Governor's Access Plan for the Seriously Mentally Ill

Evaluation Report

YEAR 2

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

Evaluation Period:
1/1/16-12/31/16

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 (1) enabled persons with SMI to access behavioral health and primary health services, (2) enhanced the treatment they receive and (3) allowed 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 two years of the Demonstration, the average monthly cost for a single GAP member has been $200 less than a single visit to an emergency room for a minor visit, providing early evidence that the program is cost effective. Anecdotally, DMAS has heard from stakeholders that member outcomes could be improved if the program included additional non-covered services, e.g., inpatient care and transportation.

The Department of Medical Assistance Services (DMAS) hypothesized that GAP members' physical and behavioral health outcomes would improve simply by having access to primary care, behavioral health and pharmacy services. During these early years of the Demonstration, GAP members are demonstrating they will choose to use person-centered, community based behavioral and health care providers in lieu of emergency rooms. For some GAP members, Recovery Navigation has shown to supplement and complement clinical treatment.

Demonstration Description

The GAP Demonstration was launched in January 2015 with support from a wide variety of stakeholders, including families, advocates, providers, the Department of Behavioral Health and Devlopmental Services (DBHDS), 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 80% 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 originally thought 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; and
- Conducted weekly stakeholder calls prior to and during initial implementation to communicate updates and problem solve concerns.

The 2016 Virginia legislative session mandated that the household income threshold be increased from 60 % to 80% of the federal poverty level (FPL). Enrollment projections were recalculated to accommodate for the increase in FPL. By the end of December 2016, Year 2 of the Demonstration, 12,114 unduplicated individuals enrolled in GAP over the course of the year. Since January 2015, 12,788 Virginians were enrolled in GAP.

Demonstration Logic Model

In order to provide a high level overview of the GAP Demonstration, DMAS developed a logic model (see Figure 1 below) as a visual presentation of the key inputs to the GAP Demonstration. The logic model identifies 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) Cover Virginia 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 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.

Figure 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 and determined to meet 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 below 80% of the FPL;
- Uninsured; and,
- Not residing in a long-term care facility, mental health facility, or penal institution.

Figure 2: 2016 GAP Eligibility

Eligibility Group Name	Social Security Act and CFR Citations	Income Level	Timeframe
Adults not otherwise eligible under the State plan	N/A	0-100% of the FPL	January 15, 2015-May 14, 2015
Adults not otherwise eligible under the State plan	N/A	0-60% of the FPL	May 15, 2015-June 30, 2016
Adults not otherwise eligible under the State plan	N/A	0-80% of the FPL	July 1, 2016 – remaining Demonstration

The GAP population remains fairly evenly distributed across the lifespan. The changes in stratification are less than 2% in each of the age groups compared to Year 1 of the Demonstration.

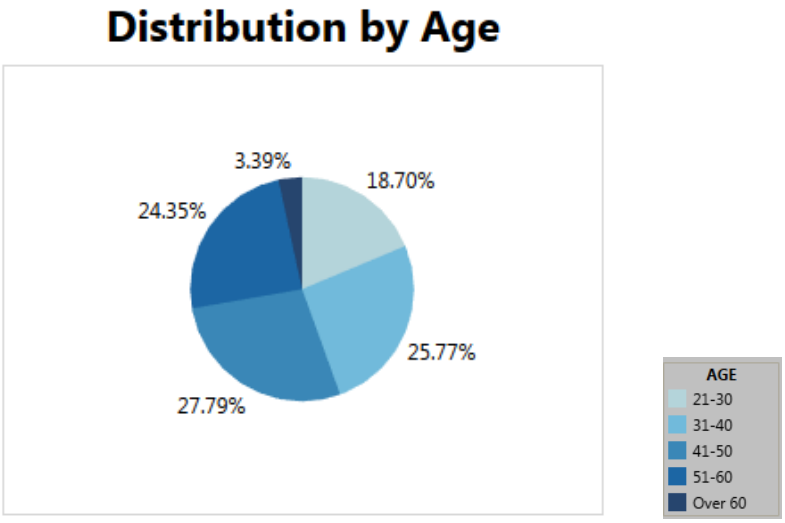


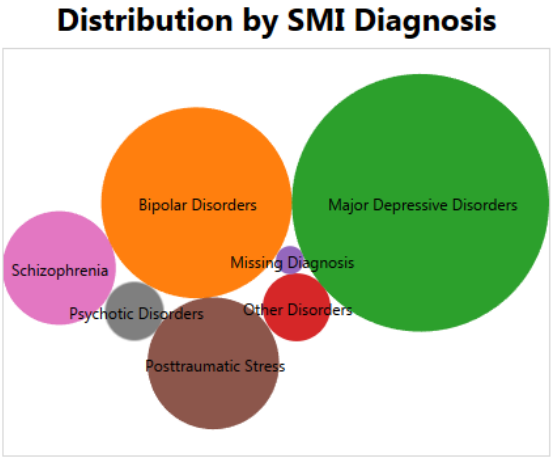
Figure 3: GAP Population Age Distribution

Prior to eligibility determinations, applicants were required to complete an SMI screening to assess 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 has 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 continue to consist mainly of Major Depressive Disorder (46.74%), Bipolar Disorders (26.78%), PTSD (12.24%) and Schizophrenia (9.118%) (See Figure 4). This continues to mirror the Virginia Medicaid fee for service population where the majority of the population seeking behavioral health services has a mood disorder as the primary diagnosis. There is less than a 3% difference in the percentage of GAP members with one of the SMI primary diagnoses in Year 2 compared to Year 1. In addition, we were able to further identify discrete diagnoses in Year 2 and found that less than 3% of the GAP population in 2016 had another psychotic disorder and just over 3% had one of the other disorders (OCD, Agoraphobia, Anorexia Nervosa or Bulimia Nervosa).

Figure 4: GAP Population by SMI Diagnosis



DMAS was fortunate to have a robust stakeholder 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 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.

Virginia has made significant efforts to grow the GAP enrollments. However, now some stakeholders (community services boards and criminal justice entities) claim that the limited diagnoses disqualify many individuals known to the providers, who may otherwise qualify for GAP.

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 the intervention of GAP 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 is using 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 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 were analyzed to identify psycho-social outcomes for GAP members.

DMAS faced challenges acquiring data from some sources as well as reconciling data from DMAS contractors. DMAS continues to work with contractors and GAP partners to ensure data access and quality issues are minimized.

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, and frequencies for each measure.

Data Sources and Collection

The evaluation draws on multiple data sources depending on the research question, the 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: 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)***:** 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. Arrays 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. Originally, the consideration to use the database that supports Cover Virginia to determine a control group population was ruled out in Year 1.

- *Temporary Detention Order (TDO) Claims:* DMAS serves as the payer of TDO claims in Virginia, even for individuals who do not have Medicaid or GAP. 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.

GAP is a limited benefit program and does not include inpatient hospitalization and Emergency Department (ED) services. Therefore, DMAS does not have access to claims for inpatient hospitalization and ED services. The GAP evaluation panel members comprised of Behavioral Health research experts emphasized that the study of hospitalizations and ED visits is important for measuring the health outcomes of the GAP members. Based on recommendations from these industry experts, DMAS explored options to acquire this information from other Virginia state agencies and organizations.
The GAP team received full support from DMAS' Agency Director and management to acquire external data for thorough research for the GAP program and helped to influence external agencies to share data.

After multiple conversations with DBHDS and Virginia Health Information (VHI), DMAS realized that it was not feasible to collect all hospitalization and ED visits for GAP members from all Virginia hospitals. DMAS was successful in establishing a data exchange with DBHDS; however, DBHDS only collects data from state hospitals and not local hospitals. In Virginia, citizens only go to a state hospital when there is no local resource to divert them from a state facility. Because GAP members are much more likely to be hospitalized at the local level using local resources, using only the state hospital data would skew the analysis of the hospitalization histories.

VHI, which maintains the 'All Claims Payers Database (APCD),' also had limitations in using their data when DMAS approached them in 2015. The APCD does not collect data from all main sources nor does it include ED data. Additionally, leveraging VHI data would require DMAS to go through VHI's governance process which includes an approval from the providers who submitted their data, in order to share their data downstream. DMAS will need to invest additional time and effort to comply with the legal requirements to report data. However, the APCD made progress in the last two years, and it is believed that this data is more complete now. DMAS may consider revisiting the use of the APCD if resources allow.

Controls for Other Interventions in the State

A major concern within evaluation research and study design is whether the effects of the 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 shares 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 of 60% federal poverty level slowed GAP enrollments. This slowing in enrollment impacted the number of uninsured individuals with SMI who could access health and behavioral healthcare services via GAP. While the household income eligibility threshold was increased to 80%FPL, and DMAS provided trainings and notification of the increase, it is possible that there may be pockets of potential applicants who are not applying due to thinking the FPL is still at 60%.

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

Data

38% of VA's uninsured SMI population applied for the GAP Demonstration. This is an increase of 18% compared to Year 1 of the Demonstration.

Unduplicated applications received*	20,871
Estimated # uninsured individuals with SMI	54,000
* Completed, unduplicated applications: excludes applications withdrawn prior to determination. NOTE: The Virginia Healthcare Foundation estimates the total number of uninsured adults in Virginia in 2014 was 759,000.	

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

Data

24% of VA's uninsured SMI population was approved for the GAP Demonstration. This is an increase of 11% compared to Year 1 of the Demonstration

Applicants approved for GAP**	13,227
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.	

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

74.95% of the 2016 GAP members utilized health care services during the evaluation period as illustrated in the table below. This is a 3.73% increase over the percentage of GAP members who accessed services in Year 1 of the Demonstration.

Figure 5: GAP Members with Health Care Claims

Health Care Services

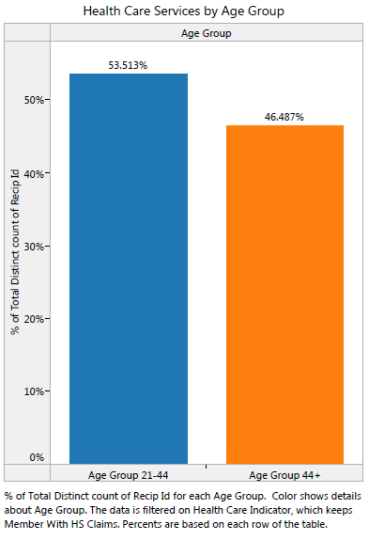
Primary Diagnosis Category	Health Care Indicator: Member With HS Claims	Health Care Indicator: Total GAP Members
Bipolar Disorders	19.82%	25.66%
Major Depressive Disorders	35.16%	46.74%
Missing Diagnosis	0.12%	0.56%
Other Disorders	2.58%	3.25%
Posttraumatic Stress	8.77%	12.24%
Psychotic Disorders	1.89%	2.44%
Schizophrenia	6.62%	9.11%
Grand Total	**74.95%**	**100.00%**

0% 50% 100% — % of Total Distinct count of Recip Id

0% 50% 100% — % of Total Distinct count of Recip Id

In 2016, DMAS was able to review this further by age groups of ages 21-44 and 44-64 years. The two groups who accessed services are fairly evenly divided with the younger group at 53.51% and the older group with 46.48%. Please see Figure 6 below.

Figure 6: GAP Members with Health Care Claims by Age Group



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

In 2015, almost 60% of GAP members with a diagnosis of schizophrenia had a claim for antipsychotic medication during the evaluation period. During 2015, DMAS did not have the capability to measure the treatment period adherence but this was achieved in 2016.

In 2016, 22% of the GAP members with a diagnosis of schizophrenia received and filled prescriptions for antipsychotic medications 80% of the time per claims data. However, another 30% filled these prescriptions but did not maintain medication adherence for 80% of their time in treatment for 2016.

Figure 7: Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Adherence to Antipsychotic Medication by Schizophrenia

Adherence_to_Antipsychotic_medication	Antispcyhotic_Ind	
80% Adherence	Received	239
Less than 80% Adherence	Received	339
	Not Received	525
Grand Total		**1,103**

Discussion

The chart reflects that over half of the members with schizophrenia did not have a claim for an antipsychotic medication. There could be several explanations for these low percentages:

- The member declines medications;

- The member does not fill prescription;
- The prescribing provider is using another type of medication, providing samples, etc., or
- It is not unusual for this population to have difficulty maintaining a compliant treatment regimen.

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

In Year 2, 35% of members (1982 out of 5662) 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 Figure 8 below, 37% of GAP members were diagnosed with major depression but DMAS did not receive a claim for medication during the evaluation period. This is a slight decrease from Year 1 of the Demonstration.

Figure 8: Anti-Depressant Medication Management

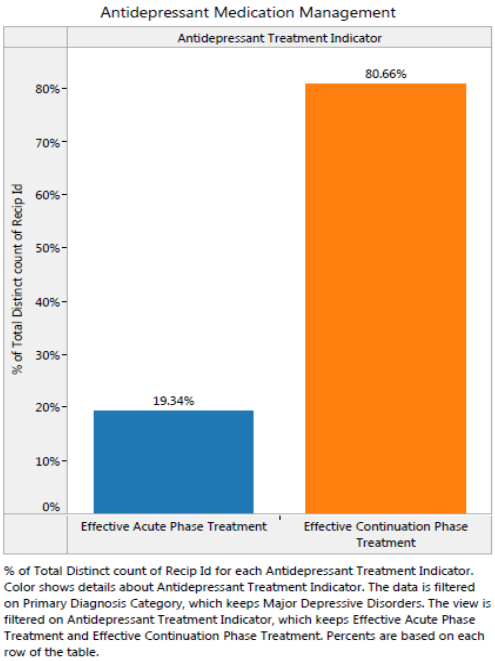
Adherence to Antidepressant Medication by MDD

Antidepressant_Adherence	Antidepressant_ind	
80% Adherence	Received	1,995
Less than 80% Adherence	Received	1,663
	Not Received	2,389
Grand Total		**6,047**

During 2015, DMAS did not have the capability to measure the treatment period adherence but this was achieved in 2016. For those GAP members who did fill their antidepressant medication, it appears that they continued to receive and fill prescriptions. Just over 80% of GAP members with major depression who filled prescriptions were still engaged in medication management for at least 6 months.

In Year 2, DMAS was able to drill deeper into the data and discern more clearly the timeframes of treatment. Figure 9 below shows that based on claims data, 19.34% of the GAP members with the diagnosis of major depression filled prescriptions in the acute phase of treatment. This jumped to just over 80% for ongoing treatment.

Figure 9: Anti-Depressant Medication Management-Phases of Treatment



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.	MMIS, HEDIS

Diabetes Data

Of the 75% of GAP members who were screened for diabetes, 29% received diabetic therapy, cholesterol reducers and/or lipotropics. This is an increase of nearly 20% from Year 1 of the Demonstration.

Figure 10: Diabetes Drugs

Diabetes Drug

Diabetic Therapy Indicator	Lipotropics & Cholestrol Reducers Indicator: NOT RECEIVED	Lipotropics & Cholestrol Reducers Indicator: RECEIVED
NOT RECEIVED	7,117	991
RECEIVED	480	585

Hypertension Data
Of the 73% GAP members with a diagnosis of hypertension, nearly 50% of those diagnosed with hypertension received medications for the condition. This is an increase of nearly 20% from Year 1 of the Demonstration however the data was not sorted to ensure no duplicated members. DMAS is reviewing this technical error.

Cardiovascular Data
In Year 1 of the Demonstration only 2 members were diagnosed with a cardiovascular condition and both were receiving medications for those conditions. Year 2 has seen growth in this measure as 1,202 GAP members (10%) were diagnosed with a cardiovascular condition and over 1,700 pharmacy claims were identified however, the data was not sorted to ensure no duplicated members.

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, NCQA National data

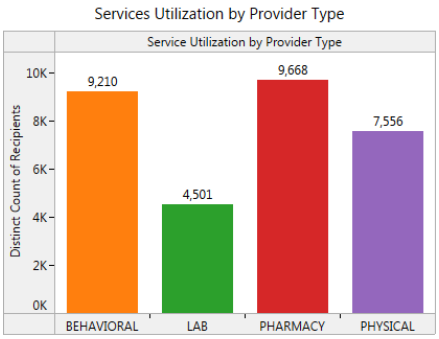
Data
In Year 2, 851(7%) of members have utilized treatment for their substance use. This is based on claims data for GAP members after enrollment in GAP. This is an increase of 2% from Year 1 of the Demonstration.

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
In Year 1 of the Demonstration, 74% of GAP members received a claim for behavioral health services during the evaluation period. In Year 2, 76% of GAP members had a claim for behavioral health services, an increase of 2% from Year 1 of the Demonstration.

Figure 11 Service Utilization by Provider Type



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

Data
In Year 1 of the Demonstration, 51% of GAP members had a claim for physical health services during the evaluation period. Figure 12 above reflects an 11% increase in this measure (62%) for Year 2.

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

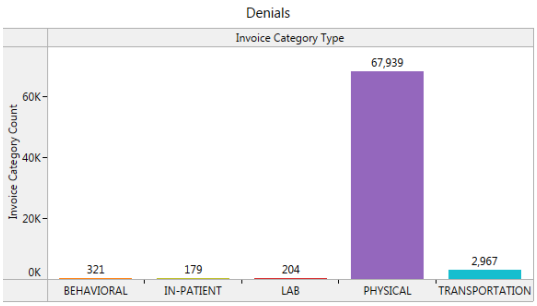
Data
In Year 1 of the Demonstration, 74 % of GAP members had a pharmacy claim during the evaluation period. Figure 12 above reflects an increase in this measure (80%) for Year 2.

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

Figure 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. Figure 12 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 being 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.

This appears to be a very high number of denied claims for physical health care and DMAS is looking into this further. DMAS is exploring possible technical errors that may be causing some outpatient "clinic" services to be denied inadvertently. Reporting may also have excluded claims that had been corrected/resubmitted for payment.

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 assisting members to maintain appointments and fill 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. In December 2016, CMS approved DMAS' request to amend the GAP waiver which authorized Virginia to strengthen Virginia's SUD delivery system and improve access to SUD treatment.The ARTS implemenation is scheduled for April 2017.

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 in recovery navigation. What percentage of GAP enrollees participated in the recovery navigation program?	Magellan

Data

In Year 1 of the Demonstration 1.7% of GAP enrollees (121 members) participated in Recovery Navigation. By the end of 2016, a total of 2,111 unduplicated GAP members were enrolled in Recovery Navigation services. The percentage of GAP members participating in Recovery Navigation Service remains at about 2%.

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.

A 39 yr. old female GAP member with a Major Depressive Disorder diagnosis has been involved with Recovery Navigation since her most recent Crisis Stabilization admission in August 2016. She disclosed to him that prior to being referred to Recovery Navigation services she was struggling with maintaining sobriety. She had received inpatient drug and alcohol treatment but would, after a short time, relapse. She continued to struggle with the urge to hide her anxiety and stress with substances. After completing Crisis Stabilization, she had her medical and mental health services arranged and had support through continuing care of the facility. However, what had made the difference for her this time was meeting her Peer Recovery Navigator. She felt "empowered and more in control and encouraged" than ever before. She appreciated the freedom to be in charge of their agenda and discuss any issues affecting her recovery on any given day. She felt understood by him on a different level. The Member disclosed to her Recovery Navigator that getting feedback and ideas on how she might deal with situations "has been life-changing for me." She feels that it is "a more intimate, honest, and realistic treatment process that offers me that piece of support that has been missing during my previous years of trying to deal with addiction." The Member strongly feels that Recovery Navigation has been the missing piece of her treatment. She now feels hopeful and excited about her recovery and feels as if she has been given all the tools to achieve success.

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 Year 1; however data was not available at that time. Negotiating reporting requirements for care coordination and the required contractor's system regarding Care Coordination numbers resulted in a delay in reporting. In Year 2, 1455 (12%) members received care coordination. Of thos 1255 members, 1,008 (69%) were enrolled in Low Level (Community Wellness), and 10 (less than 1%) were enrolled in the Moderate Level (Community Connection).

Discussion

There are two levels of care coordination provided by Magellan:

- **Community Wellness**: Magellan works closely with GAP case managers at the local Community Services Boards (CSB) 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.

Based on the data presented above, the majority of GAP members who received care coordination received the Community Wellness (Low Level) care coordination. This means that these members were able to satisfy basic needs, such as scheduling appointments and locating providers as a result of contacting Magellan.

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, VHI

Data

Data not available as noted earlier in report.

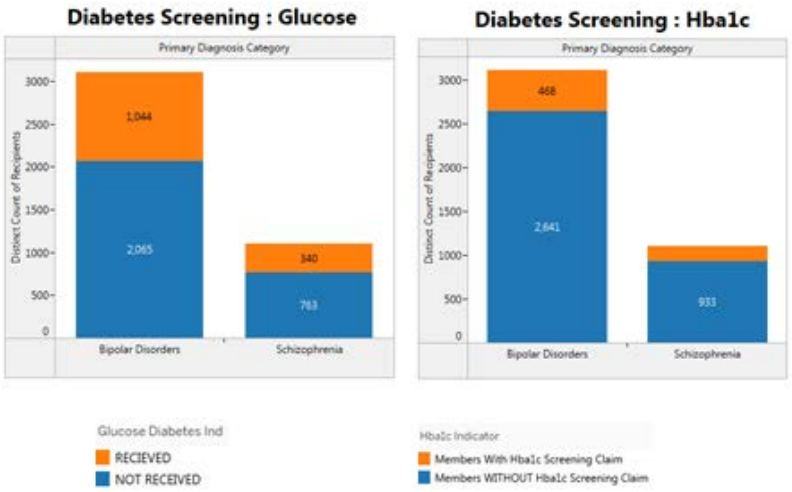
DMAS recommends this measure be deleted as this data was initially intended to be accessed via VHI and DBHDS which is not available as DMAS thought. If DMAS determines that this information is available in the future, this measure will be included.

Measure	Details	Data Source
Diabetes 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 or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	MMIS

Data

In Year 1 of the Demonstration, 1,340 members with Bipolar Disorders and 506 with Schizophrenia had glucose screenings. In Year 2, 1044 members with Bipolar Disorders and 340 with schizophrenia received glucose screenings. This is a decrease from Year 1 of the Demonstration. In Year 1 of the Demonstration, 1,618 members with Bipolar Disorders and 595 with Schizophrenia had the Hba1c screening. In year 2, 468 members with Bipolar Disorders had the Hba1c screening. A technical error occurred with the data regarding the number of members with Schizophrenia who received the Hba1c screening. DMAS is looking into this further.

Figure 13 Diabetes Screenings for Members with Schizophrenia or Bipolar Disorders



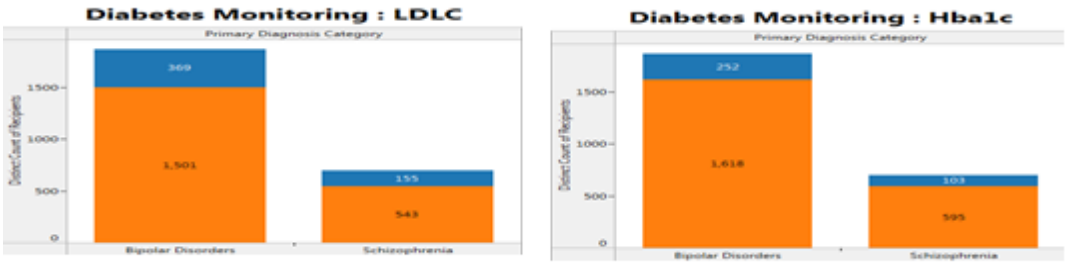
Measure	Details	Data Source
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	The percentage of members 21 to 64 years of age with schizophrenia and diabetes, who had both an LDL-C test and an HbA1c test during the measurement year.	MMIS

Data

In Year 1 of the Demonstration, 1,501 members with Bipolar Disorders and 543 with Schizophrenia had LDLC monitoring and 1,618 members with Bipolar Disorders and 595 with Schizophrenia had Hba1c monitoring.

In Year 2, 671 GAP members with Bipolar Disorders and 246 with Schizophrenia had LDLC monitoring while 468 members with Bipolar Disorders and 170 with Schizophrenia had Hba1c monitoring. This is a decrease from Year 1.

Figure 14 Diabetes Monitoring for GAP Members with Schizophrenia or Bipolar Disorders



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

In Year 1, only 2 members were reported with cardiovascular disease. In Year 2, DMAS identified 94 GAP members with schizophrenia and cardiovascular disease. Data is not available currently to indicate this specific test. DMAS is reviewing this technical error.

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

Data

In Year 1, 18.28% of providers rendered both medical and behavioral health services and in Year 2, data appears to reflect that is has dropped to less than 2%. This may be accurate as there has been significant growth in the number of physical healthcare claims/providers in Year 2 which changes the proportion of providers who provide both medical and behavioral health services.

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	MMIS

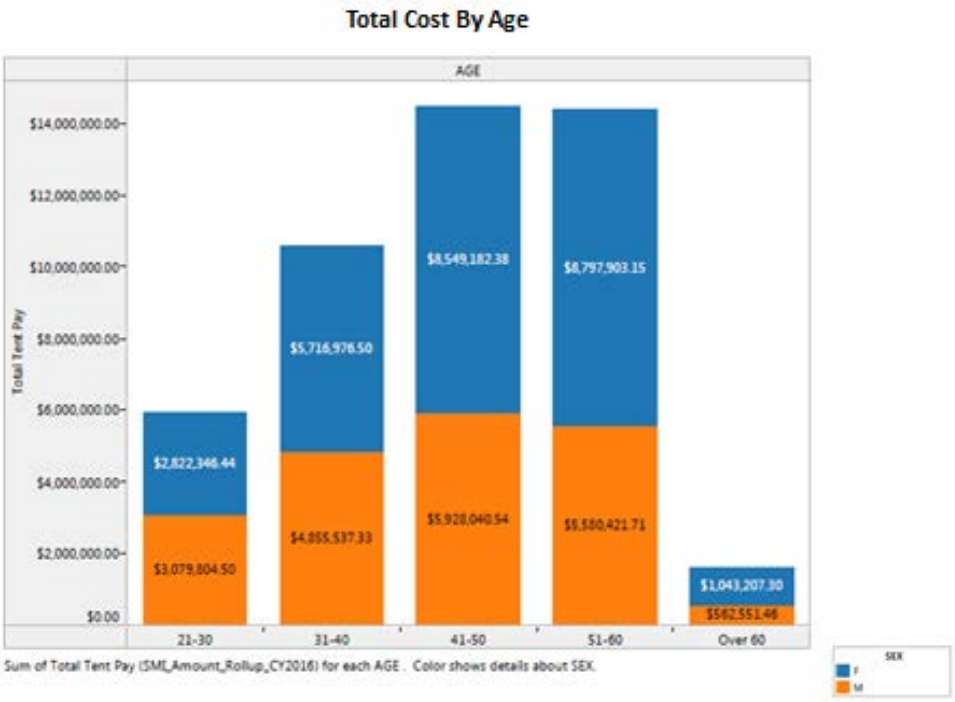
DMAS is using Year 2 of the Demonstration as the baseline for the cost analysis of the program. Year 1 was a "start up" situation and providers have up to a year to submit claims. The tables below reflect the cost of the services by age group, by diagnosis and by service type. These tables include Years 1 and 2 costs but may not include all of the claims for Year 2 as the providers still have time to submit.

The following 3 tables will be the baseline for future analysis and trending activities.

Age Related Data

Figure 15 shows the total costs for the Demonstration by age group; about 61% of the costs are for members ages 41-60 and these members comprise about 51% of the GAP membership.

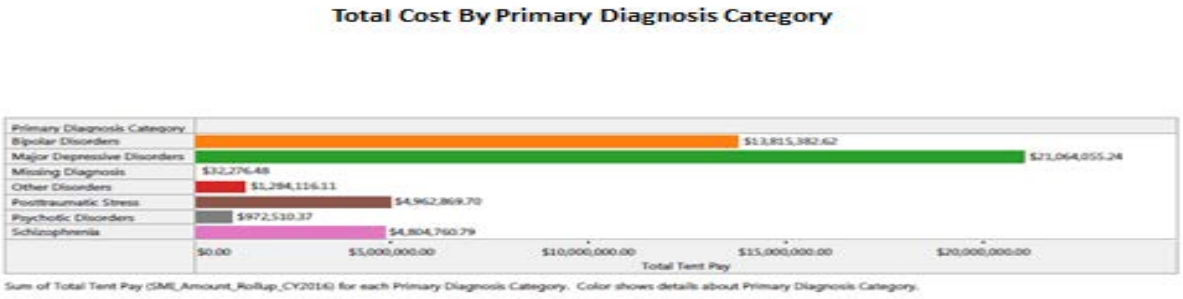
Figure 15: Costs for Program by Age



Diagnosis Related Data

Figure 16 below shows the total costs for the Demonstration by diagnoses; about 45% of the costs are for members whith a major depressive disorder and these members comprise about 46% of the GAP membership.

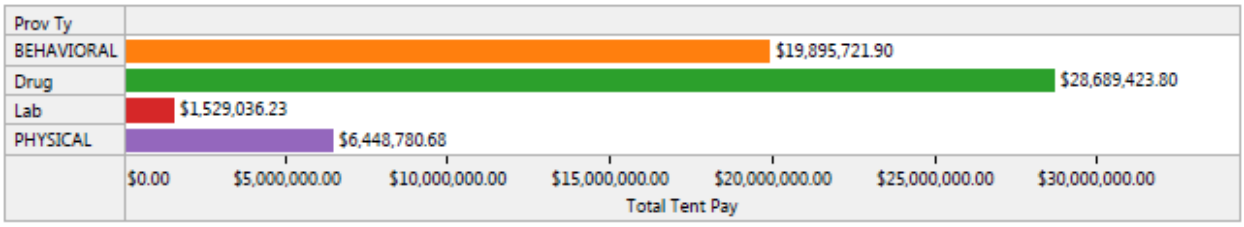
Figure 16: Costs for Program by Diagnoses



Provider Related Data

Figure 17 below shows the total costs for the Demonstration by providers; about 61% of the costs are for services related to pharmacy claims followed by 42% of the costs being related to behavioral health services.

Figure 17: Costs for Program per Provider Type



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

Data

There has been limited availability of data for GAP member interactions with the criminal justice system. Recovery Navigators attempt to solicit this information from GAP members receiving their services, but the responses are unreliable and statistically insignificant at this point in time.

DMAS originally thought this data was available through DOC; however, it is more likely that the GAP members are going to be involved in the criminal justice system at the local level rather than state. DMAS has sought other avenues including DHBDS, Magellan and CSBs, but it is not data that they currently collect. Local and Regional jails and local police departments would have to be contacted individually and requested to share data. DMAS does not have the resources to pursue this.

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

Data

Please see the table below comparing Year 1 and Year 2 of the Demonstration regarding number of TDOs by diagnostic category reflecting a 27% increase in TDOs. However, the GAP membership increased by over 130% from Year 1 to Year 2. The table below reflects nonduplicated members. The change in TDO rate went from 16% of the GAP membership in Year to to 12% of the GAP membership in Year 2 experienced a TDO.

Primary Diagnosis	TDO in 2015	TDO in 2016
Schizophrenia	352	230
Other Psychotic Disorders	41	87
Bipolar Disorders	271	413
Major Depressive Disorders	322	550
Post Traumatic Stress Disorder	97	96
Other GAP SMI Diagnoses	16	19
TOTAL:	1099	1395

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 services.

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

Data
Data not available

Measure	Data Source
Are Not Homeless	TBD

Data
277 GAP applicants self-reported a household living arrangement as "homeless" in Year 1 to the Recovery Navigators. In Year 2, only 43 GAP members reporte themselves as being homeless. This data is only collected on GAP members who are enrolled in Recovery Navigation.

DMAS recommends this measure be deleted as this data was initially intended to be accessed via Cover Virginia, however Cover Virginia does not collect this data. DMAS has sought other avenues including DHBDS, Magellan and CSBs, but it would require manually counting and reporting and it is not data that they currently collect.

Measure	Data Source
Are Employed Full or Part-Time	TBD

Data
Data not currently available. Cover Virginia does not gather data that would identify full or part-time employment status.

DMAS recommends this measure be deleted as this data was initially intended to be accessed via Cover Virginia, however Cover Virginia does not collect this data. DMAS has sought other avenues including DHBDS, Magellan and CSBs, but it would require manually counting and reporting and it is not data that they currently collect.

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

Demonstration Year	Total # GAP Members enrolled	Total # GAP members to full Medicaid by being determined disabled	Percentage to full Medicaid by being determined disabled
2015	6,983	257	4%
2016	12,114	429	4%

Only 4% of the GAP population moved from GAP to full Medicaid benefits based on a disability determination.

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

Data not currently available. Some self-report of emergency room usage was collected by the Recovery Navigators but was not statistically significant.

DMAS recommends this measure be deleted as the this data was initially intended to be accessed via VHI which is not as available as DMAS thought. If it is determined at a later date that this data is available, DMAS will begin reporting.

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,VHI -

Data not currently available. Some self-report of hospital admissions was collected by the Recovery Navigators but was not statistically significant.

DMAS recommends this measure be deleted as this data was initially intended to be accessed via VHI and DBHDS which is not as available as DMAS thought. If it determined at a later date that this data is available DMAS will begin reporting this data.

Discussion of Findings and Conclusions

DMAS' evaluation of the GAP program assumes that given health care coverage, limited though it may be, adults with SMI who have perhaps previously relied on 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 targeted 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 (Year 1) and $444 (Year 2) 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% ($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. There was no significant change in Year 2.

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, DMAS does not have access to inpatient services or other non-covered services provided by 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.

Moving the eligibility determination to Cover Virginia and away from the local departments of social services has been invaluable to the success of the project and provides a focus on the GAP members. Cover Virginia 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. Cover Virginia staff 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 recovery. As a result of these efforts, peer supports will be added to Substance Use Disorder and mental health 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 in Year 1 was the expert evaluation panel. The panel members brought 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. In Year 2, as DMAS continued to explore avenues for other data resources, the evaluation panel did not meet as often.

In 2015, changes in the household income eligibility for GAP participation (from 95% to 60% below FPL), had a significant impact on enrollment. Following the increase in July 2016 to 80% below FPL, enrollment numbers increased steadily as well, positively affecting the number of members who now have access to health and behavioral healthcare services via GAP.

With the International Classification of Diseases (ICD) coding changes made last year, data from 2016 consisted of diagnostic codes in ICD-10 format. Compared to the coding from 2015, this eliminated some of the issues reported which contributed to difficulty in identifying and tracking the GAP members' eligibility.

Challenges

While having access to data from Cover Virginia, Magellan, and DMAS data sources, challenges continue to ensure consistency in data across the three entities. DMAS is systematically addressing these challenges.

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.

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 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. Peer supports will be a covered service beginning July 1, 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 provides a level of stability to this population.

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>
</table>

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 2016

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	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	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 year 1	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 Year 1	Annually

Virginia 1115 GAP Waiver – Evaluation Measures 2016

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. - Year 1 DMAS did not have this data; future years will compare to year 2	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.	MMIS, NCQA National data	-Compare Virginia score to HEDIS Medicaid National Average -Compare to Year 1	Annually
	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 Year 1for data available in Year 1; future years will compare to Year 2	Annually
How many GAP Participants have	Number of approved applicants who have a behavioral health services claim		Magellan/MMIS	Compare to Year 1	Annually

Virginia 1115 GAP Waiver – Evaluation Measures 2016

Research Questions	Measure	Details	Data Source	Comparisons	Frequency
utilized their GAP Coverage	Number of approved applicants who have a physical health services claim		MMIS	Compare to Year 1	Annually
	Number of approved applicants who have a Pharmacy claim		MMIS	Compare to Year 1	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 recovery oriented services that will help stabilize GAP participants	Number of GAP participants enrolled in 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 using Care Coordination	Number of GAP participants enrolled in 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 2016

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	Compare to Year 1	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	Compare to Year 1	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	Compare to Year 1	Annually
	Integration of behavioral health and medical health	Percentage of providers who provide both behavioral health and medical services	MMIS	Compare to Year 1	
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	Compare to Year 1	Annually
	Show Reduced or No Substance Use*		Magellan,		Annually
	Are Not Homeless		Magellan, TBD		Annually
	Are Employed Full or Part-Time		Magellan, TBD		Annually
Has the integration of physical and behavioral health services resulted in **better health outcomes** of demonstration participants [1]	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	Compare to Year 1	Annually
	Has there been a reduction in the number of emergency department visits for GAP Participants ?	Self reported through recovery navigation survey	Magellan, VHI, TBD	Compare to Year 1	Annually

Virginia 1115 GAP Waiver – Evaluation Measures 2016

Research Questions	Measure	Details	Data Source	Comparisons	Frequency
	Has there been a reduction in the number of hospital admissions for GAP Participants?	GAP Participants who have hospital admission	DBHDS - TBD	Compare to Year 1	Annually