Health and Human Services Oversight Committee

Friday, June 26, 2026 at 9:30 a.m.

Granite Place Room 158

Present: Senators Long and Rochefort, Representatives Pearson, Mooney, MacDonald, Seaworth, Woods and Weber.

The minutes of the May 29, 2026 meting were moved, seconded and approved unanimously.

Informational update on behalf of the Commission for the Deaf and Hard of Hearing—Role of ASL Interpreters for Access to Critical Programs and Services—Representative Gary Woods and Associate Commissioner Ann H. Landry: The ASL program administered by UNH Manchester is the first fully accredited program in the nation. However, tuition is so high that only 2 of 20 places have been signed up, so the program's viability at UNH Manchester is in question. What will be the significance to the state of we lose the program? Rep. Woods has met with the staff and Dean, and there is engagement behind the scenes to explore the concept of how to perpetuate the program under another leadership. The downside, if the program cannot continue, is loss of services to the judicial system and other required ancillary service and programs.

Associate Commissioner Landry confirmed there is high need for interpreter services in the state. DHHS needs services in all programs for compliance with civil rights laws. There is a great need to have more educated interpreters. Rep. Pearson noted the large number of different programs are required by law to have interpreters, including court cases and governor's speeches. We are not fully compliant currently, but it will be far worse if the program vanishes. The program is a four year baccalaureate program interspersed with labs and practice, with 2 to 10 or 12 graduates per year. If the current class does not fill, students in years 2, 3 and 4 will finish, but no new students will be admitted. Rep. Pearson asked if people were adequately trained by churches that have sign language programs, could they fill in? A: Uncertain, but the requirements are fairly stringent. High schools have feeder programs into the college program, so there is lots of outreach in place. There is a certification board and a review board separate from the university program. Rep. Woods is looking at a separate review of the overlapping RSAs. Sen. Rochefort asked if the community college system might be a better tuition bargain. A: If we can get around the degree program the community colleges would be a natural landing spot. That is being explored.

DHHS Commissioner's Update:

SB 134, 18 Laws of 2026, Work Requirements under the State Medicaid Program –Committee Review and Approval required per RSA 126-AA:6, V—Associate Commissioner Ann H. Landry

DRAFT

and Olivia L. May, Deputy Director, Division of Medicaid Services: Rep. Pearson explained that SB 134 sets out our state priorities, and the federal government has set new interim final rules, and there are some issues between the two. A collaboration has occurred between the Department and the legislature, and a presentation was made to the fiscal committee on the changes that are needed to comply with federal rules and more changes were made. Voting on those changes was delegated by statute to this committee in light of the legislative schedule. Assoc. Commissioner Landry and Director May presented the issues to be voted on, based on the document provided to the committee members in advance.

The summary document and accompanying slide deck were reviewed by Director May. The issues of timing were reiterated. The federal final rule regarding work requirements was published June 1. There is a lot of alignment between our SB 134 and the final rule. Three topics need to be addressed to align state stature and interim federal rule.

The first topic is the short-term hardship exceptions in the final rule, and all or none of these exceptions must be adopted. The four exceptions are 1) individuals receiving in-patient or institutional services, 2) individuals living in a county for which an emergency has been declared, 3) individuals living in a county where the unemployment rate is over 8% or exceeds 1.5 times the national average, and 4) individuals travelling out of state to receive serious or complex medical treatment which is unavailable in their community. The first item is the most important for NH, but we must adopt all if we want to adopt that one. In discussions with Director Lipman, it will be possible to distinguish complete non-compliance from cases which, though non-compliant, require compassionate measures. Currently, no county comes close to meeting the standard for exception #3 the unemployment rates. The emergency declaration is one declared by the President, and is tied to the declared emergency event. With respect to extensive periods of travel time, the state would have some ability to define that more clearly, but it would be tied to that episode of acute care need requiring out of state treatment. Intermittent outpatient visits would not qualify. Rulemaking can clarify using the federal parameters to ensure that those who need exceptions get them, and those who do not, do not. The Chair asked that proposed ruled be presented to the committee as well as JLCAR. The Department is aiming to present rules to JLCAR by December and this complies with federal timelines. There is no need to put the rulemaking authority in statute, it is already there. Rep. Weber moved adoption of these exceptions as written, Rep. MacDonald seconded, and the exceptions were approved unanimously by roll call vote.

The second issue is the policy election for the cycle of assessment and verification of compliance with work requirements. The proposal is to assess for one month within every six months. In 2027, the policy reassessments will be every 6 months rather than annually. The risk of requiring verification more often is that the work of verification may overlap into the next

verification period, and this puts the Department of not being able to deal effectively with those who are truly non-compliant, given requirements for notice and response, etc., which takes about three months. The one month determination within the six month period can be aligned with the six month redetermination requirement, which allows closure at the end of the six month period if compliance cannot be demonstrated. In practice they will be looking at available data from Employment Security for verification. Indiana had to hire 400 more people to do a more in-depth verification, which would imply that NH would need 40 or so new positions for our population. For some, documentation becomes a real hurdle even when they are, in fact qualified, so any way of simplifying the process is appreciated. If this piece passes, we do not need to seek a federal waiver in addition. Rep. Weber moved adoption of the assessment and verification policy as written, Rep. MacDonald seconded, and the exceptions were approved unanimously by roll call vote.

The third issue is to align our method of determination of frailty to the approach allowed in the federal rule and adjust the algorithm used to assess frailty. Dr. Jonathan Ballard, Chief Medical Officer at DHHS, explained the conditions that are categorically excepted by federal law. The conditions are blind; actively treated substance use disorder; a disorder, mental, physical or developmental, that seriously impairs activities of daily living,; or serious or complex conditions, and a pragmatic approach is being proposed, to determine a significant impairment of the individual's ability functionally to comply with the work requirement. The use of ex parte data and a data-driven approach is required. Claims data shows a condition, but not the level of underlying functionality. Some stand-alone conditions are automatic, such as stage 4 cancer. Others can be determined by the need for treatments such as infusions and radiation. The requested approach is to use the claims data for the next year, and ask under the pains and penalties of perjury if their health care provider has verified they have a disability, and then take the time to fine-tune the algorithms going forward after the first year. The goal is to be able to use reliable automated data as much as possible. There will always be cases where an individual will need to supply additional data as to their specific abilities or lack of abilities. The Department does not have the resources to make individual assessments in all cases, which is why this pragmatic approach has been proposed. This is the approach suggested by the interim final rule. 2027 is a rollout, but in 2028 the Department is building interfaces between the eligibility system and MMIS, the Medicaid Management Information System, the claims platform which connects to MCOs and provider networks, pharmacy managers, etc. so the clinical data will be available to the eligibility system to match criteria, so that individual would not need to take further action to verify. Rep. Weber moved adoption of this approach as written, Rep. MacDonald seconded, and the exceptions were approved unanimously by roll call vote.

DRAFT

Medicaid Dental Update—Dr. Barry Chang, Medicaid Dental Director, and Olivia L. May, Deputy Director, Division of Medicaid Services. Rep. Pearson reviewed the legislative history of the benefit. Then the slides provided to the committee on the Medicaid Dental benefit were reviewed in detail by Dr. Chang. There are currently 217 unique providers in the adult program, some outside NH borders. There are now two mobile vans, five days a week, visiting 15 mobile sites in all NH counties. The vans now serve about 5500 members with preventive, restorative and extractive services. Over 30,000 individuals have been served by the program to date. Emergency room dental services have decreased since the program began, but overall emergency room use has increased. There is outreach for those using ED for non-emergency care, to divert to appropriate level of care. There is a 24/7 teledentristry coverage for those who cannot travel. The number of dentists providing services is better, but availability is still an issue, and we need some more specialists. Patient access is up 22% this year, but there is more to be done in growing the network. There has been some churn in the numbers of providers, but only about 15 terminations for reasons other than retirements, moving out of state, etc. Oral surgeons are down from 19 to 15. They are actively recruiting. Dental lab fees are skyrocketing, so they are increasing reimbursement. One of the goals of the Rural Transformation grant is to increase the number of residencies in NH, and they are looking at other incentives. They are looking at dental hubs and other options but the direction is not clear yet.

SB 127 (2023) Health Status of Rural Residents Triennial Report—Danielle H. Hernandez, Administrator, Division of Public Health Services: Administrator Hernandez reviewed the packet of information provided to the committee. The mission is to strengthen access to health care in underserved areas of the state, which are generally rural areas. It aligns well with the Community Health Needs Assessment. Using primary care measures are the best way of assessing the health care of rural residents. The data is reported at the public health region level, not county boundaries. There are 13 regions in 10 counties.

Rural classifications are aggregated towns or counties in public health regions, using a population based approach. The rural status is determined by the largest share of the assigned population. Rural regions consistently demonstrate more burdens on health care. North Country and Winnipesaukee are consistently more burdened. Substance use hospitalization is an exception as it is concentrated in Greater Manchester. The Upper Valley is also an outlier with better rates than other regions.

Demographic and socioeconomic characteristics are compared across rural and non-rural areas. Rural areas are more likely to have higher rates of the following risk factors: disability, veteran status and financial barriers, and less likely to have a four year college degree or higher. By public health region, the differences can be over 100% at the public health region level

DRAFT

depending on rurality. Sullivan and Winnipesaukee report higher rates. There are pages of more detail in the report itself.

Travel times are longer in rural areas. There is less primary care utilization and greater barriers to internet access and transportation. The regions are listed individually on the tables. The North Country has benefitted from significant workforce investment because of federal designation as a shortage area. Upper Valley has exceptionally high rates of access, despite its rurality, and therefore pulls the averages up, and masks the shortage of access.

Health care utilization and preventive care rates are lower in the more rural regions. Lead testing levels are an example. Gaps in acute and preventative dental care lead to more hospitalizations for preventable dental conditions. EDs are accessed more often for convenience due to low primary care availability.

The slides tell us in great detail the "what", but not the "how" or the "why." In areas with the highest rate of Medicaid use, high rates of ED use also result in more expense.

For health care outcomes by rurality, childhood blood lead levels remain comparatively high. Late-stage breast cancer diagnoses may indicate lack of access to timely screenings regionally. The death rate (age-adjusted number of deaths per year per 1000 population) is statistically higher and the life expectancy is statistically lower.

Maternal health: Rural regions have higher rates of smoking during pregnancy and higher rates of post-term delivery. North Country has significantly higher rates of teen births than all other regions.

Substance abuse: Rural areas have lower rates of substance use treatment, though not necessarily lower rates of substance use.

Mental Health: Rural residents have higher rates of self-inflicted harm ED visits than non-rural areas. Suicide rates are also higher, but the relatively small numbers limit the statistical usefulness.

The office makes a concerted effort to work with other entities throughout the state to determine the "how" and the "why" as a collaborative effort.

The office also analyzes provider supply rates. Physicians are leaving rural areas. There will be utilization of urgent care versus ED visits overlays in the future. Concern was also expressed about areas where care was available, but not covered by the specific health insurance available for that area.

Primary care is not limited to physicians; we are gaining APRNs.

The next meeting will be held on August 28th 2026 at 9:30 a.m. in Granite Place room 158.

DRAFT

Meeting adjourned at 11:42 am.

Respectfully submitted,

Lucy Weber, Clerk

DRAFT