DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

State Demonstrations Group

Al Gobeille
Secretary
Vermont Agency of Human Services
280 State Drive
Waterbury, VT 05671

SEP 17 2019

Dear Secretary Gobeille:

Thank you to you and your staff for the supplementary materials sent to the Centers for Medicare & Medicaid Services (CMS) on September 9, 2019, regarding Vermont's request to allow the state to receive federal financial participation (FFP) for inpatient, residential and other services provided to otherwise-eligible Medicaid beneficiaries while residing in institutions for mental diseases (IMD) for serious mental illness (SMI) and/or serious emotional disturbance (SED). The state resubmitted its proposal in response to the Secretary's announcement of the announced the SMI/SED opportunity via State Medicaid Directors Letter (SMDL) #18-011 on November 13, 2018. Vermont previously submitted an application to CMS on January 29, 2018, for expenditure authority associated with services provided to Medicaid beneficiaries in an IMD. The 2018 application was found complete on February 6, 2018. Per previous guidance CMS has shared with Vermont, CMS will post both the new materials submitted by the state and the original application to Medicaid.gov, in order to begin a new 30 day federal public comment period specific to this proposal.

If you have any questions, please contact your CMS project officer, Mr. Eli Greenfield. Mr. Greenfield is available to answer any questions concerning your section 1115(a) demonstration and his contact information is as follows:

Centers for Medicare & Medicaid Services Center for Medicaid & CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: 410-786-6157
E-mail: eli.greenfield@cms.hhs.gov

Official communication regarding official matters should be simultaneously sent to Mr. Greenfield and Mr. Francis McCullough, Director, Division of Medicaid Field Operations East. Mr. McCullough's contact information is as follows:

Mr. Francis McCullough
Director, Division of Medicaid Field Operations East Centers for Medicare & Medicaid Services
80 I Market Street, Suite 9400
Philadelphia PA 19107-3134
Telephone: (215) 861-4157
E-mail: Francis.McCullough@cms.hhs.gov

We look forward to our continued partnership on the Vermont Global Commitment to Health section 1115(a) demonstration.

Sincerely,

[redacted]

Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosure

cc: Francis McCullough, Director, Division of Medicaid Field Operations East
Gilson DaSilva, CMS State Lead, Regional Operations Group

State of Vermont
Agency of Human Services
Office of the Secretary
280 State Drive
Waterbury, VT 05671-1000
www.humanservices.vermont.gov

Martha Maksym, Acting Secretary
[phone] 802-241-0440
[fax] 802-241-0450

September 9, 2019

Judith Cash, Director
State Demonstrations Group
Center for Medicaid and CHIP Services
7500 Security Blvd
Baltimore, MD 21244

Director Cash,

In my capacity as Acting Secretary of Vermont's Agency of Human Services, I am submitting to the Centers for Medicare and Medicaid Services (CMS) a request to amend Vermont's Section 1115 Global Commitment to Health Demonstration (11-W-00194/1) pursuant to the opportunity described in the November 13, 2018 SMDL, as specified in Vermont's formal request submitted on January 29, 2018. Specifically, Vermont is seeking FFP for services provided to Medicaid beneficiaries in IMDs when the statewide average length of stay (LOS) meets the expectation of 30 days or less.

Vermont and CMS have been meaningful and effective partners in health care reform for many years. Vermont's Global Commitment to Health 1115 demonstration and the Vermont All-Payer Model Agreement are examples of how the federal government and a state can design a program that furthers federal goals while being customized for the strengths and needs of an individual state.

Vermont credits much of the success of its comprehensive approach to mental health care to the flexibilities granted under the Global Commitment to Health Demonstration and the strong federal-state partnership at its foundation. Vermont has been a leader in community-based healthcare delivery and has spent over a decade building a comprehensive, high-quality mental health system to ensure individuals receive treatment in the least restrictive setting possible.

Vermont is encouraged by the direction and commitment of CMS to provide a funding mechanism for IMDs. However, to maintain and further build on the success of Vermont's comprehensive approach to mental health delivery system reform, and to promote our mutual goals of the All-Payer Model Agreement, long-term federal flexibility around IMD treatment and length of stay is needed. Vermont is committed to a psychiatric inpatient system of care that treats patients who are most severely compromised, including highly acute individuals who require more clinically complex and longer treatment. The length of medically necessary inpatient stays appropriately varies based on clinical complexity of the patient, and Vermont is requesting flexibility within a 30-day statewide average to determine individual LOS based on medical necessity, agnostic of a "targeted" number of days. With such flexibility, Vermont can serve as a model for what a federal waiver can do to support a high-quality mental health system of care with excellent outcomes. A defined LOS requirement of 60 days or less would result in a significant loss of funding to Vermont, destabilizing our comprehensive mental health care continuum, and moving us backwards from the incredible gains the state has made in its mental health system under the flexibility of its 1115 waiver.

This amendment request seeks to ensure the continued availability of treatment supports that effectively prevent and treat Severe Mental Illness and Serious Emotional Disturbance, and to promote a comprehensive and integrated continuum of mental and physical health, substance use disorder treatment, and long-term services and supports for all Vermonters.

Thank you for your consideration of this amendment request. We appreciate your continued partnership on our 1115 Demonstration as we work to advance our shared goals for health care reform.

Sincerely,

[redacted]

Acting Secretary

CC: Julie Sharpe, CMS
Eli Greenfield, CMS
Gilson DaSilva, RO 1, CMS
Cory Gustafson, DVHA
Ashley Berliner, DVHA
Sarah Squirrel, DMH
Morning Fox, DMH
Sarah Clark, AHS
Tracy O'Connell, AHS

Global Commitment to Health

11-W-00194/1

Section 1115(a)

Demonstration Amendment Request to CMS

(1/1/2017 – 12/31/2021)

Submitted 9/09/2019

Table of Contents

1. Request for SMI/SED Demonstration Opportunity

Vermont is submitting to the Centers for Medicare and Medicaid Services (CMS) a request to amend its Section 1115 Global Commitment to Health Demonstration (11-W-00194/1) pursuant to the opportunity described in the November 13, 2018 SMDL, as specified in Vermont's formal request submitted on January 29, 2018. Under the terms of this waiver opportunity, FFP will only be claimed for services provided to Medicaid beneficiaries in an Institution for Mental Disease (IMD) when the statewide average length of stay (LOS) meets the expectation of 30 days or less, excluding FFP for any services to inmates who are involuntarily residing in the facility by operation of criminal law.

Vermont is requesting flexibility within a 30-day statewide average to determine individual LOS based on medical necessity, agnostic of a "targeted" number of days. The length of medically necessary inpatient stays is nuanced and must appropriately vary based on clinical complexity of the patient. While an overwhelming majority of Vermont's psychiatric hospitalizations across all inpatient settings resolve in 15 days or less, inpatient treatment should continue as long as medically necessary to ensure successful transition to the community and to reduce the risk of suicide, emergency department use, and/or readmission. A defined LOS requirement of 60 days or less would result in a significant loss of funding to Vermont[1], destabilizing our comprehensive mental health care continuum, and moving us backwards from the incredible gains the state has made in its mental health system of care under the flexibility of its 1115 waiver. Granting Vermont flexibility to determine appropriate and medically necessary LOS at IMDs within a 30-day statewide average will allow the state to preserve its existing psychiatric inpatient capacity, which is an essential component in delivering good outcomes for Vermonters.

This flexibility is particularly critical to adequately treat Vermont's most severely compromised patients, who are highly acute, clinically complex, and require longer hospitalization. Notably, research indicates that the national direction of "ultrashort" hospital stays has resulted in concern about patients who are discharged too early continuing to present with acute symptoms, resulting in higher readmission rates and higher emergency department utilization post discharge[2]. In 2015, SAMSHA conducted a comparative analysis for state hospitals to analyze psychiatric LOS and rehospitalization rates in the population being discharged (this analysis included 45 states and the District of Columbia)[3]. Findings indicate that patients in states with the shortest LOS were nearly three times more likely to be readmitted into state hospitals within 30 days or 180 days of discharge than patients in states with the longest LOS. Nine states had a median LOS of four months or more, and in those states, only 2.8% patients were readmitted within 30 days of discharge[4]. In 2018, national state hospital 30-day readmission rates were 7.3% per 1,000 people, compared to Vermont's 1.2%[5]. Appropriate practices

[1] VT's two SMI IMDs are currently funded through 1115 waiver investments. FFP for SMI IMD payments under the current waiver terms are required to be phased down beginning in 2021.
[2] Glick ID, Sharfstein SS, Schwartz HI: Inpatient psychiatric care in the 21st century. Psychiatric Services 62:206–209, 2011. Link
[3] Substance Abuse and Mental Health Services Association. (2015) SAMHSA Uniform Reporting System Output Tables. Link
[4] Length of Stay and Readmission Rates in State Hospitals: A Comparative State Survey. November 2016. Link
[5] Vermont 2018 Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System Link

related to psychopharmacology additionally highlight the need for LOS flexibility, as introduction, monitoring, and titration to an appropriate level of psychiatric medication can take up to six weeks alone for highly complex patients. LOS should be clinically driven and determined by each patient's treating clinicians. Rather than trying to meet target days, the LOS should be weighed against the ongoing effectiveness of the hospitalization along with the safety, stability, and successful reintegration to life outside the hospital (reducing the likelihood of readmission) for the patient.

With the flexibility requested through this demonstration opportunity, Vermont can serve as a model for what a waiver can do to support a high-quality mental health system of care with excellent outcomes.

2. Demonstration Amendment Goals

The overall goal of this amendment request is to maintain and enhance the flexibility and availability of mental health treatment supports under the Global Commitment to Health Demonstration, and to promote a comprehensive and integrated continuum of mental and physical health, OUD/SUD treatment, and long-term services and supports for all Vermonters.

Vermont shares the CMS goals for SMI/SED treatment. The State's current Demonstration and approach are fully aligned to realize these goals, as illustrated in Exhibit A below.

Exhibit A – Shared Demonstration Goals

Global Commitment to Health Goals	SMI Amendment Goals
To increase access to care	• 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, psychiatric hospitals, and residential treatment settings throughout the state.
To improve the quality of care	• Reduced preventable readmissions to acute care hospitals and residential settings.
	• Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.
To contain health care cost	• 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.
To eliminate institutional bias	• 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.

3. Demonstration Amendment Milestones and Implementation Plan

Vermont has initiated programs or met many of the milestones identified by CMS through innovation under the Medicaid State Plan and the Global Commitment to Health Demonstration.

Vermont has been aggressively pursuing SMI/SED treatment and delivery system innovations over the lifetime of the Global Commitment to Health Demonstration. Vermont is seeking CMS partnership to allow the full continuum of services for Medicaid beneficiaries. The State will maintain and enhance existing efforts to develop a fully integrated system of physical, mental health, and OUD/SUD services with our Medicaid ACO, OUD/SUD, and SMI/SED specialty providers.

Vermont has been a leader in the use of community-based care and has spent over a decade building a comprehensive mental health care continuum to ensure individuals receive treatment in the least restrictive setting possible. This is reflected in SAMHSA's 2018 Mental Health National Outcome Measures, which show that Vermont psychiatric hospital utilization per 1,000 individuals is approximately half that of the U.S. rate for both "State Hospital" (VT's .13/1,000 compared to .39/1,000) and "Other Psychiatric Inpatient Hospital" (VT's .87/1,000 compared to 1.58/1,000) utilization.[6] Additionally, Vermont's emphasis on high quality community-based care reserves the state's limited inpatient capacity for the most severely comprised patients, particularly highly acute individuals who require more clinically complex and longer treatment.

Psychiatric hospitalization in Vermont's two psychiatric IMDs (Brattleboro Retreat and Vermont Psychiatric Care Hospital) remains an essential element in the State's continuum of mental health care for patients in crisis. Vermont's IMDs are held to the same requirements as non-IMD hospitals for providing psychiatric care. Vermont's IMDs are licensed by the State of Vermont; maintain Medicare certification; are subject to unannounced regulatory visits; take part in Medicaid utilization review; and are accredited by the Joint Commission as facilities meeting the highest national standards for safety, quality of care, and commitment to continually improving patient care quality institutions. These regulatory distinctions reflect Vermont's commitment to ensure that all its hospitals, including IMDs, provide care that is treatment and patient focused.

A preliminary draft *Section 1115 SMI/SED Demonstration Implementation Plan* is included in Attachment A, below.

4. Current Assessment of Mental Health Services

Vermont has conducted a thorough assessment of its current availability of mental health services throughout the state as of State Fiscal Year 2019. This assessment reflects Vermont's current availability of mental health services, including the number of providers offering mental health care, whether they offer mental health care to Medicaid beneficiaries, and whether they are accepting new Medicaid

[6] https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/Vermont-2018.pdf

patients in different counties across the state. Vermont's current assessment of mental health services is included in Attachment B, below.

5. Maintenance of Effort Commitment

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.

Vermont's MOE for SMI/SED under this proposed demonstration: $6,577,522
This amount is equal to Vermont's State Fiscal Year 2019 state appropriations and local funding for outpatient community-based mental health services provided to Medicaid beneficiaries.

6. List of Waivers and Expenditure Authorities Requested

Vermont seeks to maintain all current Demonstration waivers and expenditure authorities and requests to add expenditure authority for and waiver of all restrictions on payments to Institutions for Mental Disease (IMDs) for individuals ages 22 to 64, per *State Medicaid Director Letter #18—011, Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance.*

Vermont's mental health inpatient programs make up the highest level of mental health services in Vermont's continuum of care. Vermont's success in treating individuals with SMI/SED is predicated on the availability of a comprehensive, flexible, and integrated range of services to meet an individual's needs, including those with co-occurring OUD/SUD needs.

Vermont seeks recognition of its mental health hospital programs as essential services under the continuum of Global Commitment to Health Section 1115 Medicaid program benefits. This proposed SMI/SED 1115 amendment will allow the State to sustain its continuum and move toward the full integration envisioned in the All Payer Model Agreement and Global Commitment to Health Demonstrations.

Exhibit B – Type and Size of IMD Facilities

Facility	Type and Target Group(s)	Treatment Focus	# of Beds
Brattleboro Retreat: Inpatient Psychiatric Hospital	Inpatient stabilization for adults	Psychiatric, Co-occurring SUD	89
Vermont Psychiatric Care Hospital	Inpatient stabilization for adults under the care and custody of DMH	Psychiatric, Co-occurring SUD	25

7. Estimate of Annual Aggregate Expenditures

The Vermont Global Commitment to Health Demonstration Budget Neutrality agreement includes all Medicaid program service expenditures and covered populations contemplated under this SMI/SED Demonstration. Vermont is not requesting any changes to the current budget neutrality agreement as part of this amendment; however, a supplemental SMI/SED budget neutrality model will be included in the submission to CMS. The summary of Medicaid expenditures in Exhibit C below is calculated based on the terms of this waiver opportunity that FFP will only being claimed for services provided to Medicaid beneficiaries during short term stays for acute care and when the statewide average length of stay meets the expectation of 30 days.

Exhibit C – Summary of Medicaid Expenditures for Mental Health in IMDs, CY 2018

Facility	**Annual Expenditure (Gross)**
Vermont Psychiatric Care Hospital	$8,932,777
Brattleboro Retreat	$15,082,200
Total	$24,014,977

8. Enrollment Data

The Vermont Global Commitment to Health Demonstration includes all Medicaid populations who will receive coverage under this demonstration request. Vermont therefore is not requesting any changes to the Global Commitment's covered populations as part of this demonstration.

Approximately 1,250 Medicaid participants access mental health IMD services annually.

Exhibit D – Number of Medicaid Participants Receiving Services and IMD Services, CY 2018

Facility	**Number of Medicaid Participants**
Vermont Psychiatric Care Hospital	131
Brattleboro Retreat	1,116
Total	**1,247**

9. Public Process

The public process for submitting this amendment request conforms with the requirements of STC 7 and 42 CFR §431.408. Vermont is committed to engaging stakeholders and providing meaningful opportunities for input as policies are developed and implemented.

Public Comment Period

The State's public comment period on the Global Commitment to Health 1115 Waiver amendment request was from August 1, 2019 through September 1, 2019.

Public Notice

Vermont released the draft amendment request for a thirty-day public comment period starting on August 1, 2019 by posting the amendment request, including a summary of the proposed amendment and instructions for submitting comments, on DVHA's website.

Comprehensive description of the proposed waiver extension:
The State posted a comprehensive description of the proposed waiver amendment on August 1, 2019 on the above-cited website. The document included: program description, goals and objectives, a description of the beneficiary groups impacted by the demonstration, the proposed health delivery system and benefit and cost-sharing requirements impacted by the demonstration, estimated increases or decreases in enrollment and in expenditures, the hypothesis and evaluation parameters of the proposal, and the specific waiver and expenditure authorities sought.

Use of an electronic mailing list to notify the public:
On August 1, 2019, the draft *Global Commitment to Health Demonstration* amendment request was distributed simultaneously to the Medicaid and Exchange Advisory Board and the Global Commitment Register Listserv, which represents a wide array of interests in Vermont health care. The Global Commitment Register Listserv includes, but is not limited to, the following parties: health care providers; hospitals; health care advocates; Vermont Legal Aid; Medicaid beneficiaries; QHP beneficiaries; Agencies on Aging; lobbyists; law firms; various State staff, managers, and directors, including all key leadership with the Agency of Human Services; Designated Agencies; state legislators; health insurance carriers; dental insurance carriers; concerned Vermont residents; vendor partners; non-profit organizations for low-income Vermonters; federal government partners; and other national organizations or companies with an interest in Vermont health care policy.

Tribal Government Notification:
The State of Vermont has no federally recognized Indian tribes or groups.

Public Comments Received:

VERMONT CARE PARTNERS

137 Elm Street, Montpelier, VT 05602
(802) 223-1773
Contact@vermontcarepartners.org

August 27, 2019

To AHS Medicaid Policy Unit:

Vermont Care Partners supports DHVA's request to amend Vermont's Global Commitment to Health for the SMI/SED Demonstration Opportunity.

Vermont Care Partners' agencies provide a wide array of comprehensive community-based mental health services that range from prevention to acute crisis care. We have been working closely with our state partners on mental health payment reform, increased care coordination activities, and new integration models in order to continue to enhance mental health resources for Vermonters. It is important for the mental health of Vermonters that the community based system is maintained and strengthened while ensuring that we are increasing access, improving care, and containing costs. The Maintenance of Effort component of this amendment reflects a commitment by the state that high-quality care and recovery are best achieved when the entire continuum of care is adequately funded.

Vermont's mental health system continues to be a values-driven system in which we work hard to ensure that no Vermonter is hospitalized or institutionalized longer than is clinically indicated. Vermont is also committed to ensuring that mental health resources, such as inpatient, crisis, and residential beds, are available regionally to promote continuity of care with community-based providers. The inpatient resources that currently exist, including the Brattleboro Retreat and the Vermont Psychiatric Care Hospital, are essential components of our statewide system of care. Furthermore, as the only inpatient hospital for children/youth in the state, the Brattleboro Retreat is a crucial care setting to Vermont families. We would be very concerned if, in the absence of this demonstration opportunity, IMD restrictions led to decreased inpatient bed capacity for children, youth, or adults in the state.

We look forward to continuing to work together with our state and service delivery partners to provide high quality care that is underpinned by a robust community mental health system.

Sincerely,

Lorna W. Mattern Todd P. B

Lorna Mattern and Todd Bauman, Board Presidents
Vermont Care Partners

Vermont Association of Hospitals and Health Systems

148 Main Street
Montpelier, VT 05602

info@vahhs.org
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VAHHS.ORG

August 29, 2019

Ashley Berliner, Director
AHS Medicaid Policy Unit
280 State Drive, Center Building
Waterbury, VT 05671-1000

Dear Ms. Berliner:

On behalf of the Vermont Association of Hospitals and Health Systems, we appreciate the opportunity to comment on the *Section 1115(a) Demonstration Amendment Request to CMS* regarding the request for an SMI/SED Demonstration. We are encouraged by the direction and commitment of CMS to provide a mechanism for reimbursement that emphasizes access and quality of services while giving IMDs the flexibility to provide treatment-focused care. Vermont's IMDs, especially the Brattleboro Retreat, are essential to maintaining and improving access to mental health services in Vermont. Without them, our entire mental health system of care and the well-being of all Vermonters is at risk.

As you know, our IMDs meet many—if not all—the same requirements as non-IMD hospitals for providing psychiatric care. Vermont's IMDs are licensed by the State of Vermont; maintain Medicare certification; are subject to unannounced regulatory visits; take part in Medicaid utilization review; and are accredited by the Joint Commission as facilities meeting the highest national standards for safety, quality of care, and commitment to continually improving patient care quality institutions.

These regulatory distinctions reflect Vermont's commitment to ensure that all of its hospitals, including IMDs, provide care that is treatment-focused. These expectations are one of many reasons why Vermont's IMDs are achieving a statewide average length of stay of less than 30 days. We are grateful that this waiver opportunity provides flexibility on length of stay. While an overwhelming majority of psychiatric hospitalizations across all inpatient settings resolve in one week or less, inpatient treatment needs to continue as long as medically necessary to ensure successful transition to the community and to reduce the risk of suicide. Allowing flexibility in this process and preserving the existing inpatient capacity in IMDs will be important in delivering good outcomes for Vermonters.

Thank you for pursuing this opportunity and we look forward to engaging in next steps.

Sincerely,

Emma Harrigan
Director of Policy Analysis and Development
Vermont Association of Hospitals and Health Systems

Section 1115 SMI/SED Demonstration Implementation Plan

Overview: The implementation plan documents the state's approach to implementing SMI/SED demonstrations. It also helps establish what **information** the state will report in its quarterly and annual monitoring reports. The implementation plan does not usurp or replace standard CMS approval processes, such as advance planning documents, verification plans, or state plan amendments.

This template only covers SMI/SED demonstrations. The template has three sections. Section 1 is the uniform title page. Section 2 contains implementation questions that states should answer. The questions are organized around six SMI/SED reporting topics:

1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings
2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care
3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services
4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration
5. Financing Plan
6. Health IT Plan

State may submit additional supporting documents in Section 3.

Implementation Plan Instructions: This implementation plan should contain information detailing state strategies for meeting the specific expectations for each of the milestones included in the State Medicaid Director Letter (SMDL) on "Opportunities to Design Innovative Service Delivery Systems for Adults with [SMI] or Children with [SED]" over the course of the demonstration. Specifically, this implementation plan should:

1. Include summaries of how the state already meets any expectation/specific activities related to each milestone and any actions needed to be completed by the state to meet all of the expectations for each milestone, including the persons or entities responsible for completing these actions; and
2. Describe the timelines and activities the state will undertake to achieve the milestones.

The tables below are intended to help states organize the information needed to demonstrate they are addressing the milestones described in the SMDL. States are encouraged to consider the evidence-based models of care and best practice activities described in the first part of the SMDL in developing their demonstrations.

The state may not claim FFP for services provided to Medicaid beneficiaries residing in IMDs, including residential treatment facilities, until CMS has approved a state's implementation plan.

Memorandum of Understanding:

The Vermont State Mental Health Authority, the Vermont Department of Mental Health (DMH), is a department under the Vermont Agency of Human Services (AHS). AHS serves as Vermont's Single State Medicaid Agency, of which DMH is a part. Therefore, no formal agreement is needed to delineate how these organizations will work with together to design, deliver, and monitor services for beneficiaries with SMI or SED.

State Point of Contact:

Name and Title: Ashley Berliner, Director of Medicaid Policy
Telephone Number: 802-578-9305
Email Address: ashley.berliner@vermont.gov

1. Title page for the state's SMI/SED demonstration or SMI/SED components of the broader demonstration

The state should complete this transmittal title page as a cover page when submitting its implementation plan.

State	Vermont
Demonstration name	Global Commitment to Health 11-W-00194/1
Approval date	*Enter approval date of the demonstration as listed in the demonstration approval letter.*
Approval period	*Enter the entire approval period for the demonstration, including a start date and an end date.*
Implementation date	*Enter implementation date(s) for the demonstration.*

2. Required implementation information, by SMI/SED milestone

Answer the following questions about implementation of the state's SMI/SED demonstration. States should respond to each prompt listed in the tables. Note any actions that involve coordination or input from other organizations (government or non-government entities). Place "NA" in the summary cell if a prompt does not pertain to the state's demonstration. Answers are meant to provide details beyond the information provided in the state's special terms and conditions. Answers should be concise, but provide enough information to fully answer the question.

This template only includes SMI/SED policies.

Prompts	Summary
SMI/SED. Topic_1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	

This template is being finalized for review and approval by OMB through the Paperwork Reduction Act (PRA). Until such time, its use is optional, although it conveys the nature and extent of implementation information that CMS is seeking on eligibility and coverage demonstrations. When this template is OMB approved, then the state will be required to use it.

Prompts	Summary
To ensure that beneficiaries receive high quality care in hospitals and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk. *Through these section 1115 SMI/SED demonstrations, FFP is only available for services provided to beneficiaries during short term stays for acute care in IMDs (See top of p. 12 in the State Medicaid Director Letter (SMDL). As part of their implementation plan, states should propose to CMS how they are defining a short term acute stay in an IMD for purposes of these demonstrations. This definition should include a length of stay (e.g., up to 60 days) that will enable the state to demonstrate that FFP is only being claimed for services provided to beneficiaries during short term stays for acute care and the statewide average length of stay meets the expectation of 30 days (stated at the bottom of p. 12 in the SMDL). States may not claim FFP for services provided to beneficiaries who require long lengths of stay beyond a short term stay for acute care as defined by the state. However, states should provide coverage of services during longer stays in these settings for those beneficiaries who need them, but with other sources of funding than FFP. States should avoid imposing a hard cap or limit on coverage of services provided to beneficiaries residing in IMDs which may not be in compliance with federal parity requirements.* *To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.*	
Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings	

Prompts	Summary
1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid	**Current Status:** Milestone achieved. Participating IMD facilities are licensed by the State and are accredited by the Joint Commission. The Vermont Department of Health's Hospital Licensing Rule requires that, "No organization or individual may establish, conduct, or maintain operation of a Hospital in Vermont without being granted a license by the State Licensing Agency." Additionally, this rule requires that hospitals comply with all CMS Conditions of Participation, and incorporates 42 CFR 482.60-482.66 specific to psychiatric hospitals and units: *5.1 Compliance with CMS Conditions of Participation* *5.1.1 To be licensed and retain licensure in Vermont, each Hospital shall comply with all applicable CMS Conditions of Participation referenced in Section 3.4 of this rule or be operating under a Plan of Correction as described in Section 7.0 of this rule.* *5.1.2 To demonstrate compliance with CoPs, each Vermont Hospital shall make themselves available for a comprehensive, on-site and unannounced survey by the State Survey Agency:* *5.1.2.1 Occurring on average once every three years or at a frequency determined by CMS.* *5.1.2.2 Whenever CMS requires a Validation Survey for an accredited Hospital with Deemed Status.*

Prompts	Summary
	5.1.2.3 Whenever the Department or its designee determines that a survey is required as referenced in Section 5.3 of this rule. *5.1.3 As part of the annual Hospital licensing process, each Hospital shall provide to the Department any documents necessary to verify that the applicant Hospital has met the requirements of the CoPs.* *5.1.4 A Hospital license is not transferable or assignable and shall be issued only for the premises and persons named in the application. A licensed Hospital contemplating a change of ownership or the elimination or significant reduction of clinical services shall provide at least ninety (90) days advance notice to the Licensing Agency.* *5.1.5 The Hospital license shall be posted in a conspicuous place on the licensed facility's premises.*
	Future Status: No changes are expected.
	Summary of Actions Needed: • None
1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements	**Current Status:** Milestone achieved. The Vermont Department of Health's Hospital Licensing Rule requires that hospitals comply with all CMS Conditions of Participation, including: *5.1 Compliance with CMS Conditions of Participation 5.1.1 To be licensed and retain licensure in Vermont, each Hospital shall comply with all applicable CMS Conditions of Participation referenced in Section 3.4 of this rule or be operating under a Plan of Correction as described in Section 7.0 of this rule.* *5.1.2 To demonstrate compliance with CoPs, each Vermont Hospital shall make themselves available for a comprehensive, on-site and unannounced survey by the State Survey Agency:* *5.1.2.1 Occurring on average once every three years or at a frequency determined by CMS. 5.1.2.2 Whenever CMS requires a Validation Survey for an accredited Hospital with Deemed Status.* *5.1.2.3 Whenever the Department or its designee determines that a survey is required as referenced in Section 5.3 of this rule.*

Prompts	Summary
	5.1.3 As part of the annual Hospital licensing process, each Hospital shall provide to the Department any documents necessary to verify that the applicant Hospital has met the requirements of the CoPs. The Vermont Division of Licensing and Protection performs the survey and certification hospital oversight functions on behalf of CMS. These functions include unannounced visits to ensure that the participating IMD facilities are meeting licensure and accreditation requirements.
	Future Status: No changes are expected.
	Summary of Actions Needed: None
1.c Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay	**Current Status:** Milestone achieved. The Vermont Department of Health's Hospital Licensing Rule adopts the federal standards in 42 C.F.R. 482.30, which details requirements for utilization review. DVHA conducts numerous utilization management and review activities to ensure that quality services, those which increase the likelihood of desired health outcomes and are consistent with prevailing professionally recognized standards of medical practice, are provided to members and that providers are using the program appropriately, effectively and efficiently. DVHA and DMH staff utilize clinical criteria for making utilization review decisions that are objective and based on sound medical evidence. In 2012, DMH and DVHA collaborated to create a unified, consistent utilization management system for all Vermont Medicaid-funded inpatient psychiatric and detoxification services. In addition to the joint DMH/DVHA Utilization Review Team, DMH formed an expanded Care Management Unit to actively support the system of care in Vermont and facilitate flow throughout the highest levels of care. The goals for the utilization management system are as follows:

Prompts	Summary
	• Inpatient care is provided only as long as necessary for safety and/or other acute needs. • There are standardized criteria for admission, continued stay, and discharge throughout the system of care. • Care is continuous between the ongoing community treatment teams and episodes of inpatient or care. The hospital or residential facility and community teams develop and share a common treatment plan developed in partnership with the individual and his/her family, beginning within 24 hours of admission. • Resources of the public system are effectively and efficiently used. • The care management system will ensure access to effective, appropriate, recovery-based services that promote health, wellness, resiliency, and successful integration into the community.
	Future Status: No changes are expected.
	Summary of Actions Needed: None
1.d Compliance with program integrity requirements and state compliance assurance process	**Current Status:** Milestone achieved. All Medicaid-enrolled providers, including the participating IMD facilities, are required to comply with all applicable state and federal laws. The terms of the Medicaid Provider Contract state: *5.1 The parties to this Agreement acknowledge and expect that over the term of this Agreement laws may change. Specifically, the parties acknowledge and expect (i) federal Medicaid statutes and regulations, (ii) state Medicaid statutes and rules, (iii) state statutes and rules governing practice of health care professions, and (iv) any other laws cited in the Agreement may change. The parties shall be mutually bound by such changes.* Additionally, Article VI. Audit Inspection, of the Medicaid Provider Contract outlines Medicaid program integrity requirements, which incorporates applicable federal program integrity regulation.

Prompts	Summary
	The participating IMD facilities are signatories to the Medicaid Provider Contract and are in compliance with its terms.
	Future Status: No changes are expected.
	Summary of Actions Needed: None
1.e 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	**Current Status:** Milestone achieved. The Vermont Department of Health's Hospital Licensing Rule requires that hospitals comply with all CMS Conditions of Participation, including 42 CFR 482.60-482.66 specific to psychiatric hospitals and units. The following Federal Conditions of Participation required for State Hospital licensure are related to this milestone: ***§482.61*** *Condition of participation: Special medical record requirements for psychiatric hospitals.* *The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution.* *(a) Standard: Development of assessment/diagnostic data. Medical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the patient is hospitalized.* *(1) The identification data must include the patient's legal status.* ***(2) A provisional or admitting diagnosis must be made on every patient at the time of admission, and must include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.*** ***§482.62*** *Condition of participation: Special staff requirements for psychiatric hospitals.*

Prompts	Summary
	The hospital must have adequate numbers of qualified professional and supportive staff to evaluate patients, formulate written, individualized comprehensive treatment plans, provide active treatment measures*, and engage in discharge planning.* *(a) Standard: Personnel. The hospital must employ or undertake to provide adequate numbers of qualified professional, technical, and consultative personnel to:* *(1) Evaluate patients;* *(2) Formulate written individualized, comprehensive treatment plans;* *(3) Provide active treatment measures; and* *(4) Engage in discharge planning.* *(b) Standard: Director of inpatient psychiatric services; medical staff. Inpatient psychiatric services must be under the supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program. The number and qualifications of doctors of medicine and osteopathy must be adequate to provide essential psychiatric services.* *(1) The clinical director, service chief, or equivalent must meet the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.* *(2) The director must monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff.* ***(c) Standard: Availability of medical personnel. Doctors of medicine or osteopathy and other appropriate professional personnel must be available to provide necessary medical and surgical diagnostic and treatment services. If medical and surgical diagnostic and treatment services are not available within the institution, the institution must have an agreement with an outside source of these services to ensure that they are immediately available or a satisfactory agreement must be established for transferring patients to a general hospital that participates in the Medicare program.*** All participating IMD facilities are currently engaged in these activities.

Prompts	Summary
	Future Status: No changes are expected.
	Summary of Actions Needed: None.
1.f Describe the state's approach to defining a 'short term stay for acute care in an IMD', as described above and as referenced in the SMDL (page 12).	Short term stay is a type of admission that can provide targeted care for patients requiring hospitalization, and is driven by the individualized plan of care, which is created upon admission collaboratively with the patient and their treatment team. Discharges occur when the acute psychiatric crisis has resolved. Vermont defines a short term stay as a hospitalization stay that is anticipated to stabilize the patient, dependent on the patient's continued cooperation in their treatment plan. Vermont's statewide average length of stay meets the 30 day expectation outlined under the terms of this waiver opportunity.
1.g Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.	**Current Status:** The Department of Mental Health uses the Results Based Accountability (RBA) framework to evaluate the performance of programs and initiatives. RBA is a framework that helps programs improve the lives of children, families, and communities and their performance. Hospital Inpatient Units: • As discussed above, for a hospital to be licensed to operate in Vermont they must abide by the Vermont Hospital Licensing Rule. This rule requires the hospitals meet CMS regulations, which are tied to Joint Commission requirements. • The Vermont Department of Mental Health also must designate hospital inpatient psychiatric units in order for involuntary patients to be treated there. This is governed by DMH's Designated Hospitals Manual and Standards. ○ It is the Designated Hospital's responsibility to provide the Department of Mental Health with copies of specific documentation demonstrating compliance with each requirement. The Commissioner requires re-designation of Designated Hospitals every two years. To enable adequate oversight by the Department, Departmental staff arrange for a visit in advance of the designation expiration date. This visit includes interviews with key staff, a review of outcomes, and a review of policies and procedures. A written decision letter and feedback is provided to the Designated Hospital following the visit. The review

Prompts	Summary
	may require the Designated Hospital to address any missing information or provide a corrective action plan. Residential Treatment Settings: • Adult residential treatment centers must be licensed by the Vermont Department of Aging and Independent Living (https://dail.vermont.gov/resources/regulations). • Child residential treatment centers must be licensed by the Vermont Department for Children and Families (https://dcf.vermont.gov/sites/dcf/files/FSD/pubs/RTP-Regs.pdf)
	Future Status: No changes are expected.
	Summary of Actions Needed: None.
SMI/SED. Topic_2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care	
Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs, must focus on improving care coordination and transitions to community-based care by taking the following actions.	
Improving Care Coordination and Transitions to Community-based Care	
2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning, and include community-based providers in care transitions.	**Current Status:** Milestone achieved. The Vermont Department of Health's Hospital Licensing Rule requires that hospitals comply with all CMS Conditions of Participation and adopts 42 CFR 482.43, which details discharge planning requirements that align with this milestone. Additionally, DMH contracts with community-based providers, called Designated Agencies, to participate in transition efforts and discharge planning. Requirements for Community Mental Health Clinic providers is specified in the Mental Health Provider Manual:

Prompts	Summary
	Transition planning is critical for the support of the individual's ongoing treatment, recovery or wellbeing. If for any reason a transition or discharge plan cannot be developed in the timelines below, the circumstances prohibiting the planning will be documented. *A transition plan must be developed for any individual who requires treatment intervention and/or family support who is transitioning to other services or providers outside the local network or moving to another region including but not limited to a transition from one level of care to another or a transition from one programming area to another. A transition plan must be developed with the individual and/or family/guardian prior to transition date.* *A discharge plan must be developed anytime an individual or child and family have completed services, chosen to discontinue services, or for whom services have been terminated. A discharge plan must be developed with the individual and/or family/guardian prior to discharge date for all individuals where the discharge is planned.* *Plans should include the following components and be developed with the individual and other appropriate participants, such as the family, whenever possible:* *• progress towards goals during program participation,* *• reason for discharge or transition.* *• condition at last contact, and* *• referrals made, if clinically indicated.* *For a child or adult who is in an out-of-home treatment setting, the local team supports the facility or out of home treatment provider for discharge planning.* *This includes settings such as* *• out-of-home community home provider placements,* *• private non-medical institutions/residential programs (in and out of state);* *• hospital diversion/emergency beds;*

Prompts	Summary
	• *inpatient psychiatric hospitalization, and* • *arrangements with other providers.* All participating IMD facilities are currently engaged in intensive discharge planning and care coordination services. Maintain and enhance current discharge planning and care coordination with improved strategies for connection with local community-based services.
	Future Status: Maintain and enhance current discharge planning and care coordination. with improved strategies for connection with local community-based services. DMH is working on the following strategies to improve connection with local community-based services: • Collaborative Network Approach) Vermont's version of "Open Dialogue" practice, to better inform transition to community with the patients' and their families' direct involvement. • Increase awareness of available community work supports for staff and individuals in psychiatric hospital care (e.g. offer short training on Evidence Based Practices for Supported Employment (EBP SE), Specialized Service Agency (SSA) work incentive. • Host employment related in-house groups based on individuals' lead (employing a Recovery-Orientated Cognitive Therapy approach). • Develop ways for the local community employment specialist or Vocational Rehabilitation counselor to meet with patients and staff prior to discharge, whenever possible.
	Summary of Actions Needed: None.
2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.	**Current Status:** Participating IMD Facilities Current Practice: • Assessment begins at the time of the referral, continues in assessment and evaluation and on units with Treatment Planning. • Active discharge planning takes place with our SW staff working with each of the state's Designated Agencies to coordinate after care planning, which includes housing and residential step-down services.

Prompts	Summary
	DMH has a housing coordinator that works with Vermont landlords to aid in securing and financing stable housing for those who are homeless or have unsuitable or unstable housing.
	Future Status: Establish State policy to maintain and enhance current efforts around housing coordination and services that ensure alignment across participating IMD facilities.
	Summary of Actions Needed: None.
2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge	**Current Status:** Vermont does not currently meet these requirements.
	Future Status: Promulgate administrative rule that requires facilities to develop protocol for meeting this expectation.
	Summary of Actions Needed: Establish State policy to ensure that facilities are providing high quality follow-up care that aligns with this milestone.
2.d Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission	**Current Status:** Milestone achieved. 1. Analyze and adjust (if warranted) bed capacity: o Vermont is in the process of adding additional inpatient and residential capacity to better meet the growth in numbers of people in need of inpatient services. 2. Telepsychiatry: o Using Telepsychiatry, Medicaid is able to fund consultation to Emergency Department staff regarding medication needs for patients to help facilitate them moving to the next appropriate level of care. In addition, Telepsychiatry helps to determine the level of care that is needed for an individual in the Emergency Department. Telepsychiatry is also being used more and more to reach people in the more

Prompts	Summary
	remote areas of the state. By being able to do this, Vermont is better able to provide psychiatric supports for individuals who have traditionally only reached these supports by presenting at an ED. 3. Peer-to-peer support services: o Peer supports in EDs help provide a safe and stabilizing environment for the patient, which has an impact on the current psychiatric crisis and can help a patient access the appropriate level of care from the ED. Vermont already has one peer run crisis stabilization unit and a peer run intensive residential program. Vermont is looking to expand peer run crisis and stabilization units to help further prevent unnecessary ED visits. 4. SBINS - Screening, Brief Intervention, and Navigation to Services: o SBINS is an approach that helps health care providers identify risks to their patients' health and wellbeing, from a wide range of sources including drug and alcohol use, housing and food insecurity, inter-partner violence, and more. When risks are present, trained counselors offer patients support and help them access the services they need to address risk factors and maintain or improve their health. Through this process, risk factors can be addressed prior to rising to the level that requires an ED visit. 5. Vermont Psychiatric Survivors (VPS) peers in EDs: o Vermont Psychiatric Survivors provide peers to EDs to provide support and advocacy for any individual in an ED who have presented in a psychiatric emergency. VPS peers in EDs help provide a safe and stabilizing environment which often leads to patients being able to stabilize and be safely discharged from the ED with supports from the VPS peer. 6. Designated Agency – Emergency Services: o Through an annual contract with DMH, Designated Agencies are required to screen all individuals who are enrolled in CRT who present to an Emergency Department for potential psychiatric inpatient treatment. The Designated Agency Emergency Services staff are also required, through the same contract, to screen all Medicaid enrolled youth who present to an Emergency Department for possible psychiatric inpatient care. By setting this expectation for ED screenings of people with SMI or SED, Vermont is better able to provide supports to individuals who otherwise would have traditionally waited for and been served only in an

Prompts	Summary
	inpatient setting, as opposed to alternatives that Designated Agency Emergency Services screening staff could offer and/or facilitate access to.
	Future Status: Maintain and enhance efforts to prevent and decrease lengths of ED stays by continuing to pursue the strategies outlined above.
	Summary of Actions Needed: None
2.e Other State requirements/policies to improve care coordination and connections to community-based care	**Current Status:** Milestone achieved. Vermont currently has technical assistance grants through the National Governor's Association and Actionable Intelligence for Social Policy. The State's goals are to develop and enhance interoperability and data sharing on a variety of different issues, including physical, SUD, and mental health providers. Vermont is also investing in care coordination through the All-Payer, Accountable Care Organization Model. OneCare Vermont makes payments to community providers for Complex Care Coordination. This care coordination includes: • Outreach to engage/maintain patients in care coordination • Provide care coordination services for your patient panel • Create shared care plans and community among care team members • Participate in shared care planning and care conferences to facilitate the patient's goals of care • Support effective transitions of care (e.g. ED follow-up calls, post hospital discharge visits) • Partner with continuum of care and human services organizations • Attend care coordination skills trainings

Prompts	Summary
	Complex Care Coordination payments to Primary Care, Home Health, Designated Mental Health Agencies, and Area Agencies on Aging were approximately $ 9.1M in CY 2018. Children Specific: Medicaid holds utilization review calls weekly with the Brattleboro Retreat, the only inpatient mental health facility for children and adolescents in Vermont, to help coordinate inpatient care. In addition, the Vermont Department of Mental Health's Provider Manual and Minimum Standards Guidelines for children's mental health requires coordination of designated agencies (local providers of community mental health care) with inpatient and residential providers to transition children/youth to community-based care.
	Future Status: Maintain and enhance current efforts around care coordination.
	Summary of Actions Needed: None.
SMI/SED. Topic_3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	
Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.	
Access to Continuum of Care Including Crisis Stabilization	
3.a The state's strategy to conduct annual assessments of the availability of mental health providers including psychiatrists, other practitioners, outpatient,	**Current Status:** Milestone achieved. DMH provides this information in the form of an annual report to the Vermont State Legislature, pursuant to Vermont Act 79, An act relating to reforming Vermont's mental health system.

Prompts	Summary
community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of the availability of mental health services submitted with the state's demonstration application. The content of annual assessments should be reported in the state's annual demonstration monitoring reports. These reports should include which providers have waitlists and what are average wait times to get an appointment	**Future Status:** Continue to conduct an annual assessment of mental health services throughout Vermont. The State will include the contents of this assessment in its annual demonstration report to CMS.
	Summary of Actions Needed: None.
3.b Financing plan	**Current Status:** Vermont funds a peer-run warm line that operates 18 hours per day/seven days a week; the State is seeking additional funding from the Vermont legislature to allow it to run 24 hours/day. All ten Designated Agencies have 24-hour crisis call centers and mobile crisis units, and many Designated Agencies have embedded mental health professionals within local and state law enforcement. DMH continues to sponsor the Team Two training that build working relationships between local law enforcement and local mental health crisis teams.
	Future Status: Continue to explore strategy to enhace availability of community-based SMI services in Vermont.

Prompts	Summary
	Summary of Actions Needed: Discussion with CMS needed in order to receive approval of Vermont's financing plan.
3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	**Current Status:** Milestone achieved. Medicaid maintains a bed board of all hospitals and residential placements funded by Medicaid.
	Future Status: Enhancements are planned to update the bed board data to include SUD placements.
	Summary of Actions Needed: None.
3.d State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay	**Current Status:** All participating IMD facilities currently use Qual/McKesson to help determine appropriate level of care and length of stay.
	Future Status: The State will establish a policy to require the use of evidence-based, publicly available patient assessment tool in order to achieve this milestone.
	Summary of Actions Needed: Establish State policy to require the use of evidence-based, publicly available patient assessment tool in order to achieve this milestone.
3.e Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	**Current Status:** Vermont has an array of community-based systems of supports: 1. There are local crisis bed alternative programs in all Designated Agency catchment areas, as well as regional Intensive Residential Recovery Programs, to provide transitionary treatment and recovery-oriented support environments was created. Peer supported crisis bed and medication-alternative residential programs exist

Prompts	Summary
	around the state. Additionally, Middlesex Therapeutic Community Residential Program also supports step-down opportunities for individuals from more restrictive hospital-based care. 2. Emergency Services are provided by designated agencies and include mobile crisis teams to respond to needs in the community, as well as phone support and prevention services. • When needed, clients are referred to crisis beds, which are part of a community-based hospital diversion program that offers emergency, short-term, 24-hour residential supports in a setting other than the person's home. They are operated by the designated and specialized services agencies. • DMH supports a peer-run crisis bed program, called Alyssum. • The total crisis bed count in Vermont is 38 for adult mental health and 18 for children and youth. Children Specific: 3. Expansion of Hospital Diversion Program • An additional six new beds have been created in southern part of VT. 4. Medicaid holds utilization review calls weekly with the Brattleboro Retreat, the only inpatient mental health facility for children and adolescents in Vermont, to help coordinate inpatient care. 5. Utilization Review of continued stay requests in children's crisis programs (including community-based hospital diversion and crisis stabilization programs)
	Future Status: Mobile Response and Stabilization Services (MRSS): Vermont is evaluating the possibility of adding more resources for MRSS, which is a face-to-face response provided to a family-defined crisis to provide support and intervention for a child/youth and their family before emotional and behavioral difficulties escalate.
	Summary of Actions Needed: None.
SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration	
Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.	

Prompts	Summary
Earlier Identification and Engagement in Treatment	
4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported education and employment	**Current Status:** Milestone achieved. The State continues to employ a number of strategies to better identify and engage individuals in treatment earlier: • Developing strategies to expand Intentional Peer Support (IPS) services to all Designated Agencies for young adults (16-22 yrs) with SED. • implementing Collaborative Network Approach (CNA) as a tool for better engaging young adults. • Regularly conducting training on Dialectical Behavior Therapy specifically for young adults. • Funding Jump On Board for Success (JOBS) programs in every Vermont region, with the goal of young adults with SED or SMI developing employment/education goals. • Funding Youth Mental Health First Aid, an 8 hour public education program which introduces participants to the unique risk factors and warning signs of mental health problems in youth or adults, builds understanding of the importance of early intervention, and teaches individuals how to help when a person is in crisis or experiencing a mental health challenge. • Funding of a peer-run Community Center to engage young adults experiencing mental health issues in a variety of ways and offering IPS supported employment and educational supports.
	Future Status: Maintain and build upon existing strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner.
	Summary of Actions Needed: None.
4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of	**Current Status:** Milestone achieved. Vermont Medicaid supports a number of programs, initiatives, and practices that support the goal of increased integration. These include:

Prompts	Summary
SED/SMI and linkages to treatment	• Advancing Wellness and Resilience in Education (AWARE): Medicaid has partnered with the Vermont Agency of Education in 5-year SAMHSA grant to promote: on-going collaboration at the state and local level regarding best practices to increase awareness of mental health issues; enhance wellness and resiliency skills for school age youth; and support system improvements for school-based mental health services. • Children's Health Integration Linkage and Detection (CHILD): 5-year SAMHSA funded grant to promote the integration and collaboration in clinical practice between primary and behavioral healthcare with the goal to improve the health and wellness of children with, or at-risk for, SED and their families. • DULCE (Developmental Understanding and Legal Collaboration for Everyone): DULCE's purpose is to ensure that newborns and their families receive quality medical care as well as all the social services and community support they need during the first six months of the newborn's life. A social worker is embedded in a pediatrician's office as a way to increase access and support to new parents. • Early Childhood and Family Mental Health (ECFMH): The Early Childhood and Family Mental Health system of care for children under the age of six and their families in Vermont provides a comprehensive cross-system, cross-agency infrastructure that sustains services and supports. • Psychiatric consult for primary care: DMH contracts with child psychiatrists to provide psychiatric consultation to pediatric and family medicine primary care providers to support their management of psychiatric needs in children. This consultation supports the PCP's mental health assessments, intervention planning and implementation. • School Mental Health: Success Beyond Six is the program that supports the provision of mental health services by a Designated Agency in a school to address the mental health needs of identified students and provide mental health consultation for the school's multi-tiered systems of supports. • STAMPP Grant: Vermont's Screening Treatment, & Access for Mothers and Perinatal Partners (STAMPP): 5-year cooperative agreement with HRSA works to improve the mental health and well-being of pregnant and postpartum women and their children and families by developing and sustaining a coordinated system of mental

Prompts	Summary
	health supports (screening, referral, access to treatment and community supports) for pregnant and postpartum women. • JOBS programs: Community and school-based program focused on keeping youth in school who are at risk of dropping out, or re-engaging youth who have stopped attending.
	Future Status: Maintain and build upon existing strategies for increasing integration of behavioral health care in non-specialty care settings.
	Summary of Actions Needed: None.
4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI	**Current Status:** Milestone achieved. Vermont Medicaid continues to foster specialized settings and services for youth with SMI or SED, including: • Crisis respite services for youth • Early Episode Psychosis Initiative to improve access and early interventions to individuals first experiencing symptoms of serious mental illness. Intensive residential programs specializing in working with youth SED/SMI populations.
	Future Status: Maintain and expand Vermont's capacity and access for specialized settings and services for young people experiencing SED/SMI.
	Summary of Actions Needed: None.
4.d Other state strategies to increase earlier identification/engagement,	**Current Status:** Vermont Act 264 of 1999 requires that Human Services and Public Education work together, involve parents and coordinate services for better outcomes for children and families. The Act developed a coordinated system of care so that children and adolescents with emotional issues and their families receive appropriate educational, mental health,

Prompts	Summary
integration, and specialized programs for young people	child welfare, juvenile justice, residential, and other treatment and support services in accordance with an individual plan. The Vermont Children's Health Improvement Program (VCHIP, administered through the University of Vermont): DMH partners with the Vermont Department of Health Maternal Child Health and VCHIP to improve screening for child developmental and mental health, as well as perinatal mood disorders during well-child visits. VCHIP also leads an annual quality improvement project with specific Pediatric and Family Practices, called Child Health Advances Measured in Practice (CHAMP), in which DMH partners in the planning and year-long project as it relates to mental health and behavioral topics. Payment Reform expanded use of Child and Adolescent Needs and Strengths nationally recognized tool for standardized measurement of child and caregiver needs and strengths.
	Future Status: Maintain and expand Vermont's strategies to increase earlier identification/engagement, integration, and specialized programs for young people.
	Summary of Actions Needed: None.
SMI/SED.Topic_5. Financing Plan	
State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state's assessment of current availability of mental health services included in the state's application.	
F.a Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment	**Current Status:** In CY 2019, Medicaid operationalized payment reform for community mental health services. Mental Health Payment Reform represents a large operational and cultural shift towards focusing on how well Vermont is doing rather than simply how much it is doing. The shift gives communities more flexibility with funding to meet the needs of the children, youth, adults, and families they serve. By simplifying the baseline payment structures and adding Value-Based payments that reward outcomes and incentivize best practice, the State aims to make it

Prompts	Summary
centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.	easier for Medicaid providers to meet the goal of efficient and effective care for Vermonters with mental health needs.
	Future Status: Payment reform efforts aim to streamline payment structures and break down silos that can sometimes be barriers to individuals and families receiving services. The first phase of payment reform combined many different funding streams into one in order to meet this aim. However, additional siloed funding streams continue to exist that were not included in this first phase (Alcohol and Drug Abuse Programs, Elder care, etc). Future efforts will examine the potential for incorporating more programs and services into the case rate bundle, and aligning quality and outcome goals.
	Summary of Actions Needed: Discussion with CMS needed in order to receive approval of Vermont's financing plan.
F.b 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.	**Current Status:** Mental Health Payment Reform represents a large operational and cultural shift towards focusing on quality over quantity. The shift gives communities more flexibility with funding to meet the needs of the children, youth, adults, and families they serve. By simplifying the baseline payment structures and adding Value-Based payments that reward outcomes and incentivize best practice, Medicaid aims to make it easier for providers to meet the goal of efficient and effective care for Vermonter with mental health needs.
	Future Status: Payment reform efforts aim to streamline payment structures and break down silos that can sometimes be barriers to individuals and families receiving services. The first phase of payment reform combined many different funding streams into one in order to meet this aim. However, additional siloed funding streams continue to exist that were not included in this first phase (Alcohol and Drug Abuse Programs, Elder care, etc). Future efforts will examine the potential for incorporating more programs and services into the case rate bundle, and aligning quality and outcome goals.

Prompts	Summary
	Summary of Actions Needed: Discussion with CMS needed in order to receive approval of Vermont's financing plan.
SMI/SED. Topic_6. Health IT Plan Emily is working on this.	
As outlined in State Medicaid Director Letter (SMDL) #18-011, "[s]tates seeking approval of an SMI/SED demonstration … will be expected to submit a Health IT Plan ("HIT Plan") that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals."[1] *The HIT Plan should also describe, among other items, the:* • *Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and* • *Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.* *Please complete* all *Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state's demonstration proposal.*	
Statements of Assurance	
Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period	Today, the State of Vermont has an established health IT infrastructure that supports the provision of care and measurement of the health care system and reform initiatives. The State's health-IT infrastructure includes, but is not limited to, a PDMP, public health registries (immunization, births/deaths, and cancer), a state-wide health information exchange with supporting data extraction capabilities, behavioral health registry, an All Payer Claims Database, and a clinical registry within the Medicaid Agency that is operated by the Blueprint for Health program. Additionally, a care coordination platform supports providers participating in Vermont's All-Payer Model and all of Vermont's hospitals and a considerable number of eligible providers have taken advantage of the Meaningful Use program to adopt electronic health record systems.

[1] See SMDL #18-011, "Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

Prompts	Summary
Statement 2: Please confirm that your state's SUD Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan and, if applicable, the state's Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period.	Vermont's SUD Health IT efforts are aligned with the State's broader Health IT Plan. In 2017, Vermont's Medicaid Agency convened the Health Information Exchange Steering Committee, who is now statutorily obligated to support DVHA in the annual development of a state-wide health-IT/exchange strategic plan. This plan is referred to as the HIE Plan. The purpose of the Plan is to provide a strategy for the implementation of an integrated electronic health information infrastructure for the sharing of electronic health information among health care facilities, health care professionals, public and private payers, and patients. Per State statute, the Plan must be approved by the Green Mountain Care Board annually. The latest HIE Plan is available here: https://healthdata.vermont.gov/sites/healthdata/files/HIE%20Strategic%20Plan.pdf. Full membership details and meeting information is available here: https://healthdata.vermont.gov/HIESteeringCommittee. The 2019 Health Information Exchange Steering Committee is heavily focused on the development of a 3-5 health-IT/exchange investment strategy. An essential component of this strategy is bolstering public health and general data infrastructure to enable clinical decision support across the continuum, including treatment of SUD. The investment strategy will envelope work currently being done (CMS funded via HITECH) to develop an informatics strategy at the Department of Health. Additionally, the Vermont General Assembly appropriated $1.5M to the State's Designated Agency network to offset the cost of purchasing electronic medical records for the behavioral health system. As part of this appropriation, the Vermont Care Partners (the agency that connects the Designated and Specialized Service Agencies that function on behalf of the Agency of Human Services) was asked to demonstrate how the implementation of these new systems would work to further the HIT goals set forth in the state-wide strategic plan before funds could be released.
Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)[2] and 45 CFR 170 Subpart B and,	All of Vermont's interoperability efforts adhere to and/or are in direct alignment with federal guidance. As illustrated in the state-wide strategic HIE Plan, Vermont continues to demonstrate success in implementing the federal Promoting Interoperability Program and has based all strategic planning on architecture and standards set forth by CMS and the Office of the National Coordinator.

[2] Available at https://www.healthit.gov/isa/.

Prompts	Summary
based on that assessment, intends to include them as appropriate in subsequent iterations of the state's Medicaid Managed Care contracts. The ISA outlines relevant standards including but not limited to the following areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.	Vermont has submitted a request to CMS to obtain HITECH funds to support an assessment to determine the best, most cost effective strategy to integrate the Prescription Drug Monitoring system and Health Information Exchange data. It is anticipated that a vendor would help the State to: understand steps required to develop Vermont's PDMP into a "qualified PDMP" (Under section 1944 of the Social Security Act, beginning October 1, 2021, states must have a qualified prescription drug monitoring program (PDMP) and must require that certain Medicaid providers check information about certain Medicaid beneficiaries' prescription drug history in the qualified PDMP before prescribing controlled substances to the beneficiary); assess how best to connect the HIE and the PDMP; determine the best strategy to facilitate integration through a PDMP hub; identify use cases and roles based access requirements as it relates to PDMP data access; develop an auditing process that meets the needs of the PMDP manager (Dept. of Health), state law, federal law, and aligns with processes at the HIE; and support implementation of strategic design to achieve PDMP integration and interoperability.
To assist states in their health IT efforts, CMS released SMDL #16-003 which outlines enhanced federal funding opportunities available to states "for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers." For more on the availability of this "HITECH funding," please contact your CMS Regional Operations Group contact. [3] *Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established "No Wrong Door System."* [4]	
Closed Loop Referrals and e-Referrals (Section 1)	
1.1 Closed loop referrals and e-referrals from physician/mental	**Current State:** It is not a consistent practice to use Certified Electronic Health Records to execute e-referrals and closed loop referrals from a mental health provider to other mental health providers.

[3] See SMDL #16-003, "Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd16003.pdf.
[4] Guidance for Administrative Claiming through the "No Wrong Door System" is available at https://www.medicaid.gov/medicaid/finance/admin-claiming/no-wrong-door/index.html.

Prompts	Summary
health provider to physician/mental health provider	**Future State**: The future state will be developed according to feedback from surveying Vermont mental health providers. The existing Vermont HIT road map will be expanded to include closed loop referrals and e-referral functionality.
	Summary of Actions Needed: 1. Develop a survey to assess the capabilities, need and / or desire for mental health providers to use e-referrals and closed loop referrals in Certified Electronic Health Records. The survey will also assess the usage and compatibility of existing e-referral systems between Vermont mental health providers. 2. Disseminate the survey to Vermont mental health providers. 3. Review survey results. 4. Discuss and develop programming and / or projects aimed at addressing survey results.
1.2 Closed loop referrals and e-referrals from institution/hospital/clinic to physician/mental health provider	**Current State:** It is not a consistent practice to use Certified Electronic Health Records to execute e-referrals and closed loop referrals from an institution/hospital/clinic to other mental health providers.
	Future State: The future state will be developed according to feedback from surveying Vermont mental health providers.
	Summary of Actions Needed: 1. Develop a survey to assess the capabilities, need and / or desire for institutions, hospitals, and clinics to use e-referrals and closed loop referrals in Certified Electronic Health Records. The survey will also assess the usage and compatibility of existing e-referral systems between Vermont institutions, hospitals, and clinics. 2. Disseminate the survey to Vermont mental health providers. 3. Review survey results. 4. Discuss and develop programming and / or projects aimed at addressing survey results.
1.3 Closed loop referrals and e-referrals from physician/mental health provider to community based supports	**Current State:** It is not a consistent practice to use Certified Electronic Health Records to execute e-referrals and closed loop referrals from a mental health provider to a community-based support.
	Future State: The future state will be developed according to feedback from surveying Vermont mental health providers.
	Summary of Actions Needed:

Prompts	Summary
	1. Develop a survey to assess the capabilities, need and / or desire for mental health providers to use e-referrals and closed loop referrals in Certified Electronic Health Records. The survey will also assess the usage and compatibility of existing e-referral systems between Vermont mental health providers and community-based supports. 2. Disseminate the survey to Vermont mental health providers. 3. Review survey results. 4. Discuss and develop programming and / or projects aimed at addressing survey results.
Electronic Care Plans and Medical Records (Section 2)	
2.1 The state and its providers can create and use an electronic care plan	**Current State:** Vermont and its providers consistently create and use electronic care plans (e-CPs). e-CPs serve as engagement points for clinicians to note and track patient care goals, as well as identify barriers to effectuating the care plan. Clinicians from multiple specialties within a network can communicate with each other and collaborate to manage a patient's comprehensive care needs. Under HITECH IAPD version 3.3, approved February 21, 2019, funding was distributed to OneCare Vermont to support the development and use of the care coordination tool for Medicaid providers participating in Vermont's All-Payer Model. As originally planned, the development and implementation of these tools continued in Calendar Year 2019. The OneCare Vermont Accountable Care Organization has been successful at developing advanced analytics tools to manage population health using e-CP information to identify geographic variations in health service delivery, utilization, cost, and quality, as well as differences in patient engagement between communities.
	Future State: Vermont seeks to expand the accessibility of e-CPs and other electronic health information retained by individual health care provider networks. In the current annual IAPD update submitted to CMS, DVHA is now seeking continued and expanded HITECH funding to support Vermont Medicaid Next Generation (VMNG)-participating providers in exchanging health information, coordinating care, and relying on trusted data sources to support clinical decision making related to priority health areas.
	Summary of Actions Needed:

Prompts	Summary
	Design and execute projects to support the expansion of VMNG-participating providers in exchanging health information, coordinating care, and relying on trusted data sources to support clinical decision making related to priority health areas.
2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers	**Current State:** Within a given health care network, electronic care plans are accessible to the team designing and providing care and treatment to the patient, including mental health providers.
	Future State: Vermont seeks to expand the accessibility of e-CPs and other electronic health information retained by individual health care provider networks. In the current annual IAPD update submitted to CMS, Vermont is now seeking continued and expanded HITECH funding to support Vermont Medicaid Next Generation (VMNG)-participating providers in exchanging health information, coordinating care, and relying on trusted data sources to support clinical decision making related to priority health areas.
	Summary of Actions Needed: Design and execute projects to support the interoperability of VMNG-participating providers in sharing and accessing eCPs.
2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	**Current State:** Youth-oriented systems of care exist in the state of Vermont and are managed via the state's mental health clinician workforce, contracted facilities, Designated Agencies and health care networks, which include hospitals and clinics. Within a given facility, designated agency or health care network, the electronic medical records of a youth are treated the same as an adult receiving treatment for behavioral health concerns. Electronic health records of children transitioning to mental health providers outside of a health care network are printed, scanned and delivered to the new provider either upon request or as part of a referral.
	Future State: The future state will be developed according to feedback from surveying Vermont mental health providers.
	Summary of Actions Needed: 1. Develop a survey to assess the capabilities, need and / or desire for mental health providers to electronically send health records of children receiving behavioral health care. The survey will also assess the usage and compatibility of existing systems between adult and pediatric mental health providers.

Prompts	Summary
	2. Disseminate the survey to Vermont mental health providers. 3. Review survey results. 4. Discuss and develop programming and / or projects aimed at addressing survey results.
2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	**Current State:** Within a given facility, designated agency or health care network, the electronic care plans (e-CPs) of a youth are treated the same as an adult receiving treatment for behavioral health concerns. e-CPs of children transitioning to mental health providers outside of a health care network are printed, scanned and delivered to the new provider either upon request or as part of a referral.
	Future State: The future state will be developed according to feedback from surveying Vermont mental health providers.
	Summary of Actions Needed: 1. Develop a survey to assess the capabilities, need and / or desire for mental health providers to electronically send electronic care plans (e-CPs) of children receiving behavioral health care to adult mental health providers. The survey will also assess the usage and compatibility of existing systems to transmit e-CPs between adult and pediatric mental health providers. 2. Disseminate the survey to Vermont mental health providers. 3. Review survey results. 4. Discuss and develop programming and / or projects aimed at addressing survey results.
2.5 Transitions of care and other community supports are accessed and supported through electronic communications	**Current State:** Within a given facility, designated agency or health care network, transitions of care are noted in the patient's electronic health record. Community supports that have responsibility for care of the youth, and are affiliated with a facility, designated agency, or health care network, can access the patient's electronic health record.
	Future State: The future state will be developed according to feedback from surveying Vermont mental health providers.
	Summary of Actions Needed: 1. Develop a survey to assess the capabilities, need and / or desire for mental health providers and community supports to electronically access transition of care documentation in a patient's electronic health record.

Prompts	Summary
	2. Disseminate the survey to Vermont mental health providers and community supports. 3. Review survey results. 4. Discuss and develop programming and / or projects aimed at addressing survey results.
Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)	
3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42 CFR part 2 and state laws)	**Current State:** Vermont mental health providers consistently adhere to Federal and state privacy laws, with respect to consent (e.g., HIPAA, 42 CFR part 2 and state laws). All Certified Electronic Medical Records transmit health information adhering to the HL7 Consent Process; Part 2 data is explicitly not exchanged, and any Part 2 related health information remains static. Within a given health care network, individual consent is captured and accessible to patients and all members of the care team. Patients sign paper consents which are then scanned and attached to the patient's electronic health record. Patients can review paper consents and revoke consent at any time. The State is interested in the results of pilot projects conducted under the ONC's Data Segmentation for Privacy Initiative (DS4P) have showed some ways that the 42 CFR Part 2 prohibition on re-disclosure notice can be transmitted, along with health information, when a patient has consented to its disclosure. For an example, you can view a 5-minute video Web Site Disclaimers or 14-minute video Web Site Disclaimers of the U.S. Department of Veterans Affairs (VA)/Substance Abuse and Mental Health Services Administration (SAMHSA) demonstration project.
	Future State: The future state will be developed according to feedback from surveying Vermont mental health providers.
	Summary of Actions Needed: 1. Develop a survey to assess the capabilities, need and / or desire for mental health providers to electronically capture and display the history of a patient's consent status. The survey will also assess mental health providers that are currently constrained by their technology's limitations and identify Certified Electronic Medical Records that offer patients the choice to share all, some, or none of their health information - including information that the patient deems to be sensitive. 2. Disseminate the survey to Vermont mental health providers. 3. Review survey results. 4. Discuss and develop programming and/or projects aimed at addressing survey results.

Prompts	Summary
	5. Discuss and develop programming and/or projects aimed at educating mental health care providers on best practices to secure Part 2 data and documenting up-to-date consent status. 6. Utilize and restructure the Vermont Health Information Exchange internal process after policy options are made.
Interoperability in Assessment Data (Section 4)	
4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem	**Current State:** Within a given facility, designated agency or health care network, mental health providers consistently use their electronic medical records system to capture intake, assessment, and screening information in a structured format and process. Vermont's Health Information Exchange does capture Continuity of Care Documentation and Admission, Discharge, and Transfer data in a structured format and process, however capturing intake, assessment, and screening information is not a current practice. VITL (Vermont Information Technology Leaders) provides HIE services to the State. Those services include data extraction & access to/from providers for continuity of care, and data aggregation for population health and analytics. Currently, no Part 2 data (including mental health data) is part of VITL's scope of work due to technical limitations. However, Vermont & VITL are planning to expand Vermont Health Information Exchange services to include 42 CFR Part 2 data that will cover mental health data exchange and aggregation allowing care coordination collaboration. Vermont's latest IAPD (FFY 2020/2021) includes funding requests for that project.
	Future State: Vermont seeks to improve the architecture of the Health Information Exchange. In the current annual IAPD update submitted to CMS, DVHA is now seeking continued and expanded HITECH funding to support Vermont Medicaid Next Generation (VMNG)-participating providers in exchanging health information, coordinating care, and relying on trusted data sources to support clinical decision making related to priority health areas. This would include enabling authorized providers access to a universal source of a patient's health information, including intake, assessment, and screening information.
	Summary of Actions Needed:

Prompts	Summary
	Design and execute a project aimed at improving the architecture and functionality of the Vermont Health Information Exchange, so that VMNG-participating providers can submit and access health information, coordinate care, and continuously rely on trusted data sources to support clinical decision making.
Electronic Office Visits – Telehealth (Section 5)	
5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care	**Current State:** The mental healthcare system in Vermont is a public-private collaboration between the Department of Mental Health (DMH) and regional Designated Agencies (DA). The Department of Corrections (DOC) is also a key stakeholder. A unified electronic health record or case/care management system between state and private partners has not been established; each entity of the system of care uses proprietary applications to coordinate and manage a client/patient's care. The electronic health record for DMH and DOC has telehealth capability, however, is not in-use as the needs of the clientele do not support its use. DMH and DOC use an independent telehealth service to consult non-psychiatric specialists (internal medicine, neurology, endocrinology, podiatry, etc) and interact with the legal/justice system. Therapeutic and counselling services for individuals in the custody of DMH and DOC are provided on-site. Psychiatric specialists (at DMH, DOC, and DA) also interview and assess their patients on-site. If a patient is to be discharged and referred a DA, coordination and transition is done by telephone. Within a given facility, designated agency or health care network, mental health providers inconsistently use telehealth services to communicate with other health service providers, which may involve simultaneous communication with the patient.
	Future State: The future state will be developed according to feedback from surveying Vermont mental health providers.
	Summary of Actions Needed: 1. Develop a survey to assess the capabilities, need and / or desire for mental health providers to integrate telehealth services into practice and practice standards. 2. Disseminate the survey to Vermont mental health providers. 3. Review survey results.

Prompts	Summary
	4. Discuss and develop programming and / or projects aimed at addressing survey results.
Alerting/Analytics (Section 6)	
6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes (Note: research shows that 50% of patients stop engaging after 6 months of treatment[5])	**Current State:** It is not a consistent practice to use Certified Electronic Health Records to identify patients that are at risk for discontinuing engagement in their treatment or have stopped engaging in treatment. It is not a current practice to use Certified Electronic Health Records to notify care teams of the risk or occurrence of patient disengagement.
	Future State: The future state will be developed according to feedback from surveying Vermont health care providers.
	Summary of Actions Needed: 1. Develop a survey to assess the need and / or desire for using Certified Electronic Health Records to identify patients that are at risk for discontinuing engagement in their treatment or have stopped engaging in treatment, and the desire / need to notify care teams of the risk or occurrence of patient disengagement. 2. Disseminate the survey to Vermont mental health providers. 3. Review survey results. 4. Discuss and develop programming and / or projects aimed at addressing survey results.
6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis	**Current State:** It is not current practice nor are there projects in progress devoted to coordinating workflow for patients experiencing their first episode of psychosis.
	Future State: The future state will be developed according to feedback from surveying Vermont health care providers.
	Summary of Actions Needed: 1. Develop a survey to assess the need and / or desire for developing a standard process to coordinate workflow for patients experiencing their first episode of psychosis in Certified Electronic Health Records. 2. Disseminate the survey to Vermont mental health providers.

[5] Interdepartmental Serious Mental Illness Coordinating Committee. (2017). *The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers*. Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf

Prompts	Summary
	3. Review survey results. 4. Discuss and develop programming and / or projects aimed at addressing survey results.
Identity Management (Section 7)	
7.1 As appropriate and needed, the care team has the ability to tag or link a child's electronic medical records with their respective parent/caretaker medical records	**Current State:** It is not current practice to link a child's electronic medical records with their respective parent/caretaker's medical records.
	Future State: The future state will be developed according to feedback from surveying Vermont mental health providers.
	Summary of Actions Needed: *1.* Develop a survey to assess the need and / or desire for linking a child's electronic medical records with their respective parent/caretaker's medical records. *2.* Disseminate the survey to Vermont mental health providers. *3.* Review survey results *4.* Discuss and develop programming and / or projects aimed at addressing survey results.
7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient	**Current State:** All participating SMI IMD facilities maintain electronic records that capture all episodes of care at their facilities and are linked to the correct patient.
	Future State: Maintain current EMR functionality.
	Summary of Actions Needed: None.

Section 3: Relevant documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan. This information is not meant as a substitute for the information provided in response to the prompts outlined in Section 2. Instead, material submitted as attachments should support those responses.

Attachment B
Mental Health Services Availability Assessment

State Name	Vermont
Date of Assessment	7/12/2019
Time Period Reflected in Assessment	FY19

Geographic Distribution	**Beneficiaries**							
	Adult			**Under 21**			**Total**	
Geographic designation	Number of Medicaid beneficiaries (Adult)	Number of Medicaid beneficiaries with SMI (Adult)	Percent with SMI (Adult)	Number of Medicaid beneficiaries (Under 21)	Number of Medicaid beneficiaries with SED (Under 21)	Percent with SED (Under 21)	Number of Medicaid beneficiaries (Total)	Number of Medicaid beneficiaries with SMI or SED (Total)
1. ADDISON	3969	99	2%	3969	992	25%	7938	1091
2. BENNINGTON	6099	94	2%	6099	1390	23%	12198	1484
3. CALEDONIA	5093	67	1%	5093	1152	23%	10186	1219
4. CHITTENDEN	16891	439	3%	16891	3783	22%	33782	4222
5. ESSEX	1173	16	1%	1173	200	17%	2346	216
6. FRANKLIN	6884	145	2%	6884	1838	27%	13768	1983
7. GRAND ISLE	953	5	1%	953	208	22%	1906	213
8. LAMOILLE	3454	92	3%	3454	829	24%	6908	921
9. ORANGE	3971	100	3%	3971	1015	26%	7942	1115
10. ORLEANS	5445	87	2%	5445	1107	20%	10890	1194
11. RUTLAND	9756	177	2%	9756	1928	20%	19512	2105
12. WASHINGTON	7595	248	3%	7595	1825	24%	15190	2073
13. WINDHAM	6507	72	1%	6507	1343	21%	13014	1415
14 WINDSOR	8659	199	2%	8659	1886	22%	17318	2085
Total	**86449**	**1840**	**2%**	**86449**	**19496**	**23%**	**172898**	**21336**

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution

	Geographic designation	Percent with SMI or SED (Total)	Beneficiary Category Notes
1.	ADDISON	14%	
2.	BENNINGTON	12%	
3.	CALEDONIA	12%	
4.	CHITTENDEN	12%	
5.	ESSEX	9%	
6.	FRANKLIN	14%	
7.	GRAND ISLE	11%	
8.	LAMOILLE	13%	
9.	ORANGE	14%	
10.	ORLEANS	11%	
11.	RUTLAND	11%	
12.	WASHINGTON	14%	
13.	WINDHAM	11%	
14	WINDSOR	12%	
	Total	**12%**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution	Providers						
	Psychiatrists or Other Practitioners Who Are Authorized to Prescribe						
Geographic designation	Number of Psychiatrists or Other Practitioners Who Are Authorized to Prescribe	Number of Medicaid-Enrolled Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Accepting New Medicaid Patients	Number of Medicaid-Enrolled Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Accepting New Medicaid Patients	Ratio of Medicaid-Enrolled Psychiatrists or Other Prescribers to Medicaid beneficiaries with SMI/SED	Ratio of Medicaid-Enrolled Psychiatrists or Other Prescribers to Total Psychiatrists or Other Prescribers	Ratio of Medicaid-Enrolled Psychiatrists or Other Prescribers Accepting New Medicaid Patients to Medicaid-Enrolled Psychiatrists or Other Prescribers	Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Category Notes
1. ADDISON	131	128	108	0.12	0.98	0.84	
2. BENNINGTON	166	163	143	0.11	0.98	0.88	
3. CALEDONIA	139	136	125	0.11	0.98	0.92	
4. CHITTENDEN	1228	1204	1055	0.29	0.98	0.88	
5. ESSEX	6	6	6	0.03	1.00	1.00	
6. FRANKLIN	128	125	115	0.06	0.98	0.92	
7. GRAND ISLE	4	4	2	0.02	1.00	0.50	
8. LAMOILLE	78	76	68	0.08	0.97	0.89	
9. ORANGE	87	85	79	0.08	0.98	0.93	
10. ORLEANS	84	82	72	0.07	0.98	0.88	
11. RUTLAND	234	229	213	0.11	0.98	0.93	
12. WASHINGTON	204	200	148	0.10	0.98	0.74	
13. WINDHAM	238	233	214	0.16	0.98	0.92	
14 WINDSOR	160	157	132	0.08	0.98	0.84	
Total	**2887**	**2828**	**2480**	**0.13**	**0.98**	**0.88**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution

Providers

Other Practitioners Authorized to Treat Mental Illness

Geographic designation	Number of Other Types of Practitioners Authorized to Treat Mental Illness	Number of Medicaid-Enrolled Other Types of Practitioners Authorized to Treat Mental Illness	Number of Medicaid-Enrolled Other Types of Practitioners Authorized to Treat Mental Illness Accepting New Medicaid Patients	Ratio of Medicaid-Enrolled Practitioners Authorized to Treat Mental Illness to Medicaid Beneficiaries with SMI/ SED	Ratio of Medicaid-Enrolled Practitioners Authorized to Treat Mental Illness to Total Practitioners Authorized to Treat Mental Illness	Ratio of Medicaid-Enrolled Practitioners Authorized to Treat Mental Illness Accepting New Patients to Medicaid-Enrolled Practitioners Authorized to Treat Mental Illness	Other Practitioner Category Notes
1. ADDISON	206	202	180	0.19	0.98	0.89	
2. BENNINGTON	262	257	229	0.17	0.98	0.89	
3. CALEDONIA	214	210	193	0.17	0.98	0.92	
4. CHITTENDEN	1,879	1842	1665	0.44	0.98	0.90	
5. ESSEX	8	8	8	0.04	1.00	1.00	
6. FRANKLIN	238	233	222	0.12	0.98	0.95	
7. GRAND ISLE	5	5	3	0.02	1.00	0.60	
8. LAMOILLE	155	152	138	0.17	0.98	0.91	
9. ORANGE	156	153	144	0.14	0.98	0.94	
10. ORLEANS	142	139	128	0.12	0.98	0.92	
11. RUTLAND	337	330	310	0.16	0.98	0.94	
12. WASHINGTON	430	422	359	0.20	0.98	0.85	
13. WINDHAM	447	438	408	0.31	0.98	0.93	
14 WINDSOR	298	292	257	0.14	0.98	0.88	
Total	**4777**	**4683**	**4244**	**0.22**	**0.98**	**0.91**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution

Community Mental Health Centers

	Geographic designation	Number of CMHCs	Number of Medicaid-Enrolled CMHCs	Number of Medicaid-Enrolled CMHCs Accepting New Medicaid Patients	Ratio of Medicaid-Enrolled CMHCs to Medicaid Beneficiaries with SMI/SED	Ratio of Medicaid-Enrolled CMHCs to Total CMHCs	Ratio of Medicaid-Enrolled CMHCs Accepting New Patients to Medicaid-Enrolled CMHCs	CMHC Category Notes
1.	ADDISON	3	3	3	0.00	1	1	
2.	BENNINGTON	3	3	3	0.00	1	1	
3.	CALEDONIA	3	3	3	0.00	1	1	
4.	CHITTENDEN	3	3	3	0.00	1	1	
5.	ESSEX	3	3	3	0.01	1	1	
6.	FRANKLIN	3	3	3	0.00	1	1	
7.	GRAND ISLE	3	3	3	0.01	1	1	
8.	LAMOILLE	3	3	3	0.00	1	1	
9.	ORANGE	3	3	3	0.00	1	1	
10.	ORLEANS	3	3	3	0.00	1	1	
11.	RUTLAND	3	3	3	0.00	1	1	
12.	WASHINGTON	3	3	3	0.00	1	1	
13.	WINDHAM	3	3	3	0.00	1	1	
14	WINDSOR	3	3	3	0.00	1	1	
	Total	**42**	**42**	**42**	**0.00**	**1**	**1**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

* There are a total of 10 CMHCs located in the various counties across the state, and two statewide CMHCs.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution	Intensive Outpatient or Partial Hospitalization Providers						
Geographic designation	Number of Intensive Outpatient/Partial Hospitalization Providers	Number of Medicaid-Enrolled Intensive Outpatient/Partial Hospitalization Providers	Number of Medicaid-Enrolled Intensive Outpatient/Partial Hospitalization Providers Accepting New Medicaid Patients	Ratio of Medicaid-Enrolled Intensive Outpatient/Partial Hospitalization Providers to Medicaid Beneficiaries with SMI/SED	Ratio of Medicaid-Enrolled Intensive Outpatient/Partial Hospitalization Providers to Total Partial Hospitalization/Day Treatment Providers	Ratio of Medicaid-Enrolled Intensive Outpatient/Partial Hospitalization Providers Accepting New Medicaid Patients to Medicaid-Enrolled Partial Hospitalization/Day Treatment Providers	Intensive Outpatient/Partial Hospitalization Category Notes
1. ADDISON				0	-	-	
2. BENNINGTON				0	-	-	
3. CALEDONIA				0	-	-	
4. CHITTENDEN	2	2	2	0.00	1	1	
5. ESSEX				0	-	-	
6. FRANKLIN				0	-	-	
7. GRAND ISLE				0	-	-	
8. LAMOILLE				0	-	-	
9. ORANGE				0	-	-	
10. ORLEANS				0	-	-	
11. RUTLAND				0	-	-	
12. WASHINGTON				0	-	-	
13. WINDHAM	1	1	1	0.00	1	1	
14 WINDSOR				0	-	-	
Total	**3**	**3**	**3**	**0.000140607**	**1**	**1**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution

Residential Mental Health Treatment Facilities

Residential Mental Health Treatment Facilities (Adult)

	Geographic designation	Number of Residential Treatment Facilities (Adult)	Number of Medicaid-Enrolled Residential Treatment Facilities (Adult)	Number of Medicaid-Enrolled Residential Treatment Facilities Accepting New Medicaid Patients (Adult)	Ratio of Medicaid-Enrolled Residential Treatment Facilities (Adult) to Medicaid Beneficiaries with SMI (Adult)	Ratio of Medicaid-Enrolled Residential Treatment Facilities (Adult) to Total Residential Treatment Facilities (Adult)	Ratio of Number of Medicaid-Enrolled Residential Treatment Facilities (Adult) Accepting New Patients to Medicaid-Enrolled Residential Treatment Facilities (Adult)
1.	ADDISON				0	-	-
2.	BENNINGTON				0	-	-
3.	CALEDONIA				0	-	-
4.	CHITTENDEN	2	2	2	0.00	1	1
5.	ESSEX				0.00	-	-
6.	FRANKLIN				0.00	-	-
7.	GRAND ISLE				0.00	-	-
8.	LAMOILLE				0.00	-	-
9.	ORANGE	1	1	1	0.01	1	1
10.	ORLEANS				0.00	-	-
11.	RUTLAND	1	1	1	0.01	1	1
12.	WASHINGTON	1	1	1	0.00	1	1
13.	WINDHAM	2	2	2	0.03	1	1
14	WINDSOR				0.00	-	-
	Total	**7**	**7**	**7**	**0.00**	**1**	**1**

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution

Residential Mental Health Treatment Facilities

Residential Mental Health Treatment Facilities (Adult)

	Geographic designation	Total Number of Residential Treatment Facility Beds (Adult)	Total Number of Medicaid-Enrolled Residential Treatment Beds (Adult)	Total Number of Medicaid-Enrolled Residential Treatment Beds Accepting New Adult Medicaid Patients	Number of Residential Treatment Facilities (Adult) that Qualify as IMDs	Number of Medicaid-Enrolled Residential Treatment Facilities (Adult) that Qualify as IMDs	Number of Medicaid-Enrolled Residential Treatment Facilities (Adult) that Qualify as IMDs Accepting Medicaid Patients
1.	ADDISON				0	0	0
2.	BENNINGTON				0	0	0
3.	CALEDONIA				0	0	0
4.	CHITTENDEN	13	13	13	0	0	0
5.	ESSEX				0	0	0
6.	FRANKLIN				0	0	0
7.	GRAND ISLE				0	0	0
8.	LAMOILLE				0	0	0
9.	ORANGE	16	16	16	0	0	0
10.	ORLEANS				0	0	0
11.	RUTLAND	4	4	4	0	0	0
12.	WASHINGTON	7	7	7	0	0	0
13.	WINDHAM	14	14	14	0	0	0
14	WINDSOR				0	0	0
	Total	**54**	**54**	**54**	**0**	**0**	**0**

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution

Residential Mental Health Treatment Facilities

Residential Mental Health Treatment Facilities (Adult)

	Geographic designation	Ratio of Medicaid-Enrolled Residential Treatment Beds to Medicaid Beneficiaries with SMI (Adult)	Ratio of Medicaid-Enrolled Residential Treatment Beds to Total Residential Treatment Beds	Ratio of Medicaid-Enrolled Residential Treatment Beds Accepting New Medicaid Patients to Medicaid-Enrolled Residential Treatment Beds	Ratio of Medicaid-Enrolled Residential Treatment Facilities that Qualify as IMDs to Medicaid Beneficiaries with SMI (Adult)	Ratio of Medicaid-Enrolled Residential Treatment Facilities (Adult) that Qualify as IMDs to Total Residential Treatment Facilities (Adult) that Qualify as IMDs	Ratio of Medicaid-Enrolled Residential Treatment Facilities (Adult) that Qualify as IMDs Accepting Medicaid Patients to Medicaid-Enrolled Residential Treatment Facilities (Adult) that Qualify as IMDs	Residential Treatment Facility Category Notes (Adult)
1.	ADDISON	0.00	-	-	0	-	-	
2.	BENNINGTON	0.00	-	-	0	-	-	
3.	CALEDONIA	0.00	-	-	0	-	-	
4.	CHITTENDEN	0.03	1	1	0	-	-	
5.	ESSEX	0.00	-	-	0	-	-	
6.	FRANKLIN	0.00	-	-	0	-	-	
7.	GRAND ISLE	0.00	-	-	0	-	-	
8.	LAMOILLE	0.00	-	-	0	-	-	
9.	ORANGE	0.16	1	1	0	-	-	
10.	ORLEANS	0.00	-	-	0	-	-	
11.	RUTLAND	0.02	1	1	0	-	-	
12.	WASHINGTON	0.03	1	1	0	-	-	
13.	WINDHAM	0.19	1	1	0	-	-	
14	WINDSOR	0.00	-	-	0	-	-	
Total		**0.03**	**1**	**1**	**0**	**-**	**-**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution

Residential Mental Health Treatment Facilities

Psychiatric Residential Treatment Facilities

Geographic designation	Number of Psychiatric Residential Treatment Facilities (PRTF) (Under 21)	Number of Medicaid-Enrolled PRTFs	Number of Medicaid-Enrolled PRTFs Accepting New Medicaid Patients	Ratio of Medicaid-Enrolled PTRFs to Medicaid Beneficiaries with SED (Under 21)	Ratio of Medicaid-Enrolled PRTFs to Total PTRFs	Ratio of Medicaid-Enrolled PRTFs Accepting New Medicaid Patients to Number of Medicaid-Enrolled PRTFs
1. ADDISON				0	-	-
2. BENNINGTON				0	-	-
3. CALEDONIA				0	-	-
4. CHITTENDEN				0	-	-
5. ESSEX				0	-	-
6. FRANKLIN				0	-	-
7. GRAND ISLE				0	-	-
8. LAMOILLE				0	-	-
9. ORANGE				0	-	-
10. ORLEANS				0	-	-
11. RUTLAND				0	-	-
12. WASHINGTON				0	-	-
13. WINDHAM				0	-	-
14 WINDSOR				0	-	-
Total	**0**	**0**	**0**	**0**	**-**	**-**

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution

Residential Mental Health Treatment Facilities

Psychiatric Residential Treatment Facilities

	Geographic designation	Total Number of PRTF Beds	Number of Medicaid-Enrolled PRTF Beds	Number of Medicaid-Enrolled PRTF Beds Accepting New Medicaid Patients	Ratio of Medicaid-Enrolled PRTF Beds to Medicaid Beneficiaries with SED	Ratio of Medicaid-Enrolled PRTFs Accepting New Medicaid Patients to Total Number of PRTFs	Ratio of Medicaid-Enrolled PRTFs Accepting New Medicaid Patients to Number of Medicaid-Enrolled PRTFs	Psychiatric Residential Treatment Facility (Under 21) Category Notes
1.	ADDISON				0	-	-	
2.	BENNINGTON				0	-	-	
3.	CALEDONIA				0	-	-	
4.	CHITTENDEN				0	-	-	
5.	ESSEX				0	-	-	
6.	FRANKLIN				0	-	-	
7.	GRAND ISLE				0	-	-	
8.	LAMOILLE				0	-	-	
9.	ORANGE				0	-	-	
10.	ORLEANS				0	-	-	
11.	RUTLAND				0	-	-	
12.	WASHINGTON				0	-	-	
13.	WINDHAM				0	-	-	
14	WINDSOR				0	-	-	
	Total	**0**	**0**	**0**	**0**	**-**	**-**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution	Inpatient					
	Psychiatric Hospitals					
Geographic designation	Number of Public Psychiatric Hospitals	Number of Private Psychiatric Hospitals	Number of Medicaid-Enrolled Public Psychiatric Hospitals	Number of Medicaid-Enrolled Private Psychiatric Hospitals	Medicaid-Enrolled Public Psychiatric Hospitals Accepting New Medicaid Patients	Medicaid Enrolled Private Psychiatric Hospitals Accepting New Medicaid Patients
1. ADDISON						
2. BENNINGTON						
3. CALEDONIA						
4. CHITTENDEN		1		1		1
5. ESSEX						
6. FRANKLIN						
7. GRAND ISLE						
8. LAMOILLE						
9. ORANGE						
10. ORLEANS						
11. RUTLAND		1		1		1
12. WASHINGTON	1	1	1	1	1	1
13. WINDHAM		2		2		2
14 WINDSOR						
Total	**1**	**5**	**1**	**5**	**1**	**5**

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution

Inpatient

Psychiatric Hospitals

Geographic designation	Ratio of Medicaid-Enrolled Public Psychiatric Hospitals to Medicaid Beneficiaries with SMI/SED	Ratio of Medicaid-Enrolled Private Psychiatric Hospitals to Medicaid Beneficiaries with SMI/SED	Ratio of Medicaid-Enrolled Public Psychiatric Hospitals to Public Psychiatric Hospitals	Ratio of Medicaid-Enrolled Private Psychiatric Hospitals to Private Psychiatric Hospitals	Ratio of Medicaid-Enrolled Public Psychiatric Hospitals Accepting New Medicaid Patients to Medicaid-Enrolled Public Psychiatric Hospitals	Ratio of Medicaid-Enrolled Private Psychiatric Hospitals Accepting New Medicaid Patients to Medicaid-Enrolled Private Psychiatric Hospitals	Psychiatric Hospital Category Notes
1. ADDISON	0	0	-	-	-	-	
2. BENNINGTON	0	0	-	-	-	-	
3. CALEDONIA	0	0	-	-	-	-	
4. CHITTENDEN	0	0.000236855	-	1	-	1	
5. ESSEX	0	0	-	-	-	-	
6. FRANKLIN	0	0	-	-	-	-	
7. GRAND ISLE	0	0	-	-	-	-	
8. LAMOILLE	0	0	-	-	-	-	
9. ORANGE	0	0	-	-	-	-	
10. ORLEANS	0	0	-	-	-	-	
11. RUTLAND	0	0.000475059	-	1	-	1	
12. WASHINGTON	0.000482393	0.000482393	1	1	1	1	
13. WINDHAM	0	0.001413428	-	1	-	1	
14 WINDSOR	0	0	-	-	-	-	
Total	**4.68691E-05**	**0.000234346**	**1**	**1**	**1**	**1**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution	Inpatient					
	Psychiatric Hospitals That Qualify As IMDs					
Geographic designation	Number of Public Psychiatric Hospitals that qualify as IMDs	Number of Private Psychiatric Hospitals that qualify as IMDs	Number of Medicaid-Enrolled Public Psychiatric Hospitals that qualify as IMDs	Number of Medicaid-Enrolled Private Psychiatric Hospitals that qualify as IMDs	Number of Medicaid-Enrolled Public Psychiatric Hospitals that qualify as IMDs Accepting New Medicaid Patients	Number of Medicaid-Enrolled Private Psychiatric Hospitals that qualify as IMDs Accepting New Medicaid Patients
1. ADDISON						
2. BENNINGTON						
3. CALEDONIA						
4. CHITTENDEN						
5. ESSEX						
6. FRANKLIN						
7. GRAND ISLE						
8. LAMOILLE						
9. ORANGE						
10. ORLEANS						
11. RUTLAND						
12. WASHINGTON	1		1		1	
13. WINDHAM		1		1		1
14 WINDSOR						
Total	**1**	**1**	**1**	**1**	**1**	**1**

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution	Inpatient						
	Psychiatric Hospitals That Qualify As IMDs						
Geographic designation	Ratio of Medicaid-Enrolled Public Psychiatric Hospitals that qualify as IMDs to Medicaid Beneficiaries with SMI/SED	Ratio of Medicaid-Enrolled Private Psychiatric Hospitals that qualify as IMDs to Medicaid Beneficiaries with SMI/SED	Ratio of Medicaid-Enrolled Public Psychiatric Hospitals that qualify as IMDs to Public Psychiatric Hospitals that qualify as IMDs	Ratio of Medicaid-Enrolled Private Psychiatric Hospitals that qualify as IMDs to Private Psychiatric Hospitals that qualify as IMDs	Ratio of Medicaid-Enrolled Public Psychiatric Hospitals that qualify as IMDs Accepting New Medicaid Patients to Medicaid-Enrolled Public Psychiatric Hospitals that qualify as IMDs	Ratio of Medicaid-Enrolled Private Psychiatric Hospitals that qualify as IMDs Accepting New Medicaid Patients to Medicaid-Enrolled Private Psychiatric Hospitals that qualify as IMDs	Psychiatric Hospitals That Qualify As IMDs Category Notes
1. ADDISON	0	0	-	-	-	-	
2. BENNINGTON	0	0	-	-	-	-	
3. CALEDONIA	0	0	-	-	-	-	
4. CHITTENDEN	0	0	-	-	-	-	
5. ESSEX	0	0	-	-	-	-	
6. FRANKLIN	0	0	-	-	-	-	
7. GRAND ISLE	0	0	-	-	-	-	
8. LAMOILLE	0	0	-	-	-	-	
9. ORANGE	0	0	-	-	-	-	
10. ORLEANS	0	0	-	-	-	-	
11. RUTLAND	0	0	-	-	-	-	
12. WASHINGTON	0.000482393	0	1	-	1	-	
13. WINDHAM	0	0.000706714	-	1	-	1	
14 WINDSOR	0	0	-	-	-	-	
Total	**4.68691E-05**	**4.68691E-05**	**1**	**1**	**1**	**1**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution	Inpatient					
	Psychiatric Units					
Geographic designation	Number of Psychiatric Units in Acute Care Hospitals	Number of Psychiatric Units in Critical Access Hospitals (CAHs)	Number of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals	Number of Medicaid-Enrolled Psychiatric Units in CAHs	Number of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals Accepting New Medicaid Patients	Number of Medicaid-Enrolled Psychiatric Units in CAHs Accepting New Medicaid Patients
1. ADDISON						
2. BENNINGTON						
3. CALEDONIA						
4. CHITTENDEN	2		2		2	
5. ESSEX						
6. FRANKLIN						
7. GRAND ISLE						
8. LAMOILLE						
9. ORANGE						
10. ORLEANS						
11. RUTLAND	2		2		2	
12. WASHINGTON	1		1		1	
13. WINDHAM		1		1		1
14 WINDSOR	1		1		1	
Total	**6**	**1**	**6**	**1**	**6**	**1**

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution	Inpatient						
	Psychiatric Units						
Geographic designation	Ratio of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals to Medicaid Beneficiaries with SMI/SED	Ratio of Medicaid-Enrolled Psychiatric Units in CAHs to Medicaid Beneficiaries with SMI/SED	Ratio of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals to Psychiatric Units in Acute Care Hospitals	Ratio of Medicaid-Enrolled Psychiatric Units in CAHs to Psychiatric Units in Critical Access Hospitals	Ratio of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals Accepting New Medicaid Patients to Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals	Ratio of Medicaid-Enrolled Psychiatric Units in CAHs Accepting New Medicaid Patients to Medicaid-Enrolled Psychiatric Units in Critical Access Hospitals	Psychiatric Unit Category Notes
1. ADDISON	0	0	-	-	-	-	
2. BENNINGTON	0	0	-	-	-	-	
3. CALEDONIA	0	0	-	-	-	-	
4. CHITTENDEN	0.000473709	0	1	-	1	-	
5. ESSEX	0	0	-	-	-	-	
6. FRANKLIN	0	0	-	-	-	-	
7. GRAND ISLE	0	0	-	-	-	-	
8. LAMOILLE	0	0	-	-	-	-	
9. ORANGE	0	0	-	-	-	-	
10. ORLEANS	0	0	-	-	-	-	
11. RUTLAND	0.000950119	0	1	-	1	-	
12. WASHINGTON	0.000482393	0	1	-	1	-	
13. WINDHAM	0	0.000706714	-	1	-	1	
14 WINDSOR	0.000479616	0	1	-	1	-	
Total	**0.000281215**	**4.68691E-05**	**1**	**1**	**1**	**1**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution	Inpatient						
	Psychiatric Beds						
Geographic designation	Number of Licensed Psychiatric Hospital Beds (Psychiatric Hospital + Psychiatric Units)	Number of Medicaid-Enrolled Licensed Psychiatric Hospital Beds (Psychiatric Hospital + Psychiatric Units)	Number of Medicaid-Enrolled Licensed Psychiatric Hospital Beds Accepting New Medicaid Patients	Ratio of Medicaid-Enrolled Licensed Psychiatric Hospital Beds to Medicaid Beneficiaries with SMI/SED	Ratio of Medicaid-Enrolled Licensed Psychiatric Hospital Beds to Licensed Psychiatric Hospital Beds	Ratio of Medicaid-Enrolled Licensed Psychiatric Hospital Beds Accepting New Medicaid Patients to Medicaid-Enrolled Licensed Psychiatric Hospital Beds	Psychiatric Beds Category Notes
1. ADDISON				-	-	-	
2. BENNINGTON				-	-	-	
3. CALEDONIA				-	-	-	
4. CHITTENDEN	28	28	28	-	1	1	
5. ESSEX				-	-	-	
6. FRANKLIN				-	-	-	
7. GRAND ISLE				-	-	-	
8. LAMOILLE				-	-	-	
9. ORANGE				-	-	-	
10. ORLEANS				-	-	-	
11. RUTLAND	23	23	23	-	1	1	
12. WASHINGTON	39	39	39	39	1	1	
13. WINDHAM	129	129	129	-	1	1	
14 WINDSOR	10	10	10	-	1	1	
Total	**229**	**229**	**229**	**229**	**1**	**1**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution	Crisis Stabilization Services						
Geographic designation	Number of Crisis Call Centers	Number of Mobile Crisis Units	Number of Crisis Observation/ Assessment Centers	Number of Coordinated Community Crisis Response Teams	Ratio of Crisis Call Centers to Medicaid Beneficiaries with SMI/SED	Ratio of Mobile Crisis Units to Medicaid Beneficiaries with SMI/SED	Ratio of Crisis Observation/ Assessment Centers to Medicaid Beneficiaries with SMI/SED
1. ADDISON	3	1	1		0.002749771	0.00091659	0.00091659
2. BENNINGTON	3	1	1		0.002021563	0.000673854	0.000673854
3. CALEDONIA	3	1	1		0.002461034	0.000820345	0.000820345
4. CHITTENDEN	3	1	1	1	0.000710564	0.000236855	0.000236855
5. ESSEX	3	1	1		0.013888889	0.00462963	0.00462963
6. FRANKLIN	3	1	1		0.001512859	0.000504286	0.000504286
7. GRAND ISLE	3	1	1		0.014084507	0.004694836	0.004694836
8. LAMOILLE	3	1	1		0.003257329	0.001085776	0.001085776
9. ORANGE	3	1	1		0.002690583	0.000896861	0.000896861
10. ORLEANS	3	1	1		0.002512563	0.000837521	0.000837521
11. RUTLAND	3	1	1		0.001425178	0.000475059	0.000475059
12. WASHINGTON	3	1	1		0.001447178	0.000482393	0.000482393
13. WINDHAM	3	1	1		0.002120141	0.000706714	0.000706714
14 WINDSOR	3	1	2		0.001438849	0.000479616	0.000959233
Total	**42**	**14**	**15**	**1**	**0.001968504**	**0.000656168**	**0.000703037**

* There are a total of 10 CMHCs located in the various counties across the state, and two statewide CMHCs.

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution

	Geographic designation	Ratio of Coordinated Community Crisis Response Teams to Medicaid Beneficiaries with SMI/SED	Crisis Stabilization Services Category Notes
1.	ADDISON	0	
2.	BENNINGTON	0	
3.	CALEDONIA	0	
4.	CHITTENDEN	0.000236855	
5.	ESSEX	0	
6.	FRANKLIN	0	
7.	GRAND ISLE	0	
8.	LAMOILLE	0	
9.	ORANGE	0	
10.	ORLEANS	0	
11.	RUTLAND	0	
12.	WASHINGTON	0	
13.	WINDHAM	0	
14	WINDSOR	0	
	Total	**4.68691E-05**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution	Federally Qualified Health Centers		
Geographic designation	Number FQHCs that Offer Behavioral Health Services	Ratio of FQHCs that Offer Behavioral Health Services to Medicaid Beneficiaries with SMI/SED	FQHC Category Notes
1. ADDISON	2	0.001833181	
2. BENNINGTON	1	0.000673854	
3. CALEDONIA	3	0.002461034	
4. CHITTENDEN	1	0.000236855	
5. ESSEX	3	0.013888889	
6. FRANKLIN	6	0.003025719	
7. GRAND ISLE	1	0.004694836	
8. LAMOILLE	4	0.004343105	
9. ORANGE	4	0.003587444	
10. ORLEANS			
11. RUTLAND	6	0.002850356	
12. WASHINGTON	2	0.000964785	
13. WINDHAM	1	0.000706714	
14 WINDSOR	13	0.006235012	
Total	**47**	**0.00220285**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

State of Vermont
Agency of Human Services
Office of the Secretary
280 State Drive
Waterbury, VT 05671-1000
www.humanservices.vermont.gov

Al Gobeille, Secretary

[phone] 802-241-0440
[fax] 802-241-0450

January 29, 2018

Brian Neale, Director
Children and Adults Health Programs Group
Center for Medicaid and CHIP Services
7500 Security Blvd
Baltimore, MD 21244

Director Neale:

In my capacity as Secretary of Vermont's Agency of Human Services, I am submitting to the Centers for Medicare and Medicaid Services (CMS) a request to amend Vermont's Section 1115 Global Commitment to Health Demonstration (11-W-00194/1).

Vermont and CMS have been meaningful and effective partners in health care reform for many years. Vermont's Global Commitment to Health 1115 demonstration and the Vermont All-Payer Model Agreement are examples of how the federal government and a state can design a program that furthers federal goals while being customized for the strengths and needs of an individual state. Vermont credits much of the success of its approach to fighting the opioid epidemic to the flexibilities granted under the Global Commitment to Health Demonstration and the strong federal-state partnership at its foundation. Vermont's innovative framework to address opioid use disorder has garnered national attention for the effectiveness of its comprehensive approach to providing Medication Assisted Treatment.

However, there is more work needed to create a sustainable system for providing care for those with substance use disorders. Vermont continues to experience deaths due to overdoses and, despite increased capacity, the health and human service systems in most regions are still unable to meet demand for assistance with mental health and health-related social needs that frequently co-occur with substance use disorders. Many people with opioid use disorder are switching from prescription opioids, which have become less readily available, to heroin. The State has seen a dramatic increase in Vermonters who use and are addicted to heroin, as demonstrated by the more than 350% increase in number of people seeking treatment for primary heroin addiction between state fiscal years 2011 and 2015.

To maintain and further build on the success of Vermont's innovative approach to fighting the opioid epidemic, and to promote our mutual goals of the All-Payer Model Agreement, long-term federal flexibility is needed. This amendment request seeks to ensure the continued availability of treatment supports that effectively prevent and treat opioid use disorder and other substance use disorders, and to promote a comprehensive and integrated continuum of mental and physical health, substance use disorder treatment, and long-term services and supports for all Vermonters.

Thank you for your consideration of this amendment request. We appreciate your continued partnership on our 1115 Demonstration as we work to advance our shared goals for health care reform.

Sincerely,

Al Gobeille
Secretary

CC: Cory Gustafson, DVHA
Ashley Berliner, DVHA
Richard McGreal, CMS
Gilson DaSilva, CMS
Michael Costa, DVHA
Sarah Clark, AHS
Tracy O'Connell, AHS

Global Commitment to Health

11-W-00194/1

Section 1115(a)

Demonstration Amendment Request to CMS

(1/1/2017 – 12/31/2021)

Submitted 1/29/2018

Table of Contents

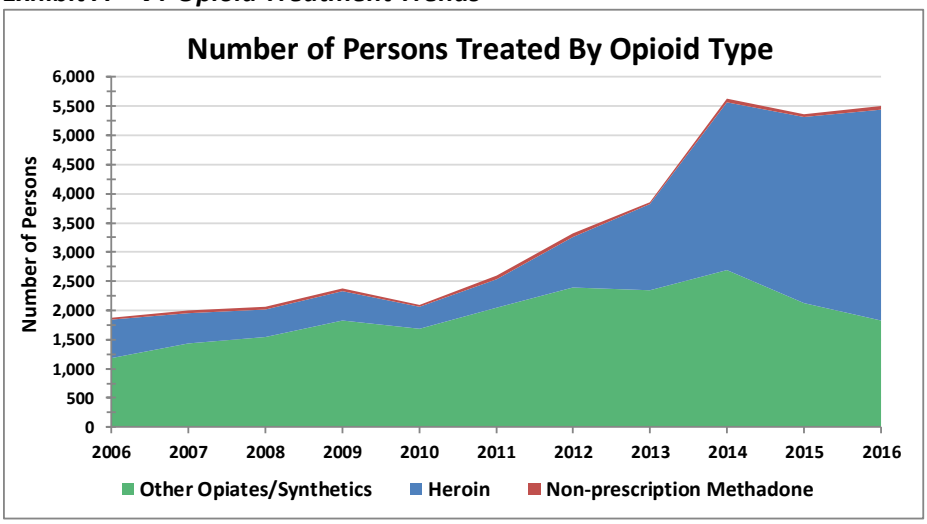
I. Introduction

The State of Vermont and federal government have been meaningful and effective partners in health care reform for many years. The Centers for Medicare and Medicaid Services has provided Vermont with flexibility and tools to improve the delivery of health care in Vermont and improve the health and lives of Vermonters. Specifically, Vermont's Global Commitment to Health 1115 demonstration and the Vermont All-Payer Model Agreement (APM) are examples of how the federal government and a state can design a program that furthers federal goals while being customized for the strengths and needs of an individual state. The APM Agreement and Global Commitment Demonstration are complementary frameworks that support Vermont's health care reform efforts. Each agreement provides federal support to further Vermont's strategic goal of creating an integrated health care system, including increased alignment across payers and providers.

Vermont credits much of the success of its approach to fighting the opioid epidemic to the flexibilities granted under the Global Commitment to Health Demonstration and the strong federal-state partnership at its foundation. Vermont's innovative framework to address opioid use disorder has garnered national attention for the effectiveness of its comprehensive approach to providing Medication Assisted Treatment (MAT). This framework integrates programs providing higher levels of care with programs offering treatment in general medical settings. 2016 data shows, when comparing Vermonters with opioid use disorders (OUDs) receiving MAT (MAT group) against a group receiving one or more inpatient visits, one or more outpatient emergency department visits, or two or more non-hospital outpatient visits with a diagnosis for opioid use disorder but who did not receive MAT (non-MAT group), the MAT group had lower expenditures excluding treatment, lower inpatient hospitalizations, lower inpatient days, lower outpatient emergency department use, and higher primary care visits than the non-MAT group. Richard Baum, the White House "drug czar" (Acting Director of the Office of National Drug Control Policy) visited Vermont in July, 2017 to learn more about Vermont's unique approach to this epidemic. In a press conference at the end of his visit, Mr. Baum said "What Vermont has accomplished by establishing a unique hub and spoke system for responding to the opioid crisis is an incredibly valuable national model."

However, there is more work needed to create a sustainable system for providing care for those with substance use disorders (SUDs). Vermont continues to experience deaths due to overdoses and, despite increased capacity, the health and human service systems in most regions are still unable to meet demand for assistance with mental health and health-related social needs that frequently co-occur with substance use disorders. Many people with opioid use disorder are switching from prescription opioids, which have become less readily available, to heroin. The dangers associated with using heroin, especially if heroin is adulterated with fentanyl, are evident in the alarming rate of overdose deaths in Vermont. In Vermont, drug-related fatalities were 37% higher in 2016 than those recorded in 2015. Of the 148 drug-related fatalities recorded in Vermont for 2016, 112 were opioid-related (Vermont Department of Health, 2017). The State has seen a dramatic increase in Vermonters who use and are addicted to heroin, as demonstrated by the more than 350% increase in number of people seeking treatment for primary heroin addiction between state fiscal years 2011 and 2015.

Exhibit A – VT Opioid Treatment Trends



To maintain and further build on the success of Vermont's innovative approach to fighting the opioid epidemic, and to promote our mutual goals of the APM Agreement, long-term federal flexibility is needed. This amendment request seeks to ensure the continued availability of treatment supports that effectively prevent and treat opioid use disorder and other substance use disorders, and promote a comprehensive and integrated continuum of mental and physical health, OUD/SUD treatment, and long-term services and supports for all Vermonters. Specifically, Vermont is seeking a waiver of all restrictions on payments to Institutions for Mental Disease (IMDs) for individuals ages 21 to 64. Without the long-term flexibility sought in this amendment, the State will be obligated to direct limited budget and staff resources to a fragmented and sub-optimal system, rather than use those resources to promote delivery system reform.

II. Description of the Demonstration

Background

The State of Vermont has been a national leader in making affordable health care coverage available to low-income children and adults, and providing innovative system reforms to support enrollee choice and improved outcomes. Vermont was among the first states to expand coverage for children and pregnant women, accomplished in 1989 through the implementation of the state-funded Dr. Dynasaur program, which in 1992 became part of the state-federal Medicaid program.

In 1995, Vermont implemented a Section 1115(a) Demonstration, the Vermont Health Access Plan (VHAP). The primary goal was to expand access to comprehensive health care coverage through enrollment in managed care for uninsured adults with household incomes below 150% (later raised to 185% of the FPL for parents and caretaker relatives with dependent children in the home). While making progress in addressing the coverage needs of the uninsured through Dr. Dynasaur and VHAP, by 2004 it became apparent that Vermont's achievements were being jeopardized by the ever-escalating cost and complexity of the Medicaid program.

In 2005, Vermont worked in partnership with CMS to develop two new 1115 Demonstration programs, Global Commitment to Health and Choices for Care. These two demonstrations enabled the State to preserve and expand the affordable coverage gains made in the prior decade, provide program flexibility

to more effectively deliver and manage public resources, and improve the health care system for all Vermonters. In 2015, the two demonstrations merged under the Global Commitment to Health 1115 waiver.

In October 2016, the All-Payer Model (APM) Agreement between the State and the Federal government was signed by the Governor and the Secretary of Human Services. The agreement includes a target for a sustainable rate of growth for health care spending in Vermont across Medicaid, Medicare, and commercial payers. The APM aims to transform health care for the entire state and its population. Through the model, the most significant payers throughout the state – Medicare, Medicaid, and commercial health care payers –aim to incentivize health care value and quality, with a focus on health outcomes, under the same payment structure for the majority of providers throughout Vermont's care delivery system.

In November 2016, CMS approved a five-year extension of the Global Commitment to Health Demonstration. This extension was written in close partnership with the Centers for Medicaid and Medicare Innovation (CMMI) to ensure alignment with the All-Payer Model Agreement include the authorities needed to make Medicaid a full partner in the Vermont All-Payer Model.

The Global Commitment to Health Demonstration includes the following fundamental elements:

1. ***Program Flexibility***: Vermont has the flexibility to invest in specified alternative services and programs designed to achieve the Demonstration's objectives (including the Marketplace subsidy program).

2. ***Managed Care Delivery System***: Under the Demonstration, the Agency for Human Services (AHS) executes an annual agreement with the Department of Vermont Health Access (DVHA), which delivers services through a managed care-like model, subject to the requirements that would be applicable to a non-risk pre-paid inpatient health plan (PIHP) as defined by the Special Terms and Conditions (STCs).

3. ***Removal of Institutional Bias***: Under the Demonstration, Vermont provides a choice of settings for delivery of services and supports to older adults, people with serious and persistent mental illness, people with physical disabilities, people with developmental disabilities, and people with traumatic brain injuries who meet program eligibility and level of care requirements.

4. ***Delivery System Reform***: Under the Demonstration, Vermont supports systemic delivery reform efforts using the payment flexibility provided through the Demonstration to create alignment across public and private payers.

The State's high-level goal for all health reform is to create an integrated health system able to achieve the Institute of Medicine's "Triple Aim" goals of improving patient experience of care, improving the health of populations, and reducing per-capita cost.[1] This is supported in the Global Commitment to

[1] Crossing the Quality Chasm: A New Health System for the 21st Century. Washington DC: National Academy Press, Institute of Medicine; 2001.

Health Demonstration through innovative delivery system reforms, including Medicaid Accountable Care Organizations (ACO) and the development of progressive in-home and community-based services and supports that are cost-effective and support persons who have long-term care service and support needs, complex medical, mental health and/or substance use disorder treatment needs.

Demonstration Amendment Goals

The overall goal of this amendment request is to maintain and enhance the flexibility and availability of OUD, SUD, and mental health treatment supports under the Global Commitment to Health Demonstration, and to promote a comprehensive and integrated continuum of mental and physical health, OUD/SUD treatment, and long-term services and supports for all Vermonters

Vermont recognizes that a continuum of services and evidence based practice include attention to co-occurring mental health disorders and to the physical health impacts of OUD/SUD for persons seeking treatment and recovery services. Vermont intends to build a fully integrated physical health, mental health, OUD/SUD and recovery support continuum. To support this goal, Vermont seeks continued flexibility federal funding for residential treatment programs, and in how the American Society of Addiction Medicine (ASAM) and other evidence-based criteria are applied to triage plans of care for persons struggling with addictions and co-occurring mental health and physical health conditions. This triage includes identifying the settings best suited to serve those enrollees with OUD/SUD and co-occurring conditions. For example, in some cases immediate access and treatment in a residential setting is the best course of treatment, while for others immediate stabilization of a psychiatric crisis or medically managed withdrawal, in a general hospital or specialized inpatient facility, followed by intensive addiction treatment may be clinically warranted.

Vermont shares the CMS goals for OUD/SUD. The State's current Demonstration and approach are fully aligned to realize these goals, as illustrated in Exhibit B below.

Exhibit B – Shared Demonstration Goals

Global Commitment to Health Goals	OUD/SUD Amendment Goals
To increase access to care	• Increase rates of identification, initiation, and engagement in treatment
	• Improve access to care for physical health conditions among beneficiaries
To improve the quality of care	• Increase adherence to and retention in treatment
	• Reduce overdose deaths, particularly those due to opioids
To contain health care cost	• Reduce utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services
To eliminate institutional bias	• Reduce readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate

Demonstration Amendment Milestones

Vermont has initiated programs or met many of the milestones identified by CMS through innovation under the Medicaid State Plan and the Global Commitment to Health Demonstration, however, the State intends to enhance its efforts to include new initiatives and delivery system reforms. Specifically, new initiatives under development include:

- Implementation of value based purchasing in alignment with the All Payer Model Agreement to support access.
- Development a centralized triage, intake, and call center for persons seeking OUD/SUD services.
- Improvement of discharge planning and transitions between care settings.

A high-level overview of plan milestones is presented in Exhibit C, with detailed descriptions in Section III (Vermont's Approach to Addressing Opioid Abuse) and Section IX (Implementation Plan).

Exhibit C – Overview of Plan Milestones

Overview of VT OUD/SUD Milestones		
CMS Milestone	**CMS Specifications**	**VT Plan**
Access to critical levels of care for OUD and other SUDs	Coverage of: a) outpatient b) intensive outpatient services c) medication assisted treatment (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state) d) intensive levels of care in residential and inpatient settings e) medically supervised withdrawal management	• Seek waiver and expenditure authority to support continued access to highest levels of ASAM care, including medically supervised withdrawal management. • Implement value based payments for residential programs, in alignment with All Payer Model to support access.
Widespread use of evidence-based, SUD-specific patient placement criteria	Implementation of requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, e.g., the ASAM Criteria, or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines	• Milestone achieved; maintain or enhance current requirements with lessons learned. • Enhance with centralized intake and call center.
	Implementation of a utilization management (UM) approach such that: a) beneficiaries have access to SUD services at the appropriate level of care b) interventions are appropriate for the diagnosis and level of care c) there is an independent process for reviewing placement in residential treatment settings	• Milestone achieved; maintain or enhance current UM. requirements with lessons learned • Place Recovery Supports in the ED to facilitate initiation, engagement and access. • Improve discharge planning and transitions between care settings.

Overview of VT OUD/SUD Milestones		
CMS Milestone	**CMS Specifications**	**VT Plan**
Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications	Implementation of residential provider qualifications in licensure requirements, policy manuals, managed care contracts, or other guidance. Qualification should meet program standards in the ASAM Criteria, or other nationally recognized, evidence-based SUD specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings	• Milestone achieved; maintain or enhance current requirements with lessons learned.
	Implementation of state process for reviewing residential treatment providers to assure compliance with these standards	• Milestone achieved; maintain or enhance current requirements with lessons learned.
	Requirement that residential treatment facilities offer MAT on-site or facilitate access off-site	• Milestone achieved; maintain or enhance current requirements with lessons learned.
Sufficient provider capacity at each level of care	Completion of the assessment of availability of providers enrolled in Medicaid and accepting new patients in the critical levels of care throughout the state (or at least in participating regions of the state) including those that offer MAT	• Milestone achieved; maintain or enhance current requirements based on capacity monitoring reports.
Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD	Implementation of opioid prescribing guidelines with other interventions to prevent opioid abuse	• Milestone achieved; maintain or enhance current requirements with lessons learned
	Expanded coverage of, and access to, naloxone for overdose reversal	• Milestone achieved; maintain or enhance current requirements with lessons learned.
	Implementation of strategies to increase utilization and improve functionality, of prescription drug monitoring programs	• Milestone achieved; maintain or enhance current requirements with lessons learned.
Improved care coordination and transitions between levels of care	Implementation of policies to ensure residential and inpatient facilities link beneficiaries, especially those with OUD, with community-based services and supports following stays in these facilities	• Milestone achieved; maintain or enhance current requirements with lessons learned.

III. Vermont's Approach to Addressing Opioid Abuse

Work is well underway to aggressively address the opioid crisis facing Vermont. Under this amendment, Vermont will maintain and enhance a full continuum of addiction treatment based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria, including withdrawal management, inpatient detoxification, short-term and longer-term residential treatment, intensive outpatient treatment, outpatient treatment, partial hospitalization, medication assisted treatment in intensive and office-based settings, and recovery supports across the State.

The following section is broken into six parts to provide a detailed description of Vermont's comprehensive approach to addressing the Opioid crisis, including: (1) efforts and strategies surrounding prevention and treatment of OUD/SUDs, (2) OUD/SUD treatment and recovery continuum of care, (3) alignment with ASAM Level of Care guidelines, (4) use of evidence-based patient placement criteria, (5) monitoring of provider capacity, and (6) planned enhancements under this amendment request.

Efforts and Strategies Surrounding Prevention and Treatment

Through the Medicaid State Plan and the Global Commitment to Health Demonstration, Vermont has developed a continuum of services and supports that provide the foundation to successfully address opioid and other substance use disorders in Vermont.

Vermont's efforts to expand treatment for Vermonters with OUD are broad based and benefit enormously from the commitment of community leaders, partners, and members to support and speak about the importance of this issue. The dedication and commitment of these individuals has resulted in increased treatment capacity in critically needed areas, increased coordination amongst community partners, and focus on treating the factors that contribute to the complexity of OUD.

- Opioid Prescribing Guidelines
  Vermont implemented "Rules Governing the Prescribing of Opioids for Pain" effective July 1st, 2017 (see Opioid Prescribing Rule). This rule provides legal requirements for the appropriate use of opioids in treating pain to minimize opportunities for misuse, abuse, and diversion, and optimize prevention of addiction and overdose and is consistent with CDC guidelines.

- Expanded Coverage of, and Access to, Naloxone for Overdose Reversal
  Vermont began distribution of Naloxone with a pilot in 2013 and has since expanded Statewide. Naloxone is provided free of charge at 27 distribution sites including syringe services programs, substance abuse treatment providers, recovery centers, and medical facilities. Naloxone is available to persons taking opioids, family members, and other community members who may come in contact with people at risk for overdose. In 2016, pursuant to legislation, all Vermont EMS agencies receive naloxone at no charge. Emergency use kits also are offered to individuals being released from a correctional facility who have identified previous opioid use or dependency.

  In August 2016, the Commissioner of Health issued a standing order for naloxone, allowing any pharmacy to dispense the life-saving drug and bill medical insurance, if available. New prescribing rules effective July 1, 2017 require an accompanying naloxone prescription for opioid prescriptions >90 MME, as well as when there are concurrent benzodiazepines prescriptions.

- Implementation of Strategies to Increase Utilization and Improve Functionality of Prescription Drug Monitoring Programs

  The rules implemented July 1, 2017 require that prescribers query the Vermont Prescription Drug Monitoring System prior to the first prescription of an extended release hydrocodone or oxycodone that is not an Abuse-deterrent Opioid; no less frequently than once every 120 days for any patient prescribed 40 mg or greater of hydrocodone or 30 mg or greater of oxycodone per day of an extended release hydrocodone or oxycodone that is not an Abuse-deterrent Opioid as long as the patient possesses a valid prescription for that amount; and no less frequently than as described in the Vermont Prescription Monitoring System rule (see VPMS rule).

  All prescribers and pharmacist dispensing schedule II-IV drugs must register and use the PDMP. Vermont also has been improving functionality of the PDMP through the development of Prescriber Insight Reports which compare a prescriber's opioid prescribing patterns to similar prescribers and Clinical Alerts to notify prescribers when patients' prescription history may be of concern. There has been extensive outreach, technical assistance, and training for prescribers on opioid prescribing and the use of the PDMP.

- Improved Care Coordination and Transitions Between Levels of Care

  ADAP continues to improve coordination between the Hub and Spoke providers and specialty substance use disorder treatment providers (residential) through referral protocols, care coordination, covered benefits, information sharing, etc. These and other collaborations are contributing to stronger relationships between primary care practices and specialty substance use disorder service providers, leading to more effective recovery management of physical and behavioral health services.

  Through Vermont's health reform initiatives, physicians are educated and trained on enhancing their own screening and referral services, so that more clients are screened and directed to OUD/SUD specialists from primary care practices.

  Vermont's OUD/SUD Treatment Standards include discharge planning expectations for all levels of care. Aftercare planning starts as early as possible in the person-centered treatment planning and service delivery process. The aftercare plan is to ensure a seamless transition when a person served is transferred to another level of care or prepares for a planned discharge to recovery support.

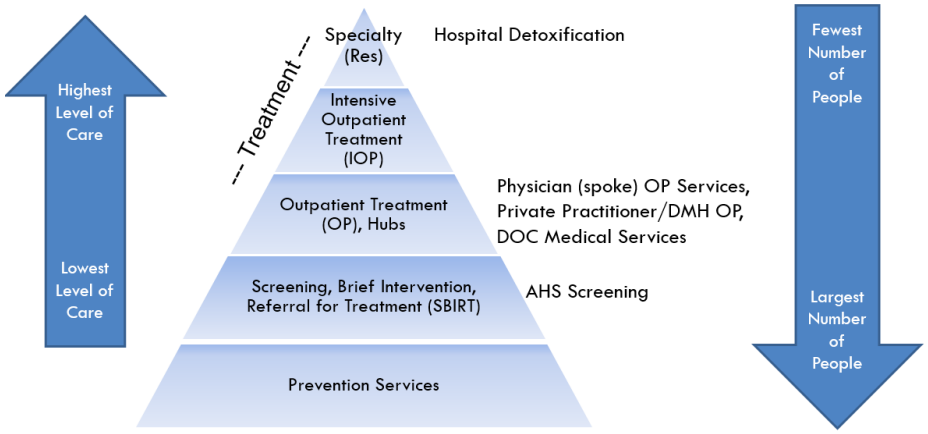
  The aftercare plan identifies the person's need for a recovery support system or other types of service that will assist in continuing the recovery and community integration. The plan also includes referral information made for additional services such as appointment dates, times, contact name, telephone number, and location. The referring provider must provide the receiving provider with the most recent assessment upon receipt of a signed release of information. Upon discharge, the provider, when prescribing medications, will document coordination of care with the primary care provider and/or external prescribing professional regarding, at a minimum, what medications are being prescribed and for what diagnoses. These standards are audited during the annual site review through the medical record audit. Should any provider be out of compliance with these standards, a corrective action plan will be required. State staff also are available to provide technical assistance to the provider on improving in this area. With the development of the centralized intake center in 2018, providers will have enhanced support for ensuring continuity of care during transitions.

OUD/SUD Treatment and Recovery Continuum of Care

Vermont has also been aggressive in public awareness and school based prevention and early intervention, in partnership with Substance Abuse and Mental Health Services Administration (SAMHSA). All treatment options follow the ASAM recommended Levels of Care and include outpatient, residential, and inpatient SUD treatment services, at various levels of intensity, for Medicaid, Medicare, commercial, uninsured, and private (self) payers.

This continuum includes specialized programs for adolescents, pregnant teens, and a specialized residential program for pregnant women and mothers with young children under the age of five (Lund Home). Vermont offers ancillary support services such as case management, recovery and peer-supports, including a statewide network of 12 Recovery Centers that complement the State's treatment programs. Exhibit D below depicts Vermont's overall approach to care.

Exhibit D – Vermont's Substance Abuse Continuum of Care



Recovery Services are Available to Those at All Service Levels

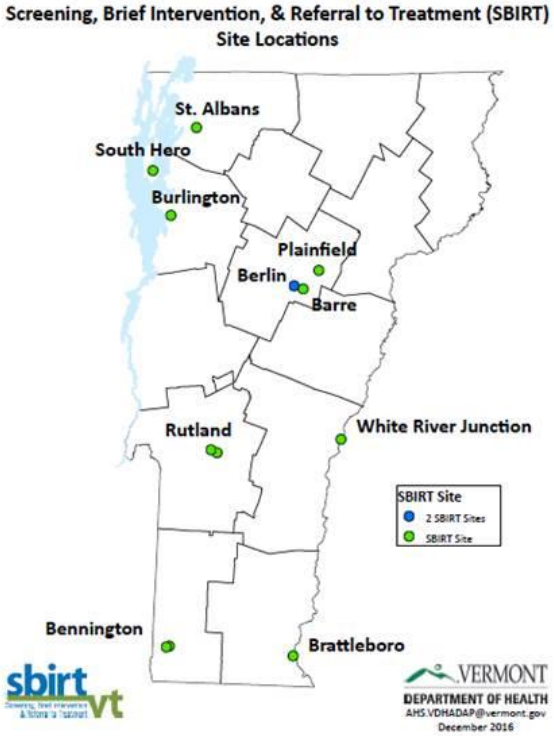
A brief description of each service within Vermont's continuum of care follows below:

- Prevention: Vermont's Alcohol and Drug Abuse Program (ADAP) provides funding to 20 school supervisory unions to help reduce 30-day use of alcohol, marijuana, and any illicit drugs, and to prevent and reduce binge drinking among adolescents. Utilizing the Whole School, Whole Community, Whole Child Model, required funded services include screening and referral to substance abuse and mental health services, and optional activities can include support of classroom health curricula, advising and training of peer leadership groups, delivery of parent information and educational programs, delivery of teacher and support staff training and delivery of educational support groups.

- Screening Brief Intervention and Referral for Treatment: Vermont is in year five of a SAMHSA grant to promulgate Screening, Brief Intervention and Referral for Treatment (SBIRT) throughout Vermont. SBIRT services are intended to identify individuals with risky alcohol and drug behavior and provide a brief intervention or a referral to treatment, if necessary. Throughout the life of the grant, SBIRT has expended to a number of emergency rooms, free health clinics, primary care offices, and a student health clinic across the State. ADAP is working with providers and other State

partners to sustain and expand the availability of SBIRT services under the Global Commitment to Health Demonstration.

Exhibit E – Screening, Brief Intervention and Referral to Treatment (SBIRT) Site Locations (2016)



- Public Inebriate/Crisis Intervention: The Public Inebriate (PI) Program is a crisis intervention program for individuals under the influence. The Vermont Public Inebriate Program screens and determines appropriate placement for individuals meeting criteria for incapacitation, due to either intoxication or withdrawal from alcohol or other drugs. Presently there is screening capacity in 13 of 14 counties. In addition to this screening capacity, there are 19-20 "diversion" beds located in several areas across the state designed as alternative's to confined placements. ADAP continues to work to assure a safe and effective response to address the need for additional community inebriate services and coordinated community level collaborations between public inebriate programs, emergency departments, law enforcement and the Department of Corrections.

- Withdrawal Management: Withdrawal management is available at a number of settings throughout Vermont depending on the medical needs of the individual. ADAP certifies two residential programs in three locations and a social detoxification program to provide higher intensity withdrawal management services. In addition, hospitals throughout Vermont also provide withdrawal management services for individuals who need the full services of a hospital. For individuals whose needs are less intense, withdrawal management services are available through the Hub and Spoke system, which includes health home services.

- Case Management: Case Management services are intended to support individuals who have complex needs that can impede access to and engagement in substance use disorder treatment. For intensive outpatient and Hub and Spoke services, case management services are included in the rate structure.

- Outpatient Treatment: Medicaid enrolled Providers currently provide outpatient services to Vermonters throughout each region of the State. Outpatient programs include individual, group and family counseling and provide services specific to elders, adolescents, youth, men and women.

- Intensive Outpatient Treatment: ADAP Certified Medicaid enrolled providers offer intensive outpatient (IOP) services to Vermonters throughout each region the State. IOP programs offer nine to 19 hours of treatment activities per week. These activities consist of a combination of case management, individual, group, and/or family therapy sessions.

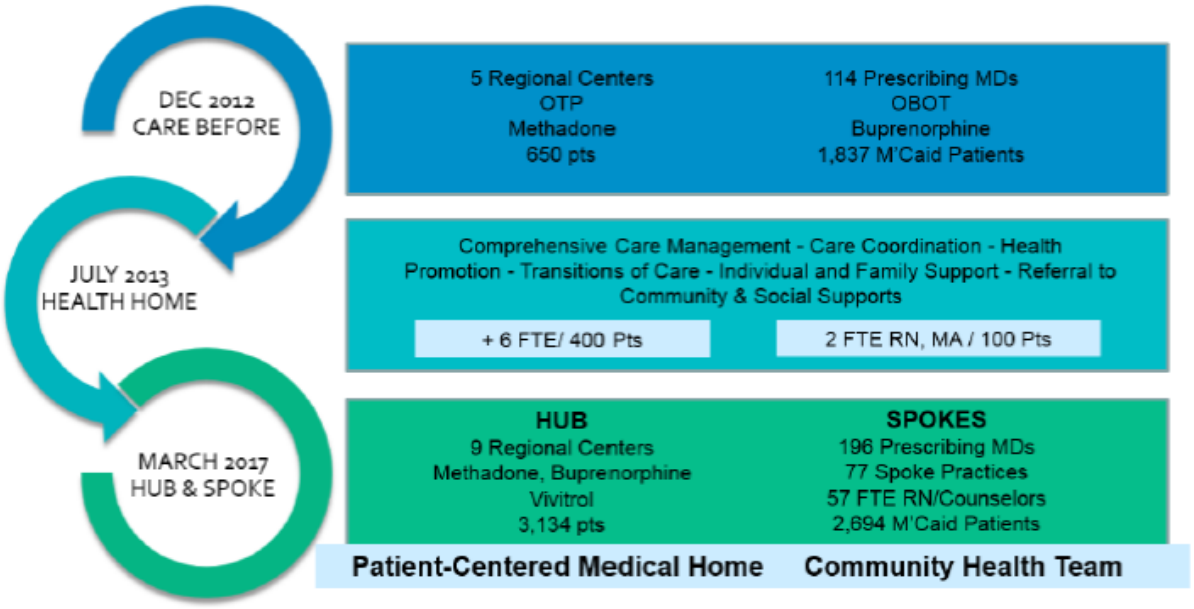
- Partial Hospitalization: Partial hospitalization is provided to individuals with co-occurring mental health and substance use disorder diagnoses, with the primary diagnosis being mental health.

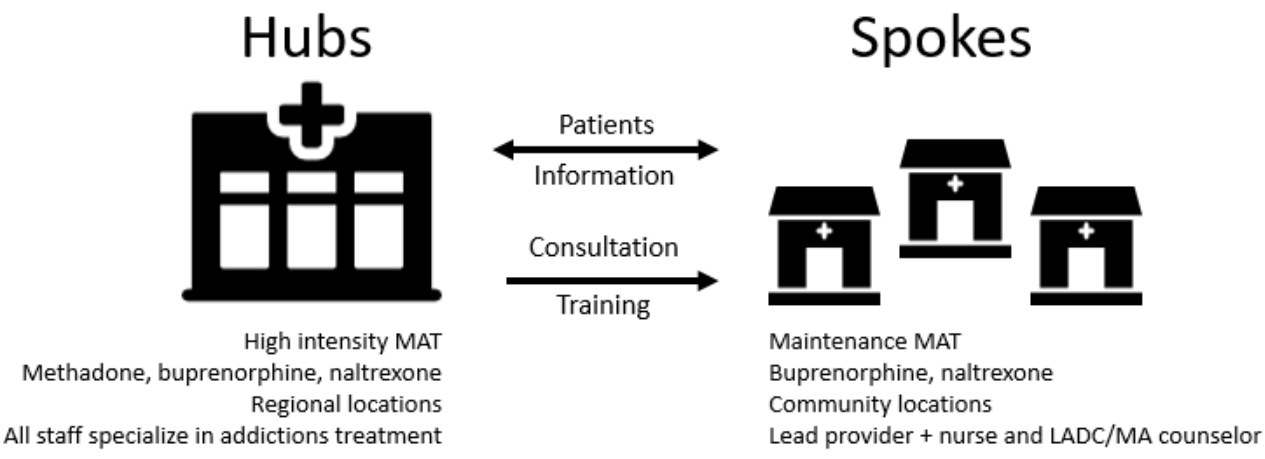
- Opioid Treatment (Hub and Spoke Program): Vermont developed the first in the nation Specialized Health Home focused on expanding evidence-based Medication Assisted Treatment (MAT) for OUD, known as the Hub and Spoke Program. Vermont's Hub and Spoke Program has garnered national attention for its effective, responsive, and comprehensive approach to providing MAT. Vermont accomplishes this through the integration of opioid treatment programs (OTPs), providing higher levels of care (Hubs) with primary care, obstetrics-gynecology, outpatient addiction treatment, and pain management practices (spokes) providing office-based opioid treatment (OBOTs). Regional Hubs offer medication, counseling, case management and health home services to complex patients. Spokes provide care to individuals who have less complex needs and they provide medication, counseling, case management and health home services.

  Hubs offer medication, counseling, case management, and health home services to complex patients. Spokes provide care to individuals who have either been stabilized at a Regional Hub or who needs do not require intensity of services offered by the Regional Hubs. Spoke staff, supported by enhanced care coordination through the Blueprint for Health Community Health Teams and local Recovery Support services, assure essential clinical and counseling support services are provided.

  Vermont uses a 21-Item checklist (Treatment Needs Questionnaire) to help determine whether a Hub or Spoke setting would be most appropriate for new beneficiaries seeking medication assisted treatment. In order to determine the need for additional hub and/or spoke services, ADAP, in partnership with DVHA, monitor the regional utilization of Hub services of Medicaid eligible individuals utilizing the Medicaid transportation benefit as well as capacity and wait time reports from hubs.

Exhibit F – "Hub and Spoke" Health Homes for Opioid Addiction





- Clinically Managed Low-Intensity Residential Care: Vermont funds a 10-bed low-intensity 3.1 ASAM level residential program in the central part of the state. This program is a step-down from a 3.5 ASAM-level program in the same county. Individuals with higher needs are able to attend the treatment programming and MAT at the 3.5-level program. Transportation is provided to individuals between the two facilities.

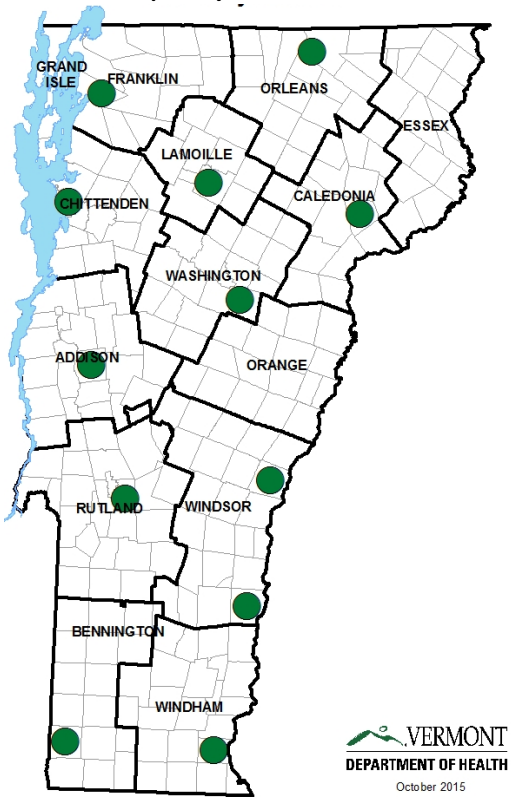
- Clinically Managed High Intensity Residential Care: Vermont supports several residential programs to provide clinically managed high intensity residential services as well as withdrawal management services. This includes women only, co-ed and specialized programs for adolescents and one for pregnant women and mothers with children under the age of five. These programs have access to psychiatric and mental health professionals for consultation and are able to provide care for individuals with co-occurring needs. All of Vermont's residential programs are required to provide access to MAT services as clinically necessary.

- Medically Monitored Intensive Inpatient Care: Vermont offers residential programming for men and women that provides medically monitored intensive inpatient services. This program has on-site psychiatric services and provides care to individuals with a wide range of co-occurring conditions, including MAT.

- Medically Managed Intensive Inpatient Care: Vermont funds inpatient services at a specialized psychiatric facility for detoxification, this program is also available to treat persons with co-occurring mental health and psychiatric conditions. Once an individual has completed the detoxification they are transferred to an appropriate level of care, typically a community residential program or Specialized Health Home (Hub).

- Recovery Support Services: Recovery services in Vermont focus on the following: helping people find, maintain, and enhance their recovery experience through peer support, sober recreation, and educational opportunities. This includes both 12 Recovery Centers located throughout Vermont and centralized Vermont Recovery Network.

Exhibit G – Recovery Center Locations (2015)



Recovery Centers provide non-clinical services that assist with establishing community connections that lead to employment, housing, and other social supports in a safe, drug and alcohol-free environment. Recovery centers are committed to supporting a person's efforts in preventing relapse and should relapse occur, in quickly returning to recovery. Individual services revolve around the support from the Peer Recovery Coach, an individual in active recovery from substance

use disorder who has received Peer Recovery Coach training. The Recovery Centers also offer several groups to support recovery, such as:

- Evidence Based Practice (EBP) groups
  - Making Recovery Easier
  - Seeking Safety
  - Wellness Recovery Action Planning (WRAP)

- Community Groups
  - Yoga, Meditation, Acupuncture
  - Age specific recovery groups
  - Ongoing 12 Step meetings

- Recovery Housing: Recovery Housing is provided to Vermonters through a number of transitional housing providers, some connected to a Recovery Center and some independent organizations. ADAP has recently begun a new partnership with the Vermont Foundations of Recovery to add new sober transitional housing beds. These programs offer supports to connect individuals to appropriate community social service and ongoing treatment and recovery resources such as individualized planning and general case management.

Alignment with ASAM Level of Care Guidelines

Vermont's OUD/SUD system follows the ASAM Level of Care guidelines and consists of the full spectrum of services, as outlined in Exhibit H beginning below. All OUD/SUD providers must be licensed and enrolled Medicaid Providers, including meeting additional State certifications for OUD/SUD treatment.

Exhibit H – ASAM Treatment Levels, Providers and Medicaid Availability

ASAM Level of Care	Brief Description	Provider	Existing Medicaid Service (Y/N)
0.5 Early Intervention	• Screening, Brief Intervention and Referral for Treatment (SBIRT)	ER, PCP, Health Clinics, Student Health Center	Y
1 Outpatient Services	• Adult: Less than 9 hours of services per week • Youth: Less than 6 hours of services per week • Individual, Family, and Group Counseling Case Management	Outpatient Clinics	Y
2.1 Intensive Outpatient Services	• Adult: 9 or more hours of services per week • Youth: 6 or more hours of services per week to treat multi-dimensional instability • Bundled rate includes case management	Outpatient Clinics	Y
2.5 Partial Hospitalization Day Treatment	• 20 hours or more per week • Clinically intensive programming	Outpatient Clinics	Y

ASAM Level of Care	Brief Description	Provider	Existing Medicaid Service (Y/N)
Psychosocial Rehabilitation Services	• Direct access to psychiatric, medical and lab services		(co-occurring only, MH diagnosis)
3.1 Clinically Managed Low-Intensity Residential Services	• 24-hour structure, at least 5 hours of clinical service/week	Residential Providers	Y
3.3 Clinically Managed Population Specific High Intensity Residential Services	• 24-hour structure, high intensity clinical services • Less intense milieu • Group treatment for those with cognitive or other impairments	Residential Providers (IMD)	Pending Continued 1115 Authority
3.5 Clinically Managed High Intensity Residential Services	• 24-hour care, high intensity services for persons who cannot be treated in less intensive levels • To stabilize multi-dimensional needs and/or safety issues	Residential Providers (IMD)	Pending Continued 1115 Authority
3.7 Medically Monitored Intensive Inpatient Services	• 24-hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3 • 16 hour/day counselor availability	Residential Providers (IMD)	Y
4 Medically Managed Intensive Inpatient	• 24-hour nursing care and daily physician care for severe unstable problems in Dimensions 1, 2 or 3 • Counseling available to engage patient in treatment (detox only)	Psychiatric Hospital (IMD)	Pending Continued 1115 Authority
Opioid Treatment Program	• Daily or several times weekly opioid agonist medication and counseling to maintain multidimensional stability for those with severe opioid use	Specialized Health Homes (Hub & Spoke)	Y
Withdrawal Management (WM)	• Levels 1 – 4	Specialized Health Homes (Hub & Spoke), Hospitals, Residential providers (IMD)	Y, Pending Continued 1115 Authority for Higher Levels

Use of Evidence-Based SUD-Specific Patient Placement Criteria

Vermont relies on evidence-based practices and clinical practice guidelines for all aspects of provider development, treatment authorization and recovery. The need for treatment often starts with a screening at one of the specialized providers, community partners, or primary care practices. Vermont promotes integrated screening for co-occurring substance use disorders and for co-occurring mental health issues.

All of Vermont's certified OUD/SUD providers are required to use evidence-based screening tools and perform a comprehensive assessment which includes elements specified by the State. All State requirement are outlined in Vermont's Preferred Provider Substance Use Disorder Treatment Standards.

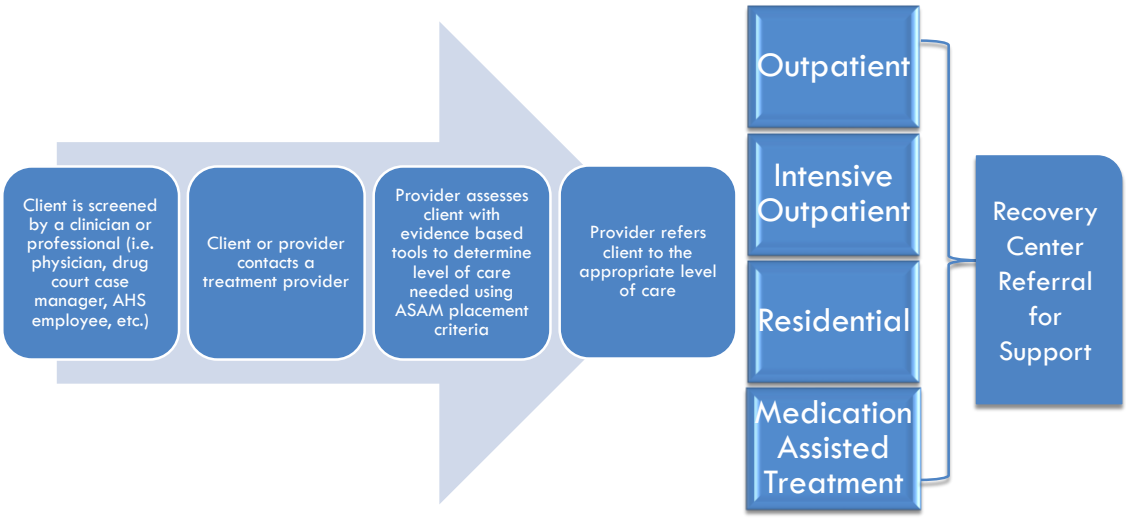
Assessments include age appropriate elements, such as, but not limited to: mental health status; OUD/SUD history; physical health status; medications; allergies; living arrangements; family and interpersonal history; social support needs; criminal justice involvement; school history; cultural and spiritual preferences; trauma history; participant strengths, goals and priorities; caregiver status; education and employment.

For a provider to maintain specialty OUD/SUD provider certification in Vermont, they must pass quality audits conducted by ADAP. These audits are performed every one to three years on all providers and are focused on compliance with standardized screening tools, comprehensive assessments, ASAM Levels of Care and evidence-based treatment standards. ADAP conducts random chart audits and reviews provider policies and procedures to ensure adherence to standards.

Vermont inpatient detoxification and residential levels of care are designated as short-term acute care for the purpose of stabilizing an individual, so they can successfully transition to clinically appropriate lower levels of care.

Vermont currently ensures that individuals are appropriately placed in residential programs and inpatient detoxification through the process of concurrent review and prior authorization. Residential programs are required to screen and assess appropriateness of admission. All programs utilize the Addiction Severity Index (ASI) multi-dimensional assessment tool. Within 24 hours or next business day of admission the Medicaid Utilization Management (UM) unit is notified. By the end of the fifth day the residential programs send the ASI results and other clinical information to the UM team for concurrent review and authorization. The UM team use the nationally recognized McKesson Interqual® decision support tool to determine continued authorization. Exhibit II-8 provides an overview of Vermont's process for accessing treatment services.

Exhibit I – Process for Accessing Treatment Services



Ensuring and Monitoring Provider Capacity at Critical Levels of Care

Vermont adheres to all Medicaid Manage Care requirements regarding network adequacy and access standards. ADAP collaborates with DVHA to use Medicaid utilization data and non-Medicaid services

provider encounter data to explore the patterns of utilization for residential care and care at Specialized Health Homes throughout the State.

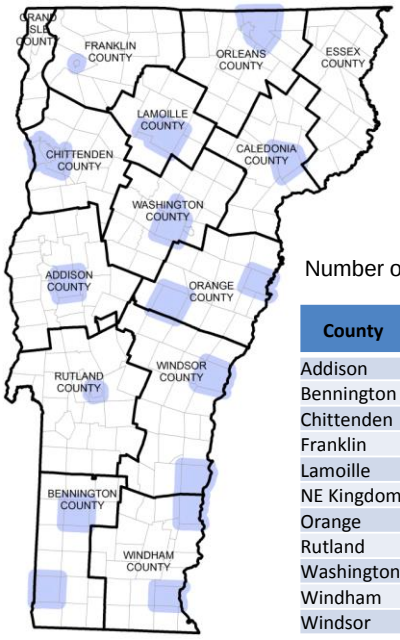
ADAP has a number of reporting requirements as a part of the granting process with the certified providers in order to monitor and ensure that the State has sufficient provider capacity for critical levels of care, including access to medication assisted treatment. Specialized Health Homes "Hubs" are required to report within seven days of reaching 90 percent capacity for serving individuals who are intravenous drug users, and immediate notice if a pregnant woman who is using intravenously is unable to be served. In addition, "Hubs" are required to submit monthly summaries of wait times for service and service requests, and census reports with numbers of individuals at each phase of treatment (induction, stabilization, maintenance) and numbers of individuals who have been transferred to office-based "Spokes". ADAP collaborates with DVHA to Medicaid medical transportation utilization data (e.g., distance to services) to monitor the need for MAT providers statewide.

Residential programs are also required to submit monthly summaries of wait times for services and daily information to an electronic bed-board, which tracks utilization of and availability of beds across residential programs statewide.

Occupancy in Vermont's OUD/SUD residential programs remain under 100 percent, suggesting capacity is at adequate levels. With the addition of a new Specialized Health Home "Hub" in 2017, wait time reports from across the Specialized Health Home "Hubs" demonstrate timely access across the State.

Exhibit J – Maps of Treatment Locations

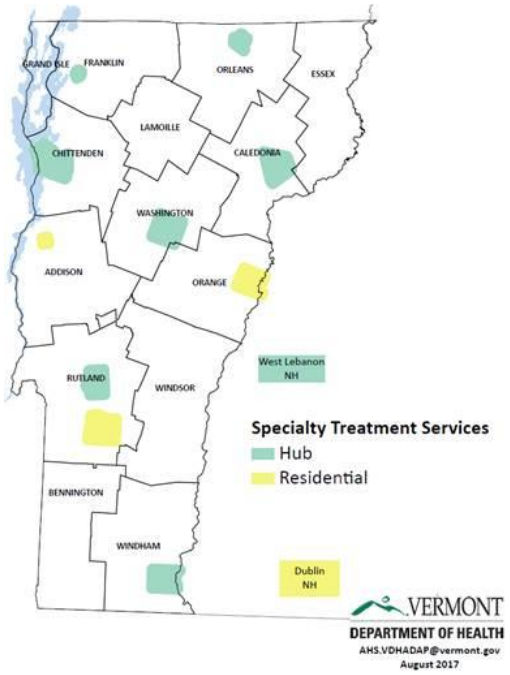
Outpatient/Intensive Outpatient Facilities



Number of Programs

County	OP	IOP
Addison	1	
Bennington	2	
Chittenden	7	3
Franklin	1	
Lamoille	2	1
NE Kingdom	2	2
Orange	2	
Rutland	2	1
Washington	2	1
Windham	1	1
Windsor	2	2

Hub and Residential Facilities



Planned Enhancements

Vermont will be enhancing its evidenced based placement process with two initiatives in 2018 and beyond. First, to improve timely access to care and placement at the appropriate level of care, the State is in the process of developing a Centralized Intake and Call Center for all Vermonters. The Center is under development in partnership with SAMHSA, through an Opioid State's Targeted Response (STR) SAMHSA grant.

The Center will perform an initial screening of individuals to determine the most appropriate referral. The Center will have current information on provider availability and be able to schedule appointments times, across all levels of care, for comprehensive assessments. Individuals having longer wait times will receive regular calls from the center to maintain engagement and facilitate initiation into treatment.

The Call Center will manage wait lists for services, assist individuals with obtaining transportation to their appointments, and assist in the transitions of individuals between levels of care. Vermont is in the initial stages of vendor procurement.

Second, Vermont is developing a value-based payment model for residential programs to align with its All Payer Model Agreement with CMS. The goal of this value- based design is to incentivize successful transitions of care, improve outcomes, and reduce costs. State staff will perform periodic chart reviews to ensure the programs are utilizing ASAM and that interventions are appropriate for the diagnosis and level of care. The value based payment and enhanced support model is targeted for implementation in 2018.

IV. Vermont's Health Care Delivery System

Vermont operates the Demonstration using a managed care-like model that complies with federal regulations at 42 CFR part 438 that would be applicable to a non-risk PIHP, including beneficiary rights and protections such as independent beneficiary support systems and formal grievance and appeal procedures.

Vermont is not proposing any change in the structure of the health care delivery system under this Amendment. The sections below provide overviews of the Demonstration's public managed care-like model, OUD/SUD delivery system of care, eligibility requirements, benefit coverage, and cost sharing.

Public Managed Care-Like Model

Vermont's Single State Medicaid Agency – the Agency of Human Services (AHS) – is responsible for oversight of the managed care-like Medicaid model. DVHA operates the Medicaid program as if it were a Managed Care Organization and in accordance with Federal managed care regulations. Program requirements and responsibilities are delineated in an inter-governmental agreement (IGA) between AHS and DVHA. DVHA also has sub-agreements with the other State entities that provide specialty care for Global Commitment enrollees (e.g., mental health services, developmental disability services, and specialized child and family services). As such, since the inception of the Global Commitment to Health Demonstration, DVHA and its IGA partners have modified operations to meet Medicaid managed care requirements, including requirements related to network adequacy, access to care, beneficiary information, grievances, quality assurance, and quality improvement.

Departments of Vermont State government that participate in the provision of covered services to enrollees under the Demonstration include:

- *Department of Vermont Health Access (DVHA)*: DVHA, which operates the Medicaid program as if it were a public managed care-like model under the Global Commitment to Health Demonstration.

- *Department of Mental Health (DMH)*: The mission of DMH is to promote and improve the mental health of Vermonters and to provide Vermonters with access to effective prevention, early intervention, and mental health treatment and supports as needed to live, work, learn, and participate fully in their communities.

- *Department of Disabilities, Aging, and Independent Living (DAIL)*: DAIL assists older Vermonters and people with disabilities to live as independently as possible.

- *Vermont Department of Health (VDH)*: VDH's goal is to have the nation's premier system of public health, enabling Vermonters to lead healthy lives in healthy communities.

- *Department for Children and Families (DCF)*: DCF promotes the social, emotional, physical, and economic well-being of Vermont's children and families.

- *Agency of Education (AOE)*: The AOE is responsible for overseeing coverage and reimbursement under the School-Based Health program.

OUD/SUD and Mental Health Delivery System

The Vermont Department of Health's Division of Alcohol and Drug Abuse Programs (ADAP), an IGA partner of DVHA in the public managed care-like model, is the unit of government designated to ensure quality and accountability, in collaboration with DVHA, for OUD/SUD prevention, treatment, and recovery services in Vermont. ADAP supports the innovative "Hub and Spokes" Medicaid Health Home program for Medication Assisted Opioid Treatment in partnerships with DVHA, as well as extensive outpatient and residential treatment and recovery support for alcohol and other drugs use disorders. All providers receiving Medicaid reimbursement must meet Medicaid requirements and enroll in the Medicaid program. Providers designated by the State for specialized funding (State or federal) must meet and maintain ADAP certification standards to receive additional State grants.

In partnership with DVHA, the Department of Children and Families is responsible for quality oversight of the Lund Home, which is Vermont's unique residentially based program for pregnant women and mothers with young children. Initially started as a program for pregnant teens, Lund Home has evolved as the state's needs have grown. Lund offers OUD/SUD and co-occurring mental health treatment for women of all ages who are struggling with addiction during their pregnancy and beyond. Pregnant women may enroll in the program for the length of their pregnancy and through a post-partum period based on their individual needs. Mothers of young children under the age five (regardless of pregnancy status) are also eligible for Lund's residential program. In this unique model, both mothers and their children live on-site. Children receive all EPSDT-required well-child screens and services, and mothers learn parenting skills, healthy eating and lifestyle routines, and receive mental health and addictions counseling. Women who are pregnant also receive prenatal care, skills training, and childbirth support.

The Department of Mental Health (DMH) contracts with community providers of mental-health services for adults with severe mental illness. The public mental-health system has ten Commissioner-designated nonprofit agencies in all major geographical areas of Vermont and one Specialized Services Agency. DMH central office staff provide leadership and direction for the community-based public mental-health system as well as program and service monitoring and assessment to assure adherence to state and federal regulations and to monitor the quality of services and supports delivered by DAs. DMH also operates the Vermont Psychiatric Care Hospital (VPCH), which provides Level 1 and non-Level 1 involuntary care for adults and is dedicated to improving the health and well-being of one of Vermont's most vulnerable populations. The 25-bed, acute care hospital offers patient areas designed for comfort and safety to promote and enhance patient recovery. A collaborative, multi-disciplinary team focuses on recovery, safety, education, and quality to provide a therapeutic environment for patients while maintaining clinical and operational best practices. Additionally, DMH contracts with Designated Hospitals for emergency inpatient psychiatric assessment and treatment of adults and youth in need of acute care that cannot be provided in a less restrictive setting. Designated Hospitals also provide voluntary inpatient psychiatric services and limited partial hospitalization.

Eligibility, Benefits and Cost Sharing

Vermont is not proposing any changes to current eligibility, premiums, or cost sharing arrangements under this amendment. The current Demonstration includes the following eight Medicaid and Demonstration groups:

- **Population 1**: Mandatory State Plan populations (except for the new adult group). This group receives benefits as described in the Medicaid State Plan and may receive HCBS benefits described in the STCs if they meet additional program eligibility standards.

- **Population 2**: Optional State Plan populations. This group receives benefits as described in the Medicaid State Plan and may receive HCBS benefits described in the STCs if they meet additional program eligibility standards.

- **Population 3**: Affordable Care Act new adult group. This group receives benefits as described in the Medicaid State Plan and may receive HCBS benefits described in the STCs if they meet additional program eligibility standards.

- **Population 4**: Individuals receiving home and community based waiver (HCBW)-like services who meet the clinical standard in the Choices for Care program for the Highest Need Group. This group receives benefits as described in the Medicaid State Plan and Choices for Care program benefits as described in the STCs.

- **Population 5**: Individuals receiving HCBW-like services who met the clinical standard in the Choices for Care program for the High Need Group. This group receives benefits as described in the Medicaid State Plan and Choices for Care program benefits as described in the STCs.

- **Population 6**: Individuals who are not otherwise eligible under the Medicaid State Plan and who would not have been eligible had the State elected eligibility under 42 CFR § 435.217, but are at risk for institutionalization and need home and community-based services. This group receives a limited HCBW-like service benefit including Adult Day Services, Case Management, and Homemaker services in the Choices for Care program as outlined in the (STCs).

- **Population 7**: Medicare beneficiaries who are 65 years or older or have a disability with income at or below 150 percent of the FPL, who may be enrolled in the Medicare Savings Program (MSP) but are not otherwise eligible for full benefits. This group receives a limited pharmacy benefit including Medicaid Prescriptions, eyeglasses and related eye exams; MSP beneficiaries also receive benefits as described in the Title XIX State Plan.

- **Population 8**: Medicare beneficiaries who are 65 years or older or have a disability with income above 150 percent and up to and including 225 percent of the FPL, who may be enrolled in the MSP, but are not otherwise eligible for full benefits. This group receives a limited pharmacy benefit including maintenance drugs; MSP beneficiaries also receive benefits as described in the Title XIX State Plan.

All covered services may be subject to review and prior approval by DVHA and/or its partner departments in the Agency of Human Services, based on medical appropriateness. OUD/SUD and mental health services are covered benefits for persons in Demonstration Populations 1 through 5.

A complete listing of covered services and limitations are contained in Vermont's approved Title XIX State Plan and statutes, regulations, and policies and procedures. Premiums and cost-sharing for populations 1, 2, and 3 must follow Medicaid requirements that are set forth in statute, regulation, and policy. Standard Medicaid exemptions from cost-sharing set forth in 42 § CFR 447(b) apply to the

Demonstration. The State does not apply co-payment requirements to excluded populations (children under age 21, pregnant women, or individuals in long-term care facilities) or for excluded services/supplies (e.g., family planning). Vermont currently charges premiums for children through age 18 with income above 195 percent of the FPL through 312 percent of the FPL.

V. List of Waivers and Expenditure Authorities Requested

Vermont seeks to maintain all current Demonstration waivers and expenditure authorities and requests to add expenditure authority for and waiver of all restrictions on payments to Institutions for Mental Disease (IMDs) for individuals ages 21 to 64 (§1905(a)(29)(B)).

Vermont's residential and hospital inpatient programs make up the highest level of OUD/SUD/mental health services in Vermont's continuum of care. Vermont's success in treating individuals with OUD/SUD is predicated on the availability of a comprehensive, flexible, and integrated range of services to meet an individual's needs, including those with co-occurring mental health and psychiatric needs.

As Vermont's needs have grown, so have providers and facilities that are now large enough to be considered IMDs. Currently, these residential facilities, specialized inpatient detoxification, and inpatient psychiatric programs are funded through a time-limited authority as Global Commitment to Health Investments under the Demonstration. Vermont seeks recognition of its residential and hospital programs, including those providing psychiatric care for persons with co-occurring SUD and mental health issues, as essential services under the continuum of Global Commitment to Health Section 1115 Medicaid program benefits.

This proposed OUD/SUD amendment will allow the State to sustain its continuum and move toward the full integration envisioned in the All Payer Model Agreement and Global Commitment to Health Demonstrations.

Exhibit K – Type and Size of IMD Facilities

Facility	Type and Target Group(s)	Treatment Focus	# of Beds
Lund Home	Residential treatment for pregnant and parenting women with children under 5 years old	OUD/SUD	26
Valley Vista (Bradford)	Residential treatment for women, men, and adolescents	OUD/SUD	80
Valley Vista (Vergennes)	Residential treatment for women	OUD/SUD	19
Serenity House	Residential treatment adults	OUD/SUD	24
Brattleboro Retreat: Substance Use Disorder	Inpatient detoxification and treatment for adults	OUD/SUD	30
Brattleboro Retreat: Inpatient Psychiatric Hospital	Inpatient stabilization for adults	Psychiatric, Co-occurring SUD	89
Vermont Psychiatric Care Hospital	Inpatient stabilization for adults under the care and custody of DMH	Psychiatric, Co-occurring SUD	25

VI. Estimate of Annual Aggregate Expenditures

The Vermont Global Commitment to Health Demonstration Budget Neutrality agreement includes all Medicaid program service expenditures and covered populations contemplated under this Amendment. Therefore, Vermont is not requesting any changes to the current budget neutrality agreement as part of this Amendment.

Exhibit L – Summary of Medicaid Expenditures for the Treatment of OUD/SUD and Mental Health in IMDs, State Fiscal Year 2017 (July 1, 2016 - June 30th, 2017)

Facility	Annual Expenditure (Gross)
Brattleboro Retreat Substance Use Treatment	$1,731,415
Lund	$3,256,810
Valley Vista -Bradford	$3,700,114
Serenity House	$1,244,510
Maple Leaf	$1,409,584
Vermont Psychiatric Care Hospital	$21,804,310
Brattleboro Retreat	$11,337,146
Total	**44,483,888**

Valley Vista-Vergennes began operations in 2017, therefore is not represented in data. Maple Leaf ceased operations in 2017.

VII. Enrollment Data

The Vermont Global Commitment to Health Demonstration includes all Medicaid populations who will receive coverage under this Amendment request. Vermont therefore is not requesting any changes to the Global Commitment's covered populations as part of this Amendment.

The Vermont OUD/SUD treatment system serves approximately 17,000 Medicaid participants annually (see Exhibit N). More than 3,000 Medicaid participants access IMD services annually.

Exhibit N – Number of Medicaid Participants Receiving Services and IMD Services, State Fiscal Year 2017 (July 1, 2016 - June 30th, 2017)

Facility	Annual Expenditure (Gross)
Brattleboro Retreat Substance Use Treatment	261
Lund	226
Valley Vista -Bradford	861
Serenity House	390
Maple Leaf	305
Vermont Psychiatric Care Hospital	88
Brattleboro Retreat	661
Total	**2,792**

Valley Vista-Vergennes began operations in 2017, therefore is not represented in data. Maple Leaf ceased operations in 2017.

VIII. Research Hypothesis

The State has identified the following overarching hypotheses for the current Demonstration and proposes no change to the hypotheses related to this amendment.

- The Demonstration will result in improved access to care;
- The Demonstration will result in improved quality of care;
- Value-based payment models will improve access to care;
- Improved access to preventive care will result in lower overall costs for the healthcare delivery system;
- Improved access to primary care will result in improved health outcomes;
- Enhanced care coordination will improve timely access to needed care;
- The Demonstration will result in increased community integration; and
- The Demonstration will maintain or reduce spending in comparison to what would have been spent absent the Demonstration.

Exhibit P – Current Global Commitment to Health Evaluation Measures

Performance Areas	Metrics	Sampling Methodologies
MAT	• Number of people receiving MAT per 10,000 Vermonters age 18-64	Total Vermont
Drug Overdose Deaths	• Deaths related to drug overdose	Total Vermont
Utilization	• ED utilization (HEDIS®)	IMD (SUD & Psychiatric), Total SUD
	• Inpatient Utilization per 1,000 population	Total Medicaid, IMD (SUD & Psychiatric)
	• Residential Utilization per 1,000 population	Total Medicaid, IMD (SUD & Psychiatric)
Lengths of stay (LOS) in Residential SUD Treatment	• Median and Mean LOS for discharged patients	SUD Residential, IMD (SUD & Psychiatric)
Readmissions for Same Level of Care (LOC)	• SUD IMD Readmissions: 30-days and 180-days	IMD (SUD & Psychiatric)
	• SUD Readmission rates by length of stay: <16 days, 16-29 days, 30 or more days	IMD - SUD
Quality of Discharge planning	• Percent of IMD enrollees using substances who initiate and engage in treatment (Modified HEDIS®)	IMD - SUD
	• Percent of persons discharged who have PCP visit (well or sick) within 30 days of discharge from IMD (Modified HEDIS®)	IMD - SUD
Overall Cost of Care	• Average cost per enrollee for IMD services	IMD (SUD & Psychiatric)
	• Average cost per enrollee for all MH/SUD services	IMD(SUD & Psychiatric), Total Medicaid

Performance Areas	Metrics	Sampling Methodologies
	• Average cost per enrollee for all Medicaid Services	IMD(SUD & Psychiatric), Total Medicaid
SUD Treatment	• Percent of enrollees using substances who initiate and engage in treatment (Modified HEDIS®)	Total Medicaid, ACO Members
Follow up after Hospitalization for Mental Illness	• Percent of enrollees discharged who had follow-up at 7-days and 30-days (Modified HEDIS®)	Total Medicaid, ACO Members
ACO Access to SUD Treatment	• VII-day and 30-day follow-up after discharge from emergency department for alcohol or other drug dependence (Modified HEDIS®)	ACO Members
ACO Depression Screening and Follow-up	• Screening for clinical depression and follow-up plan (Modified HEDIS®)	ACO Members

All measures currently collected appear to represent alignment with those recommended by CMS. The State will work with CMS to assure measure specifications are in alignment with those HEDIS and utilization measures outlined in the November 1, 2017 State Medicaid Directors Letter #17-003 *Strategies to Address the Opioid Epidemic* to the extent possible given the State's unique payment and delivery models, data collection methods, resources and budget.

IX. Implementation Plan

Vermont has been aggressively pursuing OUD/SUD treatment and delivery system innovations over the lifetime of the Global Commitment to Health Demonstration. Vermont is seeking CMS partnership to allow the full continuum of services for Medicaid beneficiaries. The State will maintain and enhance existing efforts to develop a fully integrated system of physical and mental health and OUD/SUD services with our Medicaid ACO, OUD/SUD and mental health specialty providers. A high-level summary of planned activities to support the CMS OUD/SUD goals is provided below in Q.

Exhibit Q – Goals, Activities and Timelines

CMS and VT Goals	VT Activities to Address	Timeline
Increase Rates of Identification, Initiation, And Engagement in Treatment	• Pilot 'Respondent Driven Sampling' to identify individuals in need of treatment for opioid use disorder but not receiving treatment and treatment on demand	CY 2018 pilot launch
	• Develop Performance Improvement Project (PIP) to increase the rates of initiation and engagement in treatment	In progress
	• Expand screening brief intervention referral and treatment expansion in primary care	In progress
	• Increase OUD/SUD provider workforce through education and training	In progress
Increase Adherence to and Retention in Treatment	• Develop Performance Improvement Project (PIP) to increase the rates of initiation and engagement in treatment	In progress
	• Continue Quality Facilitators – practice staff who are placed in OUD/SUD practices for two years to focus on improvement in quality of care and engagement rates	In progress
Reduce Overdose Deaths, Particularly Those Due to Opioids	• Maintain naloxone distribution: ○ Free distribution (27 sites across the state, including syringe services programs and recovery centers) ○ Broad availability for non-users (e.g., family, EMS personnel) ○ Distribution with prison reentry for persons with OUD/SUD history	In progress
	• Enhance Vermont's Prescription Monitoring System, as needed	In progress
	• Expand needle exchanges	In progress
	• Monitor prescribing rules and enhance legislative policy, as needed	In progress
	• Continue public education and awareness efforts	In progress
	• Continue Medication Assisted Treatment	In progress

CMS and VT Goals	VT Activities to Address	Timeline
Reduce Utilization of Emergency Departments and Inpatient Hospital Settings for Treatment Where the Utilization Is Preventable or Medically Inappropriate Through Improved Access to Other Continuum of Care Services	• Centralize triage, intake, scheduling and call center	2018 Procurement
	• Co-locate recovery supports in emergency rooms	2018 Launch
Reduce Readmissions to The Same or Higher Level of Care Where the Readmission Is Preventable or Medically Inappropriate	• Improve discharge planning and transitions of care with care management support from MAT Teams	In progress
	• Implement value based payment structure for critical levels of care	2018 Launch
	• Disseminate and train evidence based practice	In progress
Improve Access to Care for Physical Health Conditions Among Beneficiaries	• Continue funding of care coordination services through the Vermont Blueprint for Health	In progress
	• Continue funding of health home services in opiate treatment programs	In progress

X. Public Process

The public process for submitting this amendment request conforms with the requirements of STC 7 and 42 CFR §431.408. Vermont is committed to engaging stakeholders and providing meaningful opportunities for input as policies are developed and implemented.

Public Comment Period

The State's public comment period on the Global Commitment to Health 1115 Waiver amendment request was from December 14, 2017 through January 14, 2018.

Public Notice

Vermont released the draft amendment request for a thirty-day public comment period starting on December 14, 2017 by posting the amendment request, including a summary of the proposed amendment and instructions for submitting comments, on DVHA's website. Notice of the proposed amendment and the public comment period was also published in the Burlington Free Press. The Burlington Free Press is the Vermont's newspaper with the widest statewide distribution and paid subscribers.

Comprehensive description of the proposed waiver extension: The State posted a comprehensive description of the proposed waiver amendment on December 14, 2017 on the above-cited website. The document included: program description; goals and objectives; a description of the beneficiary groups impacted by the demonstration; the proposed health delivery system and benefit and cost-sharing requirements impacted by the demonstration; estimated increases or decreases in enrollment and in expenditures; the hypothesis and evaluation parameters of the proposal; and the specific waiver and expenditure authorities sought.

Public Hearings: The State convened to two public hearing on the Global Commitment to Health 1115 Waiver amendment request.

> On December 18, 2017, a presentation on the proposed amendment was given to the Medicaid and Exchange Advisory Board in Waterbury, Vermont. A public hearing was held immediately following the Medicaid and Exchange Advisory Board meeting, from 12:00 to 12:30 PM, at the Agency of Human Services in Waterbury, VT.
>
> On January 5th, from 12:00 to 12:30 PM, a public hearing was held at the Vermont Department of Corrections in Waterbury, VT.
>
> Both hearings offered teleconferencing for individuals who could not attend in person.

Use of an electronic mailing list to notify the public: On December 14, 2017, the Draft *Global Commitment to Health Demonstration* amendment request was distributed simultaneously to the Medicaid and Exchange Advisory Board and the Global Commitment Register Listserv, which represents a wide array of interests in Vermont health care. The Global Commitment Register Listserv includes, but is not limited to, the following parties: health care providers; hospitals; health care Advocates; Vermont Legal Aid; Medicaid beneficiaries; QHP beneficiaries; Agencies on Aging; lobbyists; law firms; various State staff, managers, and directors, including all key leadership with the Agency of Human Services; Designated Agencies; state legislators; health insurance carriers; dental insurance carriers; concerned Vermont residents;

vendor partners; non-profit organizations for low-income Vermonters; federal government partners; other national organizations or companies with an interest in Vermont health care policy.

Tribal Government Notification: The State of Vermont has no federally recognized Indian tribes or groups.

Public Comments: No formal public comments were received regarding Vermont's Draft Global Commitment amendment request. This proposed amendment does not include any changes to the Global Commitment to Health Demonstration's covered populations or current budget neutrality agreement, therefore it was not unexpected that no comments were submitted.