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

Note: PRA Disclosure Statement to be added here

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

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

State	*Vermont*
Demonstration name	*Global Commitment to Health* *11-W-00194/1*
Approval period for section 1115 demonstration	*July 1, 2022 through December 31, 2027*
SMI/SED demonstration start date[a]	*July 1, 2022*
Implementation date of SMI/SED demonstration, if different from SMI/SED demonstration start date[b]	*01/01/2020*
SMI/SED (or if broader demonstration, then SMI/SED - related) demonstration goals and objectives	*During the demonstration period, the state seeks to achieve the following* *SMI/SED goals:* *1. Reduced utilization and lengths of stay in EDs among Medicaid beneficiaries with* *SMI or SED while awaiting mental health treatment in specialized settings;* *2. Reduced preventable readmissions to acute care hospitals and residential settings;* *3. Improved availability of crisis stabilization services including services* *made available* *through call centers and mobile crisis units, intensive outpatient services,* *as well as* *services provided during acute short-term stays in residential crisis stabilization programs and psychiatric hospitals and residential treatment* *settings throughout the* *state;* *4. Improved access to community-based services to address the chronic* *mental health* *care needs of beneficiaries with SMI or SED including through increased integration* *of primary and behavioral health care; and* *5. Improved care coordination, especially continuity of care in the community following episodes of acute*
SMI/SED demonstration year and quarter	*SMI/SED DY18 Q3*
Reporting period	*July 1, 2022 - 09/30/2022*

[a] SMI/SED demonstration start date: For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state's STCs at time of SMI/SED demonstration approval. For example, if the state's STCs at the time of SMI/SED demonstration approval note that the SMI/SED demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the SMI/SED demonstration. Note that the effective date is considered to be the first day the state may begin its SMI/SED

demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on 12/15/2020, with an effective date of 1/1/2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.

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

2. Executive summary

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

With the onset of the COVID-19 pandemic in early 2020, Vermont's health care system adapted to shifts in public health guidelines and workforce capacity to ensure a safe response for all Vermonters. Despite these challenges, Vermont has continued its implementation of Vision 2030, a ten-year plan working towards a more holistic and integrated system of care. By following this roadmap, the Vermont Department of Mental Health (DMH) has continued vital work to increase the availability, capacity, affordability, and quality of mental health care for SMI/SED Medicaid beneficiary populations. The goal is to create a more person-centered and community-based system of care, empowering individuals to be served in the least restrictive setting necessary to meet their needs.

DMH is currently engaging in a robust set of activities and grant funding initiatives to increase the availability of non-hospital, non-residential crisis stabilization services. DMH hopes to expand services made available through crisis call centers, mobile crisis units, and observation/assessment centers, with a coordinated community crisis response that involves a broader range of community partners, including law enforcement and other first responders. Notable policy advancements include expanding Lifeline Call Centers and statewide efforts to successfully implement the nationwide 9-8-8 Call Center Program. Additionally, DMH has led efforts to reduce barriers to care by supporting flexible access to telehealth, peer support services, and other low-barrier mental health supports. Through these efforts, DMH aims to increase access to mental health services, promote preventative care, and establish earlier intervention points for individuals in need.

As outlined in Vision 2030, advancements to improve Vermont's mental health care system have been grounded in statewide efforts to transition healthcare payment and delivery systems away from a fee-for-service framework and into a value-based system of care. Most notably, the payment model for children and adult services transitioned from traditional reimbursement mechanisms to a monthly case rate model to encourage flexibility in service delivery, standardize the tracking of population indicators and outcomes, simplify payment structures, and improve the predictability of provider payments. DMH is currently assessing additional alternative payment and delivery models to improve accountability, increase equity and transparency, reward value-based care outcomes, and incentivize best practices.

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

Until statewide capacity is at the 2019 base level, all assessments may reflect the pandemic setting and its resulting adaptations more than the long-term needs of the system. This report serves as an update to the Vermont mental health care system improvements for SMI/SED Medicaid beneficiaries, but it should be viewed contextually as heavily impacted by the COVID-19-pandemic and its lasting effects.

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

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1. Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings (Milestone 1)			
1.1. Metric trends			
1.1.1. The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 1.		**EXAMPLE: #20: Beneficiaries with SMI/SED treated in an IMD for mental health*	**EXAMPLE: The number of beneficiaries with SMI/SED who were treated for mental health in an IMD decreased by 5% due to an increase in crisis stabilization services in the state.*
1.2. Implementation update			
1.2.1. Compared to the demonstration design and operational details, the state expects to make the following changes to: 1.2.1a. The licensure or accreditation processes for participating hospitals and residential settings	*X*		
1.2.1b. The oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements	*X*		**EXAMPLE: The state increased the frequency of unannounced visits from twice a year to three times a year in January 2020 (first reported in DY1Q4 report).*
1.2.1c. The utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay	*Update to Report*		The Vermont Department of Health's Hospital Licensing Rule was updated as of 1/1/20222, to include section 5.1.7 which states, *"Any psychiatric hospital or psychiatric facility classified as an Institution for Mental Disease for Medicaid purposes shall use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay for their patients."*
1.2.1d. The program integrity requirements and compliance assurance process	*X*		
1.2.1e. The state requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions	*X*		

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

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

2.2.1. Compared to the demonstration design and operational details, the state expects to make the following changes to: 2.2.1a. Actions to ensure that psychiatric hospitals and residential treatment settings carry out intensive pre-discharge planning, and include community-based providers in care transitions	*Update to Report*		*In addition to the activities described in section 2.a of the SMI SED Implementation Plan, the state is working to maintain and enhance current discharge planning and care coordination with improved strategies for connection with local community-based services. This work continued during DY3 Q1.* The Vermont Department of Mental Health (DMH) continues to develop the following strategies to improve connection with local community-based services: -Practice the Collaborative Network Approach, Vermont's version of the Open Dialogue approach, that supports direct involvement of clients and their families with their plans of care to better inform transitions to the community. -Increase awareness of available community work supports for staff and individuals in psychiatric hospital care (e.g., offer short training on Individual Placement & Support [IPS; an evidence-based practice for supported employment], Specialized Service Agency (SSA) work incentive). -Host employment-related, in-house groups based on individuals' lead (such, as employing a Recovery-Orientated Cognitive Therapy approach). -Develop ways for local community employment specialists or Vocational Rehabilitation counselors to meet with patients and staff prior to discharge, whenever possible. On June 1st, 2021, The State signed into effect Act 50, which tasked the Vermont Department of Mental Health with issuing a request for information from both designated and specialized service agencies, and peer-run agencies, for developing and implementing programming for unlocked community residences for transitional support for individuals being discharged from inpatient psychiatric care or for intervention to prevent inpatient care. By establishing a steering committee, DMH was tasked with providing a bed needs assessment for all levels of care in the mental health system, including among other items, an update to the statewide bed

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
			needs assessment conducted pursuant to 2019 Act 26 §2 with regard to inpatient beds and community residences. The summary of this stakeholder group was provided in the January 15, 2022 report to the Vermont Legislature, which outlined key areas for future programming, including: Prioritize peer-support programming; Consider the role of peer support in step down and diversion (as well as in prevention from inpatient psychiatric care); Peer workers deserve a fair and equitable wage for their services; psychiatric hospitalizations are generally traumatic and community-based care is strongly preferred. This work continues into Q2 of this report as the Department has continued to support efforts to create a peer credentialing system in Vermont. Please see section 2.1.1d for a full update on this initiatives. *Update for the residential capacity across the system of care report that was provided to the legislature in January of 2020:* The Act 50 Bed Needs Assessment report contains following update: "There are no updates to the Act 26 §2 (2019) bed needs analysis report. Bed numbers and resulting needs since that reporting have been profoundly influenced by the COVID-19 pandemic and accompanying public health emergency, with closures across the state in response to public health safety requirements and the lack of available workforce. Until bed capacity is at 2019 base level, any additional assessment may reflect the pandemic setting with the resulting adaptations, more than the long-term bed needs of the system."
2.2.1b. Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers	*X*		

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

2.2.1d. Strategies to prevent or decrease the lengths of stay in EDs among beneficiaries with SMI or SED (e.g., through the use of peers and psychiatric consultants in EDs to help with discharge and referral to treatment providers)	*Update to Report*		**Please see answers provided to section 2.2.1.a for updates on Act 50-related Emergency Department mitigation efforts* *Update on Peer Support Credentialing* The Department of Mental Health is currently supporting the process of creating a mental health peer credentialing certification system for the state of Vermont. Peer supports are a vital part of the mental health system of care. Over the last two decades, peer support has entered the mainstream mental health system. Forty-eight states and the District of Columbia certify mental health peer specialists. In the face of national mental health workforce shortages, peer support workers are critical to the state's ability to provide mental health services. The prospective peer support credentialing program will help to address workforce shortages in mental health by expanding the population of eligible service providers. **Status Update** In FY22, the Department granted an award to Pathways VT in order to implement this critical work. The purpose of the grant award is to fund a process for incorporating the input of stakeholders regarding each of the next steps for developing and implementing a statewide peer support specialist certification program in Vermont. Following stakeholder involvement, a recommendation will be put forward for a prospective Vermont peer credentialing process, including outlining core training curriculum and recommended governing body. The first phase of the grant execution tasked the Peer Workforce Development Initiative (PWDI) with retaining a consultant to oversee and manage the project in collaboration with designees of the Department of Mental Health. The consultant has completed four out of the six, one-hour meetings, via Zoom, with stakeholders to solicit

			recommendations for the design of a statewide, mental health peer support specialist certification program in Vermont. The sessions include representation from a wide array of stakeholders, including psychiatric survivors, service users and their families, peer support workers, leaders and staff from community mental health programs, hospitals and hospital associations, peer-run organizations, advocacy organizations, family networks and organizations, recovery community members, private health insurers, and State agencies and departments. Topics thus far have included an overview of peer support credentialing systems, models for training and assessment, defining the term peers, and integration with SUD-related peers. Peer support services need stable funding which can be supported by Medicaid as well as grants. The Department will concurrently be seeking a Medicaid State Plan Amendment towards this end. *Update on increasing Intensive Residential capacity in through CVMC.* In April 2022, the University of Vermont Health Network (UVMHN) reported that they cannot continue with the project to create 25 psychiatric inpatient beds as CVMC at this time and put the project on an indefinite hold. UVMHN cited factors such as diminishing cash reserves, workforce shortages, aging facilities and equipment, expense inflation not covered by allowed revenue, and thin or negative margins since 2018. *Update on the RFP DMH was issuing for peer workforce development:* DMH remains committed to ensuring the expansion of peer support services by advancing workforce development initiatives. Currently, the Department is supporting the work of the Peer Workforce Development Initiative (PWDI) Working Group through grant funding awarded in January 2020 to a community-based agency (Pathways Vermont). The

			goals of the initiative include creating a steering committee, evaluating statewide peer workforce needs, facilitating awareness and participation by providing resources and information to peer support workers, and ensuring the availability of peer support worker training. In 2020, PWDI commissioned an analysis of U.S. and Canadian efforts to promote and expand mental health peer specialist workforce capacity. That analysis summarized a review of mental health peer specialist certification programs across the United States and Canada. The final report provided an overview of the process of developing, implementing, an administering a statewide, peer specialist certification program. The report identified the following, general next steps to develop a statewide mental health peer support certification program: - Define a range of responsibilities and practice guidelines for peer support specialists, determine curriculum, and core competencies required for certification, and determine continuing education requirements for certification renewal. - Determine a process for complaint investigation and corrective action, which may include suspension and certification revocation. - Determine a process for an individual employed as a peer support specialist to obtain certification as of a certain date. - Amend the state plan to include peer support specialist as a provider type and to include peer support specialist services as a distinct service, which may be provided to eligible Medicaid beneficiaries enrolled in a managed care plan or a mental health plan.

			- Seek any federal waivers or other state plan amendments to implement the certification program. Currently, PWSI has begun the process for incorporating the input of stakeholders regarding each of the next steps for developing and implementing a statewide peer support specialist certification program in Vermont. The deliverables for these sessions include efforts to create: - Recommended design of a statewide, peer support specialist certification program based on consensus and/or vote. - Summary transcripts of meetings, which identify issues and concerns in need of resolution. - Work plan identifying next steps. These sessions are slated to begin during September 2022, the findings will be updated in subsequent reports. *Update on 10-Year Plan for a holistic and integrated system of care.* In January 2020, DMH published a ten-year plan for a holistic and integrated system of care, penned Vision 2030. This plan presents a path to a coordinated, holistic, and integrated system of care for Vermont. Informed by direct input from hundreds of community members and stakeholders, it furthers the State Health Improvement Plan (SHIP) and Act 200, Sect. 9 (2019) by supporting systemic improvements in the mental health system of care. This report outlined among others, the following strategies: Make Peer Supports accessible in all aspects of care as described in Action Area 6; Expand the practice of screening for social contributors to health; Expand same-day-access models which can include short term solution-based interventions; Test and assess joint programs between Vermont Departments of Mental Health and Corrections designed to improve public safety and reduce recidivism for individuals with mental illness who are involved in the criminal justice system; Implement approaches such as the Living Room Model as alternative care settings to emergency rooms; Determine potential improvements to

			address emergency department wait times, delays in discharge from emergency and inpatient, and conduct gap analysis of existing resources; Assess the current state inpatient bed capacity and make recommendations regarding any need for increased capacity for youth and children aligned with integration practices; Explore and design a model that provides mental health care and support within our "Urgent Care" provider system; Implement Continuous Quality Improvement for transitions in care; Develop universal messaging and support system for those in crisis and their families. *Update on Telepsychiatry:* On March 22, 2022, H.654, *An act relating to extending COVID-19 health care regulatory flexibility* was signed into effect providing temporary Vermont licensures to qualifying providers licensed in other states, to provide telehealth services to Vermonters. This will remain in effect until July 2023 to aid in current workforce challenges and increase access to services. In response to the Act 264 statutory requirement as outlined in 33 VSA § 4302, the State Interagency Team (SIT) is required to submit an annual report to the commissioners of developmental and mental health services, social and rehabilitation services and education on the status of programs for children and adolescents with a severe emotional disturbance which shall include a system of care plan. Within the 2021 Vermont System of Care Report, the following updates were provided regarding Telehealth Services: - A majority of clinical and case management services are now provided via phone and telehealth. Mental health screeners are conducting confidential assessments via telehealth for Vermonters in crisis who are at their homes or in Emergency Departments. - Staff at mental health agencies have reported that many families prefer telehealth opportunities as it decreases

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
			transportation challenges, increases ease of connecting with others and offers flexibility they didn't have prior to COVID. - DMH submitted and received a grant from The Vermont Community Foundation to supplement the DA/ SSA network funds for technology purchases for clients to support telehealth. Various federal grants will assist with technology for staff at DA/SSAs but there was no funding available for client technology needs. This grant of $100,000 was provided directly to the network as unrestricted funds.
2.2.1e. Other State requirements/policies to improve care coordination and connections to community-based care	*See section 2.2.1d*		
2.2.2. The state expects to make other program changes that may affect metrics related to Milestone 2.	*See section 2.2.1d*		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
3. Access to Continuum of Care, Including Crisis Stabilization (Milestone 3)			
3.1. Metric trends			
3.1.1. The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 3.	*Update to report*	**EXAMPLE: #20: Beneficiaries with SMI/SED treated in an IMD for mental health*	**EXAMPLE: The number of beneficiaries with SMI/SED who were treated for mental health in an IMD decreased by 5% due to an increase in crisis stabilization services in the state.* .

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

3.2.1b. Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	*Update to Report*		On October 21, 2021, the State of Vermont added a new service center within one of the state IMD facilities at the Brattleboro Retreat. The addition of this sub-facility, Linden Lodge, opened 12 new level one beds to help meet the demands for crisis stabilization services, and to increase our capacity for psychiatric bed placements for SMI/SED Medicaid beneficiaries. *Mobile Response and Stabilization Services* Health Management Associates (HMA) Report: Vermont is 1 of 20 States that received a Planning Grant to support expanding community-based mobile crisis intervention services for Medicaid beneficiaries. Using the federal planning grant, the Vermont Agency of Human Services partnered with HMA to conduct a statewide mental health and substance use needs assessment to identify gaps and opportunities of the current crisis system. • The needs assessment included: o Surveys – a broad-based survey was distributed to a variety of stakeholders to gather insight into Vermonters' experiences, perceived successes and challenges of the existing crisis system and recommendations for improvement. o Key Informant Interviews – interviews were conducted with key informants from organizations and agencies to confirm and gather additional detail on themes that emerged from the survey. o Focus Groups – focus groups were conducted with the following groups of people to further supplement information gathered from the survey and stakeholder interviews: (First responders including 911 public-safety answering point (PSAPs), law enforcement and EMS; Designated Agencies (DAs); Mental Health & Substance Use Providers; Schools and People, and families of people, with a history of receiving crisis services

			While Vermont has a Medicaid benefit for mobile crisis services delivered by 10 DAs, this grant presents a unique funding opportunity for all states to consider how crisis response models could be expanded upon with increased American Rescue Plan Act (ARPA) funding for up to five years, starting April 1, 2022, and ending March 31, 2027. The findings of the report have been released as of July 2022 and highlight the need for increased mobile response services that align with best practices. This includes increasing mobile response coverage areas, providing 2-person response teams, providing 24/7 coverage to the communities, incorporating peer support workers, and including harm reduction efforts for substance misuse. *Rutland County Mobile Response Pilot:* The Mobile Response and Stabilization Services (MRSS) pilot for the child, youth and family system in Rutland County completed its first year (Oct 2021-Sept 2022), with funding through the State of Vermont, Agency of Human Services, Department of Mental Health. MRSS are provided in the child, youth, and family system to respond to a family-defined crisis to help families in distress in a timely way, to interrupt a family-defined crisis, and to serve as a point of access for responding to the identified needs of the family so the child/youth can remain safe at home, in the community and school. The target population is a child/youth who is: - experiencing a psychiatric, behavioral, or emotional disruption/ escalation in a home, school, or other community setting. These disruptions/ crises arise from situations, events, and/or circumstances that are unable to be resolved with the usual resources and coping abilities or jeopardize the development of adaptive social and emotional skills and

			personal strengths development critical in healthy life functioning or, - presenting in psychiatric crisis in a hospital emergency department (ED) and in need of continued stabilization and follow-up care upon discharge from the ED. The purpose of MRSS is to provide community-based rapid de-escalation to children and their families and to provide brief follow-up care to promote continued stabilization and linkage with ongoing supports and services within the community. In addition to the direct provision of crisis intervention and stabilization services, the Rutland MRSS team engages in outreach, collaboration, coordination of care, promotion of the service, and other community-based activities to enhance access, service quality, child and family outcomes, and stakeholder satisfaction. For the first year of this pilot (Oct 2021-Sept 2022), 86% of families who received an initial mobile response have needed follow-up stabilization services. 71% of the calls for MRSS were new to the service; 29% were repeat callers. RMHS added a peer support specialist to the MRSS team in September 2022 who was part of the initial two-person response and who provided follow-up supports for families. It is notable that in 67% of calls for initial mobile response, the family requested the mobile response at a specific scheduled time rather than immediate, due to their own family needs. The mobile response was provider primarily at the youth's home, but the team also responds to the school or another community-based setting: - Youth Home or Residence: 66% - Youth's school: 12% - Other community setting: 22% ***Mobile Response Services Expansion***

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
			A directive from the 2022 Legislative Session tasked DMH with expanding the reach of statewide mobile response systems in order to build an urgent care model for mental health. The scope of this expansion shall be directly informed by the Department's analysis of statewide mobile crisis services and gaps, in accordance with the State Planning Grant from the Centers for Medicare and Medicaid Services. This model shall address geographic gaps where a lack of mobile outreach driving unnecessary emergency department visits or unnecessary law enforcement responses. Other additional directives state that it shall utilize peer supports, evidence-based practices, and be coordinated within the 988 system. Additionally, the Department is tasked with developing a sustainability plan to ensure that the services will continue to be available after expiration of FMAP funding. Currently, the Department is engaged in finalizing the Request for Proposals (RFP) for mobile crisis program expansion and is planning on posting the RFP by November 1st. The Department will potentially fund up to five expansion sites, as tasked by the Vermont legislature and he Federal Planning Grant that has funded much of this work. These efforts will be updated in subsequent reports
3.2.2. The state expects to make other program changes that may affect metrics related to Milestone 3.	*X*		
4. Earlier Identification and Engagement in Treatment, Including Through Increased Integration (Milestone 4)			
4.1. Metric trends			
4.1.1. The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 4.	*X*		

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

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

5.2.1. Compared to the demonstration design and operational details, the state expects to make the following changes to: 5.2.1a. The three statements of assurance made in the state's health IT plan	*Update to report*		The State's health data exchange and infrastructure efforts are aligned and reflected in the state's health information exchange plan, Vermont's Health Information Exchange Strategic Plan 2018-2022. There is established health IT infrastructure that supports the provision of care and measurement of the health care system and reform initiatives and is consistently being developed to embolden different facets of the health care ecosystem (e.g., public health management, Medicaid operations, etc.). In Vermont, the ecosystem of organizations, policies, people, and systems that relate to exchange and manage health data is called the Unified Health Data Space. The Unified Health Data Space exists to streamline aggregation of and access to health data to meet a variety of user needs. The philosophy behind the Unified Health Data Space is that a coordinated health information exchange architecture (relationship of systems and data) ensures there can be one health record for each Vermonter by designating a central health data repository. At the center of this concept is Vermont's health information exchange (VHIE) – the health data repository, a resource dedicated to aggregating health data from various sources, matching patient records across systems, capturing patient consent preferences, translating local terminology into a standard format (code set), and generally making health data interoperable and most useful to those authorized access to provide and coordinate care and improve or evaluate health care operations or the public's health. VHIE was recently certified by CMS as part of Vermont's Medicaid Enterprise, acknowledging the importance of this system to support Medicaid providers and the Medicaid plan in caring for Medicaid beneficiaries. All of Vermont's health data interoperability efforts adhere to and/or are in direct alignment with federal guidance. As illustrated in the state-wide strategic HIE Plan, Vermont

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
			continues to demonstrate success in implementing the federal Promoting Interoperability Program, working to adhere with federal information blocking and patient access rules, and has based all strategic planning on architecture and standards set forth by CMS and the Office of the National Coordinator. The HIE Plan, sustains a commitment to standards and tracks current activity at the federal level including recent advancement of the Trusted Exchange Framework and Common Agreement (TEFCA) and the ongoing advancement of the Fast Healthcare Interoperability Resource (FHIR) standard.
5.2.1b. Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider and/or physician/mental health provider to community-based supports			Vermont has continued to make progress on closed loop referrals using the State's Health Information Exchange (HIE). A component of this work involves establishing a Medicaid Data Warehouse and Analytics Solution (MDWAS), which will assist in the referral process through utilizing a unified health data space between mental health and general health care providers, such as physicians. As noted in previous reports, this HIE work will offer all health care providers the opportunity to be part of designing a program to onboard Medicaid providers to utilize data within the Exchange for accessing digital health records, improving care coordination, and assist with referrals between providers. Additionally, this referral process involves the development of bidirectionality of data by stakeholders, where data is both provided to and accessed from the Unified Health Data Space, where data is available to all stakeholders to assist in improving the closed loop referral process and assist in the continued development of e-referrals.
5.2.1c. Electronic care plans and medical records	*X*		

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

5.2.1e. Intake, assessment and screening tools being part of a structured data capture process so that this information is interoperable with the rest of the health IT ecosystem			Substance Use Disorder, Mental Health, Behavioral Health VHIE Pilot Background: In 2019, Vermont's Joint Fiscal Office (JFO) appropriated funds through a grant administered by DMH to Vermont's DAs to offset the cost of upgrading her systems at 9 of 10 agencies. Vermont Care Partners, on behalf of the DAs, was required to develop an interoperability strategy that considered the VHIE as a key component of data integration and exchange across the health care system. As a result, Vermont Information Technology Leaders (VITL) and Vermont Care Partners developed DA-specific Connectivity Criteria to ensure that once the DA systems are connected to the VHIE they can seamlessly transmit coded data that can be exchanged across care settings (to the extent that consent and organizational policies allow). Work is ongoing for establishing the Part II+ group that will commence in November 2022 with stakeholders to create universal policies and procedures for sharing sensitive data types. This group will assess changes to be made both to the statewide policy for consent to share data through the VHIE as well as VITL's internal policies. HIE Plan, 2021 Update Each year, the HIE Plan is updated by AHS in partnership with the HIE Steering Committee. State law (18 V.S.A. § 9351) states that "The Plan shall be revised annually and updated comprehensively every five years to provide a strategic vision for clinical health information technology." In 2022, it will be five years since this Plan was adopted, and therefore a time to update Vermont's strategic vision for health information as a crucial tool for integrated care and conducting effective population health management. The 2022 plan is currently being finalized and will provide pertinent updates related to DA Connectivity Criteria that includes data on intake, assessment, and screening tools. Updates from the Department of Mental Health on plan objectives are as follows:

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
			Objective #1: Deliver Quality Data at the Point of Care Share appropriate information with patient's care team to support care management and care coordination. The Department of Mental Health is continuing its work toward meeting this objective through: -Ensuring included data elements assist with patient identity matching to improve care coordination across all health care providers -Participating with related logistics for VHIE connection to national networks -Assisting with oversight of longitudinal health records being is based on USCDI and FHIR standards Objective #3: Manage Sensitive Health Information to create safe, effective solutions to share sensitive data (e.g., SUD, behavioral health, other), adhering to state and federal regulations. -Identifying relevant data elements specific to sensitive care settings including 42 CFR data -Collaborating with other state government departments and stakeholder agencies (e.g., Designated Agencies) to connect with the VHIE to contribute data elements Objective #4: Integrate Health & Human Services Data into the VHIE Develop tools and methods to collect, aggregate, and share Social Determinants of Health (SDOH) data. -Continuing to identify and establish specific SDOH data elements that will be reported by stakeholders to the VHIE and to connect SDOH data sources that contain these elements to the VHIE -Monitoring the creation technical and operational processes for aggregating claims data; utilize the FHIR standards model to do so (Planning Medium Term)

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

4. Narrative information on other reporting topics

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

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

7.1.3. Describe and explain any changes in the availability of mental health services for Medicaid beneficiaries with SMI/SED in the state compared to those described in the Initial Assessment of the Availability of Mental Health Services. At minimum, explain any changes across the state in the availability of the following services: inpatient mental health services; outpatient and community-based services; crisis behavioral health services; and care coordination and care transition planning. Recommended word count is 500 words or less.		With the onset of the COVID-19 pandemic in early 2020, Vermont's health care system has adapted to shifts in public health guidelines and workforce capacity fluctuation to ensure a safe response for all Vermonters. Providers managed staffing shortages as the workforce managed childcare, shifting domestic responsibilities, and financial stressors. The result is that capacity continues to shift in response to workforce challenges and changes in COVID-19 guidelines. Vermonters in need of psychiatric hospitalization are provided treatment at either the state-run inpatient facility, Vermont Psychiatric Care Hospital, or one of six Designated Hospitals throughout the state. The capacity is founded upon the balance between hospital admissions and discharges for people with acute mental health conditions. When this balance is unequal, and more admissions than discharges occur, hospital capacity is reduced over time. Level One care beds are for individuals who require the most intensive level of clinical support and services within the system. General inpatient units are for individuals facing significant mental health challenges and struggling to manage the symptoms to a degree that requires consistent, intensive clinical care and support to ensure their safety and wellbeing in daily living. The availability of inpatient beds across the system has remained relatively constant from 2015 through 2019 with bed day utilization (Total Occupied Beds) decreasing 14 percent from 2019 to 2020. The impact of the COVID-19 pandemic has contributed to a 14 percent decrease in bed day utilization, a two percent increase in bed vacancies and the 11 percent increase in beds closed in this same year. Over this eight-year period, 2021 has seen the lowest level of adult inpatient bed utilization; this remains true for 2022 utilization in large part due to staffing challenges within the field of psychiatry specifically. Community residential settings provide both transitional and longer term supports, averaging residential program lengths of stay within a 12-to-18-month time frame for residents. These services have met a key need for a significant number of individuals who are ready to leave higher levels of care, but who still require intensive support before taking steps toward independent living. From 2018 to 2019, there was a plateauing of utilization at 91 percent with a seven-year utilization history averaging between 86-93 percent. Since 2019, there has been a decrease to 84 percent in 2020 and further decrease to 76 percent in 2021. Numerous factors related to the ongoing COVID-19 pandemic are contributing to the reduced utilization, including a reduction of workforce, increased acuity in individuals, and providers adjusting operations to meet public health and safety guidance. The Department reports on the number of people served across various programs along with outcomes at discharge in the regularly updated Department of Mental Health

Prompt	State has no trends/update to report (place an X)	State response
		Scorecard. The highest number of persons served by programs offered by Vermont DAs continues to be in services for Children, Youth, and Families. These services had increased from 2012 until 2018, although between 2019 and 2021 there has been a fluctuation in the number of people served. Emergency Services saw an increase in the number of people served from 2011 to 2018 with a decrease in 2019 followed by a significant increase through 2021. Adult Outpatient programs remain reasonably level through this reporting period. Finally, Community Rehabilitation and Treatment programs continue a slow overall declining trend.
7.1.4. Describe and explain any changes in gaps the state identified in the availability of mental health services or service capacity while completing the Annual Availability Assessment compared to those described in the Initial Assessment of the Availability of Mental Health Services. Recommended word count is 500 words or less.	*X*	**See the response to section 7.1.3 for information regarding changes in gaps that have been identified in the availability of mental health services as compared to those described in the Initial Assessment of the Availability of Mental Health Services.*
7.1.5. Describe and explain whether any changes in the availability of mental health services have impacted the state's maintenance of effort (MOE) on funding outpatient community-based mental health services. Recommended word count is 500 words or less.	*X*	

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

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

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

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

9.1.1. Compared to the demonstration design and operational details, the state expects to make the following changes to: 9.1.1a. Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, and observation/assessment centers, with a coordinated community crisis response that involves law enforcement and other first responders	*Update to report*	**See section 3.2.1b for an overview of MRSS program advancements relevant to these objectives* The Department of Mental Health is currently engaging in a robust set of activities and grant funding initiatives to increase the availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, and observation/assessment centers, with a coordinated community crisis response that involves law enforcement and other first responders. The following summary provides updates to Vermont's efforts towards this end since the inception of the SMI/SED Monitoring Report Implementation Plan. Team Two is a training curriculum for law enforcement, and other first responders, and community mental health agency personnel focusing on the appropriate identification and response to individuals with mental illness who are experiencing a psychiatric crisis. Additionally, this training provides education for all first responders (mental health crisis workers, EMTs, law enforcement, ED personnel) on building the relationships necessary to working together in crises, as well as an overview of relevant mental health statutes. In 2021, The Vermont State Police, DMH, and Designated Agencies collaborated to embed mental health clinicians within VSP Barracks to work with law enforcement officers. These embedded crisis specialists are available for on-site assistance for mental health crisis assessments, de-escalation, consultation, support, resource connection and referrals. This collaboration is an effort to reduce the wait time for a person in crisis to meet with a crisis clinician for assessment services and mobile assessment. A goal of this program is to improve the education and collaboration between law enforcement and mental health crisis workers. Learning from each other's expertise has been shown to be the most effective model for the State of Vermont. *National Suicide Prevention Lifeline Capacity Building Initiative Funding Agreement with AHS* Through a one-time funding opportunity from Vibrant Emotional Health, funds from private donations were made available to the Vermont Agency of Human Service (AHS) to support the further alignment of Lifeline member call centers in Vermont with AHS state suicide prevention goals and activities and, specifically, to expand the capacity at three Vermont based Lifeline member call centers so that over a two year period and by September 30, 2021, the in-state answer rate for Vermont's Lifeline calls is at or above 70%. This funding Agreement covered the period of time from October 1, 2019-September 30, 2020. The Agreement between Vibrant Emotional Health and Vermont

		Agency of Human Services directly supported, via two-year subcontracting relationships at levels specified in the approved budget, expanded call center capacity for Lifeline calls at two Lifeline member call centers in Vermont (Northwestern Counseling and Support Services and 2-1-1 Vermont) and a third center applicant center (Pathways) so that sufficient year one progress was made towards reaching an in-state answer rate for Vermont's Lifeline calls that reaches or exceeds 70% by the end of year two of the grant (September 30, 2021). This agreement was subsequently extended through the period of September 29, 2020-September 29, 2021, and included a request on behalf of AHS for a community health center to be funded by this agency to support 24/7 phone services. This effort received an additional extension through October 31, 2021, to complete the work. Following this request, the Vermont Department of Mental Health entered into a grant agreement with Headrest Inc, in order to support Vermont Lifeline call center capacity. This agreement was effective October 1st, 2021through September 30, 2022. This grant has expired, and Vermont has since received a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to continue this work. *9-8-8 Planning Grant* Vermont has been preparing for the implementation of 9-8-8 since 2019. DMH secured funding to support the certification of two Lifeline centers to increase the in-state answer rate from 0% to 85%. Through a one-time funding opportunity from Vibrant Emotional Health, funds from private donations were available to DMH to support the development of a 9-8-8 implementation plan that ensures the federal mandate that by July 16, 2022, everyone in behavioral health crisis in the U.S. and its territories will have immediate access to effective suicide prevention and crisis services through the three-digit phone number, 9-8-8. The Services performed under this agreement occurred during the period February 1, 2021, to September 30, 2021. Vermont has dedicated intensive effort to increasing our in-state Lifeline answer rate. Through the support of the Lifeline Capacity Building Grant awarded to Vermont in 2019, we have been able to increase our in-state call rate from 0% in 2018, to 80% in the most recent quarter of 2020. From July 2020 – September 2020, 654 calls were initiated and 521 were answered in state. Vermont at the time of this agreement had one certified Lifeline Call Center, Northwestern Counseling and Support Services activated to answer

		calls, and another agency, Northeast Kingdom Human Services, who applied to become a Lifeline Call Center in November 2020; therefore, two centers will be eligible for 9-8-8 implementation planning. DMH planned to work with a broad array of stakeholders, including the State Police and Public Safety Answering Points, suicide prevention peer and advocacy groups, Lifeline members, cultural brokers representing marginalized groups, the Center for Health and Learning (the organization that is leading Zero Suicide implementation across Vermont), and representatives from the Designated Agencies who provide community mental health services, including Emergency Services throughout the state. On July 16, 2022, Vermont, along with the rest of the nation, transitioned from the National Suicide Prevention Lifeline to the 9-8-8 Suicide and Crisis Lifeline. Currently, Vermont is responding to calls 24 hours a day, 7 days a week and is working to build capacity to respond to chats and texts. The Vermont Department of Mental Health is working to create a 9-8-8 system that serves the unique needs of our residents, with the goal of providing equitable services to all Vermonters, including people of color, Native Americans, new Americans, and the LGBTQ+ community. Vermont's two Lifeline Call Centers, along with one backup center located in New Hampshire, has answered 4,041 calls in the last 12 months, with an average answer rate of 84.5%, according to our latest state metrics report from August 11, 2022. Initially the work to build capacity and implement 9-8-8 was funded through grants with Vibrant, the SAMHSA designated administrator for 9-8-8. With the support of Vermont Governor, Phil Scott, the State has now allocated state funds to continue to operate 9-8-8 into the future. In the coming year, Vermont and the two Lifeline Centers are working to build even more capacity to respond to add contacts, call, chats, and texts, 24/7 with a 90% answer rate. **Alternatives to EDs RFP** The Department has recently posted a Request for Proposals for Mental Health Urgent Care Programs as alternatives to Emergency Department (ED) use. The Department seeks to solicit proposals from qualified Medicaid providers to support start-up and program implementation costs to provide alternatives to hospital ED utilization for mental health crisis care. This opportunity will focus on crisis care that could be covered under the

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		rehabilitative services benefit and are intended to be less than 24-hour stays. The Department will accept bids for the four models in the spending plan that have been pre-approved by the Centers for Medicare & Medicaid Services: • Emergency Psychiatric Assessment, Treatment & Healing (or "emPATH") • Crisis Intervention Helping Out On The Streets (or "CAHOOTS") • Living Room, and • Psychiatric Urgent Care for Kids The Department will also allow other innovative submissions for consideration. Models not pre-approved may need to go through spending plan approvals or look to other funding options. However, all models should aim to reduce Emergency Department utilization for mental health crisis services.

9.1.1b. Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model	*Update to report*	**Program Overview:** In 2019 DMH and the Department of Vermont Health Access (State Medicaid Office) implemented an alternative Medicaid payment model for the state's Designated Agencies and Pathways Vermont, a Specialized Services Agency, for a wide array of mental health services. Most notably, the payment model for children's and adult services transitioned from traditional reimbursement mechanisms (a combination of program-specific budgets and fee-for-service payments) to a monthly case rate model. The mental health case rate model is one of the more mature alternative Medicaid payment models implemented by AHS, completing the fourth performance year on December 31, 2022. The foundational goals and principles driving mental health payment reform have remained unchanged throughout the life of this program. Those goals include: - Encouraging flexibility in service delivery that supports comprehensive, coordinated care; - Standardizing the approach to tracking population indicators, progress and outcomes; - Simplifying payment structures and improving the predictability of provider payments; - Improving accountability, equity and transparency; and - Shifting to value-based payment models that reward outcomes and incentivize best practices. **Progress to Date:** Performance Year 4 (calendar year 2022) saw a continuation of the case rate model under which agency-specific case rates are calculated for each agency's unique child and adult populations, based on the agency's allocation from DMH. Agencies are paid a fixed amount at the beginning of each month and are expected to meet established adult and child caseload targets. At least one qualifying service must be delivered during the month for an adult or child to be considered part of the agency's caseload. An important program accomplishment is that providers are now successfully submitting encounter claims to the Medicaid Management Information System (MMIS), which allows the State to monitor service delivery and other aspects of performance. Value-based payment to support quality improvement and accountability is an important component of this model. During each measurement year, DMH withholds a percentage of each agency's approved adult and child case rate allocations for these payments. **Proposed Future Model:**

		DMH is engaging in a learning collaborative with key stakeholders and decision-makers from the Designated Agency network, the Agency of Human Services, the General Assembly, and others around the Certified Community Behavioral Health Clinic Model. The exploration is intended to understand if this is a direction Vermont should pursue. Alternatively, DMH is also considering an updated alternative payment model (referred to as the "valuation model") that would be more similar to the current model but would introduce greater accountability and transparency. Certified Community Behavioral Health Clinics The Department completed the 6th of 9 meetings, facilitated by the National Council, on the Certified Community Behavioral Health Clinic Model. The exploration is intended to understand if this is a direction Vermont should pursue. The September meeting was focused on the scope of services. The October meeting will focus on Care Coordination. The U.S. Health and Human Services will release a planning grant Notice of Funding Opportunity in October 2022, with a 60-day application period and awards announcement in March 2023. Vermont would need to complete a planning grant to participate in the 2024 expansion of the Medicaid Demonstration authorized in the Bipartisan Safer Communities Act, which increases the number of demonstration states from 10 to 20. Demonstration states are eligible for an enhanced Federal Medical Assistance Percentages rate equivalent to the State's Children's Health Insurance Program rate. The Department is working with the Department of Vermont Health Access to review if a contractor, Manatt, could assist with the scope of work to analyze if Vermont could comply with demonstration state requirements, given the uniqueness of the 1115 waiver. Four of the ten Designated Agencies were awarded four-year $4 million dollar planning grants. The agencies that received the planning grants are: Northeast Kingdom Human Services; Health Care and Rehabilitation Services of Vermont; Clara Martin Center; and Rutland Mental Health Services. (See Clara Martin Center's press release here.) Whichever model Vermont chooses, the next iteration of the payment model will build upon the core principles established in current and past performance years, including caseload and quality targets, the proposed valuation model seeks to incorporate additional elements into the payment model, such as case mix, utilization, quality, and adequacy of rates. Incorporation of these additional elements supports the foundational goals of mental health payment reform by accommodating more flexible service delivery models built on transparent and equitable payments. AHS aims to conduct all necessary model

Prompt	State has no trends/update to report (place an X)	State response
		exploration, design and pre-implementation activities during 2022 and 2023 in collaboration with relevant stakeholders, to support a shift to the next iteration in Calendar Year 2024.
10. Budget neutrality		
10.1. Current status and analysis		
10.1.1. Describe the current status of budget neutrality and an analysis of the budget neutrality to date. If the SMI/SED component is part of a broader demonstration, the state should provide an analysis of the SMI/SED-related budget neutrality and an analysis of budget neutrality as a whole.		Updates on Budget Neutrality can be found in Section V. Financial/Budget Neutrality Development/Issues of the Broad Demonstration Monitoring Report.
10.2. Implementation update		
10.2.1. The state expects to make the following program changes that may affect budget neutrality.	*X*	
11. SMI/SED-related demonstration operations and policy		
11.1. Considerations		
11.1.1. The state should highlight significant SMI/SED (or if broader demonstration, then SMI/SED-related) demonstration operations or policy considerations that could positively or negatively impact beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SMI/SED demonstration's approved goals or objectives, if not already reported elsewhere in this document. See Monitoring Report Instructions for more detail.	*X*	
11.2. Implementation update		
11.2.1. The state experienced challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers) and/or noted any performance issues with contracted entities.	*X*	

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

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

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

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

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

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

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