Adult Mental Health Initiatives Statewide Meeting

Details

When: December 9 2020, 1:00-3:00pm

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

Agenda

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

DHS Updates

- General updates
- Status of contracts for 2021-2022
- Questions and Comments specific to *Status of Contracts*
- Complaint procedure tips, suggestions – example from Region V+
- Questions specific to *Complaint procedure tips*
- CCBHC updates, information
- Questions and Comments specific to *CCBHC Updates, Information*

AMHI reform

- Update on funding formula development – Medicare data
- Next steps
- Questions and Comments specific to *AMHI Reform*

General Questions, Comments, and Next Steps

- Statewide Meeting Plan for 2021
- What will make Statewide Meetings meaningful and functional for you as an AMHI system?

Minutes

Presenters

- Ashley Warling-Spiegel, AMHI Consultant (DHS)
- Abbie Franklin, AMHI Consultant (DHS)
- Helen Ghebre, Community Capacity Building Team Supervisor (DHS)
- Mike Schoeberl, Forma ACS, Contracted vendor for AMHI Reform Funding Formula
- Tami Lueck, Crow Wing County and Region V+ AMHI board member
- Jane King, Services Specialist for CCBHC (DHS)

DHS Updates

Behavioral Health Division updates

- New director joined on 12/1/20, Paul Fleissner
- New AMHI Reform project member – Elisabeth Atherly. Elisabeth is assisting us with project managing the stakeholder and community engagement aspect of AMHI reform. She will not be working as an AMHI consultant.

Status updates on 2021-2022 contracts

- As of 12/7, most contracts are in the docusign process for signatures. Thank you everyone for your patience, as we had quite a delay. They are going through, we have a lot of contracts that are fully executed.
- You'll know it's fully executed when you receive a copy from us from our AMHI email.
- Reminder – contracts are fully executed when all signatures, including DHS, are completed. Work cannot start before contracts are fully executed.
- If your contract will not be executed in time for a January 1 start, we will be reaching out to you to make a plan.
- Opened to questions about contracts and docusign. No questions received.

Region V+ compliant process, Tami Lueck

- Talking about the complaint procedure/process that Region V+ has. At this time, hand it off to Tami to talk about their process.
- Tami Lueck, member of Region V+ Adult Mental Health Initiative. These are the counties that make up Region V+: Crow Wing, Morrison, Todd, Wadena, Cass, Aitkin, Leech Lake Band, and Mille Lacs band of Ojibwe.
- We were asked to talk about our form, what we call the Mental Health Initiative and Child and Adult Crisis Services Concern form.
    - It was created as a way to address something we were seeing: some of our services didn't seem like they were getting out to our whole geographic area, and it seemed like some counties had issues that other counties didn't.
    - It felt like there wasn't a place to record a concern and track it like they did for other information.
- Developed a couple of years ago. Can be used by counties, tribes, and providers.

- Information tracked: concern information and resolutions, both of the entity raising the concern and the AMHI's resolutions. Helps with tracking and catching potential patterns if concerns continue to be raised.

- Showed some of the information collected by the form.

    - Person reporting the service concern, their affiliation, date and who was involved in concern.

    - Concern or action taken by the AMHI. AMHI chair signs the form, and either the chair or the AMHI coordinator will follow up with the reporter.

- Questions from the group:

    - Is there a spot to explain the concern? Yes, the middle of the form has space for fully describe the concern and if they took any steps to resolve it.

    - How often are you receiving complaints or concerns that you're tracking through this form? It ebbs and flows. Sometimes counties and providers need reminders to use the form. Probably 2-3 of these a year. Perhaps used to do more, but the AMHI has done more work in the last couple of years to have more ongoing conversations with providers (regular data review, prompting questions, having providers present regularly to AMHI board).

    - What kinds of complaints to you typically receive? Sometimes it's something that's not working well between providers. Sometimes get concerns with how service providers interact, either with clients or with other service providers. Haven't had any from clients/individual consumers.

    - Is there a formal process for addressing the concern? Does the AMHI board review them and follow-up on that, or are you just tracking? Yep, follow up on it. Review the form at the AMHI board meeting. Chair then signs off on the form. Usually chair will reach out if follow-up is needed, or it'll be the coordinator who will follow-up.

    - Is that form available on your website? How can we share it with other regions? Not sure if on the website, but can get it shared. AMHI team will ensure it gets shared.

CCBHC Updates, Jane King

- Provide some updates on Certified Community Behavioral Health Clinics. Focuses on services and on the CCBHC team at DHS.

- Going to go over CCBHC overview, CCBHC model, and the future of CCBHC in Minnesota.

CCBHC Overview

- Started as a federal demonstration program. Minnesota was very excited to be one of 8 states to test this model in clinic.
- Was only supposed to be 2 years, but congress continues to extend the demonstration.
- Minnesota intends to keep the 8 demonstration clinics in the federal demonstration as long as possible while also adding new clinics.
- CCBHC has support in Congress and in MN legislature. SAMHSA awarded service grant funds to create more CCBHCs. And then in 2020, MN awarded planning grants to prospective CCBHCs. Those that are grant funded will need to work on certification and transition over to Medicaid daily rate.
- 13 CCBHCs in Minnesota. 8 certified in the state, 5 in the certification process.

CCBHC model

- Transitioning from community mental health centers to an integrated behavioral health clinic.
    - Integrated behavioral health service model
    - Clinic-specific cost-based daily rate: A clinic is able to create an annual cost report of how much it costs to provide all of their services in a trauma-informed, person-centered, and evidence-based way, and divide it by their anticipated average number of encounters per day. Service cost does also include things like staff training, supervision requirements, care coordination, and outreach.
    - Data-driven outcome measurement and quality improvement: advanced outcome measurement. 22 federal outcome measures, including performance measures that can result in a bonus to a clinic.
- Also must include governance structure that includes consumers and their families. Goal is 51% of the board.
- Before CCBHC – services are siloed and not integrated, and some services only available in some contexts. In CCBHC, all services integrated together.
- Services that a CCBHC MUST provide with its own staff: Integrated assessment and treatment planning; integrated care coordination; outpatient MH and SUD treatment services; 24-hour mobile crisis; and MAT and withdrawal management.
    - Some of the CCBHCs are state sanctioned mobile crisis providers, while others contract with the state sanctioned mobile crisis providers.

    - The other services provided by CCBHCs may be provided in-house or with a contract: TCM, peer services, mental health care for veterans, psychiatric rehab services ARMHS/CTSS, and outpatient primary care.

- Question: does the CCBHC include ICTS?
    - (from another person) ICTS is a Region V+ service and not covered by CCBHC.
- Question: Is there an agency that is providing withdrawal management service in rural MN?
    - If you look to the map of CCBHCs across the state, that will answer your question. Those that are outside the metro are providing withdrawal management. Some do it in a small way and only offering it to clients already serving, but if you reach out to a CCBHC you could ask them more about that.
- Question: Are there enough peers on staff to offer peer support at all CCBHCs?
    - Not sure if we can speak to that directly. All have peers and are providing the service. Unclear if they have enough. I'm sure there are some but they could always use more.
- Question: Underinsured and uninsured clients?
    - CCBHCs cannot deny services based on inability to pay. They must serve people regardless of what payer they have. They would still be working with counties to access the funding available for uninsured and underinsured. Can't bill Medicaid for non-MA clients, but they do have to keep track of the services/utilization. Also can't deny services based on where the client lives.
- Equity standards are also part of the CCBHC model, as required by the federal criteria. CCBHCs are expected to provide services that are culturally responsive, provide language assistance, have governance that advances and sustains equity goals, and partner with the community to design and implement the services and policies.
- Question: Does Medicare cover CCBHC?
    - That cost-based daily rate is paid by Medicaid dollars. If someone has Medicare, the clinic will bill Medicare first per MN policy. Medicare pays what it will pay for that service. Medicaid will then pay the balance if Medicare didn't pay in full.
- Person-centered and family-centered care is a requirement of CCBHCs. Expectation that CCBHCs recognize cultural and other needs of individuals and work to provide that. If a CCBHC isn't able to provide something culturally appropriate for a person, they should have partners in the community they can coordinate with.

The Future of CCBHC in Minnesota

- 3 of the original 8 states in the demonstration have approved State Plan Amendments for CCBHC with CMS.
- MN submitted a State Plan Amendment to CMS to make CCBHC a Medicaid benefit available across the entire state with an October 1, 2020 effective date. When the plan is approved, services will back date to October 1, 2020.
- MN certified additional CCBHCs in October of 2020 and anticipates further expansion in the next few years.
    - Keep an eye out for certifications in 2021. Anticipate quite a few clinics to be coming online in the future. All dependent on the state plan amendment being approved, of course.
- Review of CCBHC team within BHD.
- Please check out the CCBHC webpage, on DHS page under partners and providers. You can also google MN DHS CCBHC and it'll pop right up. The webpage has been redeveloped and made it more of an online toolkit. It's meant to be a toolkit for clinics interested in becoming a CCBHC.
    - Certified Community Behavioral Health Clinics / Minnesota Department of Human Services (mn.gov)
- What happens to smaller clinics that aren't getting the higher MA rate?
    - It is an encounter rate or a daily rate. There is not a hit rate. And it is clinic specific. A clinic needs to be certified as a CCBHC. When they apply for certification, they create their own cost report based on their own costs and divide that by their own anticipated encounters in a year. That means each clinic has their own rate that takes into account the services they would provide (and the costs of those services). It is higher than the MA rate because it's a service rate, a daily rate. For smaller clinics that would like to be CCBHCs, couple of options: look at CCBHC website and assess if they want to become a larger clinic, or they could partner with other clinics to form a CCBHC with multiple organizations. There would still need to be a lead clinic that is the CCBHC, but it would allow smaller clinics to get involved.

AMHI Reform

- Same background and goals that we've been talking about from the start. Update on where were are in our project plan. We do not have a finished formula, but we do want to keep you updated on what we've done since last time in September.

Where we are now from Mike

- When we started out the project, the plan was to look at demographic information and relative risk information for the different AMHI counties/regions. We've shared a good deal of that information before, and we plan to go through that a bit more today based on new information we looked at based on last meeting.

- We've integrated relative service utilization by region which we've looked at over the last couple of months. We were hoping to present something closer to a formula proposal but we're not quite there at this point.

    - In phases 1-3, we didn't find as much explanatory information to explain why the current funding distribution looks the way it does.

    - Pushed us to look at additional factors and understanding the potential implications of using some of the factors we've looked at so far (e.g., demographics, relative risk).

- Purpose today: update where we are and set the stage for gathering more information.

Poll questions

- One thing we've seen is that right now, the single-county AMHIs receive a lower percentage of the grant funds relative to the size of their populations.

- Request to group:

    - Are there specific service requirements for metro vs. non-metro populations that could be driving these differences?

    - Are there specific service expenses for metro vs. non-metro populations that could be driving these differences?

    - Provide any supporting information in the poll and/or in the chat. Could also email the AMHI team with additional information.

- Question: what do we mean by relative risk? We'll come back to that, there's a slide covering that information.

Population and Demographics

- Why is demographic information important? It's reasonable to think that starting with relative population might provide some insight into funding needs and how the funding could be allocated.

- Also, looking at population can help assess which regions or counties are currently receiving funding that is proportionate to their proportion of the population (or where it isn't).

- Populations we looked at: overall statewide, Medicaid enrollees, and Medicare.

- Slide 40: Table on the left shows the population data we reviewed for each AMHI, and what percentage of the funding they receive.
- Note, White Earth Nation is based simply on the census population and it's a separate project to develop an appropriate population measure for White Earth Nation with them.

- Observations and comments
  - This now includes the Moose Lake Alternative funds added to the overall funding amount.
  - There is correlation between population and AMHI funding, but there are differences that aren't explained by population. Overall, larger AMHIs receive more funding.
  - The Medicare population is generally aligned with the statewide and Medicaid populations. There isn't a substantial difference that explains the current funding differences.

- What does this tell us?
  - Current grant allocations are broadly correlated with the size of the population and this holds across the populations analyzed.
  - Single county AMHIs receive a lower percentage of grant funding relative to the size of their adult populations (statewide, Medicaid, Medicare).
  - If equitable distribution is defined as 'equal funding on a per capita basis,' the funding changes would be impactful to many of the AMHIs.

Relative Risk

- Why did we review relative risk information? It is reasonable to consider that some counties or regions may have populations with greater service needs due to higher relative risk.
- Risk factors information we used: Johns Hopkins Adjusted Clinical Group (ACG) population/patient case-mix adjustment for Medicaid enrollee population; Social Determinants of Health (SDH) information for the Medicaid population.
  - We had access to the Medicaid data, so that is why we used that information to evaluate relative risk.
  - Slide 43: table shows the total and percentage of population for each AMHI based on Medicaid population, ACG risk, and SDH risk.
- Observations and comments

- The AMHI-specific relative risk of the Medicaid population ranges from 85% to 112% of the total Medicaid population.
- The distribution of Medicaid members with one or more SDH is generally correlated with the overall Medicaid population.

- What does this tell us?
  - The differences between the population sizes and distributions of the grant funding are not fully 'explained' by relative risk factors we reviewed.
  - Multi-county AMHIs do serve people with slightly higher risk and greater likelihoods of SDHs
  - If equitable distribution is defined as "equal funding on a risk-adjusted per capita basis," the funding changes would be impactful to many AMHIs.

- Question: Have we added the CBHH dollars per region and look at dollars per population, or look at other funding where metro dominates the funding?
  - We have actually looked at overall MH funding/spending – state, federal, and county. This is strictly AMHI funding that we've been talking about so far. We aren't taking into consideration other funding that you're receiving.

- Question: Is relative risk defined as relative need?
  - Yes. When you think of relative risk, the question is: are members with greater need for MH services located in particular areas? So yes, that is generally what we're trying to address here.

Service Utilization

- Why did we review service utilization by AMHI? To help assess if there are services or delivery expenses specific to certain AMHIs that may explain funding need differences.

- Utilization information we used: BRASS code spending information; overall MH spending and funding for the counties covered by the AMHIs.
  - Slide 46: table summarizes total dollars reported on as spent by BRASS code (for the most funded BRASS codes), comparing single-county and multi-county AMHIs.
  - Slide 47: table summarizes AMHI funding, statewide funding, per capita AMHI spending and all AMHI spending for each AMHI (based on 2018 spending report).

- Comments and Observations
  - The reported relative spending by category is quite different between AMHIs.

- The reported spending does not clearly indicate that there are differences in service requirements between areas covered by single-county and multi-county AMHIs.
- Differences in spending are obscured by the fact that AMHI funds only represent a portion of the total MH spending for each county and multi-county AMHI.
- Interesting information, but doesn't provide us the information needed on service or delivery costs/requirements that could impact and inform funding needs.
- The total MH spending for each county and region may indicate differently service needs and requirements of some AMHIs.
- The relative total MH per capita spending is largely correlated to the AMHI per capital grant funding.

- What does this tell us?
  - The BRASS reporting is sufficiently detailed to help us understand how AMHIs are spending their funds.
  - However, because of the flexibility in spending and reporting, it doesn't fully identify where service requirements or expenses differ between AMHIs.
  - Differences in spending are obscured by the fact that AMHI funds only represent a portion of each county's MH expenses.
  - The overall reported MH spending in the county and regions may indicate differential service needs or expenses between single-county and multi-county AMHIs.
- Overall take-ways so far:
  - There are many cases where AMHIs are receiving funding that is disproportionate to their share of the state's population.
    - If funding based solely on this, there would be fairly significant changes observed.
  - Even after adjusting the demographic information to reflect population-specific risk, there are still significant differences between the current funding levels and relative sizes of the populations within the AMHI regions of operation.
  - In summary, the relative funding levels between AMHIs cannot be reasonably explained by the differences in population sizes and the relative risk of the populations (as indicated by the available measures).
  - Because the counties have multiple funding sources and the AMHIs have considerable flexibility in choosing how to spend and report their funds, it is difficult from the

reporting we reviewed to identify where spending differences represent differential service requirements between populations served by the AMHIs.

    - We need to gather additional information and feedback to understand where there are differential service requirements or expenses in the areas covered by multi-county AMHIs.

        - Those who responded to the poll reported there are differential service requirements and expenses.

- Question from Mike to the group: transportation noted as a service difference, however it didn't show up in MH spending we looked at. Is there more information on transportation that we could use or evaluate?

- Question: have we looked at per-mile MH access?

    - Believe there is some work at DHS around that. We don't see the specific transportation spending data to help us assess that.

- Comment: suggestion made to look at economies of scale.

    - One of the things that Mike expected to see is that smaller areas would serve smallest portion of people and would have higher per capita cost. However, those differential high-per-capita dollars were observed in some of the larger area AMHIs as well. Had thought economies of scale would need to be looked at and addressed, however that hasn't been fully apparent when looking at the data itself.

- Question: what happens if you take out Moose Lake funding?

    - MLA funding is going to 2 particular AMHIs right now. It balances those numbers between rural and metro AMHIs in aggregate if you add it in, so taking it out changes that.

- Question: geography and accessibility?

    - Something we don't want to overlook as we develop a formula. Any information that can help us understand how geography impacts relative cost will be helpful. Feedback on that would be very helpful.

- Question: continuum of care?

    - Think some feedback on this would be helpful for us to review and consider how it might impact a funding formula.

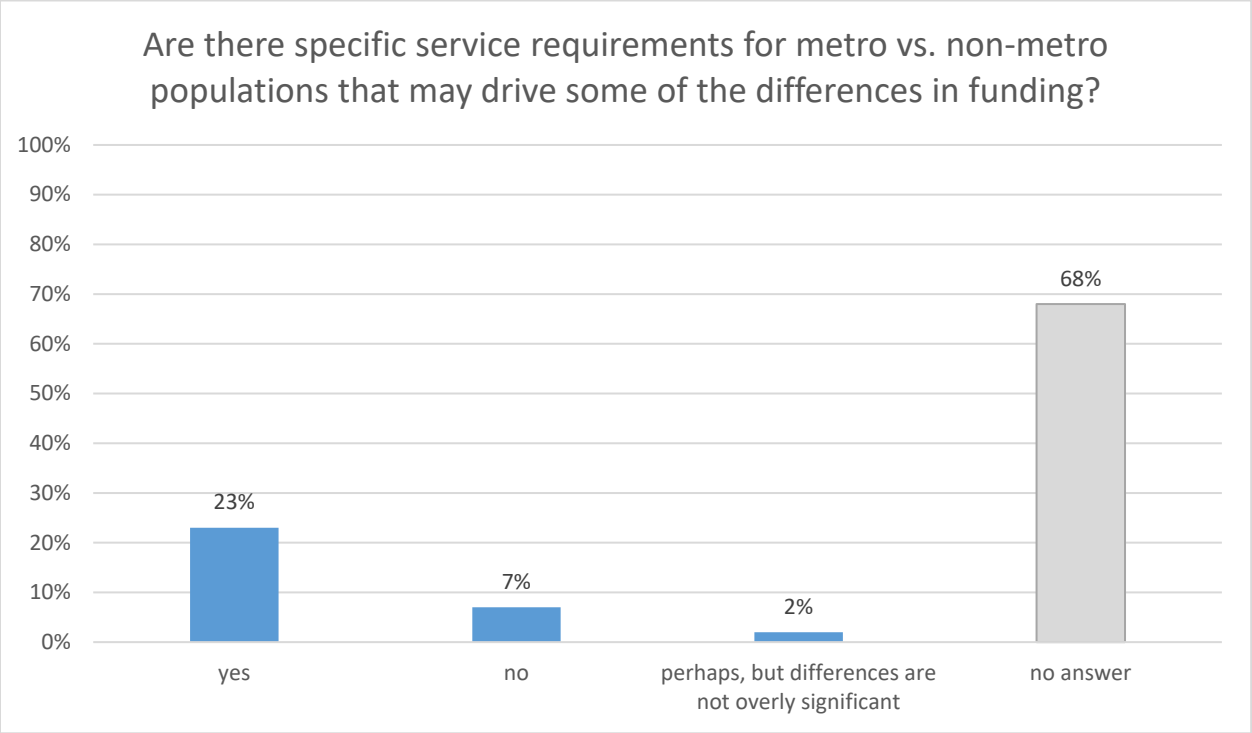
Next Steps

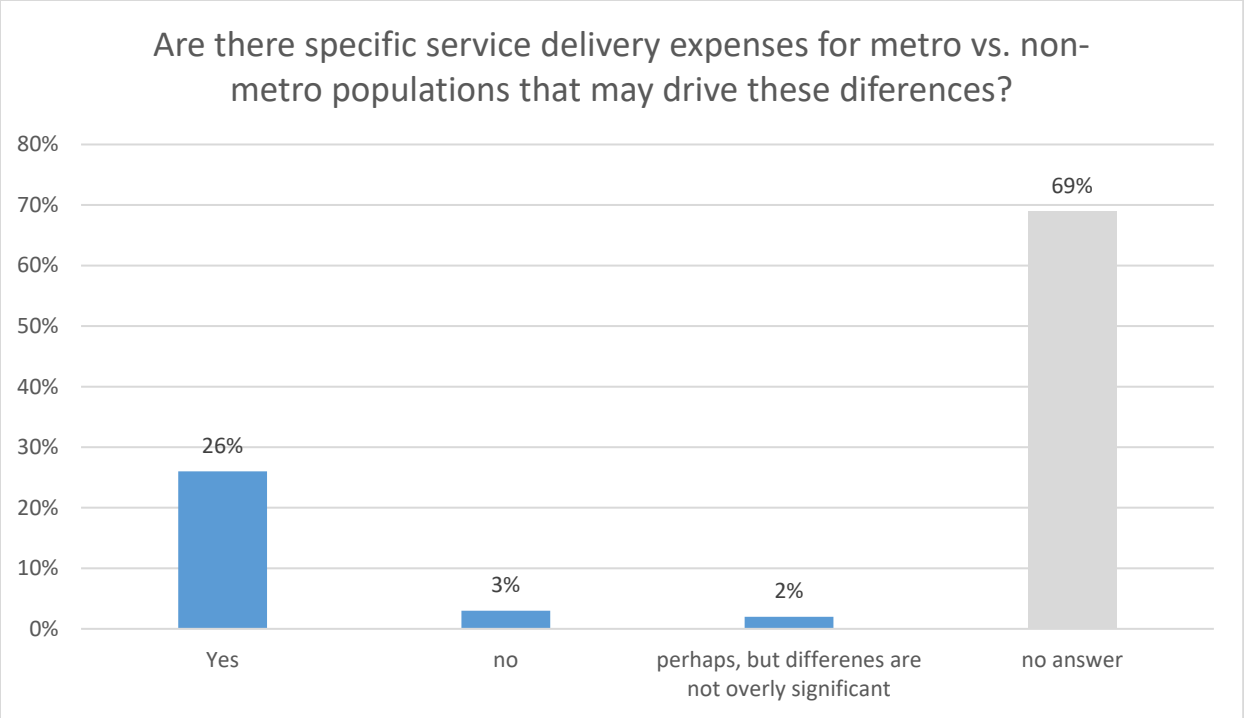
- Next AMHI statewide meeting is March 17, 2020 from 1-3pm. This meeting will be via WebEx.

Documents Shared

- Meeting PowerPoint
- Region V+ concern form

Poll Results




Are there specific service delivery expenses for metro vs. non-metro populations that may drive these diferences?
80%
70%
60%
50%
40%
30%
20%
10%
0%
26%
3%
2%
69%
Yes
no
perhaps, but differenes are not overly significant
no answer