STATE OF NEW HAMPSHIRE
Executive Council
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August 24, 2026

Commissioner Lori Weaver
New Hampshire Department of Health and Human Services
129 Pleasant St.
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Chief Medical Officer Dr. Jonathan Ballard
New Hampshire Department of Health and Human Services
129 Pleasant St.
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Director of Medicaid Services Henry Lipman
New Hampshire Department of Health and Human Services
129 Pleasant St.
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Dear Commissioner Weaver, Dr. Ballard, & Director Lipman:

On August 14, 2026, a family currently receiving services under New Hampshire's **Katie Beckett Medicaid Program** — administered through one of the State's three Medicaid Managed Care Organizations (MCO) — reported that their child's physician-prescribed enteral nutrition was being reduced. The durable medical equipment (DME) supplier responsible for fulfilling the prescription confirmed that the reduction was being made at the direction of the MCO.

This was discussed with Mr. Lipman and Dr. Ballard, who immediately raised concerns about the change, particularly with respect to prescription nutrition and thickener for patients at risk of aspiration. The matter was also raised with Commissioner Weaver at the August 19, 2026 Executive Council meeting, where data from NH Katie Beckett recipients was shared.

A questionnaire was distributed to families enrolled in the Katie Beckett Program to collect information on DME order fulfillment, the protocols governing monthly re-ordering, and the problems families are encountering with that process. Since distributing the questionnaire, I have also been informed of denials of critical services by two providers — a Physical Therapist and a Speech-Language Pathologist. Comments from these providers are included at the end of this document and warrant immediate assessment.

Two categories are flagged as priority issues because they involve items/services with no discretionary substitute: enteral nutrition/thickeners (Section II.A) and feeding/swallowing therapy (Section II.B).

II. Survey Findings & Applicable Rules, By Category

A. Enteral Nutrition & Thickeners

Enteral formula and thickening agents are prescribed, Medicaid-formulary items. For children who cannot safely eat or drink without them, they are not substitutable or discretionary.

What families reported

- Enteral/feeding supplies & formula/nutrition was the most frequently reported problem category: 55.6% of respondents (5 of 9) flagged it under reporting difficulty, and 71.4% of those with current shortages (5 of 7) named it as the specific shortage.
- One family reported the member is NPO (nothing by mouth) and has no other way to eat without feeding extensions and related supplies.
- Emerging reports (outside this survey) indicate MCOs are directing DME suppliers to reduce enteral formula shipment volume below the amount the prescribing physician ordered.

"Member is NPO and without feeding extensions and other supplies he has no other way to eat." — survey respondent

Applicable CMS / Medicaid Rule

42 CFR § 438.210 — An MCO may not apply amount/duration/scope limits to a covered service based solely on diagnosis or category; any reduction below a physician's ordered quantity requires an individualized medical necessity determination.

42 CFR § 431.210–211 — Written advance notice is required before reducing, suspending, or terminating a previously authorized amount of a covered item — applicable if enteral volumes are being cut without notice.

42 U.S.C. § 1396a(a)(8) (reasonable promptness) — Medically necessary nutrition supplies must be furnished with reasonable promptness; recurring delays are a compliance concern in their own right, independent of any denial.

B. Feeding & Swallowing (Dysphagia) Therapy

Distinct from the supplies above, this is the clinical service that determines whether/how a child can progress toward safer oral intake or maintain safe swallow function to prevent aspiration pneumonia. The clinical standard of care for aspiration risk requires oversight by a speech-language pathologist (SLP). See notes from two providers at the end of this document.

What families/providers reported

- Feeding and swallowing therapy for children who aspirate is reportedly not being authorized or covered.
- Where therapy has been denied, there is no indication the denial was reviewed by a clinician qualified to evaluate an SLP-directed feeding/swallowing plan.

Applicable CMS / Medicaid Rule

EPSDT — 42 U.S.C. § 1396d(r); 42 CFR § 441.50 et seq. — Requires coverage of medically necessary services for Medicaid enrollees under 21 to correct or ameliorate a condition, including therapy services, based on individualized necessity — a categorical non-coverage of feeding/swallowing therapy would not satisfy this standard.

42 CFR § 438.210(b)(3) — Medical necessity denials must be made by, or in consultation with, an appropriate clinician; a denial of an SLP-directed therapy plan should be reviewed by a similarly qualified reviewer.

42 CFR § 438.400–408 (appeal rights) — Every denial should come with formal notice of appeal/fair hearing rights, which can be used to compel an EPSDT-consistent re-review.

C. Syringes

What families reported

- A monthly cap of 12 syringes was enforced by an MCO despite a physician's prescription for a higher quantity, forcing the family to purchase additional syringes out of pocket.

"Our DME tells us that WellSense will not allow us to have more than 12 per month even with a prescription from our child's dr." — survey respondent

> Applicable CMS / Medicaid Rule
> 42 CFR § 438.210 — A flat numeric cap applied regardless of the prescribing provider's order is the kind of categorical limit this rule restricts; the MCO must show an individualized necessity basis for capping below the prescription.
> 42 CFR § 431.210–211 — If a prior authorization allowed a higher quantity and it was reduced, advance written notice was required.

D. Incontinence Supplies

What families reported

- 11.1% of respondents flagged incontinence supplies as a category with obtaining difficulty.
- Narrative response describes a recurring monthly cycle: orders delayed pending insurance re-verification, repeated every month even after resolving the same question the prior month, with quantities reportedly reduced since May and out-of-pocket purchases required to bridge the gap.

"...update primary and secondary insurance; items eventually come but in the meantime having to purchase products to cover delay message received each month AFTER updating insurances prior month." — survey respondent

> Applicable CMS / Medicaid Rule
> 42 U.S.C. § 1396a(a)(8) (reasonable promptness) — A recurring, self-resetting administrative delay cycle each month is inconsistent with furnishing an already-authorized supply with reasonable promptness.
> 42 CFR § 431.210–211 — If the reduction in quantity since May was a reduction from a prior authorized amount, advance notice should have been issued.

E. Suction Supplies

What families reported

- 11.1% of respondents flagged suction supplies as a category with obtaining difficulty (no further detail provided in narrative responses).

> Applicable CMS / Medicaid Rule
> 42 U.S.C. § 1396a(a)(8) (reasonable promptness) — Applies generally to any medically necessary supply reported as difficult to obtain; follow-up is needed to identify the specific cause (backorder, authorization, or MCO limit) before pinpointing the more specific rule.

F. Pulse Oximeter / Monitoring Supplies

What families reported

- 11.1% of respondents flagged this category as a difficulty area.
- Narrative describes a supplier triage system that scheduled a weekend delay for a replacement pulse oximeter for a night-only, ventilator-dependent child who does not breathe independently during sleep.

"Because she is a night only vent patient, their triage determined she needed to wait out the weekend for a new one! My child, who does not breathe on her own AT ALL during sleep, doesn't need a pulse ox overnight? The company did not budge." — survey respondent

Applicable CMS / Medicaid Rule

42 CFR § 424.57 (DME supplier standards) — Sets baseline operational expectations for DME suppliers; a triage protocol that does not account for a member's individualized clinical risk is relevant to whether the supplier is meeting these standards.

42 U.S.C. § 1396a(a)(8) (reasonable promptness) — Monitoring equipment tied to a life-sustaining condition (apnea/ventilator dependence) is medically necessary and time-sensitive; a scheduling policy that ignores that urgency implicates this standard.

G. Ventilator (Life-Support Equipment)

What families reported

- Not flagged in the survey's checkbox data (0%), but described narratively as a serious near-miss: a family was told "no drivers were available" for an urgent ventilator replacement, with no backup unit on hand.
- The same family reports no transition plan has been communicated for a ventilator model reaching end-of-support in 2029.

"My daughter needed a new VENTILATOR and they told me I would have to wait over the weekend for a delivery since 'no drivers were available.' ...she only had one at the time! No backup!" — survey respondent

Applicable CMS / Medicaid Rule

42 CFR § 424.57 (DME supplier standards) — Suppliers of life-sustaining equipment are expected to maintain contingency capacity; a sole-unit ventilator patient without a backup and without weekend delivery capability is a direct patient-safety and supplier-standards issue.

42 U.S.C. § 1396a(a)(8) (reasonable promptness) — Applies with heightened urgency to life-support equipment; "no drivers available" is not an adequate basis for delaying a ventilator replacement for a child with no backup device.

H. G-Tube Extensions / Feeding Accessories

What families reported

- G-tube extensions and mini one-buttons reported as "often missing," described by one family as a known supplier problem being addressed informally by requiring orders to go through a supervisor.

Applicable CMS / Medicaid Rule

42 CFR § 438.210 — As formulary-adjacent feeding accessories necessary to use a covered enteral regimen, sustained unavailability should be treated with the same medical-necessity/reasonable-promptness scrutiny as the formula itself.

III. Denial Letters — Documentation Needed

Families report receiving denial letters for speech pathology. A formal denial triggers Medicaid notice-and-appeal rights, including the right to a fair hearing and, in some circumstances, continuation of benefits pending appeal. For every denial identified above, the following should be collected centrally:

Under the new NH Medicaid Rules, any change is required to be reviewed by the State Medicaid Director and Staff.

- A copy of the full denial/adverse benefit determination letter, including the stated reason and clinical criteria cited.
- The date of the denial and the date the family was informed of appeal rights.

- Whether the denial was a new-authorization denial, a reduction of an existing authorization (requires advance notice under 42 CFR § 431.211), or a termination.
- Which category from Section II the denial concerns.
- Whether the family filed an appeal or grievance, and the outcome.

Applicable CMS / Medicaid Rule

42 CFR Part 431, Subpart E; 42 CFR § 438.400–408 — Governs notice, appeal, and fair hearing rights for Medicaid managed care denials; a pattern of denials across the same categories/multiple families supports escalation from individual appeals to a systemic complaint.

Physical Therapist Report

- MCO are supposed to be covering all of the same things. Disparity between what they are covering.
- When MCO were first developed all coverage was supposed to be exactly the same
- Big changes in the last 2 years; seems like DHHS has not been enforcing this.
  NHHF and AmeriHealth have been difficult with covering outpatient therapy
- Coverage for specialty beds has been difficult. Systematic denial. The standard reimbursement rate is much lower than the cost of the beds. It doesn't matter what bed is ordered by the family; MCO is giving the same amount to the DME regardless of cost. DMEs are not carrying beds because they can't afford to get the low reimbursement rate.
- All reports are denied regardless of what is written in the report; all denials say medicate child, specialized locks on the bedroom doors
- Specialized car seats are systematically denied. Denials are all saying- Why won't a regular car seat work, what kind of car does the family have, can a parent install it? MCOs want the family to trial equipment before ordering but this is not an option with the DMEs
- Adaptive stroller denials; only a wheelchair or a stroller.
- Must put in report "Child risks death or life-threatening injury" for children to be approved for a care seat or safe sleep bed.
- Patients who have primary private insurance with Medicaid as a secondary have much higher rates of coverage than straight Medicaid.
- NH ATEC home modifications became DD Waiver and IHS Waiver
- If an evaluation is done none of the work to do the evaluation is covered (Specific home modification reports) A PT will spend 10-12 hours of work doing required Home Modification Evaluations and not be paid for any of the work when the specific evaluation is required by Medicaid.
- No one is available to do Home Modification Evaluations because there is no reimbursement rate for the person who is doing this. (Once it hits ATDP)

Swallowing Report (Speech Therapist)

- Denials for thickener from NHHF
- MCOs are wanting kids to be "fixed" quickly; not ongoing therapy for serious issues
- Trying to prevent G-tubes through regular therapy but this takes time.
- NHHF being especially difficult feeding therapy
- Same denials are sent to each patient regardless of symptoms or situations
- Genetic conditions that are not taken into account when denials are issued such as down syndrome or a progressive disorder.
- Kids with primary private insurance and MCO as secondary are not impacted.
- It's the profoundly medically complex children with only MCO coverage that are the most impacted.
- Families are having a high level of difficulty obtaining suctioning equipment
- Adapt Health has the highest number of difficulties for families with DME monthly supplies. NHHF and Wellsense are both giving issues with this.
- Enteral supplies difficulties at high levels with Wellsense

- Amerihealth not having issues with DME or therapies
- Particularly kids with chronic conditions
- NHHF stopped covering therapy about a year ago.
- NHHF stopped covering thickeners in January. No children with NHHF (even those who have private insurance) are able to get thickener.
- Denials if kids have both speech therapy and feeding therapy. NHHF won't pay for both when it is 2 different services and should be covered.
- Most dangerous sample of kids

IV. Requested Action

- For each category in Section II, request the MCO's written policy or utilization-management criteria (if any) that permit reducing a physician-ordered quantity.
- Request all adverse benefit determination letters issued to surveyed families in the past 12 months, mapped to the categories above.
- Require an EPSDT medical-necessity re-review, by a qualified SLP or equivalent clinician, for any denied or reduced feeding/swallowing therapy.
- Audit ventilator backup/contingency capacity for members dependent on life-support DME, including the 2029 end-of-support transition.
- Expand data collection beyond this 9-respondent sample, organized by the same categories, to support a systemic complaint to NH DHHS or CMS if the pattern persists.

Sincerely,

Janet Stevens
Executive Councilor, District 3
State of New Hampshire