REVISED STATUTES ANNOTATED (RSA) REFERENCES TO THE HEALTH AND HUMAN SERVICES OVERSIGHT COMMITTEE

March 2021

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CHAPTER 126-A

DPARTMENT OF HEALTH AND HUMAN SERVICES

Section 126-A:13

126-A:13 Oversight Committee; Establishment; Purpose.[1] **–**
I. There shall be an **oversight committee on health and human services** consisting of 5 members as follows:
(a) Two members of the senate, at least one of whom shall be a member of the senate health and human services committee and one of whom shall be a member of the senate finance committee, appointed by the president of the senate; and
(b) Three members of the house of representatives, 2 of whom shall be from the health, human services and elderly affairs committee, and one of whom shall be from the house finance committee, appointed by the speaker of the house of representatives.
II. Membership on the oversight committee shall be for the biennium and shall be coterminous with membership in the general court.
III. The **oversight committee on health and human services** shall provide legislative oversight of the department to support a cost effective, comprehensive, coordinated system of health and human services that is family-centered and community-based. The committee shall promote greater efficiencies by consolidating and centralizing reporting requirements and other responsibilities of the department under this section to avoid duplication of efforts involving other non-regulatory boards, commissions, councils, advisory committees, and task forces.

Source. 1995, 310:1. 1998, 140:1. 2005, 177:21. 2010, 268:1, 2, eff. Sept. 4, 2010. 2020, 37:21, eff. July 29, 2020.

Hyperlink to Committee Webpage:

http://www.gencourt.state.nh.us/statstudcomm/committees/72/

Section 126-A:14

126-A:14 Organization and Compensation. – The oversight committee shall have a chairperson who shall be chosen by vote from among the committee membership. The chairperson's term of office shall be for the biennium. The committee shall have a clerk who shall be chosen by vote by the members of the committee. The clerk's term of office shall be for the biennium. The members of the committee shall receive legislative mileage when in performance of their duties.

Source. 1995, 310:1. 1998, 140:1, eff. Aug. 7, 1998.

[1] See related HB 187, (New Title) relative to the emergency powers of the commissioner of health and human services and relative to the membership of the oversight committee on health and human services.

Section 126-A:15

126-A:15 Duties of Oversight Committee. –
I. The committee shall provide legislative oversight of and informational meetings on the programs, policies, and rules of the department as brought to its attention by committee members, legislators, department personnel, or others. The committee shall monitor the efficiency of operation and the quality of service provided by the department's programs. The committee's work may include, but is not limited to, analyzing the efficacy of selected programs, studying the characteristics of target populations, researching trends affecting program costs and participation, and reviewing alternate approaches to programmatic and administrative concerns. The committee may make recommendations to the commissioner and recommendations for legislation as indicated by its findings. The committee shall maintain communications with the department, and any other departments, as necessary to accomplish its work.
II. The oversight committee shall create subcommittees, councils, task forces, or other ancillary bodies as necessary to implement its responsibilities. In developing these bodies, the committee shall take into account major program areas of the department and populations served by the department, such as public health, behavioral health, developmental disabilities, and elderly and adult services. The authorization for each such body shall be repealed on December 31 of the even-numbered year of the biennium. The committee shall:
(a) Establish specific guidelines or outcomes for each such body, including reporting requirements.
(b) Appoint members to each such body, including at least one legislator and, as appropriate, other members as determined by the expertise necessary to accomplish the work of the body. Legislative members need not be a member of the oversight committee.
(c) Appoint a chair of each such body, who shall be a legislator and who shall act as the liaison between the body and the oversight committee.
III. Directly or through an ancillary body, the oversight committee shall review quarterly the allocation of funds to and receipt of services by persons with developmental disabilities and acquired brain disorders, to assure that eligible persons receive services in a timely manner and in accordance with their needs as provided in RSA 171-A.
IV. Directly or through an ancillary body, the oversight committee shall serve as the legislative liaison for the state commission on aging, established under RSA 19-P:1, and shall consider the major problems facing elderly citizens.
V. The committee shall meet at the call of the chair but in no case less than every 2 months.
VI. The committee shall make a report no later than the first day of November of the second year of the biennium as to its activities and recommendations to the speaker of the house of representatives and the president of the senate.

Source. 1995, 310:1. 1998, 140:2. 2001, 39:1. 2003, 78:2. 2005, 175:20. 2006, 46:1. 2007, 181:4. 2010, 268:3, eff. Sept. 4, 2010. 2019, 152:3, eff. July 1, 2019.

Section 126-A:15-a

126-A:15-a Subcommittee on Alzheimer's Disease and Other Related Dementia. –
I. In addition to the subcommittees established under RSA 126-A:15, II, the health and human services oversight committee shall create a permanent subcommittee on Alzheimer's disease and

other related dementia.
II. Members of the subcommittee shall be as follows:
(a) One member of the house of representatives, appointed by the speaker of the house of representatives.
(b) One member of the senate, appointed by the president of the senate.
(c) The commissioner of the department of health and human services, or designee.
(d) The attorney general, or designee.
(e) A representative of the Alzheimer's Association, appointed by the association.
(f) A representative of the New Hampshire Medical Society, appointed by the society.
(g) The following persons appointed by the governor:
(1) A person who has Alzheimer's disease.
(2) A caregiver of a person who has Alzheimer's disease.
(3) A representative of the nursing facility industry.
(4) A representative of the assisted living industry.
(5) A representative of the adult day care services industry.
(6) A researcher with Alzheimer's-related expertise in basic transitional, clinical, or drug development science.
(h) A representative of the New Hampshire Nurse Practitioner Association, appointed by the association.
(i) A representative of the Home Care Association of New Hampshire, appointed by the association.
(j) A representative of the board of nursing, appointed by the board.
III. The subcommittee shall:
(a) Review other states' plans for Alzheimer's disease.
(b) Survey individuals with Alzheimer's disease to more accurately estimate the number of persons in the state with the disease.
(c) Study existing services and resources, including but not limited to:
(1) The type, cost, and availability of dementia services.
(2) Dementia-specific training requirements for long-term care staff.
(3) Quality care measures across all care settings.
(4) Capacity of public safety and law enforcement to respond to persons with Alzheimer's disease.
(5) Availability of home and community-based resources for persons with Alzheimer's disease and respite care to assist families and caregivers.
(6) Inventory of long-term care dementia care units and beds.
(7) Adequacy and appropriateness of geriatric-psychiatric units for persons with behavior disorders associated with Alzheimer's disease and related dementia.
(8) Assisted living residential options for persons with dementia.
(9) State support of Alzheimer's disease research through New Hampshire universities and other resources.
(d) Determine state policies and responses that are necessary to provide clear and coordinated services and supports to persons, families, and caregivers living with Alzheimer's disease and develop strategies to address any identified gaps in service.
(e) Establish a New Hampshire state plan for Alzheimer's disease and other related dementia as approved by the health and human services oversight committee.
IV. Beginning November 1, 2014, and each November 1 thereafter, the health and human

services oversight committee shall submit an annual report to the chairperson of the health, human services and elderly affairs committee, the speaker of the house of representatives, the president of the senate, the house clerk, the senate clerk, the governor, and the state library relative to:
(a) The status of implementation of the New Hampshire state plan for Alzheimer's disease and other related dementia.
(b) The subcommittee's findings and recommendations, including any recommendations for legislation.

Source. 2014, 67:1, eff. May 27, 2014.

Hyperlink to Subcommittee Webpage:

http://www.gencourt.state.nh.us/statstudcomm/details.aspx?id=166&rbl=1&txtkeyword=oversight

CHAPTER 115-D

COMMISSION ON POST-TRAUMATIC STRESS DISORDER AND TRAUMATIC BRAIN INJURY

Section 115-D:5

115-D:5 Report. – Beginning on November 1, 2014, and every November 1, thereafter, the commission shall submit an annual report of its activities and any proposed legislation to the president of the senate, the speaker of the house of representatives, the chairpersons of the senate and house committees having jurisdiction over health and human services issues, the senate and house committees having jurisdiction over veterans affairs, the chairperson of the **oversight committee on health and human services**, the chairperson of the fiscal committee of the general court, the senate clerk, the house clerk, the governor, the members of the New Hampshire congressional delegation, and the state library.

Section 126-A:3

126-A:3 General Provisions. –
I. Notwithstanding any provision of law to the contrary, the commissioner is hereby authorized to:
(a) [Repealed.]
(b) Transfer or reassign personnel within and between any division, office, unit, or other component of the department. Upon written notice to the commissioner of administrative services, such changes shall be reflected in the state's payroll and financial systems accounts.
(c) Delegate, transfer or assign the authority to administer and operate any program or service of the department to any employee, division, office, bureau, or other component of the department. Such delegation, transfer or assignment shall include the authority to conduct or perform any act necessary to administer the program or service so assigned.
II. Notwithstanding any provision of law to the contrary, the department shall have no obligation

to pay and no cause of action for payment shall be maintained against the department for payment for any product or service, sold, furnished, or leased to the department or any other person on behalf of the department unless an invoice for such product or service has been submitted to the department for payment within 12 months of the date of delivery or provision of the product or service.

II-a. Notwithstanding any provision of law to the contrary, the department shall not require payment and counties shall have no obligation to pay and no cause of action for payment shall be maintained against the counties, for payment for any product or service sold, furnished, or leased to the department or any other person on behalf of the department, unless an invoice for such product or service has been submitted to the counties for payment within 18 months of the date of delivery or provision of the product or service.

III. (a) Notwithstanding any provision of law to the contrary, and notwithstanding any fee, rate, or payment schedule established under the medical assistance program pursuant to RSA 161 and RSA 167 or any other fee, rate, or payment schedule for any other program of the department, no provider shall bill or charge the department more than the provider's usual and customary charge, as defined in this paragraph.

(b) Except as specified in subparagraph III(c), the term "usual and customary" means the lowest charge, fee, or rate charged by a provider for any product or service at the time such product or service was provided. For the purpose of determining the lowest charge, fee, or rate:

(1) If the provider offers discounts or rebates, then the amount after applying discounts or rebates shall be utilized;

(2) If the provider offers a sale for a limited period of time on any good or service, then the sale price shall be utilized during the sale period;

(3) If the provider regularly accepts less than its full charge from any customer, then the amount accepted shall be utilized;

(4) If any good or service is offered free of charge by the provider, then no charge shall be made to the department for the provision of the product or service to the department or a client of the department who satisfies the terms of the offer;

(5) If any good or service is covered under any warranty or guarantee offered by the provider, then the amount charged to the department shall not exceed the amount which would otherwise be payable solely by the customer; and

(6) If a provider structures or packages its goods or services in a manner which is exclusively or primarily used for medicaid, medicare, or other third-party payors, then the charge for the most similar good or service offered to any other consumer shall be utilized.

(c) The following items shall not be utilized in determining the "usual and customary" or lowest charge, fee, or rate:

(1) Discounts offered solely to bona fide employees or family members of employees;

(2) Discounts offered solely on the basis of age shall be utilized in determining the usual and customary charge only when the client of the department satisfies the age requirement;

(3) Free goods or services or discounts provided to a limited number of persons on the basis of financial hardship;

(4) Charges by an organization on a sliding fee scale for a good or service where the organization's charge is based on ability to pay;

(5) Charges not collected as a result of bad debts incurred by the provider. A bad debt exists where sound business judgment indicates that there is no reasonable likelihood of recovery of the amount owed; and

(6) Charges for educational-related services governed by 42 U.S.C. 1396b(c).
(d) The commissioner may waive the application of RSA 126-A:3, III if the commissioner determines such action is necessary to ensure a continuum of care and service to persons served by community mental health centers, to avert serious economic hardships to mental health centers, or to ensure that hospitals may contract for wholesale hospital-to-hospital laboratory and testing services.
(e) When a person is being assisted by a city, town, or county in the purchase of a drug product, pursuant to RSA 165 or RSA 166, no provider of pharmaceutical services shall bill or charge the person, city, town, or county for the drug product at a rate in excess of the rate that would be billed or charged the department of health and human services for that product.
IV. If the commissioner determines that the department has been charged more than the usual or customary fee, charge or rate as set forth in this section, the commissioner may levy a penalty against the provider of the good or service in the amount of 10 percent of the overcharge or $100, whichever is greater. Moneys received under this paragraph shall be deposited into the general fund.
V. Pharmacists shall substitute generically equivalent drug products for all legend and non-legend prescriptions paid for by the department of health and human services, including the Medicaid program, unless the prescribing practitioner specifies that the brand name drug product is medically necessary. Such notification shall be in the practitioner's own handwriting and shall be retained in the pharmacist's file. The provisions of paragraph III shall not apply to the dispensing by a pharmacy for medical assistance reimbursement for legend and non-legend drugs. The commissioner, in consultation with pharmacy providers, shall establish medical assistance reimbursement for legend and non-legend drugs. For Medicaid fee for service clients, no prior authorization for generically equivalent drugs shall be required.
VI. The department shall provide information to the citizens of New Hampshire, within its existing resources, about the risks and benefits of dental restorative materials including the use of amalgam in children under the age of 6.
VII. Medicaid Hospital Outpatient Services; Designation in Operating Budget.
(a) Notwithstanding any other provision of law to the contrary, beginning with the biennium beginning July 1, 2005 and continuing thereafter, the department shall designate in its operating budget requests specific class lines for hospital outpatient services. The department shall not increase expenditures in approved budgets for such outpatient services without prior approval. If expenditures are projected to exceed the annual appropriation, the department may recommend rate reduction for providers to offset the amount of any such deficit. The department of health and human services shall submit to the legislative fiscal committee and to the finance committees of the house and the senate, the rates that it proposes to pay for hospital outpatient services. The rates shall be subject to the prior approval of the legislative fiscal committee.
(b) For the purpose of Medicaid reimbursement for outpatient hospital services, the only outpatient hospital services for which Medicaid reimbursement shall be provided are those outpatient hospital services which are:
(1) Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished to outpatients;
(2) Furnished by or under the direction of a physician or dentist;
(3) Furnished in a facility that:
(A) Is licensed or formally approved as a hospital by an officially designated authority for state standard setting; and

(B) Meets the requirements for participation in Medicare as a hospital; CMS-2213-F 62; and
(4) Limited to the scope of facility services that:
(A) Would be included, in the setting delivered, in the Medicare outpatient prospective payment system (OPPS) as defined under 42 C.F.R. section 419.2(b) or are paid by Medicare as an outpatient hospital service under an alternate payment methodology;
(B) Are furnished by an outpatient hospital facility, including an entity that meets the standards for provider based status as a department of a provider set forth in 42 C.F.R. section 413.65; and
(C) Are not covered under the scope of another medical assistance service category under the state plan.
(c) The commissioner may exclude from the definition of outpatient hospital services under subparagraph (b) those types of items and services that are not generally furnished by most hospitals in the state.
VIII. The commissioner shall submit a Title XXI state plan amendment, subject to approval by the fiscal committee of the general court and the **oversight committee on health and human services**, to administer the children's health insurance program within the department commencing upon implementation of Medicaid managed care. The commissioner shall operate the children's health insurance program utilizing the program model that demonstrates the greatest efficiency and value which includes, but is not limited to, Medicaid expansion, accountable care organization, or risk-based managed care models.

Source. 1995, 310:1, 3, I. 1999, 324:2. 2001, 93:6. 2002, 96:2. 2005, 177:116. 2007, 297:8. 2009, 1:6; 144:25. 2011, 224:26, 43, eff. July 1, 2011. 2015, 213:1, eff. July 6, 2015; 276:207, eff. July 1, 2015.

Section 126-A:4-b

126-A:4-b Medicaid Waivers.[2] –
The state shall enter into medicaid waivers from the federal Centers for Medicare and Medicaid Services, subject in each case to a review by the **oversight committee on health and human services**, established in RSA 126-A:13, which shall make a report to the legislative fiscal committee which shall have final approval authority. The waivers shall:
(a) Allow the state to begin the penalty period of ineligibility for medicaid services due to transfers of assets for less than fair market value as of the date of application for medical assistance or as of the date that the applicant, but for the transfer of assets for less than fair market value, meets all of the criteria for eligibility for medical assistance, whichever is later.
(b) Allow the state to eliminate the resource ceiling for applicants for medical assistance and to exempt them from actions for recovery against their estates for the cost of medical assistance they receive when they have a long-term care insurance policy that meets the standards established by the legislature and the state.

Source. 2005, 175:12, eff. Aug. 29, 2005.

[2] On the Department's list for 2022 legislation to eliminate outdated or redundant reporting requirements.

Section 126-A:4-e

126-A:4-e Medicaid Hospice Benefit[3]. –
I. The commissioner of the department of health and human services shall submit a Title XIX Medicaid state plan amendment to the federal Centers for Medicare and Medicaid Services for the purpose of establishing a Medicaid hospice benefit. The hospice benefit shall incorporate, to the greatest extent permissible under federal law, hospice provisions pursuant to Title XVIII of the Social Security Act, Medicare.
II. The commissioner of the department of health and human services shall adopt rules under RSA 541-A relative to hospice services provided under Medicaid. The rules shall incorporate, to the greatest extent permissible under federal law, hospice provisions pursuant to Title XVIII of the Social Security Act, Medicare.
III. Beginning October 1, 2009, the department shall submit quarterly reports to **the oversight committee on health and human services**, established in RSA 126-A:13, relative to the status of the state plan amendment and implementation of the Medicaid hospice benefit. The department shall make best efforts to implement the benefit on or before July 1, 2010.

Source. 2009, 166:1, eff. July 8, 2009.

Section 126-A:5

126-A:5 Commissioner of Health and Human Services. –
I. Administrative and executive direction of the department of health and human services shall be under the direction of a commissioner of health and human services who shall be appointed by the governor and council. The commissioner shall hold office for a term of 4 years from the date of the appointment.
II. The commissioner may enter into such contracts as the commissioner deems necessary for the provision of services to clients of the department and for the operation of facilities of the department, subject to the approval of the governor and council. The commissioner further may receive, expend, control, convey, hold in trust, or invest any funds or real or personal property given or devised to or owned by any facility as the commissioner deems appropriate or expedient. At the discretion of the commissioner, the department may directly operate and administer any program or facility which provides, or which may be established to provide, services to clients of the department, or the commissioner may contract with any individual, partnership, association, agency, or corporation, either public or private, profit, or nonprofit, as, in the discretion of the commissioner, may be necessary and appropriate for the operation and administration of any program or facility which provides services to clients of the department.
II-a. Sixty days after the end of each fiscal year, the commissioner shall produce an annual report which shall consist of an aggregate schedule of payables for class 90 grant lines, which are greater than $1,000,000, for such fiscal year. Payables shall start with the date the bill for goods or services is received by the department without regard to whether the bill is subsequently adjusted or paid. All payables with a receipt date within the report period shall be included. The report shall be submitted to the legislative budget assistant, the house and senate finance committees, the house speaker, senate president, and the governor.

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III. The commissioner may designate any member of the department to act on behalf of the commissioner or the department. The commissioner further may delegate any duty or authority of the commissioner or the department to any member of the department or to any sub-unit or component of the department.
IV. Pursuant to RSA 541-A, the commissioner shall have the authority to establish fees, copayments or any other charges for services or assistance provided by or on behalf of the department.
V. The commissioner shall have the authority to direct an autopsy be made upon the death of any person admitted to, a resident of, or receiving care from the New Hampshire hospital, Glencliff home, or any other residential facility operated by the department or a contract service provider, if the commissioner deems it necessary for the purpose of determining the existence of infection or disease, cause of death, or for other good reason. The findings of any such autopsy shall be treated by the department in accordance with the quality assurance program under RSA 126-A:4, IV and by the medical examiner in accordance with the provisions of RSA 611-B:21, IV.
VI. The commissioner shall have the authority to make arrangements for the funeral and burial of any person who has not made other arrangements and dies while admitted to, a resident of, or receiving care from New Hampshire hospital, Glencliff home, or any other residential facility operated by the department or a contract service provider. If an autopsy is ordered pursuant to RSA 126-A:5, V, then following the autopsy, the medical examiner shall deliver the body to any person authorized pursuant to RSA 611:14. In the event that a dead body is unclaimed for a period of not less than 48 hours following completion of any autopsy ordered pursuant to this section, then the medical examiner shall deliver the body to a funeral home as directed by the commissioner, who shall decently bury or cremate the body at department expense, or, with consent of the commissioner, it may be sent at department expense to the medical department of a medical school or university, to be used for the advancement of the science of anatomy or surgery, as provided for by law.
VII. The commissioner shall establish advisory groups or other mechanisms to solicit input from clients and providers of the department and their families regarding the services provided by the department and its contract providers.
VIII. The commissioner shall establish an appeals process for any individual applying for or receiving services from the department or its contract service providers, any providers, programs, services, or facilities which are licensed or certified by the department, or with regard to actions related to employees of the department or any other matter within the jurisdiction of the department. Notwithstanding any other provision of law, the appeals process shall include:
(a) A jurisdictional review by the commissioner, or a hearings examiner designated by the commissioner, to determine whether a denial or change in services, benefits, or a license is automatic due entirely to a change in state or federal law. In the event the department's action is due entirely to such a change in state or federal law, the department shall provide adequate notice and provide the applicant, recipient, or licensee the opportunity to state the reasons he or she believes issues of fact or interpretation of law should be heard, prior to the commissioner or hearings examiner designated by the commissioner conducting a jurisdictional review.
(1) If the commissioner, or hearings examiner designated by the commissioner determines that sole issue on appeal is the result of the state or federal law that caused a denial or change in services, benefits, or a license, and the appeal does not require resolution of a factual disagreement or legal issue, then an order dismissing the appeal shall be issued by the commissioner, or a hearings examiner designated by the commissioner, after such jurisdictional

review and without an administrative hearing.
(2) In all other cases, if the automatic result of the new state or federal law is not the only issue on appeal, then an administrative hearing shall be conducted by the commissioner, or a hearings examiner designated by the commissioner, to address the other issues in accordance with rules established by the commissioner.
(b) For appeals of all other matters, the commissioner, or a hearings examiner designated by the commissioner, shall conduct an administrative hearing in accordance with the rules established by the commissioner.
(c) Unless the commissioner has delegated to the hearings examiner authority to issue a decision on behalf of the department, following the hearing, the hearings examiner shall submit to the commissioner a proposed decision which shall include:
(1) A statement of the issues presented in the appeal;
(2) A summary of the evidence received;
(3) Proposed findings of fact and rulings of law; and
(4) A proposed order.
(d) If following a hearing the proposed decision is adverse to the individual applying for or receiving services, facility or employee who made the appeal, or if the commissioner proposes to make an adverse finding, ruling, or order which the hearings examiner has not recommended, the commissioner shall provide the appealing party with a copy of the commissioner's proposed decision and offer an opportunity to submit a brief and make an oral argument regarding the contested findings of fact, rulings of law, or proposed order.
(e) Following a review of a proposed decision after a hearing and of a brief and argument in a contested case, if any, the commissioner shall issue a final decision on the appeal.
IX. The commissioner shall adopt rules pursuant to RSA 541-A relative to the compensation of the members of the drug use review board.
X. The commissioner may assess and collect reasonable fees for the duplication of materials made pursuant to RSA 91-A:4 and for material generally available to the public upon request. Such fees shall be based on an amount necessary to recover the cost of producing such documents, regardless of the type of medium used. Local, state and federal agencies shall be exempted from these fees.
XI. The commissioner shall adopt rules, pursuant to RSA 541-A, implementing procedures for state registry and criminal background investigations of all new department staff who have regular contact with children, according to the provisions of RSA 170-G:8-c.
XII. (a) Notwithstanding any other provision of law to the contrary, the commissioner shall, upon request, publicly disclose the information in subparagraphs (c)(3)-(c)(12) regarding the abuse or neglect of a child, as set forth in this paragraph, if there has been a fatality or near fatality resulting from abuse or neglect of a child. Information included in subparagraphs (c)(1) and (c)(2) shall also be disclosed if it is determined that such disclosure shall not be contrary to the best interests of the child, the child's siblings or other children in the household and there has been a fatality or near fatality resulting from abuse or neglect of a child. In addition, the same disclosure shall be made when there has been a fatality, to include suicide, or near fatality of a child under the legal supervision or legal custody of the department. In determining whether disclosure will be contrary to the best interests of the child, the child's siblings, or other children in the household, the commissioner shall consider the privacy interests of the child and the child's family and the effects which disclosure may have on efforts to reunite and provide services for the family. If the commissioner determines not to release the information, the

commissioner shall provide written findings in support of the decision to the requestor. As used in this section, "near fatality" means an act or event that places a child in serious or critical condition as certified by a physician.
(b) Information may be disclosed as follows:
(1) Information released prior to the completion of the investigation of a report shall be limited to a statement that a report is "under investigation."
(2) When there has been a prior disclosure pursuant to subparagraph (b)(1) of this paragraph, information released in a case in which the report has been unfounded shall be limited to the statement that "the investigation has been completed, and the report has been determined unfounded."
(3) If the report has been founded, then information may be released pursuant to subparagraph (c) of this section.
(c) For the purposes of this paragraph, the following information shall be disclosed:
(1) The name of the abused or neglected child, provided that the name shall not be disclosed in a case of a near fatality unless the name has otherwise previously been disclosed.
(2) The name of the parent or other person legally responsible for the child or the foster family home, group home, child care institution, or child placing agency where the child is placed.
(3) The date of any report to the department of suspected abuse or neglect, to include any prior reports on file, provided that the identity of the person making the report shall not be made public.
(4) The statutory basis and supporting allegations of any such report, provided that the identity of the person making the report shall not be made public.
(5) Whether any such report was referred to a district office for assessment and, if so, the priority assigned by central intake.
(6) The date any such report was referred to the district office for assessment.
(7) For each report, the date and means by which the district office made contact with the family regarding the assessment.
(8) For each report, the date and means of any collateral contact made as part of the investigation provided that the identity of an individual so contacted shall not be made public.
(9) For each report, the date the assessment was completed.
(10) For each report, the fact that the department's investigation resulted in a finding of either abuse or neglect and the basis for the finding.
(11) Identification of services and actions taken, if any, by the department regarding the child named in the report and his or her family or substitute caregiver as a result of any such report or reports.
(12) Any extraordinary or pertinent information concerning the circumstances of the abuse or maltreatment of the child and the investigation of such abuse or maltreatment, where the commissioner determines such disclosure is consistent with the public interest.
(d) Any disclosure of information pursuant to this paragraph shall be consistent with the provisions of subparagraph (c). Such disclosure shall not identify or provide an identifying description of the source of the report, and shall not identify the name of the abused or neglected child's siblings, or any other members of the child's household, other than the subject of the report.
XIII. The commissioner shall adopt rules pursuant to RSA 541-A relative to approved headgear required by RSA 265:144, X.
XIV. [Repealed.]

XIV-a. (a) The children's health insurance program shall include a public education and outreach component, the purpose of which shall be to increase enrollment by informing new parents of the program's availability and assisting families in the completion of the application process as necessary.
(b) The department shall allocate funds for the development of a volunteer program to promote the program to eligible families and to identify those families who may require assistance with the application or redetermination process, and provide training and supervision of volunteers.
(c) The department shall reimburse designated partner agencies, including health and home visiting providers, who had to provide additional follow-up with applicants an enhanced application fee for the outreach assistance to individuals requesting assistance in the application or redetermination process. Such fee shall be equal to twice the regular application fee.
XV. The commissioner shall establish a quality early learning opportunity initiative which shall be available on a first-come, first-served basis to families whose income is between 190 percent and 250 percent of the federal poverty guidelines, and whose children are enrolled in a child care program licensed under RSA 170-E, and who otherwise meet all other eligibility requirements for child care assistance. The amount of support provided to eligible families shall be calculated annually by the department and shall reflect the estimated average difference between the cost of licensed child care and unlicensed child care.
XVI. [Repealed.]
XVII. The commissioner or designee shall participate in the development of an evidence-based prescription drug education program designed to provide health care providers who are licensed to prescribe or dispense prescription drugs with information and education on the therapeutic and cost-effective utilization of prescription drugs. This program may be developed under the leadership of the New Hampshire Medical Society in partnership with area health education centers programs administered by Dartmouth Medical School and any organization in New Hampshire or other state the partnership shall see fit to consult. The commissioner or partners may seek grants and financial gifts from non-profit charitable foundations to cover planning and development of this program. The commissioner or partners shall present a progress report on the development of the program to the **oversight committee on health and human services** by November 1, 2008.
XVIII. (a) The commissioner shall establish the state office of rural health (SORH) within the department. The SORH shall:
(1) Link rural health and human service providers with state and federal resources.
(2) Seek long-term solutions to the challenges of rural health.
(3) Increase access to health care in rural and underserved areas of the state.
(4) Improve recruitment and retention of health professionals in rural areas.
(5) Provide technical assistance and coordination to rural communities and health organizations.
(6) Maintain a clearing house for collecting and disseminating information on rural health care issues and innovative approaches to the delivery of health care in rural areas.
(7) Coordinate rural health interests and activities.
(8) Participate in strengthening state, local, and federal partnerships.
(b) The commissioner may adopt rules, pursuant to RSA 541-A, relative to accomplishing the goals under subparagraph (a).
(c) The commissioner shall submit an annual report beginning on November 1, 2009 to the speaker of the house of representatives, the senate president, the governor, the **oversight committee on health and human services** established under RSA 126-A:13, the chairs of the

house and senate executive departments and administration committees, the chairs of the house and senate committees having jurisdiction over health and human services, and the commission on primary care workforce issues established under RSA 126-T:1, on the health status of rural residents incorporating current data from the bureau of health statistics and data management and the SORH.

XVIII-a. (a) The state office of rural health (SORH) established in paragraph XVIII shall receive and collect data regarding surveys completed by participating licensees pursuant to RSA 317-A:12-a, RSA 318:5-b, RSA 326-B:9-a, RSA 328-D:10-a, RSA 328-F:11-a, RSA 329:9-f, RSA 329-B:10-a, RSA 330-A:10-a, and RSA 330-C:9-a.

(b) The data collected shall be reviewed, evaluated, and analyzed by the SORH to provide policy decision makers and the commission on the interdisciplinary primary care workforce established under RSA 126-T:1, with critical information to develop and plan for New Hampshire's primary workforce current and future needs and to identify innovative ways for expanding primary care capacity and resources.

(c) Any personally identifiable information contained within the surveys collected by the SORH shall remain confidential and are exempt from disclosure pursuant to RSA 91-A. Any request for information maintained by and in the custody of the SORH under this paragraph shall require the redaction of any and all personally identifiable information by the SORH prior to the release of such information; provided, that the SORH shall be authorized to provide required data to the Health Resources and Services Administration (HRSA) pursuant to federal regulation and or directives governing receipt of federal resources by the SORH.

(d) The SORH shall be authorized to provide aggregate data and interval reports and such information shall be made available and published on the department of health and human services' Internet website. For purposes of quality assurance and validation of data including participation rates for survey completion, the SORH shall be authorized to provide the licensing boards identified in subparagraph (a) as follows:

(1) A list of National Provider Identification numbers of those licensees who have completed or appropriately opted-out of the survey; and

(2) Aggregate data results as it pertains to non-personal information listed on the survey.

(e) On or before December 1, 2019, and annually thereafter, the SORH shall make a written report to the speaker of the house of representatives, the senate president, the governor, the **oversight committee on health and human services** established under RSA 126-A:13, the chairs of the house and senate executive departments and administration committees, the chairs of the house and senate policy committee having jurisdiction over health and human services, and the commission on interdisciplinary primary care workforce established by RSA 126-T:1. The report shall include, but not be limited to, aggregate data and information on current and projected primary workforce needs and the participation rate on surveys completed pursuant to this paragraph. This report shall be incorporated into the report required pursuant to RSA 126-A:5, XVIII(c).

(f) The commissioner may adopt rules, pursuant to RSA 541-A, relative to the administration of this paragraph.

XIX. (a) The commissioner shall employ a managed care model for administering the Medicaid program and its enrollees to provide for managed care services for all Medicaid populations throughout New Hampshire consistent with the provisions of 42 U.S.C. section 1396u-2. Models for managed care may include, but not be limited to, a traditional capitated managed care organization contract, an administrative services organization, an accountable care organization,

or a primary care case management model, or a combination thereof, offering the best value, quality assurance, and efficiency, maximizing the potential for savings, and presenting the most innovative approach compared to other externally administered models. Services to be managed within the model shall include all mandatory Medicaid covered services and may include, but shall not be limited to, care coordination, utilization management, disease management, pharmacy benefit management, provider network management, quality management, and customer services. The commissioner shall enter into contracts with the vendors that demonstrate the greatest ability to satisfy the state's need for value, quality, efficiency, innovation, and savings. The commissioner shall establish rates based on the appropriate model for the contract that is full risk to the vendors. The rates shall be established in rate cells or other appropriate units for each population or service provided including, but not limited to, persons eligible for temporary assistance to needy families (TANF), aid for the permanently and totally disabled (APTD), breast and cervical cancer program (BCCP), home care for children with severe disabilities (HC-CSD), and those residing in nursing facilities. The rates and/or payment models for the program shall be presented to the fiscal committee of the general court on an annual basis. The managed care model or models' selected vendors providing the Medicaid services shall emphasize patient-centered, value-based care and include enhanced care management of high-risk populations as identified by the department. In contracting for the managed care program, the department shall ensure no reduction in the quality of care of services provided to enrollees in the managed care model and shall exercise all due diligence to maintain or increase the current level of quality of care provided. The commissioner may, in consultation with the fiscal committee, adopt rules, if necessary, to implement the provisions of this paragraph. The department shall seek, with the approval of the fiscal committee, all necessary and appropriate waivers to implement the provisions of this paragraph.

(b) [Repealed.]

(c) For the purposes of this paragraph:

(1) An "accountable care organization" means an entity or group which accepts responsibility for the cost and quality of care delivered to Medicaid patients cared for by its clinicians.

(2) "An administrative services organization" means an entity that contracts as an insurance company with a self-funded plan but where the insurance company performs administrative services only and the self-funded entity assumes all risk.

(3) A "managed care organization" means an entity that is authorized by law to provide covered health services on a capitated risk basis and arranges for the provision of medical assistance services and supplies and coordinates the care of Medicaid recipients residing in all areas of the state, including the elderly, those meeting federal supplemental security income and state standards for disability, and those who are also currently enrolled in Medicare.

(4) "A primary care case management" means a system under which a primary care case management contracts with the state to furnish case management services, which include the location, coordination, and monitoring of primary health care services, to Medicaid recipients.

(d) The vendors contracting with the department to carry out the Medicaid managed care program pursuant to this paragraph shall make quarterly reports to the commissioner regarding their efforts to implement New Hampshire's 10-year mental health plan issued in 2008. Such reports shall commence on November 1, 2013. The commissioner shall make an annual report summarizing the information in the vendors' reports to the **oversight committee on health and human services**, established in RSA 126-A:13, commencing on November 1, 2014.

(e) [Repealed.]

(f) The commissioner shall seek all necessary federal approvals, including, but not limited to, Medicaid state plan amendments and Medicaid care management contract approval, to allow the Medicaid managed care organizations to use their own drug formulary in providing pharmacy benefits and contracting with pharmacy providers. A managed care organization as defined in subparagraph (c)(3) that implements its own drug formulary shall comply with the provisions of the Federal Medicaid statute, 42 U.S.C. section 1396r-8, and RSA 420-J:7-b, II, II-a, and III.
(g)(1) By July 15, 2017, the commissioner shall develop a universal online prior authorization form for drugs used to treat mental illness and require community mental health centers and managed care organizations to use such form by September 1, 2017. A reasonably completed prior authorization request submitted using the online form shall be approved or denied by the close of the next business day. Failure to meet this time frame shall be deemed automatic approval. If the prior authorization is denied, the prescribing provider may request a peer-to-peer review with a licensed psychiatric specialist with prescribing privileges by the close of the next business day. Failure by the managed care organization to provide such review by the close of the next business day shall be deemed automatic approval unless the prescribing provider fails to participate in the peer-to-peer review within that time period.
(2) Prior authorization for drugs prescribed by community mental health centers for treatment of severe mental illness shall be suspended if the deadlines under this subparagraph are not met, or if the commissioner determines there is a pattern of missed deadlines for peer-to-peer reviews following denials, or if at any time the commissioner determines such suspension is necessary to promote the behavioral health and well-being of New Hampshire's citizens being served under Medicaid managed care.
(3) The commissioner shall monitor compliance under this subparagraph and shall report quarterly through December 31, 2018 to the fiscal committee of the general court relative to adherence to all such requirements including the rate of denial.
(h) The commissioner shall develop and implement enhanced eligibility screening to stop per member/per month payments to managed care organizations in a timely manner for services for persons who are no longer eligible.
(i) Notwithstanding RSA 126-A:5, XIX(a) and 2017, 258:1, long-term supports and services, including, specifically nursing facility services and services provided under the choices for independence waiver, the developmental disabilities waiver, the in-home supports waiver, and the acquired brain disorder waiver, as those waivers are issued by the Centers for Medicare and Medicaid Services under 42 U.S.C. section 1396(c), shall not be incorporated into the department's care management program for delivery by a managed care organization, as defined in RSA 126-A:5, XIX(c)(3), under contract with the state. The department may develop a plan to offer on a voluntary basis only county or other locally-based Programs of the All Inclusive Care for the Elderly (PACE) or similar accountable care organization (ACO) models to provide on a non-fee-for-service basis nursing facility and choices for independence home care services for beneficiaries who voluntarily elect to participate. Any such plan for voluntary PACE and/or ACO models shall be approved by the **oversight committee on health and human services**, established in RSA 126-A:13, and the fiscal committee of the general court prior to implementation.
(j)(1) Managed care organizations shall process credentialing applications from all types of providers within the following prescribed time frames:
(A) For primary care physicians, within 30 calendar days of receipt of clean and complete credentialing applications.

(B) For specialty care providers, within 45 calendar days of receipt of clean and complete credentialing applications.
(2) For the purposes of subparagraph (1), the start time begins when the managed care organization has received a provider's clean and complete application, and ends on the date of the provider's written notice of network status.
(3) For the purposes of this subparagraph, a "clean and complete" application is a claim that is signed and appropriately dated by the provider, and includes:
(A) Evidence of the provider's New Hampshire Medicaid identification; and
(B) Other applicable information to support the provider application, including provider explanations related to quality and clinical competence satisfactory to the managed care organization.
(4) If the managed care organization does not process a provider's credentialing application within the time frames set forth in this subparagraph, the managed care organization shall pay the provider retroactive to 30 calendar days or 45 calendar days after receipt of the provider's clean and complete application, depending on the prescribed time frame for the appropriate provider.
(5) Nothing in this subparagraph shall preclude the commissioner from administering the applicable contract requirements with the managed care organization as necessary to allow for exceptions to credentialing standards under this subparagraph.
(k)(1) For the purposes of this subparagraph regarding claims quality assurance standards, the commissioner shall adopt the claims definitions established by the Centers for Medicare and Medicaid Services under the Medicaid program which are as follows:
(A) "Clean claim" means a claim that does not have any defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.
(B) "Incomplete claim" means a claim that is denied for the purpose of obtaining additional information from the provider. The managed care organization shall pay or deny 95 percent of clean claims within 30 days of receipt, or receipt of additional information. The managed care organization shall pay 99 percent of clean claims within 90 days of receipt.
(2) Nothing in this subparagraph shall preclude the commissioner from administering the applicable contract requirements with the managed care organization as necessary to allow for exceptions to claims quality assurance standards under this subparagraph.
XX. The commissioner shall administer the grant for the New Hampshire Information Exchange Planning and Implementation Project.
XXI. (a) The commissioners of the departments of health and human services and corrections, and the attorney general shall enter into a memorandum of understanding establishing an inter-departmental team, to address responsibilities associated with the most challenging cases of individuals 18 years of age or older with developmental disabilities or acquired brain disorders who present a substantial risk to community safety as determined by a comprehensive risk assessment appropriate to the individual. The memorandum of understanding shall include a requirement for participation by: the department of health and human services, including the bureau of developmental services, the bureau of behavioral health, the division for children, youth and families, the bureau of drug and alcohol services, the New Hampshire hospital, the department of justice, and the department of corrections. The purpose of the memorandum of understanding is to promote collaboration and cooperation across all services systems to determine and recommend system responsibility for providing and/or funding specific services and supports to effectively meet the needs of the individual and the public safety of the

community in accordance with the rules of the respective departments.
(b) Nothing in this paragraph shall abrogate the rights of individuals or responsibilities of agencies under RSA 171-A, RSA 171-B, RSA 137-K, or any other applicable state or federal law.
(c) Any of the departments may refer a case to the team for consideration. In addition, a county house of corrections may refer a case to the team for consideration for individuals determined eligible under RSA 171-A.
(d) The commissioners and the attorney general shall submit an annual report beginning on November 1, 2011 to the president of the senate, the speaker of the house of representatives, and the governor relative to the outcomes and recommendations of the team.
XXII. The commissioner shall fully implement expanded coverage of Medicaid family planning services as required by RSA 126-A:4-c no later than July 1, 2013. At the time of implementation, the state's Medicaid plan shall be amended to enable the state to accept federal matching funds. As provided in RSA 126-A:4-c, the department shall ensure that the state realizes the 90 percent federal Medicaid match available for the family planning services. If the traditional claims payment systems are unavailable for implementation within the time frame indicated in this paragraph, the commissioner shall manually process the payment of claims or contract with a third party administrator to ensure timely provider payment capacity and uninterrupted access to eligible recipients. At least 30 days in advance of program implementation, the commissioner shall conduct an outreach effort to all participating Medicaid family planning providers to distribute guidance and technical assistance regarding patient enrollment procedures, eligibility criteria, and covered medical services and supplies. Within 60 days after program implementation as required under this paragraph and annually thereafter, the commissioner shall make a report relative to the Medicaid family planning services program to the joint legislative fiscal committee.
XXIII. [Repealed.]
XXIV. [Repealed.]
XXV. [Repealed.]
XXVI. [Repealed.]
XXVII. The commissioner, in collaboration with the commissioner of the department of safety, the director of the police standards and training council, and the local chapter of the Alzheimer's Association, shall develop an educational program on Alzheimer's disease and other related dementia, for both the general public and special interest groups, including law enforcement. Depending upon available resources, additional information and input may be sought from the fish and game department, the adjutant general's department, the board of medicine, the New Hampshire Medical Society, and other interested parties. The commissioner shall provide an interim report on or before January 1, 2015 with a final report on or before July 1, 2015 on the status of the implementation of the educational program to the **oversight committee on health and human services** established in RSA 126-A:13 and the subcommittee on Alzheimer's disease and other related dementia established in RSA 126-A:15-a. The commissioner shall post a link to the local chapter of the Alzheimer's Association on the department's website.
XXVIII. The commissioner shall include a link to the International Lyme and Associated Diseases Society (www.ILADS.org) on its Internet website and may include a disclaimer that the department of health and human services neither endorses nor supports the position of the International Lyme and Associated Diseases Society.
XXIX. The commissioner shall submit a state plan amendment to the Center for Medicare and

Medicaid Services to provide substance use disorder services to Title XIX and Title XXI beneficiaries. The commissioner shall design the benefit consistent with Substance Abuse and Mental Health Service Administration (SAMHSA) treatment guidelines. The commissioner shall also determine the process and timeline for implementing services and, if necessary, phase in the benefit.

XXX. [Repealed.]

XXXI. The commissioner may enter into a contract or contracts with one or more physicians who are certified by an accredited addiction medicine or addiction psychiatry certifying body. The physician or physicians shall provide consultation and guidance to the department related to designing, updating, and monitoring practices and policies regarding medication assisted treatment and related treatments for substance use disorders in New Hampshire.

XXXII. The department of health and human services shall comply with the provisions of RSA 541-A:29 for the timely processing of completed applications, petitions, or other administrative requests made of the agency. However, the provisions of RSA 541-A:29-a shall not apply to any federally funded program administered by the department to the extent such default approval conflicts with federal law.

XXXIII. On or before September 1, 2019, the commissioner shall submit a report on the New Hampshire 10-year mental health plan of 2018 containing the priorities for implementation of the plan to the **oversight committee on health and human services**, established under RSA 126-A:13, the chairpersons of the house and senate policy committees with jurisdiction over health and human services matters, the president of the senate, the speaker of the house of representatives, and the governor. The commissioner shall submit a report on or before September 1, 2020 and annually thereafter on the status of the implementation of the 10-year mental health plan including, but not limited to, unmet benchmarks and recommendations for any necessary barrier resolution or necessary adjustments or modifications to the plan to better serve New Hampshire citizens, to the **oversight committee on health and human services** and the chairpersons of the house and senate policy committees with jurisdiction over health and human services matters. The annual report shall include any recommendations by the commissioner for legislation as needed or appropriate in achieving important benchmarks in fully implementing the 10-year mental health plan.

Source. 1995, 310:1, 199. 1998, 354:1. 1999, 110:2; 223:2. 2003, 206:2, 3. 2004, 98:2. 2005, 100:1. 2006, 258:18; 299:3. 2007, 156:4; 167:2; 263:12, 126; 324:11; 345:1. 2008, 119:1; 367:2. 2009, 144:41. 2011, 125:1; 232:7; 235:1. 2012, 156:1. 2013, 41:1; 92:1. 2014, 3:2, eff. Mar. 27, 2014; 3:12, I, eff. Sept. 1, 2015; 3:12, II-IV, eff. Dec. 31, 2018; 67:2, eff. May 27, 2014. 2015, 42:3, eff. May 14, 2015; 199:1, eff. July 6, 2015; 199:3, eff. June 30, 2017; 276:209, 231, 261, 262, eff. July 1, 2015. 2016, 13:1, 3, 4, eff. Apr. 5, 2016. 2017, 131:1, 2, eff. June 16, 2017; 156:178, 219, eff. July 1, 2017; 195:5, eff. Sept. 3, 2017. 2018, 8:2, eff. Apr. 18, 2018; 278:1, eff. Aug. 20, 2018; 279:16, eff. Jan. 1, 2019; 309:1, eff. June 25, 2018 and Aug. 24, 2018; 342:24, VI, eff. Dec. 31, 2018. 2019, 182:1, eff. Sept. 8, 2019; 248:1, eff. July 12, 2019; 254:3, 4, eff. July 1, 2019; 268:1, eff. July 1, 2019; 346:224, 227, eff. July 1, 2019. 2020, 17:5, 6, eff. July 17, 2020; 2020, 37:9, 20, eff. July 29, 2020.

Section 126-A:17

126-A:17 Advisory Council on Child Care. –
I. There is established an advisory council on child care in New Hampshire consisting of voting and nonvoting members listed in paragraphs II and III.
II. The advisory council shall consist of the following voting members:
(a) One member of the house of representatives, appointed by the speaker of the house.
(b) One member of the senate, appointed by the president of the senate.
(c) Two representatives of Early Learning New Hampshire, one to represent the family child care provider community and one to represent the center-based child care provider community, appointed by such organization.
(d) [Repealed.]
(e) One individual representing the interests of school age child care providers, appointed by the New Hampshire Afterschool Network.
(f) The president of the New Hampshire Child Care Resource and Referral Network, or designee.
(g) The president of the New Hampshire Association for the Education of Young Children, or designee.
(h) The president of the New Hampshire American Academy of Pediatrics, or designee.
(i) The chair of the New Hampshire Head Start Directors Association, or designee.
(j) One individual representing the concerns of the business community relative to child care services, appointed by the Business and Industry Association.
(k) Three individuals who are consumers of child care services, appointed by the governor. To the extent possible, economic, cultural, and geographical diversity shall be maintained among these at-large appointees, with one residing in a city, one residing in a town with a population in excess of 5,000 persons, and one residing in a town with fewer than 5,000 persons. One consumer appointee shall have a child with a disability who attends a child care program.
(l) One representative of New Hampshire early childhood education programs, appointed by the chancellor of the community college system of New Hampshire.
(m) One representative of the university system of New Hampshire whose area of expertise is early childhood education, appointed by the chancellor of the university system of New Hampshire.
(n) One representative of the department of education, appointed by the commissioner of education. The representative shall have nonvoting status for votes pertaining to the department of education matters.
(o) One individual representing the interests of foster parents, appointed by the New Hampshire Foster and Adoptive Parent Association.
III. The advisory council shall consist of the following nonvoting members:
(a) Representatives from the department of health and human services, appointed by the commissioner of health and human services. One of the representatives shall be the administrator of the child development bureau. Additional representatives from the child development bureau shall be included. Other representatives from the department shall include, but not be limited to individuals with expertise in child care licensing, maternal and child health, behavioral health, developmental disability services, child care subsidies, Head Start, and Temporary Assistance for Needy Families.
(b) Any number of additional non-voting members appointed by a majority vote of the voting members. The purpose of this provision is to permit the council to seek out and recognize

persons with expertise and experience in the field of child care who may make significant contributions to the work of the council in specific policy areas.
IV. (a) The term of office for each member appointed under subparagraphs II(j) through (n) shall be 3 years, or until a successor is appointed and qualified in the case of a vacancy. The term of office for all other members shall be coterminous with the term of office for the position that qualifies that member to serve on the advisory council. A vacancy shall be filled in the same manner, but only for the unexpired term.
(b) The advisory council shall meet at least quarterly, and may meet more often at the call of the chair, or at the request of a majority of the members directed to the chair. The council may, by majority vote of the voting members, adopt additional bylaws as deemed necessary by the council.
(c) The council shall, at its annual meeting, elect one voting member to serve as chair for a one-year term, or until a successor is elected and qualified.
(d) No member shall receive any compensation for serving on the council, provided that the legislative members shall receive legislative mileage when in performance of their duties and the consumer members may receive compensation dependent upon the availability of funds, other than from the general fund.
V. The duties of the council shall include, but not be limited to:
(a) Developing a 5-year state plan of recommended improvements of child care services in the state of New Hampshire, copies to be sent to the speaker of the house of representatives, the president of the senate, and the governor.
(b) Submitting an annual progress report of the council's 5-year state plan to the speaker of the house of representatives, the president of the senate, the **oversight committee on health and human services**, and the governor.
(c) Reviewing and making recommendations regarding federal plan submissions and proposed legislative changes to facilitate the development and provision of quality child care services in the state of New Hampshire.
(d) Acting as a forum to receive information from child care professionals, educators, providers, consumers, government agencies, and the business community relating to the provision of child care services in the state of New Hampshire.
(e) Advising the commissioner of health and human services on any issue related to child care in New Hampshire.
(f) Informing and communicating with the commissioner of education on any issue related to child care in New Hampshire.
(g) Informing and communicating with the governor on any issue related to child care in New Hampshire.
VI. The duties of the department of health and human services shall include, but not be limited to:
(a) Informing the advisory council, in a timely manner, of any proposed legislation and any proposed changes to administrative rules relating to the provision of quality child care.
(b) Informing the advisory council, at least twice annually, on matters regarding:
(1) Federal and child care revenues and expenditures.
(2) Financial reporting and statistics related to child care subsidies.
(3) The status of other federal and state child care grants.
(4) Information on consumer and provider utilization and availability.
VII. The department of health and human services shall continue to provide administrative

support to the advisory council.
VIII. The council is the advisory body for the federally-funded Child Care Development Fund. The advisory council may serve as an advisory body when required for state participation in or may coordinate with other federally-funded child care programs granted to the state of New Hampshire.

Source. 1995, 310:1. 1999, 184:1. 2004, 92:1, 2. 2007, 361:9. 2012, 39:1-3, eff. July 1, 2012.

Section 126-A:74

[RSA 126-A:74 repealed by 2017, 197:3, effective June 30, **2022**.]

126-A:74 Commission on the Seacoast Cancer Cluster Investigation Established; Membership; Duties. –

I. There is established the commission on the seacoast cancer cluster investigation.
II. (a) The members of the commission shall be as follows:
(1) Five members of the house of representatives, 3 appointed by the speaker of the house of representatives and 2 appointed by the minority leader.
(2) Two members of the senate, one of whom shall be a member of the minority party, appointed by the president of the senate.
(3) The commissioner of the department of health and human services, or designee.
(4) The commissioner of the department of environmental services, or designee.
(5) A representative from each of the towns and cities of Portsmouth, Greenland, New Castle, Hampton, North Hampton, and Rye appointed by the governing body of such town or city.
(6) Three residents of the seacoast, appointed by the governor.
(7) The New Hampshire remedial project manager, United States Environmental Protection Agency, or designee.
(8) A hydrogeologist, appointed by the New Hampshire chapter of the United States Geological Survey.
(9) A toxicologist or environmental health professor from Boston University or the university of New Hampshire, appointed by the governor.
(b) Legislative members of the commission shall receive mileage at the legislative rate when attending to the duties of the commission.
III. (a) In response to the department of health and human services' findings on February 2, 2016, the commission shall:
(1) Develop a common understanding of the key definitions and concepts of cancer clusters and environmental investigation.
(2) Review the progress made by state and federal agencies and their partners.
(3) Delineate the potential roles and responsibilities for municipalities, state agencies, and their partners.
(4) Provide informed communication about the cancer cluster investigation to their constituencies.
(5) Calibrate and utilize the Seacoast New Hampshire Groundwater Availability Study developed by the United States Geological Survey in 2003 to assess localized groundwater flow and contaminant migration from sites selected by the commission.
(b) The commission shall solicit information from any person or entity the commission deems relevant to its study.

IV. The members of the commission shall elect a chairperson from among the members. The first meeting of the commission shall be called by the first-named house member. The first meeting of the commission shall be held within 45 days of the effective date of this section. Eleven members of the commission shall constitute a quorum.
V. The commission shall make 2 interim reports, one on or before November 1, 2020, and one on or before June 30, 2021, and issue a final report on its findings and any recommendations for proposed legislation to the speaker of the house of representatives, the president of the senate, the house clerk, the senate clerk, the governor, the **oversight committee on health and human services**, and the state library on or before June 30, 2022.

Source. 2017, 197:2, eff. July 5, 2017. 2020, 30:1, eff. July 23, 2020.

Section 126-A:79

126-A:79 New Hampshire Rare Disease Advisory Council Established. –
I. There is hereby established the New Hampshire rare disease advisory council.
II. (a) The advisory council shall consist of the following members:
(1) Two members of the house of representatives, appointed by the speaker of the house of representatives.
(2) One member of the senate, appointed by the senate president.
(3) The commissioner of the department of health and human services, or designee.
(4) A physician licensed under RSA 329, appointed by the New Hampshire Medical Society.
(5) An APRN, appointed by the New Hampshire Nurse Practitioner Association.
(6) A representative of the New Hampshire Hospital Association, appointed by the association.
(7) A representative from a health insurer issuing policies in New Hampshire, appointed by the governor.
(8) One parent or guardian of a youth with a rare disease, appointed by the governor.
(9) Two adult persons living with a rare disease that is distinct from each other's and from that of the person appointed in subparagraph (8), appointed by the governor.
(10) A physician or medical researcher specializing in a rare disease who for the first 3-year term shall be a medical expert in amyotrophic lateral sclerosis, appointed by the New Hampshire Medical Society.
(b) The council may solicit information from any person or entity the advisory council deems relevant to its quest.
III. Terms of office shall be for 3 years, except that legislative members shall serve the terms coterminous with their terms of office. No member shall serve more than 2 full consecutive terms.
IV. Members shall elect annually from among their number a chairperson and such other officers as they may determine necessary.
V. Legislative members of the advisory council shall receive mileage at the legislative rate.
VI. The advisory council shall:
(a) Advise the legislature and the department of health and human services on rare diseases in New Hampshire.
(b) Coordinate with other states' rare disease advisory bodies, community-based organizations, and other public and private organizations for the purpose of ensuring greater cooperation between state and federal activities encouraging research, diagnosis, and treatment of rare

diseases. Federal agencies may include, but are not limited to, the National Institutes of Health, and the United States Food and Drug Administration.
(c) Explore existing data on rare diseases in New Hampshire collected by the department of health and human services.
(d) Encourage public awareness regarding rare diseases in New Hampshire.
VII. The advisory council shall submit an annual report detailing its findings, including recommendations for legislation, commencing on or before December 1, 2020, to the governor, the speaker of the house of representatives, the president of the senate, the commissioner of the department of health and human services, and the **oversight committee on health and human services**, established in RSA 126-A:13.

Source. 2019, 24:1, eff. July 14, 2019.

Section 126-A:88

126-A:88 State Health Assessment and State Health Improvement Plan Advisory Council Established.[4] –
I. There is hereby established a state health assessment and state health improvement plan advisory council. The membership of the council shall be diverse with respect to race, ethnicity, geography, and age as follows:
(a) Two members of the house of representatives, one of whom shall be appointed by the speaker of the house of representatives and one of whom shall be appointed by the minority leader.
(b) Two members of the senate, one of whom shall be a member of the minority party, appointed by the senate president.
(c) The commissioner of the department of health and human services, or designee.
(d) The commissioner of the department of education, or designee.
(e) The commissioner of the department of insurance, or designee.
(f) The commissioner of the department of safety, or designee.
(g) The commissioner of the department of corrections, or designee.
(h) The New Hampshire attorney general, or designee.
(i) The director of the division of public health services, department of health and human services, or designee.
(j) The chairperson of state commission on aging, or designee.
(k) The director of the Manchester health department, or designee.
(l) A representative from the New Hampshire Public Health Association, appointed by the association.
(m) A representative of the New Hampshire Alliance for Healthy Aging, appointed by the alliance.
(n) A representative of the North Country Health Consortium, appointed by the consortium.
(o) A representative of the New Hampshire Fiscal Policy Institute, appointed by the institute.
(p) Two representatives from housing entities, one appointed by the New Hampshire Housing Finance Authority, and one appointed by the New Hampshire Housing Authorities Corporation.
(q) Two representatives of hospitals located in New Hampshire, one from a large health care system and one from a critical care hospital, appointed by the New Hampshire Hospital

[4] See related HB 157, (2021) relative to the state health improvement plan and the state health assessment and state health improvement plan advisory council.

Association.
(r) A representative of a federally qualified community health center, appointed by the Bi-State Primary Care Association.
(s) A psychiatrist or psychologist licensed in New Hampshire, appointed by the commissioner of the department of health and human services.
(t) A physician, appointed by the New Hampshire Medical Society.
(u) An advanced practice nurse practitioner licensed in New Hampshire, appointed by the New Hampshire Nurse Practitioners Association.
(v) A representative of municipal government, appointed by the New Hampshire Municipal Association.
(w) A school superintendent, appointed by the New Hampshire School Administrators Association.
(x) A representative of a peer recovery program, appointed by the commissioner of the department of health and human services.
(y) An environmental health researcher from a New Hampshire college or university, appointed by the commissioner of the department of health and human services.
(z) A representative of a philanthropic organization, appointed by the commissioner of the department of health and human services.
(aa) A substance use disorder treatment provider, appointed by the NH Providers Association.
(bb) A community action program representative, appointed by the New Hampshire Community Action Partnership.
(cc) The director of the Nashua health department, or designee.
(dd) A health officer, appointed by the New Hampshire Health Officers Association.
II. The council may solicit information and participation from any person or entity determined necessary by the council in the performance of its duties. The council shall be administratively attached to the department.
III. Members of the council appointed under subparagraphs II(a) through (j) in this section shall serve a term coterminous with their term in office. The members appointed pursuant to subparagraphs II(k) through (dd) in this section shall serve 6-year terms provided that initial appointments shall be for staggered terms of one to 6 years. Legislative members shall receive mileage at the legislative rate when attending to the duties of the council. The first-named senate member shall convene the organizational meeting of the council within 45 days of the effective date of this section for the purpose of electing officers. The chairperson shall be elected upon a majority vote of the council. Seventeen members shall constitute a quorum.
IV. The chairperson may establish subcommittees upon majority vote of the council. Membership of the subcommittees shall be established by the chairperson upon majority vote of the council. If any member of the council is absent without previously being excused by the chairperson for 3 or more regular meetings, the member may be removed upon a majority vote of the council.
V. The commissioner, in collaboration with the council, shall submit an annual report to the president of the senate, the speaker of the house of representatives, the governor, the chairpersons of the house and senate committees having jurisdiction over finance and health and human services, and **chairperson of the oversight committee on health and human services**, established under RSA 126-A:13, by November 1 of each year, commencing on November 1, 2021, on its activities and including recommendations for legislation.

Source. 2020, 39:16, eff. July 29, 2020.

CHAPTER 126-T

COMMISSION ON THE INTERDISCIPLINARY PRIMARY CARE WORKFORCE ISSUES

Section 126-T:4

[RSA 126-T:4 repealed by 2010, 114:3, effective November 1, **2024.**]

126-T:4 Reports. – The commission shall make an interim report on November 1, 2020 which shall focus on the status of the New Hampshire state loan repayment program and the New Hampshire division of public health service's health professions survey, and a final report on November 1, 2024, including its findings and any recommendations for proposed legislation, to the speaker of the house of representatives, the president of the senate, the governor, the **oversight committee on health and human services**, and the chairpersons of the senate and house executive departments and administration committees.

Source. 2010, 114:1, eff. June 1, 2010. 2015, 238:3, eff. July 13, 2015. 2018, 248:2, eff. June 12, 2018. 2020, 17:4, eff. July 17, 2020.

CHAPTER 126-X

USE OF CANNABIS FOR THERAPEUTIC PURPOSES

Section 126-X:9

126-X:9 Therapeutic Use of Cannabis Advisory Council.[5] –

I. There is hereby established a therapeutic use of cannabis advisory council comprised of:

(a) Two members of the house of representatives, appointed by the speaker of the house of representatives.

(b) One member of the senate, appointed by the senate president.

(c) The commissioner of the department of health and human services, or designee.

(d) The commissioner of the department of safety, or designee.

(e) The attorney general, or designee.

(f) One physician with experience in therapeutic use of cannabis issues, appointed by the New Hampshire Medical Society.

(g) One advanced practice registered nurse, appointed by the New Hampshire Nurse Practitioner Association.

(h) One representative of a community hospital, appointed by the governor.

(i) One representative of the New Hampshire Civil Liberties Union.

(j) One qualifying patient, appointed by the governor.

(k) One member of the public, who is not a law enforcement officer, employee of a government agency, contractor for a government agency, elected official, or healthcare provider, appointed

[5] See related HB 378, repealing the therapeutic use of cannabis advisory council.

by the governor.
(l) One member from a hospital in New Hampshire, appointed by the governor.
(m) One member from the board of medicine, appointed by the executive director of the board of medicine.
(n) One member from the board of nursing, appointed by the executive director of the board of nursing.
(o) A member of the New Hampshire Association of Chiefs of Police, appointed by the association.
II. The advisory council shall:
(a) Assist the department in adopting and revising rules to implement this chapter.
(b) Collect information, including:
(1) Satisfaction of qualifying patients with the therapeutic use of cannabis program.
(2) Any effect the therapeutic use of cannabis law has had on referrals to regulatory boards.
(3) Best practices in other states that allow the therapeutic use of cannabis.
(4) The ability of qualifying patients in all areas of the state to obtain timely access to high-quality cannabis.
(5) Any research studies regarding health effects of cannabis for patients.
(6) The effectiveness of New Hampshire's therapeutic use of cannabis program.
(7) Efforts to educate New Hampshire physicians and advanced practice registered nurses about research relating to the therapeutic use of cannabis.
(8) The effectiveness of alternative treatment centers, individually and collectively, in serving the needs of qualifying patients, including the therapeutic effectiveness of available products, the provision of educational and support services, the reasonableness of their fees, whether they are generating any complaints or security problems, and the sufficiency of the number operating to serve the registered qualifying patients of New Hampshire.
(9) The sufficiency of the regulatory and security safeguards contained in this chapter and adopted by the department to ensure that access to and use of cannabis cultivated is provided only to persons authorized for such purposes.
(10) Any illegal distribution or diversion of cannabis cultivated pursuant to this chapter to individuals who are not alternative treatment center agents, qualifying patients, or designated caregivers.
(11) Any statutory issues related to the certification of qualifying patients including, but not limited to, the definition of qualifying medical conditions, the certification process, and the number and location of providers willing and able to certify qualifying patients.
(c) Make recommendations to the legislature and the department for any additions or revisions to the department rules or this chapter.
(d) Five years after the effective date of this chapter, issue a formal opinion on whether the program should be continued or repealed.
III. The advisory council may meet as often as is necessary to effectuate its goals. The first meeting shall be called by the commissioner of the department of health and human services, or designee within 45 days of the effective date of this chapter. At the first meeting, a chairman shall be elected by the members.
IV. On or before January 1 of each year, the advisory council shall provide a report to the department of health and human services and the **health and human services oversight committee** established under RSA 126-A:13, the board of medicine and the board of nursing on its findings.

Source. 2013, 242:1. 2014, 98:1, 2, eff. Aug. 10, 2014.

Section 126-X:10

126-X:10 Annual Data Report; Release of Data. –
I. The commissioner of the department of health and human services shall report annually on the therapeutic use of cannabis program established under this chapter to the **health and human services oversight committee** established under RSA 126-A:13, to the board of medicine, and to the board of nursing.
II. The report shall be in electronic format to allow for identification of patterns of certification by patient and caregiver, location, age, medical condition, symptom, or side effect, and provider, and for analysis and research to inform future policy, educational, and clinical decisions.
III. The initial report shall be filed no later than December 1, 2014.
IV. The commissioner's data report shall include but not be limited to the following information:
(a) The number of designated caregivers and the number of qualifying patients, by town or city and county.
(b) The ages of the qualifying patients and the ages of the designated caregivers.
(c) The qualifying medical conditions and the number of each qualifying medical condition.
(d) The symptoms or side effects and the number of each symptom or side effect.
(e) The number of physicians and the number of advanced practice registered nurses issuing written certifications.
(f) The number of providers in each medical specialty issuing written certifications.
(g) Any other issues related to the therapeutic use of cannabis permitted under this chapter that the **health and human services oversight committee** shall request.
V. A summary of the report submitted by alternative treatment centers as required under RSA 126-X:8, XII.
VI. Notwithstanding any other provision of law, data collected under this chapter, including de-identified or aggregate data contained in the confidential registry database, may be released, with the approval of the commissioner or designee, to individuals or entities for the purposes of public health, health care operations, or research if such release is consistent with all applicable HIPAA standards.

Source. 2013, 242:1, eff. July 23, 2013. 2019, 85:1, 2, eff. Aug. 17, 2019.

CHAPTER 130-A

LEAD PAINT POISONING PREVENTION AND CONTROL

Section 130-A:2

130-A:2 Duties of the Commissioner. –
I. The commissioner shall:
(a) License in accordance with RSA 130-A:12, I, or deny or revoke the licensure of, any lead inspector, lead risk assessor, or lead abatement contractor advertising, offering or otherwise making available services in the state of New Hampshire, whether or not the inspector, contractor, or lead risk assessor is incorporated in the state.

(b) Certify employees of owners or managers of dwellings, dwelling units, or child care facilities, and of lead abatement contractors, who are engaged in lead base substance abatement, or refuse to provide or revoke such certification. Separate certificates shall be issued to workers who supervise other certified workers and to lead clearance testing technicians.
(c) Collect fees for the issuance of licenses and certificates under RSA 130-A:2, I(a), (b), and (h).
(d) Adopt rules required under this chapter.
(e) Implement public education programs for the general public, for owners, managers and occupants of dwelling and dwelling units, for owners and operators of child care facilities, and for physicians and other health care workers providing services to children concerning the prevention and treatment of lead poisoning and relative to the provisions of this chapter and the reporting of lead poisoning under RSA 141-A.
(f) Implement comprehensive case management for cases of lead poisoning when a child's blood lead level meets or exceeds 10 micrograms per deciliter. Case management shall include the coordination of medical services appropriate for the treatment of the reported lead poisoning.
(g) Provide training for and maintain an active program of coordination with health authorities relative to the control of lead base substances in owner-occupied and renter-occupied housing, with specific regard to the conduct of inspections, lead base substance abatement, in-place management, and enforcement activities carried out under this chapter. The commissioner shall make reasonable efforts to ensure that such training programs are held in areas with high incidence of lead exposure hazards, and that property owners are educated about methods to prevent lead exposure hazards before they arise and how hazards can be addressed once identified.
(h) Certify training programs for lead abatement contractors, lead inspectors, lead risk assessors, lead clearance testing technicians, and lead abatement workers.
(i) Develop and implement, in accordance with RSA 130-A:7, an investigation and enforcement program for lead base substances and the reduction of lead exposure hazards.
(j) Develop and maintain a data base on the incidence of lead poisoning in children. This data base shall be established using data supplied under RSA 130-A:3.
(k) [Repealed.]
(*l*) Develop educational materials in accordance with RSA 130-A:5.
II. The commissioner may establish, in accordance with rules adopted under RSA 541-A, a notification program relative to lead base substance inspection and abatement activities.
III. The commissioner shall establish, in accordance with rules adopted under RSA 541-A, a window replacement program. The program shall be made available to owners of dwellings and dwelling units and funded by the lead poisoning prevention fund, established in RSA 130-A:15, and other available moneys, when the commissioner determines there are enough moneys in such fund to sustain such a program. Pilot projects may begin as soon as funds are available. The commissioner shall make a report on the parameters of the program, funding acquired and sought, and program expenditures to the **health and human services oversight committee**, established in RSA 126-A:13, and to the chairperson of the house ways and means committee on or before September 1, 2010.

Source. 1993, 325:2. 1995, 310:183. 1997, 165:2, 3. 2000, 96:3, 4. 2002, 63:3. 2006, 314:1, 6. 2009, 256:1, eff. Sept. 14, 2009; 276:1, eff. Jan. 1, 2010.

CHAPTER 132

PROTECTION FOR MATERNITY AND INFANCY

Section 132:10-a

132:10-a Newborn Screening Tests Required; Newborn Screening Advisory Committee. –
I. The physician, hospital, nurse midwife, midwife, or other health care provider attending a newborn child shall test a newborn child for metabolic disorders. Such tests shall include, but not be limited to, phenylketonuria, galactosemia, homocystinuria, maple syrup urine disease, and hypothyroidism. Additional disorders shall be added to the newborn screening panel based upon, but not limited to, the following considerations:
(a) The disorder is well-defined with a known incidence.
(b) The disorder is associated with significant morbidity and/or mortality.
(c) The disorder can be detected with a screening test that is ethical, safe, accurate, and cost-effective.
(d) Effective treatment exists for the disorder, and that early treatment, meaning before the onset of symptoms, is more effective in improving health outcomes than later treatment.
II. Notwithstanding any provision of law to the contrary, the commissioner of the department of health and human services shall establish fees, pursuant to RSA 541-A, to be paid by hospitals for the tests required under paragraph I. All such fees shall be paid into the newborn screening fund, hereby established in the state treasury. Moneys from the newborn screening fund established under this section shall be nonlapsing and shall be continually appropriated for use by the department to cover laboratory analysis and related newborn screening program costs.
III. The department of health and human services shall establish a newborn screening advisory committee which shall include a member of the **oversight committee on health and human services**, established in RSA 126-A:13, and representation from health care subspecialties, as determined by the department.
III-a. The department shall ensure that the laboratory analyzing tests authorized under paragraph I destroys any samples no later than 6 months following the completion of testing. Any samples taken for newborn screening shall only be used for tests required under this section. No such samples may be used for other research or DNA testing purposes unless authorized by the parent or guardian.
IV. The department shall make an annual report commencing on January 1, 2006 to the **oversight committee on health and human services** relative to newborn screening tests which shall include, but not be limited to the number and type of tests performed and their fiscal impact.
V. No whole-genome DNA sequencing shall be performed pursuant to this chapter unless the general court authorizes such sequencing by statute.

Source. 1965, 48:1. 1986, 198:15. 1999, 213:2. 2005, 285:1. 2010, 233:1. 2014, 63:1, eff. Jan. 1, 2015.

Section 132:30

132:30 Maternal Mortality Review Panel Established. –
I. There is established a maternal mortality review panel to conduct comprehensive, multidisciplinary reviews of maternal deaths in New Hampshire for the purpose of identifying factors associated with the deaths and to make recommendations for system changes to improve services for women in the state. The panel shall consist of:
(a) Two members from the New Hampshire chapter of the American College of Obstetricians and Gynecologists, one of whom shall be a generalist obstetrician, and one of whom shall be a maternal fetal medicine specialist.
(b) One member from the New Hampshire chapter of the American Academy of Pediatrics, specializing in neonatology.
(c) One member from the New Hampshire chapter of the American College of Nurse-Midwives.
(d) One member from the New Hampshire section of the Association for Women's Health, Obstetric and Neonatal Nurses.
(e) The administrator of maternal and child health who also is the Title V director, division of public health services, department of health and human services.
(f) An epidemiologist from the department of health and human services with experience analyzing perinatal data, or designee.
(g) A representative of the community mental health centers.
(h) A public member.
(i) The chief medical examiner, or designee.
II. Each member in subparagraphs I(a)-(h) shall be appointed by the commissioner of health and human services, or designee, in collaboration with the organizations listed in paragraph I.
III. The term of each member shall be 3 years and the terms shall be staggered. The chair shall be appointed by the commissioner. The initially appointed chair shall call the meeting and panel together and shall serve as chair for 6 months, after which time, the panel shall elect its chair. Members of the panel shall receive no compensation.
IV. The commissioner may delegate to the Northern New England Perinatal Quality Improvement Network (NNEPQIN) the functions of collecting, analyzing, and disseminating maternal mortality information, organizing and convening meetings of the panel, and other substantive and administrative tasks as may be incident to these activities. The activities of NNEPQIN and its employees or agents shall be subject to the same confidentiality provisions as those that apply to the panel.
V. The commissioner shall submit an annual report beginning on June 1, 2011 to the **oversight committee on health and human services** describing adverse events reviewed by the panel, including statistics and causes, and outlining, in aggregate, corrective action plans, and making recommendations for system change and legislation relative to state health care operations.
VI. (a) The panel, in collaboration with the commissioner of the department of health and human services, or designee, shall conduct comprehensive multidisciplinary reviews of the maternal mortality deaths, as defined in RSA 132:29, I-III, in New Hampshire.
(b) Each member of the panel shall be responsible for the dissemination of panel recommendations to his or her respective institutions and professional organizations. All such information shall be disseminated through each participant's quality assurance program in order to protect the confidentiality of all participants and patients involved in any incident.
(c) The panel shall not:

(1) Call witnesses or take testimony from individuals involved in the investigation of a maternal death.
(2) Enforce any public health standard or criminal law or otherwise participate in any legal proceeding, except if a member of the team is involved in the investigation of the death or resulting prosecution and must participate in a legal proceeding in the course of performing in his or her duties outside the team.
(d) Proceedings, records, and opinions of the maternal mortality review panel are confidential, not subject to RSA 91-A, and not subject to discovery, subpoena, or introduction into evidence in any civil or criminal proceeding. Nothing in this subparagraph shall be construed to limit or restrict the right to discover or use in any civil or criminal proceeding anything that is available from another source and entirely independent of the proceedings of the panel.
(e) Members of the panel shall not be questioned in any civil or criminal proceeding regarding information presented in or opinions formed as a result of a meeting of the team. Nothing in this subparagraph shall be construed to prevent a member of the panel from testifying to information obtained independently of the team or which is public information.
VII. The commissioner of the department of health and human services, with the advice and recommendation of a majority of members of the panel, shall adopt rules, pursuant to RSA 541-A, relative to the following:
(a) The system for identifying and reporting maternal deaths to the commissioner, or designee.
(b) The form and manner through which the program may acquire information under RSA 132:31.
(c) The protocol to be used in carefully and sensitively contacting a family member of the deceased woman for a discussion of the events surrounding the death, allowing grieving family members to refuse such an interview.
(d) Assuring de-identification of all individuals and facilities involved in the panel review of cases.

Source. 2010, 129:2, eff. Aug. 8, 2010.

Section 132:41

132:41 Child Fatality Review Committee Established. –
I. The department of health and human services, in conjunction with the office of the chief medical examiner and in accordance with RSA 611-B, shall establish a child fatality review committee to conduct comprehensive, multidisciplinary reviews of preventable infant, child, and youth deaths in New Hampshire for the purpose of identifying factors associated with the deaths and to make recommendations for system changes to improve services for infants, children, and youth.
II. The objectives of the child fatality review committee shall be to:
(a) Describe trends and patterns of child deaths in New Hampshire, including sudden unexpected infant deaths (SUID) and sudden death in the young (SDY).
(b) Identify and investigate the prevalence of risks and risk factors among the populations of deceased children.
(c) Evaluate the service and system responses for children and families and to offer recommendations for improvement of those services.
(d) Improve the quality and comprehensiveness of child fatality data by enhancing and

integrating information obtained from autopsies, death scene investigations, death certificates, police reports, medical records, and other relevant sources.
(e) Enable state agencies, law enforcement, health care providers, and community-based organizations to more effectively prevent and investigate child fatalities.
III. The child fatality review committee shall consist of the following members:
(a) The attorney general, or designee.
(b) The chief medical examiner, or designee.
(c) The director of maternal and child health, division of public health services, department of health and human services, or designee.
(d) The director of the injury prevention program, division of public health services, department of health and human services, or designee.
(e) The director of the division for children, youth and families, department of health and human services, or designee.
(f) The director of the division for behavioral health, department of health and human services, or designee.
(g) The director of the division of family assistance, department of health and human services, or designee.
(h) The commissioner of the department of health and human services, or designee.
(i) The commissioner of the department of safety, or designee.
(j) The commissioner of the department of education, or designee.
(k) One representative of the judicial branch, appointed by the chief justice of the supreme court.
(*l*) The director of the office of the child advocate, or designee.
(m) The director of the women, infants, and children program, division of public health services, department of health and human services, or designee.
(n) The director of the division of fire standards and training and emergency medical services, department of safety, or designee.
(*o*) A member of the New Hampshire Pediatric Society, appointed by the society.
(p) An early childhood education specialist, appointed by the commissioner of the department of health and human services.
(q) A maternal and child health specialist, appointed by the commissioner of the department of health and human services.
(r) A representative of a child advocacy center, appointed by the commissioner of the department of health and human services.
(s) A representative of Court Appointed Special Advocates (CASA), appointed by the director of CASA.
(t) A psychiatrist or psychologist licensed in this state, appointed by the commissioner of the department of health and human services.
(u) A representative of a parent advocacy organization, appointed by the commissioner of the department of health and human services.
(v) An epidemiologist from a New Hampshire college or university, appointed by the commissioner of the department of health and human services.
(w) A domestic violence specialist, appointed by the commissioner of the department of health and human services.
(x) A representative of a statewide law enforcement officers' advisory council, appointed by the commissioner of the department of health and human services.
(y) A representative of a family resource center or home visiting program, appointed by the

commissioner of the department of health and human services.
(z) A member of the public, appointed by the commissioner or the department of health and human services.
(aa) A representative of the New Hampshire Hospital Association, appointed by the association.
(bb) A representative of the New Hampshire Coalition Against Domestic and Sexual Violence, appointed by the coalition.
(cc) A representative from the fire marshal's office, appointed by the fire marshal.
IV. Members of the child fatality review committee appointed under subparagraphs III(a)-(n) shall serve a term coterminous with their term in office. Members appointed under subparagraphs III(o)-(bb) shall serve a 6-year term, provided that initial appointments shall be for staggered terms of one to 6 years.
(a) The committee shall elect 2 chairpersons from among its members. The first meeting of the committee shall be called by the commissioner of the department of health and human services, or designee, and shall be held within 45 days of the effective date of this section.
(b) The committee may create additional subcommittees focused on specific populations such as for SUID and SDY. These subcommittees shall be subject to the same protections and responsibilities as the child fatality review committee. Membership of these subcommittees shall be determined by the co-chairpersons.
(c) Members of the committee shall sign confidentiality statements that prohibit any unauthorized dissemination of information except when disclosures may be necessary to enable the committee to carry out its duties under this subdivision. No material shall be used for reasons other than for which it was intended.
(d) The department of health and human services shall provide administrative support to the committee.
(e) The chairpersons may invite any expert or member of the public to committee meetings.
V. The child fatality review committee shall:
(a) Meet no fewer than 6 times per year to conduct reviews of child fatalities, including sudden unexpected infant deaths (SUID) and sudden death in the young (SDY). Subcommittees shall meet as determined by the co-chairpersons.
(b) Utilize case identification with the sole purpose of notification and data collection among state agencies. Each of the state agencies represented on the committee shall share relevant case information regarding decedents known to or enrolled in state agency programs or services. The review committee shall have access to all records of the division for children, youth and families, including case records, third party records, which include the healthcare and education records of any child receiving services from a state agency, and court records. The committee may review existing records and other information regarding the child from relevant agencies, professionals, and providers of medical, dental, prenatal, and mental health care. The information shared shall include, but not limited to, reports from health care providers, social service providers, law enforcement, and the medical examiner's office.
(c) Study the adequacy of statutes, rules, training, and services to determine what changes are needed to decrease the incidence of preventable child fatalities and, as appropriate, take steps to implement these changes.
(d) Educate the public regarding the incidence and causes of child fatalities and the public's role in preventing these deaths.
(e) Complete an annual statistical report on the incidence and causes of child fatalities in this state during the past fiscal year and submit a copy of this report, including its recommendations

for action, to the governor, the senate president, the speaker of the house of representatives, and the **health and human services oversight committee** established in RSA 126-A:13. The committee shall submit the report on or before December 15 of each year.
VI. The committee may subpoena witnesses, records, documents, reports, reviews, recommendations, correspondence, data, and other evidence that the committee reasonably believes is relevant to the committee's objectives.
VII. (a) The committee shall maintain the confidentiality of all records pursuant to RSA 169-C:25, RSA 170-G:8-a, and all other related confidentiality laws.
(b) The information and records obtained and created in execution of the child fatality review committee's official functions shall be exempt from disclosure pursuant to RSA 91-A and shall be privileged and exempt from use or disclosure in any criminal or civil matter or administrative proceeding. No person who participates in the official functions of the committee shall be compelled to testify or produce evidence in any judicial or administrative proceeding with respect to any matter involving exercise of his or her official duties.
(c) [Repealed.]
(d) Any person who knowingly discloses case records or other information obtained from committee proceedings shall be guilty of a misdemeanor.

Source. 2019, 302:1, eff. July 29, 2019. 2020, 37:43, 144-147, eff. July 29, 2020.

CHAPTER 135-C

NEW HAMPSHIRE MENTAL HEALTH SERVICES SYSTEM

Section 135-C:29

135-C:29 Delivery to Receiving Facility. –
I. Upon completion of an involuntary emergency admission certificate under RSA 135-C:28, a law enforcement officer shall, except as provided in paragraph II, take custody of the person to be admitted and shall immediately deliver such person to the receiving facility identified in the certificate. The mode and circumstances of transport to the receiving facility shall be determined in accordance with paragraph II.
II. The health care provider who is authorized to order involuntary emergency admission under RSA 135-C:28, I shall determine which transport option should be used to transport the person to New Hampshire hospital or the designated receiving facility. The transport options shall be by ambulance or by law enforcement. The transporting agency shall deliver the person to the designated receiving facility or New Hampshire hospital and shall determine whether restraint is necessary to protect the safety of the person, personnel conducting the transport, property, or the public. In the case of ambulance transport, such determination shall be in writing and shall state the factual basis for the conclusion that physical restraints are necessary. Physical restraints shall be used only to transport a person being admitted to New Hampshire hospital or a designated receiving facility, if necessary, to protect the safety of the person, personnel conducting the transport, property, or the public. For the purpose of this paragraph, "physical restraints" means the use of mechanical devices or other means to restrict the movement of a person or the movement or normal function of a portion of his or her body.
III. When the person being admitted to New Hampshire hospital or a designated receiving

facility is a child under age 18, the health care provider shall consult with the parent, guardian, or legal custodian of the child prior to making the determination required under paragraph II.
IV. Each designated receiving facility and the chief executive officer of New Hampshire hospital shall submit an annual report regarding the use of restraint and the use of different modes of transportation to their facility. The report shall be submitted on or before November 1 of each year to the **oversight committee on health and human services**, established in RSA 126-A:13, and shall document the 12 months ending on September 30 of each year. The first report shall be for the 9 months ending on September 30, 2020. The report shall detail the number of admissions of children and adults, broken down by mode of transport, how often restraints were used in each mode of transport, and if the restraint was applied before or during transport.

Source. 1986, 212:1. 2000, 231:1, eff. Jan. 1, 2001. 2019, 239:1, eff. Jan. 1, 2020.

CHAPTER 151

RESIDENTIAL CARE AND HEALTH FACILITY LICENSING

Section 151:34

151:34 Statewide Database Required. –
I. The department shall maintain a statewide database of all reported infection information and/or coverage rates of influenza vaccinations as required in RSA 151:33 for the purpose of monitoring quality improvement and infection control activities in hospitals, end-stage renal dialysis centers, nursing and other residential care facilities, the New Hampshire veterans' home, assisted living residences, and ambulatory surgical facilities. The database shall be organized so that consumers, hospitals, end-stage renal dialysis centers, nursing and other residential care facilities, the New Hampshire veterans' home, assisted living residences, ambulatory surgical facilities, health care professionals, purchasers, and payers may compare individual hospital, end-stage renal dialysis center, nursing and other residential care facility, the New Hampshire veterans' home, assisted living residence, and ambulatory surgical facility experience with that of other individual hospitals, end-stage renal dialysis centers, nursing and other residential care facilities, the New Hampshire veterans' home, assisted living residences, and ambulatory surgical facilities as well as regional and statewide averages and, where available, national data.
II. (a) Subject to subparagraph (b), on or before August 1 of each year, provided that the data collection and analytical methodologies meet accepted standards for validity and reliability, the commissioner shall report on the department's web site infection rates for each reporting hospital, end-stage renal dialysis center, nursing and other residential care facility, the New Hampshire veterans' home, assisted living facility, and ambulatory surgical facility, an analysis of trends in the prevention and control of infection rates and coverage rates of influenza vaccinations as required in RSA 151:33 in hospitals, end-stage renal dialysis centers, nursing and other residential care facilities, the New Hampshire veterans' home, assisted living residences, and ambulatory surgical facilities across the state, regional and, if available, national comparisons for the purpose of comparing individual hospital, end-stage renal dialysis center, nursing and other residential care facility, the New Hampshire veterans' home, assisted living facility, and ambulatory surgical facility performance, and a narrative describing lessons for safety and quality improvement that can be learned from leadership hospitals and programs.

(b) The department shall maintain an infection reporting system capable of receiving electronically transmitted reports from hospitals, end-stage renal dialysis centers, nursing and other residential care facilities, the New Hampshire veterans' home, assisted living residences, and ambulatory surgical facilities. End-stage renal dialysis centers, nursing and other residential care facilities, the New Hampshire veterans' home, and assisted living residences shall begin to submit reports as required by this section within 6 months of the effective date of this section.
III. To assure the accuracy of the self-reported hospital, end-stage renal dialysis center, and ambulatory surgical facility infection data and to assure that public reporting fairly reflects what actually is occurring in each hospital, end-stage renal dialysis center, and ambulatory surgical facility, the department shall validate the results and the methodology used to collect and analyze the data. If the commissioner concludes that he or she is unable to adequately validate the data, the commissioner shall notify the **oversight committee on health and human services** of that fact and the reasons therefor and, in that case, the commissioner shall not be required to include hospital, end-stage renal dialysis center, nursing and other residential care facility, the New Hampshire veterans' home, assisted living residence, and ambulatory surgical facility identifiers in the information released to the public.
IV. In addition to the department's reporting responsibilities under this section, the department shall beginning in 2012 make a biennial report to the **oversight committee on health and human services** and the house and senate ways and means committees on or before August 1, regarding the health care associated infections program costs, the amount of federal funding received for the program, and the amount of fees paid by hospitals, end-stage renal dialysis centers, and ambulatory surgical centers to support the program.

Source. 2006, 292:1, eff. July 1, 2007. 2010, 77:5, eff. July 1, 2011. 2012, 117:2, 5, eff. July 1, 2012. 2016, 192:1, eff. Aug. 2, 2016.

CHAPTER 151-E

LONG-TERM CARE

Section 151-E:11

151-E:11 Program Management and Cost Controls. –
I. The department shall designate in its operating budget requests specific class lines for nursing facility, mid-level, and home-based care provided for in this chapter. These class lines shall reflect, and the requesting documentation shall include, the anticipated number of persons to receive services. The department shall not increase expenditures in approved budgets for these class lines or the number of persons to receive mid-level or home care services without the approval of the legislative fiscal committee, and the prior review of the county-state finance commission. The medicaid rates paid for nursing facility services, mid-level care services, and home and community-based care services shall not be reduced below those levels in effect on the last day of the previous biennium. No transfers may be made from the nursing facility medicaid quality incentive program and all funding derived from that program shall be paid to nursing facilities.
II. The department shall provide a report annually no later than January 1 on the utilization of non-nursing home services to the county-state finance commission and the legislative fiscal

committee. The department may report to the county-state finance commission and the legislative fiscal committee more frequently if new information is provided by the Centers for Medicare and Medicaid Services.
III. (a) The methodology for determining the cost of care for recipients in the home and community-based care waiver program for the elderly and chronically ill shall include the cost of:
(1) Waiver program services; and
(2) Other medicaid long-term care services, including but not limited to personal care, home health services, physical therapy, occupational therapy, speech therapy, adult medical day program services, private duty nursing, and case management services.
(b) Such methodology shall not include services rendered for the treatment of an acute illness or injury.
IV. Pursuant to RSA 541-A, the commissioner of the department of health and human services, with prior reporting to the **oversight committee on health and human services**, shall adopt by rule methodologies for determining the cost and average annual cost of home-based care, mid-level care, and intermediate, skilled, or specialized nursing facility care, including:
(a) Bases for the methodologies;
(b) Identification of services considered in determining costs;
(c) Average annual costs based on the annual average number of recipients in the setting;
(d) The requirement that nursing facility care include both the initial Medicaid rate and supplemental rates paid through the Medicaid Quality Incentive Program; and
(e) The requirement that the nursing facility will include the cost for transitional case management.

Source. 1998, 388:1. 2003, 223:5, eff. July 1, 2003; 319:35, eff. July 1, 2003. 2005, 175:13, eff. Aug. 29, 2005. 2010, 112:1, 2, eff. Jan. 1, 2011. 2015, 259:16, eff. July 1, 2015. 2020, 32:7, 8, eff. Jan. 1, 2021.

CHAPTER 151-G

NEW HAMPSHIRE HEALTH CARE QUALITY AND SAFETY COMMISSION

Section 151-G:7

151-G:7 Reports. – On or before June 1 of each year, the commission shall report its findings and any recommendations for proposed legislation to the speaker of the house of representatives, the senate president, the governor, and the **health and human services oversight committee** established in RSA 126-A:13. Such report shall describe the activities of the commission, indicate the extent of each institution's participation, state the aggregate relative frequency of the causes of the medical errors, unexpected adverse outcomes, and near misses reviewed and, to the extent possible, identify strategies for reducing preventable adverse events. Any information about processes or clinical outcomes provided pursuant to this section shall be aggregate data only and shall not reference individual incidents, patients, health care providers, or institutions.

CHAPTER 161

HUMAN SERVICES

Section 161:4-a

161:4-a Rulemaking. –
The commissioner of the department of health and human services shall adopt rules under RSA 541-A relative to:
I. The development, administration and supervision of child welfare services by the department of health and human services under RSA 161:2, II.
II. The determination of eligibility for assistance to needy blind persons under RSA 161:2, V.
III. The development and operation of social and related service programs under RSA 161:2, XII.
IV. The development and administration of the food stamp program under RSA 161:2, XIII, including procedures for waiver of food stamp overpayments.
V. The establishment, maintenance and direction of a system of collecting and disbursing court ordered support payments in divorce, nonsupport and support of children of unwed parents cases under RSA 161:2, XVI.
VI. The custody, use and preservation of records, papers, files and communications relating to the department of health and human services.
VII. The decision of hearings officers appointed under RSA 161:4, IV.
VIII. Limitations on the total number of children living in foster care under RSA 161:4, V.
VIII-a. The establishment, maintenance, and direction of a reasonable and fair system of recouping payments made in error from child support collected pursuant to RSA 161:2, XVI, or other means as allowed by law. Such system shall include, but shall not be limited to, grounds for appeal on the basis of economic hardship.
IX. The implementation of the requirements of federal discretionary grants awarded to the department of health and human services and any other awards received through a successful department of health and human services response to federal requests for applications and requests for proposals.
X. Sections 1902 through 1946 of the Social Security Act, 42 U.S.C. section 1396, et seq. that reflect how the Title XIX program will be administered in New Hampshire in order to carry out the purposes of the Title XIX program. Such rules shall be adopted, consistent with the provisions of the Title XIX program, as are necessary for the proper and efficient administration of the Title XIX program in New Hampshire and in conformity with the specific requirements of Title XIX, federal regulations, and other official federal Health and Human Services issuances. Such rules shall include, as applicable, but not be limited to:
(a) Recipient eligibility.
(b) Provider participation requirements.
(c) Types and ranges of services covered and non-covered.
(d) Service limits.
(e) Co-payment requirements.
(f) Prior authorization requirements.
(g) Documentation.
(h) Third party liability.

(i) Utilization review and control.
(j) Payment for services.
(k) Rate setting methodologies.
(l) Administrative and operating procedures such as claim submission requirements, forms, payment limits and adjustments, lock-in, provider suspension and exclusion, board composition, board functions and responsibilities, appeals, dispensing limitations, prescription certifications, documentation retention policies, and informing requirements.
(m) Any other item necessary for proper operation of the title XIX program consistent with efficiency, economy, and quality of care.
XI. Requiring service providers and facilities to maintain liability insurance, as necessary.
XII. Any other matters necessary to implement his or her duties under RSA 161 or any other law delegating the commissioner rulemaking authority. As a condition of the commissioner invoking his or her rulemaking authority under this paragraph, the department of health and human services shall provide a written report detailing the necessity for the proposed rule as set forth in the rulemaking notice, to include any fiscal impact and or policy implications related to the adoption of the proposed rule, to the house and senate executive departments and administration committees, the house and senate finance committees, the joint legislative committee on administrative rules, the **oversight committee on health and human services**, and the fiscal committee of the general court.

Source. 1983, 242:2; 291:1, II. 1992, 270:1. 1995, 310:181-183. 2006, 85:2. 2012, 171:10, eff. Aug. 10, 2012.

CHAPTER 161-I

PERSONAL CARE SERVICES

Section 161-I:3-a

161-I:3-a Authorization of Legally Responsible Relative. – The department may authorize reimbursement to a legally responsible relative who provides personal care to an eligible consumer with special health care needs residing at home. Such reimbursement shall occur only when the department determines that the needs of the eligible consumer, the unavailability of appropriate providers or suitable alternative care services, and cost efficiencies make utilization of a legally responsible relative for the provision of such services necessary and appropriate. Reimbursement shall be limited to care that is medically necessary due to specific health needs and shall not be made for care generally expected and provided by a legally responsible relative. The department shall not authorize reimbursement to a legally responsible relative until a plan and rules adopted pursuant to RSA 541-A, are reviewed and approved by the **oversight committee on health and human services**, established in RSA 126-A:13.

Source. 2006, 132:2, eff. July 18, 2006. 2019, 287:3, eff. July 1, 2019.

CHAPTER 167

PUBLIC ASSISTANCE TO BLIND, AGED, OR DISABLED PERSONS, AND TO DEPENDENT CHILDREN

Section 167:4

167:4 Eligibility for Assistance. –
I. Public assistance, including medical assistance and food stamps, shall be granted under this chapter or RSA 161 to any eligible person as defined in RSA 167:6 or RSA 161 who has not sufficient income or other resources to provide a reasonable subsistence compatible with decency and health and may be granted to anyone who is an inmate of a public institution, including a patient in a public medical institution which meets the federal or state standards and is so certified by the appropriate state and federal agency, except that:
(a) In the determination of sufficiency of income and resources, the commissioner of the department of health and human services may disregard such income and resources as may be permitted by the Social Security Act of the United States, as amended, and by the Food Stamp Act of the United States, as amended.
(b) In the case of an applicant for public assistance or medical assistance who has made an assignment or transfer of assets to an individual for less than fair market value within 60 months or in the case of transfers of real estate, or transfers of assets to a trust or portions of a trust that are treated as assets disposed of by the individual within 60 months immediately preceding the date of application or while the application is pending, or in the case of a recipient of public assistance or medical assistance who makes such an assignment or transfer while in receipt of the assistance, the assistance sought shall only be granted or continue to be granted in accordance with rules establishing restrictions and eligibility criteria for such cases as adopted by the commissioner of the department of health and human services under RSA 541-A, subject to applicable federal regulations and waiver approval, if any, and review by the **oversight committee on health and human services**, established in RSA 126-A:13. The **oversight committee on health and human services** shall make a report to the legislative fiscal committee which shall have final approval authority.
(c) Public assistance, medical assistance, or food stamps shall not be granted to an applicant, or continue to be granted to a recipient, who has refused to accept suitable employment, in accordance with rules adopted by the commissioner of the department of health and human services under RSA 541-A, subject to federal regulations when applicable.
II, III. [Repealed.]
III-a. Pursuant to section 1917(c)(2)(D) of the federal Social Security Act and the Deficit Reduction Act of 2005, Public Law 109-171, section 6011(d), a transfer of asset penalty shall not be imposed if the penalty would result in an undue hardship to the transferor under any of the following conditions:
(a) The asset was transferred by an agent or authorized representative and it can be demonstrated and documented that the individual lacked the mental capacity to comprehend the disqualifying nature of the act; and
(1) A written and signed statement by a licensed physician states that the individual was mentally incapacitated at the time of the transfer; or
(2) An order of findings from a probate court concerning the individual's competency is provided

to the district office.
(b) Application of the penalty would deprive the individual of necessary care such that his or her health or life would be endangered.
(c) Application of the penalty would deprive the individual of food, clothing, shelter, or other necessities of life.
IV. (a) It is hereby found and determined by the general court that the medicaid eligibility laws of this state are in need of amendment to assure that otherwise ineligible individuals are prevented from artificially impoverishing themselves to receive benefits to which they are not otherwise entitled and to facilitate recovery of improperly obtained benefits and to assure the fiscal integrity of the funds appropriated for medicaid.
(b)(1) Notwithstanding any provision of law to the contrary and consistent with section 1917(e) of the Social Security Act as amended by the Deficit Reduction Act of 2005, (DEFRA), Public Law 190-171, for purposes of Medicaid eligibility, investment in annuities shall be limited to those annuities that:
(A) Are actuarially sound as measured against the Social Security Administration Life Expectancy tables as amended;
(B) Provide equal or nearly equal payments for the duration of the device and which exclude "balloon" style final payments; and
(C) Provide state of New Hampshire secondary or contingent beneficiary status ensuring payment if the individual predeceases the duration of the annuity, in an amount equal to the medicaid expenditure made by the state of New Hampshire on the individual's behalf.
(2) All such annuities owned by the applicant or the applicant's spouse shall be disclosed to the department at the time of the application.
(c) Notwithstanding any provision of law to the contrary, for purposes of medicaid eligibility, investment in life insurance policies with cash surrender value in excess of $1,500 shall be limited to policies that ensure payment to the state of New Hampshire of all the proceeds of the policy in excess of amounts spent on burial up to the total of medicaid expenditures made on behalf of the individual.
(d) Pursuant to section 1917(b)(1) of the Social Security Act as amended by DEFRA, the commissioner shall submit a state plan amendment establishing a long-term care partnership recognizing the investment in long-term care insurance policies by Medicaid applicants by disregarding resources or assets in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy which meets the criteria described in DEFRA and regulations promulgated thereunder. The estates of recipients of medical assistance for institutional level of care for whom the resource ceiling has been adjusted as described in this subparagraph, shall be exempt from recovery pursuant to RSA 167:13 and RSA 167:14 in an amount equal to the insurance benefit payments received.
(e) The commissioner of the department of health and human services shall adopt rules, pursuant to RSA 541-A, relative to the proper administration of this paragraph.
V. Distributions of the income or principal, or both, of a special needs trust to or for the benefit of the disabled beneficiary shall be disregarded for income eligibility purposes of all categories of public medical assistance to the same extent that such distributions are disregarded for purposes of Title XVI of the Social Security Act. Funds expended by a trustee of a special needs trust to purchase or maintain assets owned by the trustee in his or her capacity as trustee of the trust shall also be disregarded for such income eligibility purposes. For the purposes of this

paragraph "special needs trust" means any trust established by a third party for the sole benefit of an individual who is considered disabled under the provisions of section 1614(a)(3) of the Social Security Act, and any trust funded with the resources of such an individual and complying with the provisions of section 1917(d)(4) of such Act.

Source. 1937, 202:10. RL 126:10. 1951, 139:7. 1953, 87:1. RSA 167:4. 1961, 50:1. 1965, 154:1. 1967, 396:3. 1975, 29:1; 445:1. 1979, 212:1. 1981, 305:1. 1983, 288:1; 291:1, II. 1986, 183:3. 1989, 16:1. 1994, 237:1. 1995, 310:40, 170, VIII. 2003, 154:1. 2005, 175:4, 5. 2006, 278:2-4. 2007, 166:1, eff. Nov. 1, 2007; 193:1, eff. Aug. 17, 2007.

Section 167:4-a

167:4-a Financial Disclosure by Applicants and Recipients.[6] –

I. Notwithstanding the provisions of RSA 359-C or any other law to the contrary, any person who is an applicant for or recipient of any public assistance shall, by his application for such assistance, or by his continued acceptance of such benefits, whether requested or obtained directly or through another person acting on his behalf, be deemed to have authorized disclosure of his financial records to the department of health and human services, by financial institutions and by clearinghouses which disseminate financial record information.

II. The commissioner is hereby authorized to request and receive from any bank, trust company, savings and loan association, credit union, or other financial institution doing business in this state the financial records of any applicant for or recipient of medical assistance whose eligibility for medical assistance is based upon the applicant's or recipient's age, blindness, or disability. The institution shall furnish the information specified in paragraph VI within 15 days of the department's request.

III. The department or any financial institution that discloses financial records under this section shall not be subject to civil liability or criminal prosecution which is based upon its disclosure under this section, or for any other action taken in good faith to comply with the requirements of this section.

IV. [Repealed.]

V. Any records established or information collected pursuant to the provisions of this section shall be made available only to the commissioner and his or her authorized designee, and the applicant or recipient, and his or her authorized representative as authorized by the rules of the department. Such records and information shall be available and used only for purposes directly connected with the determination and verification of eligibility for medical assistance for applicants and recipients whose eligibility for medical assistance is based upon the applicant's or recipient's age, blindness, or disability. The records and information made available to the applicant or recipient, or his or her authorized representative shall not include information provided to the department that is prohibited from release by federal law, state statute, state case law, or by contract or agreement between the department and another entity if such contract or agreement prohibits release of such information.

VI. The department, in coordination with financial institutions doing business in the state, may develop and operate a data match system, using automated data exchanges to the maximum extent feasible, in which each financial institution is required to provide, when requested by the

[6] SB 162, (2021) DHHS requested omnibus bill seeks to eliminate RSA 167:4-a, VI, as part of the agency's internal review to repeal outdated or redundant reporting requirements.

department and subject to reasonable reimbursement as set forth in Public Law 110-252, up to 5 years of information regarding the name, record address, social security number or other taxpayer identification number, monthly account balance, and other identifying information for each applicant or recipient who maintains an account at the financial institution, as identified by the department by name and social security number or other taxpayer identification number. The system shall be based on a cost-effective search algorithm and shall include means to assure compliance with the provisions of this section. The department shall provide a status report regarding the implementation of the data match system to the **oversight committee on health and human services**, established in RSA 126-A:13, on or before November 1, 2010, and annually thereafter, until implementation has been fully completed. The report shall summarize the department's findings and recommendations to date, including savings generated by both incremental asset identification and the time and labor associated with the process, the feedback and reactions of applicants and recipients, any barriers to implementation, anticipated future actions, and the department's assessment of the relative success of the project.
VII. In this section, "financial institution", except as otherwise provided in 12 U.S.C. section 3414, means any office of a bank, savings bank, card issuer as defined in 15 U.S.C. section 1602(n), industrial loan company, trust company, savings association, building and loan, or homestead association, including cooperative banks, credit union, or consumer finance institution, located in any state or territory of the United States, the District of Columbia, Puerto Rico, Guam, American Samoa, or the Virgin Islands.

Source. 1983, 136:1; 291:1. 1995, 310:181, 182. 2004, 251:7. 2008, 342:2. 2010, 308:1, 2, eff. Sept. 11, 2010.

Section 167:77-a

167:77-a Work Participation Rates. –
The department shall make strong efforts to meet the work participation rate requirements of the federal TANF program, as amended by the Deficit Reduction Act of 2005.
I. Efforts may include the following actions:
(a) Using state funds not claimed as maintenance of effort for the federal TANF program to provide benefits for categories of families who are exempt from the state's work activity requirements or who have good cause reasons for not participating.
(b) Developing a diversion program for applicants for the employment program for up to 4 months to provide enhanced assessment and job placement services.
(c) Making a claim for additional caseload reduction credits based on state spending above the minimum to meet the federal TANF maintenance of effort requirement.
(d) Assigning participants into work activities that count toward the federal work participation rate where alternative activities are not better suited to assist the participant to enter, re-enter, and maintain employment and move toward self-sufficiency.
(e) Providing continuing assistance to participants who are meeting the hour requirements in an unsubsidized job, as specified in RSA 167:85, VIII.
II. The department shall submit a report to the **oversight committee for health and human services**, established in RSA 126-A:13, relative to actions taken to increase the work participation rate reported to the federal Department of Health and Human Services. The

department also shall provide the oversight committee with an estimate of whether the state shall meet the federal requirements for each federal fiscal year by January 15 of that fiscal year.

Source. 2007, 349:2, eff. Sept. 14, 2007. 2015, 259:13, eff. July 1, 2015.

Section 167:77-b

167:77-b Performance Measurement System. –
I. The department shall establish a performance measurement system designed to assist the department in meeting the goals of the TANF reauthorization program, including a mission statement identifying values that focus on qualitative outcomes. The measurement system shall be adopted on or before January 1, 2008. The system shall include: measurement and tracking of individual employee performance; tracking and analysis of programmatic outcomes; and tracking of other data or information otherwise useful in establishing success in moving clients into work participation, as defined by federal law. The department shall, for each indicator, develop performance and benchmark scores that reflect normal or expected performance. In developing these indicators, the department shall consult with the **oversight committee on health and human services**, established in RSA 126-A:13.
II. The department shall prepare an annual report that includes data and comparison with prior years and indicates normal or expected performance levels. Each annual report shall be submitted to the **oversight committee on health and human services**, the speaker of the house of representatives, the president of the senate, the governor, and the appropriate legislative policy committees. The first such report shall be submitted by December 15, 2007.

Source. 2007, 349:2, eff. Sept. 14, 2007.

Section 167:77-c

167:77-c Outcome Measurement System. –
I. The oversight committee established by RSA 126-A:13 shall monitor changes to the state TANF program made as a result of the federal reauthorization of TANF in 2005 and shall provide informational meetings on such changes to the general court.
II. The department of health and human services shall provide the federal Administration for Children and Families with the data requested by that agency to calculate the national TANF high performance rankings regardless of whether financial bonuses are paid for performance.
III. Success of the TANF program shall be based on research and statistical analysis to determine if the goals of moving TANF clients towards long term economic independence set forth in RSA 167:77, IV and V are met.
IV. The department shall establish an outcome measurement system with the following areas of analysis:
(a) The number and percent of cash assistance recipients who close each month due to employment, the average hourly, weekly, and monthly wages, the average total weekly and monthly total income, the number and percent who return to cash assistance after 3, 6, and 12 months.
(b) Numbers and percentages of TANF families that leave TANF and ranking of their income compared to the federal poverty level and the New Hampshire living wage.

(c) Poverty and child poverty rates and out of wedlock births and the national ranking of New Hampshire.
(d) The reasons for caseload increases and decreases with analysis of numbers and reasons for openings, denials, and closings and the numbers and reasons for sanctions and denials due to noncompliance with program requirements.
V. The department shall develop and maintain the indicators for the program outcomes listed in paragraph IV, subject to review and approval by the **oversight committee on health and human services**. The department shall submit a report to the oversight committee each January.

Source. 2007, 349:2, eff. Sept. 14, 2007. 2015, 259:14, eff. July 1, 2015.

Section 167:77-d

167:77-d TANF Pilot Diversion Program and Study. – The department shall perform a diversion program and study for a limited population of TANF applicants who receive an assessment and benefits prior to entry into the TANF program. The study shall assess the program's feasibility and effectiveness, as well as the impact of the diversion program on work participation rates. The department shall report its findings to the oversight committee on health and human services on December 31, 2007 and each December 31 thereafter, for the duration of the program.

Source. 2007, 349:2, eff. Sept. 14, 2007.

Section 167:77-f

167:77-f Career Ladder Initiatives. –
The commissioner shall work cooperatively with the Career One Stop Centers and the Workforce Investment Boards to develop career ladder initiatives for employment program clients and former employment program clients.
I. Career ladder initiatives shall:
(a) Promote both increased pay and increased benefits.
(b) Match the needs of the local economy.
(c) Focus on current in-demand occupations with the state.
(d) Explore self employment opportunities.
(e) Share TANF and WIA funding to the extent possible.
II. The department shall report its progress to the **oversight committee on health and human services** no later than January 1.

Source. 2007, 349:2, eff. Sept. 14, 2007. 2015, 259:15, eff. July 1, 2015.

CHAPTER 187-A

STATE COLLEGE AND UNIVERSITY SYSTEM

Section 187-A:20-b

187-A:20-b Tuition Waiver for Children in State Foster Care or Guardianship. –

[Paragraph I effective until July 1, 2021; see also paragraph I set out below.]

I. An eligible individual who enrolls full-time in a program leading to a certificate, associate, or bachelor degree at any public postsecondary institution within the state shall not be required to pay tuition or fees for attendance at such institution.

[Paragraph I effective July 1, 2021; see also paragraph I set out above.]

I. An eligible individual who enrolls full-time or part-time, with the approval of the division for children, youth and families, in a program leading to a certificate, associate, or bachelor degree at any public postsecondary institution within the state shall not be required to pay tuition or mandatory fees for attendance at such institution.

II. In this section, an eligible individual is a person who is less than 23 years of age and who is or was:

(a) In state foster care for the immediate 6-month period prior to his or her 18th birthday;

(b) In state guardianship or custody at the time of his or her 18th birthday;

(c) Adopted while in state guardianship or adopted from the care, custody, and control of the department following a surrender of parental rights; or

(d) In an out-of-home placement under the supervision of the division for juvenile justice services at the time of his or her 18th birthday.

[Paragraph III(a) effective until July 1, 2021; see also paragraph III(a) set out below.]

III. (a) Eligible individuals interested in a tuition waiver shall annually apply on forms provided and within the deadlines established by the university system of New Hampshire and the community college system of New Hampshire for their respective institutions. No more than 15 tuition waivers per year shall be granted by the university system of New Hampshire and no more than 15 tuition waivers per year shall be granted by the community college system of New Hampshire. The university system of New Hampshire and the community college system of New Hampshire shall have the authority to develop eligibility criteria for their respective institutions designed to give the children with the greatest financial need first priority in the tuition waiver program. Such eligibility criteria shall also include provisions for continuing eligibility based on continued full-time enrollment and satisfactory academic progress as defined by the institution.

[Paragraph III(a) effective July 1, 2021; see also paragraph III(a) set out above.]

III. (a) Eligible individuals interested in a tuition waiver shall annually apply on forms provided and within the deadlines established by the university system of New Hampshire and the community college system of New Hampshire for their respective institutions. No more than 15 tuition waivers per year shall be granted by the university system of New Hampshire and no more than 15 tuition waivers per year shall be granted by the community college system of New Hampshire. The university system of New Hampshire and the community college system of New Hampshire shall have the authority to develop eligibility criteria for their respective institutions designed to give the children with the greatest financial need first priority in the tuition waiver program. Such eligibility criteria shall also include provisions for continuing eligibility based on continued full-time or part-time, with the approval of the division for children, youth and families, enrollment and satisfactory academic progress as defined by the institution.
(b) Beginning November 1, 2008, and no later than November 1 each year thereafter, the division of children, youth, and families shall submit a report to the **health and human services oversight committee**, established in RSA 126-A:13, and the house children and family law committee, or their successor committees, detailing the status of the tuition waiver program.
IV. An eligible individual may also apply for a room and board scholarship under the provisions of RSA 187-A:20-a, II without having to comply with the provisions of RSA 187-A:20-a, I.

Source. 2011, 224:131. 2013, 164:4, eff. June 28, 2013. 2019, 326:6, 7, eff. Aug. 16, 2019. 2020, 34:20, 21, eff. July 1, 2021.

CHAPTER 318-B

CONTROLLED DRUG ACT

Section 318-B:10

318-B:10 Professional Use of Narcotic Drugs. –
I. A practitioner other than a veterinarian, in good faith, in the course of his professional practice, and for a legitimate medical purpose, may administer and prescribe controlled drugs, or the practitioner may cause the same to be administered by a nurse or intern under his direction and supervision. In a bona fide emergency situation, the practitioner may dispense a controlled drug to a patient under his care but only in a quantity not to exceed a 48-hour supply for all schedule II substances or a 7-day supply of schedule III, IV, or V substances.
II. A veterinarian, in good faith, in the course of his professional practice only, and not for use by a human being, may administer and prescribe controlled drugs, and the veterinarian may cause them to be administered to an animal under his care, but only in a quantity not to exceed a 48-hour supply of a schedule II substance or a 7-day supply of schedule III, IV, or V substances.
III, IV. [Repealed.]
V. An advanced emergency medical care provider licensed under RSA 153-A may possess, for emergency use only, such controlled prescription drugs as are specified by the state emergency medical services medical control board, with the concurrence of the pharmacy board, provided that there has been prior establishment of medical control for the possession of such drugs. The advanced emergency medical care provider may only administer such controlled prescription drugs upon receipt of orders to do so from a supervising physician or an emergency trauma

advanced practice registered nurse, practicing within such nurse practitioner's specialty. Such orders may be transmitted either directly or by telephone or by radio or by other communication medium, or by standing order of local medical control delineated in a protocol as defined in RSA 153-A.

VI. Notwithstanding any other law to the contrary, an attending physician, in good faith and in the course of the attending physician's professional practice only, may prescribe and administer federal Food and Drug Administration approved and classified cannabis-type drugs, or the attending physician may cause such drugs to be administered by a nurse or intern under such physician's direction and supervision.

VII. (a) The department of health and human services is hereby declared to be the state methadone authority.

(b) The commissioner of the department of health and human services shall adopt and have in effect rules, pursuant to RSA 541-A, relative to methadone detoxification and maintenance programs as follows:

(1) Application procedure and standards for approval for certification and re-certification of providers to operate methadone detoxification and maintenance programs, including certification period, for each type of certification. The department shall utilize accreditation reports obtained from national accreditation bodies that are approved by the United States Department of Health and Human Services Substance Abuse and Mental Health Services Administration in certifying methadone detoxification and maintenance programs in New Hampshire.

(2) Eligibility of individuals for admission to such programs.

(3) Qualifications of program personnel.

(4) Program content, including, but not limited to, services to be offered by the program.

(5) Mandatory records and reports to the department.

(6) Security measures to prevent diversion of methadone to illegal use.

(7) Confidentiality and disclosure of identifying information, records and reports.

(8) Financial responsibility.

(9) Any other provisions necessary to implement the purposes of this paragraph.

(c) Providers may operate a methadone detoxification or methadone maintenance program, or both, in the state of New Hampshire only if the providers are certified to operate pursuant to rules adopted under subparagraph VII(b).

(d) For the purposes of this paragraph:

(1) "Heroin" means an illegal semi-synthetic drug produced from the morphine contained in sap of the opium poppy, and known to have the potential for devastating addictive properties in vulnerable individuals.

(2) "Methadone" means a legal drug, methadone hydrochloride, which is a synthetic opioid that has been demonstrated to be an effective treatment agent for heroin abuse and dependence.

(3) "Methadone detoxification treatment" means the dispensing of methadone or similar substance in decreasing doses to an individual in order to reduce or eliminate adverse physiological or psychological effects incident to the withdrawal from the sustained use of heroin.

(4) "Methadone maintenance program" means a substance abuse treatment program substituting methadone or any of its derivatives, over time, to relieve withdrawal symptoms of heroin dependence, to reduce craving, and to permit normal functioning and engagement in rehabilitative services.

(e) Nothing in this paragraph shall prohibit a licensed health care practitioner from

administering, prescribing, or dispensing a controlled drug under paragraph I.
(f) The department shall assess a fee to be paid by providers of methadone detoxification and maintenance programs for certification and administration by the department. The fee shall be $8 per client based on the annual client census of the previous calendar year. If the provider had no clients in the previous calendar year, then the fee shall be $1,000. All moneys collected by the department from fees authorized under this subparagraph shall be deposited into the general fund.
(g) The commissioner of the department of health and human services shall report by July 31, 2010, and each July 31 thereafter, to the chairpersons of the house and senate ways and means committees, the house and senate committees having jurisdiction over health and human services, and the **oversight committee on health and human services** under RSA 126-A:13, on the number of methadone detoxification and maintenance program clinics certified under RSA 318-B:10, VII, the number of clients, the average annual census data, the amount of fees assessed providers, and any recommendations for changes to the fee structure.
VIII. (a) Notwithstanding paragraph VII or any other law to the contrary, methadone may be administered, prescribed, and dispensed to pregnant and postpartum heroin addicts and administered as part of an alcohol and drug abuse treatment program, which may include extended detoxification and which is approved by the commissioner of health and human services.
(b) The commissioner of health and human services shall adopt rules pursuant to RSA 541-A, relative to:
(1) Eligibility for the program.
(2) Length of time in the program.
(3) Requirements for participation in prenatal and postnatal care.
(4) Security measures to prevent diversion of methadone to illegal use.
(5) Any other provisions necessary to implement the purposes of this paragraph.
IX. If, in the judgment of a physician licensed under RSA 329, appropriate pain management warrants a high dosage of controlled drugs and the benefit of the relief expected outweighs the risk of the high dosage, the licensed physician may administer or cause to be administered such a dosage, even if its use may increase the risk of death, so long as it is not furnished for the purpose of causing, or the purpose of assisting in causing, death for any reason and so long as it falls within rules of the board of medicine.

Source. 1969, 421:1. 1973, 392:3. 1977, 106:2; 547:11, 12. 1981, 107:1. 1983, 292:8, 9, 21, I, II. 1985, 293:7; 324:20. 1992, 48:8. 1994, 186:2; 333:21. 1995, 286:25. 1996, 252:1, 2; 267:23. 1998, 149:1. 1999, 345:8. 2000, 268:2; 271:1. 2009, 54:5, eff. July 21, 2009; 205:1, 2, eff. July 15, 2009. 2017, 156:157, eff. July 1, 2017.

Section 318-B:35

318-B:35 Providing Controlled Drug Prescription Health and Safety Information. –
I. The program administrator may provide information in the prescription health and safety program upon request only to the following persons:
(a) By electronic or written request to prescribers, dispensers, and the chief medical examiner and delegates within the state who are registered with the program:
(1) For the purpose of providing medical or pharmaceutical care to a specific patient;

(2) For reviewing information regarding prescriptions issued or dispensed by the requester; or
(3) For the purpose of investigating the death of an individual.
(b) By written request, to:
(1) A patient who requests his or her own prescription monitoring information.
(2) The board of dentistry, the board of medicine, the board of nursing, the board of registration in optometry, the board of podiatry, the board of veterinary medicine, and the pharmacy board; provided, however, that the request is pursuant to the boards' official duties and responsibilities and the disclosures to each board relate only to its licensees and only with respect to those licensees whose prescribing or dispensing activities indicate possible fraudulent conduct.
(3) Authorized law enforcement officials on a case-by-case basis for the purpose of investigation and prosecution of a criminal offense when presented with a court order based on probable cause. No law enforcement agency or official shall have direct access to query program information.
(4) [Repealed.]
(5) A practitioner or consultant retained by the office to review the system information of an impaired practitioner program participant or a referral who has agreed to be evaluated or monitored through the program and who has separately agreed in writing to the consultant's access to and review of such information.
(c) By electronic or written request on a case-by-case basis to:
(1) A controlled prescription drug health and safety program from another state; provided, that there is an agreement in place with the other state to ensure that the information is used or disseminated pursuant to the requirements of this state.
(2) An entity that operates a secure interstate prescription drug data exchange system for the purpose of interoperability and the mutual secure exchange of information among prescription drug monitoring programs, provided that there is an agreement in place with the entity to ensure that the information is used or disseminated pursuant to the requirements of this state.
(3) [Repealed.]
II. The program administrator shall notify the appropriate regulatory board listed in subparagraph I(b)(2) and the prescriber or dispenser at such regular intervals as may be established by the office if there is reasonable cause to believe a violation of law or breach of professional standards may have occurred. The program administrator shall provide prescription information required or necessary for an investigation.
III. The program administrator shall review the information to identify information that appears to indicate whether a person may be obtaining prescriptions in a manner that may represent misuse or abuse of schedule II-IV controlled substances. When such information is identified, the program administrator shall notify the practitioner who prescribed the prescription.
IV. The program administrator shall make a report, at least annually, commencing on November 1, 2019, to the senate president, the speaker of the house of representatives, the **oversight committee on health and human services**, established in RSA 126-A:13, the advisory council established in RSA 318-B:38 and the licensing boards of all professions required to use the program relative to the effectiveness of the program.

Source. 2012, 196:2. 2015, 48:6, 11. 2016, 2:8, eff. Jan. 21, 2016. 2018, 158:2, 3, eff. July 29, 2018. 2019, 303:7-10, eff. Sept. 27, 2019.