

# Adult Mental Health Initiatives Funding Formula Workgroup Meeting

## Details

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**When:** November 10, 2021, 1:00-3:00p

[WebEx Only](#), meeting access code: 1465 10 9457, meeting password: AMHI. **This is not an in person meeting.**

## Agenda

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- Housekeeping, reminder of shared goals and group norms – 5 minutes
- Review and finalize combined priority matrix – 30 minutes
- Review survey results for scoring and potential percentages/weights – 30 minutes
- Testing out weights in the formula model – 30 minutes
- Review and confirm decisions and workgroup recommendations – 30 minutes
- Wrap up and celebrate – 10 minutes

This is the final meeting of this workgroup. We want to thank everyone for the difficult and collaborative work happening for AMHI Reform.

## Attendance

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- Ashley Warling-Spiegel, DHS
- Abbie Franklin, DHS
- Helen Ghebre, DHS
- Elisabeth Atherly, DHS
- Shauna Reitmeier, NW8 representative
- Amy Ballard, Region 2 representative
- Melissa Wright, ABHI representative
- Margaret Williams, BCOW representative
- Keshia Anderson, Region 4S representative
- Bethany Oberg, CommUnity representative
- Charles (“Chuck”) Hurd, Region 7E representative
- Jason Rodrigues, Anoka County representative
- Martin (“Marty”) Marty, Hennepin County representative
- Kenya Walker, Ramsey County representative
- Melissa Hanson, Carver County representative
- Ericka Hammer, Dakota County representative
- Kimberly Holm, SW18 representative
- Jamie Hayes, SCCBI representative

# Meeting Summary

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## Review

- Reviewed standing housekeeping items around meeting participation.
- Brief review of workgroup's norms and shared outcomes

## Review of and finalizing combined priority matrix

- Review of the priority matrix methodology
  - Reminder that we created this matrix a couple of meetings back as a way for us to prioritize the variables. We decided that we would look at it in terms of the relevance to the mission and responsiveness to the community. We'd apply those two concepts to the x-axis and the y-axis. We're also looking at the variables in the context of the 4 attributes – transparency, flexibility, alignment, and equity.
- [Looking at the matrix created by combining all previously generated individual matrices]
  - ADI, rural allocation, and SDOH were identified as high relevance and high responsiveness. Then Medicaid enrollee population was also in that quadrant, but a little bit lower. The statewide census population was in the middle for relevance but lower for responsiveness. Then scored the lowest was the Medicare population, identified as low relevance and low responsiveness.
  - Any questions or needs to clarify how we got to this point?
  - No questions.
- Review of survey results and the priority matrix generated from those results.
  - Looks similar, but ADI and rural allocation were much higher in the high responsiveness, high relevance for prioritization. SDOH was on the high end as well, but lower than ADI and rural allocation. Medicare population was placed in a similar spot as statewide census, which was a change. Medicaid enrollee population then moved lower. Basically, Medicaid and Medicare switched places based on the survey results.
  - Any questions or comments or concerns?
  - Helen asked how reflective this matrix is of the group as compared to the other matrix, and provide any thoughts or confirmations of the visuals presented.
    - 9 responses to the survey/pre-work, which is half of the workgroup. It does line up to the matrix created in the workgroup, other than the population variables shifting to lower relevance and lower responsiveness.
    - Shauna noted the feedback from her AMHI's meeting prior to the workgroup meeting today was in alignment with the survey version of the priority matrix.
    - Amy asked if the switch in Medicaid and Medicare was because of the uncovered population in Medicare.
    - Abbie – that's a possibility because we can't accurately record those who are uninsured. So using the Medicaid and Medicare populations helps get a sense of who may be using the services.
    - Amy – there's also the anecdotal experience of trying to maneuver around Medicare when you're trying to serve someone that doesn't have any money.
- Showing the two matrix visuals side by side to get input from the group and set a final version, given the slight differences between the two.
  - Group asked if there were any other thoughts that come up when looking at the two side by side.
  - Amy – to clarify, past incarceration not on here?
  - Ashley – all SDOH were grouped together for the final matrix. [showed matrix with SDOH only matrix, which shows how each were prioritized and then combined for the final matrix]

- Elisabeth asked the group if there were any other concerns or comments related to the specific SDOHs.
- Shauna asked where SMI/SPMI fall in this new one.
- Ashley showed the SDOH matrix again on one side with the primary matrix on the other side, so you can see how the individual SDOHs are averaged together to make a combined matrix.
  - We did these 2 visuals – SDOH only and all variables – to mirror how the formula model uses the percentages.
  - Also noted that both visuals are final products, because both sets need to be prioritized. They're just prioritized a bit different.
- Before shifting to plugging percentages into the model, asked group to identify which version of the all-variable priority matrix is approved as the final one that will inform the model.
  - Amy suggested the survey-based version. Support from the rest of the workgroup.
  - Kesha raised concern with Medicare being higher than Medicaid. She suggested Medicaid being moved to the center in alignment with the other two population measures.
  - Marty agreed with this.
  - Kesha asked about what the Medicare enrollee definition is, Medicare not parts B, C, D. If Medicare primary, then suggest Medicaid higher or equal to Medicare.
  - Amy noted that rationale for Medicare higher was that they're harder to serve because of gaps in coverage.
  - Shauna added that there are less providers that can touch Medicare, less services available.
  - Kesha agreed with that rationale.
  - Shauna asked a follow-up question about extrapolating from Medicaid population to get the non-Medicaid population and generate the percentage of SMI/SPMI in the general population. That might help really get at the uninsured or the types of services needed. If that, then would move it closer to the center like the other populations.
  - Abbie noted that discussion seems to lean toward moving the Medicaid enrollee population the center like the others, and then the discussion can move along to percentages.
  - Chuck noted that Medicare can act as a barrier sometimes. Elisabeth asked him to say more. Chuck noted that Medicare only allows certain types of services or certain credential people to provide billable services. In a rural area, don't have a lot of Medicare eligible providers for those individuals, so it's a barrier to them getting services. That's where Medicare could be a little higher than Medicaid, which is a little more available.
  - Melissa noted she was thinking similarly to that, as grant funds are used more for folks with Medicare than Medicaid. Also with the formula, there's a group of people we're probably not identifying, so the population seems important.
- Elisabeth asked if the percentages work might also help us set a final position for these population variables.
  - Jason raised concern that opinions are being introduced rather than using the objective values we used previously to create the matrices. Asked the group which way we should be going with this.
  - Ashley – the way to think about this is that we've ended up with two slightly different version of this based on how we got to them. We have one way where we did them individually per variable and then DHS combined them. But then we also asked you to combine it on your own through the pre-work. Since they came out

slightly different, we want to make sure we have the final version that's reflecting all of that work to date. They're both right, but which one brings it all together.

- Abbie – and you raise a good point, we want to make sure we're using those four attributes (transparent, flexible, alignment, equitable). Suggested we move on to how we translate priorities to percentages and we can finalize from there. We can revisit and make additional adjustments here based on how things line up with the attributes.

### Setting percentages

- Review how DHS converted priorities to percentages.
  - Used a 0-5 scale, linking the priority matrix and the four attributes.
  - Survey asked workgroup members to using the 0-5 to rate each variable in terms of its alignment with the four attributes and the two axes of the matrix (relevance and responsiveness).
  - 0-5 converted to percentages out of 25%
  - Respondents asked to set percentages based on how they'd rated each variable
  - Ashley also showed the group what the matrix looked like with the 0-5 banding applied to it. Also then showed the three sets of percentages available to the group to use/reference.
    - Set 1 – percentages using combined matrix with 0-5 scores applied to matrix
    - Set 2 – percentages using survey-created matrix with 0-5 scores applied to matrix
    - Set 3 – average percentages generated from the survey
  - Elisabeth asked if there are any thoughts or questions based on seeing this. Clarified that MR means Medical Risk in the notation.
- Asked the group what they thought about these percentages.
  - Shauna noted she appreciated the banding method with the 0-5, made it clearer how to get to percentages. Also suggested SDOH percentage could be bumped up a bit given previous discussions.
  - Chuck suggested adding one point across all to move from 95% to 100%. Chuck also noted that the percentages seem representative of the group's overall discussions and conversations.
  - Kesha agreed but noted the differences in the SDOH percentages from matrix to survey.
  - Elisabeth asked if SDOH will be scored separately.
  - Ashley explained that the SDOH variables do each get their own weight that adds up to 100%, and then SDOH also gets weighted in the overall 6 variables. Also noted that in the survey, MR was incorrectly not included, so that may have thrown off the weights. Even with that, the SDOH percentages are pretty consistent in terms of patterns from the three versions.
  - DHS suggested shifting to the model, using the 3 options for percentages to test out allocations.

### Applying the percentages to the formula model

- DHS showed the workgroup the formula model and reoriented the workgroup to how the model spreadsheet operates, such as what can be adjusted and what cannot. Noted that this is an updated version of the model that includes the RUCAs codes to generate the rural factor.
- The method applied was the set the SDOH individual weights first, then complete the overall variables at the top of the model. This is because the SDOH weights feed into the overall SDOH variable for the main formula.
- Ashley used the percentages from the two versions of the SDOH matrix since they were consistent. Then used that same row – survey matrix percentages – to fill in the main variable weights. Gave the group time to review the table and how the allocations adjusted based on these weights.

- Abbie noted that the per capita range decreased from the current allocations to new with these formula weights.
- Asked the group for any thoughts, comments, questions, concerns.
  - Chuck noted that it's interesting to look at the comparative changes across the regions. One of the core things is not to harm what we have. Everything we have we need. I don't care if it's a metro program or a Duluth program. They're all important. So that has to be looked at here too, what is the impact to the regions.
  - Abbie noted that is true and we also need to take a statewide approach to this effort.
- Abbie asked the group if we should try to get the formula weights to 100%
  - Kesha – I'm wondering if we should look at that extra 5%, thinking to Chuck's comment about where we could put that remaining 5%.
  - Ericka – I'd be fine adding more to the social determinants of health.
  - Shauna – yea, that's kind of an equalizer, it's impacted across the board.
  - Chuck – I would agree that it makes sense to do that.
  - Kim – me too.
  - Jason asked to see the SDOH weights again. Jason suggested removing the 5% on past incarceration and putting those 5% somewhere else, on a different SDOH.
  - Shauna asked if this meant the group now had 10% to deal with.
  - Ashley – the percentages are in different buckets, so there's 5% in SDOH and 5% in the main variables section. Also noted that SDOH as a main variable fell in the 15-20% range, so if the group increased it to 20% that would be in line with the priorities they set.
    - Group in favor of doing that. Ashley made the change from 17% to 20% for the main SDOH variable.
  - Shauna agreed with what Jason was suggesting and suggested moving the 5% from past incarceration to homelessness.
  - Kesha noted that the data source is something to keep in mind with the homelessness variable. That was self-report, right? Might not be a true reflection of what is being raised.
  - Abbie – yes, the homelessness is self-report to Medicaid.
  - Chuck – can we see the graph/matrix one more time? If you look at the top 3, for consistency over time, they've been the top 3. Maybe you take the 5% and divide it up amongst them. They are consistently high-high. So clearly that is the preference throughout this workgroup.
  - Shauna – so if you take that 5% from incarceration and move it into the SMI/SPMI or the others, even make SMI 30%.
  - Ashley – would the group like me to make that change? Yes from group. Changed past incarceration to 0% and SMI/SPMI to 30%.
  - Shauna – the remaining 2% (in the main variable section)
  - Jason – would it make sense to make all of the population variables 10%?
  - Agreement from the group. Changes made.
- Ashley asked the group how they felt about these percentages.
  - Shauna noted it's hard to want to say, we know there's going to be impact across the board. But when you match these percentages to the priorities set by the group, there isn't anything that stands out as way off. We've done a really good job even though how hard it was.
  - Chuck – I actually like it and I keep advocating for it over and over. I want to make sure that voice is clearly heard. This may be the thing to get to, it's how you get there that is where the harm will come. The percentages and what we did here, it meets all the things we were aiming for. I think it's all there. But I think the implementation is what scares me.
  - Abbie – and for implementation, we are planning to have another workgroup to figure out how things should be implemented. We also have time. This is not going to go into effect

until 2025, so there is time for planning that together so that it lessens the impact on those regions who are seeing major changes.

- Chuck – will there also be advocating for additional funds for this quite necessary thing that I think is statewide. The message was sent pretty clear.
- Abbie – that is something we have consistently heard and we will be putting it into the report. I also want to push it back on you and members of this workgroup to advocate for additional funding in the ways that you can. We are limited in how much we can request that, though I consistently say, hey this is what we’re hearing, we need more money. So I want to put back to you to go advocate for more funds. I fully support more funds. If I had it, I would give it to you.
- Ericka – I agree this process really honored the transparency and equity and kind of reevaluate the framework. But yeah, I just wish there were more dollars.
- Ashley – it’s sounding like there’s consensus around this. Maybe we switch back to the PowerPoint?
- Abbie – yes, and we can make sure we’re all in agreement with these weights. Reviewed specific weights and asked the group, are we all in agreement that these are the recommendations of this workgroup?
  - Amy – yes
  - Ericka – yes
  - Bethany – I am in agreement of the percentages shown
  - Shauna – yes
  - Martin – yes
  - Chuck – yes
  - Kenya – yes
  - Jamie – no vote
  - Rest of group used “thumbs up” emoji to vote yes

#### Other recommendations from workgroup

- Reviewed that DHS is submitting a report to the legislature as required by the last session. Noted that other recommendations have also been heard from this group, such as increased funding, and DHS plans to put those other recommendations in as well. Also have heard feedback on the implementation plan. DHS will include some specific recommendations for the implementation planning that has been suggested by the workgroup, such as a phased transition and base level funding.
- Are there other recommendations that you think are important to include in the report to the legislature?
  - Shauna – I would include a comment about covid, the impact and increase in MH needs and piggy-back on the need for increased funding.
  - Kesha – I would agree with the covid comment. Also, just commenting on the gaps that these initiatives cover for the MH system, to highlight that. It’s the safety net, especially for rural areas.
  - Shauna – and parity
  - Ericka – and it’s not just the number of people accessing but also the intensity of those seeking services.
  - Marty – If there’s a way to reflect the need for adequate services for communities of color, BIPOC communities. That wasn’t exactly called out in any of our measures, and I think that’s important.
  - Kesha – Also heard the need for flexibility with these funds. Don’t box us with BRASS codes. So hey DHS, expand our BRASS codes or give more wiggle room.
  - Chuck – that’s right on.

- Kesha – especially if there’s cuts. Some will have to get real creative to keep that safety net there.
- Shauna – doesn’t tie specifically to adult mental health initiative but it gets to that ongoing sustainability. If we are able to do more preventative work and go upstream, down the road then maybe there’s less need for the services/funding. Maybe shifting to SMI to be broader rather than narrower SPMI.
- Kesha – I agree, allowing the SMI in place of SPMI. Gives the flexibility.
- Abbie – we’ll make sure these recommendations will be included in the report. Yes, it’s outside the scope of this project, but this is very important and we hear you on this.

#### Next steps

- DHS has about 20 calendar days to finalize the report to the legislature based on all the work from this group, including reviewing the recommendations with DHS leadership. We have to work through the process with DHS to submit the report. That’s why it’s due for us December 1, not February 1.
- We then have to wait to hear form the legislature.
- Then will start an implementation workgroup to help plan how to transition from current to new allocations. And like we said before, these won’t go into effect until January 1 2025, so there is time to plan for that transition.
- Any questions on these next steps?
  - Shauna – my only recommendation is to convene the implementation workgroup sooner than summer 2022. Reflecting how long workgroups and these efforts take. Follow-up question, what is the legislature needing to do with this report? Do they need to approve this formula?
  - Abbie – Yes. We have to wait for any feedback, recommendations from the legislature. We don’t necessarily need their approval, but we do need to wait for their thoughts before we plan for how to implement it. That’s why there’s a gap in time, because we don’t expect to hear from them until probably May.
  - Shauna – I’d include that in the recommendations then, that the legislature take this up early in session so we can get to implementation planning sooner. The sooner AMHIs know the impact, the sooner they can plan for it.
    - Added to recommendations
  - Chuck – I’d just add that that would give more time for advocacy with real numbers and real impacts for legislators.
  - Kesha – who is part of that workgroup and how will it be selected.
  - Ashley – haven’t decided yet. We’ll take the learnings from this workgroup and apply it to that one to continue improving. Basically, to be determined.

#### Wrap up and celebration

- If you’ve had fun with this workgroup, we’d love to have you back in the next one. The DHS has learned a lot in the process as well.
- Spending sometime here at the end to wrap up and celebrate the work we’ve done, reflecting on the work that’s been accomplished.
- Went through an Affirm, Confirm, and Celebrate reflection process. The discussion was captured in the slide deck.

AMHI	Current historical allocation	Per Capita (Adults)	Preliminary formula-based allocation	Per capita (Adults)
<b>ABHI</b>	\$3,829,186	\$15.41	\$2,889,427	\$11.63
<b>Anoka</b>	\$765,075	\$2.81	\$1,370,917	\$5.04
<b>BCOW</b>	\$1,181,263	\$9.44	\$1,390,577	\$11.11
<b>Carver</b>	\$319,933	\$4.13	\$268,042	\$3.46
<b>CommUnity</b>	\$1,249,432	\$3.83	\$1,929,595	\$5.92
<b>CREST</b>	\$2,297,954	\$6.92	\$3,133,147	\$9.43
<b>Dakota</b>	\$482,776	\$1.49	\$1,440,388	\$4.43
<b>Hennepin</b>	\$5,809,267	\$5.87	\$5,355,162	\$5.41
<b>NW8</b>	\$1,453,914	\$21.29	\$964,816	\$14.13
<b>Ramsey</b>	\$4,466,053	\$10.57	\$2,805,213	\$6.64
<b>Region 2</b>	\$595,725	\$9.62	\$944,301	\$15.24
<b>Region 4S</b>	\$664,642	\$12.37	\$727,274	\$13.54
<b>Region 5+</b>	\$1,236,491	\$8.67	\$2,088,819	\$14.65
<b>Region 7E</b>	\$1,715,762	\$13.04	\$1,141,504	\$8.68
<b>SCCBI</b>	\$4,210,082	\$17.23	\$2,633,257	\$10.78
<b>Scott</b>	\$228,859	\$2.11	\$412,173	\$3.79
<b>SW18</b>	\$2,229,288	\$10.70	\$3,072,057	\$14.74
<b>Washington</b>	\$604,982	\$3.04	\$774,014	\$3.89
<b>White Earth Nation</b>	\$158,688	n/a	TBD	n/a
<b>Total</b>	\$33,499,372		\$33,499,372	\$7.71

Table 1: Comparison of new and former allocations by AMHI region.



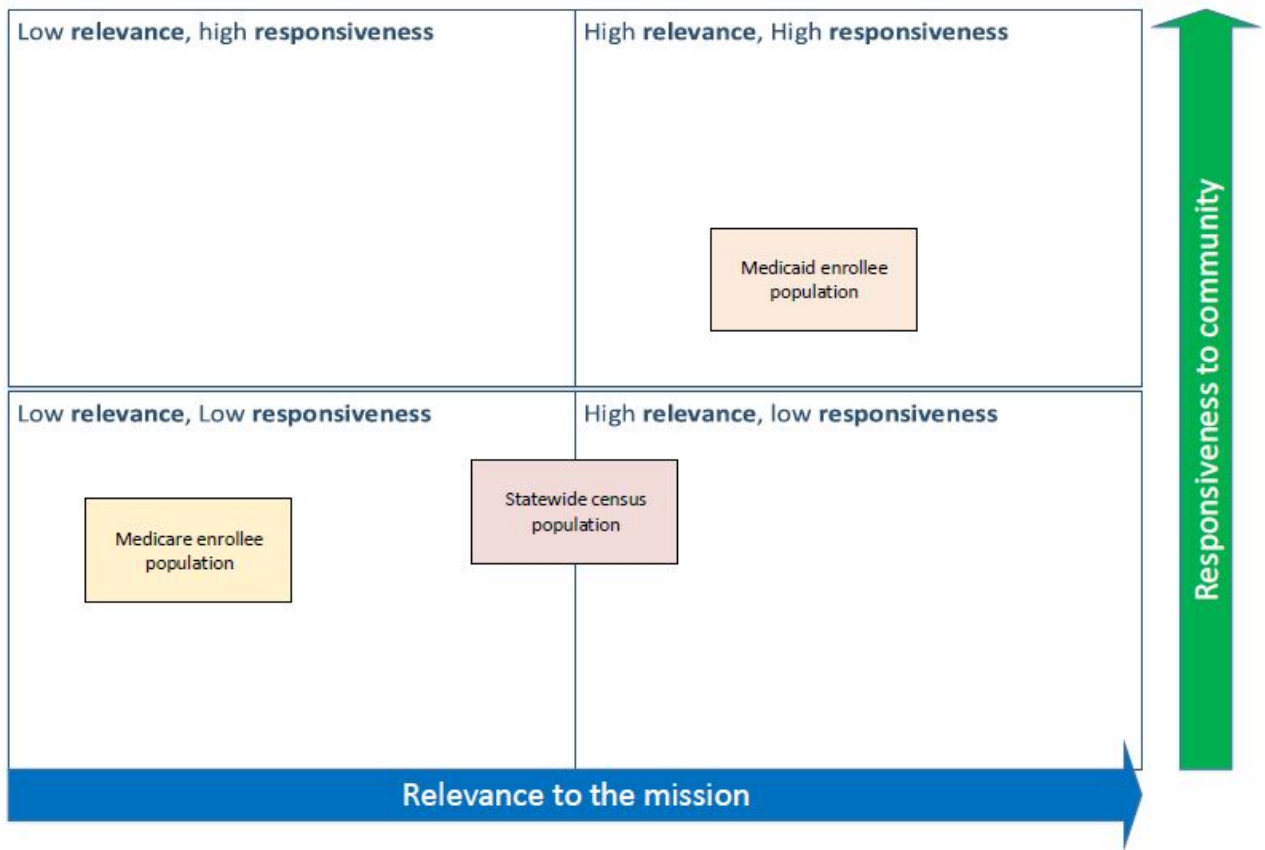


Figure 1. The workgroup used a priority matrix to prioritize the three population variables. These priorities are the basis for the final values as proposed by the workgroup.

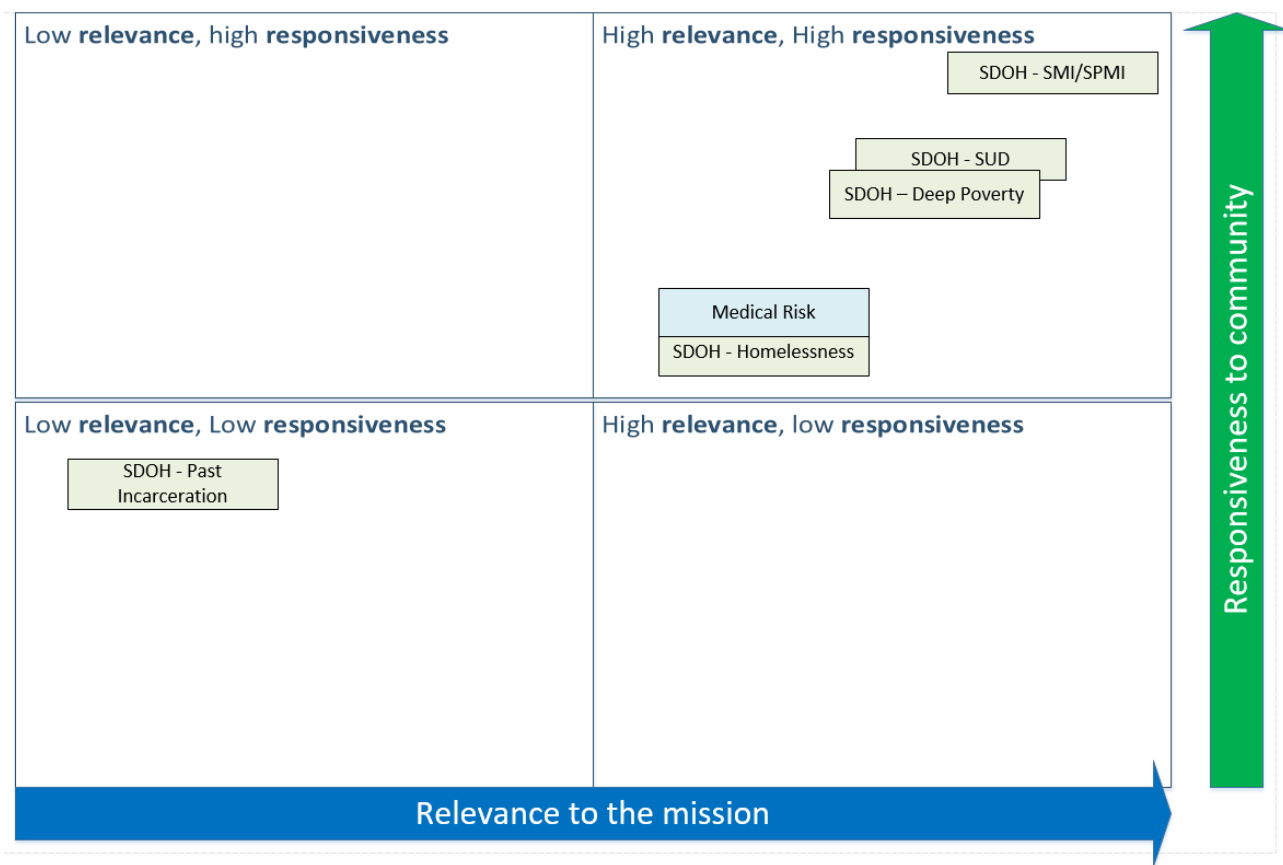


Figure 2. The workgroup used a priority matrix to prioritize the 5 social determinant of health sub-variables and medical risk. These priorities are the basis for the final values as proposed by the workgroup.

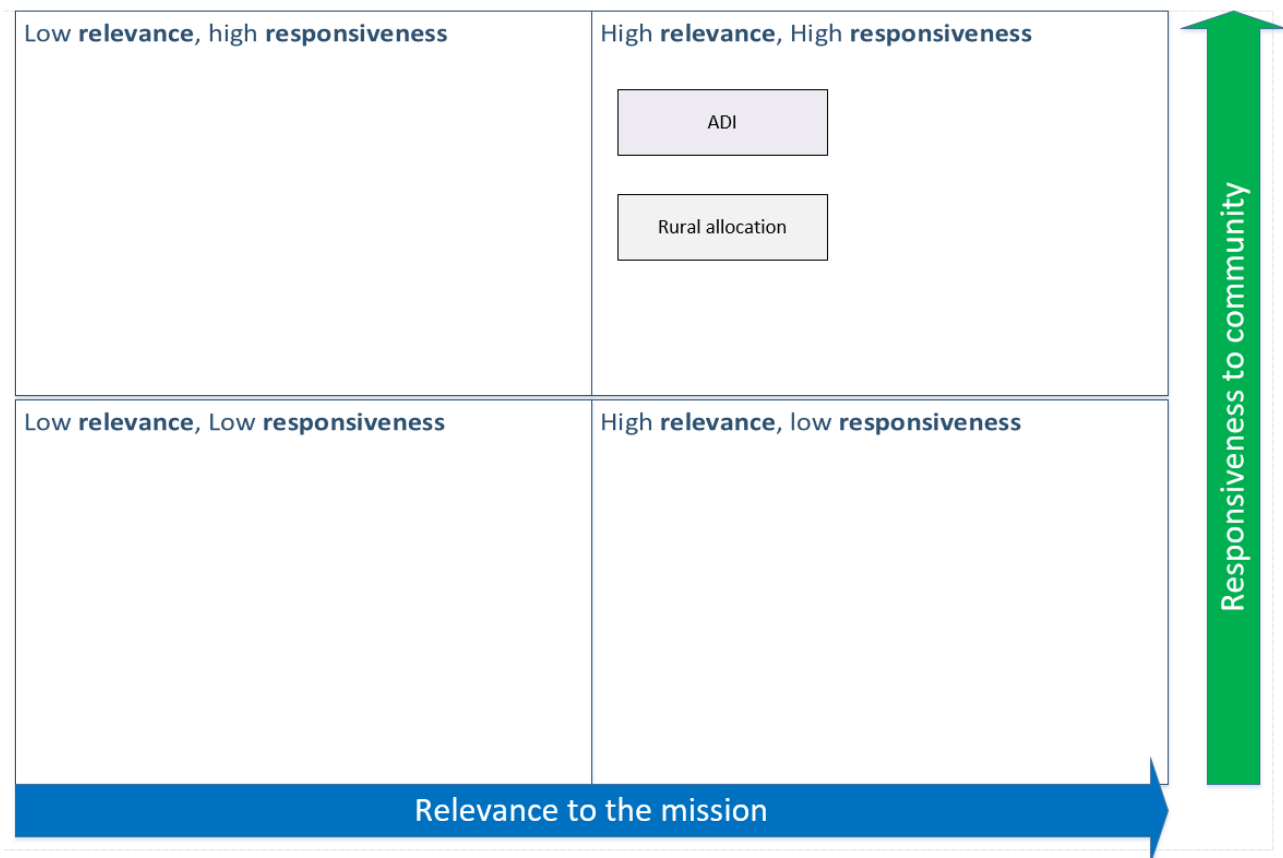


Figure 3. The workgroup used a priority matrix to prioritize the ADI and rural allocation variables. These priorities are the basis for the final values as proposed by the workgroup.

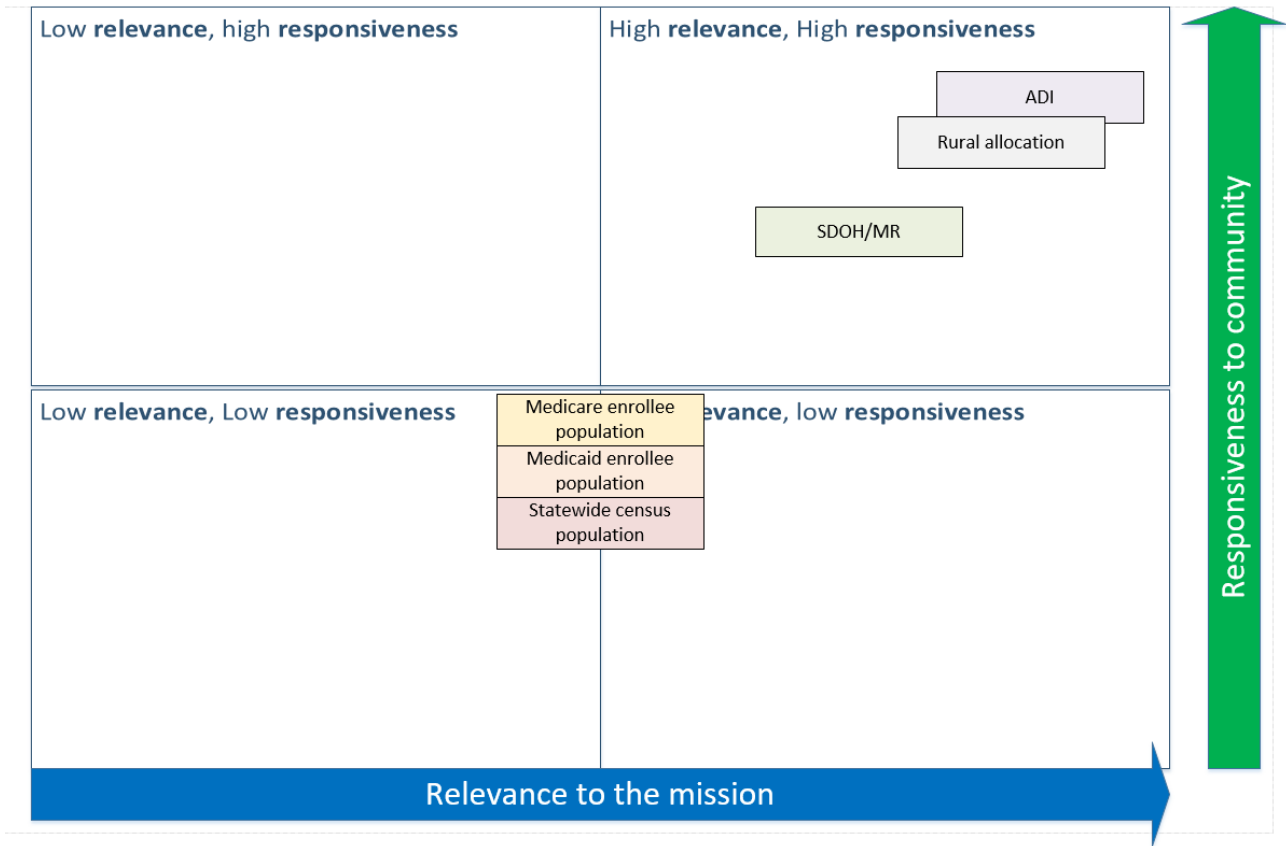


Figure 4. The final priority matrix created by the workgroup. This is a combination of all previous priority matrices and the workgroup’s response to the pre-meeting survey.