applicants had with their counsel. As explained in Section II.B, Medicaid applicants and their attorneys could agree to a financial arrangement that ensured the attorney would see the application all the way to an appeal while staying within the Medicaid spend-down requirements. The amended Rule 19-301.15 no longer permits those historical arrangements. So, if Medicaid financial eligibility requirements force Medicaid applicants to spend down their excess resources, Rule 19-301.15 prevents them from obtaining counsel to secure the benefits to which they are entitled.

The question for the Court is how to preserve protection against misuse of advance fees while ensuring that vulnerable applicants can secure continuing representation through agency processing and appeal.

III. Version A Advances Client Protection in These Circumstances

Version A advances client protection by addressing consequences of the 2024 amendment that were not considered when Maryland aligned its rule with the ABA model. The requirement to hold advance fees in trust addressed a legitimate concern about the loss of unearned client funds. In Medicaid representation, however, that requirement disrupted established fee arrangements that allowed clients to complete their spend-down while securing continuing legal assistance. The

following sections explain the amendment's protective purpose and the overlooked consequences for Medicaid applicants, showing why a targeted exception would serve that purpose while preserving access to justice.

A. The 2024 Amendment to Rule 19-301.15 Addressed a Legitimate Problem That Differs from the Circumstances Presented Here

Maryland's 2024 amendment to Rule 19-301.15 was intended to bring the rule into closer alignment with ABA Model Rule 1.15 by replacing Maryland's informed-consent exception with the requirement that advance fees remain in trust until earned.[50] The ABA added that requirement in February 2002 as part of its Ethics 2000 amendments.[51] The amendment responded to reports that the taking of unearned fees constituted the largest category of claims made to client protection funds.[52] Requiring attorneys to safeguard advance fees until earned addressed that legitimate concern and established an important protection against loss of client funds.

The Medicaid practice described in Sections I and II presents a distinct circumstance: a reasonable flat fee for necessary representation, where retaining the payment as the client's property interferes with the client's pursuit of Medicaid benefits. The client must complete the required spend-down while securing counsel's services for the substantial work that continues after the application is filed. The 229th Report identifies the resulting conflict: unearned fees held in trust remain the client's assets and can interfere with financial eligibility.[53] A carefully regulated

[50] Rules Committee, Minutes of March 15, 2024, at 45–46; 223rd Report, Reporter's Note to Rule 19-301.15, at 254.

[51] ABA, *Model Rules of Professional Conduct as Adopted by the House of Delegates, February 2002*, Rule 1.15(c).

[52] ABA, *Reporter's Explanation of Changes to Model Rule 1.15*, ¶ 2.

[53] Two Hundred Twenty-Ninth Report of the Standing Committee on Rules of Practice and Procedure ("229th Report"), at 27–28, 279–280.

arrangement that addresses this conflict serves the client's demonstrated interests. Recognizing that circumstance carries the rule's protective purpose into the actual conditions of Medicaid representation.

B. Alignment with the ABA Rule Did Not Account for the Consequences for Established Elder-Law Practice

Maryland's former rule accommodated alternative treatment of advance fees through informed consent confirmed in writing, subject to disclosure and continuing refund obligations.[54] That framework supported the historical practice described in Section II: practitioners initially deposited advance fees into trust, transferred earned portions as work progressed, and transferred the remaining agreed fee to the operating account before filing the Medicaid application as payment for the remaining services. The arrangement allowed clients to complete their spend-down while retaining counsel for the work necessary to secure agency approval.

The practitioner concerns recorded in the 229th Report explain why that established practice mattered to clients. The Report records concerns that had not been presented during the original consideration of the amendment, including the consequences of treating an unearned fee balance as the client's asset when determining benefits eligibility.[55] Those accounts connect the

[54] MSBA Ethics Docket 2021-01; former Md. Rule 19-301.15(c) & cmt. [3].

[55] 229th Report, at 27–28, 279–280. The 2024 record briefly addressed flat-fee agreements and the uncertainty surrounding when those fees become earned. Bruce Marcus discussed agreements treating fees as earned at signing or at specified benchmarks, recognized the possibility of disputes over how much had been earned, and acknowledged continuing "peril" for lawyers charging flat fees. Rules Committee, Minutes of March 15, 2024, at 45–46.

That discussion shows no consideration of Medicaid eligibility, spend-down requirements, post-filing representation, or the resulting access-to-counsel problem. *Id.* The Committee approved the proposal without a motion to amend or reject it; the minutes do not record a unanimous roll-call vote. Id. at 46. The proposed change appeared in the 223rd Report and was adopted by the Court on November 13, 2024, effective July 1, 2025. Rules Committee, 223rd Report, proposed

historical fee practice directly to its purpose: establishing the client's financial eligibility while providing for continuing representation. The change in fee treatment therefore affected both the client's eligibility objective and access to the legal services needed to achieve it.

C. The ABA's Guidance Recognizes Flexibility That Should Inform Maryland's Approach

The ABA's guidance has developed since its adoption of the advance-fee requirement in 2002, explaining how that protection operates in flat-fee representations. In 2023, Formal Opinion 505 recognized that reasonable portions of a flat fee may be earned and withdrawn upon completion of agreed stages, rather than requiring the entire fee to remain in trust until the engagement ends. ABA Standing Committee on Ethics and Professional Responsibility, Formal Opinion 505, at 4–5, 12–13 (May 3, 2023). That guidance gives practical effect to the distinction between completing an entire engagement and earning portions of a fee as particular services are delivered. It provides flexibility within the trust-until-earned framework while preserving its protective purpose.

The stages of Medicaid representation described in Section II demonstrate the importance of that flexibility. Counsel assesses the client's circumstances and develops a plan, prepares documents and implements the plan, files the application, pursues agency approval, and seeks reconsideration or appeal when necessary. Each stage delivers services toward the client's objective, and substantial work has been completed when an eligible client's application is filed. Fee regulation should account for the services and benefits delivered through those stages,

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amendment to Rule 19-301.15; Supreme Court of Maryland, Rules Order of November 13, 2024. The Court should now address the consequences of formal uniformity for arrangements developed to serve these clients' circumstances. Version A provides a direct means of doing so while retaining meaningful client protections.

including the distinction between establishing eligibility and obtaining the agency's recognition of it.

Maryland's Bar Counsel likewise explained that nothing would "prevent an attorney and client from specifying when an advance fee or portions of that fee can be considered earned."[56] The ABA's subsequent guidance and Maryland's recognition of these agreements support an approach attentive to the client's needs and the structure of the representation. Version A takes the further step of expressly addressing the demonstrated conflict between trust-account treatment and eligibility for financially restricted benefits or relief under federal law.[57] It carries the protective purpose of fee regulation forward by addressing the circumstances in which the treatment of a fee obstructs the very objective for which the client retained counsel.

D. Version A Provides a Narrow Means of Advancing Those Protective Objectives

Version A ties its exception to the precise circumstance requiring different fee treatment. It applies to a flat fee for specified services in a civil matter when trust-account treatment would prohibit or interfere with eligibility for a financially restricted benefit or program for which the services are sought, or would interfere or conflict with relief under federal law.[58] This condition connects the exception directly to the client's objective in retaining counsel. It permits different treatment because the ordinary treatment would obstruct the legal benefit the representation is intended to secure.

Version A also requires the arrangement to be established in advance through an agreement signed by the client, written in understandable language, and containing prominent disclosures.

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[56] 229th Report, at 279–280.

[57] *Id.* at 276–279.

[58] *Id.*

The agreement must identify the services, fee, payment terms, and treatment of the payment.[59] These requirements make the arrangement transparent and place its essential terms before the client at the outset.

The proposal preserves the client's continuing rights to terminate the representation and receive an appropriate refund, together with requirements for prompt efforts to resolve fee disputes.[60] Those protections remain essential when the fee is treated as earned upon receipt. They ensure that the arrangement serves the client's eligibility needs while preserving the client's rights throughout the engagement.

Version A extends beyond the ABA opinion's trust-until-earned framework to protect clients facing this demonstrated conflict.[61] Its targeted conditions, signed agreement, prominent disclosures, and continuing termination and refund rights provide a carefully regulated means of securing necessary representation. Together, these provisions advance the protective objective underlying the rule in the circumstances in which these clients need it to operate.

IV. Conclusion

The Chapter respectfully requests that the Court adopt Version A to preserve access to justice for older adults and people with disabilities seeking essential benefits. Clients who must spend down their resources to establish Medicaid eligibility also need continuing representation to secure those benefits. Version A addresses the conflict between these needs through a limited

[59] *Id.*

[60] 229th Report, at 276–279.

[61] ABA Formal Opinion 505, at 4–5, 12–13; 229th Report, at 276–279.

exception with meaningful safeguards. Its adoption will protect clients' rights while preserving access to the legal assistance necessary to obtain the care they need.

Respectfully submitted,

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