

Utilizing a Care Management Entity (CME) to Improve Quality and Cost of Care for Populations of Youth with Complex, Multisystem Needs

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By: Bruce Kamradt, MSW, Administrator of Children
Mental Health Services for Milwaukee County and
Director of Wraparound Milwaukee
Sheila A. Pires, Partner, Human Service Collaborative

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Introduction to and Examples of Care Management Entities

What Is A Care Management Entity (CME)?

An organizational entity that serves as the “locus of accountability” for defined populations of youth with complex challenges and their families who are involved in multiple systems

Is accountable for improving the quality, outcomes and cost of care for populations historically experiencing high-costs and/or poor outcomes

Child and Youth Populations Typically Served by CMEs

- Children & adolescents with serious emotional & behavioral challenges at risk of out-of-home placement in residential treatment, group homes and other institutional settings
- Youth at risk of incarceration or placement in juvenile correctional facilities
- Children in child welfare
- Returning children & adolescents from institutional placements in residential treatment, correctional facilities or other out-of-home settings
- Children & adolescents at risk of or returning from psychiatric inpatient settings
- Detention diversion and alternatives to formal court processing for juveniles
- Other populations (e.g., youth at risk for alternative school placements)

Redirecting “Deep-End” Spending through Use of Care Management Entities

Strategies:

- Redirect dollars from high cost/poor outcome services (e.g., residential, detention, group homes)
- Invest savings per youth served in home and community-based service capacity
- Promote diversification/”re-engineering” of residential treatment centers

CMEs are Values-Based*

Care is:

- Youth-guided and family-driven
- Individualized
- Strengths-based, resiliency focused
- Culturally and linguistically competent
- Community-based, integrated with natural supports
- Coordinated across providers and systems
- Solution focused
- Data-driven, evidence-informed

**Values draw on system of care values*

Care Management Entity Goals

Improve:

- Clinical and functional outcomes
- System-level outcomes (e.g., reduction in use of out-of-home placements and lengths of stay)
- Cost of care
- Community safety (e.g., reduction in recidivism rates or offense patterns)
- Child safety and permanency
- Educational outcomes (e.g., improved school attendance, reduction in school suspensions)
- Family and youth experience with care
- Other systems' experience with care

Care Management Entity Functions

At the Service Level:

- Child and family team facilitation using a Wraparound practice model
- Screening, assessment, clinical oversight
- Intensive care coordination
- Care monitoring and review
- Peer support partners
- Access to mobile crisis supports

At the Administrative Level:

- Information management – real time data; web-based IT
- Provider network recruitment and management (including natural supports)
- Utilization management
- Continuous quality improvement; outcomes monitoring
- Training

Care Management Entity Financing Mechanisms

- Use of Multiple Funding Streams
- Blended or Braided Funding
- Use of Case Rates

Financing Strategies That Support Care Management Entities

- Redirection
- Refinancing/Reinvestment
- New monies



**Across States, CME Functions Are Similar But
There Is Variation in Type of Entity Used to
Perform Functions and How Specific CME
Functions Are Structured**

Variation in Types of CME Entities

- **Public agency as CME** – Wraparound Milwaukee
- **New non profit organization with no other role** – New Jersey Care Management Organizations
- **Existing non profit organization with other direct service capability** – Massachusetts Community Service Agencies
- **Hybrid** – Non profit organization with other direct service capability in formal partnership with neighborhood organization – Cuyahoga County, OH Coordinated Care Partnerships
- **Non profit HMO** – Mental Health Services Program for Youth

Cuyahoga County (Cleveland)

SOC Funders Group
Chaired by Deputy County Administrator
for Human Services

County ASO:
Management
Entity

FCFC \$\$	}	<i>State Early Intervention & Family Preservation</i>
Fast/ABC \$\$		
Residential Treatment Center \$\$\$\$		
Therapeutic Foster Care \$\$\$		
"Unruly"/shelter care \$		
Tapestry \$\$	}	<i>System of care grants</i>
SCY \$\$		

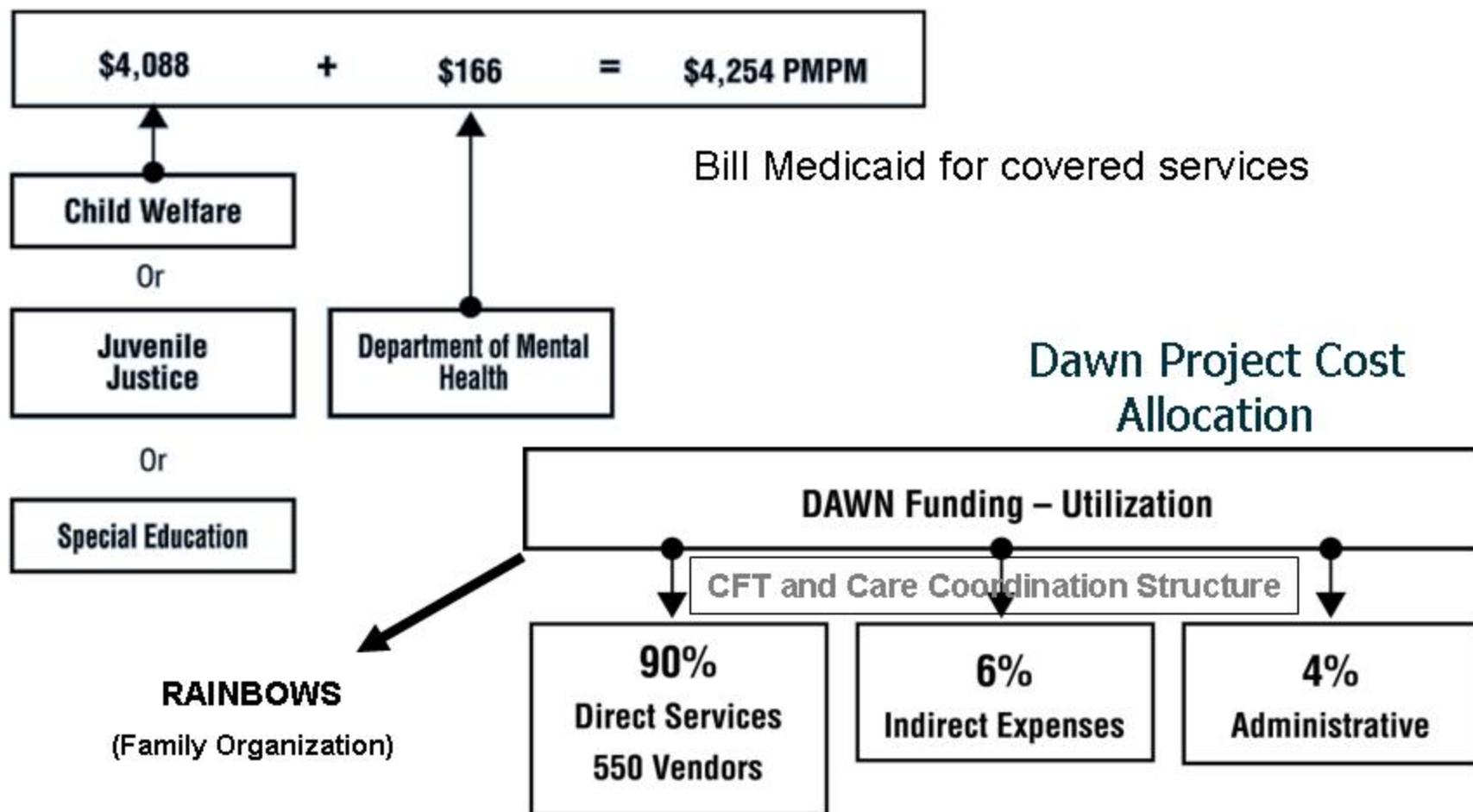
Neighborhood
Collaboratives &
Lead Provider
Agency Care
Coordination
Partnerships

Child/family teams

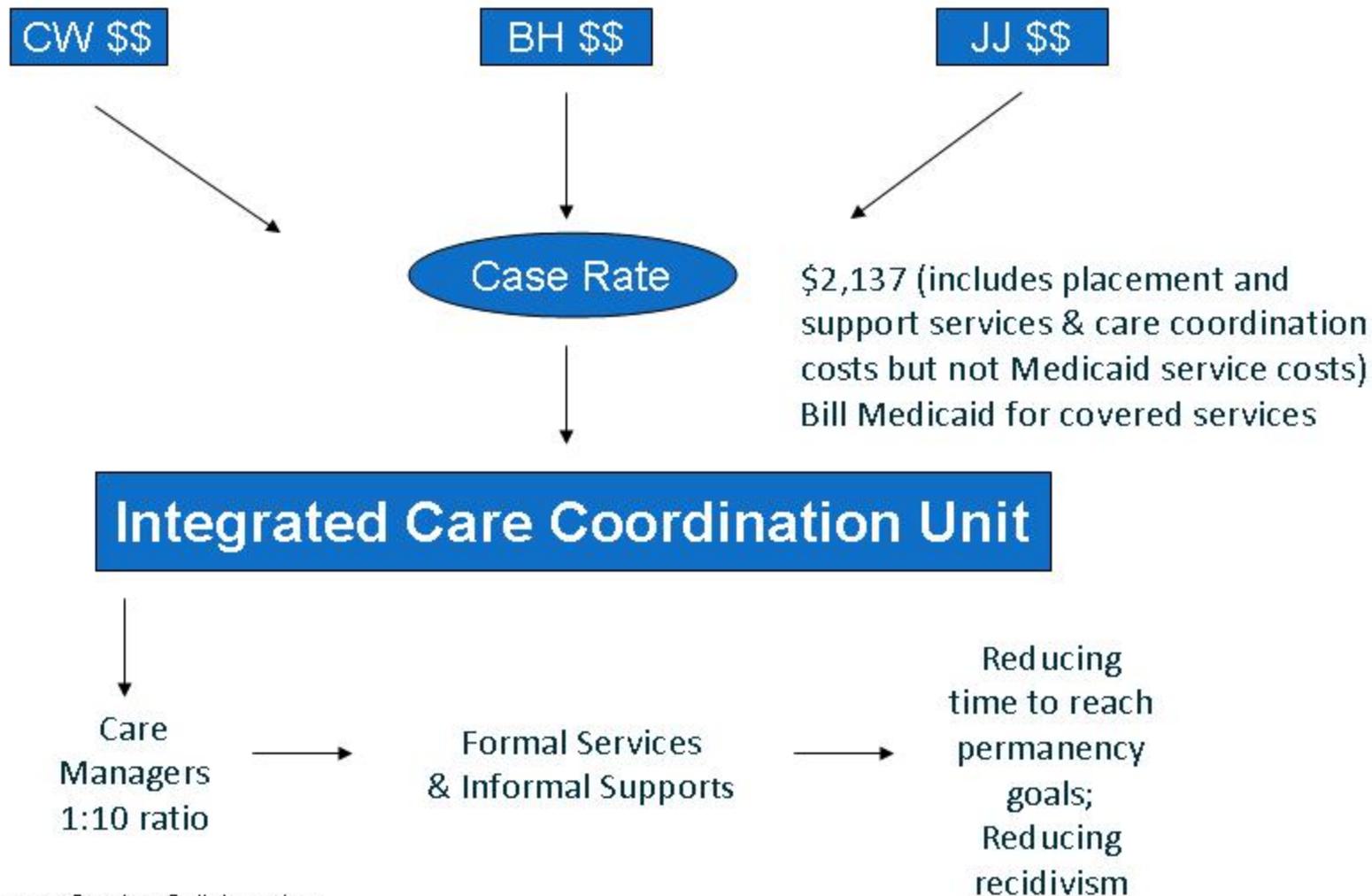
Care Coordination Bundled Rate :
\$1602 per child per mo. - Medicaid

Community providers and natural helping networks

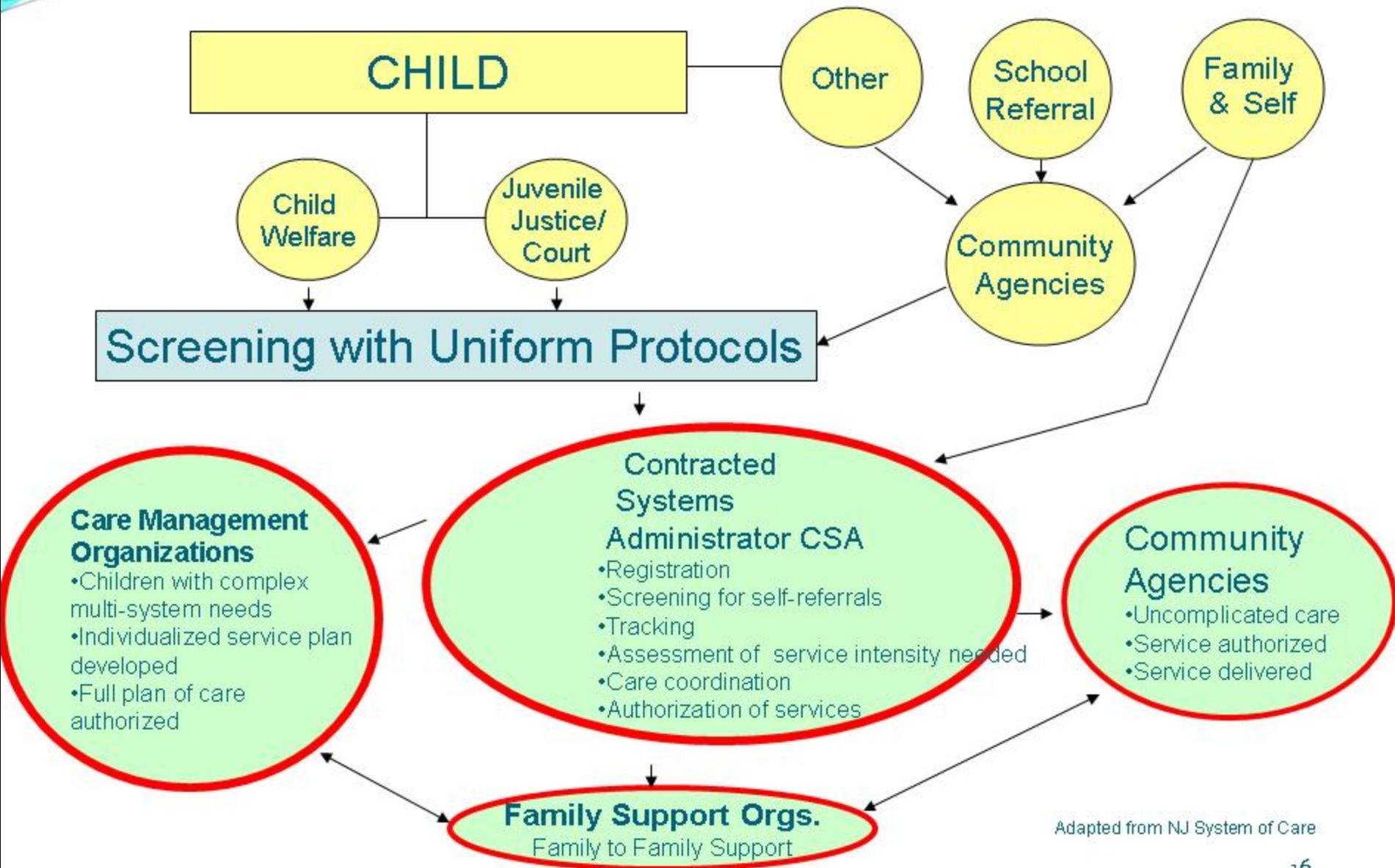
DAWN Project – Marion County, IN Indianapolis



Nebraska Region Three (22 Rural Counties)



New Jersey-Locally Based CMEs



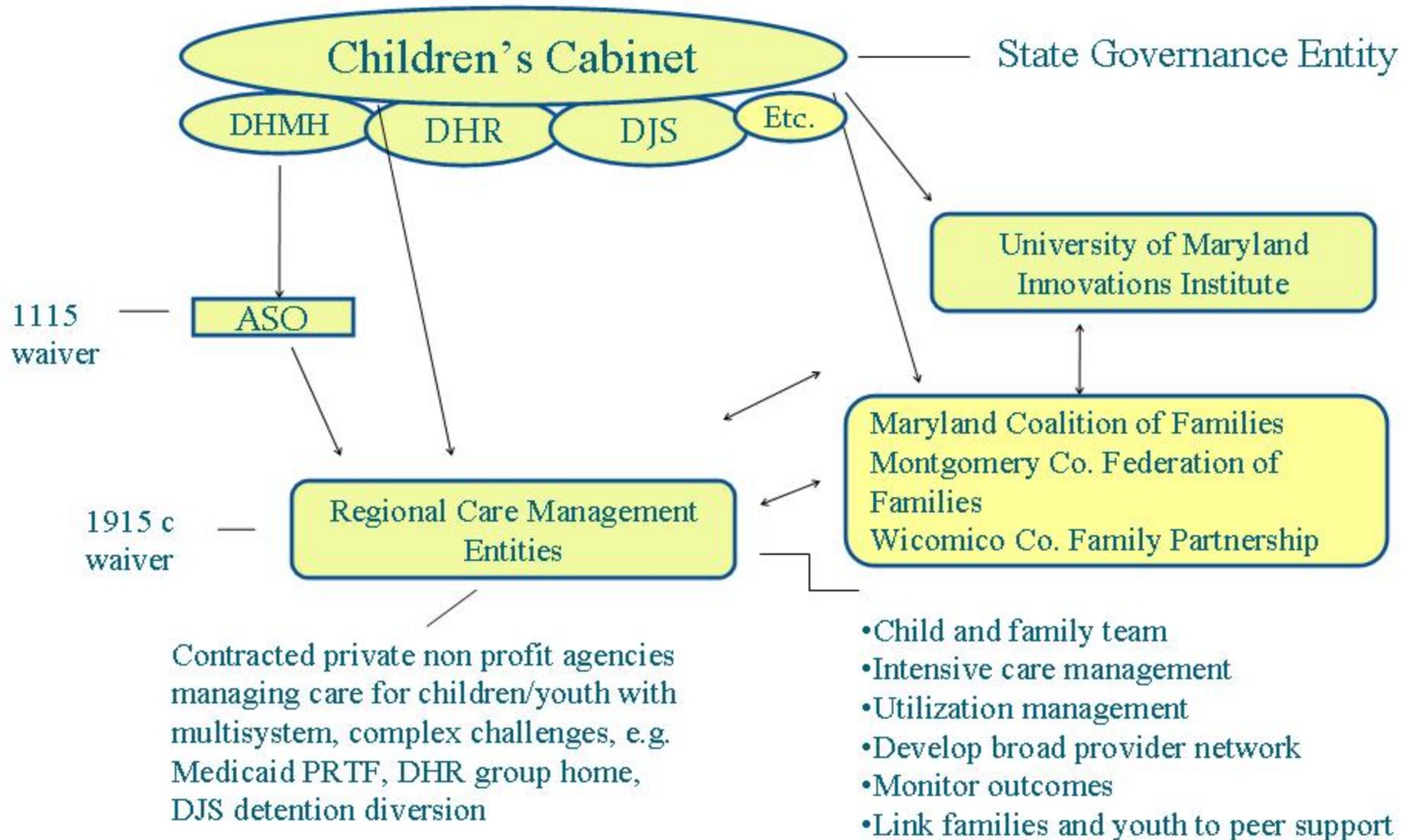
NJ System of Care Funding Streams

- State appropriations:
 - Mental Health
 - Child Welfare
 - Medicaid
- Federal revenue sources
 - Medicaid/SCHIP

Federal Funding Mechanics

- Rehab Option: In-home Services, EBPs, Mobile Response, Group Homes/Therapeutic Foster Care
- TCM: Care Management, Youth Case Management
- Cost Allocation Plan: Family Support, Administrative Services Contract, State Services

Maryland Regional Care Management Entities





Summary of Funds Supporting CMEs

Maryland has blended a variety of funding sources to support the CMEs:

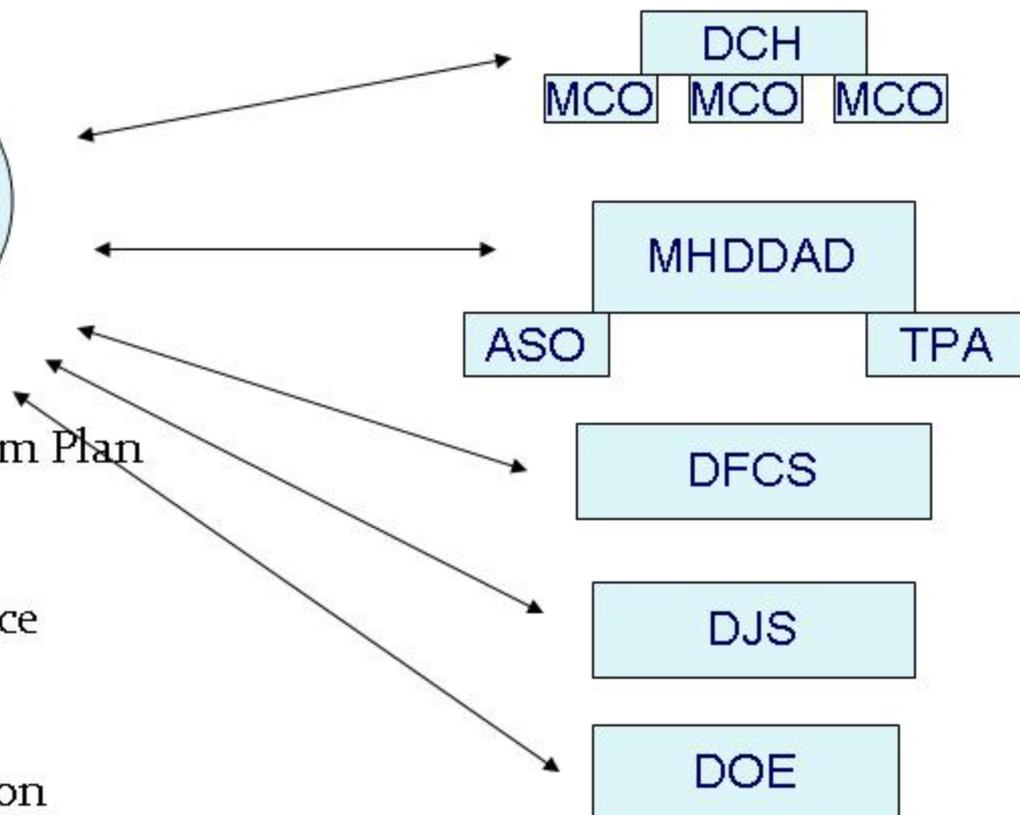
Source	Services and Supports Financed
GOC (Children's Cabinet)	<ul style="list-style-type: none">- General funds budgeted for RTC youth- Rehab option funds available when Maryland chose to use Medicaid to pay for group home health care
Federal Medicaid	<ul style="list-style-type: none">- Match for Public Mental Health System services and PRTF Waiver services- Match for administrative funding for care coordination
Title IV-E	Federal matching funds for placement cost for eligible youth
Dept. of Human Resources	Child Welfare general fund share of placement cost
Dept. of Juvenile Services	Juvenile Justice general funds share of placement cost
System of Care Grants	Federal funds awarded to Maryland to carry out specific proposed projects

Care Management Entities: Locus of Management Accountability for Children with Complex, Multi-system Needs



- Ensure Child & Family Team Plan of Care**
- Ensure Care Coordination
- Manage utilization at service level

**Plans of Care (w/priority on community-based/natural supports) determine medical necessity, except in-patient, residential/group, which require prior authorization



Use Same Decision Support Tool –
CANS – to determine need for CME



Wraparound Milwaukee

What is Wraparound Milwaukee

- Created in 1995, it is a unique system of care for Milwaukee County children & adolescents with serious emotional, mental health and behavioral needs that cross child serving systems (e.g. mental health, juvenile justice, child welfare) who are at imminent risk of institutional type placements
- 1,400 youth/families served (950 daily census)
- Operated by Milwaukee County government as a unique special managed care entity under the 1915a provision of Social Security Act it acts as a type of behavioral health HMO
- Pools funds across child serving systems (\$47 million for 2011) to increase flexibility and availability of funding – Wraparound Milwaukee is single payor
- One service plan and one care manager
- 52% of youth served are from juvenile justice system

Value Base

- Individualized care
- Strength-based
- Needs driven
- Family focused, youth guided
- Community-based
- Culturally informed
- Collaboration across systems
- Holistic (treat entire family)
- Outcome driven

Rationale for the Creation of Wraparound Milwaukee

- Over-utilization of institutional care for juvenile justice and child welfare youth including residential treatment, juvenile correctional placements and psychiatric in-patient care – too many kids being placed and for too long
- High cost of institutional care was causing budget deficits in Milwaukee County resulting in increasing expenditures of local property tax monies
- Poor outcomes for youth coming out of institutional placements

Twenty-Five Kid Project

- Wis. Dept. of Health & Social Services and Milwaukee County received a federal SAMHSA grant in 1995 to initiate a system of care for SED youth
- Small planning group with local administration of mental health, juvenile justice, child welfare, chief juvenile court judge met to discuss and “brainstorm” about possible changes in the delivery of services to Milwaukee County youth currently being institutionalized in increasing numbers
- 25 Kid Project was pilot project developed to test whether utilizing a different approach based on the system of care values, wraparound philosophy and components of care that included care coordination, access to crisis team, family advocates, and access to a provider network to deliver whatever services the youth & family needed could be effective with an already institutionalized population of youth

Elements of the Pilot

- 25 youth, currently placed in residential treatment with no immediate discharge plan (there were 375 youth in RTCS's at that time – 1995/6)
- No screening out of referrals and all youth would be accepted with goals of:
 - Return home or to a community placement, i.e. foster home
 - Community/safety maintained
 - Equal or less cost in community placement
- 17 of 25 youth were returned home within 90 days of enrollment in pilot
- Success of pilot created plan to move forward on a large scale where Wraparound Milwaukee program would begin to monthly enroll youth in RTC's as well as newly identified youth for that level of care

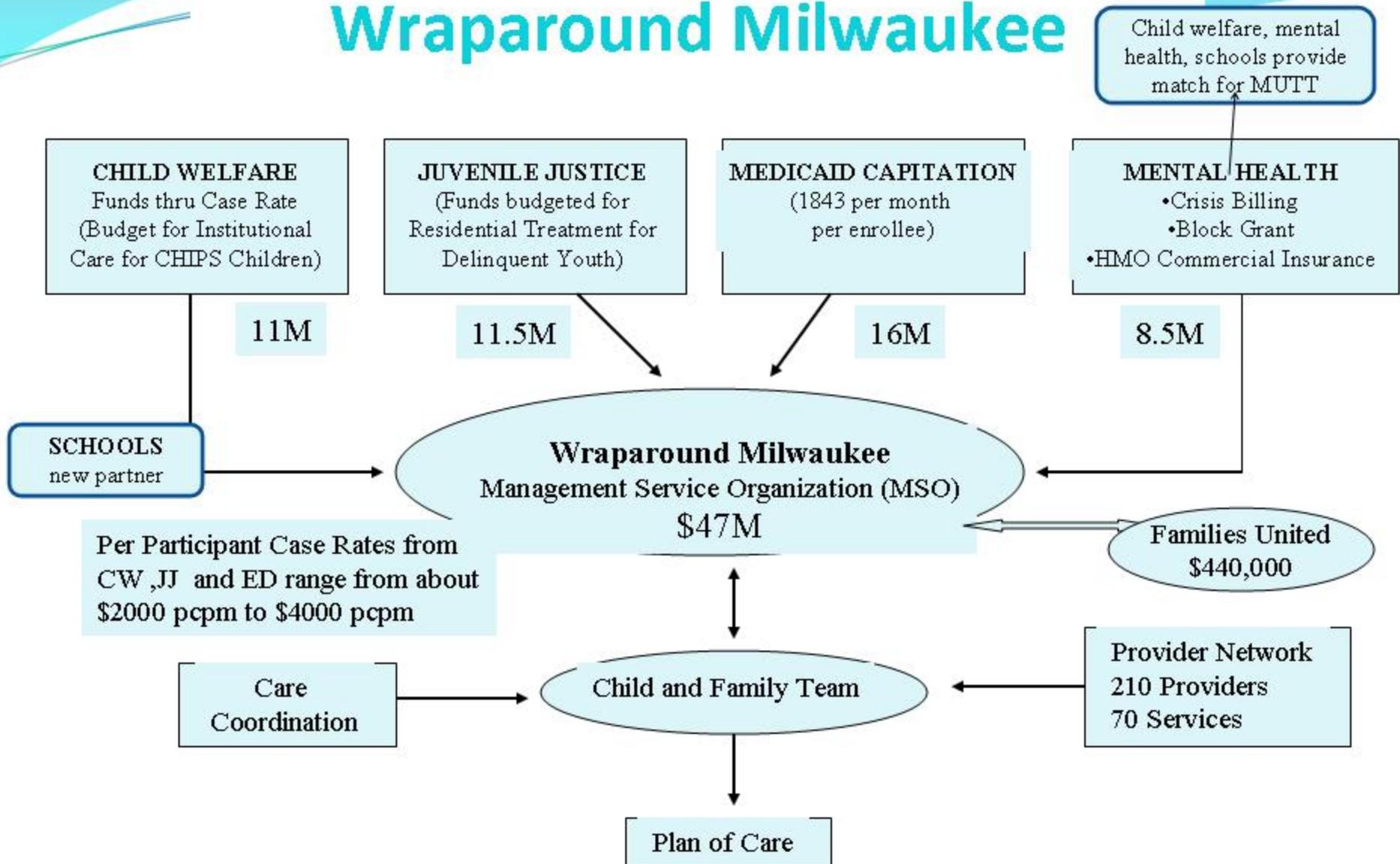
What Does Wraparound Milwaukee Care Management Entity Do?

- Contracts with Child Welfare, Juvenile Justice and Medicaid to serve youth identified with serious emotional and mental health needs at risk of institutionalization in residential treatment, juvenile correctional placement and psychiatric hospitalization
- Governance is with Milwaukee County Human Services Department – Behavioral Health Division – Children Mental Health Services
- Administrator of Children’s Mental Health Services serves as Director of Wraparound Milwaukee CMO and responsible to the Director of the Behavioral Health Division
- Milwaukee County Board of Supervisors is ultimately responsible for operation of program & approving contracts
- Partnership Council is the voluntary advisory committee to the Program made of community representatives, system stakeholders, advocates, and providers

What Functions Does Wraparound Milwaukee CME Do?

- Program Administration
- Assess/screen youth for enrollment
- Care Coordination
- Operates Provider Network
- Provides crisis services
- Finance – claims processing and payment of providers
- Medical oversight
- Quality Assurance/Quality Management including utilization review
- Evaluation
- Information technology
- Family advocacy
- Contracting with Child Welfare, Medicaid, etc.
- Public relations
- Training and consultation
- Liaison with courts
- Transitional services
- Dispute resolution

Wraparound Milwaukee





Key Components of Wraparound Milwaukee Delivery Model

Care Coordination Services

- Wraparound Milwaukee contracts with 8 community agencies to provide care coordination services
- 110 care coordinators
- Responsibilities include
 - Facilitate planning teams
 - Implement wraparound approach
 - Identify & obtain formal services from provider network and informal services from community agencies
 - See child weekly
 - Provide crisis intervention services so they must be reachable 24/7
 - Carry out legal roles as required
 - Coordinate with probation worker or child welfare worker

Provider Network

- No formal contracting – Wraparound Milwaukee utilizes fee-for-service system to obtain & pay for services
- Rates and service definitions established by Wraparound Milwaukee
- 70 services and 200 provider agencies
- Wraparound Milwaukee is single payor for all services, including community-based and out-of-home services
- Consumer choice of provider
- Extensive Quality Assurance/Quality Management measures in place
- All providers and care coordinators linked through one Internet-based IT system (*Synthesis*) for service authorizations, plan submission, invoice, payment, and progress notes

List of Available Services in Social/Mental Health Plan

- Case Management
- Referral Assessment
- Medication Management
- Outpatient
 - Individual/Family
- Outpatient - Group
- Outpatient - AODA
- Psychiatric Assessment
- Psychological Evaluation
- Mental Health Assessment/Evaluation
- Inpatient Psychiatric
- Nursing Assessment/Management
- Consultation with Other Professionals
- Daily Living Skills - Individual
- Daily Living Skills - Group
- Parent Aide
- Child Care
- Housekeeping
- Mentoring
- Tutor
- Life Coach
- Recreation
- After School Programming
- Specialized Camps
- Discretionary Funds
- supported Work Environment
- Group Home Care
- Respite
- Respite – Foster Care
- Respite - Residential
- Crisis Bed - RTC
- Crisis Home
- Foster Care
- Treatment Foster Care
- In-Home Treatment (Case Aide)
- Day Treatment
- Residential Treatment
- Transportation



Mobile Crisis Services

- All families have access to Wraparound Milwaukee's Mobile Urgent Treatment Team
- 24/7 Availability
- Mobile crisis teams gatekeep inpatient psychiatric treatment
- Wraparound Milwaukee has dedicated crisis teams in Milwaukee Public Schools and Child Welfare
- Mobile Crisis can make available optional crisis stabilization services
 - Crisis 1:1 stabilizers in home and school
 - Crisis group home
 - Short-term crisis case management
- 23 crisis intervention workers

Family Advocacy Component

Families United of Milwaukee

- Advocacy
- Support Groups & Activities
- Family & System Education
- Satisfaction Surveys
- Serve on Committees, Boards, etc.
- Train Care Coordinators
- Crisis Intervention
- Resource Development
- Develop Newsletter, Brochures, Other Info.



Information Technology

- One electronic health record and single information system links all care coordinators, providers and system partners
- *Synthesis* IT system developed by Wraparound Milwaukee has now been purchased by other communities and states

What Does *Synthesis* Automate

- Enters All Demographic Information
- Enrollments
- Crisis Plan
- Automated Care Planning
- Provider Service Authorizations Entered On-Line
- Electronic Invoicing
- Electronic Claims Processing & Payment
- Progress Notes for Care Coordinator & Providers Done On-Line
- Reports Accessible to Managers
- Audit
- Family Access to Provider Resource Directory On-Line
- Credentialing Information on Providers

How Wraparound Milwaukee CME Model Serves Different Populations of Youth at Risk of Institutional Placement

- Adjudicated delinquent , child welfare , school-referred or other youth who are at immediate risk of out-of-home placement in a residential treatment center, correctional facility or psychiatric hospital are identified through screening process conducted by Wraparound and Probation
- DSM-IV diagnosis required but conduct disorder/oppositional defiant disorders are acceptable
- Screeners makes recommendations in court, Judge adds “care & treatment services in community or out-of-home placement up to residential treatment to be arranged or provided by Wraparound Milwaukee”
- Youth enrolled in Wraparound Milwaukee CME and special managed care entity which makes them eligible for monthly capitated payment (\$1843) & eligible for separate T-19 crisis services

Win-Win Scenario for Juvenile Justice and Child Welfare Systems

- WM reduced the number of delinquent and child welfare youth being placed in residential treatment centers by Child Welfare and Delinquency Services which reduced their “out of control” expenditures for RTC services
- Expanded the dispositional options for Judges
- Placed accountability for care for delinquents with one agency so that there would not be cost shifting and moving youth between various child serving systems.
- Reduced number of delinquent youth being committed to state correctional system which reduced costs to Milwaukee County who had to pay 100% of cost of each placement
- Redefined mission of children’s mental health system to take more complex, higher risk youth based on need for out-of-home placement versus being diagnostically driven

Juvenile Justice Populations Managed By Wraparound Milwaukee Care Management Entity (CME)

- Adjudicated delinquent youth with serious emotional and mental health needs who are at imminent risk of out-of-home placement in a residential treatment center, group home, state juvenile correctional facility or psychiatric hospital – 724 youth in 2009
- Milwaukee County youth committed to the WI State Dept. of Corrections for placement in a state juvenile correctional facility who are put on a “stayed order” and placed in Wraparound Focus Program – 74 youth in 2009
- Milwaukee County youth with emotional or mental health needs currently in a state juvenile correctional facility who are selected for early re-entry home or to a community placement – 25 youth targeted for 2010-2011

FOCUS Program – New WrapMilw. Alternative to Youth Committed to State Corrections

- FOCUS includes these components
 - Wraparound philosophy and approach
 - Assignment to a care coordinator and child & family team
 - Required 3-4 month placement in a non-secured residential treatment program on county grounds
 - Placement at home with comprehensive safety plan and wraparound services and supports
 - Designated probation worker is part of team
- Judge “stays” commitment order and youth is placed in Wraparound FOCUS Program, violation of terms of order means the lifting of the “stay” and placement in a correctional facility

FOCUS Program – Alternative to Correctional Placement – cont'd

- Delinquency services pays Wraparound a monthly case rate of \$3500 per child and Wraparound Milwaukee pulls down capitated Medicaid rate of \$1843 per month as child remains in T19 eligible under County custody
- Average FOCUS cost is \$5200 per month per child versus \$8500 corrections and average stay is 12 months in FOCUS versus 2 ½ years in corrections
- Saved state youth aids monies are reinvested by County into funding local juvenile services that would otherwise require tax levy funds

Tracking Outcomes In Wraparound Milwaukee – Does the CME Model Work?

Wraparound Milwaukee generally looks at six outcome areas:

- Programmatic
- Financial
- Legal/Community Safety
- Clinical
- Educational
- Child Permanency

Programmatically

- Average daily residential treatment population (both delinquent and child welfare) has gone down from 375 placements (average daily census in RTC care) to about 90 per day
- Average length of stay in an RTC for delinquent or child welfare youth down from 12 months to 4 months
- Average number of commitments of youth to the Dept. of Corrections for placement in secure facility has dropped from an average of 25 to 30 youth per month to 10-15 youth
- Psychiatric inpatient utilization for juveniles enrolled in Wraparound CMO has dropped from 5000 to 300 days per year (average 2.5 days LOS). 50% of psychiatric beds for children have closed in Milwaukee since Wraparound Milwaukee initiated services, particularly mobile crisis teams

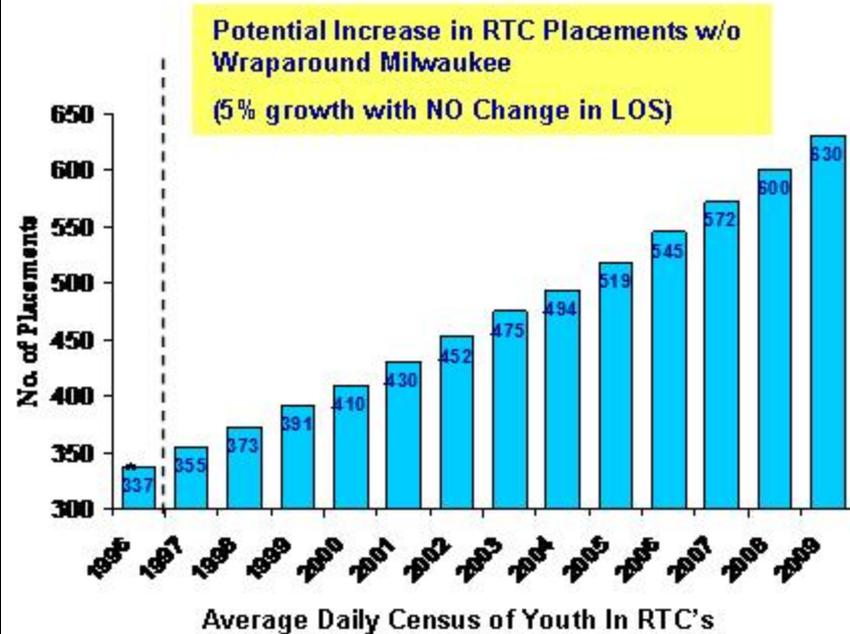
Financial

- Wraparound Milwaukee average monthly cost is \$3900 per month for system involved youth (delinquent and child welfare) versus average cost in 2010 of \$8600 per month for a residential treatment placement, \$8000 monthly for a state juvenile correctional placement or \$1600 a day for psychiatric inpatient care
- Overall savings to Milwaukee County over past 10 years in excess of \$150 million

Cost of Doing Nothing

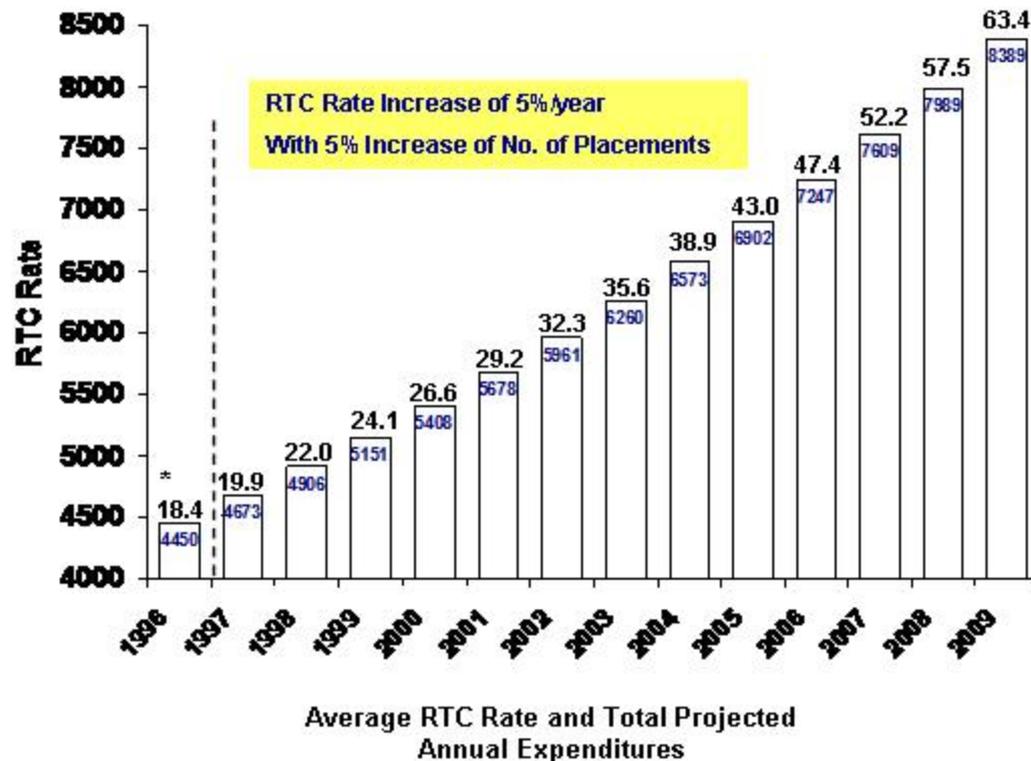
Residential Treatment Placements & Costs Without Wraparound Milwaukee

RTC Placements



*Actual Number of Placements and Costs for That Year

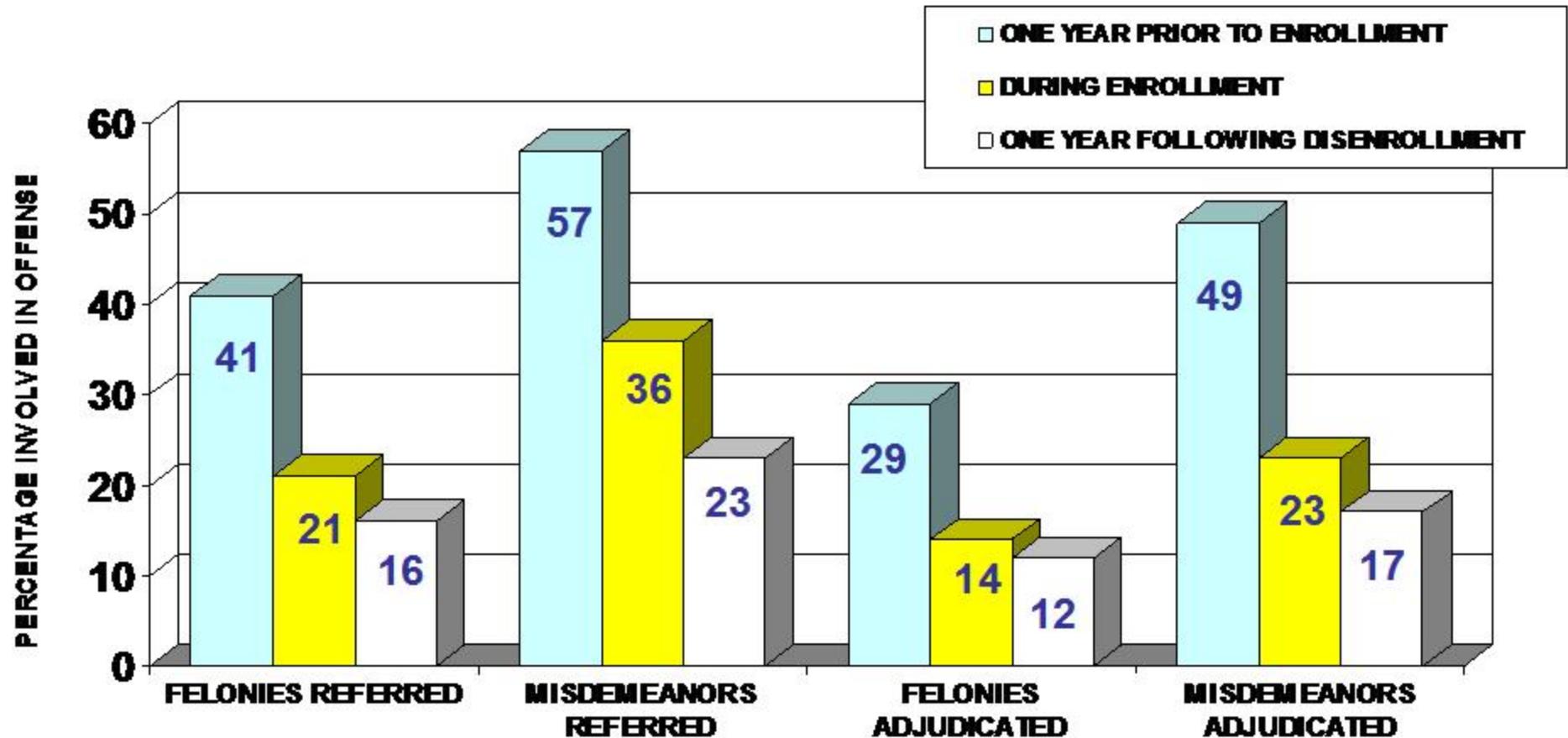
Child Welfare/Juvenile Justice Expenditures for RTC without Wraparound Milwaukee



Legal/Community Safety

- Impact on recidivism before, during and after enrollment and disenrollment

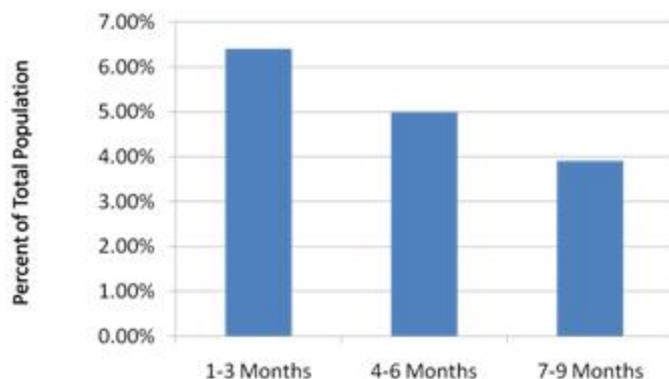
Legal Offense Referrals & Adjudications One Year Prior to Enrollment, During Enrollment, & One Year Following Disenrollment



Current On-Going Study of Recidivism of Delinquent Youth in Wraparound Milwaukee

- For 9 month period between Oct 1, 2009 and July 31, 2010 only 11.9% or 46 youth out of the total delinquent population of 411 enrolled during that period committed a new delinquency offense

Reoffending Pattern Wraparound Youth
During the First 9 months of enrollment



- Data also reveals that youth who reoffend will do so at higher rates earlier in the program and the number that recidivate decreases as the youth becomes more involved in the Wraparound Milwaukee Program

Does This Approach Work with High Risk Juvenile Offenders? Wraparound Milwaukee's Work With Juvenile Sex Offenders – Long-Term Outcomes

- Evaluation study (Seybold & Gilbertson, 2007) of all (N=528) youth adjudicated of a sexual offense and served by Wraparound Milwaukee between 1998-2006 found the following:
 - 10% committed a new sexual offense while enrolled
 - 4% committed a new sexual offense during the first year following their discharge from Wraparound Program
 - 11% committed a new sexual offense during the first 3 years post Wraparound CMO services
 - 14% committed a new sexual offense during the first 5 years post Wraparound enrollment
- Average cost per month in 2009 for services to youth (N=157) enrolled in Wraparound Milwaukee of a sexual offense was \$3918.00 (includes cost of any needed out of home care) versus \$8500 per month for average cost of a residential treatment placement

Clinical Outcomes

- Statistically significant improvement in functioning on Child Behavioral Checklist (CBCL), Youth Self Report (YSR) and Child & Adolescent Functional Assessment (CAFAS)

Educational Improvement

- 40% increase in school attendance from time of enrollment to disenrollment

Child Permanency

- 85% of youth achieved permanency plan of return home, relative placement or independent living



Variations to Consider in Structuring Care Management Entities

Variation in How CME Functions Are Structured

Wraparound and Care Coordination

- CME may do these functions itself (many do – e.g., Massachusetts, New Jersey, Maryland)
- CME may contract out for these functions – Wraparound Milwaukee

Access to Family and Youth Peer Supports and Advocacy

- CME may hire its own peer support staff, contract with a family-run organization, utilize peer supports as a billable, combination

Variation in How CME Functions Are Structured

Access to Crisis Supports

- CME may operate its own mobile response and stabilization service – Wraparound Milwaukee
- CME may utilize mobile response and stabilization capacity contracted by the State – New Jersey
- CME may utilize crisis capacity in Medicaid managed care network - Massachusetts

Variation in How CME Functions Are Structured

Provider network development and management

- CME controls provider network directly – Wraparound Milwaukee
- State (sometimes working with a statewide ASO) develops and manages provider network; role of CME is to identify gaps, develop natural supports and community resources – New Jersey
- Medicaid managed care organizations develop and manage provider network; role of CME is to identify gaps, develop natural supports and community resources - Massachusetts

Variation in How CME Functions Are Structured

Utilization Management (UM)

- CME solely responsible for UM – Wraparound Milwaukee
- Statewide ASO has formal UM responsibility; CME role is to monitor utilization at child/family level, ensure plans of care meet quality and cost goals – NJ
- Medicaid managed care organizations have formal UM responsibilities; CME role is to monitor utilization at child/family level, ensure plans of care meet quality and cost goals - Massachusetts

Variation in How CME Functions Are Structured

Quality Improvement and Outcomes Management

- Is a shared function among purchasers, CMEs and other statewide management entities such as ASOs where they are playing a role, but CME plays critical role at child/family level

Training

- CME is responsible for training – Wraparound Milwaukee
- State is responsible for training – Maryland
- State and CME share training responsibilities – New Jersey

Variation in How CME Functions Are Structured

Information Management

- CME has its own Internet-based IT system – Wraparound Milwaukee, Cuyahoga County, OH, Maryland
- CME is tied into statewide ASO IT system – New Jersey

Communications Technology

Hand-held communication devices for Care Coordinators; videoconferencing, telemental health, etc.

CME Financing

Often, CMEs use Case Rates or Bundled Rates

What is the rate? Depends on what's in the rate –
i.e., how functions are structured

Variation in CME Rates

All-inclusive rate (covers all services and supports, placements and administrative functions) –
Wraparound Milwaukee: average of \$3,900 pmpm
(compared to \$8,600 per month for RTC, for example)

Variation in CME Rates

Partial Case Rates:

- Rate covers Wraparound, intensive care coordination, outcomes management, shared role in QI and UM at the child/family level, access to (but not payment of) peer supports and crisis supports, community resource development – NJ: Medicaid rate of \$1,034.12 per child per month plus State BH contract of \$53,693 per month (assumes CME serves 200 children a month)

Maryland: Average rate of \$16,000 per child per year

Cuyahoga County, OH: Medicaid rate of \$1,602 pmpm

Variation in CME Rates

Partial Case Rates:

- Rate includes care coordination, placements, support services, funding for family organization for peer supports and advocacy; Medicaid services are outside of the rate – Nebraska's Integrated Care Coordination Units: \$2,137 pmpm

Variation in CME Rates

Example from Choices, Inc. – a CME operating in multiple states

Case rate tiers ranging from \$6,500 pmpm for highest complexity to \$4,290 (very high risk for out of home placement) to \$2,780 (community based care, no placement costs) to \$1,565 (Care Coordination and Wraparound)

Average across populations about \$4,200 pmpm

Sometimes there is no case rate or bundled rate

Massachusetts: 15-minute billing increments for Targeted Case Management at \$19.09 for Masters level care manager and \$15.72 for Bachelor's level care manager

Rate includes: home-based assessment; Wraparound; care coordination, monitoring and review; access to peer supports and advocacy; access to crisis supports; outcomes management and documentation; clinical oversight; training; translation; participation in system of care community meetings

Variation in Use of Medicaid Options

1915a

Wraparound Milwaukee,; Cuyahoga County, OH

Targeted Case Management

Massachusetts; New Jersey

Administrative Case Management; 1915c

Maryland; New Jersey

Redirection

Where are you spending resources on high cost service and/or poor outcomes?

- Juvenile Correctional Placements
- Residential Treatment
- Detention
- Group Homes
- Psychiatric Inpatient Care
- Too Long Stays in Therapeutic Foster Care

Refinancing/Reinvestment

Example of Refinancing:

Milwaukee County, WI – Schools & child welfare contribute \$450,00 each to expand mobile crisis response & stabilization services (prevent placement descriptions in child welfare and prevent classroom incidents leading to school suspension) as a Medicaid billable service those contributions generate nearly \$400,000 in additional Medicaid monies

Example of Reinvestment Strategy

Milwaukee County, WI – monies saved from reduction in out-of-home placements in residential treatment and juvenile correctional care is reinvested to serve more youth in community-based services

Strategic Financing Analysis for New York City

1. Identify your population(s) of focus
2. Identify city, state agencies that spend dollars on services to the target population (s)
 - ❑ how much each agency is spending
 - ❑ types of dollars being spent (e.g., federal, state, local tax levy)
3. Identify resources that are untapped or underutilized (e.g., Medicaid, education, IV-E)
4. Identify utilization patterns & expenditures associated with high costs/poor outcomes and strategies for redirection (e.g., inappropriate youth placed in state corrections, lack of resources with re-entry youth, etc.)

Strategic Financing Analysis for New York City

5. Identify disparities & disproportionately in access to resources & supports & strategies to address these
6. Identify the funding structures that will best support the system design (e.g., blended or braided funding, risk based financing, purchasing collaborative, etc.)
7. Identify short-long term financing strategies (e.g., federal revenue maximization, re-direction from restrictive levels of institutional care to community care, waivers, performance incentives, etc.)



**Populations Focus, Values, Goals
and System Design
Drive Financing Strategies
Not the Other Way Around**