TITLE X
PUBLIC HEALTH

Chapter 126-A
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Section 126-A:1

126-A:1 Declaration of Purpose. – The purpose of this chapter is to provide an integrated, administrative structure for the design and delivery of a comprehensive and coordinated system of health and human services which is family-centered and community-based for the citizens of New Hampshire.

Source. 1995, 310:1, eff. Nov. 1, 1995.

Section 126-A:2

126-A:2 Definitions. –
In this chapter:
I. "Commissioner" means the commissioner of the department of health and human services.
II. "Department" means the department of health and human services.

Source. 1995, 310:1, eff. Nov. 1, 1995.

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(a) [Repealed.]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.
III-a. (a) Pharmacists shall be considered providers under RSA 126-A:3, III for the purpose of billing for providing services performed within the scope of a person's license when said service would have been covered under this section if furnished by a physician or as an incident to a physician's service, or furnished by a physician assistant or an advanced registered nurse practitioner.
(b) The commissioner shall submit a Title XIX Medicaid state plan amendment to the federal Centers for Medicare and Medicaid Services to implement this paragraph, if necessary.
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. 2021, 189:1, eff. Jan. 1, 2022.

Section 126-A:4

126-A:4 Department Established. –

I. There shall be a department of health and human services under the executive direction of a commissioner of health and human services, which department shall be organized to provide a comprehensive and coordinated system of health and human services as needed to promote and protect the health, safety, and well-being of the citizens of New Hampshire. Such services shall be directed at supporting families, strengthening communities, and developing the independence and self-sufficiency of New Hampshire citizens to the extent possible.

II. The commissioner shall have authority to establish, reorganize, or abolish such divisions, offices, bureaus, or other components of the department as may from time to time be necessary to carry out the mission and duties of the department. The commissioner shall make a quarterly report on the progress of the reorganization to the governor and the fiscal committee beginning with the quarter ending March 31, 1996.

II-a. [Repealed.]

II-b. [Repealed.]

III. The department shall establish an office of the ombudsman to provide assistance to clients of the department by investigating and resolving complaints regarding any matter within the jurisdiction of the department including services or assistance provided by the department or its contractors. The ombudsman's office may provide mediation or other means for informally resolving complaints. The records of the ombudsman's office shall be confidential and shall not be disclosed without the consent of the client on whose behalf the complaint is made, except as may be necessary to assist the service provider to resolve the complaint, or as required by law.

IV. The department may establish a quality assurance program.

(a) Any quality assurance program may consist of a comprehensive ongoing system of mechanisms for monitoring and evaluating the appropriateness of services provided to individuals served by the department or any of its contract service providers so that problems or trends in the delivery of services are identified and steps to correct problems can be taken.

(b) Records of the department's quality assurance program including records of interviews, internal reviews or investigations, reports, statements, minutes, and other documentation except for individual client medical records, shall be confidential and privileged and shall be protected from direct or indirect discovery, subpoena, or admission into evidence in any judicial or administrative proceeding, except as provided in subparagraphs IV(c) or (d).

(c) In a case of legal action brought by the department against a contract service provider or in a proceeding alleging repetitive malicious action and personal injury brought against a contract service provider, the quality assurance program's records may be discoverable.

(d) The department may refer any evidence of fraudulent or other criminal behavior gathered by the quality assurance program to the appropriate law enforcement authority.

(e) No employees of the department or employees of a contract service provider or vendor shall be held liable in any action for damages or other relief arising from the providing of information to a quality assurance program or in any judicial or administrative procedure relating to the department's quality assurance program.

V. (a) The department shall collect relevant demographic data concerning the projected increase in the population of New Hampshire that is 65 years of age or older and analyze the impact of such data and projections over the period through 2025 on the economic, social, and governmental systems within New Hampshire, including health care, housing, transportation, business, employment, the economy, and the state budget.

(b) In the development and analysis of the demographic data and projections, the department:

(1) May request and shall receive the assistance of all other state agencies, including the office of planning and development, and the departments of transportation, administrative services, and business and economic affairs.

(2) Shall solicit assistance and input from representatives from the general court, business and industry, service providers, consumer and advocacy groups, and members of the general public.

(c) The department shall report on or before November 1, 2001 and thereafter on or before November 1 in odd-numbered years to the governor, the president of the senate, and the speaker of the house relative to the progress of its efforts under this paragraph and such report shall include recommendations for legislation. The final report shall be submitted on or before November 1, 2007.

Source. 1995, 310:1. 2001, 152:2, 286:3. 2003, 319:9. 2004, 257:44. 2012, 110:1, I, eff. May 29, 2012. 2017, 156:14, II, 64, eff. July 1, 2017. 2021, 91:198, eff. July 1, 2021; 122:8, eff. July 9, 2021.

Section 126-A:4-a

126-A:4-a Health Care Plan Report Required. – The department of health and human services is responsible for activities to improve and protect the health and well-being of citizens of the state of New Hampshire. A part of such activities is an assessment of the health status of the residents of New Hampshire. The department shall continually conduct such an assessment and shall issue a report thereon to the governor, the president of the senate, and the speaker of the house every 2 years commencing on December 31, 2000.

Source. 1999, 324:1, eff. Sept. 14, 1999.

Section 126-A:4-b

126-A:4-b Medicaid Waivers. –
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.

Section 126-A:4-c

126-A:4-c Family Planning Waiver. – The department shall develop a Medicaid waiver to support the extension of Medicaid-allowable family planning services, as defined in the state's Medicaid plan, to Medicaid-eligible clients. The department shall present the proposed waiver design, including proposed coverage groups and budget neutrality calculation, to the fiscal committee of the general court prior to submission of a final concept paper to the Centers for Medicare and Medicaid Services (CMS) for federal approval. The department shall provide periodic reports to the fiscal committee of the general court and the standing committees of the house of representatives and state senate with authority over health and human services issues throughout the waiver development, approval, and implementation processes. The department shall seek input from health care providers and the public in the course of developing the waiver. The department shall ensure that the state realizes the enhanced 90 percent federal Medicaid match available for these services and ensure that budget neutrality is maintained or exceeded through the 5-year life of the waiver. The department may contract with an independent third party on an annual basis for the life of the waiver to evaluate the clinical and financial outcomes of the waiver. A report shall be made to the fiscal committee of the general court and the standing committees within 6 months of the end of the first full year of waiver implementation and subsequently on an annual basis.

Source. 2007, 247:1. 2012, 247:18, eff. Aug. 17, 2012.

Section 126-A:4-d

126-A:4-d Repealed by 2009, 144:28, eff. July 1, 2009. –

Section 126-A:4-e

126-A:4-e Medicaid Hospice Benefit. –
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:4-f

126-A:4-f Repealed by 2020, 37:4, VII, eff. July 29, 2020. –

Section 126-A:4-g

126-A:4-g Children's Oral Health Initiative. –

I. The department shall seek funding for a Medicaid children's oral health initiative program as part of the department's budget for the biennium ending June 30, 2013, and each biennium thereafter. The program shall provide reimbursement to primary care providers who deliver preventative oral health services, such as dental screenings and fluoride varnish treatments, to children between 0 and 3 years of age enrolled in the state Medicaid program. Primary care providers who choose to participate in the program shall complete training approved by the department and submit evidence of program completion to the department, which shall maintain a list of trained providers. Program implementation, including adoption of rules required by paragraph II, and submission of a Medicaid state plan amendment as required by paragraph III, shall be contingent upon sufficient funding.

II. The commissioner shall adopt rules under RSA 541-A relative to administration of the children's oral health initiative, including eligibility criteria, the type and frequency of services covered, reimbursement rates, and provider training requirements. The department also shall develop a list of approved training programs, which shall include, but may not be limited to, those offered by the American Academy of Pediatrics and the Southern New Hampshire Area Health Education Center. Upon implementation of the program, the department shall provide, upon request, a list of dentists participating in the state Medicaid program to primary care providers in the oral health initiative.

III. The department shall submit a Title XIX Medicaid state plan amendment to the Centers for Medicare and Medicaid Services for the purpose of establishing the children's oral health initiative.

Source. 2010, 76:1, eff. July 18, 2010.

Section 126-A:4-h

126-A:4-h Repealed by 2011, 224:299, eff. July 1, 2014. –

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. [Repealed.]

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 model shall reimburse pharmacists for services described in RSA 126-A:3, III-a. 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. (a) 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, the governor, and the office of the child advocate established in RSA 21-V. 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.

(b) As part of the annual report required by this paragraph, the commissioner of the department of health and human services, in conjunction with the commissioner of the department of education, shall issue a joint report on the implementation of 2019, 44 (SB 14), relative to child welfare. This portion of the report shall address in detail the implementation status of each section of 2019, 44 (SB 14) and include all information related to progress toward full implementation of a system of care under RSA 135-F. The report shall also address the following:

(1) The total cost of children's behavioral health services.

(2) The identification of barriers and service gaps in the array of children's behavioral health services, along with a description of efforts and plans to fill those gaps.

(3) The availability of mobile crisis and stabilization services in each part of the state and plans to fill any gaps.

(4) Changes to statutes, administrative rules, policies, practices, and managed care and provider contracts which will be necessary to fully implement the system of care.

(5) Shortfalls in workforce sufficiency affecting full implementation of the system of care as well as efforts and plans for addressing those shortfalls.

(6) Numbers of children and youth awaiting services in various categories.

(7) Plans to coordinate the system of care with existing efforts addressing early childhood interventions, primary prevention, and primary care integration.

(8) Plans to develop and/or coordinate a cross-system assessment tool and data collection system to measure outcomes, including but not limited to status upon exit from the system of care, measured treatment results, recidivism, and other returns to the service system.

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. 2021, 91:395, eff. July 1, 2021; 122:9, eff. July 9, 2021; 189:2, eff. Jan. 1, 2022.

Section 126-A:5-a

126-A:5-a Access to Budget and Expenditures for Persons Receiving State Services. – The commissioner of the department of health and human services and the area agencies shall provide to any person, or that person's guardian, who is receiving state services pursuant to a plan with an individualized budget, a copy of such budget and the expenditures made under such budget.

Source. 2013, 144:108, eff. July 1, 2013.

Section 126-A:5-b

126-A:5-b Repealed by 2014, 3:12, V, eff. Dec. 31, 2018. –

Section 126-A:5-c

126-A:5-c Repealed by 2018, 342:24, IV, eff. Dec. 31, 2018. –

Section 126-A:5-d

126-A:5-d Repealed by 2018, 342:24, V, eff. Dec. 31 2018. –

Section 126-A:5-e

126-A:5-e Repealed by 2016, 13:15, eff. Dec. 1, 2017. –

Section 126-A:5-f

126-A:5-f Status in Retirement System. – For purposes of classification under RSA 100-A, any person who is or becomes the bureau chief for emergency preparedness with the department's division of health public services, shall be included in the definition of group II under RSA 100-A:1, VII(h) and VIII(c) under the retirement system, provided that, notwithstanding RSA 100-A:1, VII(h) or VIII(c), any person not already a group II member for at least 10 years during or prior to his or her appointment shall be eligible for or remain as a group I member for the duration of service as the bureau chief for emergency preparedness.

Source. 2021, 122:10, eff. Sept. 7, 2021.

Section 126-A:6

126-A:6 Department Administrator of Title XX Social Security. – Notwithstanding any other provision of law to the contrary, the governor shall designate the department of health and human services to administer the provisions of Title XX of the Social Security Act, Public Law 93-647, and the commissioner is hereby authorized to receive and distribute funds under said act.

Source. 1995, 310:1, eff. Nov. 1, 1995.

Section 126-A:7

126-A:7 Deputy Commissioner of Health and Human Services. – Subject to the approval of the governor and council, the commissioner of health and human services shall appoint a deputy commissioner who shall serve for a term of 4 years. The deputy commissioner shall perform such duties as may be assigned by the commissioner, which may include, but not be limited to, the authority and power with approval of the commissioner to direct and supervise the operation and administration of any division of the department. The annual salary of the deputy commissioner shall be as prescribed in RSA 94:1-a.

Source. 1995, 310:1, eff. Nov. 1, 1995.

Section 126-A:8

126-A:8 Acting Commissioner; Appointment. – The commissioner of health and human services may appoint one member of the commissioner's staff who shall act in the commissioner's stead when the commissioner is absent from the state and at such other times as directed by the commissioner. When acting for the commissioner such person shall have all the power, duties, and authority of the commissioner.

Source. 1995, 310:1, eff. Nov. 1, 1995.

Section 126-A:9

126-A:9 Positions Established; Staffing. –

I. There shall be established within the department the following unclassified positions, in addition to existing unclassified positions and positions established in paragraph II of this section.

(a) Subject to the approval of the governor and council, the commissioner of health and human services shall appoint a deputy commissioner and 3 associate commissioners, each of whom shall serve for a term of 4 years and shall perform such duties as may be assigned by the commissioner. Each appointee shall be qualified by reason of professional competence, education, and experience for his or her position. Any vacancy shall be filled for the unexpired portion of the 4-year term in the same manner as the original appointment. The duties of one of the associate commissioners shall include oversight of the division for children, youth and families and assigned responsibilities of the department under RSA 170-G. The annual salary of the deputy commissioner and associate commissioners shall be as prescribed in RSA 94:1-a.

(b) [Repealed.]

(c) The commissioner shall appoint an unclassified mental health medical supervisor who shall perform such duties as may be assigned by the commissioner. These duties shall include, but not be limited to, collecting and reporting information regarding patients in need of high acuity mental health treatment and information regarding treatment options. The mental health medical supervisor shall be clinically qualified to assist in the triage for appropriate inpatient, partial hospitalization, and/or community based services. The mental health medical supervisor shall be a psychiatrist or psychiatric nurse practitioner licensed or qualified to practice in New Hampshire. The salary of the mental health medical supervisor shall be determined after assessment and review of the appropriate temporary letter grade allocation in RSA 94:1-a, I(b) for the position which shall be conducted pursuant to RSA 94:1-d and RSA 14:14-c.

II. (a) [Repealed.]

(b) The commissioner shall appoint a person to each position established pursuant to subparagraph (a). Any vacancy shall be filled in the same manner as the original appointment. The annual salary of such unclassified employees shall be as prescribed in RSA 94:1-a. The provisions of RSA 21:33-a shall not apply to appointments made under this subparagraph.

(c) Each person appointed under subparagraph (b) shall serve subject to the following provisions:

(1) The commissioner, at any time, upon written notice to the employee, may terminate the appointee from the position for either:

(A) Good cause, which shall include, but not be limited to malfeasance, misfeasance, or insubordination; or

(B) The abolition of a position because of a change in organization, lack of work, unappropriated or insufficient funds, or like reasons.

(2) Within 10 days after receipt of the notice of the termination, the appointee may appeal the termination in writing to the commissioner.

(3) Within 20 days of receiving the notice of appeal, the commissioner shall conduct a hearing in accordance with RSA 126-A:5, VIII.

(4) Within 10 days after completion of the hearing process, the commissioner shall render a written decision. If the termination is reversed, the employee shall be reinstated to the same position and all pay and benefits lost during the time of the appeals process shall be restored to the appointee.

(d) Any positions that were established under this section and subsequently transferred to the department of information technology and become vacant may be filled by the commissioner of the department of information technology in the same manner as prescribed for the commissioner.

Source. 1995, 310:1. 2001, 158:109, II. 2008, 335:4, eff. Sept. 5, 2008. 2017, 156:191, 194, eff. July 1, 2017. 2018, 335:3, eff. June 25, 2018. 2019, 185:2, eff. July 10, 2019.

Section 126-A:10

126-A:10 Salaries. – The annual salaries of the commissioner of health and human services, deputy commissioner of health and human services, associate commissioner, division directors, and unclassified employees of the department shall be as prescribed by RSA 94:1-a.

Source. 1995, 310:1, eff. Nov. 1, 1995. 2017, 156:192, eff. July 1, 2017.

Section 126-A:10-a

126-A:10-a Repealed by 2015, 276:108, I, eff. July 1, 2015. –

Section 126-A:11

126-A:11 Medical and Scientific Research Information. –

I. Personal medical and/or other scientific data of any kind whatsoever obtained for the purpose of medical or scientific research by the commissioner or by any person, organization, or agency authorized by the commissioner to obtain such data shall be confidential and shall be used solely for medical or scientific purposes. Such data shall include, but not be limited to, all information, records of interviews, written reports, statements, notes, memoranda, or other data procured in connection with such scientific studies and research conducted by the department, or by other persons, agencies, or other organizations so authorized by the commissioner.

II. No hospital, sanitarium, rest home, nursing home, other person, or agency shall be held liable in any action for damages or other relief arising from the furnishing of personal medical and/or other scientific data to the department of health and human services or to the representative of an authorized medical or scientific research project.

III. Personal medical and/or other scientific data obtained by the department of health and human services or by an authorized research project shall not be admissible as evidence in any action of any kind in any court or before any tribunal, board, agency, or person.

IV. Personal medical and/or other scientific data shall not be exhibited nor their contents disclosed in whole or in part by any officer or employee of the department, or by any other person, except as may be necessary to further the study or research project to which they relate.

V. Any person who violates the provisions of this section by the unauthorized disclosure of any confidential medical or scientific data, in whole or in part, is guilty of a misdemeanor.

Source. 1995, 310:1, eff. Nov. 1, 1995.

Section 126-A:12

126-A:12 Small Claims. –

I. The commissioner may use funds accruing to the department of health and human services for the payment of small claims of $100 or less occasioned by non-insured personal loss or accidents due to the activities of the department. Any person claiming loss or damage due to the activities of the department in an amount of $100 or less may make application to the commissioner for payment. The application shall be filed within 60 days of the date the loss or damage is incurred. If the commissioner, upon investigation, is of the opinion that the loss or damage was caused as a result of the activities of the department, the commissioner shall make payment to the claimant from department funds.

II. Any person claiming loss or damage due to the activities of the department in an amount of less than $500, but greater than $100, may make application to the commissioner for payment of such claim. The application shall be filed within 60 days of the date the loss or damage is incurred. If the commissioner, upon investigation, is of the opinion that the loss or damage was caused because of the activities of the department, the commissioner shall submit a recommendation to the board of claims for approval of payment to the claimant from department funds.

Source. 1995, 310:1, eff. Nov. 1, 1995.

Section 126-A:12-a

126-A:12-a Prompt Payment Required. – The department shall pay health care providers, including dental providers, within 45 days of receipt of a clean claim for services rendered to medicaid recipients. For the purposes of this section "clean claim" means a claim for payment of covered health care expenses that is submitted to the department on the department's standard claim form using the most current published procedural codes, with all the required fields completed with correct and complete information in accordance with the department's published filing requirements.

Source. 2000, 274:1, eff. Jan. 1, 2001; 314:1, eff. Jan. 1, 2001.

Section 126-A:13

126-A:13 Oversight Committee; Establishment; Purpose. –

I. There shall be an oversight committee on health and human services consisting of the following members :

(a) Three 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.

(b)(1) Five members of the house of representatives, 3 of whom shall be from the health, human services and elderly affairs committee, and one of whom shall be from the house finance committee division responsible for the department of health and human services, appointed by the speaker of the house of representatives.

(2) 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 leader of the minority party of the house of representatives, shall be available to serve, at the request of the committee chairperson, as an alternate member for an absent committee member. An alternate member shall have full voting authority while serving for an absent committee member.

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. 2021, 211:3, eff. Aug. 11, 2021.

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.

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.

Section 126-A:16

126-A:16 Repealed by by 1995, 310:3, II, eff. Dec. 31, 1998. –

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:17-a

126-A:17-a Repealed by 2018, 298:2, eff. Nov. 1, 2020. –

Section 126-A:18

126-A:18 Primary Preventative Health Services. –
The commissioner shall:
I. (a) Develop primary preventive health services for low-income and underserved populations.
(b) Establish a network of primary care and family support services for children with chronic illness.
(c) Recruit and establish retention of primary care practitioners in rural communities and areas of high primary care needs.
(d) Provide technical assistance to communities, health care agencies, and primary care providers developing comprehensive care services.
II. On June 30, 1999, any unexpended funds appropriated for the purposes of this section shall lapse to the fund from which they were appropriated.

Source. 1995, 310:1, eff. Nov. 1, 1995.

Section 126-A:18-a

126-A:18-a Rate Setting for Home Health Services. –
I. The commissioner of health and human services shall adopt rules under RSA 541-A to establish a rate setting methodology which establishes unit medicaid reimbursement rates for home health services which reflect the average cost to deliver services. The commissioner shall consider the factors of economy, efficiency, quality of care, and access to care, in accordance with guidelines in federal regulations.
II. The department of health and human services shall annually on or before October 1 establish unit rates for home health services paid under medicaid which better reflect the average cost to deliver services.
III. The commissioner shall make a biennial report commencing on November 1, 2017 and thereafter before November 1 of odd-numbered years relative to the rates for home health services, to the speaker of the house of representatives, the president of the senate, and the chairpersons of the house and senate finance committees.

Source. 1997, 346:2, eff. Aug. 23, 1997. 2015, 259:17, eff. July 1, 2015.

Section 126-A:18-b

126-A:18-b Repealed by 2013, 80:1, eff. Aug. 18, 2013. –

Community Living Facilities

Section 126-A:19

126-A:19 Community Living Facilities. – The commissioner shall develop a statewide program of community living facilities for persons with developmental disabilities or mental illnesses. The commissioner shall be responsible for the selection, certification, and monitoring of such community living facilities in accordance with rules adopted by the commissioner pursuant to RSA 541-A. The commissioner shall also be responsible for prior approval of all individual residential placements and shall adopt rules relative to monitoring the care, treatment, and habilitation provided to all residents of community living facilities. Rates for enhanced family care residents shall be set according to the severity of the resident's disability. Placements of children shall be consistent with RSA 170-A, 170-C, and 170-E, as appropriate. Approval by the commissioner of an individual for placement in a community living facility shall be based on a finding by the commissioner that the community living facility is the least restrictive environment appropriate to the needs of the individual. "Least restrictive environment" means the facility, program, or service which least inhibits a person's freedom of movement, freedom of choice, and participation in the community, while achieving the purposes of habilitation and treatment.

Source. 1995, 310:1, eff. Nov. 1, 1995.

Section 126-A:20

126-A:20 Standards and Certification for Community Living Facilities. –
I. The commissioner shall adopt rules pursuant to RSA 541-A to govern the establishment and operation of community living facilities. The certification of community living facilities shall be based on these rules. Certification of such community living facilities shall be on a permanent, temporary, or emergency basis in accordance with these rules. No placements shall occur in the absence of such certification. The commissioner may withdraw certification at any time the commissioner has reasonable cause to believe that there exist violations of federal, state, or local law or of department rules adopted pursuant to RSA 541-A pertaining to community living facilities.
II. Certifications shall be subject to periodic review and renewal by the commissioner.
III. The commissioner of the department of health and human services, after notice and hearing, pursuant to rules adopted under RSA 541-A, may impose an administrative fine not to exceed $2,000 for each offense upon any person who violates any provision of this subdivision or rules adopted under this subdivision. Rehearings and appeals from a decision of the commissioner shall be in accordance with RSA 541. Any administrative fine imposed under this section shall not preclude the imposition of further penalties or administrative actions under this subdivision. The commissioner shall adopt rules in accordance with RSA 541-A relative to administrative fines which shall be scaled to reflect the scope and severity of the violation. The sums obtained from the levying of administrative fines under this subdivision shall be forwarded to the state treasurer to be deposited into the general fund.

Source. 1995, 310:1. 2003, 73:1, eff. Jan. 1, 2004.

Section 126-A:21

126-A:21 Standards for Fire Safety. – Notwithstanding RSA 153:5, 153:10-b, or any law to the contrary, the fire code applicable to single family dwellings, as defined in RSA 153:1, X, or, where applicable, single rental units in multi-unit dwellings, as defined in RSA 153:1, IX-a and VI, respectively, shall be the fire code applied by the state fire marshal and local fire departments to community living facilities housing 3 or fewer clients.

Source. 1995, 310:1, eff. Nov. 1, 1995.

Section 126-A:22

126-A:22 Rates for Community Living Facilities. –
I. The commissioner shall establish rates, by rules adopted under RSA 541-A, sufficient to provide a reasonable subsistence compatible with decency and health for persons in placement under this program. Payments hereunder may be made monthly by the commissioner from appropriated funds.
II. The commissioner may establish rates pursuant to RSA 167:7, I-a for certain programs administered by the department.

Source. 1995, 310:1, eff. Nov. 1, 1995.

Section 126-A:23

126-A:23 Repealed by 2012, 40:1, eff. July 1, 2012. –

Section 126-A:24

126-A:24 Placement. – Community living facilities serving persons with developmental disabilities shall be considered a part of the service delivery system as defined in RSA 171-A.

Source. 1995, 310:1, eff. Nov. 1, 1995.

Emergency Shelter Program

Section 126-A:25

126-A:25 Purpose. – The purpose of this subdivision is to assist in maintaining and making available additional emergency shelter facilities and other supportive and preventive services and to assist in meeting the operating costs of such shelters and services.

Source. 1995, 310:1, eff. Nov. 1, 1995.

Section 126-A:26

126-A:26 Program Established. – There is hereby established an emergency shelter program to assist in providing safe and sanitary shelters on a short-term emergency or transitional basis for persons who are destitute, mentally ill, abandoned, or developmentally disabled, and other poor persons.

Source. 1995, 310:1, eff. Nov. 1, 1995.

Section 126-A:27

126-A:27 Capital Construction and Rehabilitation. – Such funds as the general court may specifically appropriate from time to time may be granted to private nonprofit organizations on an equal matching grant formula basis for the capital costs of renovation, major rehabilitation, or conversion of buildings for use as

emergency shelters for the homeless. Such organizations may also use such funds to add additional beds to existing emergency shelters, to maintain such shelters and to provide related supportive and preventive services.

Source. 1995, 310:1, eff. Nov. 1, 1995.

Section 126-A:28

126-A:28 Operating Funds. – Such funds as the general court may specifically appropriate from time to time may be granted to private nonprofit organizations on an equal matching formula basis to provide essential services including, but not limited to, maintenance, operation, utilities, and furnishings, and to support and maintain the volunteer operational structure.

Source. 1995, 310:1, eff. Nov. 1, 1995.

Section 126-A:29

126-A:29 Eligibility; Grants. –

I. For the purposes of this subdivision, the term "private nonprofit organization" means a secular or religious organization described in section 501(c) of the Internal Revenue Code of 1986 which is exempt from taxation under subtitle A of such code. Such organization shall also have an accounting system, a voluntary board, and shall practice nondiscrimination in providing assistance.

II. No grant shall be awarded unless the commissioner makes an administrative finding of fact that the grant is primarily for the public benefit. To make a finding that the grant is primarily for public benefit, the commissioner shall find that:

(a) With respect to grants for a new shelter or additional beds for an existing shelter:

(1) That insufficient shelter facilities exist in the area; and

(2) That the proposal will increase the supply of such facilities.

(b) With respect to grants for operations, that such assistance is needed to maintain essential services or structures under RSA 126-A:29.

(c) In all cases, that the shelter is for the public use and public benefit.

(d) With respect to grants for supportive and preventive services, that such assistance will enable persons assisted to obtain permanent housing and that such services are for the public use and the public benefit.

III. If the grant is to be made to a religious organization, it must have a primary effect of neither advancing nor inhibiting religion. In awarding grants under this subdivision, the department shall give substantial weight to the performance record and general stability of the grant applicant.

Source. 1995, 310:1, eff. Nov. 1, 1995.

Section 126-A:30

126-A:30 Residency. – Persons receiving short-term emergency housing under this subdivision shall continue to maintain their legal residence as it existed at the time of entering the emergency shelter.

Source. 1995, 310:1, eff. Nov. 1, 1995.

Section 126-A:31

126-A:31 Rulemaking. – The commissioner may adopt such rules, pursuant to RSA 541-A, as the commissioner deems reasonable and necessary to carry out the provisions of this subdivision.

Source. 1995, 310:1, eff. Nov. 1, 1995.

Section 126-A:32

126-A:32 Repealed by 2010, 368:1(41), eff. Dec. 31, 2010. –

Office of Reimbursements

Section 126-A:33

126-A:33 Office Established. – There shall be an office of reimbursements within the department of health and human services.

Source. 1995, 310:1, eff. Nov. 1, 1995.

Section 126-A:34

126-A:34 Duties. –

I. Subject to the direction and supervision of the commissioner, the office of reimbursements shall:

(a) Review and investigate all records of the New Hampshire hospital, Laconia developmental services, the secure psychiatric unit, the Glencliff home, and the Anna Philbrook center, relative to expenses incurred by patients, residents, or clients at such institutions, facilities, or programs or expenses incurred by patients, residents, or clients receiving care, treatment, services, or maintenance at the direction of the commissioner of health and human services, and make recommendations to the commissioner and to the respective superintendents or directors of such institutions, facilities, or programs as to the rates to be charged for the care, treatment, and maintenance of such patients, residents, or clients.

(b) Investigate the ability of patients, residents, or clients of such institutions and of the persons receiving care, treatment, maintenance, or services either in public or private institutions or otherwise at the direction of the commissioner and those legally chargeable for their support and maintenance to pay for such care, treatment, maintenance, and/or services and recommend to the commissioner the charge to be rendered.

(c) Submit monthly to the commissioner any recommended changes in the schedule of charges based upon the ability of the patient, resident, or client or those legally chargeable for their support to pay.

(d) Submit monthly to the commissioner a report setting forth any facts or information which bear upon or affect the domicile of any patient, residents, or clients of such institution, facility, or program which the office of reimbursements has found in conjunction with investigations under this subdivision.

(e) Administer estates.

(f) Serve as appraiser without certification if appointed by the probate court, notwithstanding any other provision of law.

(g) Consistent with RSA 126-A:42, II, file a notice of lien with the register of deeds of the county in which the patient or resident of any of the institutions named in RSA 126-A:34 or at a public or private institution owns real property.

II. The commissioner of health and human services shall take such action as the commissioner deems advisable.

Source. 1995, 310:1. 1997, 215:1. 2007, 263:12. 2010, Sp. Sess., 1:27. 2011, 224:300. 2012, 228:2. 2013, 144:39, eff. July 1, 2013.

Section 126-A:35

126-A:35 Other State Departments. – The office of reimbursements, with the approval of the commissioner, may, upon request, act on behalf of any state department, as defined in RSA 9:1, to recover any moneys due such department. The office of reimbursements shall not be liable for any expenses or costs incurred in any action brought pursuant to this section.

Source. 1995, 310:1, eff. Nov. 1, 1995.

Section 126-A:36

126-A:36 Persons Chargeable With Support of Patients or Residents of Public Institutions. – Except as limited in RSA 126-A:43, II, expenses incurred in the institutions named in RSA 126-A:34 or at the direction of the commissioner in any public or private institution or elsewhere, may be recovered in any action in the name of the state from the person, or the person's spouse, or, if a minor, the minor's father or mother, whose income or other resources are more than sufficient to provide a reasonable subsistence compatible with decency and health, and the spouse, father and mother are declared jointly and severally liable for such expenses, unless otherwise ordered by the court.

Source. 1995, 310:1, eff. Nov. 1, 1995.

Section 126-A:37

126-A:37 Estates Chargeable for Support. –
Except as limited in RSA 126-A:39, expenses incurred by anyone in the institutions named in RSA 126-A:34, or, at the direction of the commissioner in any public or private institution, or elsewhere, may be recovered in any action in the name of the state from the estate of the person, or the person's spouse, or mother or father, whose estate is more than sufficient to pay priorities in RSA 554:19. The spouse and the father and mother are declared jointly and severally liable for expenses, unless otherwise ordered by the court, except that recovery of expenses against a mother or father shall be limited:
I. To the expenses incurred before their child reached the age of majority.
II. As provided for in RSA 126-A:42.
III. To the share the patient or resident is entitled to if the father or mother died intestate.
IV. To the greater of the share the patient or resident is entitled to under the will or the share the patient or resident would have been entitled to if the father or mother had died intestate.

Source. 1995, 310:1. 2010, 189:2, eff. Jan. 1, 2011.

Section 126-A:38

126-A:38 Financial Statements. –
I. (a) Within 60 days after admittance, except as provided in paragraph II, and annually thereafter if requested by the commissioner, a financial statement shall be filed under penalty of perjury by a person legally chargeable for expenses pursuant to RSA 126-A:36 on forms provided for this purpose by the office of reimbursements.
(b) The commissioner is hereby authorized to request and receive from any and all former or current employers, including, but not limited to, personal information with respect to dates of employment, number of hours worked, rate of pay, date of birth, available health insurance, current address, payroll deductions, and social security number of any person with respect to whom the department is investigating the ability to pay; provided, however, the commissioner shall limit the request to the minimum information necessary for the review of the individual's ability to pay. The employer shall furnish the information within 15 days of the department's request unless the time period is extended for good cause shown. If the request for the information is burdensome to the employer, it shall give written notice to the commissioner within the 15-day period, and the commissioner shall review the request of the employer and modify the request if reasonably possible to alleviate the burden on the employer.
(c) The department or employer who discloses financial or employment 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.
(d) Any records established or information collected pursuant to the provisions of this section shall be made available only to the commissioner and the attorney general and their authorized designees, attorneys employed by the department of health and human services, and the client or the client's authorized representative. Such records and information shall be available and used only for purposes directly connected with the investigation of a person's ability to pay under this chapter. The records and information made available to the client or the client's 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.

II. Persons admitted to the multiple DWI offender intervention program (M.O.P.) prior to January 1, 2013 who do not pay program fees in full at the time of admission shall file a financial statement under penalty of perjury on forms provided for this purpose by the office of reimbursements and shall enter a payment contract for balance of fees due. The office of reimbursements shall be entitled to recover reasonable attorneys' fees and costs of collection for program fees not paid in accordance with a payment contract.
III. Persons admitted to the multiple DWI offender intervention program (M.O.P.) prior to January 1, 2013 shall notify the office of reimbursements of each change of mail address and actual street address until that person has made payment in full of fees due in accordance with an M.O.P. payment contract. Whenever notice to a person subject to a payment contract is required, notice to the last mail address on file with the office of reimbursements shall be deemed notice to and binding on the payer.

Source. 1995, 310:1. 1997, 215:2. 2010, Sp. Sess., 1:28. 2013, 144:40, eff. July 1, 2013.

Section 126-A:39

126-A:39 Educational Expenses. –
I. Educational expenses of any resident or patient, who is capable of being benefited by instruction and who is between 3 and 21 years of age, as required under statute and incurred in the institutions named in or at the direction of the commissioner in any public or private institution or elsewhere, shall be recovered from the school district in which the patient's or resident's parents or legal guardian reside up to the state average elementary cost per pupil, as determined by the state board of education for the preceding school year. The liability of the school district for such expenses shall precede that of the persons or estates named in RSA 126-A:36 and RSA 126-A:37, which are hereby relieved of liability for such expenses to the extent of the school district's liability.
II. Rates for private providers of special education services shall be set as provided in RSA 186-C:7, III, by the departments of health and human services, education, and administrative services.

Source. 1995, 310:1. 2002, 67:1, eff. June 25, 2002.

Section 126-A:40

126-A:40 Liability for Expenses and Hearing on Liability. –
I. (a) Whenever the court issues an order for evaluation, care, or treatment of a child at the Philbrook center pursuant to RSA 169-B, 169-C, or 169-D, the expenses of such evaluation, care, or treatment shall be borne by the department, except as otherwise provided in this section.
(b) Subparagraph (a) shall not apply to expenses incurred for special education and related services.
(c) The state shall have a right of action over for such expenses against the parents or the people chargeable by law for the minor's support and necessities. The court shall require the individual chargeable by law for the minor's support and necessities to assign to the state any insurance coverage that may be available to pay for all or a portion of the services provided and to submit a financial statement to the court upon which the court may make an order as to reimbursement to the state as may be reasonable and just, based on the person's ability to pay. Such financial statement shall include, but not be limited to, any benefits received from the Social Security Administration or insurance coverage available to the individual. The court shall include disposition of these benefits in its order as to reimbursement. Such reimbursement shall be established on a per month or per week basis and shall continue for a duration of time equal to the duration of time in which expenses are incurred on behalf of the minor by the state. The court's jurisdiction to order reimbursement shall continue until the obligation to reimburse has been fulfilled. If the state receives reimbursement for the expenses of a child under this section, the state shall return to the formerly liable county that percentage of the reimbursement equal to the percentage of expenses paid by the county for the child.
II. Upon the issuance of an order under paragraph I, the court shall send notice to the state. The state may, within 30 days from the receipt of notice, request a hearing on the issues of the cost or appropriateness of services, or recovery. At such hearing, the court shall provide all financial information, including names and addresses of persons chargeable by law for the minor's support and necessities, to the state.
III. The office of reimbursements, acting on behalf of the New Hampshire hospital, is authorized to compromise

or reduce any expense to be charged to the state.
IV. [Repealed.]
V. [Repealed.]
VI. [Repealed.]
VII. [Repealed.]

Source. 1995, 310:1. 2008, 274:33, eff. July 1, 2008; 296:21-23, eff. July 1, 2008.

Section 126-A:41

126-A:41 Support Order. – Upon petition for support in the name of the state, the superior court may enter an order requiring any patient or resident or persons legally chargeable for the support of a patient or resident to contribute to the support of such patient or resident. Anyone against whom an order is entered requiring a person to contribute to the support of such relative who fails to comply therewith shall be deemed to be in contempt of court and may be imprisoned not less than 60 nor more than 90 days.

Source. 1995, 310:1, eff. Nov. 1, 1995.

Section 126-A:42

126-A:42 Recovery of Expenses. –
I. Subject to the provisions of RSA 126-A:43, II, the state is entitled to recover the expense of care, treatment, and maintenance of any patient or resident at any of the institutions named in RSA 126-A:34 or at a public or private institution or otherwise at the direction of the commissioner from the patient or resident, if of sufficient ability to pay, or the person's estate, or from persons legally chargeable with such person's support as defined in RSA 126-A:36 or from the estates provided in RSA 126-A:37.
I-a. The department shall file with the register of deeds of the county in which the patient or resident or the spouse of the patient or resident, if any, owns real property, notice of the lien for reimbursement of expenses, as provided in RSA 126-A:37, after providing all owners of the real property known to the department with prior notice and an opportunity for a hearing. Such notice of lien shall contain the names of the patient or resident and that patient's or resident's spouse, if any. All such liens shall continue until released by the department. The register of deeds shall keep a suitable record of such notices of lien without charging any fee therefor and enter on the record an acknowledgment of satisfaction or release upon written request from the department.
II. Recovery of the past due expense of care, treatment, and maintenance of a patient or resident in any of the institutions named in RSA 126-A:34 is limited in amount as follows:
(a) If such person is living and is a resident of the institution, recovery is limited to the expense incurred within the last 5 years of residence at the institution.
(1) If such person is living and is a resident of the institution, and if the person legally chargeable for such person's support dies, subject to the provisions of RSA 126-A:43, II, recovery from an estate legally chargeable for expenses as provided in RSA 126-A:37 is limited to the expenses incurred within the 5 years immediately preceding the death of the person chargeable.
(b) If such person dies while a resident of the institution, subject to provisions of RSA 126-A:43, II, recovery is limited to the expense incurred within the 5 years immediately preceding death.
(c) If such person is discharged from the institution, subject to the provisions of RSA 126-A:43, II, recovery is limited to the expense incurred within the 5 years immediately preceding discharge.
(d) If such person dies after discharge from the institution, subject to the provisions of RSA 126-A:43, II, recovery is limited to the expense incurred within the 5 years immediately preceding discharge.
(e) Expenses incurred by the institution during the time such person is on parole from the institution shall not be included in the total charges for expenses.
(f) If an agreement was made under RSA 126-A:43, III, recovery shall be limited to any payment obligation resulting from such agreement.
III. In an action by the state for recovery of the expenses of a patient or resident at any of the institutions named in RSA 126-A:34 who is discharged from the institution, or is dead, the action shall be brought within 6 years after the person's discharge or death. Notwithstanding RSA 556:5 or any other provision of law to the contrary,

the administrator of the estate of a patient or resident at any of the institutions named in RSA 126-A:34 or at a public or private institution shall be conclusively presumed to have accepted a claim for reimbursement of expenses as provided in RSA 126-A:37 which is subject to the jurisdiction of the probate court unless, within 12 months from the initial grant of administration, the administrator commences an equitable action in the superior court challenging the validity or amount of the department's claim and lien.

Source. 1995, 310:1. 2011, 224:301, 302. 2013, 144:42, eff. July 1, 2013.

Section 126-A:43

126-A:43 Regular Rate. –

I. The commissioner shall establish for any patient, resident, or client of an institution, facility, or program named in RSA 126-A:34, a uniform rate to cover the expenses of the several categories of service provided to patients, residents, or clients such as but not necessarily limited to the following: intensive medical care, treatment, and maintenance; intensive psychiatric care, treatment, and maintenance; and custodial care, treatment, and maintenance. The commissioner is not required to establish such rate by rules adopted under RSA 541-A. The categories or classifications of service provided may be modified by the commissioner.

II. After any person has been a resident or patient in any of the institutions named in RSA 126-A:34 for 10 years or has reached the age of majority, the liability of persons other than the patient or resident or such patient's or resident's spouse to provide payments to cover the expenses of care, treatment, and maintenance shall cease, except for recoveries from the estates of such persons which shall be limited as provided in RSA 126-A:42, II. The liability of a spouse under RSA 126-A:36 shall cease after the person has been a patient or resident of any of the institutions named in RSA 126-A:34 for 10 years. The liability of the patient or resident under this paragraph shall continue unless it is determined by the office of reimbursements, in consultation with the commissioner, that the patient or resident lacks sufficient income from any source including, but not limited to, social security, retirement, civil service or veterans administration income, trust fund, or other income to pay a full rate or a higher partial rate.

III. The commissioner may compromise or reduce any debt or obligation owed to the state pursuant to an agreement with a group health plan carrier, as defined in RSA 420-G:2, or any health insurer as defined in 607(1) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. section 1167(1), federal and or state funded assistance, or any other legally liable third party or persons chargeable for support.

IV. The office of reimbursements shall, upon request, furnish to each estate from which, or to each person chargeable from whom, a recovery of expenses is sought pursuant to RSA 126-A:42, a record of the accumulated charges against said estate or said person.

Source. 1995, 310:1. 1997, 215:3. 2013, 144:43, eff. July 1, 2013.

Section 126-A:44

126-A:44 Partial Charges. – The commissioner may charge less than the uniform rate when the commissioner finds a patient or any relative chargeable therewith is able to bear only a portion of the expense incident to the patient's care, treatment, and maintenance at such institution, or care, treatment, and maintenance furnished at the direction of the commissioner. In establishing such charge, the commissioner shall consider the report, investigation and recommended charge of the office of reimbursements. The established charge shall be billed by the superintendent of such institution. The office of reimbursements shall make further recommendations as provided in this section where conditions affecting the ability to pay of persons legally chargeable for the support of the patient or resident have changed. The establishment of a partial rate as provided herein shall not preclude the collection of the balance between the partial rate and the full rate from an estate of the patient or resident or the estate of those legally chargeable as provided in RSA 126-A:37.

Source. 1995, 310:1, eff. Nov. 1, 1995.

Section 126-A:45

126-A:45 Support by the State. –
I. Any person transferred to the New Hampshire hospital under RSA 135:17 for observations as to sanity under court order shall be at state expense for the observation period only.
II. Any patient or resident of such institutions defined in RSA 126-A:34 or patient receiving care, treatment, or maintenance at the direction of the commissioner who has no means of support and no person chargeable for the patient's or resident's support shall be supported by the state.

Source. 1995, 310:1, eff. Nov. 1, 1995.

Section 126-A:46

126-A:46 Special Services. – The commissioner shall adopt rules, pursuant to RSA 541-A, relative to rates for special services rendered to patients or residents of institutions named in RSA 126-A:34.

Source. 1995, 310:1, eff. Nov. 1, 1995.

Section 126-A:47

126-A:47 Reports. – The superintendent of such institutions shall forward forthwith to the commissioner any change in population at such institutions, any change affecting the rates charged patients or residents, and any other changes affecting expenses incurred by a patient or resident.

Source. 1995, 310:1, eff. Nov. 1, 1995.

Section 126-A:48

126-A:48 Nature of Payment. – All payments, except for educational payments made pursuant to RSA 126-A:39, made by or with respect to a patient at any institution named in RSA 126-A:34, which furnished medical services shall conclusively be deemed to be made on account of medical services.

Source. 1995, 310:1, eff. Nov. 1, 1995.

Poison Information and Control Center

Section 126-A:49

126-A:49 Poison Information and Treatment. – The commissioner shall develop or designate a statewide program for poison information and treatment. In connection with this program, the commissioner shall be responsible for establishment or designation of a poison information and treatment center which shall make available to New Hampshire residents information and medical consultation on a daily, 24-hour basis.

Source. 1995, 310:1, eff. Nov. 1, 1995.

Housing Security Guarantee Program

Section 126-A:50 to 126-A:59

126-A:50 to 126-A:59 Repealed by 2021, 122:11, I, eff. July 9, 2021. –

Section 126-A:60

126-A:60 Repealed by 2000, 316:8, II, eff. July 1, 2000. –

Section 126-A:61

126-A:61 Repealed by 2021, 122:11, I, eff. July 9, 2021. –

Section 126-A:62

126-A:62 Repealed by 2000, 316:8, III, eff. July 1, 2000. –

Section 126-A:63

126-A:63 Repealed by 2021, 122:11, I, eff. July 9, 2021. –

New Hampshire Comprehensive Cancer Plan

Section 126-A:64

126-A:64 Repealed by 2017, 195:15, eff. Sept. 3, 2017. –

Section 126-A:65

126-A:65 Repealed by 2007, 263:98, II, eff. June, 30, 2011. –

Commission to Study Expansion of Medicaid Eligibility

Section 126-A:66

126-A:66 Repealed by 2014, 3:12, VIII, eff. Mar. 27, 2014. –

Statewide Section 1115 Demonstration Waiver

Section 126-A:67

126-A:67 Statewide Section 1115 Demonstration Waiver. –

I. On or before June 1, 2014, the commissioner, after consultation with stakeholders including state, county, and local officials and health care providers, shall submit a statewide section 1115 demonstration waiver to enhance designated state health programs and transform the Medicaid care delivery system. The section 1115 demonstration waiver will promote the improvement of overall health through increased access to private insurance coverage options and will integrate and align New Hampshire's Medicaid care management program, the provision of coverage to the newly eligible under this chapter, existing Medicaid waivered programs, and other department initiatives in a manner that improves public health, and improves the quality of care and access to care for all Medicaid and CHIP beneficiaries. The waiver shall be used to allow the state maximum flexibility to redesign Medicaid including establishing premium assistance programs that are customized to transform the state's reform goals. To the greatest degree possible programs funded under the demonstration waiver shall complement the mental health settlement and shall be designed to promote innovation, reform delivery systems, and reduce the number of uninsured patients who seek treatment from health care providers.

II. Prior to submitting the waiver to CMS, the commissioner shall present the waiver to the fiscal committee of the general court for approval. The waiver shall be approved by the CMS by December 1, 2014.

Source. 2014, 3:5, eff. Mar. 27, 2014.

Commission to Study Oversight, Regulation, and Reporting of Patient Safety and Infectious Disease Prevention and Control Issues

Section 126-A:68

126-A:68 Repealed by 2015, 147:3, eff. Nov. 1, 2015. –

Commission to Study Narcan

Section 126-A:69

126-A:69 Repealed by 2016, 1:1, eff. Nov. 1, 2017. –

Administration of Epinephrine

Section 126-A:70 to 126-A:71

126-A:70 to 126-A:71 Repealed by 2021, 122:34, eff. July 9, 2021. –

Commission to Study Volunteer Health Care Services

Section 126-A:72

126-A:72 Repealed by 2016, 274:2, effective Nov. 1, 2017. –

Commission to Study Environmentally-Triggered Chronic Illness

Section 126-A:73

126-A:73 Repealed by 2017, 166:3, eff. Nov. 1, 2018. –

Section 126-A:73-a

[RSA 126-A:73-a repealed by 2019, 229:6, effective November 1, 2024.]

126-A:73-a Commission to Study Environmentally-Triggered Chronic Illness Reestablished. –

I. There is established a commission to study environmentally-triggered chronic illness.

II. (a) The members of the commission shall be as follows:

(1) Five members of the house of representatives, 3 of whom shall be appointed by the speaker of the house of representatives and 2 of whom shall be appointed by the house 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 program manager of the environmental public health tracking program, department of health and human services, or designee.

(4) The commissioner of the department of environmental services, or designee.

(5) The director of the university of New Hampshire institute for health policy and practice, or designee.

(6) The director of Boston University public health policy and practice, or designee.
(7) A representative from the New Hampshire Medical Society, appointed by the society.
(8) The chair of the board of trustees of the New Hampshire Hospital Association, or designee.
(9) An advanced practice registered nurse, appointed by the New Hampshire Nurse Practitioner Association.
(10) Two community members with backgrounds in environmental science and/ or public health, one of whom shall be appointed by the president of the senate and one of whom shall be appointed by the speaker of the house of representatives.
(b) Legislative members of the commission shall receive mileage at the legislative rate when attending to the duties of the commission.
III. (a) The commission's study shall include, but not be limited to:
(1) Determining which entities may report confirmed cases of chronic conditions or other health-related impacts to the public health oversight program.
(2) Recommending ways to alert public health officials regarding higher than expected rates of chronic disease or other health-related impacts which may be related to exposures of unrecognized environmental contaminants.
(3) Recommending a method to inform citizens regarding programs designed to manage chronic disease or other environmental exposure health-related impacts.
(4) Recommending data sources and a method to include data compiled by a public or private entity to the greatest extent possible in the development of the public health oversight program.
(5) Defining by codes, the health status indicators to be monitored, including chronic conditions, medical conditions, and poor health outcomes.
(6) Studying current health databases, including years available, potential for small area analysis, and privacy concerns.
(7) Researching currently existing health data reports by agency, bureau, or organization.
(8) Creating a model of desired data outputs and reports for chronic conditions and other health-related impacts.
(9) Identifying the gaps between what currently exists and the model output.
(10) Recommending the organizational structure responsible for the oversight function and mandatory reporting requirements.
(11) Reviewing results of stages 1, 2 and 3 of the pilot study recommended by the previous commission established by 2017, 166 and identifying changes to subparagraphs (8), and further identify items in (9) and (10).
(12) Identifying technology system changes necessary to carry out the charge of the commission.
(13) Collaborating with the National Institutes of Health, the United States Environmental Protection Agency, and the Centers for Disease Control and Prevention to develop protocols for the department of health and human services to educate and provide guidelines for physicians and other advanced health care practitioners to identify and evaluate appropriate diagnostic screening tests to assess health effects from exposure to emerging contaminants.
(14) Collaborating with the National Institutes of Health, the United States Environmental Protection Agency, and the Centers for Disease Control and Prevention to develop protocols for programs to streamline education and outreach to health care providers about how to implement the guidelines specified in subparagraph (13). The protocols shall include education relative to methods to reduce further exposures and to eliminate the contaminants, if effective methods are available.
(15) Recommending legislation, as necessary, to carry out the charge of the commission.
(b) The commission shall solicit information from any person or entity the commission deems relevant to its study.
(c) The commission may, with input from a state agency or agencies, decide whether additional appropriations are necessary to complete the work of the commission. The commission may recommend additional appropriations for approval by the general court.
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. Seven members of the commission shall constitute a quorum.
V. The commission may form subcommittees or appoint technical committees composed of commission members and non-voting nonmembers to advance the goals of this section.
VI. The commission shall submit interim reports on November 1 of each year beginning November 1, 2020 containing its findings and any recommendations for proposed legislation and a final report on or before

November 1, 2024 to the speaker of the house of representatives, the president of the senate, the house clerk, the senate clerk, the governor, and the state library.

Source. 2019, 229:2, eff. July 12, 2019.

Commission on the Seacoast Cancer Cluster Investigation

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.

Excess Appropriation Allocation Account

Section 126-A:75

126-A:75 Repealed by 2018, 57:8, eff. July 1, 2019. –

Data Sharing Between the Department of Environmental Services and the Department of Health and Human Services

Section 126-A:76

126-A:76 Data Sharing Between the Department of Environmental Services and the Department of Health and Human Services. –

I. The department of environmental services and the department of health and human services shall develop and implement a method by which the departments share certain health outcome and environmental data. On or before September 1, 2018, the commissioners of the department of environmental services and the department of health and human services shall:

(a) Enter into an updated memorandum of agreement on cooperation regarding data sharing between the department of health and human services and the department of environmental services.

(b) Sign a joint standard operating procedure on how data layers can be shared between the 2 departments to identify linkages between environmental contaminants and health outcomes in a collaborative fashion.

(c) Hold a presentation on the departments' ongoing, joint efforts under the Centers for Disease Control and Prevention environmental public health tracking cooperative agreement.

(d) Make a presentation to the commission to study environmentally-triggered chronic illness regarding the departments' use of the standard operating procedure developed under subparagraph (b) to compare data, analyze community impacts, and communicate the results to the community.

II. Nothing in this section shall require the disclosure of confidential or personally identifiable information otherwise protected by state or federal law. In order to assure the privacy of protected health information, only non-protected health information or aggregated data shall be made available where it is pertinent to the matter being assessed.

III. On or before September 1, 2019, and at a minimum every 6 months thereafter, the commissioners of the department of environmental services and the department of health and human services shall submit a report regarding the data sharing practices required under paragraph I to the speaker of the house of representatives, the senate president, the state library, and the commission to study environmentally-triggered chronic illness. The report shall include results of the 2-way pilot project between the departments on arsenic in drinking water, where both health effects and environmental data exist.

Source. 2018, 296:1, eff. Aug. 24, 2018. 2019, 229:4, 5, eff. July 12, 2019.

Commission to Study Greater Transparency in Pharmaceutical Costs and Drug Rebate Programs

Section 126-A:77

126-A:77 Repealed by 2018, 350:2, eff. Nov. 1, 2018. –

Section 126-A:77-a

126-A:77-a Repealed by 2019, 320:6, eff. Nov. 1, 2020. –

New Hampshire Rare Disease Advisory Council

Section 126-A:78

126-A:78 Definition. – For the purposes of this subdivision, a rare disease means a disease affecting 200,000 people or fewer in the United States.

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

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.

Commission on the Environmental and Public Health Impacts of Perfluorinated Chemicals

Section 126-A:79-a

[RSA 126-A:79-a repealed by 2019, 335:2, effective November 1, 2024.]

126-A:79-a Commission on the Environmental and Public Health Impacts of Perfluorinated Chemicals. –

I. There is established a commission to study environmental and public health impacts resulting from per fluorinated chemicals (PFAS) releases to the air, soil, and water in Merrimack, Litchfield, Londonderry, and Bedford.

II. (a) The members of the commission shall be as follows:

(1) Five members of the house of representatives, 3 of whom shall be appointed by the speaker of the house of representatives and 2 of whom shall be appointed by the house minority leader.

(2) Two members of the senate, appointed by the president of the senate.

(3) The program manager from the department of health and human services environmental public health tracking program, or designee.

(4) The commissioner of the department of environmental services, or designee.

(5) The director of the university of New Hampshire Institute for Health Policy and Practice, or designee.

(6) A representative from the New Hampshire Medical Society, appointed by the society.

(7) Two citizens with backgrounds in environmental science and/or public health, recommended by the senators appointed to the commission and appointed by the president of the senate.

(8) A representative from each of the affected towns of Merrimack, Bedford, Londonderry, and Litchfield, appointed by the governing body of such town.

(9) Four residents, one from each of the affected towns of Merrimack, Bedford, Londonderry, and Litchfield, who are members of drinking water related environmental advocacy citizen organizations which are not affiliated with any government or state agency, recommended by the senators appointed to the commission and appointed by the president of the senate.

(10) A hydrogeologist, appointed by the New Hampshire chapter of the United States Geological Survey.

(11) A toxicologist, epidemiologist, or environmental health professor from the university of New Hampshire, appointed by that institution.

(b) Legislative members of the commission shall receive mileage at the legislative rate when attending to the duties of the commission.

III. (a) The commission's study shall include, but not be limited to:

(1) Obtaining information necessary to delineate the extent of PFAS drinking water contamination from airborne, soil, and groundwater releases.

(2) Assessing and implementing steps necessary to investigate public health impacts from PFAS exposures to air, soil, and drinking water.

(3) Assessing sources and impacts to surface water from wastewater and other discharges from the Merrimack, New Hampshire Saint Gobain plant.

(4) Assessing whether soil regulations are sufficient to contain contaminated materials.

(5) Receiving updates at each commission meeting from the department of environmental services and the department of health and human services on matters including but not limited to, scientific findings and related materials, enforcement actions, and regulatory status.

(6) Receiving ongoing copies of all correspondence between state and federal agencies and responsible parties; including but not limited to, documents related to scientific findings, interim progress and regulatory or enforceable matters from the department of environmental services and the department of health and human services.

(7) Developing prioritized governmental and community actions.

(8) Reviewing the progress made by state and federal agencies, if appropriate, and their partners.

(9) Delineating the potential roles and responsibilities for municipalities, state agencies, and their partners.

(10) Communicating to the public about the environmental and public health impacts of the PFAS exposure investigation and analysis.

(11) Assessing whether current rules or regulations are sufficiently protective of public health and proposing legislation, as necessary, to protect public health.

(12) Recommending legislation, as necessary, to carry out the charge of the commission or resulting from any

commission findings.
(13) Assessing whether current penalties and regulatory controls are sufficiently protective of the environment and public health and recommending changes necessary.
(14) Assessing agreements between the state and Saint Gobain and proposing additional actions necessary to achieve the charge of the commission and,
(b) The commission shall solicit information from any person or entity the commission deems relevant to its study. The commission may, with input from a state agency or agencies, decide whether additional appropriations are necessary to complete the work of the commission.
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. Seven members of the commission shall constitute a quorum.
V. The commission shall submit an interim report of its findings on November 1, each year between 2020 and 2024, and a final report of 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, and the state library on or before November 1, 2024.

Source. 2019, 335:1, eff. Aug. 16, 2019. 2021, 22:1, 2, eff. May 6, 2021.

New Hampshire Pharmaceutical Assistance Pilot Program for Seniors

Section 126-A:80

126-A:80 New Hampshire Pharmaceutical Assistance Pilot Program for Seniors. –
I. The commissioner of the department of health and human services shall establish a prescription drug assistance pilot program for seniors. The purpose of the pilot program shall be to wraparound or supplement the federal prescription drug benefit under Medicare Part D by paying the out-of-pocket costs for prescription drugs for eligible individuals who have reached the coverage gap, known as the donut hole, under Medicare Part D. The pilot program shall be the payer of last resort and shall cover all out-of-pocket prescription drug costs for which assistance is not otherwise available in the coverage gap, known as the donut hole. The pilot program shall be available to the first 1,000 individuals age 65 or older who apply for such assistance, who have a gross annual household income of 250 percent or less of the federal poverty level, and who otherwise meet the eligibility criteria established by the department. Assistance shall be available under the pilot program from January 1, 2020 to January 1, 2021. The commissioner shall make available an online application, a telephone number for applications and questions, and shall provide written applications upon request. Applications shall include information on income, household size, Medicare Part D enrollment and coverage information, the prescription drugs for which assistance is sought, the age of the applicant, and the location of the applicant. On or before February 1, 2020, the commissioner shall adopt rules, under RSA 541-A, relative to pilot program enrollment, administration, and evaluation.
II. On or before March 1, 2021, the commissioner of the department of health and human services shall submit an evaluation report of the pilot program to the senate president, the speaker of the house of representatives, the governor, the senate finance committee, the house finance committee, the senate health and human services committee, and the house health, human services and elderly affairs committee. The report shall include information regarding the number of applications, age and location of applicants, prescription drugs for which assistance was provided, costs per eligible applicant, likely costs per non-eligible applicant, and descriptions regarding applicant ineligibility.

Source. 2019, 346:383, eff. July 1, 2019.

Access to Health Care and Mental Health Services for Veterans

Section 126-A:81

[RSA 126-A:81 effective upon receipt of sufficient funding for positions required to carry out the purpose of this section.]

126-A:81 Access to Health Care for Veterans; Navigator Training Program. –

I. In this subdivision, "veteran" means veteran as defined in 38 U.S.C. section 101(2).

II. The commissioner, in coordination with the adjutant general, shall develop and operate a veteran health navigator training program to increase access to health care coverage and services for veterans. The commissioner shall identify, train, and deploy veteran health navigators who have direct knowledge of the veteran communities they serve. For the purposes of the training program, the commissioner shall use the veterans service officers currently employed by the department of military affairs and veterans services. The veteran health navigators shall help identify all federal and other health benefits, coverage, and services available to veterans and their families. Veteran health navigators shall coordinate with relevant departments, health care providers, and health insurance programs to help veterans and their beneficiaries apply for coverage under such programs, including helping veterans overcome barriers within the health care system to ensure enrollment in health plans and effective delivery and coordination of health services. The activities under this program shall use existing resources and structures where veterans and their families are likely to be found.

III. Using the veteran health navigator training program under paragraph I as a source of information about the needs, coverage, and treatment gaps faced by veterans and their families, the commissioner shall examine all existing programs designed to increase access to affordable quality health care and to evaluate whether the needs of veterans and their families are met by those programs or whether further coordination with the veteran health navigators or other steps would better meet such needs. The commissioner shall execute any necessary steps identified under this paragraph.

Source. 2020, 34:4.

Section 126-A:82

[RSA 126-A:82 effective upon receipt of sufficient funding for positions required to carry out the purpose of this section.]

126-A:82 Access to Mental Health Services for Veterans. –

I. The veteran health navigators shall identify all federal and other mental health benefits, coverage, and services available to veterans and their families, including for post-traumatic stress disorder, depression, and suicide prevention.

II. (a) In coordination with local, state, and federal governmental agencies, in consultation with nonprofit corporations, service providers including Veterans Affairs Medical Centers, the United States Department of Veterans Affairs, localities, and cities that have an effective prevention and treatment system for mental health, the commissioner shall develop and implement a strategy to reduce barriers to access to mental health services and treatment for veterans and their families by:

(1) Identifying structural and logistical barriers to accessing treatment, including perceived stigma, long out of state travel distances to receive care, and any other barriers.

(2) Resolving all barriers identified in subparagraph (1) that can be resolved without legislative or budgetary action, including through increased coordination between departments, nonprofit providers, and the federal government, application for and use of private and federal grants, and other actions.

(b) The commissioner shall submit an annual report containing additional legislative or budgetary steps that would resolve the barriers under subparagraphs (a)(1) and (2) to the president of the senate, the speaker of the house of representatives, the governor, and the chairpersons of the house and senate committees having jurisdiction over public health issues on or before each November 1, commencing on November 1, 2021. The report shall also be posted on the department's Internet website.

III. The commissioner shall in coordination with local, state, and federal government agencies, and in consultation with nonprofits corporations, service providers including Veterans Affairs Medical Centers, the United States Department of Veterans Affairs, localities, and cities that have effective prevention and treatment systems for mental health, enhance and strengthen suicide prevention programs in keeping with proven best practices and research, by:

(a) Identifying and applying for federal and private grants focused on veteran suicide prevention;
(b) Coordinating local, state, federal, and nonprofit programs that include community-based approaches for at-risk veterans and veterans at large;
(c) Providing technical assistance to communities to develop strategic plans to reduce veteran suicide, including through coordination and participation by local leaders, faith communities, schools, workplaces, and other stakeholders; and
(d) Evaluating community strategic plans within the state and disseminating learnings and best practices to optimize the impact of efforts by all partners and stakeholders.
IV. (a) The commissioner shall create a centralized provider database, identifying by region mental health providers with expertise and ability to assist veterans and their families, including highlighting providers with training or experience in the prevention and treatment of veteran suicide.
(b) Using existing resources, and incorporating best practices and research from the United States Department of Veterans Affairs, and state and nonprofit services providers in New Hampshire, the commissioner shall develop a continuing education course for mental health providers in New Hampshire to obtain expertise in veteran suicide assessment, prevention, treatment, and risk management and make that program available for free to providers in regions of New Hampshire identified in subparagraph (a) as lacking sufficient trained providers.
(c) From existing or appropriated resources, the commissioner shall identify evidence-based best practices to increase awareness of any veteran suicide prevention hotline in New Hampshire or nationally, and other crisis resources with proven effectiveness to reduce veteran suicide.

Source. 2020, 34:4.

Opioid Abatement Trust Fund

Section 126-A:83

126-A:83 Opioid Abatement Trust Fund Established. –
I. There is hereby established in the state treasury the opioid abatement trust fund that shall be kept distinct and separate from all other funds. All proceeds received by the state from all consumer protection settlements or judgments against opioid manufacturers or distributors shall be deposited in accordance with RSA 7:6-f. Any amount that would have been deposited in the general fund under 7:6-f shall, instead, be placed in the trust fund. All other opioid-related settlement funds or judgments from New Hampshire counties and all political subdivisions shall, likewise, be placed in the trust fund. The state treasurer shall be the trustee of the trust fund, and shall invest the trust fund in accordance with RSA 6:8. Any earnings on trust fund moneys shall be added to the trust fund. All moneys in the trust fund shall be nonlapsing and shall be continually appropriated to the state treasury. The state treasurer shall disburse funds from the trust fund solely for the purposes and in the manner set forth in RSA 126-A:84.
II. The treasurer shall distribute 15 percent of all funds received prior to any deposit in the consumer escrow account or the opioid abatement trust fund to the counties and the political subdivisions that filed lawsuits, on or before September 1, 2019, against opioid manufacturers, distributors and other persons identified as defendants in the multidistrict opioid litigation pending in the federal district court for the northern district of Ohio. This distribution shall occur on an annual basis. The distribution of funds shall be based on the 2010 census population of each qualifying county and political subdivisions. The population of any political subdivision which receives funds under this section shall not be included in the population of the county for determining the distribution to that county.

Source. 2020, 39:55, eff. July 1, 2020.

Section 126-A:84

126-A:84 Opioid Abatement Trust Fund; Management and Distribution of Funds. –
I. The commissioner of the department of health and human services, in consultation with the opioid abatement advisory commission established in RSA 126-A:85, shall administer the opioid abatement trust fund established

in RSA 126-A:83. The commissioner shall draw from the opioid abatement trust fund for qualifying opioid abatement projects under RSA 126-A:86, I(b).
II. Funds shall be distributed between the state, counties, cities and towns as follows:
(a) Fifteen percent of the funds each year shall be distributed to the counties and political subdivisions as identified in RSA 126-A:83, II.
(b) All remaining funds shall be deposited into the opioid abatement trust fund as established by RSA 126-A:83, I to be distributed by the commissioner of the department of health and human services, with approval of the opioid abatement advisory commission. Funds may be awarded to a qualifying governmental entity or program for an approved use under RSA 126-A:86, I(b).
III. The commissioner of the department of health and human services shall continue to make distributions from the trust fund under this section for as long as defendants in the opioid litigation make payments to the state or until such time that the funds in the opioid abatement trust fund are exhausted.
IV. On or before September 1, 2020, each county, city, town or program that receives funds under paragraph II shall annually provide to the department of health and human services and the opioid abatement advisory commission a detailed account of all monies spent on approved uses, including, but limited to, an analysis and evaluation of the projects and programs it has funded.
V. The department of health and human services shall adopt rules under RSA 541-A necessary to implement this subdivision. Such rules shall include funding qualifications, application procedures, time-lines for receiving, reviewing and acting upon application requests, and reporting requirements.
VI. On or before November 1, 2020, the commissioner of the department of health and human services shall submit an annual report to the governor and fiscal committee of the general court detailing the activities of the advisory commission, the administration of the opioid abatement trust fund, the amount distributed in the past year, the amount remaining in the trust fund, a summary of how funds were used in the past year, and any recommendations for future legislation.

Source. 2020, 39:55, eff. July 1, 2020.

Section 126-A:85

126-A:85 New Hampshire Opioid Abatement Advisory Commission Established. –
I. There is hereby established the New Hampshire opioid abatement advisory commission, which shall consult with and advise the commissioner of the department of health and human services relative to the proper administration and management of the opioid abatement trust fund, as established in RSA 126-A:83, and which shall approve all qualifying grants, loans, and matching funds from that fund under RSA 126-A:86, I(b).
II. The commission shall consist of the following members:
(a) The governor, or designee.
(b) The attorney general, or designee.
(c) The state treasurer, or designee.
(d) The commissioner of the department of corrections, or designee.
(e) The commissioner of the department of health and human services, or designee.
(f) One member of the house of representatives, appointed by the speaker of the house of representatives.
(g) One member of the senate, appointed by the president of the senate.
(h) The chairperson of the governor's commission on alcohol and drug abuse, prevention, treatment and recovery, or designee.
(i) A county attorney appointed by the governor.
(j) A county corrections superintendent, or designee, appointed by the governor.
(k) A county nursing home supervisor, or designee, appointed by the governor.
(l) A New Hampshire municipal fire chief, appointed by the governor.
(m) A New Hampshire municipal police chief, appointed by the governor.
(n) One designee from a county with a population of 100,000 or more, appointed by the governor.
(o) One designee from a county with a population of less than 100,000, appointed by the governor.
(p) One designee of a city with a population over 75,000, appointed by the governor.
(q) One designee of a city or town with a population under 75,000, appointed by the governor.
(r) One designee representing a town with a population under 20,000, appointed by the governor.

(s) One designee representing victims of the opioid crisis, appointed by the attorney general.
(t) One member representing prevention, appointed by the governor's commission alcohol and drug abuse prevention, treatment, and recovery, or designee.
(u) One member representing treatment, appointed by the governor's commission on alcohol and drug abuse prevention, treatment, and recovery, or designee.
(v) One member representing recovery, appointed by the governor's commission on alcohol and drug abuse prevention, treatment, and recovery, or designee.
III. Members appointed under subparagraphs (n) through (v) shall be appointed for staggered 2-year terms. Members appointed under subparagraphs (a) through (m) shall serve a term coterminous with their term in office. The advisory commission shall elect a chairperson every year with no person serving as chairperson for more than 2 consecutive one-year terms.
IV. Each member of the advisory commission shall have one vote, with all actions being taken by an affirmative vote of the majority of present members. Eleven members shall constitute a quorum.
V. Members of the advisory commission shall receive no compensation except for legislative members who shall receive the legislative rate for mileage when attending to their duties on the commission.
VI. Meetings of the advisory commission shall be conducted in accordance with RSA 91-A and take place no less than twice per year.
VII. The department of health and human services shall provide administrative support to the advisory commission.

Source. 2020, 39:55, eff. July 1, 2020.

Section 126-A:86

126-A:86 New Hampshire Opioid Abatement Advisory Commission; Duties. –
I. The opioid abatement advisory commission shall:
(a) Consult with and advise the commissioner of the department of health and human services on the administration and management of the opioid abatement trust fund, and approve the selection of eligible fund recipients under RSA 126-A:83, II(b).
(b) Award grants, revolving loan funds, and matching funds to projects from the opioid abatement trust fund under RSA 126-A:83, I, in a manner consistent with the following criteria. All disbursements or grants shall require approval of the governor and executive council. Funds may be awarded if the project meets one of the following criteria:
(1) Reimburse the state and any political subdivision within the state for any portion of the cost related to outpatient and residential opioid use disorder (OUD) and any co-occurring substance use disorder or mental health (SUD/MH) treatment services, including, but not limited to, services provided to incarcerated individuals, Medication assisted treatment (MAT); abstinence-based treatment; treatment, recovery or other services provided by states, subdivisions, community health centers, or not-for-profit providers;
(2) Reimburse the state and any political subdivision for emergency response services related to OUD and any co-occurring SUD/MH issues provided by law enforcement and first responders;
(3) Support mobile intervention, treatment, and recovery services, offered by qualified professionals, for persons with OUD and any co-occurring SUD/MH issues or persons who have experienced an opioid overdose;
(4) Support detoxification services for persons with OUD and any co-occurring SUD/MH issues, including medical detoxification, referral to treatment or connections to other services;
(5) Reimburse the state and any political subdivision within the state for any portion of the cost of administering naloxone;
(6) Provide access to housing for people with OUD and any co-occurring SUD/MH issues, including supportive housing, recovery housing, or housing assistance programs;
(7) Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH issues;
(8) Provide employment training or educational services for persons in treatment for or in recovery from OUD and any co-occurring SUD/MH;
(9) Create or support centralizes call centers that provide information and connections to appropriate services and supports for persons with OUD and an co-occurring SUD/MH issues;

(10) Improve oversight of opioid treatment programs (OTPs) to assure evidence-based, evidence-informed practices;
(11) Provide scholarships and supports for certified addiction counselors and other mental and behavioral health providers involved in addressing OUD and any co-occurring SUD/MH issues, including, but not limited to, training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas of the state;
(12) Support efforts to prevent over-prescribing and ensure appropriate prescribing and dispensing of opioids through evidence-based, evidence-informed programs or strategies;
(13) Support enhancements or improvements consistent with state law to the prescription drug monitoring program; and
(14) Support the education of law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.
II. The commission or the commissioner of the department of health and human services may identify additional responsibilities including reporting on projects and programs related to addressing the opioid epidemic, developing priorities, goals and recommendations for spending on such projects and programs, working with state agencies or outside entities to develop measures for projects and programs that address substance use disorders, making recommendations for policy changes on a state and local level, including statutory law and administrative agency regulations.
III. The commission shall create and maintain a website on which it shall publish its minutes, attendance rolls and votes, including records of all votes on funding requests, funding awards, and reports of funding by recipients.

Source. 2020, 39:55, eff. July 1, 2020.

State Health Improvement Plan

Section 126-A:87

126-A:87 State Health Improvement Plan. –
I. The commissioner of the department of health and human services shall, in consultation with the state health assessment and state health improvement plan advisory council established in RSA 126-A:88, and others, develop a state health assessment and a state health improvement plan.
II. The state health assessment shall:
(a) Describe the status of health and well-being in New Hampshire, access to critical healthcare services including maternity care, the cost of healthcare and insurance coverage, and the fiscal stability and sustainability of critical services to ensure sufficient and equitable access throughout the state.
(b) Utilize input from state and local level stakeholders obtained through public forums.
(c) Identify disparities in social determinants that may impact health, health outcomes, and access to care.
(d) Map health care service delivery, utilization, inter-entity collaboration, and identification of gaps or redundancies.
(e) Describe the role of state agencies in supporting the public health system in New Hampshire.
(f) Utilize existing data and plan for future data to support statewide and local planning.
(g) Identify priorities for the state health improvement plan.
III. The state health improvement plan shall guide the department in assessing, planning, implementing, and monitoring improvement in the health and well-being of New Hampshire's population.
IV. The state health improvement plan shall focus on strategies to:
(a) Improve the overall health and wellness of populations; improve the quality and experience of care and reduce cost both to individuals and overall to the healthcare system.
(b) Improve specific health outcomes and reduce inequities in measurable ways; and
(c) Optimize the public health and human service delivery systems.
V. The state health improvement plan shall identify priorities and evidence-based practices, recommend integration of services, and encourage the leveraging of resources across the state.
VI. The department shall make publicly available through an Internet website an analysis pertaining to state

health assessment indicators, identification of state health priorities, goals, and the development of the state health improvement plan.
VII. The information made available shall be maintained as a public resource for centralized and decentralized decision making and policy analysis by state and local health and human service entities, housing developers, municipalities, policy makers, the public, and other entities as they consider health improvement planning and health in all policies.
VIII. The information may also be used by the department to align planning, integrate services, and leverage resources across the department.
IX. The commissioner, in consultation with the state health assessment and state health improvement plan advisory council, shall release to the public, the state health assessment no later than 12 months after the effective date of this section and the state health improvement plan no later than 24 months after the effective date of this section. The plan shall be reviewed annually and updated every 5 years, or earlier if determined necessary by the commissioner.

Source. 2020, 39:16, eff. July 29, 2020. 2021, 35:1, eff. May 17, 2021.

Section 126-A:88

126-A:88 State Health Assessment and State Health Improvement Plan Advisory Council Established. –
I. There is hereby established a state health assessment and state health improvement plan advisory council. The council should be diverse with respect to race, ethnicity, geography, ideology, and age, and shall be comprised of the following members:
(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 insurance department, or designee.
(f) The commissioner of the department of safety, or designee.
(g) The commissioner of the department of corrections, or designee.
(h) The 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) Three representatives of hospitals located in New Hampshire, One from an academic medical center, one from a community hospital which is not a critical access hospital, and one from a critical access hospital, appointed by the New Hampshire Hospital 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.
(ee) The commissioner of the department of business and economic affairs, or designee.
(ff) A representative from Community Support Network, Inc. (CSNI), appointed by CSNI.
(gg) A representative from New Hampshire Community Behavioral Health Association, appointed by association.
(hh) The director of the office of health equity, department of health and human services, or designee.
(ii) The director of the Josiah Bartlett Center for Public Policy, or designee.
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 I(a) through (j) shall serve a term coterminous with their term in office. The members appointed pursuant to subparagraphs I(k) through (ii) 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. Twenty 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 council shall be subject to the provision of RSA 91-A.
VI. 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 the council's activities and including the council's recommendations for legislation to include estimated cost and benefit summary based on existing resources.

Source. 2020, 39:16, eff. July 29, 2020. 2021, 35:1, eff. May 17, 2021.

Controlled Drug Prescription Health and Safety Program

Section 126-A:89

126-A:89 Definitions. –
In this subdivision:
I. (a) "Chronic pain" means a state in which pain persists beyond the usual course of an acute disease or healing of an injury, or that might or might not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years. It also includes intermittent episodic pain that might require periodic treatment.
(1) For the purpose of this subdivision, chronic pain does not cover or in any way determine treatment for pain from terminal disease.
(2) For the purpose of this subdivision, chronic pain includes but may not be limited to pain defined as "chronic," "intractable," "high impact," "chronic episodic," and "chronic relapsing."

(b) A diagnosis of chronic pain made by a practitioner licensed in any of the states in the United States or the District of Columbia and supported by written documentation of the diagnosis by the treating practitioner shall constitute proof that the patient suffers from chronic pain.

II. "Commissioner" means the commissioner of the department of health and human services.

III. "Controlled substance" means controlled drugs as defined in RSA 318-B:1, VI.

IV. "Department" means the department of health and human services, established in RSA 126-A:4.

V. "Dispense" means to deliver a controlled substance by lawful means and includes the packaging, labeling, or compounding necessary to prepare the substance for such delivery.

VI. "Dispenser" means a person or entity who is lawfully authorized to deliver a schedule II-IV controlled substance, but does not include:

(a) A licensed hospital pharmacy under RSA 318 that dispenses less than a 48-hour supply of a schedule II-IV controlled substance from a hospital emergency department or that dispenses for administration in the hospital;

(b) A practitioner, or other authorized person who administers such a substance;

(c) A wholesale distributor of a schedule II-IV controlled substance or its analog;

(d) A prescriber who dispenses less than a 48-hour supply of a schedule II-IV controlled substance from a hospital emergency department to a patient;

(e) A veterinarian who dispenses less than a 48-hour supply of a schedule II-IV controlled substance to a patient; or

(f) A practitioner who does not hold or operate under an active Drug Enforcement Agency registration number to prescribe or dispense controlled substances.

VII. "Patient" means the person or animal who is the ultimate user of a controlled substance for whom a lawful prescription is issued and for whom a controlled substance or other such drug is lawfully dispensed.

VIII. "Practitioner" means a physician, dentist, podiatrist, veterinarian, pharmacist, APRN, physician assistant, naturopath, or other person licensed or otherwise permitted to prescribe, dispense, or administer a controlled substance in the course of licensed professional practice. "Practitioner" shall also include practitioners with a federal license to prescribe or administer a controlled substance.

IX. "Prescribe" means to issue a direction or authorization, by prescription, permitting a patient to lawfully obtain controlled substances.

X. "Prescriber" means a practitioner or other authorized person who prescribes a schedule II, III, or IV controlled substance.

XI. "Program" means the controlled drug prescription health and safety program that electronically facilitates the confidential sharing of information relating to the prescribing and dispensing of controlled substances listed in schedules II-IV, established by the department pursuant to RSA 126-A:90.

Source. 2021, 91:45, eff. July 1, 2021; 148:6, eff. July 1, 2021.

Section 126-A:90

126-A:90 Controlled Drug Prescription Health and Safety Program Established. –

I. The department shall design, establish, and contract with a third party for the implementation and operation of an electronic system to facilitate the confidential sharing of information relating to the prescribing and dispensing of schedule II-IV controlled substances, by prescribers and dispensers within the state.

I-a. The department may enter into agreements or contracts to facilitate the confidential sharing of information relating to the prescribing and dispensing of schedule II-IV controlled substances, by practitioners within the state and to establish secure connections between the program and a practitioner's electronic health record keeping system. An electronic health record keeping system may allow for the query and retrieval of the provider specified, individual's program information for display and retention in the patient's medical information; provided that nothing in this section shall allow the electronic health record keeping system owner or license holder to perform data queries unrelated to individuals under the practitioner's care. The electronic health record keeping system owner or license holder shall be responsible for ensuring that only authorized individuals have access to program information. The program shall record and retain in its database what information was transferred and the identity of the organization who received the information. The program shall include this information when a patient requests a report pursuant to RSA 126-A:93, I(b)(1).

II. The department may establish fees for the establishment, administration, operations and maintenance of the

program. The program may also be supported through grants and gifts. The fee charged to individuals requesting their own prescription information shall not exceed the actual cost of providing that information.
III. Prescription information held by the program relating to any individual shall be deleted 3 years after the initial prescription was dispensed. All de-identified data may be kept for statistical and analytical purposes in perpetuity.
IV. The commissioner shall establish an advisory council, as provided in RSA 126-A:96.

Source. 2021, 91:45, eff. July 1, 2021; 148:7, eff. July 1, 2021.

Section 126-A:91

126-A:91 Controlled Drug Prescription Health and Safety Program Operation. –
I. The department shall develop a system of registration for all prescribers and dispensers of schedule II-IV controlled substances within the state. The system of registration shall be established by rules adopted by the department, pursuant to RSA 541-A.
II. All prescribers and dispensers authorized to prescribe or dispense schedule II-IV controlled substances within the state shall be required to register with the program as follows:
(a) Practitioners who prescribe but do not dispense schedule II-IV controlled substances shall register with the program as a prescriber;
(b) Practitioners who dispense but do not prescribe schedule II-IV controlled substances shall register with the program as a dispenser unless exempted pursuant to RSA 126-A:89, VI; and
(c) Practitioners who prescribe and dispense schedule II-IV controlled substances shall register with the program as both a prescriber and a dispenser unless exempted pursuant to RSA 126-A:89, VI.
III. Only registered prescribers, dispensers, or their designees, and federal health prescribers and dispensers working in federal facilities located in New Hampshire, Massachusetts, Maine, and Vermont shall be eligible to access the program.
IV. The chief medical examiner and delegates may register and access the program.
V. Each dispenser shall submit to the program the information regarding each dispensing of a schedule II-IV controlled substance. Any dispenser located outside the boundaries of the state of New Hampshire and who is licensed and registered by the pharmacy board, established in RSA 318:2, shall submit information regarding each prescription dispensed to a patient who resides within New Hampshire.
VI. Each dispenser required to report under paragraph V of this section shall submit to the program by electronic means information for each dispensing that shall include, but not be limited to:
(a) Dispenser's Drug Enforcement Administration (DEA) registration number.
(b) Prescriber's DEA registration number.
(c) Date of dispensing.
(d) Prescription number.
(e) Number of refills granted.
(f) National Drug Code (NDC) of drug dispensed.
(g) Quantity dispensed.
(h) Number of days supply of drug.
(i) Patient's name.
(j) Patient's address.
(k) Patient's date of birth.
(l) Patient's telephone number, if available.
(m) Date prescription was written by prescriber.
(n) Whether the prescription is new or a refill.
(o) Source of payment for prescription.
VII. (a) Except as provided in subparagraphs (b) and (c), each dispenser shall submit the required information in accordance with transmission methods daily by the close of business on the next business day from the date the prescription was dispensed.
(b) Veterinarians shall submit the information required under subparagraph (a) no more than 7 days from the date the prescription was dispensed.
(c) Dispensers who have a federal Drug Enforcement Administration license, but who do not dispense controlled

substances may request a waiver from the requirements of subparagraph (a) from the department.
VIII. The program administrator may issue a waiver to a dispenser that is unable to submit prescription information by electronic means. Such waiver may permit the dispenser to submit prescription information by paper form or other means, provided all information required by paragraph VI is submitted in this alternative format and within the established time limit.
IX. The program administrator may grant a reasonable extension to a dispenser that is unable, for good cause, to submit all the information required by paragraph V within the established time limits.
X. Any dispenser who in good faith reports to the program as required by paragraphs V and VI shall be immune from any civil or criminal liability as the result of such good faith reporting.

Source. 2021, 91:45, eff. July 1, 2021.

Section 126-A:92

126-A:92 Confidentiality. –
I. Information contained in the program, information obtained from it, and information contained in the records of requests for information from the program, is confidential, is not a public record or otherwise subject to disclosure under RSA 91-A, and is not subject to discovery, subpoena, or other means of legal compulsion for release and shall not be shared with an agency or institution, except as provided in this subdivision. This paragraph shall not prevent a practitioner from using or disclosing program information about a patient to others who are authorized by state or federal law or regulations to receive program information.
II. The department shall establish and maintain procedures to ensure the privacy and confidentiality of patients and patient information.
II-a. A practitioner who intends to request and use information from the program about a patient shall post a sign that can be easily viewed by the public that discloses to the public that the practitioner may access and use information contained in the program. In lieu of posting a sign, the practitioner may provide such notice in written material provided to the patient.
III. The department may use and release information and reports from the program for program analysis and evaluation, statistical analysis, public research, public policy, and educational purposes, provided that the data are aggregated or otherwise de-identified at all levels of use. The department shall not acquire, use or release information from the program for these purposes unless all patient-specific protected health information has been de-identified in accordance with section 164.514(b)(2) of the HIPAA Privacy Rule.

Source. 2021, 91:45, eff. July 1, 2021; 148:8, eff. July 1, 2021.

Section 126-A:93

126-A:93 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 with whom the requester has a practitioner-patient relationship. This shall not include department staff seeking to access the program for state, federal or private agency purposes, or on behalf of the department or other requesting agency;
(2) For reviewing information regarding prescriptions issued or dispensed or for conducting medication reconciliation by the requester;
(3) For the purpose of investigating the death of an individual; or
(4) For the purpose of administering RSA 318:29-a, VI, RSA 326-B:36-a, RSA 329:13-b, and other participating health professional boards.
(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.]

(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.

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 department 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, 2021, 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 126-A:96 and the licensing boards of all professions required to use the program relative to the effectiveness of the program.

Source. 2021, 91:45, eff. July 1, 2021; 148:9, 10, eff. July 1, 2021.

Section 126-A:94

126-A:94 Unlawful Act and Penalties. –

I. Any dispenser or prescriber who fails to submit the information required in RSA 126-A:91 or knowingly submits incorrect information shall be subject to a warning letter and provided with an opportunity to correct the failure. Any dispenser or prescriber who subsequently fails to correct or fails to resubmit the information may be subject to discipline by the appropriate regulatory board.

II. Any dispenser or prescriber whose failure to report the dispensing of a schedule II-IV controlled substance that conceals a pattern of diversion of controlled substances into illegal use shall be guilty of a violation and subject to the penalties established under RSA 318-B:26 and the department's and appropriate regulatory board's rules as applicable. In addition, such dispenser or prescriber may be subject to appropriate criminal charges if the failure to report is determined to have been done knowingly to conceal criminal activity.

III. Any person who engages in prescribing or dispensing of controlled substances in schedule II-IV without having registered with the program may be subject to discipline by the appropriate regulatory board.

IV. Any person, including department staff, authorized to receive program information who knowingly discloses such information in violation of this subdivision shall be subject to discipline by the appropriate regulatory board and to all other relevant penalties under state and federal law.

V. Any person authorized to receive program information who uses such information for a purpose in violation of this subdivision shall be subject to disciplinary action by the appropriate regulatory board and to all other relevant penalties under state and federal law.

VI. Unauthorized use or disclosure of program information shall be grounds for disciplinary action by the relevant regulatory board.

VII. Any person who knowingly accesses, alters, destroys, or discloses program information except as

authorized in this subdivision or attempts to obtain such information by fraud, deceit, misrepresentation, or subterfuge shall be guilty of a class B felony.

Source. 2021, 91:45, eff. July 1, 2021.

Section 126-A:95

126-A:95 Rulemaking. –

The department shall adopt rules, pursuant to RSA 541-A, necessary to implement and maintain the program including:

I. The criteria for registration by dispensers and prescribers.

II. The criteria for a waiver pursuant to RSA 126-A:91, VIII for dispensers with limited electronic access to the program.

III. The criteria for reviewing the prescribing and dispensing information collected by the program.

IV. The criteria for reporting matters to the applicable health care regulatory board for further investigation.

V. The criteria for notifying practitioners of individuals that are engaged in obtaining controlled substances from multiple practitioners or dispensers.

VI. Content and format of all forms required under this subdivision.

Source. 2021, 91:45, eff. July 1, 2021.

Section 126-A:96

126-A:96 Advisory Council Established. –

I. There is hereby established an advisory council to carry out the duties under this subdivision. Members of the council shall not be compensated for serving on the council, or serve on the council for more than one 5-year term except for the attorney general, or designee, or the commissioner of the department of health and human services, or designee. The members of the council shall be as follows:

(a) A member of the board of medicine, appointed by such board.

(b) A member of the pharmacy board, appointed by such board.

(c) A member of the board of dental examiners, appointed by such board.

(d) A member of the New Hampshire board of nursing, appointed by such board.

(e) A member of the board of veterinary medicine, appointed by such board.

(f) A physician appointed by the New Hampshire Medical Society.

(g) A dentist appointed by the New Hampshire Dental Society.

(h) A chief of police appointed by the New Hampshire Association of Chiefs of Police.

(i) A community pharmacist appointed jointly by the New Hampshire Pharmacists Association, the New Hampshire Independent Pharmacy Association, and the New Hampshire Association of Chain Drug Stores.

(j) Two public members appointed by the governor's commission on alcohol and drug abuse prevention, treatment, and recovery, one of whom may be a member of the commission.

(k) A hospital administrator appointed by the New Hampshire Hospital Association.

(l) A nurse practitioner appointed by the New Hampshire Nurse Practitioner Association.

(m) A veterinarian appointed by the New Hampshire Veterinary Medical Association.

(n) The attorney general, or designee.

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

(p) A member of the senate, appointed by the president of the senate.

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

II. The council shall:

(a) Make recommendations to the department relating to the design, implementation, and maintenance of the program, including recommendations relating to:

(1) Rules.

(2) Legislation.

(3) Sources of funding, including grant funds and other sources of federal, private, or state funds;

(b) Review the program's annual report and make recommendations to the department regarding the operation of

the program.
(c) Provide ongoing advice and consultation on the implementation and operation of the program, including recommendations relating to:
(1) Changes in the program to reflect advances in technology and best practices.
(2) Changes to statutory requirements.
(3) The design and implementation of an ongoing evaluation component of the program.
(d) Advise the commissioner regarding the implementation of this subdivision.
(e) Adopt rules necessary for the operation of the council.
(f) Develop a mission statement for the program and strategic goals for its implementation, develop metrics in conjunction with the legislative budget assistant to measure the program's efficient operation, review the performance of the program against the metrics, and make recommendations to the program and ensure they are incorporated.
III. The council shall meet at least quarterly to effectuate its goals. A chairperson shall be elected by the members. A majority of the members of the council constitutes a quorum for the transaction of business. Action by the council shall require the approval of a majority of the members of the council.
IV. Members of the advisory council, previously established in RSA 318-B:38, shall be appointed as members of the advisory council established under this section to the extent possible.

Source. 2021, 91:45, eff. July 1, 2021.

Section 126-A:97

126-A:97 Competency Requirements. – Except for veterinarians who shall complete continuing education requirements in accordance with RSA 332-B:7-a, XV, all prescribers required to register with the program who possess a United States Drug Enforcement Administration (DEA) license number shall complete 3 contact hours of free appropriate prescriber's regulatory board-approved online continuing education or pass an online examination, in the area of pain management and addiction disorder or a combination, as a condition for initial licensure and license renewal. Verification of successful completion of the examination or of the required continuing education shall be submitted to the prescriber's regulatory board with the licensee's application for initial licensure or renewal. A list of the prescriber's regulatory boards' approved continuing education courses and online examinations in pain management and addiction disorder, shall be available on the department of health and human service's Internet website.

Source. 2021, 91:45, eff. July 1, 2021.