Medicaid Section 1115 Serious Mental Illness and Serious Emotional Disturbance Demonstrations
Monitoring Report Template

Note: PRA Disclosure Statement to be added here

1. Title page for the state's serious mental illness and serious emotional disturbance (SMI/SED) demonstration or the SMI/SED component of the broader demonstration

The state should complete this title page at the beginning of a demonstration and submit it as the title page for all monitoring reports. The content of this table should stay consistent over time. Definitions for certain rows are below the table.

State	*Vermont*
Demonstration name	*Global Commitment to Health* *11-W-00194/1*
Approval period for section 1115 demonstration	*July 1, 2022, through December 31, 2027*
SMI/SED demonstration start date[a]	*July 1, 2022*
Implementation date of SMI/SED demonstration, if different from SMI/SED demonstration start date[b]	*01/01/2020*
SMI/SED (or if broader demonstration, then SMI/SED - related) demonstration goals and objectives	*During the demonstration period, the state seeks to achieve the following* *SMI/SED goals:* *1. Reduced utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings;* *2. Reduced preventable readmissions to acute care hospitals and residential settings;* *3. Improved availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs and psychiatric hospitals and residential treatment settings throughout the state;* *4. Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care; and* *5. Improved care coordination, especially continuity of care in the community following episodes of acute*

SMI/SED demonstration year and quarter	*SMI/SED DY19 Q3*
Reporting period	*7/1/23 - 9/30/23*

[a] **SMI/SED demonstration start date:** For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state's STCs at time of SMI/SED demonstration approval. For example, if the state's STCs at the time of SMI/SED demonstration approval note that the SMI/SED demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020, to be the start date of the SMI/SED demonstration. Note that the effective date is considered to be the first day the state may begin its SMI/SED demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on 12/15/2020, with an effective date of 1/1/2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.

[b] **Implementation date of SMI/SED demonstration:** The date the state began claiming federal financial participation for services provided to individuals in institutions of mental disease.

2. Executive summary

The executive summary should be reported in the fillable box below. It is intended for summary-level information only. The recommended word count is 500 or less.

Vermont's health care system continues to evolve from the impact of the COVID-19 pandemic. Some of these impacts include workforce capacity and burnout. Vermont continues its implementation of Vision 2030, a ten-year plan working towards a more holistic and integrated system of care, in addition to other statewide initiatives focusing on integrating mental health care into broader health care. A few examples include the Mental Health Integration Council and implementation of Certified Community Behavioral Health Clinics (CCBHCs) via Vermont being awarded a CCBHC Planning Grant. The Vermont Department of Mental Health (DMH) continues to work towards increasing availability, capacity, affordability, and quality of mental health care for SMI/SED Medicaid beneficiary populations through a person-centered and community-based system of care, empowering individuals to be served in the least restrictive setting necessary to meet their needs.

DMH is engaged in a comprehensive set of activities to increase the availability of non-hospital, non-residential crisis stabilization services. DMH will be conducting a soft launch of a statewide mobile crisis program on November 1, 2023. This program will align with national mobile crisis standards and will work in partnership with ongoing efforts to serve Vermonters through 9-8-8 Call Centers, local crisis call centers and observation/assessment centers with a coordinated community crisis response that involving community partners, including law enforcement and other first responders.
Additionally, DMH has led efforts to reduce barriers to care by supporting flexible access to telehealth, peer support services, and other low-barrier mental health supports. Through these efforts, DMH aims to increase access to mental health services, promote preventative care, and establish earlier intervention points for individuals in need.

As outlined in Vision 2030, advancements to improve Vermont's mental health care system have been grounded in statewide efforts to transition healthcare payment and delivery systems away from a fee-for-service framework towards value-based care through Mental Health Payment Reform, which was instituted January 1, 2019. This payment model for children and adult services transitioned from traditional reimbursement mechanisms to a monthly prospective case rate model to allow for flexibility in service delivery, standardize the tracking of population indicators and outcomes, simplify payment structures, and improve the predictability of provider payments. DMH monitors various indicators related to these to improve accountability, increase equity and transparency, reward value-based care outcomes, and incentivize best practices.

Vermont has prioritized addressing workforce shortages and emergency department wait times, including delays in discharge from emergency and inpatient services. Improving assessment and screening systems, including strengthening our care transitions, collaborations, and communication protocols with community providers, has been critical for increasing emergency department capacity and better integrating crisis stabilization services into a broader system of health care. These efforts have been combined with Health IT advancements to address wait times and information sharing, as well as creating new policies and best practices to impact the efficiency and capacity of our mental health care system.

This report serves as an update to the Vermont public mental health care system of care improvements for SMI/SED Medicaid beneficiaries within the lingering effects of the COVID-19 pandemic.

3. Narrative information on implementation, by milestone and reporting topic

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1. Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings (Milestone 1)			
1.1. Metric trends			
1.1.1. The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 1.	*X*		
1.2. Implementation update			
1.2.1. Compared to the demonstration design and operational details, the state expects to make the following changes to: 1.2.1a. The licensure or accreditation processes for participating hospitals and residential settings	*X*		
1.2.1b. The oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements	*X*		
1.2.1c. The utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay	*X*		
1.2.1d. The program integrity requirements and compliance assurance process	*X*		
1.2.1e. The state requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions	*X*		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1.2.1f. Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings	*X*		
1.2.2. The state expects to make other program changes that may affect metrics related to Milestone 1.	*X*		
2. Improving Care Coordination and Transitions to Community-Based Care (Milestone 2)			
2.1. Metric trends			
2.1.1. The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 2.	*X*		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
2.2. Implementation update			

2.2.1. Compared to the demonstration design and operational details, the state expects to make the following changes to: 2.2.1a. Actions to ensure that psychiatric hospitals and residential treatment settings carry out intensive pre-discharge planning, and include community-based providers in care transitions	*X*		*In addition to the activities described in section 2.a of the SMI SED Implementation Plan, the state is working to maintain and enhance current discharge planning and care coordination with improved strategies for connection with local community-based services. This work continued during DY19 Q2.*

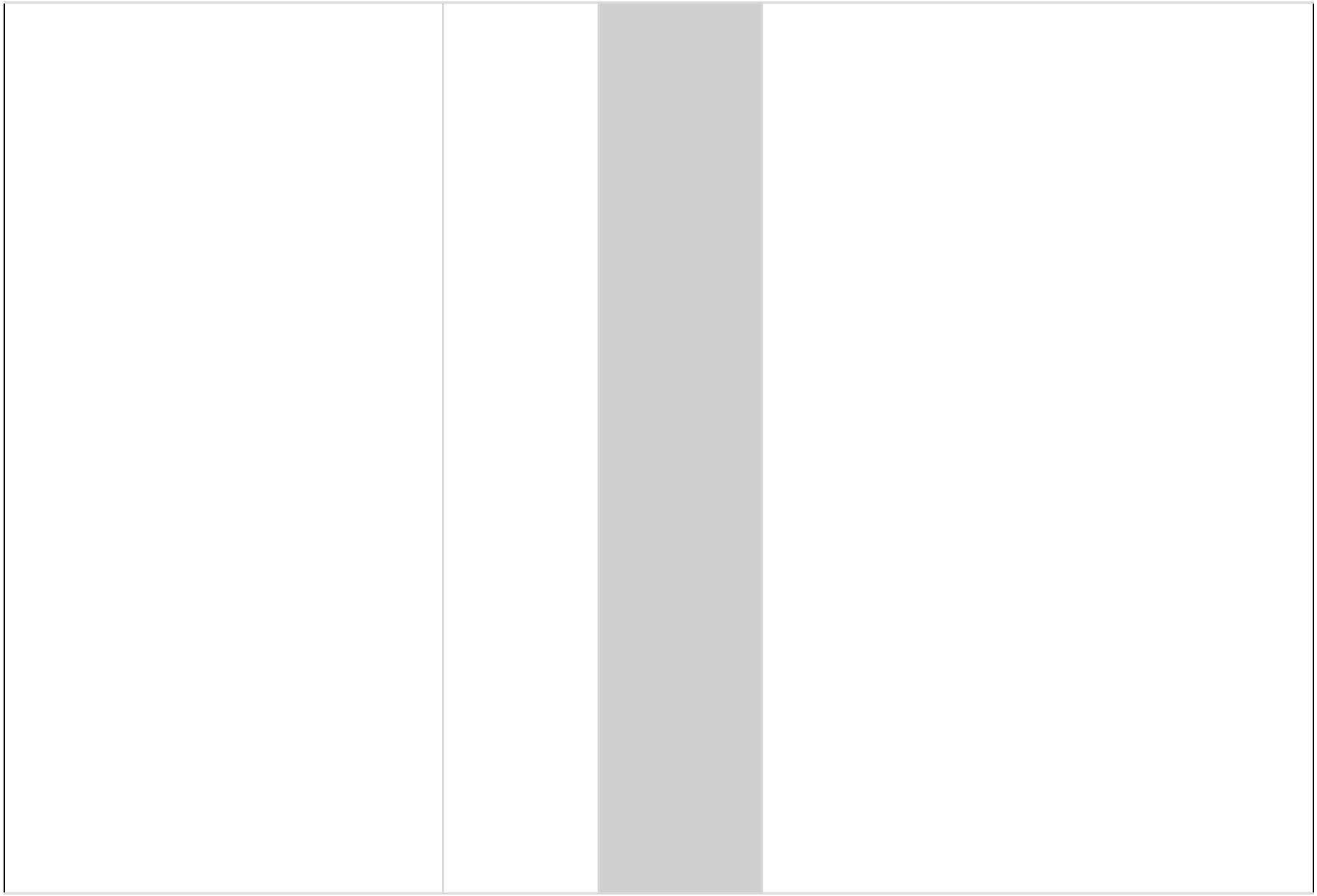
Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
2.2.1b. Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers	*X*		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
2.2.1c. State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers within 72 hours post discharge	*Update to Report*		The Vermont Department of Health's Hospital Licensing Rule was updated as of 1/1/20222, to include section 5.1.6 which delineates that *"Any psychiatric hospital or psychiatric facility classified as an Institution for Mental Disease for Medicaid purposes shall follow up with patients within 72 hours of discharge. This shall be done by the most effective means possible including via email, text, or phone. Hospitals shall continue to follow up with the patient until either contact is made, or at least 5 attempts every 24 hours for up to 72 hours have been made and documented."* DMH has continued to monitor this information to ensure compliance by psychiatric facilities in Vermont.

2.2.1d. Strategies to prevent or decrease the lengths of stay in EDs among beneficiaries with SMI or SED (e.g., through the use of peers and psychiatric consultants in EDs to help with discharge and referral to treatment providers)	*Update to Report*		

			Update on increasing Intensive Residential capacity. The Department of Mental Health solicited proposals for Inpatient Psychiatric Units for Children and Adolescents from qualified health care organizations connected or affiliated with a general medical facility to provide inpatient psychiatric services for children under the age of 18 years. One vendor, Southwestern Vermont Medical Center (SVMC), was selected from the competitive bid process and the Certificate of Need process is still being finalized. This new unit will further stabilize and improve current availability of services for this population of Vermonters to ensure children and youth with mental health needs and possible comorbid medical or developmental disability concerns can access inpatient psychiatric care. SVMC continues to conduct a feasibility study to ensure that this inpatient psychiatric unit will meet the needs of the system of care.

			-



Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
2.2.1e. Other State requirements/policies to improve care coordination and connections to community-based care	*See section 2.2.1d*		
2.2.2. The state expects to make other program changes that may affect metrics related to Milestone 2.	*See section 2.2.1d*		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
3. Access to Continuum of Care, Including Crisis Stabilization (Milestone 3)			
3.1. Metric trends			
3.1.1. The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 3.	*Update to report*	*See metric number in last column.*	*#13: The number of beneficiaries with SMI/SED who utilized inpatient services related to mental health increased 6.64%. This reflects a continued increase in the availability of inpatient beds in the system of care and ongoing seasonal trends with people seeking inpatient care.* *#14: The number of beneficiaries with SMI/SED who used intensive outpatient and/or partial hospitalization services related to mental health increased 5.53% due to the ability to serve more individuals to be served in an outpatient setting by these types of facilities.* *#15: The number of beneficiaries with SMI/SED who used outpatient services related to mental health increased 2.13% due to the continued increase in outpatient staffing. Note that this was an incremental increase based on reported counts.* *#17: Number of beneficiaries in the demonstration population who used telehealth services related to mental health decreased 9.59%. This reflects more individuals seeking care through other means than telehealth.* .

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
3.2. Implementation update			
3.2.1. Compared to the demonstration design and operational details, the state expects to make the following changes to: 3.2.1a. State requirement that providers use an evidenced-based, publicly available patient assessment tool to determine appropriate level of care and length of stay	*Update to Report*		All participating IMD facilities continue to use InterQual/McKesson to help determine appropriate level of care and length of stay.

3.2.1b. Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	*Update to Report*		***River Valley Therapeutic Residence.*** The need for a secure level of care was first identified in 2005 as part of the ongoing planning process to replace the Vermont State Hospital. A secure residential level of care was first statutorily created in 2012 after Tropical Storm Irene flooded and closed the Vermont State Hospital in Act 160 (2012) and Act 79 (2012). In Act 79 (2012), State of Vermont committed to building a permanent secure residential program and created the temporary Middlesex Therapeutic Community Residence (MTCR), a seven-bed secure residential program. This facility was built using Federal Emergency Management (FEMA) funds as a step-down facility for those who are no longer in need of inpatient care, but who needed intensive services in a secure setting. Patients that were on involuntary legal status under the Care and Custody of the Commissioner of Mental Health; this required an Order of Non-Hospitalization in which the court indicates that the individual requires a secure setting. To provide equitable care possible for all Vermonters, a robust continuum of step-down treatment programs was made available. A permanent secure program is a key component in Vermont's system of programs available to individuals needing 24/7 treatment and support services. The replacement and expansion of the current Middlesex Therapeutic Residence was an essential and smart solution in addressing systemic challenges. This replacement, River Valley Therapeutic Residence (RVTR), which opened May 8, 2023, is a 16-bed physically secure recovery residence that provides the highest quality of recovery-oriented care, ensures the safety of residents and promotes rejoining and rebuilding a life in the community. This treatment option provides care for individuals who are ready to discharge from inpatient hospitals but have higher treatment needs and risk factors that impact public safety and exceed the capacity of community providers. The goal of this new facility is to provide enhanced transitional support to successfully step

			down from inpatient level of care to a safe and stable environment, and enhance equitable access to appropriate, timely and high-quality care and treatment. RVTR continues to increase capacity as staffing patterns and resident acuity needs are able to be met. ***Mobile Response and Stabilization Services.*** Health Management Associates (HMA) Report: Vermont is 1 of 20 States that received a Planning Grant to support expanding community-based mobile crisis intervention services for Medicaid beneficiaries. Using the federal planning grant, the Vermont Agency of Human Services partnered with HMA to conduct a statewide mental health and substance use needs assessment to identify gaps and opportunities of the current crisis system. • The needs assessment included: ○ Surveys – a broad-based survey was distributed to a variety of stakeholders to gather insight into Vermonters' experiences, perceived successes and challenges of the existing crisis system and recommendations for improvement. ○ Key Informant Interviews – interviews were conducted with key informants from organizations and agencies to confirm and gather additional detail on themes that emerged from the survey. ○ Focus Groups – focus groups were conducted with the following groups of people to further supplement information gathered from the survey and stakeholder interviews: (First responders including 911 public-safety answering point (PSAPs), law enforcement and EMS; Designated Agencies (DAs); Mental Health & Substance Use Providers; Schools and People, and families of people, with a history of receiving crisis services

			While Vermont has a Medicaid benefit for mobile crisis services delivered by 10 DAs, this grant presents a unique funding opportunity for all states to consider how crisis response models could be expanded upon with increased American Rescue Plan Act (ARPA) funding for up to five years, starting April 1, 2022, and ending March 31, 2027. The findings of the report have been released as of July 2022 and highlight the need for increased mobile response services that align with best practices. This includes increasing mobile response coverage areas, providing 2-person response teams, providing 24/7 coverage to the communities, incorporating peer support workers, and including harm reduction efforts for substance misuse. During November 2022 the Department released a Request for Proposals for Community Mobile Crisis Services from qualified vendors across the state. It is the Department's vision to achieve a statewide, equitable, mobile crisis response system of care that is community-based rather than relying on emergency departments and meets the needs of individuals of all ages experiencing a mental health and/or substance use related crisis. The specific services include rapid community crisis response, screening and assessment, stabilization and de-escalation services, coordination with and referrals to health, social, other services and supports, and follow-up services as needed. The Department has awarded a contract to Health Care and Rehabilitation Services (HCRS), a local Designated Agency. HCRS will be subcontracting with the remaining 9 Designated Agencies to provide statewide coverage *Rutland County Mobile Response Pilot:* ***Rutland County Mobile Response Pilot:*** The Mobile Response and Stabilization Services (MRSS) pilot for the child, youth and family system in Rutland County providing services from October 2021 through June 2023, with

			funding through the State of Vermont, Agency of Human Services (AHS), Department of Mental Health (DMH). The pilot ended June 30, 2023, and RMHS communicated with their community about the transition. The Department, in collaboration with other AHS departments, is launching a new statewide community mobile crisis service for children, youth and adults with mental health and substance use concerns, beginning November 1, 2023, with full capacity by early 2024, to align with the new Medicaid covered community mobile crisis benefit and enhanced federal share (FMAP). MRSS within provided in the child, youth, and family system to respond to a family-defined crisis to help families in distress in a timely way, to interrupt a family-defined crisis, and to serve as a point of access for responding to the identified needs of the family so the child/youth can remain safe at home, in the community and school. The target population was a child/youth who was: • experiencing a psychiatric, behavioral, or emotional disruption/ escalation in a home, school, or other community setting. These disruptions/ crises arise from situations, events, and/or circumstances that are unable to be resolved with the usual resources and coping abilities or jeopardize the development of adaptive social and emotional skills and personal strengths development critical in healthy life functioning or, • presenting in psychiatric crisis in a hospital emergency department (ED) and in need of continued stabilization and follow-up care upon discharge from the ED. The purpose of MRSS was to provide community-based rapid de-escalation to children and their families and to provide brief follow-up care to promote continued stabilization and linkage with ongoing supports and services within the community.

From October 2021 through June 2023, the RMHS MRSS pilot received 167 calls, 125 (75%) of which resulted in a mobile response. The calls that did not result in a mobile response were due to: the issue was resolved by phone (18% of total calls received); the family declined a mobile response and there was no need to contact Emergency Services (4%); or a direct referral was made to Emergency Services due to imminent safety concerns (3%). RMHS MRSS provided a timely response in 98% of the immediate responses (onsite in less than 45 minutes). Nearly 59% of families who contacted RMHS MRSS for an initial mobile response requested to schedule the mobile response at a later time, rather than an immediate response, to accommodate their family's needs (e.g., family called in the morning but requested the MRSS team to come to the home in the late afternoon when the parent(s) was home from work).

The mobile response was provided primarily at the youth's home, but the team also responds to the school, MRSS office, or another community-based setting, based on the family's identified preferred location:

Response Location of Initial Response	% of responses
youth/family's home or residence	60%
youth's school	11%
youth's/family's Primary Care Practice	0%
Emergency Department	0%
youth's/family's workplace	0%
in the MRSS office	13%
other community setting	16%

			Mobile Response Services Expansion

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
			A directive from the 2022 Legislative Session tasked DMH with expanding the reach of statewide mobile response systems in order to build an urgent care model for mental health. The scope of this expansion shall be directly informed by the Department's analysis of statewide mobile crisis services and gaps, in accordance with the State Planning Grant from the Centers for Medicare and Medicaid Services. This model shall address geographic gaps where a lack of mobile outreach drives unnecessary emergency department visits or unnecessary law enforcement responses. Other additional directives state that it shall utilize peer supports, evidence-based practices, and be coordinated within the 9-8-8 system. Additionally, the Department is tasked with developing a sustainability plan to ensure that the services will continue to be available after expiration of FMAP funding.
3.2.2. The state expects to make other program changes that may affect metrics related to Milestone 3.	*X*		
4. Earlier Identification and Engagement in Treatment, Including Through Increased Integration (Milestone 4)			
4.1. Metric trends			
4.1.1. The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 4.	*X*		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
4.2. Implementation update			
4.2.1. Compared to the demonstration design and operational details, the state expects to make the following changes to: 4.2.1a. Strategies for identifying and engaging beneficiaries in treatment sooner (e.g., with supported education and employment)	*X*		
4.2.1b. Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	*X*		
4.2.1c. Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED	*X*		
4.2.1d. Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people	*X*		
4.2.2. The state expects to make other program changes that may affect metrics related to Milestone 4.			
5. SMI/SED health information technology (health IT)			
5.1. Metric trends			
5.1.1. The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to its health IT metrics.	*X*		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
5.2. Implementation update			

5.2.1. Compared to the demonstration design and operational details, the state expects to make the following changes to: 5.2.1a. The three statements of assurance made in the state's health IT plan	*Update to report*		The State's health data exchange and infrastructure efforts are aligned and reflected in the state's health information exchange strategic plan, Vermont Health Information Exchange (HIE) Strategic Plan, per statute 18 V.S.A. § 9351. This work establishes health IT infrastructure that supports the provision of care and measurement of the health care system and reform initiatives and is consistently being developed to embolden different facets of the health care ecosystem (e.g., public health management, Medicaid operations, etc.). In Vermont, the ecosystem of organizations, policies, people, and systems that relate to exchange and manage health data is called the Unified Health Data Space. The Unified Health Data Space exists to streamline aggregation of and access to health data to meet a variety of user needs. The philosophy behind the Unified Health Data Space is that a coordinated health information exchange architecture (relationship of systems and data) ensures there can be one health record for each Vermonter by designating a central health data repository. At the center of this concept is Vermont's health information exchange (VHIE) – the health data repository, a resource dedicated to aggregating health data from various sources, matching patient records across systems, capturing patient consent preferences, translating local terminology into a standard format (code set), and generally making health data interoperable and most useful to those authorized access to provide and coordinate care and improve or evaluate health care operations or the public's health. VHIE was recently certified by CMS as part of Vermont's Medicaid Enterprise, acknowledging the importance of this system to support Medicaid providers and the Medicaid plan in caring for Medicaid beneficiaries. All of Vermont's health data interoperability efforts adhere to and/or are in direct alignment with federal guidance. As illustrated in the state-wide strategic HIE Plan, Vermont

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
			continues to demonstrate success in implementing the federal Promoting Interoperability Program, working to adhere with federal information blocking and patient access rules, and has based all strategic planning on architecture and standards set forth by CMS and the Office of the National Coordinator. The HIE Plan, sustains a commitment to standards and tracks current activity at the federal level including recent advancement of the Trusted Exchange Framework and Common Agreement (TEFCA) and the ongoing advancement of the Fast Healthcare Interoperability Resource (FHIR) standard.
5.2.1b. Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider and/or physician/mental health provider to community-based supports	*Update to report*		Vermont has finalized the connectivity criteria of "Tier 2" data elements that will be critical to ensuring closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider and/or physician/mental health provider to community-based supports. These data elements include information about diagnoses, procedures and services, and demographics, as well as insurance and claim information that will assist with care coordination to improve the continuity of care.
5.2.1c. Electronic care plans and medical records	*X*		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
5.2.1d. Individual consent being electronically captured and made accessible to patients and all members of the care team	*X*		

5.2.1e. Intake, assessment and screening tools being part of a structured data capture process so that this information is interoperable with the rest of the health IT ecosystem	*See 5.2.1b*		Substance Use Disorder, Mental Health, Behavioral Health VHIE Pilot

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
5.2.1f. Telehealth technologies supporting collaborative care by facilitating broader availability of integrated mental health care and primary care	*X*		
5.2.1g. Alerting/analytics	*X*		
5.2.1h. Identity management	*X*		
5.2.2. The state expects to make other program changes that may affect metrics related to health IT.	*X*		
6. Other SMI/SED-related metrics			
6.1. Metric trends			
6.1.1. The state reports the following metric trends, including all changes (+ or -) greater than two 2 percent related to other SMI/SED-related metrics.	*X*		
6.2. Implementation update			
6.2.1. The state expects to make the following program changes that may affect other SMI/SED-related metrics.	*X*		

4. Narrative information on other reporting topics

Prompt	State has no trends/update to report (place an X)	State response
7. Annual Assessment of the Availability of Mental Health Services (Annual Availability Assessment)		
7.1. Description of changes to baseline conditions and practices		
7.1.1. Describe and explain any changes in the mental health service needs (for example, prevalence and distribution of SMI/SED) of Medicaid beneficiaries with SMI/SED compared to those described in the Initial Assessment of the Availability of Mental Health Services. Recommended word count is 500 words or less.	*X*	

Prompt	State has no trends/update to report (place an X)	State response
7.1.2. Describe and explain any changes to the organization of the state's Medicaid behavioral health service delivery system compared to those described in the Initial Assessment of the Availability of Mental Health Services. Recommended word count is 500 words or less.	*X*	

7.1.3. Describe and explain any changes in the availability of mental health services for Medicaid beneficiaries with SMI/SED in the state compared to those described in the Initial Assessment of the Availability of Mental Health Services. At minimum, explain any changes across the state in the availability of the following services: inpatient mental health services; outpatient and community-based services; crisis behavioral health services; and care coordination and care transition planning. Recommended word count is 500 words or less.	*Update to report*	With the lingering effects of the COVID-19 pandemic, Vermont's health care system has had to deal with many workforce capacity fluctuations to ensure a safe response for all Vermonters. Workforce-related challenges have persisted, as staff across the system of care have faced immense challenges. The Vermont General Assembly allocated funds to support the recruitment and retention of staff within the outpatient public mental health system to stabilize these workforce shortages and ensure continuation of care for Vermonters. Vermonters in need of psychiatric hospitalization are provided treatment at either the state-run inpatient facility, *Vermont Psychiatric Care Hospital*, or one of six *Designated Hospitals* throughout the state. The capacity is founded upon the balance between hospital admissions and discharges for people with acute mental health conditions. When this balance is unequal, and more admissions than discharges occur, hospital capacity is reduced over time. Level One care beds are for individuals who require the most intensive level of clinical support and services within the system. General inpatient units are for individuals facing significant mental health challenges and struggling to manage the symptoms to a degree that requires consistent, intensive clinical care and support to ensure their safety and wellbeing in daily living. The availability of inpatient beds across the system has remained relatively constant from 2015 through 2019 with bed day utilization (Total Occupied Beds) decreasing 14 percent from 2019 to 2020. The impact of the COVID-19 pandemic has contributed to a 14 percent decrease in bed day utilization, a two percent increase in bed vacancies and the 11 percent increase in beds closed in this same year. Over this period, there was a significant decrease in adult inpatient bed utilization. In the past 2 years, there has been an increase in occupied beds from 61% in 2021 to 66% in 2022 to 77% in 2023. This data indicates that Vermont is rebounding from the impacts related to the COVID-19 pandemic as the system of care continues to stabilize. The Department reports on the number of people served across various programs along with outcomes at discharge in the regularly updated Department of Mental Health

Prompt	State has no trends/update to report (place an X)	State response
		Scorecard. In FY2023, the highest number of persons served by programs offered by Vermont DAs was Emergency Services, which was 10,340. This was followed by services for Children, Youth, and Families, which was 9,799. Additionally, in FY2023, there was a slight decrease in those served by Adult Outpatient programs from 7,164 in FY2022 to 7,075. Finally, Community Rehabilitation and Treatment programs that serve adults with SMI continued a slow overall declining trend from 2,228 served in FY2022 to 2,220.
7.1.4. Describe and explain any changes in gaps the state identified in the availability of mental health services or service capacity while completing the Annual Availability Assessment compared to those described in the Initial Assessment of the Availability of Mental Health Services. Recommended word count is 500 words or less.	*X*	**See the response to section 7.1.3 for information regarding changes in gaps that have been identified in the availability of mental health services as compared to those described in the Initial Assessment of the Availability of Mental Health Services.*
7.1.5. Describe and explain whether any changes in the availability of mental health services have impacted the state's maintenance of effort (MOE) on funding outpatient community-based mental health services. Recommended word count is 500 words or less.	*X*	

Prompt	State has no trends/update to report (place an X)	State response
7.2. Implementation update		
7.2.1. Compared to the demonstration design and operational details, the state expects to make the following changes to: 7.2.1a. The state's strategy to conduct annual assessments of the availability of mental health services across the state and updates on steps taken to increase availability	*Update to report*	The Department of Mental Health reports annually on or before January 15th to the Vermont Senate Committee on Health and Welfare and the Vermont House Committee on Human Services regarding the extent to which individuals with a mental health condition or psychiatric disability receive care in the most integrated and least restrictive setting available. The Department considers measures from a variety of sources, including the Joint Commission, the National Quality Forum, the Centers for Medicare and Medicaid Services, the National Institute of Mental Health, and the Substance Abuse and Mental Health Services Administration. The Department will report on this information in subsequent SMI/SED program monitoring as reporting becomes available. The Agency of Human Services uses the Results Based Accountability (RBA) framework to evaluate the performance of programs and initiatives, as well as make data-driven decisions. RBA is a key component of achieving value-based care in an integrated system of care. The DMH website presents how to use the regularly updated RBA Scorecards containing longitudinal data and performance measures related to programs and the broader system of care. The scorecards are a valuable resource for tracking progress toward clearly defined targets that align with national quality standards and compliance measures. Vermont providers offer a broad spectrum of mental health services delivered by practitioners in the least restrictive setting necessary to meet an individual's needs. The Department's annual Statistical Report contains detailed information on the use of those supports and services. DMH tracks over 30 measures related to different levels and types of care across the continuum. Each measure has a summary overview, list of partners, and information on the measure itself.

Prompt	State has no trends/update to report (place an X)	State response
7.2.1b. Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	*Update to report*	The Vermont Department of Mental Health continues the previously reported strategies to improve state tracking of availability of inpatient and crisis stabilization beds that includes: 1. DMH Leadership receiving a brief report every morning with the number of available inpatient and crisis beds for adults and youth through the DMH Bed Board Reporting System (aka "Bed Board"). This system is a part of a greater Care Management System at DMH. The Bed Board allows various facilities throughout the state to update their bed information in real time and allows those in need of a bed to easily search for available beds. The system provides bed availability for adult beds in all facilities throughout the state with crisis, inpatient, residential, and intensive residential beds, as well as children's beds in all facilities throughout Vermont with crisis and inpatient beds. DMH tasks each of our inpatient and crisis facilities with updating the bed board every 8 hours, as well as when there are changes in capacity and usage. Intensive residential facilities utilize this same framework but with more stringent reporting guidelines to update this system daily, and residential facilities are asked to report within these guidelines once a month. This information is inputted into Clear Impact, the virtual platform that hosts DMH's RBA Scorecards to better guide programming towards improved outcome measures. Data provided through the Bed Board is then inputted into an RBA Scorecard for DMH to analyze these data and assess inpatient capacity. DMH Scorecards provide current numbers across a variety of categories including number of service users, outcome assessments, trends, and other relevant data points. Additional data regarding community mental health services and perceptions of care can be found on the Department's website, under statistical reports and data. 2. In addition, The Department of Mental Health receives a weekly report that includes a review of that week's average occupancy and availability; this report is sent to the Governor weekly. There is also a report provided annually for the Vermont General Assembly.
8. Maintenance of effort (MOE) on funding outpatient community-based mental health services		
8.1. MOE dollar amount		
8.1.1. Provide as a dollar amount the level of state appropriations and local funding for outpatient community-based mental health services for the most recently completed state fiscal year.	*X*	

Prompt	State has no trends/update to report (place an X)	State response
8.2. Narrative information		
8.2.1. Describe and explain any reductions in the MOE dollar amount below the amount provided in the state's application materials. The state should confirm that it did not move resources to increase access to treatment in inpatient or residential settings at the expense of community-based services.	*Update to report*	Vermont is committed to maintenance of effort (MOE) on funding for outpatient community-based mental health services in its application. Under the terms of an SMI/SED 1115 Demonstration, the State would assure that resources would not be disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services. Vermont understands the expectation under the Demonstration that it is expected to maintain a level of state appropriations and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of this demonstration that is no less than the amount of funding provided at the beginning of the demonstration**.**

Prompt	State has no trends/update to report (place an X)	State response
9. SMI/SED financing plan		
9.1. Implementation update		

9.1.1. Compared to the demonstration design and operational details, the state expects to make the following changes to: 9.1.1a. Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, and observation/assessment centers, with a coordinated community crisis response that involves law enforcement and other first responders	*X*	

		.

Prompt	State has no trends/update to report (place an X)	State response

9.1.1b. Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model	*Update to report*	***Program Overview:*** In 2019 DMH and the Department of Vermont Health Access (State Medicaid Office) implemented an alternative Medicaid payment model for the state's Designated Agencies and Pathways Vermont, a Specialized Services Agency, for a wide array of mental health services. Most notably, the payment model for children's and adult services transitioned from traditional reimbursement mechanisms (a combination of program-specific budgets and fee-for-service payments) to a monthly case rate model. The mental health case rate model is one of the more mature alternative Medicaid payment models implemented by AHS, completing the fourth performance year on December 31, 2022. The foundational goals and principles driving mental health payment reform have remained unchanged throughout the life of this program. Those goals include: - Encouraging flexibility in service delivery that supports comprehensive, coordinated care; - Standardizing the approach to tracking population indicators, progress and outcomes; - Simplifying payment structures and improving the predictability of provider payments; - Improving accountability, equity and transparency; and - Shifting to value-based payment models that reward outcomes and incentivize best practices. ***Progress to Date:*** Performance Year 5 (calendar year 2023) has seen the sustained efforts associated with the case rate model under which agency-specific case rates are calculated for each agency's unique child and adult populations, based on the agency's allocation from DMH. Agencies are paid a fixed amount at the beginning of each month and are expected to meet established adult and child caseload targets. At least one qualifying service must be delivered during the month for an adult or child to be considered part of the agency's caseload. Caseload counts are calculated via administrative claims submitted to the Medicaid Management Information System (MMIS), which allows the State to monitor service delivery and other aspects of performance. Also, value-based payments to support quality improvement and accountability continues to be an integral component of this model through incentivizing value-based care to Medicaid beneficiaries. ***Proposed Future Model:***

		DMH is continuing to engage with key stakeholders and decision-makers from the Designated Agency network, the Agency of Human Services, the General Assembly, and others around the Certified Community Behavioral Health Clinic Model. The exploration is to understand if this is a direction Vermont should pursue. Additionally, DMH is moving forward with an updated alternative payment model (referred to as the "valuation model") that is similar to the current model but has increased accountability, transparency, and performance requirements. ***Certified Community Behavioral Health Clinics (CCBHCs).*** As noted in the Executive Summary, Vermont received a SAMHSA CCBHC State Planning Grant in March 2023. Work to date has included identifying certification criteria and finalizing certification requirements for 2 organizations that the state will select to move forward with becoming a CCBHC in 2024. Future quarterly reports will continue to include updates as this initiative continues to evolve towards DMH deciding whether to pursue becoming a CCBHC Demonstration State.

Prompt	State has no trends/update to report (place an X)	State response
10. Budget neutrality		
10.1. Current status and analysis		
10.1.1. Describe the current status of budget neutrality and an analysis of the budget neutrality to date. If the SMI/SED component is part of a broader demonstration, the state should provide an analysis of the SMI/SED-related budget neutrality and an analysis of budget neutrality as a whole.	*X*	
10.2. Implementation update		
10.2.1. The state expects to make the following program changes that may affect budget neutrality.	*X*	
11. SMI/SED-related demonstration operations and policy		
11.1. Considerations		
11.1.1. The state should highlight significant SMI/SED (or if broader demonstration, then SMI/SED-related) demonstration operations or policy considerations that could positively or negatively impact beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SMI/SED demonstration's approved goals or objectives, if not already reported elsewhere in this document. See Monitoring Report Instructions for more detail.	*X*	
11.2. Implementation update		
11.2.1. The state experienced challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers) and/or noted any performance issues with contracted entities.	*X*	

Prompt	State has no trends/update to report (place an X)	State response
11.2.2. The state is working on other initiatives related to SMI/SED.	*X*	
11.2.3. The initiatives described above are related to the SMI/SED demonstration as described (The state should note similarities and differences from the SMI/SED demonstration).	*X*	
11.2.4. Compared to the demonstration design and operational details, the state expects to make the following changes to: 11.2.4a. How the delivery system operates under the demonstration (e.g. through the managed care system or fee for service)	X	
11.2.4b. Delivery models affecting demonstration participants (e.g. Accountable Care Organizations, Patient Centered Medical Homes)	*X*	
11.2.4c. Partners involved in service delivery	*X*	
11.2.4d. The state Medicaid agency's Memorandum of Understanding (MOU) or other agreement with its mental health services agency		
12. SMI/SED demonstration evaluation update		
12.1. Narrative information		
12.1.1. Provide updates on SMI/SED evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the demonstration. There are specific requirements per the Code of Federal Regulations (CFR) for annual reports. See Monitoring Report Instructions for more details.	*X*	
12.1.2. Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.	*X*	

Prompt	State has no trends/update to report (place an X)	State response
12.1.3. List anticipated evaluation-related deliverables related to this demonstration and their due dates.	*X*	
13. Other demonstration reporting		
13.1. General reporting requirements		
13.1.1. The state reports changes in its implementation of the demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol.	*X*	
13.1.2. The state anticipates the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes.	*X*	
13.1.3. The state identified real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation.	*X*	
13.1.4. Compared to the demonstration design and operational details, the state expects to make the following changes to: 13.1.4a. The schedule for completing and submitting monitoring reports	*X*	
13.1.4b. The content or completeness of submitted monitoring reports and/or future monitoring reports	*X*	
13.2. Post-award public forum		
13.2.1. If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues. A summary of the post-award public forum must be included here for the period during which the forum was held and in the annual monitoring report.	*X*	

Prompt	State has no trends/update to report (place an X)	State response
14. Notable state achievements and/or innovations		
14.1. Narrative information		
14.1.1. Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the SMI/SED (or if broader demonstration, then SMI/SED related) demonstration or that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms, e.g., number of impacted beneficiaries.	*X*	

*The state should remove all example text from the table prior to submission.

Note: Licensee and state must prominently display the following notice on any display of Measure rates:

The MPT, FUH-CH, FUH-AD, FUA-AD, FUM-AD, AAP, and APM measures (#13, 14, 15, 16, 17, 18, 7, 8, 9, 10, 26, 29) are Healthcare Effectiveness Data and Information Set (HEDIS®) measures that are owned and copyrighted by the National Committee for Quality Assurance (NCQA). HEDIS measures and specifications are not clinical guidelines, do not establish a standard of medical care and have not been tested for all potential applications. The measures and specifications are provided "as is" without warranty of any kind. NCQA makes no representations, warranties or endorsements about the quality of any product, test or protocol identified as numerator compliant or otherwise identified as meeting the requirements of a HEDIS measure or specification. NCQA makes no representations, warranties, or endorsement about the quality of any organization or clinician who uses or reports performance measures and NCQA has no liability to anyone who relies on HEDIS measures or specifications or data reflective of performance under such measures and specifications.

The measure specification methodology used by CMS is different from NCQA's methodology. NCQA has not validated the adjusted measure specifications but has granted CMS permission to adjust. A calculated measure result (a "rate") from a HEDIS measure that has not been certified via NCQA's Measure Certification Program, and is based on adjusted HEDIS specifications, may not be called a "HEDIS rate" until it is audited and designated reportable by an NCQA-Certified HEDIS Compliance Auditor. Until such time, such measure rates shall be designated or referred to as "Adjusted, Uncertified, Unaudited HEDIS rates."