

Adult Mental Health Initiatives Statewide Meeting

Details

When: April 28, 2021, 1:00-2:00pm

WebEx Only. This is not an in-person meeting.

Agenda

AMHI Team Introductions, review agenda for the day, any housekeeping

DHS Updates

- General Updates

AMHI reform

- Update on funding formula development
- Questions and Comments specific to *AMHI Reform*

General Questions, Comments, and Next Steps

Minutes

Presenters

- Ashley Warling-Spiegel, AMHI Consultant (DHS) / MH Program Evaluator
- Elisabeth Atherly, Evaluation Coordinator
- Mike Schoeberl, Forma ACS, Contracted vendor for AMHI Reform Funding Formula

DHS Updates

Staffing changes

- Cortney Jones has taken a work out of class assignment to another area of DHS for the next year.
- Ashley Warling-Spiegel has then taken the work out of class assignment for the next year for Cortney's position in BHD. Ashley is also covering AMHI.
- Reminders of where to send information provided on slide 5.

AMHI Reform

Addressing concerns raised

- Heard some questions, concerns raised at past statewide meetings and between meetings.
- Concerns raised about how MHIS data will impact the funding formula, and similarly, how the COVID-19 pandemic will impact the data.
 - At this time, we are not using MHIS data specifically to build the funding formula. We're using other variables we can use year after year. MHIS is not part of the funding formula at this time.
 - We're aware of the COVID-19 pandemic and working to ensure it's not impacting the funding formula.
- Reform will go into effect for CY23-24 contract.
 - What we mean when we say that is that will be the first contract cycle where allocations will be informed by the funding formula.
 - Now what that looks like will get figured out after the funding formula is figured out. After that, we'll be developing the implementation strategy.
 - Anticipate it will be a phased approach of some sort, not an abrupt flipping the switch. Our goal is to minimize disruptions.
 - Yes, the funding formula will go into effect in some form starting CY 2023, but we will be working together to figure out the best way to roll that out.

AMHI Reform Workgroup

- Sent out a call for nominations on the 19th for an AMHI reform workgroup specific to the funding formula.
- The purpose is to have an in-depth review of the final model recommendations from Mike and then have an in-depth discussion of those elements themselves. It's a space to have deeper and tougher conversations about how the allocations are impacted. Finally, the ask is for the group to provide recommendations to DHS on how to use the funding formula.
- We're asking each AMHI to submit nominations, up to 3. We'll select 1 per AMHI. This is to keep the size of the group manageable for those conversations.
- All meetings will be virtual for the time being.
- Please send nominations to the AMHI inbox through end of day May 7th.

- We anticipate the first meeting will be in June, with monthly meetings thereafter through summer and into fall as needed.
- We anticipate having other workgroups as well for other goals of AMHI reform, such as working on the implementation strategies or updating the statutory language.

Summary of process to date

- Project steps
 - Collected demographic and risk information for each AMHI's county or region. This included the relative number of adults, risk related information (medical risk, age, race, etc.), and social determinants of health.
 - Reviewed spending and utilization information from AMHIs. We looked at budgeting information, BRASS data that was reported, and information related to the overall MH spending from the counties.
 - Developed a preliminary model that uses the relative size and risk of the populations served by the AMHIs to develop an allocation recommendation.
- We want to develop a model that is based not only on specific quantifiable information, but also feedback from AMHIs and stakeholders to ensure we're not making assumptions and that we're including all relevant variables.

Survey Results

- Survey conducted to gather broad representative input on the payment model design. Both calculations and design itself.
 - Launched March 9th, closed April 16th.
 - We were requesting information on risk factors, population characteristics, and other AMHI factors.
 - Goal was to confirm or refine our assumptions with the model, assess which risk factors were most critical to AMHI stakeholders, determine the applicability of the various risk information to overall population assumptions, and develop more detailed inputs for the model.
 - The survey seemed relatively easy to complete and the number and quality of responses is very much appreciated.
 - 123 responses, with 88 of those within the first 2 weeks of the survey
 - On average, took about 22 minutes to complete
 - We really appreciate the time and effort people put into the survey responses.

- There was a broad array of respondents and representation of stakeholders, from county social service staff to providers to MCOS to people with lived experience. The scope of who responded is helpful for understanding the landscape of the funding formula.
- All AMHIs were represented. There was at least 1 respondent per AMHI. Sixteen AMHIs had 5 or more respondents. Eight AMHIs had 10 or more respondents. It'll be important for us to keep those responses in mind as we analyze the results and feedback.
 - Multi-county AMHIs were heavily represented in the responses (76% versus 24%). The single county AMHIs cover about 55% of the state's population and 38% of the distributed AMHI dollars.
 - The single county AMHIs were also represented by a fair amount of providers, and those providers in many cases indicated they represented more than one AMHI.
- Response highlights - Insurance status
 - We assume this was one of the tougher questions to answer, but there are a couple of reasons we wanted to understand this.
 - We have access to Medicaid and Medicare information and wanted to verify how representative that information is. So we have this question of whether or not the funding formula should be more heavily weighted toward the relative number of Medicaid or Medicare population, if they're a disproportionate share of a county or region's population.
 - Meaning, additional funding could be allocated if a region serves a disproportionate share of Medicaid or Medicare population.
 - Of course we don't want to overlook the uninsured or privately/commercially insured.
 - This information was based on 82 responses, about 67%, who gave us some numbers to work with.
 - We also asked for input on the rationale for people seeking services when insured. The predominant response was for services not covered by insurance (e.g., transportation) and the cost of deductibles/co-payments.
- Question – any effort given to see what other funding (state/federal/local grants) were coming into various regions?
 - That has been part of what we were looking at in the initial phases. We looked at the extent to which AMHI dollars are in alignment with spending from other resources.

However, we didn't drill down to the grant-specific information. We looked at the aggregate spending that was reported by the counties for MH services, the sources being state/federal/local.

- That was not part of the survey, however.
- Response highlights – Formula Methodology
 - The response indicated general support for basing the funding formula on population size and population risk. Wouldn't say that everyone fully agreed that this was the fully appropriate approach.
 - 78% indicated size and risk should have some influence on the funding formula.
 - This tells us that there is general support for a size and risk based approach, with a higher emphasis on making sure we're integrating risk into the funding formula.
 - Some of the supplemental comments are informative. There was a lot of feedback about the different sizes of the regions, and then the fact that a larger population likely indicates more resources available. Examples of feedback provided:
 - Less populated regions suffer from more isolation.
 - Poor, less populated areas lack employment, transportation, housing resources.
 - Size of the population does not correlate with socioeconomic abilities of the county/region.
 - Not all relevant factors captured using the current relative risk of population statistics.
 - Both should be considered, not a forced choice.
 - These comments indicate concerns for additional needs driven by rural-specific factors. Service access, isolation, poverty.
 - We've been considering additional adjustments related to these rural-specific cost factors, and the ways those can be captured via data or additional information.
- Response highlights – Risk Factors
 - We talked about trying to figure out how to utilize and integrate the risk information into the model. We asked about the relative impact of the different risk factors and social determinants of health from the respondent's perspective.
 - The information overall indicates that additional funding could be allocated to the AMHIS that serve a disproportionate share of clients with certain social determinants of health.

- We started off with the acceptance and understanding that it's appropriate to include risk characteristics. If risk factors are determined to be social determinants of health or other related health factors, then the question is which ones carry more weight.
 - The responses indicate that all factors have some impact.
 - The ones that really stood out as being very impactful, the primary influencers, were SMI and SUD. These were considered at least somewhat impactful by nearly all respondents (94-99% of respondents).
 - The next level of responses or secondary influencers were deep poverty and physical health. These were considered at least somewhat impact by a majority of respondents (89-90% of respondents).
 - Worth recognizing that all of these factors are reasonably impactful and important. When it comes to force ranking and prioritizing, these are the 4 factors that really stand out.
- Response highlights – Differential Service Needs or Expenses
 - Are there patterns of spending that could be driving differential service needs? We asked about a series of different service needs and asked respondents to indicate how impactful.
 - The responses indicated that most of the factors were impactful. Again, there were some that stood out.
 - Access to reliable transportation
 - Geographic distance
 - Scarcity issue
 - Insufficient funding
 - We do need to consider the relative number of responses between single- and multi-county AMHIs as we consider weighing these factors.
 - It does have us take a step back and consider this question as to whether or not DHS can consider adding additional per capita funding to AMHIs that serve large, less populated geographic regions.
- Response highlights – Additional Feedback

- In addition to the more quantitative response feedback we asked, we also asked for general comments related to the process. The responses were very thoughtful and Mike highlighted some that especially stood out.
 - Value of transparent reporting
 - A lot of commentary related to access to services
 - Telehealth emerging as a way to reach participants
 - Lack of technology was a factor that was indicated to be impactful
 - Concerns with abrupt changes and its impact on participants
 - The group is aware of this and working to build the formula effort with this in mind.
 - Mission and vision of the AMHs being key to the work
 - Rural MN needs and challenges
 - Understanding that there will be winners and losers in this process and worries about changes impacting providers. Comments that changes should be gradual.
- Learnings summary
 - Again, we really appreciate the number and quality of responses.
 - General support for basing the formula on population size and risk
 - Additional funding could be allocated if AMHs serve a disproportionate share of Medicaid and Medicare clients.
 - Risk information from Medicaid data is a credible estimate of overall population risk. It's not the whole story, but it's a reasonable proxy for determining the relative risk of the populations.
 - There's some consideration for very specific social determinants of health – SMI, SUD, deep poverty, and overall physical health
 - The information indicates the value of additional funding for AMHs that serve larger, less populated geographic regions

Next steps for the funding formula work

- The information in the survey is being used to help finalize the model inputs and develop the weights.

- The deliverable from Forma ACS is due to DHS by June 30. SO there's still a fair amount of work to do, but we're moving to finalization.
- We are working towards additional areas of research based on the survey results.
 - Area Deprivation Index
 - This is a source of information developed through the University of Wisconsin.
 - It ranks neighborhoods by socioeconomic disadvantages and regions of interest.
 - What we can do is take a look at information for the state of MN, down to the 9 digit zip code level, and look at relative income, employment, and housing quality that may be impacting the additional need for funding in these communities.
 - Mike is exploring these data to explore how to integrate this into the funding formula.
 - Service counts reported to DHS
- Additional next steps
 - Convening the AMHI workgroup to help us really do that least deep dive onto the funding formula based on the work that Mike has done.
 - Elisabeth Atherly – if you recall she has been helping Abbie, Helen, and Ashley look at stakeholder engagement and understand how we can better build that into this project and our work. She's been integral in helping us put together this work. You'll be seeing her more with the workgroup. She has a wealth of knowledge and experience with this work, and will be helping us to facilitate these workgroup meetings so we all get the most of out of it.
 - Finalize the funding formula and share it out.
 - Potentially forming an additional workgroup to form the implementation strategies and make a solid plan for how this starts to roll out in CY 2023-2024.

Questions or Comments specific to AMHI reform, funding formula work, or the survey results

- Elisabeth – could you review again what is included in those rural-specific factors, and how might you be incorporating that into the formula that is being developed?
 - Mike – the ADI is a very interesting survey tool. It is trying to assess via neighborhood the relative level of socioeconomic disadvantage. It looks at employment, the education level, and housing quality, and comes up with a scale from 1-100. It then scores the relative level of deprivation for each community or neighborhood. I can look at the

survey information and break it down by zip code, and then aggregate those zip codes into the AMHI regions. IN other words, I can come up with an average for each AMHI region of the relative deprivation index. If you look at the information on the website, what you'll see is that are some pretty significant differences in this deprivation index across Minnesota. If you think of a band going from Fargo/Moorhead to the Twin Cities to Rochester, you see a lot less deprivation. Then in the NE side to iron range and SW side of the state, t hose deprivation indexes indicate more deprivation. What we need to do is understand how much of that is already integrated into the factors we're already looking at, and determining whether or not this can help us get our arms around some of the other things that aren't apparent in the data (the other areas measured in this index).

- Neighborhood Atlas website - <https://www.neighborhoodatlas.medicine.wisc.edu/>
- Other comment from Mike - One of the things that is interesting is that the feedback is fairly similar between the single-county and multi-county AMHIs based on the survey results. When we get to the social determinants of health, they were consistent between the groups, along with the overall support for the funding formula itself.
 - The differences were more apparent in things like the geographic distances. While faced by all the AMHIs, there were some differences between the two groups.
- Mike – reviewing the supplemental comments/feedback slide again to point out a few additional items.
 - The last point on slide 23 speaks to how the AMHIs are spending differently across services. We saw this in the AMHI spending via BRASS codes. We could see where dollars were spent, but we weren't able to see how the spending matched up to service need. For example, transportation is called out a factor, but we don't see that level of spending in the BRASS code data.
- Thank you to Kathleen Johnson for the comment in the chat, thanking the team for a thoughtful process in developing the funding formula. We do want to have a thoughtful process that takes into account the factors that the AMHIS are facing and we hope that the survey process and how we've integrated/consolidated that feedback speaks to that.

Next Steps

- Next AMHI statewide meeting is June 16, 2021 from 1-3pm. This meeting will be via [WebEx](#). Event number: 146 225 6990, Event Password: AMHI, or by phone: 855-282-6330

Documents Shared

- Meeting PowerPoint