Health and Human Services Oversight Committee

Regular Meeting, 27 March 2026, 9:30 am--Granite Place Room 158

Present: Sen. Gray, Sen. Rochefort, Rep. Pearson, Rep. Mooney, Rep. Seaworth, Rep. Weber, Rep. LaMontagne, Rep. Woods.

Rep. MacDonald arrived during the Commissioner's report.

Absent: Sen. Rosenwald

Minutes: The minutes of the meeting of February 20, 2026 were duly moved, seconded and approved with the correction of one typo in the Commissioner's Report.

DHHS Commissioner's Update—Commissioner Lori A. Weaver:

Back of the budget reductions: The Department submitted its final report to Fiscal on the required back of budget reductions. They have been reporting the reductions regularly. With respect to the reductions proposed for the next biennium, the Department is able to make them but people will not like them. They are trying hard not to reduce services going forward. The Department has not proposed expanded services or new programming, but they have already squeezed the budget as much as they can. With the current 22% vacancy rate for staff, it will be a real challenge. They are looking at how to maximize the CMS waivers. They may have to take across the board cuts but would prefer not to. It is the hardest time in budgeting, trying to find that last $25 million reduction, and looking at FY 2028-29 is going to be tough. The lapse is less and less because they are getting better at projections of revenue and expenses. Rep. Mooney stated that she appreciates the summary of how the Department is dealing with these extraordinary cuts, because this is important for everyone to hear. However, yesterday, HB 1705, with new assistance for first responders, and HB 1809, setting up a psilocybin board, passed the House, and both carry costs and the requirement of new employees for DHHS. Her concern is that these are still bills with price tags that are wants and not needs.

Medicaid Community Re-entry Program: Olivia May, Deputy Medicaid Director, and Ann Landry, Associate Commissioner overseeing Medicaid: The program is a partnership between DHHS and the Department of Corrections which went live about a year ago. It involves multiple agencies within DHHS. New Hampshire was one of the first states to start this program, and they recently got positive feedback from CMS about the program, which really makes a difference in the lives of inmates. Medicaid had an exclusion for inmates, who lost their coverage while they were incarcerated. In 2023, CMS gave new guidance with limited services available for 90 days before release. Montana and Oregon have withdrawn their applications recently. They are not able to go ahead with the program as their capacity is being used for all

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the requirements of the OBBB. The OBBB changes are having the same demands here in NH as well, but our implementation was already going well. The program was implemented January of 2025, and covers 45 days before release for adult inmates who have a substance use disorder or serious mental illness, which is an intentionally targeted population. The goal is to decrease recidivism, and to encourage appointment follow-up in the community, with early enrollment into an MCO, prerelease visits, medication assisted treatment if indicated, peer supports, and a 30-day supply of their prescriptions on release. There is also a federally mandated youth reentry program for youth up to age 21 or age 26 if the youth was formerly in foster care. The program has certified nurse case management and provides screening and diagnostic or preventative screenings and care. If the youth qualifies for both benefits, they are entitled to use both benefits. The adult program was started before the youth program was mandated, so the infrastructure was already in place.

The final slide shows early indicators of how program is going. There is a rolling cohort of 267 individuals with somewhat complete data. 78% are still in the community. Of the 154 in the community, 51% are employed. They have routine meetings with Department of Corrections, the participants value the outreach and having a dedicated point of contact, increasing their confidence in being able to get to medical appointments. There is a strong partnership with the community mental health centers. The first releases were April 2025.

The Department sent the program leader to the national CMS conference, where they were on a panel and got a lot of positive feedback from CMS staff and others. We were the first to have data so it was exciting for CMS staff. Our Medicaid team is the most engaged in the country. We have statistics from before the program began, and we are now looking for the right comparison group. The statistics are definitely a higher percentage than a broader group of incarcerated individuals. This is a very high-risk population, which is why they were targeted. Rep. LaMontagne asked if all inmates eligible to apply for Medicaid upon release. A: They might have been enrolled prior to incarceration, or they might have become eligible while incarcerated, but they cannot be enrolled while they are incarcerated. This program allows them to start the re-enrollment process prior to release, rather than after release. The re-enrollment allows the provision of a 30 day supply of medications upon release, along with their Medicaid card and contacts for ongoing treatment. They must also choose to enroll in program, which helps create efficiencies in the overall enrollment process. Rep. Weber asked if this also saves money for the counties. A: Yes. The adults enrolled are from the state Department of Corrections; none of the county jails have had the program rolled out yet. The counties are going to be rolled out by end of this calendar year, starting with Merrimack, by the end of end of the month. Counties can choose to opt out. They might not choose to do it if too few people enroll. Ch. Pearson asked Ms. May about her background. A: Ms. May has been with the Department for four years. She was the DHHS Director of Medicaid Enterprise Development,

and prior to that, she was a consultant to CMS, and before that, she was on the MCO side. She is originally from Virginia, and has a Master's Degree in Public Health.

Health Care Acquired Infections Report Update – Katrina Hansen, Administrator, Division of Public Health Services, New Hampshire Department of Health and Human Services, and Darlene Creck, Infectious Disease Control:

The full report, which was lengthy, was provided electronically. The goal is the reduction of health care infections, and making data available to the public. The report covers infections that are acquired in an institution while the patient is being treated for something else, as for example, an infection following a knee surgery. The reports are used for quality initiatives , health care transparency, and patient health care discussions.

All NH hospital report data regarding infections following surgical procedures, infections caused by bacteria, and personnel vaccination rates. NH hospitals have fewer incidents as compared to national data. There were 100 infections reported in hospitals and 187 bacterial infections. These are both lower than national data. Personnel vaccination rate was 90.4% vaccinated, down from 91% the year before still above goal. For ambulatory surgery centers, 9 facilities reported infections following surgical procedures and practices put into place to protect patients. This is an increase in infections compared to national data and compared to past year. Vaccination coverage for these facilities was coverage 85.7, up from prior season. For dialysis centers, the reporting was higher than national data, and up from the prior year. This is an opportunity to look at mere prevention measures. Certain facilities had higher rates of infection which drove the numbers up. Vaccination rates ranged from 38% to 90.9 percent.

Long term care facilities reported influenza vaccines at 47.2% which is a decrease from the prior year at 50.1%. The facilities also report investigations of infections which nearly doubled from the prior year due to super bugs—antibiotic resistant organisms. In 2024, there were 211 investigations, up from 105 in the prior year. They have put significant effort into investigation, coordination with institutions, and patient follow up. They also provide on-site assessment and training. They must also report their operating budget to this committee: in 2024, it was $373,909. Several core and supplemental grants were received, so no fees were assessed to the facilities due to receipt of those federal funds. In the next year, they be offering training on how to report data due to staff turnovers. They will be reaching out to facilities with higher infection rates about instituting quality improvements. They also respond to drug diversion events and infection control breaches. They will continue to offer training to rural areas of the state.

Sen. Rocheford asked if Medicaid has claw-backs similar to Medicare due to infection rates. The fee system was established around 2013 to support operating costs of program staff based on beds, procedures, or flat rate for dialysis, not based on infection rate or punitive measures.

They are not tied to infection rates. NH has not had to pay fees since 2017 because of success obtaining federal grants. Rep. Mooney asked about the 128 investigations—are there any common sources or targeted areas to be addressed? A: It is mostly antibiotic-resistant bacteria and primarily driven by that. There are also suspected drug diversion events. That reporting started after 2012 Hepatitis C outbreak due to drug diversion. There is maybe one event per year. There are also events like improperly sterilized equipment or needle sticks, where they try to rule out harm, and have the appropriate notifications to patients for appropriate follow-up. Rep. MacDonald asked about transmission when everything is carefully sterilized. A: For antibiotic-resistant bacteria most transmission is not in sterile environment, but in patient care environment, mostly at health care touch points, providers and bedside surfaces. Are there cases of negligence? A: There are gaps in infection prevention, in certain cleaning procedures one must keep surfaces wet longer for transmission control to be effective. Also handwashing gaps. They do recommendations, and trainings for providers—for the whole range of providers, not just the direct care providers. Rep. Woods asked is the data sufficiently granular to identify MERSA or TB outbreaks? A: That falls under other reporting laws. They do keep data for specific organisms, but don't have all of the most specific data.

RSA 126-A:79 NH Rare Disease Advisory Council Annual Report – Mary Beth Dinulos, MD, Dartmouth Health, Chair; and Courtney Keane, MS, Bureau Chief, Family Health and Nutrition, Division of Public Health Services, New Hampshire Department of Health and Human Services:

Dr. Dinulos is a medical geneticist presenting the annual report of the Council. For an overview, there are over 10,000 rare diseases affecting 20-30 million Americans. The National Organization for Rare Disorders initiated the Rare Disease Advisory Councils (RDAC). NH was the first RDAC in New England. The NH Council is twelve appointees including two Representatives and one Senator. They meet monthly in hybrid meetings with a set agenda, to get legislative updates, and consider newborn screenings sudden death in the young and telehealth. Telehealth is important for the rare disease community, because they don't want to be exposed to health threats in big health centers. Telehealth allows for expert treatment from afar for diseases where they do not have the expertise in our state. The Council advises the legislature and the Department on rare diseases. They have an Excel spreadsheet created for bills coming up so they can monitor those related to rare diseases. The spreadsheet is updated weekly. Members have provided testimony on important bills on telehealth, on updating the RDAC membership and on stopping the required rotation off after 6 years. All meetings are open to public and they have good public attendance. A big one was step therapy put forward by Dr. Nagel. The Right to Try bill was important for those with life-threatening illness. The next grouping is how they interact with regional and national organizations such as NORD and New England organizations via regular emails to keep up with what other RDACs are doing. Dr. Dinulos spoke at the RARE New England meeting in 2025 about our RDAC and meaningful

change. Lots of people thanked them for having an RDAC as not every state does. She also spoke at a national medical geneticist meeting, and it turned out that some geneticists did not know about RDACs, so they are spreading the word about what we are doing in NH.

The next charge is encouraging public health awareness. Their membership does a lot to make NH aware. They do public service announcements for Rare Disease Day, Feb 28. They get word out via radio, television and lighting the Memorial Bridge in Portsmouth to increase awareness about rare diseases.

The Council has a Sudden Death in the Young committee. This is a collaboration between DHHS, the CDC, and the University of Michigan Biodepositiory. They discuss sudden and unexpected deaths with a whole range of folks from police to medical professionals. There are intrinsic and extrinsic factors leading to sudden death in infants. Intrinsic reasons can be genetic or other internal conditions. Extrinsic factors include co-sleeping and too much bedding in the crib. They have concluded that 20-25% of kids who die unexpectedly die from genetic predisposition. They decided to try epilepsy panels and cardiology panels. This year they proposed using Dartmouth Health rather than outsourcing this work to Massachusetts. They call it a molecular autopsy to see if genetics contributed to the death. The Medical Examiner would not see this during an autopsy. Keeping the work in NH means the state can have access to the results. They want to have genetic counsellors specifically involved, to advise the family about gene changes and test at-risk relatives so no one falls through the cracks, and these services can be offered from Dartmouth.

Newborn Screening Program—Three new disorders were considered in the report. They voted to approve all three for a total count of 39 tests on newborn screening. This is important for robust newborn screening especially when there are new therapies to address the condition, and parents are not just left hanging out there. Confirmatory tests and immediate treatment protocols may be started, which is a major criterion for inclusion in the screening panel. This panel is in line with what other states recommend.

Rep. Mooney asked how rare diseases are defined. Do they ever fall out of the category? At a guestimate, maybe 1 in 10,000. She didn't know the exact answer. Rep. MacDonald asked How many rare diseases there are. A: There are more than 10, 000 diseases affecting 20-30 million Americans.

SFY 25 Child Fatality Review Committee Annual Report – Josephine Porter and Angie Raymond LeDuc, Co-Chairs of the Child Fatality Review Committee and Courtney Keane, MS, Bureau Chief, Family Health and Nutrition, Division of Public Health Services, New Hampshire Department of Health and Human Services.
The role of the Committee is to review key data and develop recommendations for systemic changes to keep children safe. The data leads to targeted strategies to keep children safe. 114

children died in NH before reaching their 21st birthday in 2024. This is a long-term decline, but the number has remained steady since 2022. NH is consistently lower than the national average across age groups. In NH, the rate is 35 per 100,000 versus 53 per 100,000 nationally. Infant mortality continues to fall with 34 deaths in 2022, compared with 84 deaths in 2000. In children 0-14, the deaths are mostly from natural causes. For youths 15-21, the majority of deaths are intentional or unintentional injuries.

Data suggests interventions should include driver safety interventions, suicide prevention and mental health interventions, substance use prevention ,and harm reduction efforts.

Areas of significant concern remain and are detailed on page 18 of the report. In FY 2025, 15 detailed reviews were conducted. The purpose of a review is to recommend actionable prevention strategies. Motor vehicle crashes are the highest cause of preventable death, so seatbelt use, and impaired driving and driver safety programs should be targeted. Suicide prevention is also urgent so warning signs are recognized. Removal of lethal means and active safety planning are important.

In the area of storage of high-risk substances and accidental overdone, they emphasize safe storage arrangements. Homicide reviews suggest work on adverse childhood experiences, strengthening services for victims of violence, expanding culturally responsive mental health supports, grief support and increasing public awareness of both suicide and violence warning signs. There is need for grief support and family services. There were two recreational fatalities in state parks, suggesting that helmet use and refraining from substance use are key. An enhanced injury prevention program that actively engages youth would be a benefit.

Rep. Mooney asked in ages 15-21 where does opioid/illegal drug use come in? A: That is in the unintentional category.

The Chair then took up the questions left over for Assoc. Comm'r. Landry. With respect to Medicare, there are certain reimbursement tools when infection rates rise or there is post-discharge infection. Does Medicaid have the parallel claw-backs as related to infections? She will bring the question back to Director Lipman, but MCO contracts may not make payments for hospital acquired conditions. Medicaid doesn't do claw-backs, like Medicare. The assumption is that the institution should be responsible for treatment regardless of reimbursement. Rep. LaMontagne asked about a revolving fund to cover the time of presumptive eligibility for long term care, which sometime takes up to 18 months to get through the process. What is the Department doing to speed up process? A: There is an ongoing Department initiative to speed up the process and make it easier, including interpretation of Fed requirements in this area.

Rep. Weber noted there was a mention at a prior meeting that there is an effort to make the detail required in the lookback period less granular with respect to the transfer of assets. Is

there a move in the direction of not looking as hard at the smaller details? A: This is one of the areas being looked at. If everything looks in order at a certain point, how much further do you have to go. They are looking at standardizing an algorithm for determining if all looks okay for 36 months, you would have discretion not have to go back the full five years with every single bank statement. Mr. Williams referred to the bill to create the revolving fund, funded with a dollar. They have been working on turning around the determination time. They do now look back 36 months, and can avoid the fill 5 years if all looks okay. Senator Rocheford commented that there has been significant work on the look back period. There are case managers in each facility to help with that. There are calls with the Department to have the ducks in a row. When that happens, they can process the application pretty quickly. The issue is when families must produce records for parents with dementia or other issues and the facilities cannot control that. The fund was to make the facilities able to draw down to offset costs of care and pay the fund back when the determination is retroactive. They had the bill a year ago, and brought it back to fund with $1 just to get the process started.

Dr. Dinulos clarified that a rare disease is defined as a single medical condition affecting fewer than 200,000 people in the United States.

The next meeting is set for Apr 17th at 9:30 a.m. The meeting was adjourned at 11:08 a.m.

Respectfully submitted,

Lucy Weber, Clerk.

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