DISABILITIES RIGHTS CENTER, Inc.

Care Management Entity Policy Audit

Prepared by the Disabilities Rights Center
for the New Hampshire Children's Behavioral Health Collaborative

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The Disabilities Rights Center is New Hampshire's designated Protection and Advocacy agency and authorized by federal statute "to pursue legal, administrative and other appropriate remedies" on behalf of individuals with disabilities. DRC is a statewide organization independent from state government and service providers.

Table of Contents

Executive Summary

Introduction

New Hampshire is undertaking a process to implement a *system of care* to address the needs of children with complex behavioral health conditions, particularly those who are at risk for placement outside their home and community. New Hampshire's establishment of a system of care follows a strategic planning process conducted by the state's Children's Behavioral Health Collaborative involving child-serving agencies, family representatives, advocates, policymakers, and elected officials. The plan that resulted from that process identifies creation of a Care Management Entity (CME) as the most significant infrastructure change needed.

The Disabilities Rights Center was asked by the Endowment for Health to conduct an analysis of available policy levers to support creation of a CME in New Hampshire. As part of that analysis, a review was conducted of other jurisdictions that have developed similar systems of care and have utilized CMEs to coordinate care for youth involved in multiple systems and with complex behavioral health needs.

Approaches to the Establishment of a System of Care and CME Implementation

Some jurisdictions have approached establishment of a system of care through broad enabling legislation using a range of approaches, including: 1) direction of an agency or agencies to facilitate the coordination of services for children's behavioral health needs; 2) creation of pilot projects; 3) creation of an interagency body (or assignment of new duties to a pre-existing body) to oversee and advise policymakers during the process; 4) a mandate for various agencies to cooperate and coordinate; and 5) a requirement for memoranda of understanding or creation of new offices to support establishment of the new process.

Other states have utilized Medicaid and other contracts in the absence of new statutory or regulatory authority. Pre-existing statutory frameworks may also facilitate development of a system of care. Existing New Hampshire statutes contain some general direction that would support creation of a system of care.

Although enabling legislation is a common method for establishment of a system of care, such statutes are less likely to specifically address the establishment of CMEs themselves. Some jurisdictions have established CMEs through new interagency relationships, contracts and administrative regulations. New Hampshire does not have a pre-existing system which could be assigned the functions of a statewide CME, but it has a history of delegating significant human service delivery, coordination, and management functions to non-profit and other private organizations.

If New Hampshire proceeds with establishment of a CME through comprehensive enabling legislation, consideration should be given to including explicit references to development of a uniform assessment, an interagency body to oversee and recommend legislative, policy and procedure changes, modification of the

interagency agreement statute to explicitly provide for development of a system of care approach and procedures to integrate the CME into both departments' service systems.

Integration with Juvenile Justice, Child Protection and Public School Systems

Integration with the juvenile justice and child protection systems is considered critical to successful implementation of a CME. Many children at risk of residential placement become involved in the juvenile justice and child protection systems, and a large share of the expenditures for children's mental health treatment, particularly very high-cost children, follow dispositional orders of the juvenile courts.

There are a number of opportunities for integration of a CME with the New Hampshire children in need of services (CHINS) and delinquency systems. New Hampshire juvenile court procedures could easily be modified to incorporate the involvement of a CME, most importantly when the court develops its dispositional order which sets out the services a child will receive. In order to maintain fidelity to the principle of voluntary and active family involvement, any amendment to the juvenile dispositional statutes should provide that CME dispositions can only be ordered with the consent of the family.

Integration with the child protection system is another common feature of CMEs and is described in the strategic plan as one of the systems expected to participate in the project. Children involved in this system share many of the same risk factors to children involved in the juvenile justice system. Many of the mechanisms for integration of the juvenile justice system are also available within the New Hampshire Child Protection Act and can easily be modified to bring the CME into the process in appropriate cases.

Another important partner in the coordination of care for children with complex needs is the public school system. To operate most effectively in New Hampshire a CME would need to be well integrated with the special education system. Using legal requirements to impose cooperation with a CME on local school districts would be problematic, given their exclusive authority and legal mandate to develop and deliver special education services. Instead, integration of schools and the CME may most successfully be based on creating incentives for the coordination of efforts with the CME, primarily based on the effectiveness of CMEs in creating effective services that do not rely on expensive out-of-home placements.

CHINS "Restoration"

In 2011, significant changes were made to the definition of a "child in need of services," resulting in a major reduction in both the number of children in the CHINS system and the extent of services provided through that part of the juvenile justice system. In 2012, there were unsuccessful legislative attempts to restore some of the former jurisdiction, and it is expected that the effort will continue in 2013. The debate over these initiatives is expected to turn in part on whether families seeking services will be permitted to obtain them through a voluntary process or only through the former vehicle of court action, which did not provide for voluntary access to services. Even if the former CHINS statute is reinstated without a voluntary option, the CME process

could be integrated through the changes discussed in the juvenile justice section of this report.

Medicaid Managed Care

The strategic plan identifies as part of its financing strategy the incorporation of a CME into New Hampshire's developing Medicaid Managed Care structure. Because the majority of services in CMEs tend to be publicly funded, particularly through Medicaid, and New Hampshire is developing a Medicaid managed care system, it will be important for New Hampshire's CME to be able to operate successfully in such an environment. CME operations are compatible with managed care; several states have both Medicaid Managed Care and CMEs.

New Hampshire could proceed either with integration of the CME into the managed care system or exemption from it. The current contractual framework for Medicaid managed care appears to anticipate the development of programs which share many of the characteristics of CMEs. Regardless of how integration (or exemption) is pursued, the characteristics of a CME may prompt the MCOs to welcome CME services into their systems.

Financing CME Services

A comprehensive analysis of financing options for the CME project is not included in this report; however a brief summary of financing approaches in other jurisdictions and how they could be applied in New Hampshire is included. Financing strategies vary significantly from jurisdiction to jurisdiction. Effective approaches appear to begin with a careful accounting of existing funding and a review of those funds that are not yet leveraging federal matches.

A common financing strategy for CMEs is the redirection of funds from expensive and often ineffective out-of-home placements to home and community based services, particularly evidence-based practices. Additionally, implementation of systems to share financial responsibility for the treatment of children involved in multiple systems has also been utilized. This often includes the ability of the CME to combine funding from multiple sources and the utilization of a case rate system. Although rare in other jurisdictions, New Hampshire's strategic plan includes private insurance as one source of funding for CME services. Establishing private insurance as a major funder of CME services in New Hampshire may be challenging, due to the uncertainty of the scope of future coverage requirements and the traditional resistance of the private insurance industry to statutory coverage mandates.

New Hampshire could approach CME financing in part by expansion of Medicaid funded services, either through additions to state plan services or expanded utilization of Medicaid's Early Periodic Screening, Diagnosis, and Treatment program. Pending federal legislation may allow states to put in place Medicaid waivers specifically focused on funding community services for children who otherwise would be in residential treatment.

Introduction

New Hampshire is undertaking a process to implement a *system of care* to address the needs of children with complex behavioral health conditions, particularly those who are at risk for placement outside their home and community. A system of care "is a coordinated network of effective community-based services and supports which help children and youth to function better at home, in school, in the community, and throughout life."[1] It operates in a manner that is family-driven, youth-guided, community-based, and culturally and linguistically competent.[2]

Coordination of services is considered particularly important in systems which deal with *children's* behavioral health. A child with a serious emotional disorder may become involved in multiple systems, such as special education, juvenile justice, or child protection, creating the risk of overlapping, redundant, or conflicting efforts to deal with the same set of problems: "The service system in many communities is more fragmented for children than that for adults, with even more uncoordinated funding streams and differing eligibility requirements. This problem is partly the unintended result of good intentions: there are more programs set up to serve children than adults. But this leaves coordination up to families who are coping with their children's behavioral problems and who may not have the knowledge to navigate the maze."[3]

States have developed system of care approaches in an effort to change the manner of behavioral health care delivery so that through careful coordination of services children can remain in their communities and out of the child welfare and juvenile justice systems. A key goal of a system of care approach is to reduce the use of highly restrictive, expensive, and often ineffective out-of-home placements while improving child and family outcomes.

New Hampshire's establishment of a system of care follows a strategic planning process conducted by the state's Children's Behavioral Health Collaborative involving child-serving agencies, family representatives, advocates, policymakers, and elected officials. The plan that resulted from that process identifies creation of a Care Management Entity (CME) as the most significant infrastructure change needed.[4]

CMEs are organizations that coordinate care for youth involved in multiple systems and with complex behavioral health needs. They utilize system of care principles and typically focus on high-cost youth populations in or at risk of placement in

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[1] *New Hampshire Children's Behavioral Health Strategic Plan* [draft for comment and input as of November, 2012], Cover sheet p. 3.

[2] Stroul, B., Blau, G., & Friedman, R. (2010). *Updating the system of care concept and philosophy*. Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health, http://gucchdgeorgetown.net/data/documents/SOC_Brief2010.pdf, accessed January 16, 2013.

[3] Interim Report of the President's New Freedom Commission on Mental Health Rockville, MD: New Freedom Commission on Mental Health, October 29, 2002. p. 5, http://govinfo.library.unt.edu/mentalhealthcommission/reports/Interim_Report.htm, accessed January 13, 2013.

[4] *Strategic Plan*, supra note 1, Goal 3.1, p.10.

residential treatment.[5] Using multiple funding streams, CMEs redirect resources toward intensive community-based services to reduce the high cost and poor outcomes associated with placement outside the community. Their focus is commonly children in the juvenile justice and child protection systems, and among their tools are uniform screening and assessment, high-fidelity wraparound services, and mobile crisis response. CMEs typically accept referrals from a broad array of sources.[6]

CMEs (and system of care approaches in general) are associated with significantly lowered use of high-cost residential treatment, reduced use of secure detention in the juvenile justice system, decreased recidivism in delinquent populations, and improvements in clinical assessments and school attendance. CMEs may be government agencies, non-profit organizations, or health maintenance organizations.

According to the Collaborative's strategic plan, children served by the New Hampshire CME will meet criteria for Serious Emotional Disturbance,[7] be involved in at least 2 service systems, and be at risk for immediate placement in a corrections, psychiatric, or residential treatment facility. It is estimated that more than 400 New Hampshire children are currently in such facilities.[8] Although the current initiative is primarily focused on children and families served by publicly funded systems, eventually allowing privately insured families to participate is one of the goals of the strategic plan.[9]

This report results from a request by the Endowment for Health to the Disabilities Rights Center for an analysis of "policy levers" which may be available to support creation of a CME in New Hampshire.[10] The project consisted of a review of statutes, regulations, and other policy changes used in other states to create systems of care and CMEs, followed by a review of such devices in New Hampshire to identify those which can be used to support a CME initiative as well as those that may need review and revision to allow for it to proceed.

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[5] See, generally, Center for Healthcare Strategies, Care Management Entities: A Primer (2011), http://www.chcs.org/usr_doc/CHIPRA_CME_Primer_v5.pdf.

[6] Rhode Island's system provides for referrals from "[f]amilies, community and law enforcement agencies, health care providers, schools, early care and education programs and other programs serving children and families . . . " RI ADC 14-3-91:4-III.

[7] Serious Emotional Disturbance is the condition qualifying a child for community mental health services in New Hampshire, He-M 401.08, and is defined as "severe mental disability in persons under the age of 18, and includes psychiatric disorders classified as axis I disorders or an axis II borderline personality disorder in the DSM-IV-TR with the exception of substance abuse disorders and V codes, which are conditions not attributable to a mental disorder." He-M 401.02. The phrase, along with "emotional disturbance" is used to describe one of the conditions recognized as potentially qualifying a child for special education services, 20 U.S.C.A. § 1401(3)(A)(i), RSA 186-C:2 I.

[8] Maine Health Information Center, *Children in Out-of-Home Placement in New Hampshire, SFY2007,* Office of Medicaid Business and Policy, NH Department of Health and Human Services, February 2009, page 12, http://www.dhhs.nh.gov/ombp/documents/outofhome.pdf.; accessed January 10, 2013. Children in such placements have higher rates of psychiatric and intellectual disabilities, as well as epilepsy and similar conditions.

[9] *Strategic Plan*, supra note 1, Goal 3.3, p.13.

[10] The Disabilities Rights Center's analysis was supported by Discretionary Grant 2323 from the Endowment for Health.

With few exceptions CMEs operate within a larger system of care infrastructure. This report begins with a discussion of avenues to the establishment of a system of care, then proceeds to discuss CME formation, integration with New Hampshire's juvenile justice, child protection, and school systems, and the potential impact of the current Medicaid managed care initiative and legislative efforts to expand the current Children in Need of Services (CHINS) system. A brief discussion of financing and a summary of potential legislative approaches complete the report.

Approaches to the establishment of a system of care

Systems of care and CMEs have come into being in other jurisdictions through a variety of mechanisms. In some instances, they have been established without explicit new legislative authority. In Wisconsin, for example, a county-based CME was established purely through a series of Medicaid and other contract mechanisms without any statutory or regulatory enactments.[11] Pre-existing statutory frameworks also may facilitate development of a system of care; it is not uncommon for states' statutory frameworks for human services to include pre-existing legislative direction for cooperation among agencies, with systems of referral and payment for services that can be developed or modified at the regulatory or policy level as the system of care is assembled.

New Hampshire itself has statutes that include some direction for child-serving departments to cooperate and integrate their services. RSA Chapter 170-G (Services for Children, Youth, and Families) establishes the authority and framework for the Department of Health and Human Services' child service delivery system and sets out a comprehensive array of duties and authorities which are compatible with establishment of a system of care. It includes the authority to:

- provide for services to children in placement and at risk of placement,
- develop comprehensive service plans for children pursuant to Title IV-E of the Social Security Act (Foster Care and Adoption Assistance),
- "[p]repare and administer a comprehensive statewide service plan which addresses the needs of the state's children and youth on a geographic basis,"
- "[c]ooperate with local programs and services [to] develop treatment options for children and youth; [and to] assist communities to develop services and placement options for children and youth," and
- "[m]ake recommendations to the general court relative to legislation necessary to ensure the coordination of services for children and youth."[12]

[11] See, generally, WrapAround Milwaukee web site at http://county.milwaukee.gov/WraparoundMilwaukeeP7890.htm.

[12] RSA 170-G:4

There is also an existing requirement that the leaders of New Hampshire's Education and Health and Human Services departments cooperate in providing services to children with disabilities involved in multiple systems:

> I. The commissioner of the department of education, the state board of education, and the commissioner of the department of health and human services shall, consistent with applicable state and federal law, enter into an interagency agreement for the purposes of:
>
> (a) Meeting the multi-service agency needs of children with disabilities in an efficient and effective manner and without delays caused by jurisdictional or funding disputes;
>
> (b) Providing for continuity and consistency of services across environments in which children function; and
>
> (c) Ensuring well-planned, smooth, and effective transitions from early intervention to special education and from special education to postsecondary life.[13]

The current interagency agreement does not address the level of system integration that is considered necessary for a true system of care, nor the importance of family-driven and youth-guided processes.[14]

Although they are not comprehensive, existing New Hampshire statutes thus appear to contain some direction to some of the agencies which would be expected to operate in a system of care. That direction includes instruction to cooperate and coordinate services, one of the hallmarks of the system of care approach.

In those jurisdictions that have established a system of care through legislation, there are a range of approaches. Typically, a principal component of such legislation is the direction of an agency or agencies to facilitate the coordination of services for children's behavioral health needs. In Connecticut, the commissioners of two departments were required to "develop and administer an integrated behavioral health service delivery system."[15] In Massachusetts, the Secretary of Health and Human Services was directed to oversee the coordination of children's behavioral health services by convening regular meetings of child-serving state agencies and monitoring demand and capacity in the children's behavioral health system.[16] The Massachusetts

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[13] RSA 186-C:7-a. The current agreement, completed in 2008, and its 1999 predecessor are on file with the author.

[14] An example of an agreement that is focused on integrated behavioral health services for children is the 2006 Connecticut Memorandum of Understanding between its Commissioners of Social Services and of Children and Families, http://www.ct.gov/dcf/lib/dcf/mou/moa_001_bhp_d05_funding_-_dss.pdf, accessed January 14, 2013.

[15] Conn. Gen. Stat. Ann. § 17a-22a.

[16] Mass. Gen. Laws Ann. ch. 6A, § 16P. The Massachusetts statute was passed in the wake of a court determination that the state was in violation of the Early Periodic Screening Diagnosis and Treatment provisions of the federal Medicaid program.

statute was passed in the wake of litigation that required Massachusetts to make extensive changes to its system.[17]

Although most system of care initiatives operate throughout a state, some jurisdictions began with pilot projects. Rhode Island's statute established two "local coordinating councils" in 1998, providing funding for the entities equal to all public funds used for children in residential treatment and directing that the resources by used for a much broader array of services.[18] In Wisconsin, CMEs operate in only the two largest counties.

Another common feature of enabling legislation is the creation of an interagency body (or assignment of new duties to a pre-existing body) to oversee and advise policymakers during the process. The Massachusetts statute established a children's behavioral health advisory council, with broad membership from state agencies, professional associations, consumers, and advocates. The council has responsibilities for monitoring the system and making legislative and regulatory recommendations.[19] Similarly, Missouri's enabling statute requires establishment of a "comprehensive system management team," with membership drawn from child-serving agencies, the courts, families, and advocates.[20]

Many such interagency bodies are composed of agency heads or their designees. In what may have been an effort to ensure that experts in children with complex needs were active in the state interagency body, Vermont's statute is highly prescriptive with regard to its makeup, specifying that it include among its members the director of special education, the department of education's consultant for children with severe emotional disturbance, and the department of social and rehabilitative services' placement consultant.[21]

Some enabling legislation simply mandates cooperation and coordination in general, while others explicitly require memoranda of understanding or create new offices to support establishment of the new process. Connecticut's statute requires that participating government departments enter into memoranda of understanding for the joint administration of the system of care and is quite prescriptive regarding the content of the memorandum, requiring certain responsibilities to be apportioned to particular

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[17] See the Children's Behavioral Health Initiative website http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/childrens-behavioral-health-initiative-overview.html.; accessed January 10, 2013.

[18] R.I. Gen. Laws Ann. § 42-72.7-5.

[19] Mass. Gen. Laws Ann. ch. 6A, § 16Q; Reports of the Council are available at http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/childrens-behavioral-health-advisory-council.html. The full enabling statute is available at http://www.malegislature.gov/Laws/SessionLaws/Acts/2008/Chapter321; accessed January 10, 2013.

[20] Mo. Ann. Stat. § 630.097

[21] Vt. Stat. Ann. tit. 33, § 4302

agencies.[22] Missouri's enabling legislation established an "Office of Comprehensive Child Mental Health" with responsibility to lead the process of establishing its system and to provide support to the system management team.[23]

Should an interdepartmental entity be needed to oversee a system of care in New Hampshire, there does not appear to be a pre-existing body to which that function could be assigned. During the Shaheen administration, there was a "Kid's Cabinet," composed of the leaders of child-serving agencies, but it was not based in statute and no longer exists. If New Hampshire proceeds to put such a body in place, it may be helpful for legislative drafters to review the design and operations of the state's Interbranch Criminal and Juvenile Justice Council,[24] which has more than 20 representatives of the New Hampshire legislative, executive and judicial branches as well as professional and advocacy organizations and a mandate to "[f]oster effective communication, understanding, cooperation, and coordination among those involved in, or affected by, the criminal and juvenile justice system."[25]

Care management entity implementation

Although enabling legislation is a common method for establishment of a system of care, such statutes are less likely to specifically address the establishment of CMEs themselves. As previously mentioned, one of the pioneering CMEs, WrapAround Milwaukee, was established without any statutory or regulatory changes. It is one of two county-based CMEs in Wisconsin. Milwaukee County operates its own CME, while Dane County (home of Madison) uses a non-profit corporation. They are entirely creatures of interagency relationships at the county level and contracts with state Medicaid and child welfare agencies.

The Milwaukee Medicaid contract was entered into pursuant to Section 1915(a) of the Social Security Act. That provision authorizes a state to enter into "a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization... "[26] The process does not require either a waiver or a state plan amendment. The contract with the state child welfare system is described by the Milwaukee program's director as essentially a provider agreement.

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[22] Conn. Gen. Stat. Ann. § 17a-22a. The 2006 Memorandum of Understanding between Connecticut's Commissioner of Social Services and Commissioner of Children and Families can be accessed at http://www.ct.gov/dcf/lib/dcf/mou/moa_001_bhp_d05_funding_-_dss.pdf.

[23] See Mo. Ann. Stat. § 630.1000

[24] See RSA Chapter 651-E

[25] RSA 651-E:3 III

[26] 42 U.S.C.A. § 1396n; 13 states operate voluntary managed care programs under this provision, see http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Managed-Care/Managed-Care.html; accessed January 10, 2013.

Connecticut's enabling legislation directs that private regional entities be established for service planning and coordination by requiring the Department of Children and Families to contract with "lead service agencies" in each area.[27]

Massachusetts' statute established regional "interagency review teams to collaborate on complex cases when a child... may qualify for services from multiple state agencies consisting... of representatives selected from agencies within the executive office of health and human services, the department of early education and care, and the department of elementary and secondary education. If appropriate and if proper consent has been provided, representatives of local education agencies and juvenile probation shall be invited to participate."[28]

Apart from the statutorily created review teams, Massachusetts has assembled a network of privately operated CMEs. Known as "Community Service Agencies", or CSAs, they were created in 2009 through the Children's Behavioral Health Initiative and in partnership with the 4 managed care organizations (MCOs) operating in that state's Medicaid managed care systems.[29] CSA applicants were limited to pre-existing service providers with a physical location in the region to be covered and demonstrated readiness to provide wraparound services.[30] There are now 29 regional CSAs and 3 devoted to specialized populations (black, hispanic, and deaf/hard of hearing).[31]

Each of the MCOs operating in Massachusetts contract with the CSAs for intensive care coordination and other services for children with SED, and all of the CSAs use a common operations manual. CSAs are the eligible Medicaid providers for Targeted Case Management, a Medicaid service.[32] [Capitation and quality management occur at the MCO level, see http://www.chcs.org/usr_doc/S_Fields_CME_Financing_Presentation.pdf]

North Carolina's statute establishes "Local Management Entities," (LMEs) which are county or other human service agencies[33] and "responsible for the management

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[27] See Conn. Gen. Stat. Ann. § 17a-22b. The Connecticut implementation plan discusses the operation of the lead service agencies in detail, as well as other aspects of the system. It is at http://www.ct.gov/dcf/lib/dcf/behavioral_health/pdf/kidcare_legislative_report2.pdf.; accessed January 10, 2013. The particular framework established in the statute – "Connecticut Community KidCare" – is no longer being utilized, according to staff at the Department of Social Services. The system is now overseen by the "Behavioral Health Partnership," which includes state agencies and a behavioral health managed care organization, with continued attention to integrated services. See the partnership website at http://www.ctbhp.com/index.htm.; accessed January 10, 2013.

[28] Mass. Gen. Laws Ann. ch. 6A, § 16R

[29] New Hampshire has entered into contracts with 3 managed care organizations as part of its transition to Medicaid Managed Care.

[30] The Massachusetts solicitation for CSA applications, with amendments, is at http://www.masspartnership.com/provider/index.aspx?lnkid=CSARequestForResponse.ascx.; accessed January 10, 2013.

[31] A list of the CSAs is at http://www.rosied.org/resources/Documents/CSA%20awards.pdf.; accessed January 10, 2013.

[32] 114.3 Mass. Code Regs. 52.02

[33] N.C. Gen. Stat. Ann. § 122C-3

and oversight of the public system of mental health, developmental disabilities, and substance abuse services at the community level."[34] LMEs, as the entry point for residential care, are given a role in controlling the supply of residential treatment beds. Their verification of the need for new resources is required before new facilities are licensed so that high vacancy rates do not contribute to increases in the cost of care.[35] Medicaid enrollment of intensive community service and residential providers requires LME endorsement as well.[36]

New Jersey's CME system is based on the use of private Contracted System Administrators and is set out in detail in its administrative code. A Contracted System Administrator is defined in regulation as "an administrative organization contracted by, and serving as an agent of, the Department of Children and Families to provide utilization management, care coordination, quality management and information management for the Division of Child Behavioral Health Services in its administration of the locally managed system of care that provides mental and behavioral health services and supports to eligible children, youth and young adults."[37] New Jersey regulations explicitly provide Contracted System Administrators the authority to manage utilization of the service system – they are empowered to determine eligibility for services,[38] required to participate in the process of certification of need for residential treatment services (a prerequisite for admission),[39] and to authorize intensive community mental health services.[40]

New Jersey also has extensive regulations setting up mobile response and stabilization management services,[41] requiring providers to keep data in accordance with the Contracted System Administrators' requirements,[42] and mandating that providers participate in outcome studies.[43]

Although the detailed regulation seen in the New Jersey and North Carolina systems may need development over time in New Hampshire, they contain examples of devices which seem likely to facilitate successful CME implementation. For example, requiring the CME to be involved in the process for authorizing reimbursable services would create a strong incentive for referral of appropriate children to the CME. Linking certification for payment to participation in data management and outcome studies makes it more likely that the service system will operate effectively and in an integrated

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[34] N.C. Gen. Stat. Ann. § 122C-115.4

[35] N.C. Gen. Stat. Ann. § 122C-23.1

[36] See the policy statement of the North Carolina division of Medical Assistance, http://www.ncdhhs.gov/dma/services/lmes.htm.; accessed January 10, 2013.

[37] N.J. Admin. Code 10:77-1.2

[38] N.J. Admin. Code 10:77-5.4

[39] N.J. Admin. Code 10:75-2.2

[40] N.J. Admin. Code 10:77-5.10

[41] N.J. Admin. Code 10:77-6.1 et seq.

[42] N.J. Admin. Code 10:77-6.11

[43] N.J. Admin. Code 10:77-5.13

manner. Requiring the principal agency at the entry point to intensive services to participate in the assessment of the need for resource expansion may contribute to control of costs.

New Hampshire does not have a pre-existing system which could be assigned the functions of a statewide CME, but it has a history of delegating significant human service delivery, coordination, and management functions to community-based non-profit organizations.[44] It has also involved private agencies in Medicaid prior authorization[45] and certain functions of the child welfare system.[46] As discussed below, each of the court systems addressing children's issues have experience with the involvement of multiple agencies in the process of determining appropriate services for court-involved children.

Integration with Juvenile Justice

Integration with the juvenile justice system is considered critical to successful implementation of a CME. Many children at risk of residential placement become involved in the juvenile justice and child protection systems, and a large share of the expenditures for children's mental health treatment, particularly very high-cost children, follow dispositional orders of the juvenile courts.

The term "juvenile justice system" in this report refers to both the delinquency and children in need of services (CHINS) systems. The delinquency system handles children up to age 17 who are alleged to have committed an offense which would be a crime if committed by an adult. Courts exercising delinquency jurisdiction have broad dispositional authority which can include commitment to the youth corrections facility and in some cases, adult corrections facilities.[47] The CHINS system historically has handled "status offenders," those children whose behaviors are only unlawful because of their status as children. Such behaviors included truancy, habitual running away from home, and repeated disregard of the lawful commands of parents. In 2011, New Hampshire's CHINS statute was amended to remove most of its jurisdiction and now only applies to children under 18 with significant disabilities who have engaged in dangerous behaviors and are not subject to other juvenile statutes.[48] The courts' dispositional authority under the CHINS statute does not typically include commitment to correctional facilities.[49]

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[44] RSA 135-C:3 (authorizing the Commissioner of Health and Human Services to enter into contracts with private entities to establish the mental health and developmental services systems)

[45] See He-W 531.01, http://www.mynewhampshirecare.com/default.aspx; accessed January 10, 2013.

[46] RSA 169-C:21 (role of "child placing agency," defined in RSA 169-C:3 as including certain private entities)

[47] RSA 169-B:19

[48] RSA 169-D:2 II

[49] RSA 169-D:17

There are a number of opportunities for integration of a CME with the CHINS and delinquency systems. Current statutory provisions include procedures for the identification of children with disabilities and involvement of outside agencies in court decision-making, which could easily be modified to provide for referral to the CME and incorporation of CME input.

Looking first at a child's entry into the juvenile justice system, in cases subject to diversion from the formal court process New Hampshire law provides for notification to the child's school district when disability is suspected so that an evaluation can be conducted for special education eligibility.[50] Diversion is a process to remove a case from the court system and redirect the response to a child's behavior to a less formal program which may involve treatment, restitution, community service, and the like. It may be initiated by a police or prosecution agency, or by the court itself, and is commonly utilized when a child has not previously been involved in the justice system and the conduct of the child is not serious. Adding to diversion procedures the optional referral of a child to the CME may bring some eligible children to the attention of that agency. Children at significant risk of placement outside the home may not be seen as likely candidates for diversion in the current system. Explicit authority to divert a child to the CME, with its focus on children with complex needs, may help to overcome any reluctance to direct such children to the CME without the requirement of court adjudication.

If a child is not diverted, the first appearance of the child and family in delinquency court is currently used in part as an opportunity to determine if there is a history of disability. The statute provides for brief inquiry by the court regarding the existence of "cognitive disability,... mental illness, emotional or behavioral disorder, or another disorder that may impede the child's decision-making abilities; or… eligib[ility] for special education services."[51] This information can then be used by the court to help determine whether to require the involvement of counsel[52] and whether to require the school district to become involved in the court proceedings. This inquiry could be expanded to provide for questions about possible involvement with the CME, as well as for the use of a uniform assessment in appropriate cases.

The first appearance procedures in CHINS cases do not contain the same disabilities inquiry,[53] although they could be expanded to parallel the delinquency system, and such expansion would facilitate court integration with the CME.

It should be noted that screening and assessment procedures have been controversial in the juvenile justice community. Advocates for children have raised concerns that cooperation with such procedures risks the disclosure of information which may be damaging to the defense or trigger more restrictive and intrusive dispositions in response to treatment needs that would not have otherwise been known

[50] RSA 169-B:10 II, 169-D:9 I.

[51] RSA 169-B:13 I (f).

[52] RSA 169-B:12 I, 169-D:12 I

[53] RSA 169-D:11

to the court. Depending on how they are integrated into the judicial process, issues of interference with the right to counsel and compelled self-incrimination can also arise. These issues are less likely to be significant if screening is utilized in diverted cases or procedures are in place to limit the purpose and timing of their use.[54] New Hampshire's Child Protection Act contains one example of the kind of procedure that would allow assessment but limit the purposes to which it could be used.[55]

In both the CHINS and delinquency systems the court is directed to consider joinder[56] of the responsible public school district. Joinder can be ordered at any point in the proceedings. It is permissive in all cases and mandatory when "the court contemplates a residential placement."[57] Following joinder, procedures are in place to give the school access to court records and for the court to receive school information regarding the child's condition and recommendations from the school regarding dispositions which best meet educational needs.[58]

These procedures provide a useful template for the possible incorporation of the CME into juvenile justice proceedings. The existing residential placement trigger for mandatory school joinder closely parallels the expected criteria for children that should be referred to the CME. Input into disposition from the CME about alternatives to placement would presumably be welcomed by not only the court but particularly by the school district which would pay for the educational component of any placement. Adding CME references to the existing provisions would be one legislative option, although it may be useful to set out in separate sections all CME-related procedures, such as assessment, referral, and input into dispositions.

Perhaps the most important point in the juvenile justice process to incorporate a CME is when the court develops its dispositional order. Roughly equivalent to the sentencing phase of an adult criminal case, this is the stage where the court considers input from the parties, including the child's school district if a joinder order has been issued, and issues an order for services and/or sanctions. Current law provides broad authority to order dispositions which include:

1. Commitment to the Youth Development Center until age 17 if not previously released by the Center (in delinquency cases only);
2. Home detention;

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[54] For a comprehensive discussion of the self-incrimination issue and procedures in various jurisdictions to address it, see Lourdes M. Rosado & Riya S. Shah, Juvenile Law Center, *Protecting Youth from Self-Incrimination when Undergoing Screening, Assessment and Treatment within the Juvenile Justice System* (2007), http://sccounty01.co.santa-cruz.ca.us/prb/media%5Cyouth%20screening.pdf; accessed January 10, 2013.

[55] RSA 169-C:18 VI ("The social study will be used only after a finding of neglect or abuse... Any psychiatric report shall be used by the court only after a finding of neglect or abuse unless such report is submitted for determination of competency.")

[56] Joinder in this context essentially means bringing the school into the proceedings and in some respects treating it as a party by giving it access to information and input into certain court decisions.

[57] RSA 169-B:22 I, 169-D:18 I.

[58] RSA 169-B:22 II, 169-D:18 II.

3. Release to the custody of the department for placement in a group home, foster home, or shelter care facility;
4. Conditional release, which is roughly analogous to probation in criminal cases; and
5. Mental health treatment for the child, the family, or both.[59]

This dispositional authority is broad enough to allow a New Hampshire court to order CME services, so an amendment would not be strictly necessary. However, in order to encourage use of its services, particularly if the CME in New Hampshire is expected to be a non-profit agency, it may be advisable to explicitly provide for it as an alternative.[60] Treatment of the CME as simply another dispositional alternative would be inconsistent with one of the guiding principles of CMEs around the country – that they must be "youth-guided and family-driven."[61] According to its director, the Milwaukee CME program is only ordered by a juvenile court with the consent of the family. If they decline the option, other dispositions are ordered. In order to ensure voluntary and active family involvement, any amendment to the New Hampshire juvenile dispositional statutes should provide that CME dispositions can only be ordered with the consent of the family.

In some Milwaukee cases where the family consents, a conventional disposition is ordered but the order is stayed pending successful participation in the CME program.[62] Wisconsin law explicitly provides for stayed dispositions,[63] which is not a feature of New Hampshire juvenile law. However, New Hampshire juvenile court judges have been known to issue commitment orders to the Youth Development Center and stayed or deferred their execution pending satisfaction of conditions for remaining in the community, and that authority does not appear to have been questioned.

The last stage of juvenile justice proceedings to consider for incorporation of CME involvement is discharge from a corrections or other residential placement. Children who have been placed outside their homes by a court are almost by definition at continuing risk for a return to placement. The process of re-entry to home, school, and community is notoriously difficult in New Hampshire and elsewhere, and the failure to re-connect with supportive community institutions makes it more likely that children will drop out of school and engage in delinquent conduct in the future. Early discharge planning by the placement facility, particularly if it involves service providers in the community, can enhance the likelihood of success.

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[59] RSA 169-B:19, 169-D:17

[60] The Milwaukee CME accepts children under dispositional orders issued under a statute which makes no mention of that particular disposition, but it is a county agency. Wis. Stat. Ann. § 938.34

[61] http://www.chcs.org/usr_doc/CHIPRA_CME_Primer_v5.pdf., p. 1; accessed January 10, 2013.

[62] See Center for Health Care Strategies, *CME Engagement and Work with Judges and the Court* (presentation slides) (2012), http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261352; accessed January 10, 2013.

[63] Wis. Stat. Ann. § 938.34 (16)

Rhode Island addresses discharge by corrections facilities by requiring notification to the local "family care community partnership" well in advance of the anticipated discharge date.[64] New Hampshire's statute dealing with discharge from the Youth Development Center does not provide for either discharge planning or involvement of other agencies in that process[65] Appropriate planning and referrals would be facilitated if CME referral in appropriate cases were mandated through amendments to that statute. A starting point would be to utilize the Rhode Island approach and begin involvement of the CME in discharge planning beginning 60 to 90 days before the anticipated discharge date. To ensure that appropriate discharge planning occurs in court-ordered placements other than the Youth Development Center, additions would also need to be made to the juvenile justice statutes themselves.

In some cases, the discharge from a facility occurs abruptly, as New Hampshire juvenile judges retain jurisdiction over cases until the case is closed.[66] This continued jurisdiction allows the modification of dispositional orders, which can trigger a discharge from placement that is earlier than originally expected.[67] This can create difficulties in the discharge preparation process. The statutes authorizing modification of a dispositional order could be amended to provide that when such a modification will result in a change in the expected discharge date for a child, that the CME will be receive an immediate referral in appropriate cases.

Tables I and II summarize the potential changes to juvenile justice statutes discussed in this report.[68]

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[64] RI ADC 14-3-91:4-III A 6 (a)

[65] RSA 621:19

[66] RSA 169-B:31, 169-D:3 III

[67] RSA 169-B:31, 169-D:19

[68] Juvenile proceedings are governed by court rules and protocols as well as by statute. The court rules relating to juvenile proceedings are not as detailed as the corresponding statutes and do not appear to present any obstacles to implementation of a CME in New Hampshire. Although amendment is typically a lengthy process, modification of the rules so that they reflected any statutory changes would facilitate integration. For the rules governing proceedings in delinquency and CHINS matters, see N.H. R. Fam. Div. Rule 3.1 et seq., particularly 3.6 (conditional release conditions), and 3.7 (notice to interested persons of proceedings after child placed out of home). For those governing child protections cases, see NH R FAM DIV Rule 4.1 et seq., particularly 4.2, Attendance of Non-Parties and 4.4 (notice and opportunity to be heard for interested persons). New Hampshire courts also use detailed protocols to regulate procedure in some types of cases, including child protection cases. See N.H. District Court Improvement Project, *Protocols Relative to Abuse and Neglect Cases and Permanency Planning* (Rev. April 2003), http://www.courts.state.nh.us/district/protocols/abuseneglect/abusenegprotocol.htm; accessed January 10, 2013.

Table I: New Hampshire Delinquency Statutes to Consider for Amendment

Statute	Potential Amendment
169-B:10 II Juvenile Diversion	Addition of CME as potential referral during diversion process
169-B:12 Appointment of Counsel; Waiver of Counsel	Include referral to CME in cases where disability present
169-B:13 I (f) (Court inquiry regarding disability at first appearance)	Add inquiry regarding prior CME involvement; incorporate use of uniform assessment in appropriate cases
169-B:13 II Arraignment; Court Referrals; Uncompensated Public Service by Minors	Court may dispose of petition through referral to CME in cases where the family consents
169-B:14 II-a Release or Detention Pending Adjudicatory Hearing.	Following arraignment court shall consider whether referral to CME is appropriate
169-B:16 III (a) Adjudicatory Hearing	Court orders following delinquency adjudication to include CME referral and evaluation for services in cases where child known to be involved in multiple systems and/or being considered for placement outside the home
169-B:16 III (b) Adjudicatory Hearing	Court again to consider whether CME referral/joinder appropriate
169-B:16 VI Adjudicatory Hearing	When court considering disposition which will involve placement outside home, order/consider CME referral
169-B:19 IX Dispositional Hearing	Concurrent with school opportunity to be heard in cases involving out of district placement, CME referral and opportunity to be heard
169-B:19 I Dispositional Hearing	Add referral to CME as dispositional alternative in cases where child may be eligible for CME services
169-B:19-c Court Order for Services, Placements, and Programs Required for Minors From Certain Providers Qualified for Third-Party Payment.	Preferences for services to include CME-related services
169-B:22 Disposition of a Minor with a Disability	Apply permissive and mandatory school joinder provisions to CME; add procedural subsection
621:19	Referral to CME during discharge planning process for eligible children

Table II: New Hampshire CHINS Statutes to Consider for Amendment

Statute	Potential Amendment
169-D:5 VI Petition	In petitions filed by schools involving a child with a disability, include information regarding involvement, if any, of the CME
169-D:5-b Consent Order	May be the appropriate disposition in some cases where family agrees to CME referral
169-D:9 I (Diversion may include referral for school evaluation)	Referral to CME encouraged in appropriate cases
169-D:10-a Removal of Child From Home	Require court to refer to CME or issue written explanation for declining referral
169-D:11 Initial Appearance	Consideration of CME referral at first appearance and in cases to be diverted by court Add inquiry regarding prior CME involvement and existence of disability; incorporate use of uniform assessment in appropriate cases
169-D:14 VI Adjudicatory Hearing.	If court contemplates placement outside the home, referral to CME to be considered/required in certain cases
169-D:17 I Dispositional Hearing.	CME referral added as a permitted disposition
169-D:17 VII Dispositional Hearing.	Prior to placement outside home, CME referral required or to be considered
169-D:17-c Court Order for Services, Placements, and Programs Required for Minors From Certain Providers Qualified for Third-Party Payment	Preferred services to include those provided by/coordinated by CME
169-D:18 Disposition of Child With a Disability	Apply permissive and mandatory school joinder provisions to CME; add procedural subsection
169-D:19 Modification of Dispositional Orders	In cases where CME involved in coordinating services, allow CME to seek court orders to facilitate those services

Integration with the child protection system

Integration with the child protection system is a common feature of CMEs and is described in the strategic plan as one of the systems expected to participate in the project.[69] The principles of the New Hampshire Child Protection Act, with its preferences

[69] *Strategic Plan*, supra note 1, Goal 3.3, p.13.

for services in the child's home and coordination of care,[70] are consistent with the CME model.

Many of the mechanisms for integration of the juvenile justice system are also available within the Child Protection Act. The child protection system has an existing framework for involvement of public school districts in appropriate cases. There is statutory authority for consideration of information provided by schools, and for actual joinder of a school in appropriate cases.[71] The joinder provisions are mandatory when residential treatment is "contemplated" by the court. These sections of the statute would easily be modified to bring the CME into the process in appropriate cases.

Just as with the juvenile justice statutes, the Child Protection Act grants authority to the court to order treatment for family members of a child as part of a plan for keeping a child in the home.[72] This parallels the CME preference for coordinated treatment of the family when appropriate. This provision could be modified to provide for explicit reference to the CME, but its current language appears to be sufficient.

The first opportunity for referral to the CME by a child protection court is at the preliminary hearing. At that hearing, if the court finds that there is "reasonable cause" to support the petition, it has the authority at that hearing to issue a "preliminary disposition," putting in place protective services, changes in custody, and orders for evaluation.[73] Modification of these statutes could provide for optional CME referral in all cases, and mandatory referral whenever a residential treatment placement is being seriously considered. A preference for use of a uniform assessment could also be included.

If the court finds at the adjudicatory hearing that a child has been abused or neglected, it is required to consider joinder of the responsible school district and to order a comprehensive investigation into the family and home conditions.[74] This is another appropriate point to insert a statutory requirement that the court consider a referral to the CME and preparation of a dispositional recommendation from the CME if the child has a significant behavioral health condition.

Following adjudication, the court proceeds to consider a dispositional order, and operates under a statute that grants authority which is sufficiently broad to include CME services.[75] As with the other juvenile statutes, explicit reference in the dispositional statute to CME services will encourage referrals in appropriate cases, and could incorporate a requirement that CME services must be agreed to by the family.

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[70] RSA 169-C:2 I ("This chapter seeks to coordinate efforts by state and local authorities, in cooperation with private agencies and organizations... to... correct problems in order to avoid removal of children from the family [and]... [p]rovide protection, treatment and rehabilitation, as needed, to children placed in alternative care.")

[71] RSA 169-C:18 V, 169-C:19 VI, 169-C:20

[72] RSA 169-C:19 I (b)

[73] RSA 169-C:15, 169-C:16

[74] RSA 169-C:18 III

[75] RSA 169-C:19

As with the juvenile justice system, appropriate referrals to the CME of children in the child protection system could also be encouraged by requiring referral to the CME during the discharge planning process for a child who has been placed in residential treatment.[76]

Because the child protection statute includes a preference for services certified under RSA 170-G:4, XVIII, it will be important to either ensure that that statute covers CME or expressly provide for CME services as a preference in appropriate cases

Table III summarize the potential changes to child protection statutes discussed in this report.

Table III: New Hampshire Child Protection Statutes to Consider for Amendment

Statute	Potential Amendment
169-C:16 (Dispositional orders following preliminary hearing)	Include referral to CME as an option for the court, possibly mandatory if residential treatment contemplated or if CME already involved
169-C:18 V (upon finding of abuse and neglect, court to order investigations and dispositional recommendations0	Include request for dispositional recommendations from CME if involved in case
169-C:19 (dispositional orders)	New subsection requiring referral to CME during discharge planning for eligible children
169-C:19 VI (referral to school for dispositional recommendations)	Include mandatory CME referral in cases involving placement for residential treatment and optional referral in other cases
169-C:19-c (court to limit orders for services and placements to providers certified pursuant to RSA 170-G:4)	Include CME as an authorized provider (or ensure that CME is certified by department as a provider)
169-C:20 (Joinder of school district when child has disability)	Include optional referral to CME, mandatory when placement for residential treatment contemplated
169-C:23 (consideration of return of child from out-of-home placement)	Require court to make referral in appropriate cases to CME for discharge and community service planning
169-C:24 Periodic Review Hearings (regarding status of dispositional orders)	Require court to make referral to CME if disposition being modified so that discharge to community is anticipated

[76] RSA 169-C:23 and 24 may be appropriate provisions to amend to require referral, as they address court review of dispositions and conditions for return to the home from placement. Such a requirement could also be included in an amendment to the dispositional statute, RSA 169-C:19.

Integration with the public school system

An important partner in the coordination of care for children with complex needs is the school system, and to operate most effectively in New Hampshire a CME would need to be well integrated with the public education system.[77] Many of the CMEs around the country do not work closely with the public school system. In Massachusetts, the schools are only optional members of its interagency review teams,[78] and in Milwaukee, schools only use the CME's services for limited purposes.[79]

It is generally understood that children in juvenile justice and child protection have higher rates of both identified and unidentified educational disabilities, and even in states without a system of care, the juvenile courts are seen as one way for children not previously identified to be brought to the attention of the school system.[80]

Under the federal Individuals with Disabilities Education Improvement Act[81] (IDEA) and its New Hampshire counterpart,[82] children with disabilities must be provided specially designed instruction and "related services" needed to make progress in school and prepare for independent living. "Related services" are those services which are required to enable or assist a child to benefit from special education, and may include psychological and counseling services.[83] Services provided through a CME will more likely qualify as related services than as educational services.

Public schools are required to evaluate children who are referred for possible special education services, and if such services are needed, to develop an individualized education program (IEP). The IEP must set out specific instructional and related services and program modifications that will enable progress in the curriculum. For children nearing age 16, the IEP must also address the child's transition to

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[77] Such coordination is important regardless of whether a child is placed or attending school in a home community. On the whole children in the child protection and delinquency systems are less likely to receive adequate educational services. See Center for Juvenile Justice Reform, *Addressing the Unmet Educational Needs of Children and Youth in the Juvenile Justice and Child Welfare Systems,* p. 51 (2012), http://cjjr.georgetown.edu/pdfs/ed/edpaper2012.pdf; accessed January 10, 2013. New Hampshire administrative rules address integration of schools and the juvenile justice and child protection systems when a child with an educational disability is placed outside the home, see Part He-C 6443.

[78] Mass. Gen. Laws Ann. ch. 6A, § 16R

[79] According to the director of WrapAround Milwaukee, the schools make some use of mobile crisis response services provided by his agency. See http://www2.milwaukee.k12.wi.us/sshs/subpages/programs/mutt.htm, accessed January 13, 2013.

[80] Burrell, S., & Warboys, L. (2000, July). Special education and the juvenile justice system. *Juvenile Justice Bulletin.* Washington, DC: Office of Juvenile Justice and Delinquency Prevention, https://www.ncjrs.gov/pdffiles1/ojjdp/179359.pdf.; accessed January 10, 2013. See University of New Hampshire Justiceworks, *Children with Disabilities in the New Hampshire Juvenile Justice System* (2004) (addressing the elevated rate of disability in both corrections and court samples of delinquent youth in New Hampshire), http://www.unh.edu/justiceworks/media/pdfs/Child-Disabilities-RPT.pdf, accessed January 12, 2013.

[81] 20 U.S.C.A. § 1400 et seq.

[82] RSA Chapter 186-C: Special Education

[83] 20 U.S.C.A. § 1401 (26), RSA 186-C:2 V.

independent living, training, postsecondary education, and employment.[84] Public schools are required to pay for all required services, which may include services in settings such as residential treatment centers.

Children may if necessary be placed in separate schools either within or outside the district, including residential schools, as part of their special education program, with significant financial consequences for the budgets of school districts and the state. Even when children are placed due to involvement in the juvenile justice or child protection system, the public schools remain financially responsible for special education services received while in placement.[85]

Both state and federal law require that services be provided in the least restrictive environment appropriate to the child's needs.[86] This legal mandate, along with the incentive to limit expenditures, is consistent with the CME approach of keeping children in their homes, schools, and communities if possible through the use of intensive and carefully coordinated services. The legal mandate that families be fully involved in special education decision-making is also consistent with the typical CME's "family-driven" service model.

Although state and federal law requires special education programming to include community-based mental health treatment if it is necessary to enable a child to benefit from special education services, schools are generally reluctant to include it. School-based mental health counseling is sometimes included in IEPs, but generally for strictly limited time periods. However, when a child with complex needs is at risk of an expensive residential placement, local districts may have equally strong incentives to participate in programs like those of a CME which use home and community services to keep children out of placements.

Integration of schools and the CME thus may most successfully be based on creating incentives for the coordination of efforts with the CME. The alternative of using legal requirements to impose cooperation with a CME on local school districts would be problematic, as the existing framework must remain consistent with federal law, which places exclusive authority and responsibility to develop and deliver special education services on school districts.

A number of these incentive opportunities can be found in the statutes and administrative rules governing special education. Starting at the beginning of a child's involvement in the special education system, New Hampshire administrative rules require that school districts establish referral procedures to ensure that "every child who is suspected or known to be a child with a disability shall be referred to the IEP team for further evaluation," and that "any person" may refer a child for evaluation.[87] These provisions support acceptance of CME referrals by schools when a previously

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[84] 20 U.S.C.A. § 1414

[85] RSA 186-C:19-b (school responsible for up to 3 times per-pupil average expenditure, with remainder the state's responsibility)

[86] 20 U.S.C.A. § 1412(a)(5); RSA 186-C:1 I, Ed 1111.01, Placement in the Least Restrictive Environment

[87] Ed 1105.02.

unidentified educational disability is suspected. Although the rule's current language is broad, it could be amended to explicitly address CME referrals to encourage cooperation with the CME project. The juvenile justice system is known to have a disproportionately high rate of children with both identified and unidentified disabilities; presumably the CME population will include some children who have not been properly identified by one or more of the service systems for which they are eligible.

In provisions addressing cooperation between school districts' special education programs and area agencies for services to persons with developmental disabilities, the administrative rules provide what may be a template for linking CMEs and school special education programs. The rules require that area agencies and local school districts enter into interagency agreements for the purpose of identifying young children with disabilities served by the area agency system.[88] Its requirements are quite specific and require such agreements to address practices that enable collaboration, exchange of information and confidentiality, referral procedures, utilization of previously administered evaluations, etc. Given the low number of children who will be involved in the project, at least in the early stages, it may be unnecessary for every district to negotiate an agreement with the CME. However, such agreements would be a useful vehicle for the establishment of procedures which facilitate cooperation, and it may be sensible to empower the Commissioner of Education to require them in selected districts.

In the special education evaluation process itself, New Hampshire's regulations currently allow some flexibility for using evaluations from outside agencies. The rule requires that "qualified examiners" perform evaluations, and includes psychologists and psychiatrists in the list of approved evaluators.[89] In order to allow the school evaluation process to incorporate uniform assessments conducted by the CME (or other agencies involved with the CME project), this rule could either be amended to provide for acceptance of such assessments or measures could be taken to ensure that the CME process utilizes members of the rule's approved occupations.

In addition to facilitating referral *to* the school, referral *by* the school to the CME should be addressed. Rule provisions could be adopted that require referral to the CME if a child is involved in multiple systems, if an assessment finds emotional disturbance at a level where placement may be considered, if particular disorders are present, or similar criteria. Incorporating use of a uniform assessment instrument in the schools could also be accomplished through amendment of the rules regarding evaluation,[90] either in all cases where an emotional disturbance is suspected or when particular types or levels of disability are believed to be present.

The IEP development stage of the process also presents opportunities for integration with a CME. State and federal regulations include as potential participants in the IEP process "other individuals who have knowledge or special expertise regarding

[88] Ed 1105.04

[89] Ed 1107.04

[90] Ed 1107.01-1107.05

the child, including related services personnel as appropriate... ,"[91] a description that would apply to a CME providing services that enable a child to benefit from education. To prompt an invitation to the CME to actively participate in the planning process, the rule could be amended to identify such entities as potential IEP team members. In addition, requirements for referral to the CME could be included in the administrative rules for IEP development in cases where assessment results exceed a particular threshold, a child is involved in multiple systems, and/or placement is being considered.[92]

To ensure that the CME becomes involved in cases where its services could avoid residential placement, consideration may be given to mandating CME referrals in the statutes which govern state financial participation in expensive special education cases, including residential placement cases. Two statutes are in play; when the school places a child, state "catastrophic aid" funds are available for partial reimbursement after a local district exceeds a payment threshold[93], and when a court places a child the district has an absolute cap on its share of special education service costs. To provide an incentive, a school CME referral requirement in both types of cases could be added. If the actual reduction of state funding participation as a consequence is disfavored, an increase in the ratio of state participation could be applied in cases where a CME is involved. An even milder approach would be to require that any school applying for catastrophic aid funds include in its application an explanation of its decision regarding referral to the CME[94]. The state could then make its own referral to the CME in appropriate cases. This last alternative would have the advantage of centralized and consistent referral decisions, removing the need to ensure that all school districts have sufficient expertise to make appropriate referral decisions.

Tables IV and V summarize the changes to education statutes and administrative rules discussed in this report.

Table IV: New Hampshire Education Statutes to Consider for Amendment

Statute	Potential Amendment
RSA 186-C:3-b II (Advisory Committee membership)	Add system of care and/or CME member(s)
RSA 186-C:3-b IV (Advisory Committee duties)	Add duty to advise Department of Education regarding the development of coordinated system of services for multi-system involved children.

[91] 34 C.F.R. § 300.321, incorporated by reference in Ed 1103.01.

[92] Ed 1109.01, Elements of an Individualized Education Program.

[93] RSA 186-C:18 III

[94] Because according to the statute state monies do not flow to a district until the year after services are provided, this incentive may be weakened unless procedures were put into place to induce appropriate referrals during the year of service delivery.

RSA 186-C:7-a III (Subject matter of Interagency Agreement for Special Education)	Add requirement that agreement specifically address procedures to be followed to integrate schools, juvenile justice and juvenile protection, and CME
186-C:18 III (Catastrophic aid formula)	State contribution to payment for high-cost children conditioned on concurrent or prior referral to CME if otherwise appropriate; requirement for discharge planning in conjunction with CME where applicable
RSA 186-C:19-b II Liability for Children With Disabilities in Certain Court Ordered Placements	Limitation of school district financial liability for children placed by court dependent upon referral to CME; possibly allow Department to make referral; requirement for discharge planning in conjunction with CME where applicable

Table V: Administrative Rules related to Special Education to Consider for Amendment

Regulation	**Potential Amendment**
Part Ed 1105. Child Find	Acceptance of referrals from CMEs
Ed 1107.01 Evaluation	Add reference to use of previously conducted CME assessments.
Ed 1107.04 Qualified Examiners	Include CME as qualified examiner for emotional disturbance (or ensure that CME evaluations are conducted by one of the approved professional groups)
Ed 1111.02 Placement Decisions	Add reference to CME as means to keep child in least restrictive environment or add requirement that referral to CME precede placement in appropriate cases
Ed 1117.04 (d) (Considerations when making placements)	Add referral to CME as recommended consideration prior to changing placement of child placed by court
Ed 1117.04 (e) (Juvenile Justice representatives to be invited to placement meetings)	Add CME representative to persons to be invited to meetings considering placement
Ed 1117.06 (a) Preplacement and Placement Review Procedures for Children Not Previously Determined to Have Disabilities.	Add CME in list of referring agencies triggering review
Ed 1127.02 (Financial assistance to schools with children in placement where DCYF has financial responsibility)	Allow DCYF to make a referral to CME in appropriate cases upon receiving claim for state financial contribution

CHINS "Restoration"

As previously discussed, in 2011 significant changes were made to the definition of a "child in need of services," resulting in a major reduction in both the number of children in the CHINS system and the extent of services provided through that part of the juvenile justice system. In 2012, there were unsuccessful legislative attempts to restore some of the former jurisdiction, and it is expected that the effort will continue in 2013. The debate over these initiatives is expected to turn in part on whether families seeking services will be permitted to obtain them through a voluntary process or only through the former vehicle of court action.[95]

Supporters of a voluntary access model for children's services emphasize that many, if not most, families involved in the former system would have used voluntary services if they had been available and affordable, and that the court system creates unproductive adversarial relationships and needless procedural expense in circumstances where everyone involved shares the objective of securing appropriate services.

The CME model depends on voluntary family engagement in the process, and providing access to the public service system without necessitating a court order would be more compatible with system of care principles. Allowing voluntary service access also appears to be fully compatible with New Hampshire's former CHINS model. A voluntary service access avenue would not interfere with those cases which required court intervention.[96] Of course, there are numerous examples of addiction and mental health services in both outpatient and inpatient settings being accessed simultaneously by persons acting on their own and persons ordered to participate by a court. Even if the former CHINS statute is reinstated without a voluntary service option, the CME process could be integrated with it through the kinds of changes discussed in the juvenile justice section of this report.

Massachusetts has recently begun a reformation of its CHINS system that may be instructive as the CME project proceeds and New Hampshire policy makers contemplate CHINS restoration. The Massachusetts process will be converted to one that no longer requires court petitions to access needed services. The "CHINS" terminology has been abandoned in favor of "Families and Children Engaged in

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[95] Most of the cases handled by the former CHINS system did not involve children likely to be placed outside their homes. According to HHS representatives, the former system handled 900-1000 cases per year, and relatively few of them involved residential placement. Some number of CHINS cases under a "restored" statute may, however, be potential CME referral candidates.

[96] New Hampshire has some experience in the child protection system with providing voluntary behavioral health services to families that would otherwise become court involved, see RSA 169-C:34 V; New Hampshire Division for Children, Youth, and Families, *2010-2014 Comprehensive Child and Family Services Plan*, June 30, 2009, available at http://www.dhhs.state.nh.us/dcyf/documents/2010-2014cfsp.pdf; accessed January 11, 2013.

Services," or FACES,[97] and many aspects of a system of care appear to be present in the planned system. The legislation requires the use of "standard intake screening and assessment tools to evaluate families and children seeking community-based services." Services will be available either through direct referral to community services or through the court, families seeking assistance will be directed to the voluntary system whenever possible, and law enforcement must make referrals to the voluntary system in cases where doing so would not risk a child's safety. In addition, the courts are required to initiate meetings of schools, community service providers, and other agencies involved with a child to coordinate appropriate services.

Medicaid Managed Care

The draft strategic plan identifies as part of its financing strategy the incorporation of the CME into the "managed care organization structure."[98] Because the majority of services in CMEs tend to be publicly funded, particularly through Medicaid, and New Hampshire is developing a Medicaid managed care system,[99] it will be important for New Hampshire's CME to be able to operate successfully in such an environment. CME operations are certainly compatible with managed care, as the overwhelming majority of states have Medicaid managed care,[100] including several that have CMEs.

There are two general approaches that could be taken in this regard – integration into the managed care system or exemption from it. Integration would mean that Medicaid children whose care is being coordinated by the CME would also be enrolled with one of New Hampshire's 3 MCOs. This has been pursued in Massachusetts, with each MCO in that state working with the same network of CMEs. So that services do not vary based on the MCO in which a child has been enrolled, each of the MCOs use identical contracts and each of the CMEs use the same policy manual. If New Hampshire pursues an integration approach, it will be important to establish relationships between the CME and each of the MCOs that are sufficiently similar to allow the CME to operate consistently with all children.[101] Even if the contractual

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[97] Mass. St. 2012, ch. 240. A comparison of the old and new systems can be found at the website of Massachusetts' Children's Mental Health Campaign: http://hcfama.org/document/docWindow.cfm?fuseaction=document.viewDocument&documentid=2167&documentFormatId=2651; accessed January 10, 2013.

[98] *Strategic Plan*, supra note 1, Goal 4.2, p.15-16.

[99] See RSA 126-A:5 XIX

[100] Kaiser Commission on Medicaid and the Uninsured, *Medicaid Today; Preparing for Tomorrow A Look at State Medicaid Program Spending, Enrollment and Policy Trends Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013,* http://www.kff.org/medicaid/upload/8380.pdf; accessed January 10, 2013.

- [101] In Maryland, "[a]ll five Medicaid managed care entities . . . were required to develop a collaborative, cross-health-plan approach to network development . . . All five are mandated . . . to have the same network of [CMEs] as part of their provider networks." Center for Health Care Strategies, *Case Rate Scan for Care Management Entities*, p.5, http://www.chcs.org/usr_doc/Case_Rate_Scan_for_CMEs.pdf, accessed January 13, 2013.

relationships do not vary from one MCO to another, differences in such things as administrative procedures and ease of service approval may require careful management on an ongoing basis.

Although technically not the "incorporation" contemplated by the strategic plan, *exemption* of CME cases from the managed care system entirely is another option to be considered.[102] Full exemption carries the advantage of avoiding differences in provider panels among MCOs, which could occur even if all MCOs had identical CME contracts and criteria for approval of services. Such differences in availability of services based on MCO enrollment would at the least create inefficiencies for the CME, and possibly reduce its effectiveness.

Complete exemption would avoid any problem of differences from one MCO to another, and could be pursued using current federal statutory exemptions that would apply to many, if not most, of the children who would be involved with the CME. Those exemptions prohibit mandatory enrollment in a managed care system for children who qualify for supplemental security income (SSI), who are receiving foster care/adoption assistance under Title IV-E of the Social Security Act, and who are in foster care or other out-of-home placements.[103] Presumably, these federal exemptions would not apply to every child served by the CME, so relying on current exemptions may not be a satisfactory solution. If the New Hampshire CME is established through comprehensive enabling legislation, a provision could be included that created a state statutory exemption for children receiving CME-coordinated services. Although a proposal to remove any part of the Medicaid population could prompt objections from the MCOs that relied on a particular population composition in negotiating contracts with the state, the companies may not object to removal of the CME population, which will be composed of children with conditions that are complex and expensive to address.

If a true integration strategy is pursued, allowing the CME to coordinate the care of children with complex needs is arguably consistent with the MCO contracts now in place. Those agreements require each MCO to develop programs that are specifically focused on populations which share many of the expected characteristics of CME children.

For example, one section of the MCO contract[104] provides that each MCO is responsible for the development of "effective chronic and complex care management programs" for chronic conditions (including mental illness), that the member be "actively engaged in the development of the care plan," and that those programs may be delegated to patient centered medical homes or health homes. Delegation of this

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[102] The strategic plan also speaks in terms of the CME being "recognized" by the managed care organization structure, which may be consistent with a system wherein the MCOs defer to the CME for management of certain populations through an exemption from the principal managed care system. *Strategic Plan*, supra note 1, Goal 4.2, p.16.

[103] 42 U.S.C.A. § 1396u-2

[104] *New Hampshire Medicaid Care Management Services Agreement,* 2012 [hereinafter "*Agreement*"] Section 10.7

required managed care program to a CME would appear to be fully compatible with this provision.[105]

The contract also requires each MCO to "create an organizational structure to function as patient navigators to... reduce any barriers to care encountered by members with special needs... ", and to identify such members based on a number of different criteria including but not limited to: multiple chronic conditions, serious and persistent mental illness and children in foster care.[106]

Finally, the contract requires the MCOs to link members with "state, local, and community programs that may provide or assist with related health and social services to members, including... Juvenile Justice,... Schools, [and] [t]he court system."[107]

The current contractual framework for Medicaid managed care thus appears to anticipate the development of programs which share many of the characteristics of CMEs. Those provisions could simply be applied voluntarily by the MCOs to incorporate CME operations into the system, or an amendment to the contract could be pursued that explicitly addresses the details of the working relationship among the entities. Regardless of how integration (or exemption) is pursued, the particularly challenging and expensive nature of the CME population, along with the demonstrated cost-effectiveness of CME initiatives in other states, may prompt the MCOs to welcome CME services into their systems.

Financing of CME Services

A comprehensive analysis of financing options for the CME project is not included in this report, as its scope is limited to possible legal pathways to establishment of the CME itself. However, a brief description of financing approaches in other jurisdictions and how they could be applied in New Hampshire is included.[108]

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[105] CMEs are considered to be candidates for designation as health homes, see Center for Health Care Strategies, *Using Care Management Entities for Behavioral Health Home Providers: Sample Language for State Plan Amendment Development* (2012), http://www.chcs.org/usr_doc/CMEs_as_Behavioral_Health_Homes_-_SPA_Development.pdf; accessed January 10, 2013.

[106] *Agreement* Sec. 10.8

[107] *Agreement* Sec. 10.9

[108] For an excellent general resource with examples of financing approaches used in a variety of jurisdictions, see Stroul, B.A., Pires, S.A., Armstrong, M. I., McCarthy, J., Pizzigati, K., & Wood, G.M., (2008). *Effective financing strategies for systems of care: Examples from the field—A resource compendium for developing a comprehensive financing plan.* Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute (FMHI), Research and Training Center for Children's Mental Health, http://rtckids.fmhi.usf.edu/rtcpubs/hctrking/pubs/Study03-exp-fr-field.pdf; accessed January 10, 2013. A helpful resource describing various state strategies for financing home and community based services for children is *Public Financing of Home and Community Services for Children and Youth with Serious Emotional Disturbances: Selected State Strategies*, Department of Health and Human Services, Office of Disability, Aging, and Long-Term Care Policy, & and Mathematica Policy Research, Inc. (2006), http://www.chcs.org/usr_doc/youthSED.pdf, accessed January 12, 2013.

Financing strategies vary significantly from jurisdiction to jurisdiction. Effective approaches appear to begin with a careful accounting of existing funding for the child population that is expected to be in the CME system. Identification of the sources and amounts of federal, local, and state general funds sets the stage for determining how resources can be re-aligned. Funds that are not yet leveraging federal matches are particularly important to identify, as maximization of such opportunities is fundamental to most financing schemes.

In New Hampshire, state general funds and local school district funds are used for educational services in residential placements, without significant federal matching.[109] Matching funds under both Medicaid and Title IV-E of the Social Security Act[110] support certain services for eligible children in residential treatment centers.

Financing strategies will of necessity focus on Medicaid, the primary source of funding for CMEs and the services they coordinate, as well as the services being provided under New Hampshire's current system. New Hampshire Medicaid funding is generally composed of state funds equally matched by federal funds, and reimburses through several methods. State plan services are those services which are part of the agreement between a state and the federal government for the operation of the state's Medicaid program. In addition to those services which are required to be included in all state plans, states may select optional state plan services from a number of available options.

Optional state plan services which are generally considered important components of a successful CME initiative are *targeted case management* and *peer support services* for youth and families. Targeted case management services are services which "assist individuals eligible under the [Medicaid] plan in gaining access to needed medical, social, educational, and other services,"[111] and are the Medicaid vehicle for CME service coordination activities. These services are part of the current New Hampshire Medicaid plan, although allowing the CME to be reimbursed as a provider of such services and for the services to cover all categories of children who may be served by a CME may require a state plan amendment, administrative designation of the CME as a community mental health provider,[112] or both. Peer support services typically involve trained members of the community with experiences similar to the consumer assisting with participation in the treatment process and the development of natural supports. New Hampshire's Medicaid plan does not currently include peer support services.[113]

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[109] Under either RSA 186-C:18 if placed by a school, or RSA 186-C:19-b if placed by a court.

[110] Title IV-E matching funds (50% in New Hampshire) support some services for children placed outside the home by a court (or under a voluntary placement agreement) as part of the federal adoption assistance and foster care program. See 42 U.S.C.A. § 672.

[111] 42 U.S.C.A. § 1396d(a)(19); see 42 U.S.C.A. § 1396n(g)(2).

[112] Thereby putting the CME in the same position as Community Mental Health Centers for purposes of Medicaid reimbursement.

[113] For a general resource on public financing of peer support services, see Center for Health Care Strategies, *Medicaid Financing for Family and Youth Peer Support: A Scan of State Programs*

The addition of new state plan services to improve reimbursement of community treatment and case management services is typically part of system of care initiatives in recognition that such additions help to reduce the use of more expensive residential programs. These expansions are often initiated by executive policy directives, but have also been included in enabling legislation. Missouri directed by statute that its state Medicaid plan be changed to include specific community-based services and to permit reimbursement to "child-serving agencies" within its comprehensive system of care system.[114] Connecticut took a less specific approach, simply directing that "[a]ll necessary changes to the IV-E, Title XIX and Title XXI state plans shall be made to maximize federal financial participation . . . "[115] When Rhode Island began its pilot program, the enabling statute directed that each catchment area be provided with funds equal to the previous year's total spending on residential treatment for children from all state sources, with the funds to be available for both residential and community-based treatment,[116] but did not specify what Medicaid or other changes were to be used to accomplish that result.

New Hampshire could include in any enabling legislation a combined approach, delegating the detailed decision-making to the Commissioner of Health and Human Services, for example, but directing that appropriate changes to the Medicaid plan, administrative rules, and department policies and procedures be made to redirect funding from residential to home and community based services. The legislation could also set a maximum level of total expenditures, calculated on the basis of previous funding of residential services.

States have also utilized Medicaid's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program to expand funding for intensive home and community services. EPSDT is a mandatory category of medical assistance under the Medicaid program for eligible individuals under age 21,[117] and includes all "necessary health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate defects and physical and mental illness and conditions discovered by the screening process, whether or not such services are covered under the State plan."[118] It is the responsibility of states to determine medical necessity on a case-by-case basis.[119]

Among the categories of medical assistance the Department must cover under EPSDT are "rehabilitation services, including any medical or remedial services

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http://gucchdtacenter.georgetown.edu/Activities/TrainingInstitutes/2012/Resources/Inst_3_R2_FamilyYouthPeerSupportMatrix052512.pdf; accessed January 10, 2013.

[114] Mo. Ann. Stat. § 208.152

[115] Conn. Gen. Stat. Ann. § 17a-22a

[116] R.I. Gen. Laws Ann. § 42-72.7-5.

[117] See 42 U.S.C.A. § 1396a; 42 U.S.C.A. § 1396d (a)(4)(B); He-W 546.

[118] 42 U.S.C. §1396d(r)(5)

[119] The New Hampshire standard of necessity is set forth in administrative rule: "'Medically necessary' means reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and no other equally effective course of treatment is available or suitable . . ." HE-W 546.01.

(provided in a facility, a home, or other setting) recommended by a physician . . . for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level."[120] Although rehabilitative services are an optional service, they are mandatory under the EPSDT mandate when medically necessary.

Medicaid "waivers" have also been used to expand availability of publicly funded community behavioral health services for children. In this context, a Medicaid waiver is a vehicle for states to provide home and community-based services to populations that otherwise might be served in an institution. Waiver services can be used in a way that limits a states' financial commitment more effectively than expansion of state plan services; there can be geographic or numerical restrictions, for example. New Hampshire has a home and community-based service waiver in place for children with development disabilities, but not for mental health services.

Temporary federal authority for waiver services to children who otherwise would be in residential treatment centers recently expired;[121] federal legislation is pending which would extend and broaden that authority.[122] Current authority only allows waivers for children who would otherwise be in a psychiatric hospital, which is considered to be a standard that is too restrictive to be applicable to significant numbers of children who would be served by a CME.

Successful coordination of services for children involved in multiple systems relies in part on the ability of the CME to combine funding from multiple sources. Combined funding also allows the CME to utilize intensive services that any one of the systems might not be able to financially support. Flexibility is generally considered to be best supported by a case rate system, where schools, juvenile justice, and other systems pay flat rates to the CME, with the amount depending on the service system involved and the severity of the child's condition.[123] Case rates can be used solely for the coordination and peer support services typically delivered by CMEs themselves, or for part or all of the clinical services it coordinates as well. Case rates have the advantage of providing intensive treatment resources to youth without the risk of uncontrolled expenditures under a state plan amendment. Case rate systems also give greater funding predictability to the CME in assembling services for a child.

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[120] 42 U.S.C. §1396d(a)(13).

[121] Maryland is one of the demonstration waiver states; a description of its approach to financing its three regional Care Management Entities can be found at http://www.chcs.org/usr_doc/G_Grimm_-_Care_Management_Financing_in_Maryland.pdf, accessed January 12, 2013. Similar descriptions of the financing systems in Massachusetts and New Jersey can be found at http://www.chcs.org/usr_doc/S_Fields_CME_Financing_Presentation.pdf; and http://www.chcs.org/usr_doc/B_Hancock_CME_Financing_Presentation.pdf, respectively, both accessed January 10, 2013.

[122] The legislation, the Children's Mental Health Accessibility Act of 2012 (SB 3289), has not received committee action. The text is available at http://thomas.loc.gov/cgi-bin/query/z?c112:S.3289:; accessed January 10, 2013, and an explanation is at the Children's Mental Health Network website, http://www.cmhnetwork.org/news/support-the-childrens-mental-health-accessibility-act; accessed January 10, 2013.

[123] Case rates are anticipated in the strategic plan; see *Strategic Plan,* supra note 1, Goals 3.1 and 3.3, pp. 10, 13.

Establishing case rates effectively requires that the system have enough cases to ensure that the CME can manage the risk of particularly expensive children and to establish the experience base to set the rates.[124] It may therefore be unlikely that a workable case rate structure could be established until the current project has handled a significant number of cases. The approach to development of a case rate structure would also depend on whether CME participants are also enrolled in a managed care organization.

The Collaborative's strategic plan includes private insurance as one anticipated source of funding for CME services.[125] Private insurance participation is rare in the states reviewed for this project, and in some systems the CME is limited to Medicaid-eligible families and children. Private insurance coverage of residential treatment is generally severely limited, so private insurance companies have not seen participation in CMEs or other similar entities as a way to reduce their costs.

New Jersey invites CME participation by persons covered by commercial insurance, then requires all families not already eligible for Medicaid to go through the application process. Service providers bill private as well as public insurance. Non-Medicaid public funds are sometimes used to pay for services after private insurance coverage limits are reached. In the New Jersey system, providers receive the same reimbursement regardless of funding source.[126]

If private insurance coverage were to be mandated for CME services, it could be implemented through amendments to RSA Chapter 417-E, which addresses parity between mental and physical health, or to Chapter 415, which contains most of the statutory mandates for private health insurance coverage.[127] Expansion of the areas of mandated coverage has typically been resisted by the insurance industry, which has argued that such mandates result in increased costs for all of their customers, particularly smaller private employers. A more limited mandate to consider would be to require coverage of intensive community services coordinated by a CME if residential treatment for the child would be covered by the insurance plan. Thus, the coverage mandate would only apply in cases where the insurance company would stand to benefit.

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[124] For examples of case rates around the country (including what the rate covers in each state as well as sources of funding), see Center for Health Care Strategies, *Case Rate Scan for Care Management Entities* (2012), http://www.chcs.org/usr_doc/Case_Rate_Scan_for_CMEs.pdf; accessed January 10, 2013.

[125] *Strategic Plan*, supra note 1, Goal 3.3, p.13.

[126] Hancock, New Jersey System of Care Financing Overview, http://www.chcs.org/usr_doc/B_Hancock_CME_Financing_Presentation.pdf.; accessed January 10, 2013.

[127] The coverage mandates begin at section 6-a of the chapter. Section 6-b, Coverage of Certain Psychiatric and Psychological Services, addresses coverage for court-ordered services provided to children, and so may be an appropriate section for CME service coverage.

Conclusion

There are a number of options available to policy makers as the formation of a system of care and care management entity proceeds. There are well-regarded CMEs that have been established without legislation. Moving forward in the absence of legislation has the advantage of maintaining flexibility, particularly during the early stages of CME formation. However, a comprehensive legislative approach would presumably build support among political and agency leaders, as well as make successful integration with the various child-serving systems more likely. There is also the intermediate option of implementing legislation which puts a general direction and framework into place, including an oversight body which is required to make recommendations for more specific legal and policy changes to facilitative the process as it progresses.

Should New Hampshire proceed with establishment of a CME through comprehensive legislation, consideration may be given to the following subject matter:

General direction for formation of an integrated system of care and authorization for establishment of a CME. Specific provisions may include:

- Establishment of an interagency body to oversee the system and make legislative and other policy recommendations. Potential membership would include the Departments of Health and Human Services and of Education, the judiciary, the Community Behavioral Health Association and other provider associations, local school districts, law enforcement, families of children with complex behavioral health conditions, and advocates for children and people with disabilities.
- Increases in federal funding participation, either by the requirement of specific Medicaid services or direction to the Commissioner of Health and Human Services to implement policies which maximize the various types of federal funding.
- Expansion of the existing interagency agreement statute to require provisions which facilitate integration of the care management entity with the services of each department and the juvenile justice and child protection systems.
- Development of and use of uniform assessment methods throughout the system of care.
- Exemption or incorporation with Medicaid Managed Care

Integration with juvenile justice and child protection systems. Potential provisions include:

- Timely referrals to the CME, with the consent of families, at each stage of the process, from diversion to discharge from out of home placement.
- Early inquiry by court officials regarding the presence of qualifying behavioral health condition and other criteria for CME referral, along with access to uniform assessment instruments and protective procedures to encourage cooperation of court-involved youth early in the process.

Integration with the public education system, possibly including:

- Expansion of the special education Advisory Committee to include CME representation and additional responsibility to advise Commissioner of Education regarding effective system integration
- Modification of statutes governing state participation in funding of children in residential placement and with other high-cost needs to encourage district-level referral to the CME or to provide the department with information necessary to make referrals itself.
- Inclusion of CMEs in Individual Education Program process in appropriate cases