

SB 125-FN - AS INTRODUCED

2025 SESSION

25-1000

05/09

SENATE BILL ***125-FN***

AN ACT relative to clinical eligibility criteria for nursing facility and home and community based care.

SPONSORS: Sen. Avar, Dist 12

COMMITTEE: Health and Human Services

ANALYSIS

This bill updates clinical eligibility criteria for nursing facility and home and community based care; adds mobility to the activities of daily living; corrects the federal reference for the definition of “skilled professional medical personnel”; requires information from the applicant’s primary care physician be considered; clarifies the medical eligibility determination is the responsibility of “skilled professional medical personnel”; and gives the department staff authority to obtain medical information for the eligibility decision making process.

Explanation: Matter added to current law appears in ***bold italics***.
 Matter removed from current law appears ~~[in brackets and struckthrough.]~~
 Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty Five

AN ACT relative to clinical eligibility criteria for nursing facility and home and community based care.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 1 Long-Term Care; Eligibility. Amend RSA 151-E:3 to read as follows:

2 151-E:3 Eligibility.

3 I. A person is medicaid eligible for nursing facility services or Medicaid home and
4 community-based care waiver services if the person is:

5 (a) Clinically eligible for nursing facility care because the person requires 24-hour care
6 for one or more of the following purposes:

7 (1) Medical monitoring and nursing care when the skills of a licensed medical
8 professional are needed to provide safe and effective services;

9 (2) Restorative nursing or rehabilitative care with patient-specific goals;

10 (3) Medication administration by oral, topical, intravenous, intramuscular, or
11 subcutaneous injection, or intravenous feeding for treatment of recent or unstable conditions
12 requiring medical or nursing intervention; or

13 (4) Assistance with 2 or more activities of daily living involving eating, toileting,
14 transferring, **mobility**, bathing, dressing, and continence; and

15 (b) Financially eligible as either:

16 (1) Categorically needy, as calculated pursuant to rules adopted by the department
17 under RSA 541-A; or

18 (2) Medically needy, as calculated pursuant to rules adopted by the department
19 under RSA 541-A.

20 II. Skilled professional medical personnel employed by or designated to act on behalf of the
21 department shall determine clinical eligibility in accordance with the criteria in subparagraph I(a).
22 The clinical eligibility determination shall be based upon an assessment tool, approved by the
23 department, performed by skilled professional medical personnel employed by the department, or by
24 an individual with equivalent training designated by the department. The department shall train
25 all persons performing the assessment to use the assessment tool. For the purposes of this section,
26 "skilled professional medical personnel" shall have the same meaning as in 42 C.F.R. section
27 ~~[432.50(d)(1)(ii)]~~ **432.2**.

28 II-a. Subject to written approval by the Center for Medicare and Medicaid Services, financial
29 eligibility rules in paragraph II shall include eligibility if the person's countable income is at or
30 below the nursing facility special income standard, as defined in 42 C.F.R. 435.236, for the Medicaid

program or the person incurs allowable medical expenses each month, including the anticipated cost of waiver services, which when deducted from the individual's income would reduce the individual's income to an amount that is no higher than the nursing facility special income standard. The department shall submit a request for such approval within 30 days of the effective date of this paragraph.

III. [Repealed.]

IV. If the skilled professional medical personnel employed by or designated to act on behalf of the department are unable to determine that an applicant is eligible following the clinical assessment tool pursuant to paragraph II, the ~~[skilled professional medical personnel]~~ **department shall obtain a determination for the need for long term care from the applicant's primary care physician or nurse practitioner. The department shall request information from and give substantial weight to other clinical information provided by the applicant's [physician or nurse practitioner, including, but not limited to diagnosis, prognosis, and plan of care recommendations, and consider information from other licensed practitioners, including occupational or physical therapists, if available. All clinical information obtained shall also be used in the preparation of the initial support plan] other known health care providers, including but not limited to specialty care physicians, case management providers, or occupational or physical therapists, including diagnosis, prognosis, and plan of care recommendations. All clinical information obtained by the department shall be reviewed by skilled professional medical personnel employed by or designated to act on behalf of the department for an eligibility decision.**

V. **No applicant who is being assessed for annual redetermination shall be denied eligibility under this section without the individual's primary care physician or nurse practitioner's agreement that the applicant no longer meets the level of care identified in paragraph I.**

2 Effective Date. This act shall take effect 60 days after its passage.

SB 125-FN- FISCAL NOTE
AS INTRODUCED

AN ACT relative to clinical eligibility criteria for nursing facility and home and community based care.

FISCAL IMPACT: This bill does not provide funding, nor does it authorize new positions.

Estimated State Impact				
	FY 2025	FY 2026	FY 2027	FY 2028
Revenue	\$0	\$0	\$0	\$0
<i>Revenue Fund(s)</i>	None			
Expenditures*	\$0	\$5 million+ (half general funds, half federal funds)	\$5 million+ (half general funds, half federal funds)	\$5 million+ (half general funds, half federal funds)
<i>Funding Source(s)</i>	General Fund, Federal Funds			
Appropriations*	\$0	\$0	\$0	\$0
<i>Funding Source(s)</i>	None			

*Expenditure = Cost of bill

*Appropriation = Authorized funding to cover cost of bill

METHODOLOGY:

This bill modifies RSA 151-E:3, relative to long-term care eligibility, by:

- (1) Adding mobility to the list of activities of daily living;
- (2) Changing how eligibility for long-term care is determined and redetermined by requiring the Department of Health and Human Services to get a determination of an applicant's need for long term care from the applicant or participant's primary care physician or nurse practitioner; and
- (3) Allowing the Department to deny clinical eligibility for long-term care at a redetermination only if the participant's primary care provider agrees that the participant no longer meets the level of care.

The Department notes that, with respect to (1), the bill does not define mobility or provide guidance regarding determining eligibility for long-term care based on an individual needing assistance with mobility. Currently, individuals may be clinically eligible for long-term care if they need assistance with two or more activities of daily living, such as eating, toileting, transferring, bathing, dressing, or continence. Per the Department, adding mobility to this list without definition will result in a lack of clarity as to what would qualify an individual for eligibility. The Department does not have a way to determine the potential number of

individuals who would be eligible for long-term care as a result of the bill, but expects a cost in excess of \$2.5 million per year.

With respect to (2), the Department already seeks medical information from an applicant's primary care provider if they have one. The Department notes that the bill may result in situations in which it is unable to issue a denial of clinical eligibility, either because a primary care provider has failed to respond or because the individual lacks a primary care provider. Failing to issue a denial of clinical eligibility will result in delays to processing applications, which may result in the Department failing to meet the federal requirement that determinations be made within 45 days of the application. The Department therefore contends that this requirement could potentially put federal financial participation for Medicaid in jeopardy. Since the Department does not otherwise expect this change to cost money to implement, this provision will have no cost as long as there is no federal penalty for failing to meet eligibility determination deadlines.

Finally, with respect to (3), the Department assumes that this requirement will render moot the requirement that individuals have clinical eligibility redetermined every year. The Department further contends that the requirement that primary care providers agree with a clinical determination of ineligibility is unlikely to be approved by CMS. Without approval federal financial participation for Medicaid may be jeopardized. Assuming CMS were to approve the change, the proposed legislation would result in indeterminable growth of the Choices for Independence (CFI) program. The Department expects the proposed change will cost in excess of \$2.5 million per year.

The costs cited above would be paid for with 50 percent general funds and 50 percent matching federal funds.

AGENCIES CONTACTED:

Department of Health and Human Services