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Tenacity, Creativity and Results are the three words that best describe Shaheen & Gordon's approach to addressing complex legal issues. Our health care team closely monitors the rapidly changing legal environment so that our clients are prepared to meet the challenges of today as well as tomorrow. Relying on a wealth of experience, we offer practical advice and assist in implementing recommendations tailored specifically to meet the needs of both large and small health care clients.

FEDERAL DEVELOPMENTS

Affordable Care Act Implementation

Health Insurance Marketplaces Open in October

Individual and small business health insurance marketplaces (also known as "exchanges") become available throughout the United States on October 1, 2013, for coverage beginning January 1, 2014. The marketplace is available online at www.healthcare.gov. Individuals who need assistance in accessing the marketplace may call a federally-run call center at (800) 318-2596. Community organizations, under the leadership of two "Navigators" who have received federal grants to assist New Hampshire residents, will also be assisting with enrollment starting in October.

In New Hampshire, Anthem has been approved to offer health plans and Northeast Delta Dental has been approved to offer dental plans through the marketplace. Anthem will be offering a "narrow network" plan with access to 16 of the state's 26 hospitals, plus one in Massachusetts. Harvard Pilgrim recently announced its own narrow network plan in partnership with Dartmouth-Hitchcock and Elliott Health Systems, "ElevateHealth," with access to 5 of the state's hospitals. Harvard Pilgrim expects to offer this plan in the New Hampshire marketplace starting in 2015.

In addition to individuals, self-employed individuals, and families, the marketplaces will also be available to businesses with 50 or fewer full-time equivalent (FTE) employees for coverage starting in 2014, and 100 or fewer full-time equivalent employees for coverage starting in 2016.

Small Business Health Care Tax Credit

For two tax years starting in or after 2014, employers with up to 25 employees and average annual wages below $50,000 are entitled to a tax credit of up to 50% of their actual cost of insurance (limited by the average annual cost of insurance in New Hampshire). The credit percentage decreases for businesses with more than 10 employees, average wages above $25,000, or both. Unlike in previous years, to obtain the credit in 2014 and beyond, insurance must be purchased in the new health insurance marketplace. Employers' costs for health insurance not covered by the credit will continue to be tax-deductible.

Employer Mandate Delayed

On July 2, the Treasury Department announced a one-year delay, until January 1, 2015, of the Affordable Care Act's requirement that employers with 50 or more full-time equivalent employees provide health insurance to their full-time employees or pay a penalty. The requirement had been scheduled to go into effect on January 1, 2014. Employer reporting requirements and related penalties for failure to comply have

also been delayed by one year.

Although further transition relief may be granted, at present, it is expected that for purposes of determining whether or not an employer has 50 or more full-time equivalent employees for 2015, the law will look to whether the employer employed an average of 50 or more full-time equivalent employees during calendar year 2014.

Individual Mandate Going Into Effect

On January 1, 2014, the individual mandate will go into effect. Those not exempt from the mandate must purchase insurance or pay a penalty. Exemptions will be provided to those:

- whose employer-provided coverage or any "bronze" plan available through the marketplace would require a contribution of greater than 8% of their household income;
- who are not required to file a tax return because their income is too low (in 2012, $9,750 for singles and $19,500 for married filing jointly);
- who are uninsured for a period of less than three months during the year;
- whose income is below 138% of the federal poverty line and who live in a state that has chosen not to expand Medicaid;
- who are unlawfully present in the United States (that is, do not have citizenship or valid immigration status);
- who are members of federally recognized Indian tribes;
- who participate in health care sharing ministries;
- who are incarcerated; or
- who are members of a recognized religious sect with religious objections to health insurance.

There is also a catchall hardship category. Some exemptions are available exclusively through an application to the marketplace, some exclusively when filing a tax return, some through either method, and some do not require an application.

In 2014, the initial annual penalty is $95/adult and $47.50/child, up to a maximum of $285 per family, or 1% of taxable income, whichever is greater. In 2015, the annual penalty increases to $325/adult and $162.50/child, up to a maximum of $975 per family, or 2% of taxable income, whichever is greater. In 2016, the annual penalty further increases to $695/adult and $347.50/child, up to a maximum of $2085 per family, or 2.5% of taxable income, whichever is greater.

Medicaid Expansion

Under the Affordable Care Act, states have the option of expanding their Medicaid programs to cover all adults aged 19 to 64 with a "modified adjusted gross income" of up to 138% of the federal poverty level (approximately $15,800/year for an individual and $32,500/year for a family of four). In June, in a letter responding to an inquiry from Governor Maggie Hassan, CMS confirmed that if the state chooses to expand Medicaid, it may drop expanded coverage at any time, without financial penalty from the federal government.

New Hampshire has not yet made a decision on whether to expand Medicaid. In late June, the legislature defeated various proposed plans and created a Commission to Study the Expansion of Medicaid Eligibility. The Commission is studying the potential costs and benefits of expanding Medicaid, the possibility of tailoring Medicaid expansion to maximize the receipt of federal funds, whether federal Medicaid monies can or should be used to purchase private health insurance, whether the health

insurance marketplace should be used to cover individuals at 100-138% of the federal poverty level, the possibility and optimal use of co-payments and incentives, how other states have approached this issue, the availability of providers, the impact of cost-shifting, and ways to ensure the state will have financial and legal protections if the federal government reneges on its funding obligation. Several of the options under consideration would require a waiver from CMS.

The nine-member Committee was up and running by early July, and faces an October 15 deadline to issue its recommendations. After the release of the Committee's report this fall, it is expected that a special legislative session will be convened to consider the issue of Medicaid expansion.

Meanwhile, on July 26, CMS approved an amendment to New Hampshire's Medicaid State Plan that expands coverage for preventive services.

Navigators

Planned Parenthood of Northern New England and the Bi-State Primary Care Association have received federal grants to help enroll individuals in the health insurance marketplace and to provide information to consumers about health insurance, the marketplace, and Medicaid. Bi-State Primary Care, which represents sixteen community health centers, will get $434,839, while Planned Parenthood will get $145,161. Bi-State Primary Care will primarily serve individuals in Belknap, Carroll, Coos, Grafton, Hillsborough, Merrimack, Rockingham, and Strafford counties, while Planned Parenthood will primarily serve individuals in Cheshire, Hillsborough, Grafton, Rockingham, and Sullivan Counties. These two organizations, in turn, are training other community organizations to assist in a statewide educational and outreach effort. (For the time being, individuals with questions should still go to www.healthcare.gov or call (800) 318-2596.)

The federal government also awarded a $5.4 million grant to the state to provide education and outreach on the health insurance marketplaces, health insurance, and available financial assistance. However, the legislature blocked the state Insurance Department from accepting the money. With the Insurance Commissioner's blessing, the New Hampshire Health Plan, a quasi-governmental non-profit which runs the state's high risk insurance pool, has now applied for the funding.

HIPAA

The HIPAA Omnibus Final Rule was published on January 25, 2013. While the Final Rule was effective on March 26, 2013, the date by which covered entities and business associates must come into compliance with the rule's requirements is September 23, 2013. As a reminder, the Omnibus Rule makes some significant changes to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules.

With regard to business associates, the Omnibus Rule makes business associates directly liable for compliance with certain provisions of the HIPAA Privacy and Security Rules, and changes the requirements for business associate agreements. Existing Business Associate Agreements are deemed compliant through September 22, 2014, unless the agreement is renewed or modified prior to that date. However, you should take the time now to identify all business associates and subcontractors to ensure that appropriate Business Associate Agreements are in place. Starting September 23, 2013, any new business associate agreements, or renewals or modifications of existing agreements, must conform to the Omnibus Rule.

The Omnibus Rule requires modifications to the Notice of Privacy Practices to advise individuals of new rights. If you have not already done so, you will want to revise your Notice of Privacy Practices to bring it into compliance with the new requirements on or before September 23, 2013.

The Omnibus Rule makes significant changes to the process of determining when a security breach has occurred, and hence when breach notification must take place. Specifically, the Omnibus Rule provides that an unauthorized use or disclosure of PHI is deemed a breach unless the covered entity concludes that there is a low probability that the information has been compromised.

The Omnibus Rule also:

- Restricts the use and disclosure of PHI for marketing and fundraising purposes. (Note that New Hampshire law also restricts the use of PHI for marketing and fundraising purposes.)
- Prohibits the sale of PHI without individual authorization.
- Expands the rights of individuals to receive electronic copies of their PHI, and to restrict disclosures of their PHI to health plans when they pay in full for the service out of pocket.
- Changes the requirements to allow certain disclosures of immunization information to schools.
- Changes the requirements to allow certain disclosures concerning a deceased individual to family members and others involved in the individual's care or payment for that care prior to the individual's death, unless the decedent expressed contrary wishes prior to death.
- Increases the penalties for violations of the Privacy and Security Rule, and clarifies how penalties are calculated.

OIG Advisory Opinions

The U.S. Department of Health and Human Services, Office of Inspector General (OIG) issued several advisory opinions this summer. These include:

- Advisory Opinions 13-12 and 13-06 (concerning use of a 'preferred hospital' network as part of certain Medicare Supplemental Health Insurance ("Medigap") policies);
- Advisory Opinion 13-11 (concerning two proposed arrangements involving the provision of emergency medical services for a township);
- Advisory Opinion 13-10 (concerning a proposal to contract with hospitals to provide services to patients with certain diagnoses following hospital discharge with the goal of reducing preventable hospital readmissions);
- Advisory Opinion 13-09 (concerning a proposal to offer members of a group purchasing organization ("GPO") an equity interest in the GPO's parent organization in exchange for the member: (1) extending its contract with the GPO for five to seven years; (2) committing not to decrease purchasing volume; and (3) relinquishing its right to a portion of the administrative fees that would otherwise have been passed through to the members);
- Advisory Opinion 13-08 (concerning a fire protection district's policy of billing only individuals who reside outside the fire protection district for emergency medical services);
- Advisory Opinion 13-07 (concerning a tiered rebate program in which the rebate tiers would be reached based on the combination of purchases of both Federally reimbursable products and non-Federally reimbursable products);
- Advisory Opinion 13-05 (concerning an exclusive contract for emergency medical services and transports between a municipality and an ambulance company);
- Advisory Opinion 13-04 (concerning an arrangement among a county, a county health district, and various municipalities concerning the provision of non-emergency ambulance transportation

services by the county health district); and

- Advisory Opinion 13-02 (concerning a proposal to establish a limited liability company that would enter into arrangements with manufacturers and other entities to provide industrial orthotics for use by these entities' employees).

In Advisory Opinion No. 13-03, the OIG addressed an issue that may be of interest to the MGMA members. There, the OIG declined a clinical laboratory company's proposal to provide various laboratory services to physician practice groups for those patients of the physician practices not covered by a federal healthcare program. The OIG reasoned that doctor groups operating under the proposed arrangement might feel pressure to use the parent lab company for federal health care beneficiary services and would have a financial incentive to overuse lab services in general for all patients.

In analyzing the proposed arrangement, the OIG first noted its long-standing concern about arrangements under which parties "carve out" referrals of federal health care program beneficiaries or business generated by federal health care programs. The OIG noted that such arrangements "implicate, and may violate" the federal Anti-kickback Statute. The OIG also reasoned that under the proposed arrangement, the Parent Lab would be offering the physician practices remuneration in the form of the opportunity to expand into a financially profitable clinical laboratory business with little or no risk. The OIG further reasoned that the proposed arrangement could affect the physicians' decision-making, causing them to make future referrals to the Parent Lab for laboratory services covered by a federal health care program. For these reasons, the OIG declined to issue a favorable opinion protecting the proposed arrangement.

HHS Guidance on DOMA

The Department of Health and Human Services recently announced its first guidance implementing the Supreme Court's recent decision on the Defense of Marriage Act ("DOMA"). On June 26th, the U.S. Supreme Court found Section 3 of DOMA, which defines marriage as the union of one man and one woman for purposes of all federal laws, to be unconstitutional. The case of *United States v. Windsor* was brought by a woman named Edith Windsor who was married to another woman named Thea Spyer in a lawful ceremony in Ontario, Canada in 2007. In 2009, Ms. Spyer passed away, leaving her entire estate to Ms. Windsor. Ms. Windsor tried to claim the estate tax exemption available for estates left to a surviving spouse. Her claim was denied, however, because of DOMA, which denies benefits such as the estate tax exemption to same-sex couples. The Court held that by treating some married persons differently than other married persons, the federal government violated the Equal Protection principles guaranteed by the Fifth Amendment.

The full impact of this decision on federal benefits programs has yet to be seen. For example, the IRS recently announced that, for tax purposes, same-sex couples legally married in any state are married, so far as the federal government is concerned, no matter where they live. Similarly, on August 29th, HHS issued a memo clarifying that all beneficiaries in private Medicare plans have access to equal coverage with regard to care in a nursing home where their spouse lives. Prior to this memo, a beneficiary in a same-sex marriage enrolled in a Medicare Advantage plan did not have equal access to such coverage and, as a result, could have faced time away from his or her spouse or higher costs because of the way that marriage was defined for this purpose. The guidance specifically clarifies that this guarantee of coverage applies equally to couples that are in a legally recognized same-sex marriage, regardless of where they live.

Mail-Order Diabetic Supplies

Effective July 1, 2013, a Medicare National Mail-Order Program for diabetes testing supplies went into effect. This program applies to all beneficiaries in the United States who have Original Medicare. Under the program, beneficiaries who want their diabetes testing supplies delivered to their home must use a Medicare national mail-order contract supplier. Beneficiaries also have the option to pick up their testing supplies in person from any Medicare-enrolled supplier of diabetic testing supplies.

The Medicare-approved amount for diabetic testing supplies will be the same regardless of where the supplies are furnished. Medicare mail-order contract suppliers must always accept assignment on these items, meaning that they must accept the Medicare-approved amount as payment in full and cannot charge beneficiaries more than 20 percent coinsurance and any unmet deductible. Local retail locations, however, may choose whether or not to accept assignment, and those that do not accept assignment may charge beneficiaries an amount above the 20 percent coinsurance. Mail-order contract suppliers are prohibited from influencing or incentivizing beneficiaries to switch to a different brand of glucose monitor and testing supplies, and beneficiaries are not required to change their glucose testing monitor.

The program allows a physician or treating practitioner to prescribe a specific brand or mode of delivery to avoid an adverse medical outcome. The physician or treating provider must document in the patient's medical record why a specific brand or mode of delivery is required, including: the product's brand name or mode of delivery; the features that the product or mode of delivery has versus other brand name products or modes of delivery; and an explanation of how these features are necessary to avoid an adverse medical outcome. In these situations, the mail-order contract supplier is required to give the patient the exact brand or mode needed, help the patient find another contract supplier that offers that brand or mode, or work with the patient's provider to find another brand or mode that is safe and effective. If the supplier does not ordinarily furnish the specific brand or mode and cannot obtain a revised prescription or locate another contract supplier that will furnish the item, the supplier must furnish the item as prescribed.

2014 Proposed Physician Fee Schedule

On July 19, 2013, CMS published the proposed 2014 Medicare Physician Fee Schedule. The comment period for the Proposed Rule closed on September 6 and the Final Rule is expected to be published on or around November 1. New rates will be effective beginning January 1, 2014. We summarize some essential provisions here.

Payment for Care Coordination

CMS is proposing to expand coverage of care coordination services. Specifically, CMS proposes to pay for complex chronic care coordination as of 2015. The proposal would allow reporting for patients who have two or more chronic conditions, are at risk for death or significant decline, and are expected to require care management for at least 12 months or until the patient's death. CMS has also added several requirements intended to ensure that beneficiaries have consented to the arrangement, and would require reporting in 90-day increments.

Potentially Misvalued Services

For over 200 services where the Medicare payment is currently greater for services performed in the physician's office than in a hospital outpatient department or ambulatory surgical center, CMS is proposing, with exceptions, to cap the physician payment for the services at the level paid to these other

types of providers.

Physician Compare

Starting in 2014, CMS is proposing to expand the quality measures posted on the Physician Compare website by publicly reporting performance on all measures for groups that participate in the Group Practice Reporting Option (part of the Physician Quality Reporting System). There will be a 30 day preview period so that groups can view their data before it is publicly posted. CMS has proposed to add individual eligible practitioners starting in 2015, based on 2014 data.

Liability for Overpayment

CMS waives recovery of overpayments in certain "without fault" situations where the overpayment is not identified within a specific time period. Previously, the law allowed a three-year look-back period. The proposed rule implements changes enacted by the American Taxpayer Relief Act of 2012 that gave Medicare more time to recover overpayments – extending the three-year time limit to five years. CMS still retains its authority to reopen claims at any time in cases of fraud. It is important to note that in a proposed rule issued in 2012, CMS proposed a ten-year look-back period for overpayments. A final rule has not yet been issued.

Telehealth Services

CMS proposes an expansion of geographic locations where telehealth services may be covered by Medicare. Currently, CMS is permitted to cover Medicare telehealth services in a county that is not a Metropolitan Statistical Area, in rural health professional shortage areas, or at sites participating in a federal telemedicine demonstration project. The proposed rule would expand permissible sites located in rural census tracts as determined by the Office of Rural Health Policy. The rule would establish the originating site's geographic eligibility on an annual basis, as of December 31 of the prior year, to avoid mid-year interruptions in service. CMS also proposes to expand telehealth service codes that will be reimbursed by Medicare to include transitional care management services.

Physician Quality Reporting System

The 2014 Proposed Physician Fee Schedule contains a number of changes to the Physician Quality Reporting System. Specifically, CMS proposes to retain the 12-month calendar year reporting period for the PQRS program in 2014 and beyond. In addition, in 2013, a physician will earn a 0.5 percent bonus for reporting successfully on three PQRS measures. For 2014, CMS proposes to increase the requirement to successful reporting on nine measures covering three of the six domains of the National Quality Strategy. Domains include efficiency, safety and effectiveness. This requirement would apply regardless of whether measures are reported via claims, registry, or electronic health record. CMS proposes to equalize the successful reporting levels for claims and registry so that eligible professionals must report on 50 percent of the eligible professional's applicable patients rather than 80 percent, regardless of the method of reporting. CMS also proposes to eliminate the option to report on claims-based measures groups.

PQRS is also transitioning from a bonus to a penalty system. In this rule, CMS proposes to establish the same criteria for a bonus and a penalty. This means that physicians who do not report successfully in 2014 will receive a 2 percent penalty in 2016.

Medicare Patient Access and Quality Improvement Act of 2013 (Pending Federal Legislation)

Both the House and Senate are considering legislation that would change how Medicare pays physicians. On July 31, the House Energy and Commerce Committee reported out, by unanimous vote, H.R. 2810, the Medicare Patient Access and Quality Improvement Act of 2013. The Senate Finance Committee has held hearings but has not yet produced its own plan. The House bill would repeal the currently scheduled annual cuts in payments to physicians (known as the Sustainable Growth Rate), replacing them with annual increases of 0.5% per year from 2014-2018. Current payment incentives such as the Physician Quality Reporting Program and Electronic Health Record Incentive Program would continue. Starting in 2019, the 0.5% annual increase would continue, but additional increases and reductions in payments would take place based on a new "Update Incentive Program," which would include yet-to-be-determined performance quality measures.

Employment

On June 24, 2013, the Supreme Court issued a major ruling in the area of sexual harassment law. The Court ruled that for purposes of sexual harassment employment discrimination claims, a supervisor is defined as an employee "empowered by the employer to take tangible employment actions against the victim." Tangible employment actions include hiring, firing, promoting, demoting, or reassigning an employee to significantly different responsibilities. "Supervisors" who have the power to direct another employee's tasks but do not have the power to take a tangible employment action are now treated as co-workers under the law.

This ruling is significant because under prior Supreme Court precedent, where a harassing supervisor is found to have taken an adverse employment action against an employee, the employer is strictly liable for that action. Even in the absence of an adverse employment action, the employer can be held liable for harassment by a supervisor if it cannot demonstrate that it exercised reasonable care to prevent and promptly correct any harassing behavior, or that the plaintiff-employee unreasonably failed to take advantage of any preventive or corrective opportunities provided by the employer (for example, by not reporting the harassment under an anti-harassment policy.). On the other hand, employers are only liable for harassment by co-workers where the plaintiff-employee can prove that the employer was negligent in failing to stop the behavior.

Cloud Computing

An official of the Office for Civil Rights in the Department of Health and Human Services, speaking at a recent conference, emphasized that cloud service providers that maintain PHI are business associates with whom business associate agreements are required. Any covered entity storing PHI in the cloud should ensure that appropriate safeguards, including the existence of a business associate agreement, are in place.

NEW HAMPSHIRE DEVELOPMENTS

Medical Marijuana

On July 23, Governor Hassan signed a new bill into law, making New Hampshire the 19th state – and the last New England state – to legalize medical marijuana. The law allows the Department of Health and Human Services to register up to four non-profit alternative treatment centers ("ATCs") to grow and dispense marijuana to qualified patients with "chronic or terminal diseases" or "debilitating medical conditions" including, for example, cancer, multiple sclerosis, or Crohn's disease.

To obtain a registry identification card from DHHS, qualifying patients must obtain a prescription from a physician or APRN who they have been seeing for at least 90 days. The provider must be primarily responsible for treating the patient's qualifying condition. Under the law, each ATC can grow a maximum of 80 marijuana plants and 160 seedlings, and possess up to 80 ounces of marijuana, or 6 ounces per patient. Patients will be allowed to possess up to two ounces at a time, as long as they have an ID card. They may obtain up to two ounces every 10 days from their designated ATC. The law does not allow patients to grow marijuana at home.

The law takes effect immediately; however, it may take up to 12 months before the Department begins issuing ID cards and 18 months before the first ATC opens. Patients do not have any legal protection until they obtain an ID card. The next step is the creation of an advisory council to oversee implementation of the law, addressing such issues as where the ATCs will be located and how they will be monitored.

Certificate of Need Board

Earlier this spring, the New Hampshire House considered a bill (HB 677) to repeal and replace the Certificate of Need statute. This legislation was inserted into the budget document during the final budget negotiations. These CON changes adopt almost entirely the recommendations by a 2010 legislative study committee.

The current 10-member CON Board will be replaced by a five-member board with no professional or financial relationship to the health care system. The new CON Board would have broad authority to deny hospital construction or expansion plans, and could veto large capital equipment purchases. Specifically, the Board will be required to: develop a state health plan to provide guidance to the CON process as well as to provide strategies for improving the health of NH citizens that ensure quality of health care, access to care, and efficient spending; regulate all types of equipment leases; develop standards and criteria by which projects are reviewed that include "the financial impact of increased utilization, the effect on the average cost of a procedure, whether total health care costs will be increased, not just whether unit costs will be decreased, and health outcomes." The moratorium on nursing home and rehab hospital beds has been extended until June 2016 and there is a prospective repeal of the entire statute on June 30, 2016 in anticipation of accountable care organizations and other market reforms.

Though the legislation calls for an effective date of August 1, 2013 for the process of creating the new Board, the timing of the transition from the current Board to the new Board is uncertain. The current Board, however, will remain in place until the new Board is established. The remaining CON changes go into effect February 1, 2014.

State Budget

Medicaid State Budget – Payment Rates and DSH

The Legislature passed a $10.7 billion budget for the next two years, beginning July 1, 2013. Throughout the final budget deliberations, the Legislature acknowledged that the Medicaid program is vastly underfunded and that additional revenues are needed to support patients and communities. In an attempt to revitalize the disproportionate share hospital (DSH) program, an additional $40 million for DSH payments are front-loaded in the first year (fiscal year 2014). The Senate had included a provision to create an "Innovation in Medicaid Delivery Commission," which the House rejected. The commission would have worked to create a new 1115 Medicaid waiver, to "obtain federal matching funds for so-called

'costs not otherwise matchable' to improve access and quality of care for Medicaid-dependent patients." It is likely that the State will seek to create a 1115 waiver to obtain additional federal funding by the second year of the budget.

Medicaid Managed Care

As part of the budget bill, the legislature mandated the time frame by which hospitals must participate in the Medicaid managed care network in order to qualify to receive their DSH payments. The final budget required that hospitals be in active negotiations with the MCOs by July 1 with final agreements in place by August 1. As of early July, all of the State's hospitals had either signed up for the program or agreed to do so.

The new state budget assumes that managed care will save the State $47.5 million over the next two years, with $24.4 million coming in the second year of the biennium from the second stage of managed care, which will cover long-term care services. The first stage of managed care starts December 1, when coverage of current Medicaid beneficiaries will be provided by one of the following plans: Meridian Health Plan, New Hampshire Healthy Families, or Well Sense Health Plan. Enrollment begins in September.

Behavioral Health Services

The 2014-2015 budget increases state funding for behavioral health services by $24.6 million to boost the state's behavioral health system in order to implement New Hampshire's Ten-Year Mental Health Plan, "Addressing the Critical Mental Health Needs of NH's Citizens: A Strategy for Restoration." Over the next two years, the budget will expand inpatient capacity to reduce and/or eliminate wait times in hospital emergency departments for an inpatient bed. This includes adding a new designated receiving facility and a 16-bed community-based inpatient unit. It will also expand housing options to reduce readmissions to NH Hospital, reduce inpatient stays at NH Hospital, discharge patients who are homeless into stable housing, improve treatment outcomes, and reduce costs. The budget also adds ten new Assertive Community Treatment teams to help adults and children in crisis and increases funding for the Referral Education and Assistance Program to provide outreach and evaluation to older adults with mental illness or substance abuse problems.

Legal Challenge to Medicaid Managed Care

On August 15, a lawsuit was filed in the Hillsborough County Superior Court, Northern District, seeking to prevent the state from including developmentally disabled adults in the Medicaid managed care program. The lawsuit was filed by developmentally disabled adults, the ten nonprofit Area Agencies that provide care to Medicaid recipients with developmental disabilities or acquired brain disorders, and the Community Support Network, which coordinates the Area Agencies' work. The suit seeks a declaratory judgment that the state law setting up Medicaid Managed Care simply does not apply to the Medicaid long-term care services provided to the developmentally disabled or those with acquired brain disorders. It also seeks a judicial determination that the Area Agencies are not required to contact with the managed care organizations in order to provide services to developmentally disabled Medicaid recipients.

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Cinde Warmington, Clara Dietel, and Benjamin Siracusa Hillman contributed to this month's Legal Update.

BIOS

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