



# AMHI/CSP Statewide Meeting 12/9/20

AMHI Team

- Agenda review and housekeeping
- DHS Updates
- Complaint policy/procedure example from Region V+
- CCBHC updates
- AMHI Reform
- Q/A

- Mute your microphone
- If you want to ask a question during Q/A time:
  - Use the “raise hand” feature, or
  - Type in the chat box your question or ask to speak, or
  - If you’re on phone only, unmute, announce yourself, and ask your question
- After the meeting, we’ll send out:
  - All meeting materials (PowerPoints, handouts)
  - Meeting notes

# DHS – Behavioral Health Division Updates

# DHS - BHD Updates

- General updates
- Status update for 2021-2022 contracts

# General updates

- New BHD director joined 12/1/20 – Paul Fleissner
- New AMHI Reform project member – Elisabeth Atherly

# Contracts Update

- UPDATE on 12/7: Most contracts are in the docuSign process for signatures
- You will receive a copy of the executed contract once all signatures are completed
- Will be sent electronically from [mn\\_dhs\\_amhi.dhs@state.mn.us](mailto:mn_dhs_amhi.dhs@state.mn.us)

# Contracts Update: Reminders

- Contracts are executed once DHS completes internal signatures. This happens after AMHI/County/Tribe signatures.
- Work cannot start/be reimbursed before contracts are fully executed (all electronic signatures received)
- If your contract will not be executed in time for a 1/1/21 start, the AMHI team will be reaching out directly to make a plan with you



Contracts/DocuSign Questions or Comments?

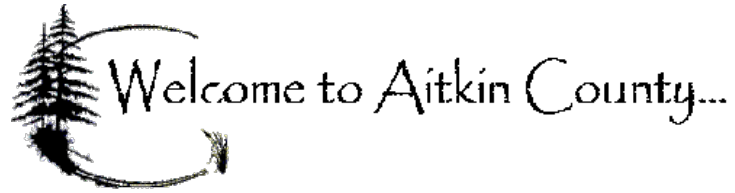
# Complaint procedure example from Region V+

Region V<sup>+</sup>  
Adult Mental Health  
I n i t i a t i v e

***dedicated to improving the  
mental health of our  
community through intentional  
planning and partnerships  
across the region***

# Region V<sup>+</sup>

## Adult Mental Health Initiative



# Region V<sup>+</sup>

Adult Mental Health  
I n i t i a t i v e



## Mental Health Initiative and Child and Adult Crisis Services Concern Form



# Region V<sup>+</sup>

## Adult Mental Health

I n i t i a t i v e

Person reporting the service concern:

County/Tribe:

Date of concern:

Service Provider/Individual who was involved in the issue or concern:

Name/Title:

Agency (if applicable) :

Phone:

Fax:

# Region V<sup>+</sup>

## Adult Mental Health

I n i t i a t i v e



**Concern/Action**



# Region V<sup>+</sup>

## Adult Mental Health

I n i t i a t i v e

Region 5+ Use Only

Action Taken: Concern Reviewed

Has this concern been raised before? When: \_\_\_\_\_

Request to Meet with Provider if warranted. Date: \_\_\_\_\_

Documented in Tracking Log and added to Provider Contract File

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Signature of AMHI Chair

# Region V<sup>+</sup>

## Adult Mental Health

I n i t i a t i v e



Thank You

Questions or Comments?



# Certified Community Behavioral Health Clinics (CCBHC)

Jane King, PsyD, LP

# CCBHC Agenda

- CCBHC overview
- CCBHC model
- The future of CCBHC in Minnesota

## Certified Community Behavioral Health Clinics

- Started as a federal demonstration program in just 8 states transforming Community Mental Health Centers into clinics using an integrated behavioral health service model
- The demonstration is scheduled to end December 11, 2020. It is expected that congress will further extend the date.
- SAMHSA awarded service grant funds in 2018 and 2020 to create more CCBHCs
- MN awarded planning grants to prospective CCBHCs in 2020



# CCBHCs in Minnesota (cont.)

- **Amherst H. Wilder Foundation** (Ramsey)
- **Northern Pines Mental Health Center** (Cass, Wadena, Todd, Morrison, Crow Wing and Aikin)
- **Northwestern Mental Health Center** (Kittson, Marshall, Red Lake, Polk, Norman and Mahnomen)
- **People Incorporated** (Anoka, Dakota, Hennepin and Ramsey)
- **Ramsey County Mental Health Center** (Ramsey)
- **Zumbro Valley Health Center** (Olmsted and Fillmore)
- **Human Development Center** (Southern St. Louis, Carlton, and Lake)
- **Western Mental Health Center** (Lyon, Lincoln, Redwood, Murray and Yellow Medicine)
- **Comunidades Latinas Unidas En Servicio (CLUES)** (Hennepin and Ramsey)—*in process of becoming certified*
- **North Homes, Inc.** (Beltrami, Carlton, Cass, Clearwater, Hubbard, Itasca and St. Louis) —*in process of becoming certified*
- **Central Minnesota Mental Health Center** (Benton, Sherburne, Stearns and Wright) —*in process of becoming certified*
- **Wayside Recovery Center** (Hennepin, Ramsey)—*in process of becoming certified, SAMHSA funded*
- **Northland Counseling Center** (Aitkin, Itasca, Koochiching and St. Louis)—*in process of becoming certified, SAMHSA funded*



- Integrated Behavioral Health Service Model
- Clinic-specific, cost-based daily rate
- Data-driven outcome measurement and quality improvement

# CCBHC Service Delivery Model

- Comprehensive, trauma-informed, evidence based, person-and family-centered services
- Serve as a “one-stop-shop” for all ages
- Provide outreach and increase access to underserved populations
- Telehealth
- Governance structure includes consumers and their families
- Collaboration within multi-disciplinary teams

# Before Integrated Care - Community Mental Health Centers

- Mental health only Assessment
- Treatment planning within each service
- Services provided in silos
  - Diagnostic Assessments
  - Outpatient Mental Health Services
  - Targeted Case Management
  - Psychiatric Rehab Services: ARMHS, CTSS
  - 24 hour Mobile Crisis
  - Outpatient SUD Treatment
- Peers only available within rehab and crisis services

# CCBHC Integrated Care

Directly provided by CCBHC:

- Integrated Assessment & Treatment Planning
- 24hr Mobile Crisis
- MAT and Withdrawal Management
- Outpatient MH & SUD Services
- Integrated Care Coordination

Directly provided by CCBHC or by designated contractor:

- Adult & Children's Targeted Case Management
- Peer Services
- Mental Health Care for Veterans
- Psychiatric Rehab Services: ARMHS/CTSS
- Outpatient Primary Care Screening and Monitoring

# Equity Standards

- Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.
- Advance and sustain organizational governance and leadership that promotes health equity through policy, practices and allocated resources.
- Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
- Partner with the community to design, implement and evaluate policies, practices and services to ensure cultural and linguistic appropriateness.

# Person-Centered and Family-Centered Care

- Person-centered and family-centered care **includes care which recognizes the particular cultural and other needs of the individual.** This includes services for consumers who are American Indian or Alaska Native (AI/AN), for whom access to traditional approaches or medicines may be part of CCBHC services. For consumers who are AI/AN, these services may be provided either directly or by formal arrangement with tribal providers.
- Interdisciplinary teams work together to coordinate the medical, psychosocial, emotional, therapeutic, and recovery support needs of CCBHC consumers, including, as appropriate, traditional approaches to care for consumers who may be American Indian or Alaska Native.

# The Future of CCBHC in Minnesota

- 3 of the original 8 states in the demonstration have approved State Plan Amendments for CCBHC
- 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
- MN certified additional CCBHCs in October of 2020 and anticipates further expansion in the next few years

- Julie Pearson, CCBHC Project Director
- Jane King, Services Specialist
- Nichole Rucker, Certification Specialist
- DiAnn Robinson, Payment Specialist
- Ma Xiong, Evaluation Specialist
- John Zakelj, Policy Specialist
- Jeffrey Hunsberger, SUD policy



# CCBHC Questions or Comments?

# AMHI Reform

# AMHI Reform – Background and Goals

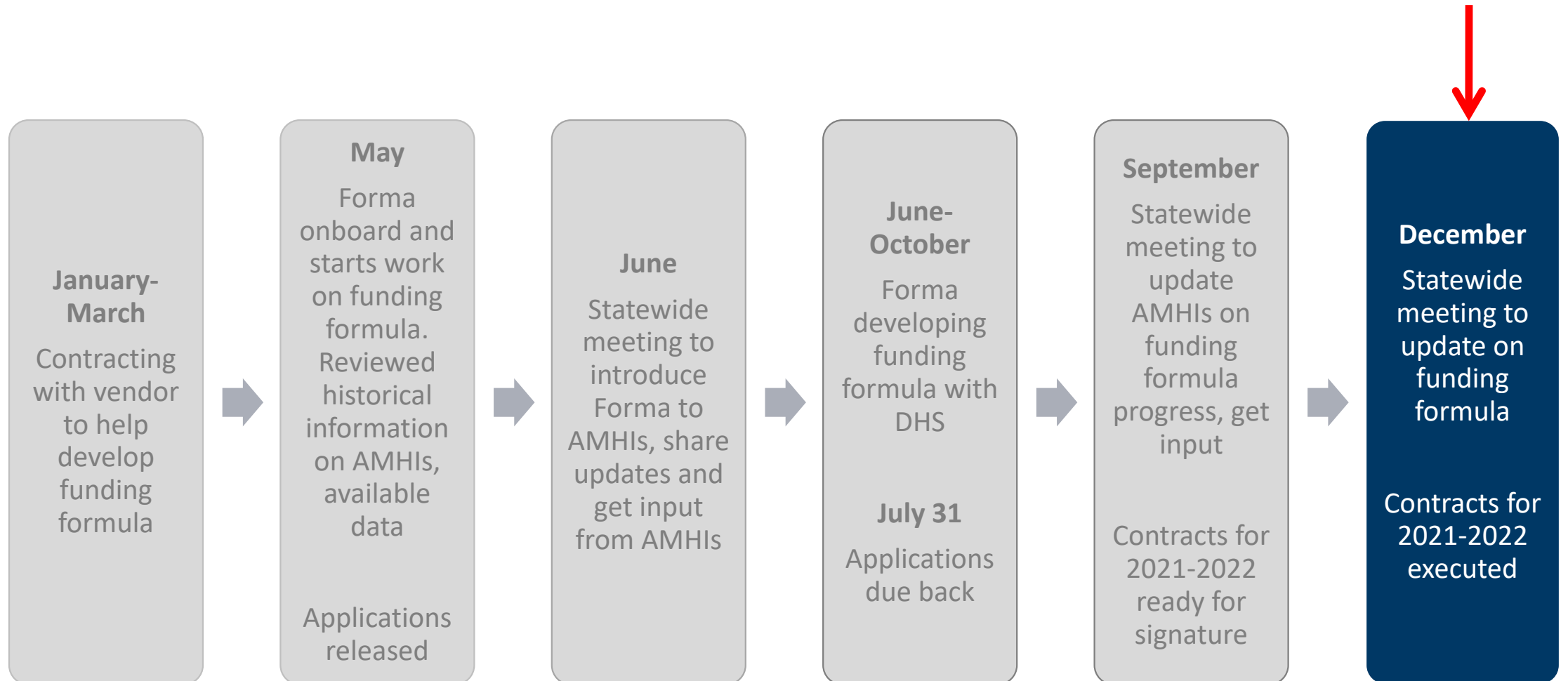
- **Background**

- Approximately \$67M distributed to 19 AMHI regions across the state in two-year contract periods
- Initial funding levels were set over 20 years ago
- In collaboration with the AMHI regions, DHS will develop a credible, data-driven funding formula reflecting the relative regional-specific risk factors and resource requirements

- **Funding Formula Goals**

- **Transparency** – Provide DHS and stakeholders with a more detailed understanding of the funding allocation rationale
- **Flexibility** – Allow for adjustments over time to reflect population changes or other circumstances
- **Equity** – Distribute resources in a manner consistent with quantifiable difference in regional needs
- **Alignment** – Minimize disruption to existing service delivery

# AMHI Reform Timeline – 2020



# Project Phases

- *Phases 1 & 2 – Review demographic and relative risk information by region (July and August 2020)*
- *Phase 3 – Review relative service utilization by region (September and October 2020)*
- Phase 4 – Preliminary formula observations (November/December 2020)

# Poll Question and Feedback Request

## Observation

- Overall, the single county AMHIs receive a lower percentage of Grant \$\$s relative to the sizes of their Statewide, Medicare and Medicaid adult populations:
  - AMHIs Grant Distribution: **38% Single County AMHIs, 62% Multi-County AMHIs**
  - Statewide population distribution: **55% Single County AMHIs, 45% Multi-County AMHIs**
- Generally, the single county AMHIs cover the Twin Cities Metro area and the multi-county AMHIs cover the Greater Minnesota and rural areas

## Poll Questions

1. Are there specific **service requirements** for Metro vs. Non-Metro populations that may drive some of these differences?
  - Yes
  - No
  - Perhaps, but differences are not overly significant
2. Are there specific service delivery expenses for Metro vs. Non-Metro populations that may drive some of these differences?
  - Yes
  - No
  - Perhaps, but differences are not overly significant
3. To help support the Q&A portion of this meeting, please submit any explanatory comments or supplemental feedback in the chat.

# AMHI Reform Phases 1 & 2: Demographic Information

## Why did we review Demographic information?

- As we examine updates to the AMHI funding formula, we would reasonably consider starting with an allocation based on relative population size by county and region
- Comparing demographic information to the current funding levels helps assess which regions or counties are currently receiving funding that is proportionate to their relative population size

## What types of demographic information did we review?

- Statewide population – all adults in Minnesota
- Medicaid enrollee population – Medicaid enrolled adults in Minnesota
- *Medicare enrollee population*

# Demographic Information by County/Region

County/Region	Statewide Population <sup>1</sup>		Medicaid Population <sup>2</sup>		Medicare Population <sup>3</sup>		Grant <sup>4</sup>
	Adults	%	Adults	%	Adults	%	%
Hennepin	989,707	22.8%	219,223	24.1%	178,722	18.9%	17.3%
Ramsey	422,368	9.7%	119,418	13.1%	83,035	8.8%	13.3%
CREST	332,081	7.7%	62,528	6.9%	80,498	8.5%	6.9%
Dakota	324,966	7.5%	54,750	6.0%	61,683	6.5%	1.4%
CommUnity	325,988	7.5%	58,350	6.4%	63,527	6.7%	3.7%
Anoka	272,162	6.3%	50,208	5.5%	52,170	5.5%	2.3%
ABHI	248,430	5.7%	60,104	6.6%	71,653	7.6%	11.4%
SCCBI	244,289	5.6%	48,715	5.3%	59,762	6.3%	12.6%
SW18	208,386	4.8%	47,994	5.3%	60,248	6.4%	6.7%
Washington	198,767	4.6%	26,656	2.9%	40,734	4.3%	1.8%
Region 5+	142,575	3.3%	36,903	4.1%	46,732	4.9%	3.7%
Region 7E	131,584	3.0%	28,108	3.1%	32,702	3.5%	5.1%
BCOW	125,161	2.9%	29,409	3.2%	34,016	3.6%	3.5%
Scott	108,655	2.5%	15,702	1.7%	16,518	1.7%	0.7%
Carver	77,387	1.8%	8,490	0.9%	12,596	1.3%	1.0%
NW8	68,281	1.6%	16,193	1.8%	18,456	1.9%	4.3%
Region 2	61,956	1.4%	17,699	1.9%	16,755	1.8%	1.8%
Region 4S	53,732	1.2%	10,729	1.2%	17,190	1.8%	2.0%
White Earth Nation <sup>5</sup>	9,192	0.2%					0.5%

## Notes:

1. Adults (18+) based on information national census data.
2. Medicaid enrollees (18+) based on information from DHS.
3. Medicare enrollees based on 2018 enrollment reported by CMS.
4. CY 2021 preliminary AMHI Grant Allocation. Includes Moose Lake Allocation
5. Based on US Census information. Size of the population served subject of further review.

## Comments and Observations

- Information on table differs slightly from what was shared in September
  - Statewide Population reflects 2019 estimated census data
  - Grant distribution includes Moose Lake Allocations
- Although the AMHI Grant distribution is broadly correlated with the sizes of the different populations, there are differences:
  - Overall, AMHIs covering the areas with larger proportions of the people get larger proportions of the funding
  - However, there are observed differences between the relative percentages of the population and the relative AMHI Grant distribution
- The distribution of the Medicare population is generally aligned with the Statewide and Medicaid populations

*Note: For White Earth Nation, the relative Medicaid and Medicare enrollment still need to be assessed*



# AMHI Reform Phases 1 & 2: Demographic Info (cont.)

## What does this information tell us?

- Although the AMHI Grant distribution is broadly correlated with the size of the population, there are differences
  - The magnitude of the differences depends on the population being used to assess the relative sizes of the Statewide, Medicare and Medicaid populations
- Overall, the single county AMHIs receive a lower percentage of Grant \$\$s relative to the sizes of their Statewide, Medicare and Medicaid adult populations:
  - *AMHIs Grant Distribution*                      **38% Single County AMHIs, 62% Multi-County AMHIs**
  - Statewide population distribution:    55% Single County AMHIs, 45% Multi-County AMHIs
  - Medicare enrollee Distribution:        47% Single County AMHIs, 53% Multi-County AMHIs
  - Medicaid enrollee distribution:        54% Single County AMHIs, 46% Multi-County AMHIs
- If equitable distribution is defined as “equal funding on a per capita basis” the funding changes would be impactful to many of the AMHIs

# AMHI Reform Phases 1 & 2: Relative Risk Information

## Why did we review Relative Risk information?

- In addition to the population size, it is reasonable to consider that some counties or regions may have populations with greater service needs due to higher relative risk
  - *i.e. Do some counties or regions have higher or lower relative risk than other counties and does that help explain some of the existing differences between demographic-only funding distributions and the current funding distributions?*

## What types of relative risk information did we review?

- Johns Hopkins Adjusted Clinical Group® (ACG®) population/patient case-mix adjustment for the Medicaid enrollee population
- Social Determinants of Health (SDOH) information for the Medicaid enrollee population

# Relative Risk Information by County/Region

County/Region	Medicaid Population <sup>1</sup>		Relative Risk <sup>2</sup>		SDOH Population Distribution <sup>3</sup>			Grant <sup>4</sup>
	Adults	%	vs. Avg.	Adj. % <sup>5</sup>	Any SDOH <sup>6</sup>	MHCD <sup>7</sup>	Other <sup>8</sup>	%
Hennepin	219,223	24.1%	104%	25.0%	25.1%	24.2%	26.6%	17.3%
Ramsey	119,418	13.1%	95%	12.5%	13.5%	12.5%	15.1%	13.3%
CREST	62,528	6.9%	93%	6.4%	6.6%	6.8%	6.3%	6.9%
Dakota	54,750	6.0%	90%	5.4%	5.8%	5.4%	6.4%	1.4%
CommUnity	58,350	6.4%	99%	6.4%	6.1%	6.3%	5.8%	3.7%
Anoka	50,208	5.5%	93%	5.1%	5.3%	5.0%	5.8%	2.3%
ABHI	60,104	6.6%	112%	7.4%	7.1%	8.1%	5.6%	11.4%
SCCBI	48,715	5.3%	102%	5.4%	5.3%	5.4%	5.0%	12.6%
SW18	47,994	5.3%	97%	5.1%	4.8%	4.8%	4.7%	6.7%
Washington	26,656	2.9%	89%	2.6%	2.7%	2.7%	2.9%	1.8%
Region 5+	36,903	4.1%	108%	4.4%	4.1%	4.5%	3.4%	3.7%
Region 7E	28,108	3.1%	103%	3.2%	3.1%	3.4%	2.6%	5.1%
BCOW	29,409	3.2%	107%	3.4%	3.3%	3.5%	2.9%	3.5%
Scott	15,702	1.7%	85%	1.5%	1.5%	1.4%	1.8%	0.7%
Carver	8,490	0.9%	90%	0.8%	0.8%	0.8%	0.9%	1.0%
NW8	16,193	1.8%	107%	1.9%	1.8%	1.9%	1.6%	4.3%
Region 2	17,699	1.9%	113%	2.2%	2.1%	2.3%	1.8%	1.8%
Region 4S	10,729	1.2%	109%	1.3%	1.1%	1.2%	1.0%	2.0%

**Notes:**

1. Medicaid enrollees (18+) based on information from DHS.
2. Relative Risk as indicated by the diagnostic and demographic data for the County/Regional Medicaid populations. Risk calculated using the Johns Hopkins ACG risk-adjustment methodology.
3. Percentage distribution across counties and regions of the members with one or more of the six Social Determinants of Health (SDOH) included in the analysis.
4. CY 2021 preliminary AMHI Grant Allocation.
5. Relative population percentages after adjusting population "size" for the relative risk of the Medicaid enrollees.
6. Distribution of the 55% of Medicaid enrollees with one or more of the six SDOH included in the analysis.
7. Distribution across counties and regions of the 34% of Medicaid enrollees identified with an SHD related to Mental Health or Chemical Dependency (SMI, SPMI or SUD).
8. Distribution across counties and regions of the 21% of Medicaid enrollees identified with one of the other SDOH (Homelessness, Deep Poverty, Past Incarceration), but without a MHCD-related SDOH.

## Comments and Observations

- The AMHI-specific relative risk of the Medicaid population ranges from 85% to 112% of the total Medicaid population
  - Although Medicaid enrollees may have average risk that is higher than commercial populations, the average relative risk shown in the table is “normalized” to 1.00
- The distribution of Medicaid members with one or more SDOH is generally correlated with the overall Medicaid population
  - There are no substantial differences between the overall Medicaid population and the populations with one or more SDOH in the counties or regions covered by the AMHIs

# AMHI Reform Phases 1 & 2: Relative Risk Info (cont.)

## What does this information tell us?

- The differences between the population sizes and the distributions of the Grant \$\$s are not fully “explained” by the risk factors we reviewed
- The Multi-County AMHIs do serve members with slightly higher relative risk and greater likelihoods of SDOH:
  - *AMHIs Grant Distribution*                      *38% Single County AMHIs, 62% Multi-County AMHIs*
  - Statewide population distribution:    55% Single County AMHIs, 45% Multi-County AMHIs
  - Medicare enrollee Distribution:        47% Single County AMHIs, 53% Multi-County AMHIs
  - Medicaid enrollee distribution:
    - Risk Adjusted Medicaid:            53% Single County AMHIs, 47% Multi-County AMHIs
    - With one or more SDOH:            55% Single County AMHIs, 45% Multi-County AMHIs
    - With MHCD-related SDOH:        52% Single County AMHIs, 48% Multi-County AMHIs
- If equitable distribution is defined as “equal funding on a risk-adjusted per capita basis” the funding changes would be impactful to many of the AMHIs

# Phase 3 – Review relative service utilization by region

- **Why did we review service utilization by AMHI?**
  - Based on our observations that the current funding levels are disproportionate relative to the sizes of the populations in the geographic areas served by the AMHIs:
    - *Is it reasonable to assume that there are services or delivery expenses specific to specific AMHIs that may explain some of these differences?*
    - *Are there broader differences between the services or delivery expenses for single county AMHIs vs multi-county AMHIs?*
- **What types of relative information did we review?**
  - 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

# Spending by BRASS Code – Single- vs. Multi-County AMHIs

Code	BRASS Codes - AMHI Reporting 2019	Total	Single County AMHIs			Multi-County AMHIs		
			Reported \$\$	%	PMPY	Reported \$\$	%	PMPY
491x	Targeted Case Management	8,197,754	6,696,501	45%	\$2.80	1,501,253	9%	\$0.77
443x	Housing Subsidy	3,792,257	1,558,627	11%	\$0.65	2,233,630	13%	\$1.14
446x	Basic Living/Social Skills	3,718,333	1,989,982	13%	\$0.83	1,728,351	10%	\$0.89
438x	Assertive Community Treatment	3,317,194	1,833,676	12%	\$0.77	1,483,518	9%	\$0.76
434x	Community Support Program Services	2,656,529	388,868	3%	\$0.16	2,267,661	13%	\$1.16
454x	Medication Management	2,224,726	60,805	0%	\$0.03	2,163,921	12%	\$1.11
436x	Adult Residential Crisis Stabilization	2,004,733	664,766	5%	\$0.28	1,339,967	8%	\$0.69
437x	Employment Placement	1,328,876	559,098	4%	\$0.23	769,778	4%	\$0.39
403x	Adult Client Outreach	1,250,309	196,711	1%	\$0.08	1,053,598	6%	\$0.54
418x	Client Flex Funds	632,624	255,416	2%	\$0.11	377,208	2%	\$0.19
474x	Intensive Residential Treatment Services	548,232	65,995	0%	\$0.03	482,237	3%	\$0.25
431x	Adult Mobile Crisis Services	535,479	0	0%	\$0.00	535,479	3%	\$0.27
416x	Transportation	402,719	81,774	1%	\$0.03	320,945	2%	\$0.16
Other	<i>Nine Additional Categories<sup>1</sup></i>	1,523,921	399,521	3%	\$0.17	1,124,400	6%	\$0.58
Total		32,133,686	14,751,740			17,381,946		

1. Includes Case Management, Community Education and Prevention, Psychotherapy, Emergency Response Service, Outpatient Diagnostic Assessment, Peer Support Services, Adult Day Treatment and Partial Hospitalization.

## Comments and Observations

- The reported relative spending by category is quite different between AMHIs
  - For example, about two-thirds of AMHIs report spending a portion of their funds on targeted case management
  - Some allocated as much as 75% of the funds towards that service, while others reported \$0 spending on that service
- The reported spending does not clearly indicate that there are differences in service requirements between areas covered by single county AMHIs and multi-county AMHIs
  - Some services could potentially be impacted by metro vs. rural differences
  - However, the total amounts spent on these services (transportation, adult mobile crisis services) is relatively minor (1-2%)
- Differences in spending are obscured by the fact that the AMHI funds only represent a portion (2-12%) of the total mental health expenditures for each county and multi-county region

# AMHI Funding vs. Total MH Spending

County/Region	AMHI Funding <sup>1</sup>		Statewide <sup>2</sup>		Per Capita AMHI <sup>3</sup>		All MH Spending <sup>4</sup>		AMHI vs
	Grant \$\$	%	Adults	%	Per Adult	vs. Avg	Per Adult	vs. Avg	Total MH
Hennepin	5,809,267	17.4%	989,707	22.8%	\$5.87	76.3%	\$156.35	112.3%	3.8%
Ramsey	4,466,053	13.4%	422,368	9.7%	\$10.57	137.5%	\$173.01	124.3%	6.1%
CREST	2,297,954	6.9%	332,081	7.7%	\$6.92	90.0%	\$144.55	103.9%	4.8%
Dakota	482,776	1.4%	324,966	7.5%	\$1.49	19.3%	\$82.55	59.3%	1.8%
CommUnity	1,249,432	3.7%	325,988	7.5%	\$3.83	49.9%	\$88.13	63.3%	4.3%
Anoka	765,075	2.3%	272,162	6.3%	\$2.81	36.6%	\$85.05	61.1%	3.3%
ABHI	3,829,186	11.5%	248,430	5.7%	\$15.41	200.5%	\$174.74	125.6%	8.8%
SCCBI	4,210,082	12.6%	244,289	5.6%	\$17.23	224.2%	\$179.25	128.8%	9.6%
SW18	2,229,288	6.7%	208,386	4.8%	\$10.70	139.1%	\$171.01	122.9%	6.3%
Washington	604,982	1.8%	198,767	4.6%	\$3.04	39.6%	\$76.39	54.9%	4.0%
Region 5+	1,236,491	3.7%	142,575	3.3%	\$8.67	112.8%	\$149.12	107.1%	5.8%
Region 7E	1,715,762	5.1%	131,584	3.0%	\$13.04	169.6%	\$127.12	91.3%	10.3%
BCOW	1,181,263	3.5%	125,161	2.9%	\$9.44	122.8%	\$140.19	100.7%	6.7%
Scott	228,859	0.7%	108,655	2.5%	\$2.11	27.4%	\$99.58	71.5%	2.1%
Carver	319,933	1.0%	77,387	1.8%	\$4.13	53.8%	\$128.15	92.1%	3.2%
NW8	1,453,914	4.4%	68,281	1.6%	\$21.29	276.9%	\$183.33	131.7%	11.6%
Region 2	595,725	1.8%	61,956	1.4%	\$9.62	125.1%	\$206.21	148.2%	4.7%
Region 4S	664,642	2.0%	53,732	1.2%	\$12.37	160.9%	\$176.03	126.5%	7.0%
	33,340,684		4,336,475		\$7.69		\$139.18		5.5%

## Comments and Observations

- The total mental health spending for each county and region may indicate differential service needs and requirements of some AMHIs
  - On a per capita basis, the amount of MH spending for many AMHI service areas is 20%+ higher than the statewide average
- The relative total Mental Health per capita spending is largely correlated to the AMHI per capita grant \$\$
  - In most cases, counties or regions with higher than average per capital AMHI \$\$ have higher overall per capita mental health spending
  - Notable exceptions include Hennepin County, CREST and Region 7E

1. CY 2021 preliminary AMHI Grant Allocation

2. Adults (18+) based on information national census data.

3. Amount of AMHI Grant \$ per adult in the counties in the AMHI service area

4. Total mental health spending as reported in the 2018 MN County Human Service Cost Report

# Phase 3 – Review relative service utilization by region (cont.)

## What does this information tell us?

- The Budgeting, Reporting, and Accounting for Social Services (BRASS) reporting submitted by the AMHIs is sufficiently detailed to help understand how the AMHIs are spending their funds
- However, because the AMHIs have considerable flexibility in choosing how to spend and report their funds, the reporting does not fully identify where service requirements or expenses differ between AMHIs
- Differences in spending are obscured by the fact that the AMHI funds only represent a portion (2-12%) of each county's mental health expenses
- The overall reported mental health spending in the counties and regions may indicate differential service needs or expenses between single county AMHIs and multi-county AMHIs



# AMHI Reform – Overall Observations

- There are many cases where AMHIs are receiving funding that is disproportionate to their share of the state's population (Total Adult, Medicare or Medicaid populations)
- 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 operations
- *In summary, the relative funding levels between AMHIs cannot be reasonably explained by 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 being served the AMHIs
- We need to gather additional information and feedback to understand whether there are differential service requirements or expenses in the areas covered by multi-county AMHIs

- Analyze gaps and needs that impact services and service cost, which may or may not be reflected in current population-based data
- Collaborate with AMHI stakeholders to determine the funding formula variables
- Finalize the new funding formula

# AMHI Reform Questions or Comments?

# Thank You!

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