



AMHI/CSP Statewide Meeting 4/28/21

AMHI Team

Agenda

- Agenda review and housekeeping
- DHS Updates
- AMHI Reform

- Mute your microphone
- If you want to ask a question:
 - Type your question into the chat box
 - Questions will be addressed either in the moment or during the Q&A time
- After the meeting, we'll send out:
 - All meeting materials (PowerPoints, handouts)
 - Meeting notes

DHS – Behavioral Health Division Updates

DHS - BHD Updates

- Cortney Jones will be working in another area of DHS for the next year.
- Ashley Warling-Spiegel will be taking over Cortney's role within the Behavioral Health Division for the next year
 - Continue to send MHIS system-specific questions to the MHIS inbox, dhs.amhis@state.mn.us
 - For other MHIS questions specific to AMHI/CSP, or questions about SSIS or the supplemental spreadsheet, contact: Ashley Warling-Spiegel, Ashley.a.warling-Spiegel@state.mn.us
 - Continue to send any and all AMHI or CSP questions to the AMHI inbox, MN_DHS_amhi.dhs@state.mn.us

Questions or Comments on DHS updates?

AMHI Reform

Addressing concerns raised

- We're not using any particular year of MHIS data to develop the funding formula at this time / the impact of covid-19 on the MH service system will NOT impact how we develop the formula
- Reform will begin to go into effect for CY23-24 contract
 - Allocations will be informed by the funding formula
 - Will likely be some sort of phased approach or roll-out rather than abrupt change
 - Specifics haven't been developed yet

AMHI Reform Workgroup

- Workgroup purpose:
 - In-depth review of funding formula recommendations from Forma ACS
 - In-depth review and discussion of funding formula variables, how different variables impact allocations across the state
 - Develop final recommendations for DHS on the funding formula (e.g., using formula recommendations as developed, including other variables, adjusting weights of variables)
- 1 representative per AMHI
- Virtual meetings

AMHI Reform Workgroup

- Email sent to AMHI coordinators/key contacts on 4/19/21
- Nominations open until EOD 5/7/21
 - Send nominations to [MN DHS amhi.dhs@state.mn.us](mailto:MN_DHS_amhi.dhs@state.mn.us)
- Anticipate first meeting in June, with monthly meetings through summer/early Fall as needed to complete the goal
- Anticipate having different workgroups for different objectives/goals related to AMHI reform (e.g., funding formula, implementation strategies, updating statutory language)

Funding Formula Development – Agenda

- Summary of process to-date
- Survey Results
 - Background
 - Response highlights
 - Learnings summary
- Next steps
 - Workgroup process and feedback integration
 - Model development
 - Additional areas of research
- Questions

Summary of Process To-Date

Project Steps

- Collected demographic and risk information for each AMHI's county or region
 - Relative number of overall Adults, relative numbers of Medicaid and Medicare enrollees
 - Social Determinants of Health (SDOH), medical risk, age, race, ethnicity
- Reviewed spending and utilization information from AMHIs
 - The Budgeting, Reporting, and Accounting for Social Services (BRASS) information from the AHMIs
 - Overall mental health spending and funding for the counties covered by the AMHIs
- Developed preliminary model that allocates funds based on the size and relative risk served of the populations served by the AMHIs

Survey Results - Background

DHS conducted a survey to gather broad, representative input from AMHIs and stakeholders for integration into payment model design and formula calculations

- Survey Launched March 9, 2021
 - Survey submitted to AMHI coordinators, providers, and clients
 - Requested feedback around risk-factors, population characteristics, and other AMHI-specific factors
- Purpose of survey
 - Confirm or refine assumptions behind the initial funding model framework
 - Assess which population characteristics were believed to be the most critical in determining the relative level of population care requirements
 - Determine the applicability of risk information to overall population assumptions
 - Develop more granular assumptions for payment model inputs

Technical Highlights

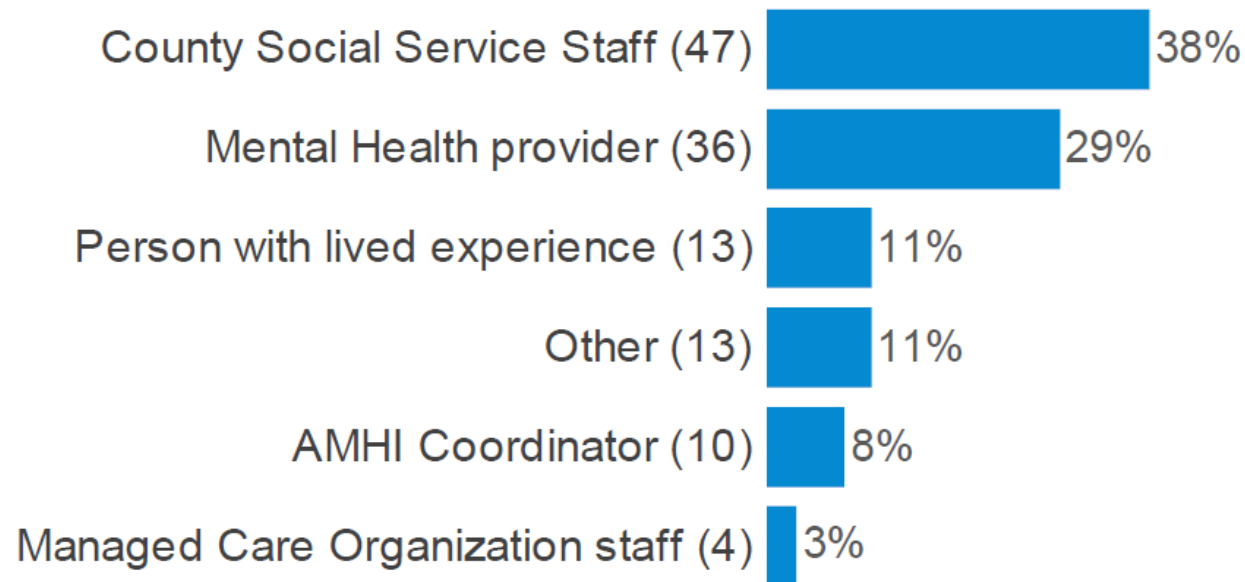
The survey did not appear to be overly difficult to complete and the number and quality of responses is very much appreciated

- Dates and Numbers of Responses since survey launched (March 9, 2021)
 - 88 responses as of March 18
 - 115 responses as of April 2
 - 123 responses as of April 16 (survey close date)
- Other highlights
 - On average, survey took about 22 minutes to complete
 - Some respondents indicated spending additional time gathering information and internal feedback prior to completion

Respondents

The number and characteristics of respondents indicated good representation from multiple key stakeholders

Please identify your current role



(If "Other", please specify)

- Chairman for county mental health local advisory council
- Community Outreach - connecting people to services
- Nursing director for critical access hospital emergency department
- Board and Lodge Provider
- Long-term homeless supportive housing case manager
- Admin responsibilities
- Job Placement and Supports Provider
- Clinical Director
- Admin services for Region 7E Mobile Crisis Services
- Probation Agent
- Housing Resource Specialist
- Certified Peer Support Specialist II, Clinical Program Therapist 1
- Evidence Based Supported Employment Provider

AMHIs represented

Although all AMHIs are represented, we need to consider the relative level of representation when developing our conclusions around the survey results

- All AMHIs were represented in the survey responses
 - All Nineteen AMHIs had at least 1 associated respondent completing the survey
 - Sixteen of the AMHIs had 5 or more respondents
 - Eight of the AMHIs had 10 or more respondents
- Respondents were asked to indicate which AMHIs (one or more) they worked with
 - 11% of respondents (typically providers) indicated that they were associated with more than one AMHI
 - Many of the single county AMHIs were represented by respondents that covered multiple counties
- The multi-county AMHIs were more heavily represented in the survey responses
 - 76% of the responses were related to multi-county AMHIs
 - 24% of the responses were related to single-county AMHIs

AMHIs <u>Represented</u>	Survey <u>Respondents</u>
1	110
2 - 4	8
5 - 10	3
10+	2

Question Responses – Insurance Status

The responses indicated that additional funding could be allocated if the AMHIs serve a disproportionate share of Medicaid and Medicare clients.

In addition, the information indicates that risk information from the Medicaid data could be a credible estimate of the overall relative population risk


Observations

- 82 respondents (67%) submitted an estimate of the insurance status of their clients
- Of the reported 90% with some type of insurance, respondents indicated that clients were largely seeking services from AMHIs due to:
 - Clients needing services not typically covered by insurance (transportation, housing, etc.)
 - Client seeking services frequently covered by insurers, but are not covered by the member's insurance
 - Costs of deductibles, copayments were also submitted as factors (“If mental health parity was actually enforced for private insurance companies, [it] would help”)

<u>AMHI Reported Insurance Status</u>	<u>%</u>
Commercially Insured	13%
Medicare	19%
Medicaid	54%
Indian Health Services	1%
Uninsured	10%
Other	2%

Question Responses – Formula Methodology

The responses indicated general support in basing the funding formula on population size and population risk

Primary Distribution Considerations	Significant Influence  No Influence				
	<u>5</u>	<u>4</u>	<u>3</u>	<u>2</u>	<u>1</u>
Population Size	22%	16%	40%	16%	6%
Population Risk	40%	30%	21%	5%	3%

Observations

- Although 78% of respondents indicated that these factors should have at least some influence on the funding formula, 22% and 8% indicated that population size and risk should have little to no influence on the funding formula
- Supplemental comments related to these questions included:
 - *Size of the area is just as important. We have a lot of miles to cover with less people in those miles.*
 - *I understand that if there's a larger population, than more funding is needed; however, where there is a larger population there is also usually more resources available. In a lesser populated/rural area, we need additional funding because we simply do not have the resources available that a larger city can provide.*

Formula Methodology continued

In general, these comments reflect concerns around additional needs driven by rural-specific factors (service access, isolation, poverty). DHS is considering integrating additional adjustments for rural populations to address some of these cost factors.

Supplemental comments (continued)


- *Less populated/sparsely populated regions suffer from isolation, a risk factor for MI which may cause a need for more attention and funding. Also, sparsely populated regions have people that are more independent and less sophisticated--they may need more reaching out to than people of densely populated areas.*
- *Poor less populated areas lack employment, transportation and housing resources.*
- *Over-relying on population alone will eliminate services or create significant barriers for rural providers to continue to provide necessary services*
- *Rural areas do not have access to as many services and lack transportation to get to services further away. There are fewer funding options. Our clients rely on the funding we provide to meet their basic needs like housing deposits.*
- *The size of the population a given county does not correlate with socioeconomic abilities in a given county. I believe there is more need for mental health services in areas with lower socioeconomic status.*
- *Small population bases tends to add to the actual need for clients as there are often limited resources.*
- *Not all relevant factors are captured using the current relative risk of population statistics.*
- *Both of these factors - size of population and risk of population should be considered. Not just one or the other.*

Question Responses – Risk Factors

The information indicates that additional funding could be allocated if the AMHIs serve a disproportionate share of clients with certain SDOH, particularly SMI, SUD, Deep Poverty and Overall Physical Health

Observations

- Nearly all factors were considered at least somewhat impactful on the service requirements of the population
 - Eight of the ten factors were considered “somewhat impactful” by 60% or more of the respondents (ESL and “other cultural factors” were considered less impactful)
- The responses did indicate the potential for assigning greater relative weight to some factors:
 - SMI and SUD could be considered more “Primary” influencers of service requirements (considered at least “somewhat impactful” by 94-99% of respondents)
 - Deep Poverty, Physical Health could be considered “Secondary influencers” (considered at least “somewhat impactful” by 89-90% of respondents)

SDOH and Other Risk Factors	<i>Very Impactful</i>  <i>Not Very Impactful</i>				
	<u>5</u>	<u>4</u>	<u>3</u>	<u>2</u>	<u>1</u>
Severe Mental Illness	75%	17%	7%	0%	1%
Substance Use Disorder (SUD)	48%	36%	13%	1%	3%
Deep Poverty	39%	29%	24%	7%	2%
Clients’ overall physical health	24%	34%	33%	8%	3%

Question Responses – Differential Service Needs or Expenses

The information indicates that DHS could consider adding additional per-capita funding for AHMIs that serve larger, less populated, geographic regions

Observations

- Nearly all factors were considered at least somewhat impactful on the relative service needs within a region
- The responses did indicate the potential for some access-related factors to be considered when developing the funding formula
 - Transportation needs and geographic distance considered to be very impactful by a large portion of respondents
 - Other access issues (not necessarily geographic-based) were also considered impactful
- The relative number of responses between single- and multi-county AMHIs need to be considered when weighing these factors

Cost Differential Factors	<i>Very Impactful</i> → <i>Not Very Impactful</i>				
	<u>5</u>	<u>4</u>	<u>3</u>	<u>2</u>	<u>1</u>
Lack of reliable transportation (e.g., car, public transportation)	66%	23%	6%	4%	1%
Scarcity of specialists / MH workforce shortage	46%	30%	17%	5%	3%
Geographic distance between providers and clients	63%	17%	12%	5%	3%
Insufficient funding from other sources (County, State, etc.)	35%	30%	22%	9%	3%
Lack of access to services covered under clients' insurance	24%	28%	33%	9%	5%
Lack of consistent technology infrastructure within the county	19%	39%	22%	15%	5%
Absence of specialized health center (e.g., CBHH) in region	33%	26%	21%	13%	7%

Question Responses – Additional Feedback

Supplemental Comments of Interest

- AMHI that have been good stewards of the funding with transparent reporting and responsible use of funding should be supported.
- The challenge as I see it - is the ability to gain access to a provider in a timely manner - often times one can not get appointments for weeks or months this will not work well for someone suffer[ing] from an immediate issue
- Social Clubs need to be run by consumers with the best interest of quality services ,understanding it's not a business of therapy, behavior modification, it's a place to develop friendships and learn by experience the social interaction, the skills needed to navigate in their lives.
- There is concern and skepticism regarding the data that will inform AMHI funding decisions. The MHIS system is not reliable nor is SSIS. If DHS is going to use these platforms to extrapolate data, then the systems need to be 100% user-friendly and consistently reliable.
- The outlying, lower populated counties within the AMHI regions were undeserved until the pandemic. With tele-health emerging as the only way to reach the people we serve, those areas finally had access to services. Let's not go backwards. Let's take note of what is working.
- Abrupt changes could have a significant impact to the current existing provider network that is in place, thereby causing a disproportionate number of rural counties to be negatively impacted.

Additional Feedback continued

Supplemental Comments of Interest (continued)

- These funds are essential for communities, large or small. The need for these funds is clearly increasing as evidenced by our 911 calls, our suicide rates, and by the clear impact of isolation due to COVID19 and aging. These funds must be increased to help support these increasing needs. We support these funds following and established formula, but overall resources need to grow across our mental health systems as a whole
- I think it is important to have clear communication about the mission of the AHMI is, what role, responsibilities and resources they have. Sometimes the AHMI Board seems like a well kept secret and having general community understanding about what the AHMI is about is lacking.
- It would be interesting to study the average cost of adequate services in each geographical region including such things as transportation, time involved, etc.
- I believe rural Minnesota needs to be creative on how we address the high needs of the individuals in our communities. We have significant health issues that are directly related to the lack of services in all areas that could positively impact social determinants of health. There are high poverty rates due to transportation, daycare and employment opportunity shortages.
- Clearly there will be winners and losers in this process. The challenge is that at least in our case we have allocated these dollars for services that is our money is decreased we may not be able to continue to support. And in some cases our providers rely on these dollars and may cease to exist.
- Funding was set up in the 90s to compensate for lack of resources such as CBHH's. This puts some areas at a significant disadvantage and costly to serve long distance. Many counties and regions count on current funding and any changes should be gradual
- Supported Employment is a huge factor to people producing their own income, this area has already been reduced from our AMHI in the past and should remain a factor moving forward.

Survey Summary

Primary Takeaways

- The survey did not appear to be overly difficult to complete and the number and quality of responses is very much appreciated
- The responses indicated general support in basing the funding formula on population size and population risk
- The responses indicated that additional funding could be allocated if the AMHIs serve a disproportionate share of Medicaid and Medicare clients.
- In addition, the information indicates that risk information from the Medicaid data could be a credible estimate of the overall relative population risk
- The information indicates that additional funding could be allocated if the AMHIs serve a disproportionate share of clients with certain SDOH, particularly SMI, SUD, Deep Poverty and Overall Physical Health
- The information indicates that additional funding could allocated be for AHMIs that serve larger, less populated, geographic regions

Funding formula next steps

- Model development
 - Information from survey will be used to finalize model inputs and develop weights for the adjustment factors
 - Recommended approach to be delivered by June 30
- Additional areas of research based on survey feedback
 - Area Deprivation Index (ADI)
 - Service counts

AMHI reform next steps

- AMHI grantee workgroup convened to help finalize the funding formula
- DHS finalizes the funding formula and shares with all AMHI stakeholders
- AMHI grantee workgroup convened to help identify implementation strategies for funding formula
- DHS develops implementation plan and timeline for changes that begin CY23-24

Questions or comments on AMHI Reform, funding formula work, or the survey results?

Thank You!

AMHI Team

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