Global Commitment to Health

11-W-00194/1

Section 1115(a)

Demonstration Amendment Request to CMS

(1/1/2017 – 12/31/2021)

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1. Request for SMI/SED Demonstration Opportunity

Vermont is 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. Under the terms of this waiver opportunity, 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.

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; and
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; and

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. 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 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 Member Months Receiving Services and IMD Services, CY 2018

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

9. Public Process

Public Comments and Associated Responses

Public comments and the state's responses will be posted after the public comment period has been closed.

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.

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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.

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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.*

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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	

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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	

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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.*

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	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.*

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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:

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	• 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.

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	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.*

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	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.

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	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

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	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:

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	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;*

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	• *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.

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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

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	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.
	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

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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 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

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	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, 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	**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.
	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.

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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	
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.
	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.

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	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 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:

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	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.	
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.

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	• 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 SED/SMI and linkages to treatment	**Current Status:** Milestone achieved. Vermont Medicaid supports a number of programs, initiatives, and practices that support the goal of increased integration. These include: • 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.

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	• 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 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:

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	• 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, integration, and specialized programs for young people	**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, 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.

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	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 centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.	**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 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.

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	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.
	Summary of Actions Needed: Discussion with CMS needed in order to receive approval of Vermont's financing plan.

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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.

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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/.

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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)	

[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.

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Prompts	Summary
1.1 Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider	**Current State:** Vermont does not currently have closed loop referrals or e-referrals occurring between physician and mental health providers.
	Future State: Expand existing Vermont HIT road map to include closed loop referrals and e-referral functionality.
	Summary of Actions Needed: Expand existing Vermont HIT road map to include closed loop referrals and e-referral functionality.
1.2 Closed loop referrals and e-referrals from institution/hospital/clinic to physician/mental health provider	**Current State:** Vermont does not currently have closed loop referrals or e-referrals occurring between hospitals/clinics/intuitions and physician and mental health providers.
	Future State: Expand existing Vermont HIT road map to include closed loop referrals and e-referral functionality.
	Summary of Actions Needed: Expand existing Vermont HIT road map to include closed loop referrals and e-referral functionality.
1.3 Closed loop referrals and e-referrals from physician/mental health provider to community based supports	**Current State:** Vermont does not currently have closed loop referrals or e-referrals occurring between and physician and mental health providers to community-based supports.
	Future State: Expand existing Vermont HIT road map to include closed loop referrals and e-referral functionality.
	Summary of Actions Needed: Expand existing Vermont HIT road map to include closed loop referrals and e-referral functionality.
Electronic Care Plans and Medical Records (Section 2)	

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Prompts	Summary
2.1 The state and its providers can create and use an electronic care plan	**Current State:** To achieve the vision of a Complex Care Coordination model, in 2017-2018, OneCare Vermont developed Care Navigator as a tool for organizations implementing community-based care coordination. The tool acts as a collaboration, communication, and engagement solution designed to deliver scalable care coordination recognizing ACO attribution, geography, and accessibility. Care Navigator and WorkBench One were developed to work in concert to support clinical care and enable patient engagement and care coordination. For example, care coordination data, such as goals and barriers to care, are fed from OneCare's Care Navigator software tool into WorkBenchOne where the data are combined with utilization, cost, and quality data to create a comprehensive view of the impact of the complex care coordination program across care-settings. These outputs are then used to identify care gaps, drive clinical insights, and identify variations in engagement and care across organizations and communities. The advanced analytics tools can be accessed by care team members, providers, and clinical governance committees to drive reform efforts, including opportunities to refine and advance the ACO's clinical model, quality foci, and payment models as they relate to driving clinical improvements (e.g. complex care coordination payment model). 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.
	Future State: In the current annual IAPD update submitted to CMS, DVHA is now seeking continued and expanded HITECH funding to support Medicaid 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. The developments of OneCare's systems are also aimed at engaging patients in their care
	Summary of Actions Needed: Work to expand support to Medicaid -participating providers in exchanging health information, coordinating care, and relying on trusted data sources to support clinical decision making related to priority health areas.

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Prompts	Summary
2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers	**Current State**: Participating IMD facility treatment plans are interoperable and accessible by all relevant members of the care team because they are accessed and written on by multiple clinical staff members while in draft form in the shared drive. Then the plans are refined, printed, signed and scanned into the patient's electronic medical record. Hard copies remain on the units.
	Future State: Expand HIT roadmap to ensure alignment across facilities.
	Summary of Actions Needed: None.
2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	**Current State:** Vermont does not currently meet this HIT milestone.
	Future State: Expand existing Vermont HIT road map to include functionality that provides for Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications.
	Summary of Actions Needed: Expand existing Vermont HIT road map to include functionality that provides for Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications.
2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	**Current State:** Vermont does not currently meet this HIT milestone.
	Future State: Expand existing Vermont HIT road map to include functionality that provides for Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications.
	Summary of Actions Needed: Expand existing Vermont HIT road map to include functionality that provides for Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications.

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Prompts	Summary
2.5 Transitions of care and other community supports are accessed and supported through electronic communications	**Current State:** Regarding outward-facing electronic communications for transitions of care, Medical Records scans and faxes clinical information to community providers. Direct access to the electronic medical record is restricted almost exclusively to internal facilities employees. Doctors have the ability to prescribe electronically to remote pharmacies during the patient discharge process.
	Future State: Expand HIT roadmap to ensure alignment across facilities.
	Summary of Actions Needed: None.
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:** Several workflows provided by VITL ▶ NVRH HL7 Consent Process ▶ UVMMC HL7 Consent Process ▶ All HL7 General Consent Setting Process ▶ All VHIE for patient search, including "breaking the glass" ▶ Meditech Expanse – External Application ▶ VCCI Query Process ▶ Setting VITLAccess Consent Process ▶ Changing Existing VITLAccess Consent Process 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 videoWeb Site Disclaimers or 14-

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Prompts	Summary
	minute videoWeb Site Disclaimers of the U.S. Department of Veterans Affairs (VA)/Substance Abuse and Mental Health Services Administration (SAMHSA) demonstration project.
	Future State: Utilize above workflows to inform the future state process. • Aggregating steps in HL7 ALL and facility specific HL7 diagrams • Utilize and restructure the VHIE internal process after policy options are made • Utilize VCCI diagrams to create template that will inform other par
	Summary of Actions Needed: Begin to build future state Use Case/Workflow Diagrams based on process options. Consider developing and providing guidance materials to providers/health care facilities on best practice workflows.
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:** **Current State:** Intake: Electronic Health Record (EHR) software application "Evident" or "Thrive" by CPSI includes a registration module where patient intake information is input by Admissions. Any information known about the patient, such as name, personal information, address, condition, family, insurance, etc., is entered into the system. Intake/assessment: The admitting doctor fills out an admissions template in the physicians' side of the EHR software ("Thrive UX"). The medical director requests changes to the admissions template as needed, such as compliance with the Joint Commission requirements. Point of care (POC, nursing) also has their own documentation for an initial assessment via a flowsheet. All clinical staff have ways to continue documenting their patient assessments in the EHR during the patients' stays and upon discharge. Doctors and social workers have a selection of templates to guide their input into patient care issues in the Thrive UX application. This can include progress notes, medical consults, certificates of need for involuntary procedures, discharge, etc. Nursing staff, dietary staff, and recovery staff may document in the Thrive POC application via flowsheets (nursing) and e-forms (nursing, dietary, recovery). However, while doctors/social

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Prompts	Summary
	workers in Thrive UX may view Thrive POC documentation, and nursing/dietary/recovery staff in Thrive POC may view the Thrive UX documentation, there is no cross-platform interactivity.
	Future State: Integrate tools into part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem.
	Summary of Actions Needed: Integrate tools into part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem.
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 DMH and regional Designated Agencies. A unified electronic health record or case/care management system between state and private partners has not 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 has telehealth capability. Therapeutic and counselling services for individuals in the custody of DMH are provided on-site. Psychiatric specialists (DMH 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. Telehealth services are used by an independent application to consult non-psychiatric specialists (internal medicine, neurology, endocrinology, podiatry, etc) and interact with the legal/justice system.
	Future State: Broader use of telehealth technologies leading to improved statewide mental health and primary care access.
	Summary of Actions Needed: VITL (Vermont Information Technology Leaders) provides HIE services to the State. Those services include data extraction and access to/from providers for continuity of care, and data aggregation for population health and analytics. Currently, no sensitive data (including mental health data) is part of VITL's scope of work due to technical limitations. However, the State & VITL are currently planning to expand VT HIE services to include 42 CFR part2 data that will cover mental health data exchange and aggregation allowing care coordination collaboration.
Alerting/Analytics (Section 6)	

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Prompts	Summary
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:** Vermont does not currently meet this HIT milestone.
	Future State: Expand existing Vermont HIT road map to include functionality that identifies 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.
	Summary of Actions Needed: Expand existing Vermont HIT road map to include functionality that identifies 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.
6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis	**Current State:** Vermont does not currently meet this HIT milestone.
	Future State: Expand existing Vermont HIT road map to ensure that Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis.
	Summary of Actions Needed: Expand existing Vermont HIT road map to ensure that Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis.
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	**Current State:** Vermont does not currently meet this HIT milestone.
	Future State: Expand existing Vermont HIT road map to include functionality for care team to tag or link a child's electronic medical records with their respective parent/caretaker medical records.

[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

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Prompts	Summary
respective parent/caretaker medical records	**Summary of Actions Needed:** Expand existing Vermont HIT road map to include functionality for care team to tag or link a child's electronic medical records with their respective parent/caretaker medical records.
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.

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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.

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Attachment B

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**

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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%**	

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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	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	130.56	130.56	130.56	0.119670027	1	1	
2. BENNINGTON	166.26	166.26	166.26	0.11203504	1	1	
3. CALEDONIA	138.72	138.72	138.72	0.113798195	1	1	
4. CHITTENDEN	1228.08	1228.08	1228.08	0.290876362	1	1	
5. ESSEX	6.12	6.12	6.12	0.028333333	1	1	
6. FRANKLIN	127.5	127.5	127.5	0.06429652	1	1	
7. GRAND ISLE	4.08	4.08	4.08	0.01915493	1	1	
8. LAMOILLE	77.52	77.52	77.52	0.084169381	1	1	
9. ORANGE	86.7	86.7	86.7	0.077757848	1	1	
10. ORLEANS	83.64	83.64	83.64	0.070050251			
11. RUTLAND	233.58	233.58	233.58	0.110964371			
12. WASHINGTON	204	204	204	0.098408104			
13. WINDHAM	237.66	237.66	237.66	0.167957597			
14 WINDSOR	160.14	160.14	160.14	0.076805755	1	1	
Total	**2885**	**2885**	**2885**	**0.13519685**	**1**	**1**	

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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	206.04	206.04	206.04	0.188854262	1	1	
2. BENNINGTON	262.14	262.14	262.14	0.176644205	1	1	
3. CALEDONIA	214.2	214.2	214.2	0.175717801	1	1	
4. CHITTENDEN	1878.84	1878.84	1878.84	0.445011843	1	1	
5. ESSEX	8.16	8.16	8.16	0.037777778	1	1	
6. FRANKLIN	237.66	237.66	237.66	0.119848714	1	1	
7. GRAND ISLE	5.1	5.1	5.1	0.023943662	1	1	
8. LAMOILLE	155.04	155.04	155.04	0.168338762	1	1	
9. ORANGE	156.06	156.06	156.06	0.139964126	1	1	
10. ORLEANS	141.78	141.78	141.78	0.118743719			
11. RUTLAND	336.6	336.6	336.6	0.159904988			
12. WASHINGTON	430.44	430.44	430.44	0.2076411			
13. WINDHAM	446.76	446.76	446.76	0.315731449			
14 WINDSOR	297.84	297.84	297.84	0.142848921	1	1	
Total	**4777**	**4777**	**4777**	**0.223877953**	**1**	**1**	

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State Name
Date of Assessment
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Geographic Distribution

Community Mental Health Centers

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	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	0.002749771	1	1	
2.	BENNINGTON	3	3	3	0.002021563	1	1	
3.	CALEDONIA	3	3	3	0.002461034	1	1	
4.	CHITTENDEN	3	3	3	0.000710564	1	1	
5.	ESSEX	3	3	3	0.013888889	1	1	
6.	FRANKLIN	3	3	3	0.001512859	1	1	
7.	GRAND ISLE	3	2	3	0.009389671	0.6666667	1.5	
8.	LAMOILLE	3	3	3	0.003257329	1	1	
9.	ORANGE	3	3	3	0.002690583	1	1	
10.	ORLEANS	3	3	3	0.002512563	1	1	
11.	RUTLAND	3	3	3	0.001425178	1	1	
12.	WASHINGTON	3	3	3	0.001447178	1	1	
13.	WINDHAM	3	3	3	0.002120141	1	1	
14	WINDSOR	3	3	3	0.001438849	1	1	
	Total	**42**	**41**	**42**	**0.001921635**	**0.9761905**	**1.0243902**	

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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	0.000473709	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	0.000706714			
14 WINDSOR				0	-	-	
Total	**3**	**3**	**3**	**0.000140607**	**1**	**1**	

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State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution

Residential Mental Health Treatment Facilities

Residential Mental Health Treatment Facilities (Adult)

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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	0.000473709	1	1
5. ESSEX				0	-	-
6. FRANKLIN				0	-	-
7. GRAND ISLE				0	-	-
8. LAMOILLE				0	-	-
9. ORANGE	1	1	1	0.01	1	1
10. ORLEANS				0		
11. RUTLAND	1	1	1	0.005649718		
12. WASHINGTON	1	1	1	0.004032258		
13. WINDHAM	2	2	2	0.027777778		
14 WINDSOR				0	-	-
Total	**7**	**7**	**7**	**0.000328084**	**1**	**1**

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State Name
Date of Assessment
Time Period Reflected in Assessment

Geographic Distribution

Residential Mental Health Treatment Facilities

Residential Mental Health Treatment Facilities (Adult)

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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**

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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	-	-	0	-	-	
2. BENNINGTON	0	-	-	0	-	-	
3. CALEDONIA	0	-	-	0	-	-	
4. CHITTENDEN	0.029612756	1	1	0	-	-	
5. ESSEX	0	-	-	0	-	-	
6. FRANKLIN	0	-	-	0	-	-	
7. GRAND ISLE	0	-	-	0	-	-	
8. LAMOILLE	0	-	-	0	-	-	
9. ORANGE	0.16	1	1	0	-	-	
10. ORLEANS	0			0			
11. RUTLAND	0.02259887			0			
12. WASHINGTON	0.028225806			0			
13. WINDHAM	0.194444444			0			
14 WINDSOR	0	-	-	0	-	-	
Total	**0.029347826**	**1**	**1**	**0**	**-**	**-**	

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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						
11. RUTLAND						
12. WASHINGTON						
13. WINDHAM						
14 WINDSOR				0	-	-
Total	**0**	**0**	**0**	**0**	**-**	**-**

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State Name
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Geographic Distribution

Residential Mental Health Treatment Facilities

Psychiatric Residential Treatment Facilities

DRAFT

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							
11. RUTLAND							
12. WASHINGTON							
13. WINDHAM							
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				
5. ESSEX						
6. FRANKLIN						
7. GRAND ISLE						
8. LAMOILLE						
9. ORANGE						
10. ORLEANS						
11. RUTLAND		1				
12. WASHINGTON	1	1				
13. WINDHAM		2				
14 WINDSOR	1					
Total	**2**	**5**	**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.

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State Name
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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	-	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	0					
13. WINDHAM	0	0					
14 WINDSOR	0	0	0	-	-	-	
Total	**0**	**0**	**0**	**0**	**-**	**-**	

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State Name
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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	**2**	**0**	**2**	**0**	**2**	**0**

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State Name
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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					
13.	WINDHAM	0.000706714	0					
14	WINDSOR	0	0	-	-	-	-	
	Total	**9.37383E-05**	**0**	**1**	**-**	**1**	**-**	

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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						
Total	**5**	**1**	**5**	**1**	**5**	**1**

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State Name
Date of Assessment
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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					
12. WASHINGTON	0.000482393	0					
13. WINDHAM	0	0.000706714					
14 WINDSOR	0	0	-	-	-	-	
Total	**0.000234346**	**4.68691E-05**	**1**	**1**	**1**	**1**	

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State Name
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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				-	-	-	
5. ESSEX				-	-	-	
6. FRANKLIN				-	-	-	
7. GRAND ISLE				-	-	-	
8. LAMOILLE				-	-	-	
9. ORANGE				-	-	-	
10. ORLEANS							
11. RUTLAND							
12. WASHINGTON	25	25	25				
13. WINDHAM	99	99	99				
14 WINDSOR				-	-	-	
Total	**124**	**124**	**124**	**62**	**1**	**1**	

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State Name
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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	**3**	**14**	**15**	**1**	**0.000140607**	**0.000656168**	**0.000703037**

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State Name
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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**	

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State Name
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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**	

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