Governer's Access Plan for the Seriously Mentally Ill

Evaluation Report

YEAR 1

June 27, 2016

Section 1115 Waiver Demonstration
Approval Period: 1/1/2015 – 12/31/2019

Evaluation Period:
1/1/15-12/31/15

Executive Summary

On June 20, 2014, Governor Terry McAuliffe declared, "I am moving forward to get Virginians healthcare." To that end, he charged Secretary of Health and Human Resources Dr. Bill Hazel to create a detailed plan, outlining opportunities and implementation targets to provide Virginians greater access to physical and behavioral health care. A Healthy Virginia was the outcome of the work of the secretariat, and is a ten-step plan to expand healthcare services to over 200,000 Virginians. The Governor's Access Plan (GAP) for the Seriously Mentally Ill (SMI) was the first step, aiming to offer a targeted benefit package to Virginians who have income less than the federal poverty level and are living with a serious mental illness.

The three key goals of the GAP Demonstration are to:

1. Improve access to health care for a segment of the uninsured population in Virginia who have significant behavioral and medical needs;
2. Improve health and behavioral health outcomes of demonstration participants; and,
3. Serve as a bridge to closing the insurance coverage gap for Virginians.

Without access to treatment, individuals with SMI are often unnecessarily hospitalized, may be unable to find and sustain employment, struggle with affordable and available housing, become involved with the criminal justice system, and suffer with social and interpersonal isolation. Preliminary evidence indicates that the opportunities provided through the GAP demonstration have enabled persons with SMI to access both behavioral health and primary health services, enhancing the treatment they received and allowing their care to be coordinated among providers. With such treatment, individuals with SMI and co-occurring or co-morbid conditions can recover and live, work, parent, learn and participate fully in their community.

During the first year of the demonstration the average monthly cost for a single GAP member was $200 less than a single visit to an emergency room for a minor visit, providing early evidence that the program is cost effective. Early evidence suggests the need for continued examination of the impact of non-covered services, e.g., inpatient care and transportation on member outcomes.

DMAS hypothesized that GAP members' health and behavioral health outcomes would improve simply by having access to health and behavioral health care. Within the first year of the demonstration GAP members have demonstrated they will choose to use person-centered, community based behavioral and health care providers in lieu of emergency rooms even with a limited benefit plan and a fragmented service delivery system. For some GAP members, Recovery Navigation Services have been shown to supplement and complement clinical treatment, i.e., to improve care for a previously underserved population with complex medical conditions who require coordinated care to better manage their own healthcare.

Demonstration Description

The GAP demonstration was launched in January 2015 with support from a wide variety of stakeholders, including providers, advocates, families, and other state agencies. GAP offers a targeted benefit package (see Appendix A) to Virginians who have a serious mental illness and income less than 95% of the federal poverty level (FPL).

Of the 300,000 individuals in Virginia with SMI, about 50,000 individuals are uninsured. Working with stakeholders, it was determined that many of those 50,000 individuals were already known to the safety net of indigent care providers in Virginia, i.e., community services boards (CSBs) , federally qualified health clinics (FQHCs), hospitals, etc. Although limited, the GAP benefit plan includes behavioral health, primary and specialty health care coverage. The intent of the benefit package is to ensure that each GAP member acquires a primary care physician to coordinate the member's physical and behavioral health care with the assistance of Magellan of Virginia, DMAS' behavioral health services administrator. Magellan also provides assistance to GAP members who need help identifying or accessing a health care provider.

DMAS used a variety of strategies to improve access to health care, improve health and behavioral health outcomes, and bridge the insurance coverage gap. Strategies included the following:

- Trained providers on the new benefit plan and the eligibility criteria;
- Conducted outreach and presentations across the state;
- Targeted correspondence to pharmacies about the GAP benefits;
- Distributed Medicaid Memos about the benefit plan to all providers;
- Created a dedicated webpage and email account for GAP;
- Targeted correspondence to potential screening entities to encourage participation
- Conducted weekly stakeholder calls prior to and during initial implementation to communicate updates and problem solve concerns.

The 2015 Virginia legislative session mandated that the household income threshold be decreased to 60% of the federal poverty level from 95%. Enrollment projections were recalculated to accommodate for the decrease in FPL. By the end of December 2015, there were 6,983 unduplicated individuals enrolled in GAP over the course of the year.

Demonstration Logic Model

In order to provide a high level overview of the GAP demonstration, DMAS developed a logic model (see Table 1 below) as a visual presentation of the key inputs to the GAP demonstration, the activities and outputs produced by these resources, and the expected outcomes of the activities which support achievement of the goals of the demonstration.

Inputs	Activities	Outputs	Outcomes - Impact		
			Short-Term	*Medium-Term*	*Long-Term*
Federal government – CMS State government – VA Medicaid, Behavioral Health Behavioral Health Services Administrator (BHSA) Providers (including physical health, behavioral health) VA citizens and advocacy groups	Enroll individuals in the GAP Demonstration Provide access to physical health and behavioral health through an integrated care coordination model Provide coverage for services often not reimbursable for uninsured individuals Improve overall health of GAP participants through access to primary care, medications, and behavioral health supportive services Ensure more appropriate use of the overall health system by providing recovery navigation (peer support) and other services that will help stabilize GAP participants	Participants have improved access to care, even when their health needs are complex, requiring physical health, and behavioral health coordination Medicaid Providers are compensated for providing services to a complex population that traditionally lack health insurance Providers have responsible point of contact through the CSB and BHSA GAP participant conditions are stabilized and therefore they do not deteriorate to a disabling status, being less likely to seek a disability determination Citizens and advocates receive value for Medicaid expenditures	Participants access appropriate physical health and behavioral health services, to include their medications Participants receive continuity of care across the spectrum of services for the duration of their needs Support for participants through new service, Recovery Navigation (peer support)	Appropriate utilization of outpatient and inpatient services Provider network collaboration across all domains of service (physical health, behavioral health, pharmacy) Satisfaction among all providers of care (physical health, behavioral health) GAP Participant satisfaction GAP participants stabilized and seek a disability determination for SMI only when necessary.	Improved overall health status to include behavioral health stabilization for GAP Participants Decline in growth rate of Medicaid expenditure due to diverting individuals from disability determination and likely full Medicaid eligibility, unless it is medically necessary Stronger collaboration among physical health and behavioral health providers Increased use of natural supports in the community; i.e. peer provided resources.

Table 1: GAP Logic Model

Impacted Populations and Stakeholders

The GAP demonstration targets individuals who meet eligibility parameters resulting from a diagnosis related to SMI. In addition to having been screened as meeting the diagnostic criteria for SMI, individuals must meet all of the requirements outlined below to be eligible for the demonstration:

- Adult ages 21 through 64 years old;
- SMI criteria, including documentation related to the duration of the mental illness and the level of disability based on the mental illness:
- Not otherwise eligible for any state or federal full benefits program including: Medicaid, Children's Health Insurance Program (CHIP/FAMIS), or Medicare;
- Household income that is initially below 95% FPL and as of May 15, 2015, below 60% of the FPL;
- Uninsured; and,
- Not residing in a long term care facility, mental health facility, or penal institution.

Table 2: 2015 GAP Population

Eligibility Group Name	Social Security Act and CFR Citations	Income Level	Timeframe
Adults not otherwise eligible under the State plan	N/A	0-60% of the FPL	Entire demonstration
Adults not otherwise eligible under the State plan	N/A	60-100% of the FPL	No longer than July 1, 2016

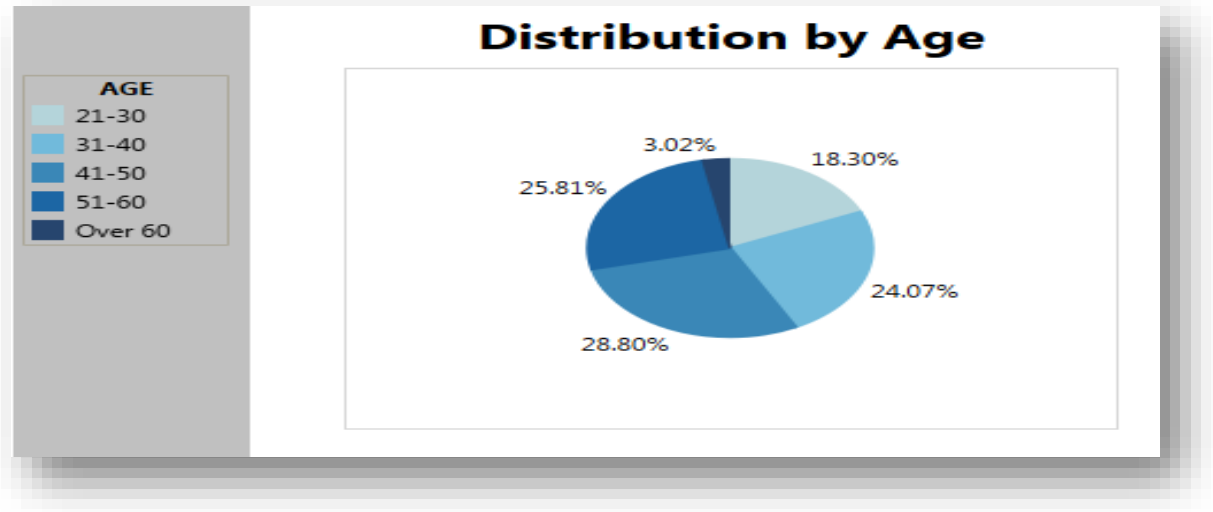

Table 3: GAP Population Age Distribution

Prior to eligibility determinations, applicants were required to complete an SMI screening; this tool assessed the following areas to determine whether SMI criteria were met: Age, Diagnosis, Duration of Illness, Level of

Disability and whether due to the mental illness, the applicant requires assistance to consistently access and to utilize needed medical and/or behavioral health servicer/supports. With regard to the diagnosis, the applicants' primary diagnosis had to be at least one of the approved diagnoses listed:

- Schizophrenia spectrum disorders and other psychotic disorders with the exception of substance/medication induced psychotic disorders;
- Major Depressive Disorder;
- Bipolar and related disorders with the exception of cyclothymic disorder;
- Post-Traumatic Stress Disorder (PTSD); and
- Other disorders including Obsessive-Compulsive Disorder (OCD), Panic Disorder, Agoraphobia, Anorexia nervosa and Bulimia nervosa.

Enrolled members' primary diagnoses consisted mainly of Major Depressive Disorder (42.45%), Bipolar Disorders (26.78%), Schizophrenia (10%) and PTSD (9.94%) (see Table 3.3). This somewhat mirrors the Virginia Medicaid fee for service population where the majority of the population has a mood disorder as the primary diagnosis.

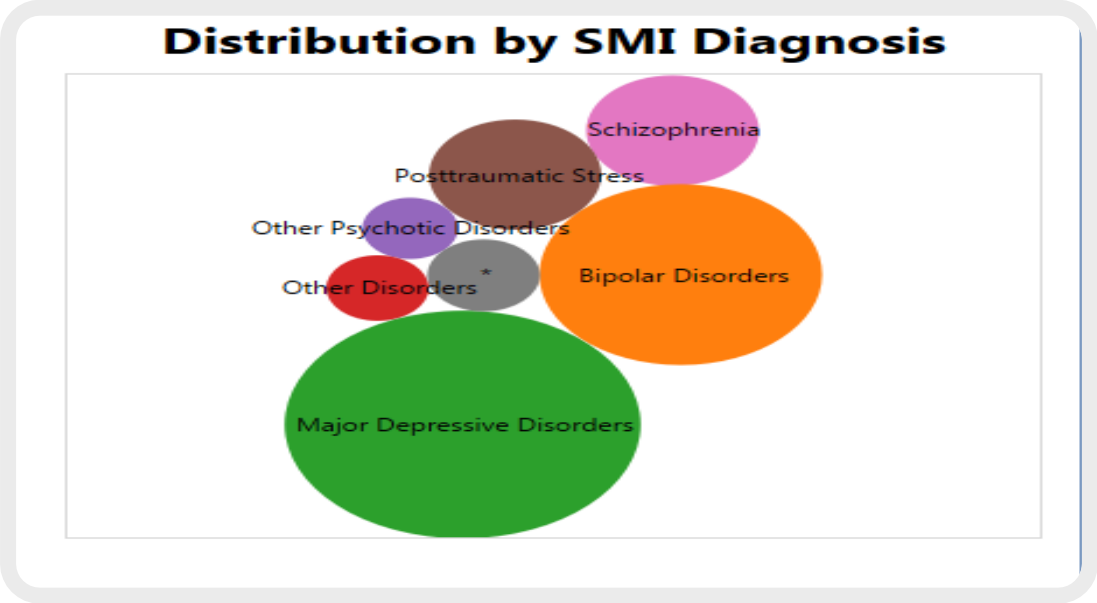

Table 4: GAP Population by SMI Diagnosis

DMAS was fortunate to have a robust stakeholders group involved in the development and implementation of the demonstration. Stakeholders were knowledgeable about the current Medicaid service delivery system, indigent care services, and the target population of uninsured individuals with SMI who are indigent or very low income. Stakeholders included the Department of Behavioral Health and Developmental Services (DBHDS), state universities, providers, community services boards, FHQCs, Magellan of Virginia, family members and individuals with lived experience with a mental health condition. In addition to the large stakeholder group, several smaller workgroups, comprised of these stakeholders and including individuals with topic specific expertise, met and advised DMAS about program areas, e.g., what psychiatric diagnoses should be considered for SMI criteria and the eligibility application process.

Study Design

The GAP evaluation is a simple pre- and post- single group design. DMAS anticipates that by defining the GAP members' baseline in certain areas and measuring the outcomes in those same areas post GAP participation, there will be improvement in members' behavioral health and/or health conditions. It will be assumed that GAP, the intervention, is the cause of the positive change over time. This design was selected as there is no feasible means to collect members' clinical histories within the resources available. DMAS will use year 1 of the demonstration to establish the baseline and year 2 as the intervention. It is recognized that this is a limited design as it will not allow for trends or the progress of change for the members, nor does it allow for other variables; however, it will identify where the members were in year 1 compared to where they finish in year 2 after using GAP benefits.

The GAP metrics were identified using the data elements that could be collected once the member is enrolled in GAP and rely heavily on claims data. With the evaluation panel advice and recommendations, specific Healthcare Effectiveness and Data Information Set (HEDIS) performance measures were selected based on the prevalence of co-occurring conditions for the SMI population. Additionally, data from the Recovery Navigators and Cover Virginia were analyzed to identify psycho-social outcomes for GAP members.

DMAS has faced challenges acquiring data from some sources as well as reconciling data from DMAS contractors. While Cover Virginia (DBHDS) reports that 7077 members have enrolled in GAP over the calendar year 2015, DMAS data reflect a total of 6,983 members participating in GAP. The DMAS count has been used for evaluation reporting. DMAS continues to work with contractors and GAP partners to address data access and quality issues.

Measures

Appendix B presents the measures that are being used to determine whether each program goal has been achieved. This table describes the data source, stratification categories, comparison groups, and frequencies for each measure.

Data Sources and Collection

The evaluation draws on multiple data sources depending on the research question, variable being measured, and population. The study design includes both individual-level and aggregate measures of relevant utilization, expenditures, health status, and other outcomes. Data sources include:

- *The Virginia Medicaid Management Information System (MMIS)*: Virginia's MMIS contains information about enrollment, providers, and claims/encounters for health services. Encounter data, in measuring each participant's interaction with the health care system, will underlie many of the measures of cost and utilization of particular services by individual participants. Detailed data on participant characteristics maintained in the MMIS will allow analyses to be stratified by participants' demographic and health and pharmacy service use characteristics. The MMIS system will be used to generate specific reports required by the evaluation.

- *Behavioral Health Services Administrator (BHSA) -Specific Reports***:** DMAS' contract with the Behavioral Health Services Administrator, Magellan of Virginia, requires the submission of extensive reporting on multiple aspects of participant and behavioral health care provider activity such as: specialized services, care coordination, utilization management, quality, and claims management. Many of these reports supply information that answers research questions and provides or supplements the measures used to test research hypotheses with detailed specifications and uniform templates for reporting.

- *Peer Administered Survey*: Recovery Navigator Program Metrics capture primary measures of self-reported information valuable to the evaluation of the GAP Demonstration. Metrics include primary measures such as inpatient and outpatient hospital visits, engagement with the criminal justice system, and psycho-social indicators.

- *The National Committee for Quality Assurance (NCQA)*: is used and cross referenced when evaluating measures pertaining to improving access to health care for GAP members. The evaluation panel has drawn from NCQA's large set of data elements that pertain to individuals who compare to the GAP member. An array of measures were chosen ranging from prescription adherence to engagement of treatment.

- *Cover Virginia*: The Cover Virginia portal and call center is integral to the application process of the GAP demonstration. During the eligibility determination process and renewal, Cover Virginia captures information pertaining to the GAP member. Although originally there consideration to use the database that supports Cover Virginia to determine a control group population, this was ruled out.

- *Temporary Dettention Order (TDO) Claims:* DMAS serves as the payer of TDO claims in Virginia. Having access to these claims means that TDO Claims can be cross referenced with GAP Participants to measure success in reducing inpatient days, thus improving social and behavioral health outcomes of demonstration participants.

- *Virginia Health Information (VHI) Data:* VHI serves as Virginia's source of health care information, data and reporting. VHI was created to promote informed decision making by Virginia consumers and purchasers and to enhance the quality of Virginia's health care. DMAS will continue to communicate with VHI to obtain hospital data, attempting to track hospital or emergency room utilization of GAP participants.

- *Department of Behavioral Health and Developmental Services (DBHDS):* DBHDS is Virginia's state agency overseeing programs, supports, services, and providers for individuals and their families who experience behavioral health and developmental disabilities. In its support structure, DBHDS is responsible for the state operated mental hospitals, which will be a data source of hospital data. DMAS has been and will continue to collaborate with DBHDS to obtain this and other necessary data available to support evaluation of the GAP demonstration.

Controls for Other Interventions in the State

A major concern within evaluation research and study design is whether the effects of a demonstration can be separated from other activities and external influences that may affect the measured outcomes. DMAS and the evaluation panel have ensured that while conducting the evaluation, the measures and outcomes are as isolated as possible. The expert evaluation panel share significant experience and resources to inform the demonstration evaluation. These partners and resources are sensitive to the importance of isolating data and have supported the evaluation team in providing clean data for use by the expert evaluation panel and DMAS evaluation team.

While there have been no external activities or influences on developing the goals and hypotheses or for data collection for GAP, an external activity did influence the enrollment numbers. The household income eligibility federal poverty level changed from 95% to 60% causing GAP enrollment to slow down. This slowing in enrollment impacts the number of uninsured individuals with SMI who could access health and behavioral healthcare services via GAP.

Discussion of Findings

Goal 1

The GAP demonstration will serve as a bridge to closing the insurance coverage gap for Virginians.

Hypothesis 1.
Individuals who do not have health coverage will seek to gain access to health and behavioral health care by applying for the GAP demonstration.

What percentage of uninsured Virginians have applied for the GAP Demonstration?

Measure	Data Source
Number of complete applications submitted to Cover Virginia for the GAP Demonstration compared to total uninsured SMI population in Virginia	Cover Virginia, DBHDS

Data

20% of VA's uninsured SMI population applied for the GAP Demonstration.

Unduplicated applications received*	10,752
Estimated # uninsured individuals with SMI	54,000
* Completed, unduplicated applications: exludes applications withdrawn prior to determination. NOTE: The total estimated number of uninsured Virginians is 995,000	

What percentage of uninsured Virginians have applied and enrolled in the GAP Demonstration?

Measure	Data Source
Number of approved applications submitted to Cover Virginia for the GAP Demonstration compared to total uninsured SMI population in Virginia	Cover Virginia, DBHDS

Data

13% of VA's uninsured SMI population was approved for the GAP Demonstration

Applicants approved for GAP**	6,983
Estimated # uninsured individuals with SMI	54,000
**Includes members who: 1) were approved but subsequently requested coverage cancellation; 2) were approved, but later found to have or begin receiving Medicare in the period; 3) were approved but dis-enrolled during the renewal period. NOTE: The total estimated number of uninsured Virginians is 995,000	

Goal 2

The GAP demonstration will improve access to health care for a segment of the uninsured population in Virginia which has significant behavioral and medical needs

Hypothesis 2. *Integrating care coordination, primary care, specialty care, pharmacy, and behavioral health care for individuals with SMI, who are otherwise uninsured and do not have adequate access to care, will result in better health for GAP participants.*

Has the GAP Demonstration impacted access to care for GAP eligible individuals through access to primary care, medications, and behavioral health supportive services?

Measure	Details	Data Source
Adults' Access to Preventive/ Ambulatory Health Services (AAP)	The percentage of members 21 years and older who had an ambulatory or preventive care visit during the measurement year. ♦ 21 to 44 years of age ♦ 45 to 64 years of age	MMIS

Data

71.22% of the 6,983 enrolled GAP members utilized health care services during the evaluation period as illustrated in the table below.

Health Care Services

Primary Diagnosis Category	Health Care Indicator: Member With HS Claims	Health Care Indicator: Total GAP Members
*	2.32%	4.24%
Bipolar Disorders	19.78%	26.78%
Major Depressive Disorders	30.29%	42.45%
Other Disorders	2.35%	3.52%
Other Psychotic Disorders	2.05%	3.08%
Posttraumatic Stress	7.40%	9.94%
Schizophrenia	7.03%	10.00%
Grand Total	**71.22%**	**100.00%**

0% 50% 100% 150% — % of Total Distinct count of Recip ..

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Table 5: GAP Members with Health Care Claims

Measure	Details	Data Source
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	The percentage of members with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.	MMIS, NCQA National data

Data

25% (174 members out of 698) of GAP members with schizophrenia were dispensed anitispsychotic medication and continued their medication for at least 80% of their treatment period. As illustrated in the table below, over 40% of GAP members with schizophrenia and prescribed medication did not receive a claim for medication during the evaluation period. This is being explored by DMAS.

Adherence to Antipsychotic Medication by Schizophrenia

Adherence_to_Antipsychotic_m..	Antispcyhotic_Ind	
80% Adherence	Received	174
Less than 80% Adherence	Received	225
	Not Received	299
Grand Total		**698**

Table 6

Measure	Details	Data Source
NQF Measure 0105: Anti-depressant Medication Management	The percentage of members with a diagnosis of major depression and treated with antidepressant medication, and remained on an antidepressant medication treatment. ♦ Effective Acute Phase Treatment (on medication for at least 84 days/12 weeks) ♦ Effective Continuation Phase Treatment (for at least 180 days/6 months)	MMIS, NCQA National data

Data

41% of members (1,203 out of 2,964) with a diagnosis of major depression were treated with antidepressant medication and remained on an antidepressant medication for at least 80% of the treatment period. As shown in Table 5 below, 44% of GAP members were prescribed antidepressant medication but did not receive a claim for medication during the evaluation period. This is being explored by DMAS.

Adherence to Antidepressant Medication by MDD

Antidepressant_Adherence	Antidepressant_ind	
80% Adherence	Received	1,203
Less than 80% Adherence	Received	585
	Not Received	1,176
Grand Total		**2,964**

Table 7

Measure	Details	Data Source
Drug utilization for chronic health condition	Members with chronic conditions such as diabetes, cardiovascular health condition and hypertension utilizing drugs for these medical conditions.	

Data

Of the 72% GAP members with a diabetes diagnosis, 504 (10% of those diagnosed) received cholesterol reducers, 271 (5%) received lipotropics anad 283 (5%) received both medications. Of the 71% GAP members with a diagnosis of hypertension, 1522 (30% of those diagnosed with hypertension) received medications for the condition. Only 2 members were diagnosedwith a cardiovasucular condition and both were receiving medications for those conditions.

Measure	Details	Data Source
NQF Measure 0004: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) (National Committee for Quality Assurance)	The percentage of adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following. - Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. - Engagement of AOD Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	MMIS, DBHDS, NCQA National data (tbd)

Data

Of the 6983 total GAP members, 346 or 5% have used Substance use disorder treatment. Data are based on claims data for GAP members after enrollment in GAP. DMAS will explore this more thoroughly in year 2 of the demonstration.

How many GAP Participants have utilized their GAP Coverage?

Measure	Data Source
Number of approved applicants who have a behavioral health services claim	Magellan/MMIS

Data

74% of GAP members received a claim for behavioral health services during the evaluation period.

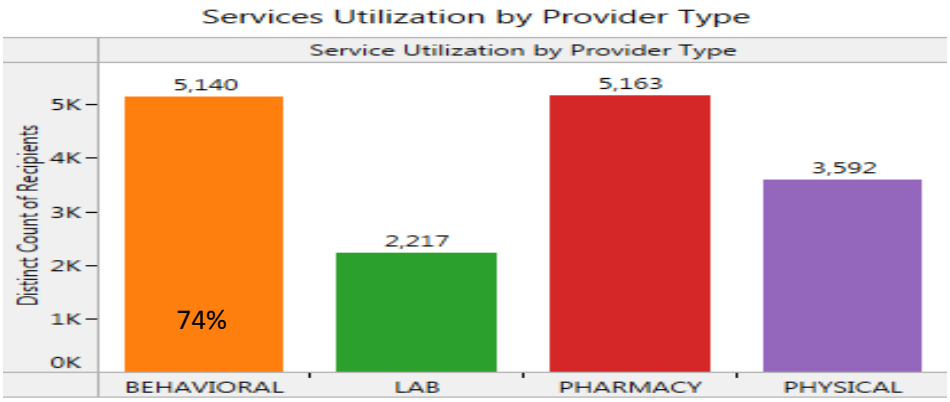

Table 8: GAP Members with Behavioral Health Service Claim

Measure	Data Source
Number of approved applicants who have a physical health services claim	MMIS

Data

51% of GAP members had a claim for physical health services during the evaluation period.

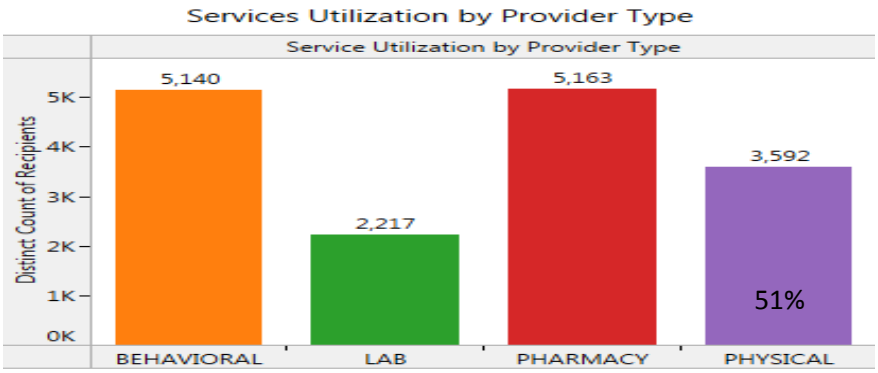

Table 9: GAP Members with Physical Health Services Claim

72% of GAP members have co-occuring behavioral health diagnoses and diabetes. The table below, based on claims that have diabetes as the primary diagnosis, illustrates that GAP members with diabetes received care for their physical health needs.

Diabetes

Primary Diagnosis Category	Diabetes Indicator	
	Members With Diabetes	**Total GAP Members**
*	2.41%	**4.24%**
Bipolar Disorders	19.93%	**26.78%**
Major Depressive Disorders	30.66%	**42.45%**
Other Disorders	2.33%	**3.52%**
Other Psychotic Disorders	2.13%	**3.08%**
Posttraumatic Stress	7.50%	**9.94%**
Schizophrenia	7.20%	**10.00%**
Grand Total	**72.18%**	**100.00%**
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	% of Total Distinct count of R..	% of Total Distinct count of R..

Table 10: GAP Members with Diabetes Diagnosis

Discussion

DMAS recognizes also that pharmacy claims demonstrate access to and utilization of care, i.e., GAP members must see a prescribing practitioner to be evaluated and receive a prescription.

Measure	Data Source
Number of approved applicants who have a Pharmacy claim	MMIS

Data

74 % of GAP members had a pharmacy claim during the evaluation period.

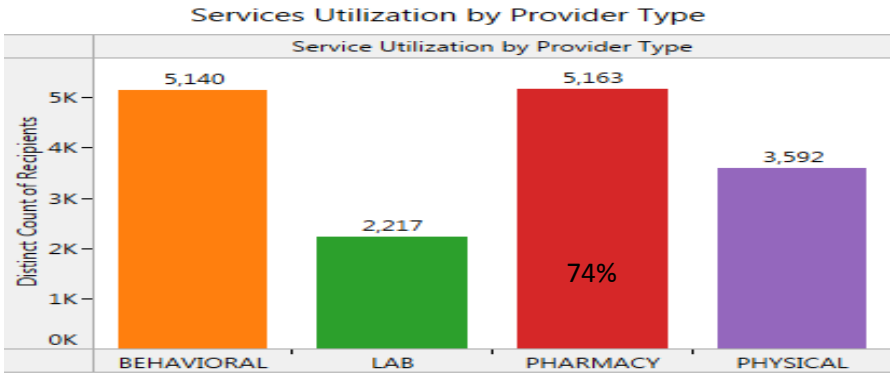


Table 11: GAP Members with Pharmacy Claim

Are there critical services participants do not have access to that are necessary for this population to achieve improved health and wellness outcomes?

Measure	Details	Data Source
Measure access to common treatment elements to promote recovery including: Prevention and Wellness, Medications. Behavioral health services, Inpatient Services, and Transportation	% of claims denied because the service was not covered	MMIS

Data

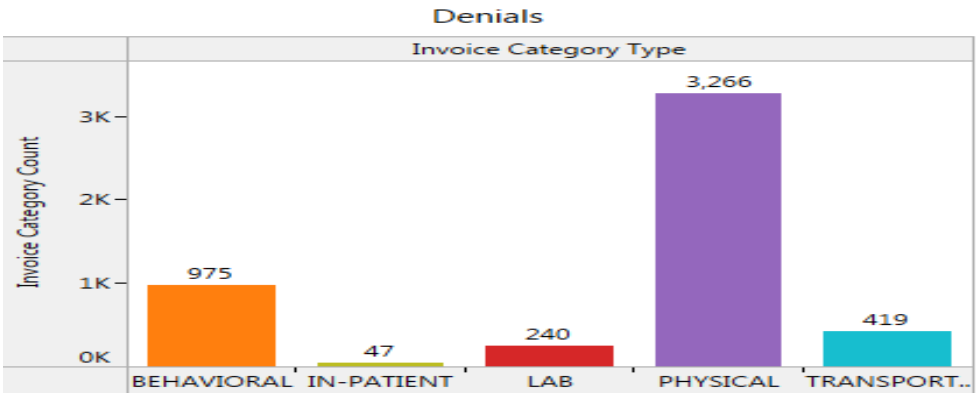


Table 12: Service Denials by Category Type

Discussion

Of the Virginia Medicaid covered services, there are critical services that are not covered which would provide needed assistance to members related to medical and behavioral health needs. These include inpatient services, outpatient services, surgeries in a hospital setting, and transportation. Table 10 illustrates denied claims submitted for services not covered by GAP. As the GAP is a limited plan, emergency, ambulatory and inpatient services (which provide immediate care for severe medical issues) are not be covered. Members, however, are assisted by Magellan care coordinators to identify providers on the Preferred Pathway Provider list that are able to aid in administering care for uncovered services. DMAS is exploring a possible technical errors that may be causing some outpatient "clinic" services to be denied inadvertently.

Transportation is an uncovered service and DMAS has heard anecdotally that this is a much needed service. As well, DMAS is aware that transportation is key to accessing services and is a major factor in influencing members to maintain appointment compliance and filling prescriptions. It has been of great concern for members who need substance use disorder (SUD) treatment as DMAS has a very limited provider network for that specialty; not having transportation in order to reach distant SUD providers negatively impacts members' ability to access SUD treatment.

Have GAP participants utilized Recovery Navigation?

Measure	Details	Data Source
Ensure more appropriate use of the overall health system by providing recovery navigation (peer support) and other services that will help stabilize GAP participants	Number of GAP participants with a claim for recovery navigation. What percentage of GAP enrollees participated in the recovery navigation program?	Magellan

Data

1.7% of GAP enrolles (121 members) participated in Recovery Navigation.

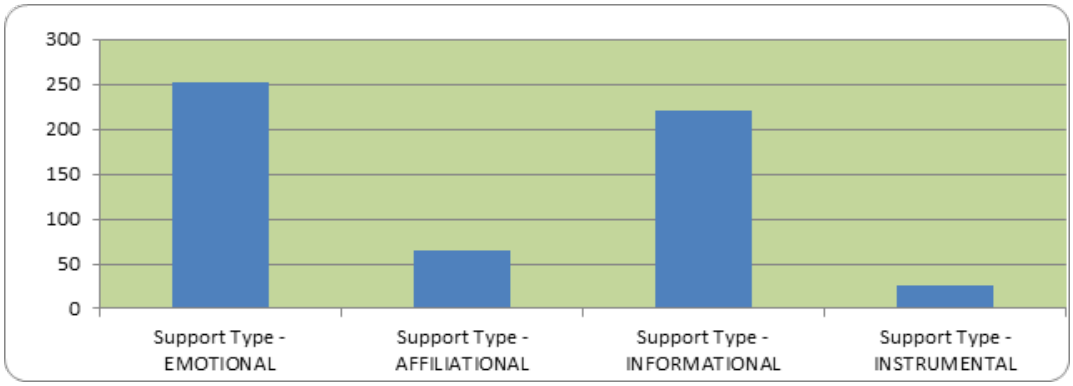


Table 13: Recovery Navigation Supports Provided

Discussion

Recovery Navigators delivered a total of 563 types of supports during the evaluation period. GAP members received peer supports from Recovery Navigators provided by Magellan. Magellan Recovery Navigation Services are provided by trained Recovery Navigators, who self-disclose as living with or having lived with a behavioral health condition. The goal of Recovery Navigation Services is to make the transition into the community a successful one and avoid future psychiatric inpatient hospital stays by providing an array of linkages to peer run services, natural supports, and other recovery oriented resources. During the evaluation period, there were 121 unduplicated members enrolled in Recovery Navigation Services. With emotional and informational support representing 84% of the supports delivered, there is evidence that the members receiving Recovery Navigation services are building skills needed to identify and employ positive coping skills that can reduce the likelihood of emergency room visits and inpatient admissions. The vignette in Figure 1 illustrates the progress of a GAP member through the eyes of a Recovery Navigator.

When I first met the GAP member, he was hesitant to share anything about himself. In fact, he wasn't sure he wanted to speak to me at all. The first time we spoke he requested that I contact his Case Manager and if she told him Recovery Navigation would be good for him he would do it, he "trusted her opinion."

When we met face to face, I shared a little of my recovery story and something clicked with him. He asked if I had been afraid when I saw my daughter for the first time after a long period away. It seemed we shared the commonality that we both were forced to spend some time away from our children. Once I answered his question, he began to open up and started showing me pictures of his daughter, whom he had not seen in two years. As part of a custody agreement the courts had ordered Robert to attend anger management, parenting, and alcohol awareness classes. At the time of this first meeting, he had not made any progress towards attending those court ordered classes. In fact, he had not done anything that would bring him closer to seeing his daughter. As we parted from our first meeting, I shared some resources along with suggestions on what had worked for me. But honestly I was just there as someone who understood and that he could talk to.

Over the past 6 months he has made significant strides in regaining stability in his life and towards seeing his daughter. He has finished the second of the three classes needed to satisfy the courts. He volunteered this summer at a friend's marina which allowed him to be more social and grow his support system. He has scheduled volunteer activities at a local ice skating center at the end of October teaching children how to ice skate. He is maintaining his recovery and working on his goals. He is a lot closer to receiving his disability and securing housing.

Figure 1: Recovery Navigator Vignette

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), there are different types of recovery navigation supports categorized as follows:

- Emotional - Demonstrating empathy, caring, or concern to bolster person's self-esteem and confidence. Ex: Recovery Navigator sharing information about their lived experience to help member identify with common themes and identify ways to cope;

- Affiliational - Facilitating contacts with other people to promote learning skills, create community, and acquire a sense of belonging. Ex: Recovery Navigator meeting with member in the community to attend support groups or visiting entities such as peer run organizations to learn about the services they offer;
- Informational - Sharing knowledge and information and/or providing life or vocational skills training. Ex: Recovery Navigator providing education on what a Wellness Recovery Action Plan (WRAP) plan is and how to customize one specifically for the member; and
- Instrumental - Providing concrete assistance to help others accomplish tasks. Ex: Recovery Navigator assisting the member with completing an application to renew benefit coverage by facilitating a conference call to Cover Virginia.

Have GAP participants utilized Care Coordination?

Measure	Details	Data Source
Number of GAP participants with a claim for Care Coordination	Number of GAP participants with a claim for care coordination.	Magellan

Data

GAP members received care coordination from Magellan during the evaluation period, however data are not available for the evaluation period. Negotiating reporting requirements for care coordination and the required contractor's system regarding Care Coordination numbers resulted in a delay in reporting. DMAS has received data for the second evaluation year which will be reported in the future.

Discussion

There are two levels of care coordination provided by Magellan:

- **Community Wellness**: Magellan works closely with GAP case managers at the local CSB/BHA and help to facilitate communication and collaboration between the physical health and behavioral health providers.
- **Community Connection:** Includes all supports of community wellness at a higher frequency.Designed for individuals with a higher level of care coordination needs, such as those with high social stressors, frequent emergency room visits and hospitalizations, and those at risk for readmission.

A predictive model has been developed and collection of data over the next year will enable robust analysis prior to reporting of Year 2 data. This predictive modeling strategy will help DMAS to identify not only the individuals who appear to be using a lot of services and may need assistance with care coordination, but also those members who do not appear to be using any/many services who may need assistance with accessing services.

Have GAP participants had their care coordinated with a Medical Doctor?

Measure	Details	Data Source
Follow-up after Hospitalization for Mental Illness	The percentage of discharges for members who were hospitalized for treatment of selected mental health disorders and had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported as the percentage of discharges for which the member received follow-up within: ♦ seven days of discharge ♦ 30 days of discharge	MMIS, DBHDS, TBD

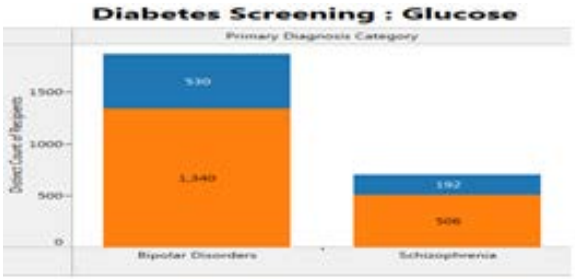
Data

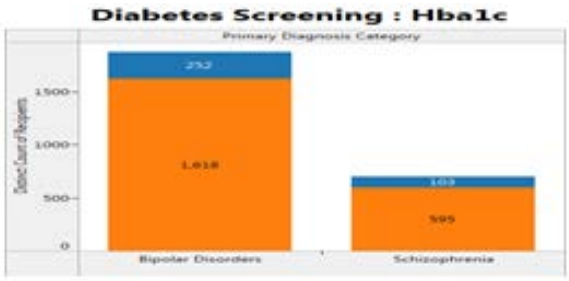
Data not available.

Measure	Details	Data Source
Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications	The percentage of members 18 to 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	MMIS

Data

1,340 members with Bipolar Disorders and 506 with Schizophrenia had glucose screenings.
1,618 members with Bipolar Disorders and 595 with Schizophrenia had the Hba1c screening.

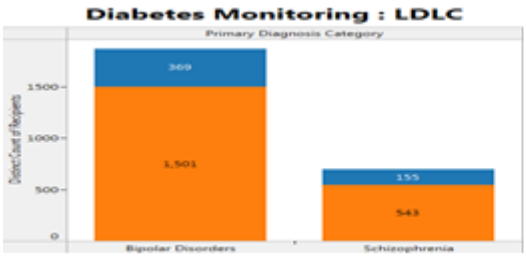


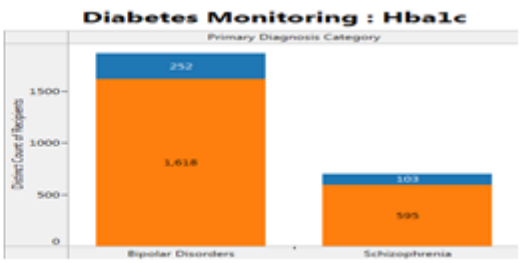


Measure	Details	Data Source
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	The percentage of members 18 to 64 years of age with schizophrenia and diabetes, who had both an LDL-C test and an HbA1c test during the measurement year.	MMIS

Data

1,501 members with Bipolar Disorders and 543 with Schizophrenia had LDLC monitoring.
1,618 members with Bipolar Disorders and 595 with Schizophrenia had Hba1c monitoring.





Discussion

There are more members involved in monitoring their diabetes than were initially screened after GAP enrollment. This is likely due to members with a diabetes diagnosis prior to GAP enrollment.

Measure	Details	Data Source
Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications	The percentage of members 18 to 64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.	MMIS

Data:

Only 2 members were reported with cardiovascular disease. Sample size was not sufficient for analysis.

Measure	Details	Data Source
Integration of behavioral health and medical health	Percentage of providers who provide both behavioral health and medical services	MMIS

Data

18.28% of providers have rendered both medical and behavioral health services as shown in the table below.

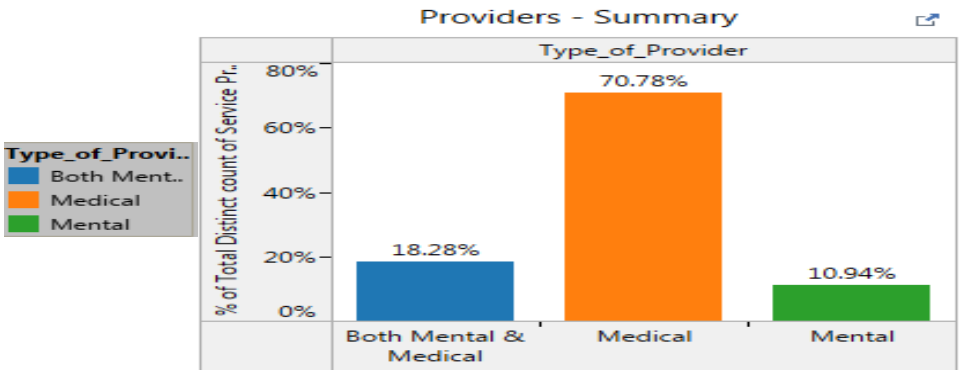


Table 15

The table below illustrates the number of service providers by provider type.

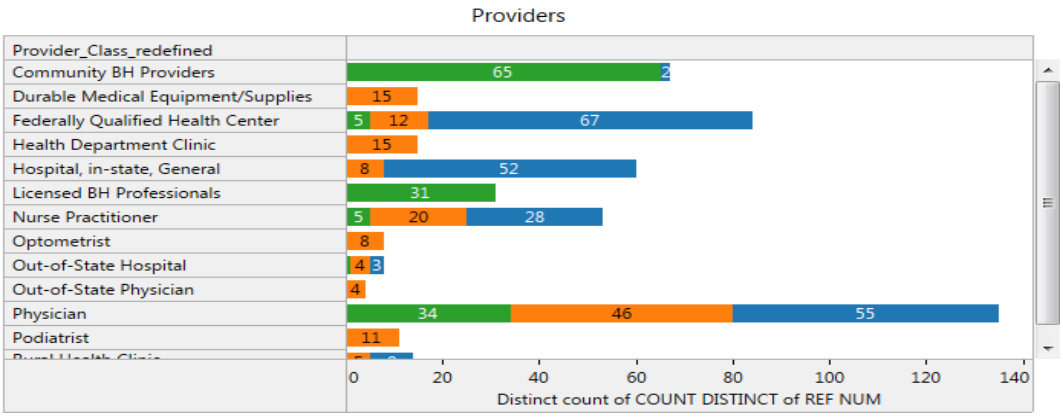


Table 16

Discussion

Of interest but not currently avaiable, is the number of individual GAP members who are actually experiencing integrated care. DMAS will consult with CMS about this measure. Table 12 demonstrates that GAP members are accessing a variety of practitioners and specialists.

Has there been a reduction in costs as a result of improved quality of service and timely preventive services?

Measure	Details	Data Source
Cost analysis of program - by age group - by diagnosis - by service type	Trending costs for the program	

Data

Trend data will become available after multi-year data collection.

Goal 3

Improve health, social and behavioral health outcomes of demonstration participants.

Hypothesis 3. *Through the provision of coverage and access, GAP participants will experience a better quality of life and better health outcomes.*

Has the integration of physical and behavioral health services resulted in better quality of life and psycho -social outcomes?

Measure	Details	Data Source
Reduction in the number of interactions with the criminal justice system for GAP Participants	Reduction in/no change in number of incarcerations/arrests in past 30 days from date of first service to date of last service.	DOC - TBD

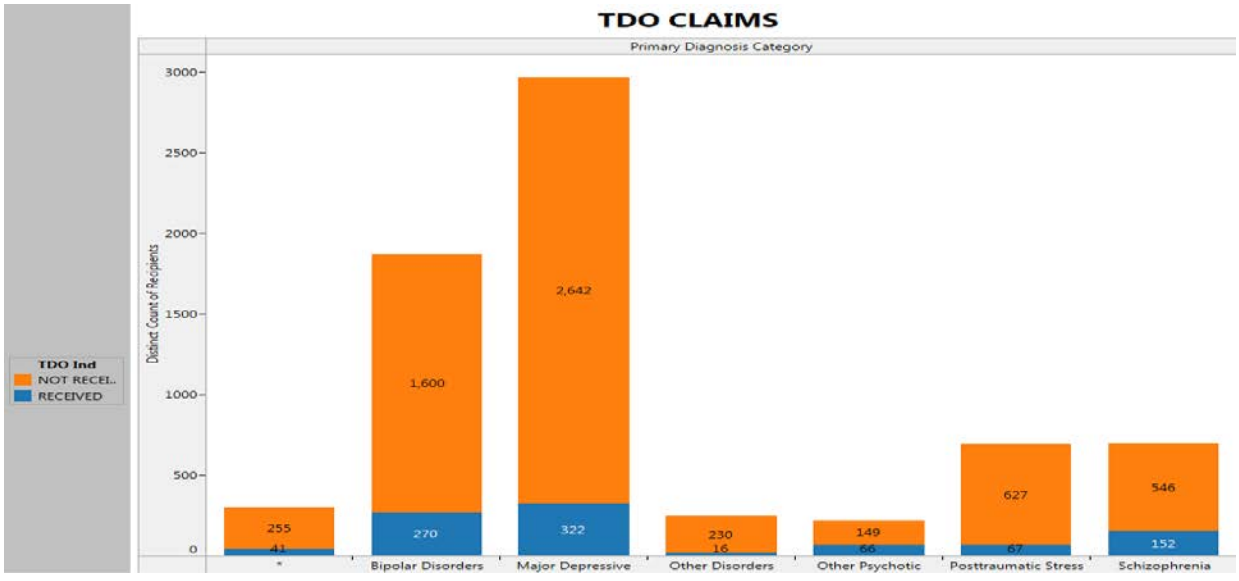
Data

There has been limited availability of data for GAP member interactions with the criminal justice system. DMAS continues to work with the Department of Corrections to obtain this information for future evaluation reports.

Measure	Data Source
Reduction in Temporary Detainment Order (TDO) Claims and ECO orders	MMIS

Data

Temporary Detention Orders (TDOs) were highest among GAP members with Major Depression (322), Bipolar Disorders (270) and Schizophrenia (152). As the demonstration period continues, more data will be collected to be used in efforts to identify trends (i.e. reduction in TDOs). The table below does not reflect multiple TDOs of the same member.



Discussion

TDOs are legal orders from a magistrate allowing the local law enforcement to escort individuals exhibiting behaviors that appear to be a danger to the individual or others to a facility for a psychiatric evaluation and decision regarding involuntary hospitalization. Because GAP members do not have coverage for inpatient, the rate of TDOs could be indicative of a need for inpatient coverage.

Measure	Data Source
Show Reduced or No Substance Use*	Magellan, DBHDS - TBD

Data

Data not available

Measure	Data Source
Are Not Homeless	Magellan, DBHDS

Data

277 GAP applicants self-reported a household living arrangement as "homeless." Applicants were not asked to describe their living arrangement if a response such as "living with a relative,", "living with a friend," etc. was provided in an attempt to ensure quality of data collection regarding homelessness.

Measure	Data Source
Are Employed Full or Part-Time	Magellan, DBHDS

Data

Data not currently available. Cover Virginia does not gather data that would identify full or part-time employment status. Some self-report of employment status was collected by the Recovery Navigators but was not statistically significant.

Has the integration of physical and behavioral health services resulted in better health outcomes of demonstration participants?

Measure	Details	Data Source
Did GAP Participants become eligible for full Medicaid as a result of a disability determination?	GAP Participants who became eligible for full Medicaid as a result of a disability determination	MMIS

Data

Data not available.

Measure	Details	Data Source
Has there been a reduction in the number of emergency department visits for GAP Participants ?	Self reported through recovery navigation survey	Magellan, VHI

Data

7 members self-reported Emergency Room visits.

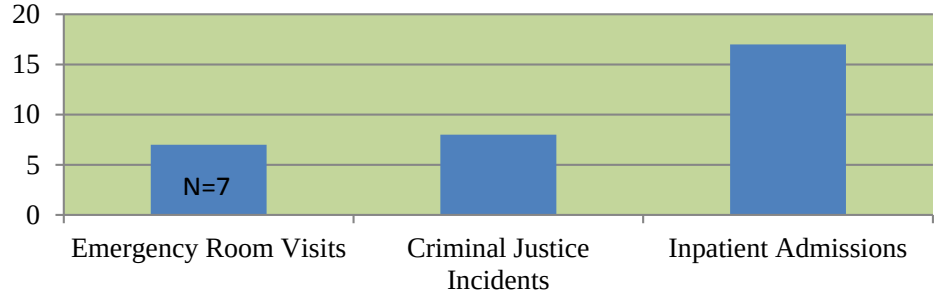


Table 17: Recovery Navigation Self Report of Emergency Room Visits

Measure	Details	Data Source
Has there been a reduction in the number of hospital admissions for GAP Participants?	GAP Participants who have hospital admission	DBHDS - TBD

Data

17 members self-reported inpatient hospitalizations.

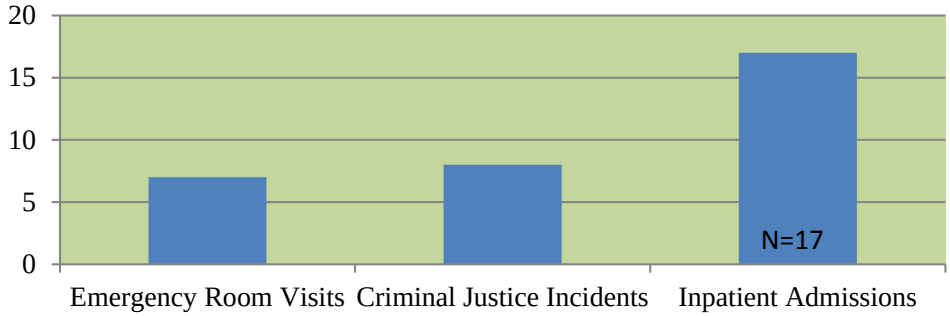


Table 18: Recovery Navigation Self Report of Inpatient Admission

Discussion of Findings and Conclusions

First year evaluation of the GAP program provides evidence that given health care coverage, limited though it may be, adults with SMI who have previously relied emergency departments and entities that service the indigent/uninsured populations accessed more traditional health care providers.

Cost Effectiveness and Budget Neutrality

As a large financier of health care in Virginia, DMAS is committed to designing and implementing programs that meet the Triple Aim of better health, better care, and lower costs. For the demonstration, Virginia assumed risk through the Per Capita Method. Virginia used a diversionary budget neutrality model based on projected expenditures for its non-long term care Aged, Blind and Disabled (ABD) population. The basic hypothesis of the model is that providing a targeting subset of Medicaid services will prevent the demonstration population from becoming ABD-eligible.

On average, claims reflect that the cost of serving the GAP population averaged $418 per month including both behavioral health and physical health care. The Virginia Health Information (www.vhi.org) estimates that it costs an average of $687 per visit for a "very minor" emergency room visit. This minor visit could include prescription refills, minor scrapes/abrasions and a very brief interview/examination in order to make treatment recommendations. Thus, during the first year of the demonstration, the average monthly cost for a single GAP member represented $200 less than a single visit to an emergency room for a minor visit.

For behavioral health conditions about 65% , approximately $267, of the total average monthly cost is related to behavioral health services and prescriptions. For 2015 the average cost of crisis intervention services for fee for service Medicaid recipients was $1030 per month. In contrast, the GAP average monthly cost in 2015 for all behavioral health services per member was $267.

It is anticipated that the GAP average monthly cost will increase over time as members begin to access more services and their treating providers order more labs and/or medications to treat conditions that are identified. The caveat to this analysis is that DMAS has not gained access, and will not gain access, to all data related to non-covered services specifically inpatient services or other non-covered services provided by DMAS preferred pathway providers or enrolled providers who are providing the non-covered services and not being reimbursed by DMAS. This gap in the data impacts our ability to better analyze and demonstrate cost effectiveness.

Implementation Successes

The greatest success of the GAP program is that individuals with SMI are accessing health and behavioral health care. The data demonstrates that nearly 75% of all enrolled GAP members have used their GAP benefits as demonstrated by the diabetes and hypertension data reflected earlier in the report.

Moving the eligibility determination to CoverVirginia and away from the local departments of social services has been invaluable to the success of the project. CoverVirginia established a GAP specific unit that processes all of the applications and is continuously brainstorming strategies to make the application and renewal process easier for the potential members to navigate. They have shown great compassion when working with individual GAP members and have offered recommendations for changes to processes that are under consideration. The local social service agencies could not have isolated the GAP applicants from the great volume of Medicaid applications they receive; thus the GAP applicants would not have received the individual attention needed to help this population manage the application process.

Recovery Navigation services have made an influential impact on the service delivery system in Virginia. As this service was a unique benefit to the GAP plan, much effort has gone into providing an experience for the GAP members in their journey toward better mental health. As a result of these efforts, peer supports will be added to Substance Use Disorder benefits as a reimbursable service for all Medicaid members, not limiting it to only Fee-For-Service members. This will allow for a larger population to gain additional support through the efforts of those who identify with the members and can provide insight on how to work toward healthier living.

Of utmost value to the GAP evaluation process and planning is the expert evaluation panel. The panel members bring not only expertise in the area of conducting research but their experience and familiarity with Virginia service delivery systems, the SMI population, and stakeholder influences enhanced the development of the goals and hypotheses. They challenged the DMAS team to not only think critically about data and the metrics but also to explore other avenues to acquire data. They also cautioned the DMAS team to limit the evaluation to what could realistically be measured

Challenges

While having access to data from Cover Virginia, Magellan, and DMAS data sources, it is a challenge to ensure consistency in data across the three entities.

The evaluation design was kept to a single group pre-post study due to the difficulty in accessing GAP members' clinical or psychosocial information prior to their GAP enrollments. The uninsured SMI population seeks medical care from emergency rooms, hospitals, free clinics and/or charitable organizations. Without a single consistent record-keeping mechanism, collecting data from the variety of entities serving the uninsured GAP member is not feasible.

As noted earlier, the household income eligibility for GAP participation changed from 95% to 60% of the federal poverty level with significant impact on enrollment, i.e., reduced number of individuals who could access health and behavioral healthcare services via GAP.

In 2015, diagnostic coding included codes from DSM-IVTR, DSM-V, ICD9 and ICD10. With those coding changes, some diagnoses also changed from one resource to another. These changes made identifying and tracking the GAP members' eligibility difficult and caused much of the delay in reporting.

Lessons Learned

The foremost lesson learned is the importance of effective collaboration and communication among the demonstration partners from the earliest stages of the project as well as timely communication between the partners throughout the project. Key staff within DMAS and DBHDS, i.e,. those with institutional knowledge about the

demonstration and/or partner agency functions, left the GAP effort. Data initially thought to be available from partner agencies was not available to DMAS for the evaluation. Discussions with DBHDS and VHI are on-going to assess data availability.

A second lesson learned is of the need to build in more quality checks on data from different systems to ensure accuracy and consistency. This will need to be included in future contracts/agreements with outside entities.

Policy Implications

Since the benefit package for GAP is a subset of the overall Medicaid benefit package, there are few lessons learned or strategies that would be replicated in other Medicaid programs. The efforts of the Recovery Navigators, however, have been of great interest to Virginia Medicaid stakeholders and have become one of the great success stories for the program. By including the Recovery Navigators in GAP, not only did GAP members benefit from a type of peer support, but Virginia learned how this service could work in our state. To that end, the 2016 General Assembly approved including peer supports in the entire Medicaid program for those members with mental health and substance use needs. This service will be included in the new substance use disorder program that Virginia will implement in the Spring of 2017.

The decision to have GAP's financial eligibility criteria not take into consideration an individual's assets as regular Medicaid does has been well received by applicants and stakeholders. Not including assets in the financial eligibility criteria allowed applicants to maintain a vehicle, to continue to live in a family home, and not have to sell all of their belongings or empty their bank accounts simply to qualify for Medicaid. This has been a great addition to the program as it allows a level of stability that this population needs when so much of the rest of their life is unstable.

Excluding transportation from GAP was a financial decision due to limited state resources for the demonstration. As noted earlier in this report, transportation is key to service and treatment access. Virginia has large rural geographic areas with great distance between providers and services. The impact of excluding transportation is heightened by the very low income allowance for GAP eligibility, i.e.,GAP members have little to no extra funds to pay for cabs, paratransit or other transportation.

Although the intent of the GAP is to divert members away from using emergency rooms and needing inpatient services, not covering these services may cause GAP members to delay treatment for emergency situations or accidental injuries. Further, not covering inpatient treatment excludes members from some care that can only be done on an inpatient basis, e.g., joint replacements or complex surgeries.

There is early evidence to support that, given the opportunity to access person-centered, community based services in lieu of emergency rooms, people will use a limited benefit plan rather than go without health care.
The GAP demonstration was planned as a small step to address an insurance gap in Virginia. As it was a small step, a population with much stigma, and an overwhelmed Medicaid provider and preferred pathway provider network, it was of great value to have the Governor's and Secretary's support to help move the demonstration along. That "top down" interest, support, and accountability motivated many of the GAP partners to collaborate more effectively.

Interactions with Other State Initiatives

Virginia's criminal justice system has become a behavioral health provider by default. Prisons and jails are faced with addressing inmates' behavioral health needs in addition to providing rehabilitation and restoring accountability for criminal convictions. Re-entry best practices include ensuring that inmates are linked to necessary services and supports upon release in an effort to better ensure community adjustment and decrease recidivism rates. DMAS is collaborating with the Virginia Department of Corrections around GAP and exploring

strategies for making applications while an inmate is still incarcerated. Similar efforts will be made with the Department of Criminal Justice and local/regional jails.

DMAS is involved in a Housing+Healthcare initiative that involves housing advocates, the Department of Housing and Community Development and Medicaid managed care organizations. Within this initiative, GAP has been promoted as an alternative Medicaid benefit for a targeted sub-population of individuals with SMI that meets the initiative's definition of "chronically homeless." Having healthcare can support an individual who is seeking or trying to maintain housing. Untreated health conditions may place members at risk of eviction from housing.

Virginia is moving increasingly toward person-centered integrated care models. The GAP demonstration has provided initial evidence that individuals with SMI and complex medical conditions will seek care when services are covered. Virginia needs to ensure a mechanism to monitor that adequate care coordination is available and that members can navigate the fragmented service delivery system. Providers need to be become more nimble in linking members to other specialties and understanding that a lack of treatment to another condition can negatively impact the condition that they are treating. There is a need to refresh the system on the concept of "treating the whole person" through collaboration across providers and systems with the common goal to improve member's health conditions, quality of life, and societal contributions.

GAP Benefits, Scope of Service, and Provider Qualifications			
Benefit	**Provider Qualifications**	**Scope and Limitations**	**Differences from current VA Medicaid Program**
Serious Mental Illness (SMI) Eligibility Screenings			
SMI Eligibility Screenings (short and long) will be performed as part of the GAP eligibility process, and can be performed by Community Services Boards, Federally Qualified Health Centers, and hospitals with psychiatric units or free-standing psych hospitals (state or private).			
GAP Services to be provided through the Department's Behavioral Health Services Administrator (BHSA) – Administrative Costs			
Care Coordination	Same as the current VA Medicaid Program; services will be provided through the Department's BHSA, Magellan. Magellan care managers are all licensed mental health professionals.	Care managers will provide information regarding covered benefits, provider selection, and how to access all services including behavioral health and medical and using preferred pathways. Magellan care managers will work closely with CSB providers of mental health case management services to assist GAP members in accessing needed medical, psychiatric, social, educational, vocational, and other supports as appropriate	None
Crisis Line	Same as the current VA Medicaid Program (BHSA)	The crisis line will be available to GAP members within the same manner as currently provided to the Medicaid and CHIP populations through Magellan. The crisis line is available 24 hours per-day, 7 days per-week and includes access to a licensed care manager during a crisis.	None
Recovery Navigation	Initially recovery navigation services will be provided through the Department's BHSA; however, the Department may transition these to allow coverage and reimbursement through trained peer support providers as certified by the Department of Behavioral Health and Developmental Services (DBHDS).	Magellan Recovery Navigation services are provided by trained Recovery Navigators, who self-disclose as living with or having lived with a behavioral health condition. The goal of Recovery Navigation services is to make the transition back into the community a successful one and avoid future inpatient stays. It is expected that there will be more frequent face-to-face engagement via the Recovery Navigation team compared to clinical team members. These voluntary services are designed to facilitate connections with local peer-run organizations, self-help groups, other natural supports, and to engage them in treatment with the appropriate community-based resources to prevent member readmissions, improve community tenure and meaningful participation in communities of their choice. The scope of services provided through Recovery Navigation will	Not currently a service provided under the current VA Medicaid program.

GAP Benefits, Scope of Service, and Provider Qualifications			
Benefit	**Provider Qualifications**	**Scope and Limitations**	**Differences from current VA Medicaid Program**
		include services in the home, community, or provider setting including but not limited to: • Visiting members in inpatient settings to develop the peer relationship that is built upon mutual respect, unique shared experiential knowledge, and facilitates a foundation of hope and self-determination to develop, or enhance, a recovery-oriented lifestyle. • Exploring peer and natural community support resources from the perspective of a person who has utilized these resources and navigated multi-level systems of care. These linkages will expand to educating members about organizations and resources beyond the health care systems. • Initiating dialogue and modeling positive communication skills with members to help them self-advocate for an individualized discharge plan and coordination of services that promotes successful community integration upon discharge from adult inpatient settings. • Assisting in decreasing the need for future hospitalizations by offering social and emotional support and an array of individualized services. • Developing rapport and driving engagement in a personal and positive supportive relationship, demonstrating and inspiring hope, trust, and a positive outlook, both by in-person interactions on the inpatient unit and a combination of face-to-face and 'virtual' engagement for GAP participants in the community. • Providing social, emotional and other supports framed around the 8 dimensions of wellness. • Brainstorming to identify strengths and needs post-discharge, assisting member to be better self-advocates, and ensure that the discharge plan is comprehensive and complete.	

GAP Benefits, Scope of Service, and Provider Qualifications			
Benefit	**Provider Qualifications**	**Scope and Limitations**	**Differences from current VA Medicaid Program**
		• Brainstorming with the member to identify the triggers and/or stressors that led to the psychiatric hospitalization. • Direct face-to-face as well as toll-free warm-line services to eligible GAP members 7 days per week. The warm-line is a telephonic peer support resource staffed by as needed PSNs, trained specifically in warm-line operations and resource referrals. The warm-line associated with the Recovery Navigation GAP services program would offer extended hours, toll-free access, and dedicated data collection capabilities.	
GAP Services to be provided through the Department's Medicaid provider network			
Outpatient physician, clinic, specialty care, consultation, and treatment; includes evaluation, diagnostic and treatment procedures performed in the physician's office; includes therapeutic or diagnostic injections.	Same as the current VA Medicaid Program	No exclusions where the place of treatment is the physician's office except as shown in Attachment 1; otherwise, the scope of coverage is within the current Virginia Medicaid coverage guidelines. Exclusions are listed in Attachment 1.	No emergency room or inpatient coverage; no coverage for excluded services per Attachment 1.
Outpatient hospital coverage, including diagnostic and radiology services electrocardiogram, authorized CAT and MRI scans.	Same as the current VA Medicaid Program	No exclusions where the place of service is the physician's office except as shown in Attachment 1; otherwise, the scope of coverage is within current Virginia Medicaid coverage guidelines.	No emergency room or inpatient coverage. Outpatient hospital treatment coverage is limited; see exclusions in Attachment 1.
Outpatient laboratory	Same as the current VA Medicaid Program	No exclusions where the place of service is the physician's office except as shown in Attachment 1; otherwise, the scope of coverage is within current Virginia Medicaid coverage guidelines.	None

GAP Benefits, Scope of Service, and Provider Qualifications			
Benefit	**Provider Qualifications**	**Scope and Limitations**	**Differences from current VA Medicaid Program**
Outpatient pharmacy	Same as the current VA Medicaid Program	Coverage is within the current Virginia Medicaid coverage guidelines.	None
Telemedicine	Same as the current VA Medicaid Program	No exclusions where the place of service is the physician's office except as shown in Attachment 1; otherwise, the scope of coverage is within current Virginia Medicaid coverage guidelines.	None
Outpatient medical equipment and supplies	Same as the current VA Medicaid Program	Coverage is limited to certain diabetic equipment and supply services, where the scope of coverage is shown in Attachment 2.	Limited to certain diabetic equipment and supply services.
GAP Case Management	Same as the current VA Medicaid Program for targeted mental health case management for individuals with serious mental illness.	GAP Case Management (GCM) will be provided statewide and does not include the provision of direct services. GCM will have two tiers of service, regular and high intensity. Regardless of the level of service, GCM will work with Magellan care managers to assist GAP members in accessing needed medical, behavioral health (psychiatric and substance abuse treatment), social, educational, vocational, and other support services. Individuals who need a higher intensity of service will receive face to face GCM provided in the community. Higher intensity GCM will be paid at the high intensity rate. GAP case managers will work closely with Magellan care coordinators. GCM service registration will be required with Magellan.	Primary differences between GCM and Mental Health Targeted Case Management : • GCM (regular intensity) does not require face to face visits. • GCM requires monthly collaboration with Magellan care management. • GCM reimbursement rates are different: • $195.90-Regular • $220.80–High Intensity
Crisis Intervention	Same as the current VA Medicaid Program	Scope of coverage is within current Virginia Medicaid coverage guidelines.	None
Crisis Stabilization	Same as the current VA Medicaid Program	Scope of coverage is within current Virginia Medicaid coverage	Service authorization

GAP Benefits, Scope of Service, and Provider Qualifications			
Benefit	**Provider Qualifications**	**Scope and Limitations**	**Differences from current VA Medicaid Program**
		guidelines.	will be required to enable effective coordination.
Psychosocial Rehab Assessment and Psychosocial Rehab Services	Same as the current VA Medicaid Program	Scope of coverage is within current Virginia Medicaid coverage and reimbursement guidelines and limitations.	None
Substance Abuse Intensive Outpatient (IOP) Treatment	Same as the current VA Medicaid Program	Scope of coverage is within current Virginia Medicaid coverage and reimbursement guidelines and limitations.	None
Methadone	Same as the current VA Medicaid Program	Scope of coverage is within current Virginia Medicaid coverage and reimbursement guidelines and limitations.	None
Opioid Treatment administration	Same as the current VA Medicaid Program	Scope of coverage is within current Virginia Medicaid coverage and reimbursement guidelines and limitations.	None
Psychiatric evaluation and outpatient individual, family, and group therapies (mental health and substance abuse treatment).	Same as the current VA Medicaid Program	No exclusions except as shown in Attachment 1. Under GAP, there are no maximum benefit limitations on traditional behavioral health psycho-therapy services.	Under GAP, there are no maximum benefit limitations on traditional behavioral health psycho-therapy services. (Current Medicaid program limits for psychotherapy services are 26 visits per year with an additional 26 in the first year of treatment.)

Attachment 1 - Non-Covered Services

Note: Traditional benefits are considered behavioral health services that are typically included in commercial health insurance plans. Non-traditional, refers to behavioral health services that are covered by Virginia's Medicaid program, but not through commercial insurance.

<table>
<tr><th colspan="2">Non-Covered Medical Services</th></tr>
<tr><td>

Any medical service not otherwise defined as covered in Virginia's State Plan for Medical Assistance Services
Chemotherapy
Colonoscopy
Cosmetic procedures
Dental
Dialysis
Durable medical equipment (DME) and supply items (other than those required to treat diabetes)
Early and Periodic Screening Diagnosis and Treatment (EPSDT) services
Emergency room treatment
Hearing aids
Home health (including home IV therapy
Hospice
Inpatient treatment
Long-term care (institutional care and home and community-based services)

</td><td>

Nutritional supplements
OB/maternity care (gynecology services are covered)
Orthotics and prosthetics
Outpatient hospital procedures (other than the following diagnostic procedures)

Diagnostic ultrasound procedures
EKG/ECG, including stress
Radiology procedures (excludes PET and Radiation Treatment procedures)

PT, OT, and speech therapies
Private duty nursing
Radiation therapy
Routine eye exams (to include contact lenses and eyeglasses)
Services from non-enrolled Medicaid providers
Services not deemed medically necessary
Services that are considered experimental or investigational
Sterilization (vasectomy or tubal ligation)
Transportation

</td></tr>
<tr><th colspan="2">Non-Covered Traditional Behavioral Health Services</th></tr>
<tr><td>

Any behavioral health or substance abuse treatment services not otherwise defined as covered in Virginia's State Plan for Medical Assistance Services
Electroconvulsive therapy and related services (anesthesia, hospital charges, etc.)
Emergency room services,
Hospital observation services,
Psychological and neuropsychological testing

</td><td>

Inpatient hospital or partial hospital services
Smoking and tobacco cessation and counseling
Services specifically excluded under the State Plan for Medical Assistance
Services not deemed medically necessary
Services that are considered experimental or investigational
Services from non-enrolled Medicaid providers

</td></tr>
<tr><th colspan="2">Non-Covered Non-Traditional Behavioral Health Services</th></tr>
<tr><td>

Any behavioral health or substance abuse treatment services not otherwise defined as covered in Virginia's State Plan for Medical Assistance Services
Day treatment partial hospitalization
EPSDT services including multi-systemic ABA treatment,
Intensive in home services
Intensive community treatment (PACT)
Levels A, B, or C residential treatment services for individuals up to 21 years of age
Mental health skill building services
VICAP

</td><td>

Services not deemed medically necessary
Services that are considered experimental or investigational
Services from non-enrolled Medicaid providers
Substance abuse crisis intervention
substance abuse day treatment for pregnant women
substance abuse residential treatment for pregnant women
substance abuse day treatment
Substance abuse targeted case management services
Therapeutic day treatment
Transportation
Treatment foster care case management

</td></tr>
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Attachment 2 – Durable Medical Equipment Coverage

PROVIDER CLASS TYPE 62 COVERED SERVICES FOR GAP					
Diabetic Products					
HCPCS Code	**Description**	**Billing Unit**	**SA Type**	**Fee**	**Limit**
	Supplies				
A4250	Urine test or reagent strips or tablet	Tablets or Strips - 100	N	$38.88	3/2 Months
A4253	Blood glucose test or reagent strips for home blood glucose monitor,	Strips - 50	N	**$10.41**	3/Month
A4256	Normal, low, and high calibrator solution/chips	Pkg.(5 ml vials)	N	**$4.00**	1/Month
A4258	Spring-powered device for lancet	Each	N	**$2.52**	1/month
A4259	Lancets	Box (of 100)	N	**$10.22**	3/2 Months
S8490	Insulin Syringes	100/box	N	$29.67	1/Month
A4245	Alcohol wipes	Box of 100	N	$4.08	1/Month
	Glucose Monitors				
E0607	Home blood glucose monitor	Each	N	**$65.75**	1/36 Months
E2100	Blood glucose monitor with integrated voice synthesizer	Each	Y	**$597.01**	
E2101	Blood glucose monitor with integrated lancing/blood sample	Each	N	**$185.58**	
E0607 RR	Home blood glucose monitor	Day	N	$0.21	3 Months
E2100 RR	Blood glucose monitor with integrated voice synthesizer	Day	N	**$1.83**	
E2101 RR	Blood glucose monitor with integrated lancing/blood sample	Day	N	**$0.60**	
	Replacement Batteries				
A4233	Replacement battery, alkaline (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each	Each	N	**$0.58**	1/6 Months
A4234	Replacement battery, alkaline, J cell, for use with medically necessary home blood glucose monitor owned by patient, each	Each	N	**$2.50**	
A4235	Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each	Each	N	**$1.06**	
A4236	Replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each	Each	N	**$1.19**	

Virginia 1115 GAP Waiver – Evaluation Measures

Research Questions	Measure	Details	Data Source	Comparisons	Frequency
Goal 1. Serve as a bridge to closing the insurance coverage gap for Virginians					
What percentage of uninsured Virginians have applied for the GAP Demonstration?	Number of complete applications submitted to Cover Virginia for the GAP Demonstration compared to total uninsured SMI population in Virginia		Cover Virginia, DBHDS	Compared to number of uninsured SMI population in Virginia	Annually
What percentage of uninsured Virginians have applied and enrolled in the GAP Demonstration?	Number of approved applications submitted to Cover Virginia for the GAP Demonstration compared to total uninsured SMI population in Virginia		Cover Virginia, DBHDS	Compared to number of uninsured SMI population in Virginia	Annually
Goal 2. Improve access to health care for a segment of the uninsured population in Virginia who have significant behavioral and medical needs.					
Has the GAP Demonstration impacted access to care, through access to primary care, medications, and behavioral health supportive services.	Adults' Access to Preventive/Ambulatory Health Services (AAP)	The percentage of members 21 years and older who had an ambulatory or preventive care visit during the measurement year. ♦ 21 to 44 years of age ♦ 45 to 64 years of age	MMIS, NCQA National data	Compare to the preventive care services utilization of control group population	Annually
	Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	The percentage of members with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.	MMIS, NCQA National data	- Compare Virginia score to HEDIS Medicaid National Average. - Compare to the adherence of medication of control group population	Annually

Virginia 1115 GAP Waiver – Evaluation Measures

Research Questions	Measure	Details	Data Source	Comparisons	Frequency
	NQF Measure 0105: Anti-depressant Medication Management	The percentage of members with a diagnosis of major depression and treated with antidepressant medication, and remained on an antidepressant medication treatment. ♦ Effective Acute Phase Treatment (on medication for at least 84 days/12 weeks) ♦ Effective Continuation Phase Treatment (for at least 180 days/6 months)	MMIS, NCQA National data	- Compare Virginia score to HEDIS Medicaid National Average. - Compare to the adherence of medication of control group population	Annually
	Drug utilization for chronic health condition	Members with chronic conditions such as diabetes, cardiovascular Health condition and hypertension utilizing drugs for these medical conditions.			
	NQF Measure 0004: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) (National Committee for Quality Assurance)	The percentage of adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following. - Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. - Engagement of AOD Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	MMIS, DBHDS, NCQA National data (tbd)	Compare it to control group population	Annually
How many GAP Participants have utilized their GAP	Number of approved applicants who have a behavioral health services claim		Magellan/MMIS	Compare it to service utilization of control group population	Annually

Virginia 1115 GAP Waiver – Evaluation Measures

Research Questions	Measure	Details	Data Source	Comparisons	Frequency
Coverage	Number of approved applicants who have a physical health services claim		MMIS	Compare it to service utilization of control group population	Annually
	Number of approved applicants who have a Pharmacy claim		MMIS	Compare it to service utilization of control group population	Annually
Are there critical services participants do not have access to, that are necessary for this population to achieve improved health and wellness outcomes?	Measure access to common treatment elements to promote recovery including -Prevention and Wellness -Medications -Behavioral health services -Inpatient Services -Transportation	% of claims denied because the service was not covered and	MMIS	Compare the denied claims to approved claims and identify what services are not covered that are necessary for recovery.	
Have GAP participants utilized Recovery Navigation ?	Ensure more appropriate use of the overall health system by providing recovery navigation (peer support) and other services that will help stabilize GAP participants	Number of GAP participants with a claim for recovery navigation. What percentage of GAP enrollees participated in the recovery navigation program?	Magellan	Number of participants who have utilized recovery navigation compared to total number of GAP enrollees	Annually
Have GAP participants utilized Care Coordination?	Number of GAP participants with a claim for Care Coordination	Number of GAP participants with a claim for care coordination.	Magellan	Number of Gap participants with a Referral for Care Coordination compared to Number of participants who engaged in Care Coordination	Annually
Have GAP participants had their care coordinated with a Medical Doctor	Follow-up after Hospitalization for Mental Illness	The percentage of discharges for members who were hospitalized for treatment of selected mental health disorders and had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported as the percentage of discharges for which the member received follow-up within: ♦ seven days of discharge ♦ 30 days of discharge	MMIS, DBHDS, TBD		Annually

Virginia 1115 GAP Waiver – Evaluation Measures

Research Questions	Measure	Details	Data Source	Comparisons	Frequency
	Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications	The percentage of members 21to 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	MMIS		Annually
	Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	The percentage of members 21 to 64 years of age with schizophrenia and diabetes, who had both an LDL-C test and an HbA1c test during the measurement year.	MMIS		Annually
	Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications	The percentage of members 21 to 64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.	MMIS		Annually
	Integration of behavioral health and medical health	Percentage of providers who provide both behavioral health and medical services	MMIS		
Has there been a reduction in cost as a result of improved quality of service and timely preventive services?	Cost analysis of program - by age group - by diagnosis - by service type	Trending costs for the program			Annually beginning year 2
Goal 3. Improve health, social and behavioral health outcomes of demonstration participants.					
Has the integration of physical and behavioral health services resulted in better **quality of life** and psycho -social outcomes?	Reduction in the number of interactions with the criminal justice system for GAP Participants	Reduction in/no change in number of incarcerations/arrests in past 30 days from date of first service to date of last service.	DOC - TBD		Annually
	Reduction in Temporary Detainment Order (TDO) Claims and ECO orders		MMIS		Annually
	Show Reduced or No Substance Use*		Magellan, DBHDS - TBD		Annually
	Are Not Homeless		Magellan, DBHDS		Annually
	Are Employed Full or Part-Time		Magellan, DBHDS		Annually
Has the integration of physical and behavioral health services resulted in **better health**	Did GAP Participants become eligible for full Medicaid as a result of a disability determination?	GAP Participants who became eligible for full Medicaid as a result of a disability determination	MMIS	Number of GAP Participants who became eligible for full Medicaid as a result of a disability determination.	Annually

Virginia 1115 GAP Waiver – Evaluation Measures

Research Questions	Measure	Details	Data Source	Comparisons	Frequency
outcomes of demonstration participants [1]	Has there been a reduction in the number of emergency department visits for GAP Participants ?	Self reported through recovery navigation survey	Magellan, VHI	Self reported peer navigator survey results compared over time	Annually
	Has there been a reduction in the number of hospital admissions for GAP Participants?	GAP Participants who have hospital admission	DBHDS - TBD	Number of GAP participants who have previous mental health hospital admissions compared to their hospital admissions while participating in the program	Annually