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

State Demonstrations Group

September 26, 2023

Cheryl Roberts
Director
Virginia Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Dear Director Roberts:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Summative Evaluation Report, which was required by the Special Terms and Conditions (STCs), specifically STC #55 "Final Evaluation Report" of the section 1115 demonstration "Virginia Governor's Access Plan (GAP) (Project No: 11-W -00297/3). The demonstration was approved on January 9, 2015 and was effective through December 31, 2019. This Summative Evaluation Report covered the period from January 2015 through December 2018.[1] CMS determined that the Evaluation Report, submitted on August 26, 2021 and revised on March 8, 2022, is in alignment with the CMS-approved Evaluation Design and the requirements set forth in the STCs, and therefore, approves the state's Summative Evaluation Report.

The report provided suggestive and preliminary indications that the state made progress on its demonstration goals. During the evaluation period, there was an increase in medication adherence for members with schizophrenia and an increase in medication treatment for those members with major depressive disorder. There was also an increase in the proportion of members with a Serious Mental Illness (SMI) who saw a primary care provider. The state primarily used descriptive statistics in its analysis, which limited the inferences that could be drawn from the data. However, the state's Evaluation Design for the current "Building and Transforming Coverage, Services, and Supports for a Healthier Virginia" demonstration (approval period January 1, 2020 through December 31, 2024) is comprehensive and robust with the potential to provide CMS and the state with greater insight into the state's performance toward the goals and the effectiveness of the demonstration components that are carried into the current demonstration period.

In accordance with STC #57, "Public Access," the approved Evaluation Report may now be posted to the state's Medicaid website within 30 days. CMS will also post the Summative Evaluation Report on Medicaid.gov.

[1] The state will assess progress made in 2019 as part of its current Building and Transforming Coverage, Services, and Supports for a Healthier Virginia demonstration evaluation efforts.

We appreciated our partnership on the Virginia Governor's Access Plan and look forward to our continued partnership with the ongoing Virginia section 1115 demonstrations. If you have any questions, please contact your CMS demonstration team.

Sincerely,

Paula M. Kazi -S

Digitally signed by Paula M. Kazi -S
Date: 2023.09.27 10:17:00 -04'00'

Paula M. Kazi
Acting Director
Division of Demonstration Monitoring and Evaluation

cc: Margaret Kosherzenko, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

Governor's Access Plan for the Seriously Mentally Ill

SUMMATIVE EVALUATION PERIOD: 1/1/15-12/31/18

Executive Summary

On June 20, 2014, former Governor Terry McAuliffe declared, "I am moving forward to get Virginians healthcare." To that end, he charged then 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 was 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, which provided limited medical and behavioral health care coverage for low-income, uninsured individuals with Serious Mental Illness (SMI). The GAP demonstration included mental health, substance use treatment services, medical doctor visits, medications, access to a 24-hour crisis line, recovery navigation (peer support) services, and care coordination.

The three key goals of the GAP Demonstration included:

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.
3. Serve as a bridge to closing the insurance coverage gap for Virginians.

Without access to treatment and other supports such as healthcare, care coordination, and Recovery Navigation, individuals with SMI are often unnecessarily hospitalized, may be unable to find and sustain employment, struggle with finding affordable and available housing, become involved with the criminal justice system, and suffer with social and interpersonal isolation. The opportunities provided through the GAP Demonstration enabled persons with SMI to access both behavioral health and primary health services, enhanced the treatment they could receive, allowed their care to be coordinated among providers, and therefore addressed the severity of their condition. With treatment and support, individuals with SMI and co-occurring or co-morbid conditions can recover and live, work, parent, learn, and participate fully in their community. Anecdotally, DMAS has heard from stakeholders that member outcomes could be improved if the program included additional non-covered services, specifically inpatient care and transportation.

The Department of Medical Assistance Services (DMAS) hypothesized those GAP members' physical and behavioral health outcomes would improve simply by having access to primary care, behavioral health and pharmacy services. Throughout the course of the Demonstration, GAP members have chosen to use person-centered, community based behavioral and health care providers in lieu of emergency rooms. For some GAP members, Recovery Navigation has supplemented and complemented clinical treatment.

Demonstration Description

(Governor's Access Plan for the Seriously Mentally Ill (11-W-00297/3)-approval period by Centers for Medicare and Medicaid Services (CMS) January 12, 2015 through December 31, 2019; GAP component of the waiver ended March 31, 2019)

The GAP Demonstration was launched in January 2015 with support from a wide variety of stakeholders, including families, advocates, community mental health and healthcare providers, primary health care providers, Magellan of Virginia, (the Behavioral Health Services Administrator (BHSA)), the Department of Behavioral Health and Developmental Services (DBHDS), and other state agencies. Throughout the project, DMAS continued to collaborate with these stakeholders to ensure the success of the program. Outreach and training efforts ensured that individuals knew the program existed and that providers were aware of and able to offer the care GAP members need. GAP offered a targeted benefit package (see Appendix A) to Virginians who met the GAP criteria of being seriously mentally ill and had incomes less than 100% of the federal poverty level (FPL) among other eligibility criteria.

Of the 300,000 individuals in Virginia with SMI in 2014 when the planning for GAP began, about 50,000 individuals were uninsured. In working with stakeholders, it was originally thought that many of those 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 included behavioral health, primary, and specialty health care coverage. The intent of the benefit package was to ensure that each GAP member acquired a primary care physician to coordinate the member's physical and behavioral health care with the assistance of Magellan of Virginia. Magellan also provided assistance to GAP members who needed 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;
- Conducted Regional Town Halls/ Listening Tours; and
- Conducted education and outreach to criminal justice entities

The 2015 Virginia General Assembly legislative session revised the GAP financial eligibility criteria to 60% of the FPL, this led to a waiver amendment being submitted to CMS that was approved in May 2015. After a year of successful implementation, the 2016 Virginia General Assembly legislative session again revised the GAP financial eligibility criteria to 80% of the FPL leading to a waiver amendment that was approved by CMS in June 2017. That amendment also included a request to extend the waiver to 2019 which CMS also approved.

The 2017 Virginia General Assembly legislative session was even more supportive of the GAP program. The General Assembly authorized DMAS to revise the eligibility to 100% FPL and to add a full array of

substance use treatment services to the GAP program, including residential and residential detox services. This amendment was approved by CMS in September 2017.

The 2018 Virginia General Assembly legislative session was very positive for uninsured Virginians and for GAP members. The General Assembly authorized DMAS to pursue Medicaid Expansion for uninsured Virginians; and as part of that expansion, GAP members could be enrolled in the new Expansion benefit plan, thus being eligible for a full comprehensive benefit plan.

The evaluation design was approved by CMS and when the substance use disorder services were enhanced in 2017, there was some consideration given to modifying the design. However, in late 2018 CMS representatives noted that since GAP was ending due to Virginia pursuing Medicaid Expansion, DMAS should use the original design. With the Medicaid Expansion 1115 amendment, the evaluation design was again considered and CMS again allowed Virginia to continue to use the original design.

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.

Figure 1: GAP Logic Model

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 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.

Impacted Populations and Stakeholders

The GAP Demonstration targeted individuals who met eligibility parameters resulting from meeting the GAP SMI criteria. In addition to having been screened and determined to meet the clinical criteria for SMI, individuals must have met all of the requirements outlined below to be eligible for the Demonstration:

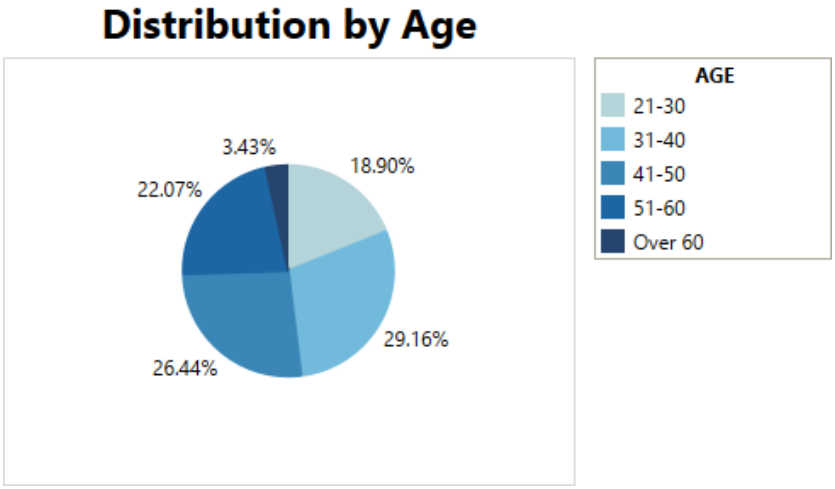
- Adult ages 21 through 64 years old;
- U.S. Citizen or lawfully residing immigrant;
- Not otherwise eligible for any state or federal full benefits program including: Medicaid, Children's Health Insurance Program (CHIP/FAMIS), or Medicare;
- Household income that is below the required level ranging from 60 to 100% of the FPL during the Demonstration (Figure 2 details the time table of changes in financial eligibility);
- Uninsured;
- Not residing in a long-term care facility, mental health facility, or penal institution; and
- Screened and meet SMI criteria, including documentation related to the duration of the mental illness and the level of disability based on the mental illness;

Figure 2: Time Table of Financial Eligibility Changes

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 – September 31, 2017
Adults not otherwise eligible under the State plan	N/A	0-100% of the FPL	October 1, 2017 – remaining Demonstration

The GAP population remained evenly distributed across the lifespan with little change over the 4 years of the demonstration. Figure 3 represents the distribution as of the end of Year 4 (2018). Nearly every year of the demonstration, there were more enrolled females than males.

Figure 3: GAP Population Age Distribution

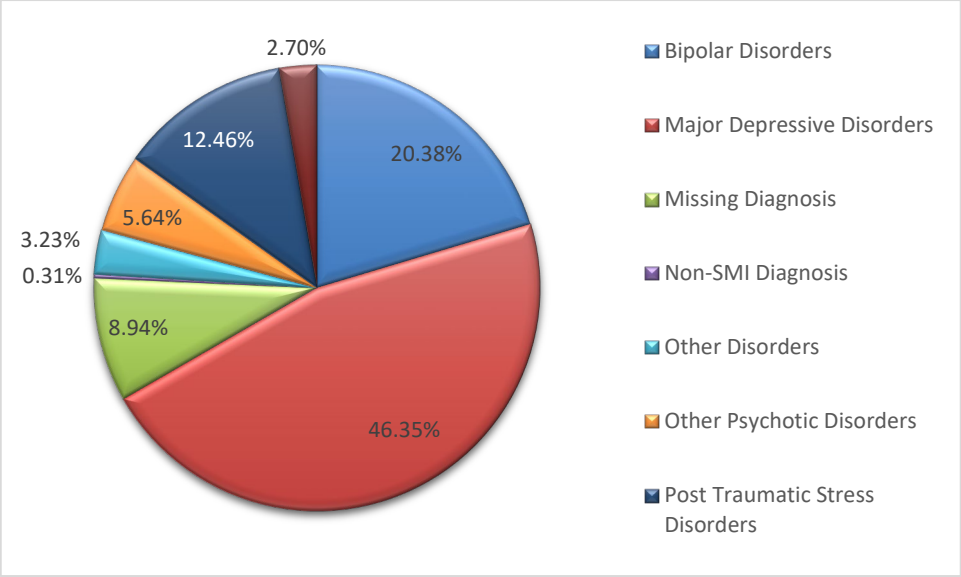


Prior to eligibility determinations, applicants were required to complete an SMI screening to assess the following areas to determine whether SMI criteria were met: Age, Diagnosis, Duration of Illness, Level of Disability and whether due to the mental illness, the applicant required assistance to consistently access and to utilize needed medical and/or behavioral health services/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.

Among members enrolled in the GAP program at the end of 2018, the primary diagnoses mainly consisted of Major Depressive Disorder (46.35%), Bipolar Disorders (20.38%), and Post-Traumatic Stress Disorder (12.46%) (See Figure 4). This mirrors 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. Other disorders including Obsessive-Compulsive Disorder (OCD), Panic Disorder, Agoraphobia, Anorexia Nervosa and Bulimia Nervosa categories represent roughly 10% of the GAP population. Less than 10% of members have diagnoses that appear to not meet the SMI criteria or are missing data. Importing data from external sources revealed glitches in technology and DMAS processes for requesting and analyzing data. These revelations are being noted as DMAS develops its new data warehouse and MMIS system.

Figure 4: GAP Population by SMI Diagnosis Category



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, CSBs, FQHCs, 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 made significant efforts to grow the GAP enrollments. However, some stakeholders (CSBs and criminal justice entities) claimed that the limited diagnoses disqualified many individuals known to the providers, who may otherwise qualify for GAP. Of note, some stakeholders were advocating for personality disorders to be added to the eligibility criteria.

Methodology

The GAP evaluation is a simple pre- and post- single group design. DMAS hypothesized that by defining the GAP members' baseline in certain areas and measuring the outcomes in those same areas post GAP participation, there would be improvement in members' behavioral health and/or health conditions. DMAS 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 with the resources available. DMAS used Year 1 of the Demonstration to establish the baseline, and subsequent years as "the intervention." It is recognized that this design is limited as it does not allow for trends or the progress of change for the members, nor does it control for other variables; however, it does identify where the members were in Year 1 on average compared to where they finish after using GAP benefits.

The GAP metrics were identified using the data elements that could be collected once the member was enrolled in GAP and rely primarily 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 psychosocial outcomes for a segment of the GAP members.

DMAS faced fairly significant challenges acquiring data from some sources as well as reconciling data from DMAS contractors. Data challenges were identified and reported in quarterly and annual monitoring reports to CMS. DMAS worked with contractors and GAP partners to ensure data access and quality issues are minimized.

Measures

Appendix B presents the measures that were used to determine whether each program goal had been achieved. This table describes the data sources, stratification categories, and frequencies for each measure.

Data Sources and Collection

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

- *The Virginia Medicaid Management Information System (MMIS)*: Virginia's MMIS contains information about enrollment, providers, and claims for health services. Claims data, in measuring each participant's interaction with the health care system, underlie many of the measures of cost and utilization of particular services by individual participants. Data on participant characteristics maintained in MMIS allow analyses to be stratified by participants' demographic and health and pharmacy service use characteristics. The MMIS system was used to generate specific reports required for 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 answered research questions and provided or supplemented the measures used to test research hypotheses with detailed specifications and uniform templates for reporting.

- *Peer Administered Survey***:** Recovery Navigator Program Metrics captured primary measures of self-reported information valuable to the evaluation of the GAP Demonstration. Metrics included primary measures such as self reported inpatient hospital visits, engagement with the criminal justice system, and psychosocial indicators for those GAP members participating in Recovery Navigation Services.

- *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. While usually used to measure progress of managed care members, these measures were used for the GAP/fee for-serve members as they are nationally recognized and accepted.

- *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 captured 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, for individuals who do not have Medicaid. 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 was a limited benefit program and did not include inpatient hospitalization and Emergency Department (ED) services. Therefore, DMAS did 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 was 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 into 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 as planned in the original evaluation design. 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 Virginia All Claims Payers Database (ACPD), also had limitations in using their data when DMAS approached them in 2015. The ACPD 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 would have needed to invest significant additional time and effort to comply with the legal requirements to report data and did not have the staffing resources to do this.

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 has ensured that while conducting the evaluation, the measures and outcomes are as isolated as possible.

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. In 2015, the household income eligibility of 60% federal poverty level slowed GAP enrollments. This slowing in enrollment influenced 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 in 2016, and DMAS provided trainings and notification of the increase, it is possible that there will have been pockets of potential applicants who did not apply for GAP due to thinking the FPL was still at 60%. In 2017, with the 100% FPL eligibility increase, DMAS staff witnessed a substantial increase in the GAP enrollment population. The fluctuating of the eligibility criteria also impacted those GAP members who were re-enrolling annually.

Evaluation Questions and Hypotheses

GAP Demonstration Population

The demonstration population consisted of uninsured Virginians, with Serious Mental Illness, that were eligible for the GAP Demonstration during the period of January 2015 - December, 2018 or 26,306 GAP members. A total of 17,089 were still enrolled at the end of 2018; this would include new and re-enrolling members. Of that total for 2018, DMAS has also noted a sub-population of GAP members who were consistently enrolled from January 2015 through December 2018. This sub population was a total of 3,438 members.

Waiver Goal 1

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

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

Data Source: Cover Virginia

Data Analysis: Data was used to examine year-over-year changes in access to health and behavioral health care during the demonstration period. Reporting captured numbers of distinct completed applications submitted to Cover Virginia for the GAP Demonstration compared to total uninsured SMI population in Virginia, and the number of approved applications submitted to Cover Virginia for the GAP Demonstration compared to total uninsured SMI population in Virginia.

1) What percentage of uninsured Virginians applied for the GAP Demonstration?

Discussion: The Virginia Healthcare Foundation estimated the total number of uninsured adults in Virginia was 747,000. According to the Substance Abuse and Mental Health Services Administration, Virginia's prevalence rates of serious mental illness suggest that about 4.4% (279,000) of all adults age 18+ have a serious mental illness. Approximately 69,750 individuals (0.25% of 279,000) diagnosed with a serious mental illness are uninsured.[1] Cover Virginia received and processed 43,469 unduplicated applications since GAP inception. This reflects that an estimated 62% of the targeted population applied for the GAP Demonstration over the course of the demonstration's four years (43,469 GAP applicants out of 69,750 uninsured adults with SMI). Over the time span of the demonstration, the percentage of uninsured Virginians with SMI applying to the GAP demonstrated increased from approximately 20% in Year 1 to 62% by Year 4, an increase of 42 percentage points.

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

Discussion: Approximately 38% of Virginia's uninsured SMI population were approved for the GAP Demonstration since the program's inception (26,308 GAP members out of 69,750 uninsured adults with SMI). Over the time span of the demonstration, the percentage of uninsured Virginians with SMI who applied and enrolled in the GAP Demonstration increased from approximately 13% in Year 1 to 38% by Year 4, an increase of 25 percentage points.

Waiver 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: *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.*

Data Sources: MMIS

Data Analysis: Annual assessment of the GAP Demonstration program and the quality data presented in the report are a subset of the Healthcare Effectiveness Data and Information Set (HEDIS) measures, along with other subsequent measures of quality care surrounding the utilization of behavioral health services, adherence to pharmaceutical therapy, etc. Reporting will capture performance measures to evaluate, provide episode of care benchmarks and report the access to healthcare for GAP enrollees.

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

GAP Demonstration Scores on Selected HEDIS Quality Measures

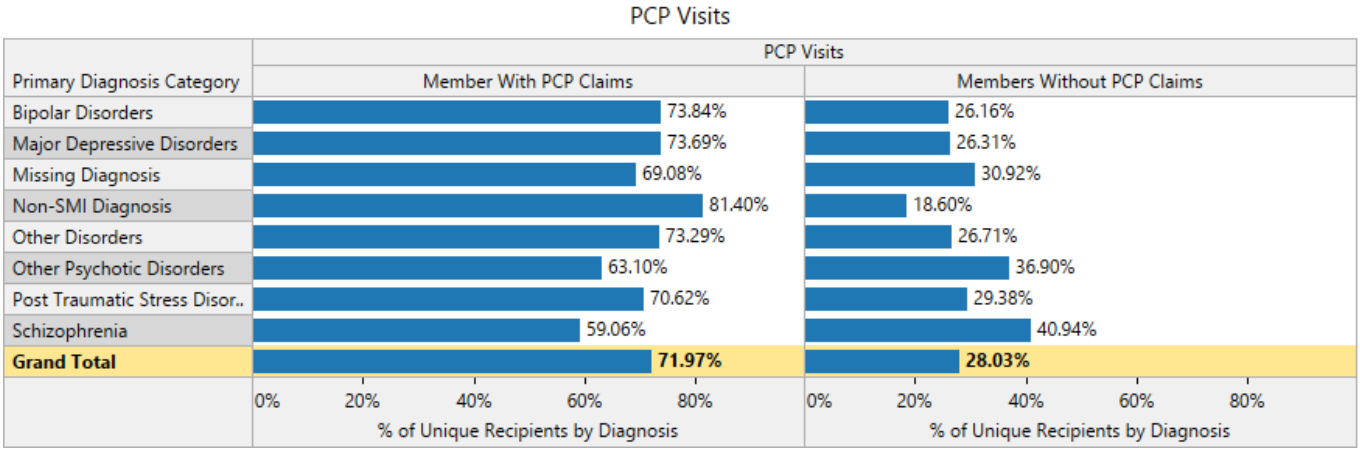
Measure: Adults' Access to Preventive/ Ambulatory Health Services (AAP): The percentage of members 21 years and older who had an ambulatory or preventive care visit during the measurement year.

- ♦ 21 to 44 years of age
- ♦ 45 to 64 years of age

Data Sources: MMIS

Discussion: In general, noncritical conditions are best addressed as outpatient and/or ambulatory healthcare services. Figure 5 identifies the percentages of PCP visits for each primary SMI diagnosis category. Collectively, 71.97% of the entire GAP population during Year 4 of the demonstration was seen by a primary care provider (PCP). This was an increase of 4 percentage points of GAP members accessing primary care in 2018 compared to 67.97% in 2017. Thirty-nine percent of GAP members in age group of 45+ accessed services via a primary care provider and 61% of GAP member in age group 21-44 accessed a PCP. On average, a primary care provider saw GAP enrollees 2.21 times in the fiscal year.

Figure 5: Percentage of Primary Care Visit by Primary SMI Diagnosis Category, 2018



The practice of providing ambulatory healthcare for noncritical conditions is not entirely new. What has evolved during the course of the assessment period is the use of dedicated facilities for ambulatory care mostly as a way to improve access to medical care. Institutions such as Federally Qualified Health Centers (FQHCs) and rural health centers are also providing outpatient medical care and/or are considered to be PCPs facilities. Exploration of the data reveals that, in many cases, GAP members are receiving some form of "primary care" from non-traditional providers such as Nurse Practitioners.

Measure: 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.

Data Source: MMIS

Discussion: Among individuals with schizophrenia, non-adherence to pharmacological treatment with antipsychotic medications is associated with a greater number of clinic and emergency room visits and more psychiatric hospitalizations. On average, 50% of patients with schizophrenia are non-adherent to their pharmacological treatment [2-6]. As for the GAP population, 54% of GAP recipients had antipsychotic medication(s) dispensed during Year 4 which is an increase from previous year of 49%. Moreover, 50% of GAP members diagnosed with Schizophrenia were adherent to treatment regimen 80% of the evaluation period, while 6% were non-adherent (44% of recipients with Schizophrenia did not have a pharmacy claim(s) for antipsychotics). In comparison to prior years, adherence within the GAP population increased with only 25% of GAP members with schizophrenia adherent to treatment regimen for at least 80% of the treatment period in Year 1 of the GAP demonstration. DMAS attributes the increases in medication adherence potentially due to the work of the recovery navigators and GAP care managers, as this was a focus for their roles. GAP members were encouraged to organize their medications using pill packs and also encouraged to talk to their physicians about side effects. Other initiatives to support medication adherence were the increase in access to primary care through individuals' relationships with local entities including Community Services Boards (CSBs) and Magellan of Virginia, and growing relationships with Federally Qualified Health Centers (FQHCs). National research shows that first-line antipsychotic medications are effective in approximately 70%–80% of persons diagnosed with schizophrenia (PWS); however, an estimated 50% of those who respond well to medications are nonadherent to their treatment regimen[1]. The table below identifies GAP recipients diagnosed with Schizophrenia and their status with medication adherence for Year 4, 2018. Probable explanations for the high frequency of members with schizophrenia not having a claim for antipsychotics include but are not limited to: (1) member declined to take medication, (2) member neglects to fill prescription; (3) the prescribing provider is using another type of medication, providing samples, etc., and (4) nonadherence to pharmacological treatment is common for this population.

Figure 6: Adherence to Antipsychotic Medication by Eligibility Diagnosis of Schizophrenia-2018

80% Adherence	Dispensed	315
Less than 80% Adherence	Dispensed	37
	Not Dispensed	278
Grand Total		**630**

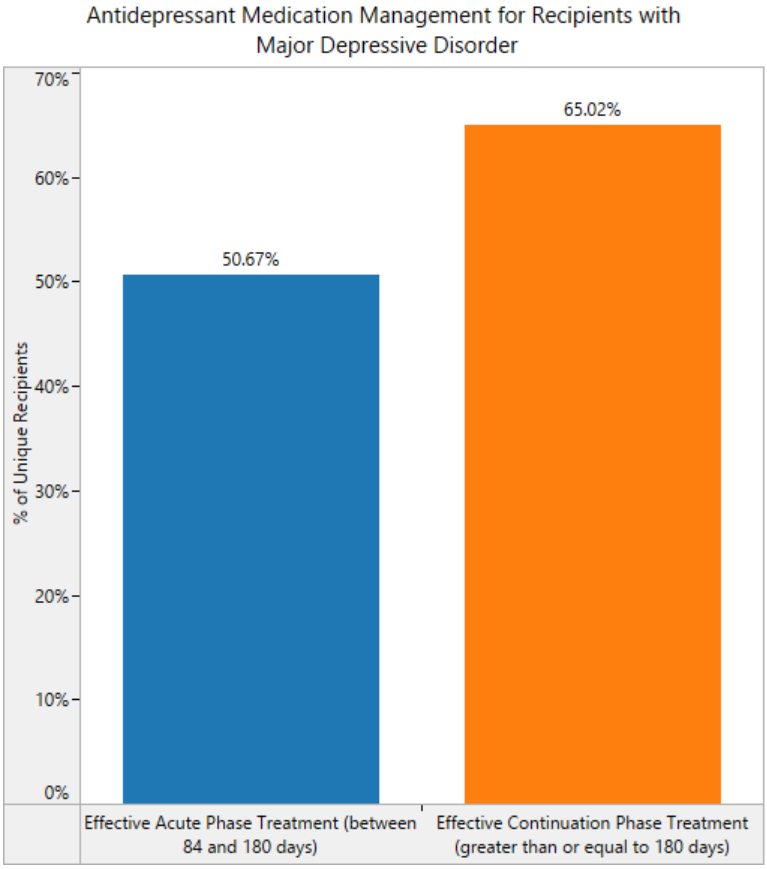
Measure: NCQF Measure 0105: Antidepressant Medication Management: The percentage of members with a diagnosis of major depression and treated with antidepressant medication and remained on an antidepressant medication treatment.
♦ Effective Acute Phase Treatment (on medication for at least 84 days/12 weeks)
♦ Effective Continuation Phase Treatment (for at least 180 days/6 months)

[1] Zipursky RB. Why are the outcomes in patients with schizophrenia so poor? *J Clin Psychiatry*. 2014;**75**(Suppl 2):20–24. [PubMed] [Google Scholar]

Data Source: MMIS and NCQA National Data

Discussion: Antidepressant medications are prescribed for several common mental disorders and serious mental illness. In recent years, growing bodies of evidence have suggested maximizing the potential for response in patients; clinical guidelines suggest an antidepressant regiment of treatment to continue for at least 6 months following diagnosis. In spite of clinical recommendation, nonadherence to antidepressant is high with 42% discontinuation after 4 weeks, increasing to 76% at six months.[7] During SFY 2018, 5,546 GAP recipients with Major Depression, were dispensed antidepressant medication.

Figure 7: Percentage of GAP Recipients by Antidepressant Treatment Phase-2018



The NCQF data presented in Figure 7 indicates that approximately 65.02% (slightly lower than 2017's 67.7% estimate) of the GAP recipients with Major Depression received dispensed antidepressants effective for a continuation of 180 days or more, while 50.67% (down from 2017's 59.7% estimate) of the GAP members with the diagnosis of major depression filled prescriptions in the acute phase of treatment.

Figure 8: Adherence to Antidepressant Medication by Eligibility Diagnosis of Major Depression Disorder-2018

80% Adherence	Dispensed	5,385
Less than 80% Adherence	Dispensed	326
	Not Dispensed	5,081
Grand Total		**10,792**

Figure 8 composite scores show that 50% of the population diagnosed with major depression in 2018 (5,385) were dispensed and adherent to treatment regimen 80% of the evaluation period. More importantly, only 3.0% were nonadherent during the treatment period. In contrast, during Year 1 of the demonstration, 41% of members (1,203 out of 2,964) with a diagnosis of major depression were treated with antidepressant mediction and remained on an antidepressant medication for at least 80% of the treatment period.

Measure: 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 Source: MMIS, HEDIS Measure

Discussion: Patients with serious mental illness are highly susceptible to physical health problems. While physical conditions such as diabetes, cardiovascular disease and hypertension are also prevalent in the general population, their impact on individuals with SMI is notably greater.[8] According to Parks J, Svendsen D, Singer P, et al, approximately 60% of the excess mortality rates in people with severe mental illness (SMI) is due to physical illness.[9] In the following Figures 9-11, the population displayed includes GAP members who were screened for diabetes, hypertension and cardiovascular and received pharmacological treatment. Please note that Figures 9-11 reflect Year 4 of the demonstration only, except where otherwise noted.

> ***Update to Analysis****: Please note that we have re-configured our prior logic concerning cardiovascular, hypertension, high cholesterol and diabetes drug therapies. For example, during SFY 2016 of the GAP evaluation, our logic for diabetes drug therapy focused merely on therapies for conditions that resulted from diabetes such as hyperlipidemia, high cholesterol and diabetic retinopathy. In Years 3 and 4, we considered treatment for primary diabetes and have moved the focus to insulin and Type II non-insulin therapies such as Glucophage. We also noticed that there was some confounded logic around hypertension and cardiovascular treatment and therefore, we have separated the drug classes to focus on the primary conditions rather than resultant conditions.*

Diabetes: During the first year that GAP was implemented, 72% of GAP members were identified as having a co-occuring behavioral health diagnoses and diabetes. This was based on claims for GAP members where diabetes was the primary diagnosis (See Figure 9a). 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. In demonstration year 2, 75% of GAP members who were screened for diabetes were identified as having a co-occuring behavioral health diagnosis and diabetes, 29% received diabetic therapy, cholesterol reducers and/or lipotropics. This is an increase of nearly 20% points from Year 1 of the Demonstration (See Figure 9b). In 2018, approximately 33.40% of

the GAP population enrolled at the time were screened for diabetes. Of those screened members (positive and negative outcomes of testing), only 14.4% received diabetic therapy. (See Figure 9c-total number of recipients reflects eligibility fluctuations over the course of the year or perhaps GAP members who were screened multiple times.)

Figure 9a: Frequency of GAP Recipients by Utilization of Diabetic Medications-2015

	Recipients with Diabetes	Recipients without Diabetes
Not taking Diabetes related Drugs	5,040	Not reported for first year
Taking Diabetes related Drugs	504	Not reported for first year

Figure 9b: Frequency of GAP Recipients by Utilization of Diabetic Medications-2016

Diabetes Drug

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

Figure 9c: Frequency of GAP Recipients by Utilization of Diabetic Medications-2018

Diabetes Drugs

	Recipients with Diabetes	Recipients without Diabetes
Not taking Diabetes related Drugs	598	18,904
Taking Diabetes related Drugs	1,311	598

Hypertension: During the first year that GAP was implemented, 73% of GAP members were identified as having a co-occuring behavioral health diagnoses and hypertension. This was based on claims for

GAP members where hypertention was the primary diagnosis. Of the 73% GAP members with a diagnosis of hypertension, 1522 (30% of those diagnosed with hypertension) received medications for the condition (Figure 10a).

In 2018, approximately 28.4% of the GAP population (4889 members) screened positive for hypertension. Of those screened members (positive and negative outcomes of testing), 11.7% received hypertension therapeutic regimens. (See Figure 10b-total number of recipients reflects eligibility fluctuations over the course of the year or perhaps GAP members who were screened multiple times)

Figure 10a: Frequency of GAP Recipients by Utilization of Hypertension Medications-2015

	Recipients with Hypertension	**Recipients without Hypertension**
Not taking Hypertension related Drugs	**5,073**	**Not reported for first year**
Taking Hypertension related Drugs	**1,522**	**Not reported for first year**

Figure 10b: Frequency of GAP Recipients by Utilization of Hypertension Medications-2018

Hypertension Drugs

	Recipients with Hypertension Diagnosis	Recipients without Hypertension Diagnosis
Not taking Anti-Hypertensives	2,871	17,201
Taking Anti-Hypertensives	2,018	1,483

Cardiovascular: During the first year that GAP was implemented, only 2 members were diagnosed with a cardiovasucular condition and both were receiving medications for those conditions. Year 2 experienced 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. In 2018, approximately 10.4% of the GAP population (1793 members) screened positive for cardiovascular disease. Of those screened members (positive and negative outcomes of testing), 59.4% received cardiovascular therapeutic regimens. See Figure 11.

Figure 11: Frequency of GAP Recipients by Utilization of Cardiovascular Medications-2018

Cardiovascular Drugs

	Recipients with Cardiovascular Diagnosis	Recipients without Cardiovascular Diagnosis
Not taking Cardio-related drugs	728	16,899
Taking Cardio-related drugs	1,065	4,784

Substance Use Disorders: Between January 1 and December 31, 2018, there were 2,718 GAP members enrolled in substance use treatment and or received services, double the number enrolled during 2017. Among those identified as utilizing Substance Use Disorder services from claims data, 2,135 were prescribed medication as a part of their substance use treatment in 2018. See Figure 12.

Measure: 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.

Figure 12: Substance Use Disorder Services and Medication Utilization, 2018

Primary Diagnosis Category	Service Utilization	Medication Utilization
Other Disorders	120	85
Bipolar Disorders	574	434
Major Depressive Disorders	1475	1233
Posttraumatic Stress	449	317
Psychotic Disorders	79	57
Schizophrenia	21	9
Grand Total	**2718**	**2135**

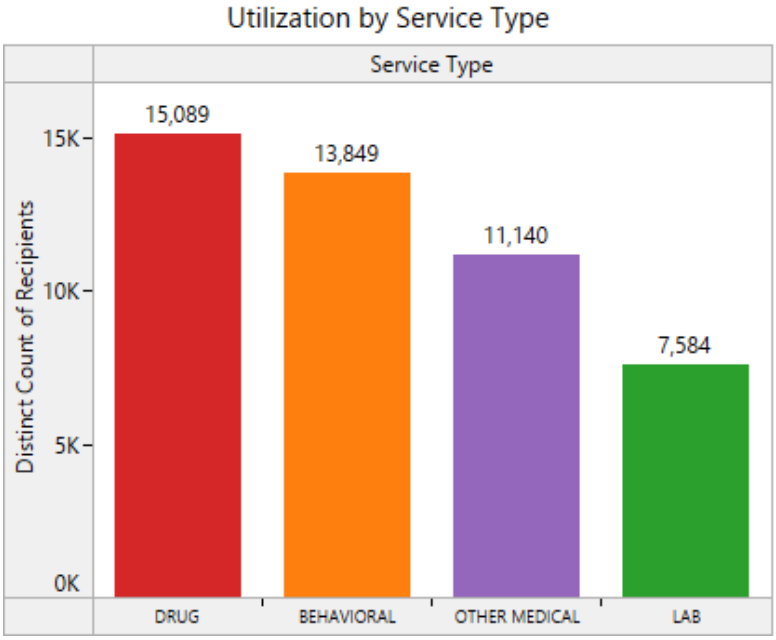
2) How many GAP Participants have utilized their GAP Coverage?

GAP Demonstration Scores on Utilizations Measures

Measure: Number of approved applicants who had behavioral health services, physical health services, and pharmacy claims.

Data Source: MMIS

Figure 13: Frequency of Utilized Services by Provider Type-2018



Discussion: Addressing the whole patient and his or her physical and behavioral health needs is essential for positive health outcomes and cost-effective care. In Figure 13 for 2018, the data displays the utilization of physical, pharmacy, and medical services obtained during the evaluation period. Over 88% of GAP enrollees were dispensed and/or had access to medications, 81% of GAP enrollees used behavioral health services and 65% of enrollees used other physical/medical services. During the evaluation period, the vast majority of GAP members were receiving access to care under an integrated care model. Moreover, utilization of services by GAP members overall increased across the demonstration period: for example utilization of medications was 14% points greater (74% in Year 1 vs. 88% in Year 4) and utilization of behavioral health services was 7% points greater (74% in Year 1 vs. 81% in Year 4). ~~; and, utilization of other physical/medical services was 14% points higher (51% in Year 1 vs. 51% in Year 4).~~

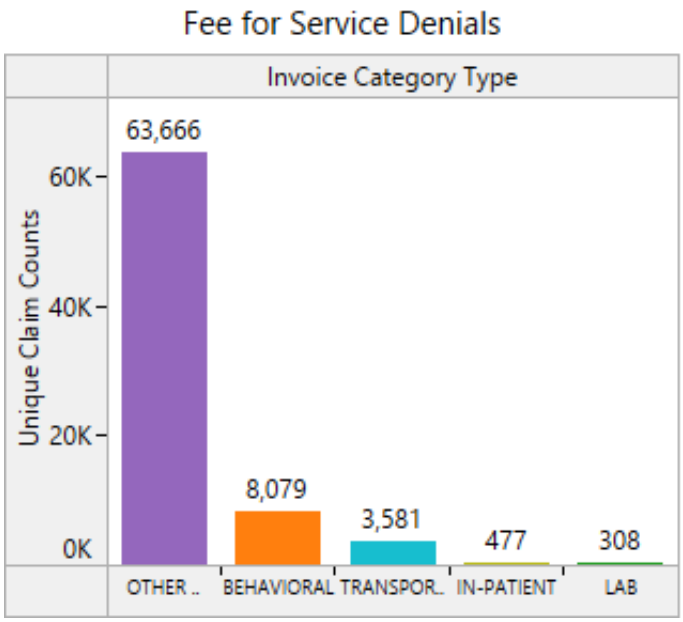
3) Are there critical services participants who do not have access to GAP that are necessary for this population to achieve improved health and wellness outcomes?

GAP Demonstration Scores on Denied Claims Measures

Measure: Measure access to common treatment elements to promote recovery including prevention and wellness, Medications, specialized behavioral health services, inpatient Services, and transportation. The measure determines the percentage of specialized claims denied because the GAP Program did not cover the service.

Data Source: MMIS

Figure 14: Denied Claims by Invoice Category Type-2018



Discussion: Of the approved, Virginia Medicaid covered services; there are essential services that are not covered which would provide needed assistance to members related to medical and behavioral health care needs. These include inpatient services, more comprehensive outpatient services, surgeries in a hospital setting, and transportation. Figure 14 identifies denied claims submitted for services not covered by GAP. Because the GAP Program is a limited plan, emergency, ambulatory and inpatient services (which provide immediate care for severe medical issues) are not covered. The "Other" category in Figure 14 represents services such as inpatient, ambulatory and emergency. 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. As with most individuals that have a low social economic status, transportation is basic but a major barrier to health care access. [10] Transportation is an uncovered service for the GAP Program and DMAS has heard from various stakeholders, anecdotally, that this is a much-needed service.

4) Have GAP participants utilized Recovery Navigation?

GAP Demonstration Scores on Utilization of Recovery Navigation

Measure: Ensure more appropriate use of the overall health system by providing recovery navigation (peer support) and other services that will help stabilize GAP participants. The measure will identify the number and percentage of GAP participants in recovery navigation.

Data Source: Magellan

Discussion: 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. At the end of the last quarter of 2018, 1.3% of GAP enrollees (138 members) were enrolled in Recovery Navigation. For the entire Year 4, 1,857 unduplicated GAP members were enrolled in Recovery Navigation services, a decrease of 14% points from Year 1. This decrease during Year 4 resulted as the Recovery Navigators were actively transitioning the members to other community based supports due to the GAP program ending.

Recovery Navigators delivered 1,930 supportive services during the evaluation period. GAP members received peer supports from Recovery Navigators provided by Magellan. Trained Recovery Navigators, who self-disclose as living with or having lived with a behavioral health condition provides Magellan Recovery Navigation Services. 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. Emotional support is the top category of the supports delivered. There is evidence that the members receiving Recovery Navigation services are building skills needed to cope effectively, build, and maintain relationships with others. The Recovery Navigator Vignette illustrates the progress of a GAP member through the eyes of a Recovery Navigator.

A 32-year-old female GAP member presented with diagnosis of Bipolar Disorder and Posttraumatic Stress Disorder. She was experiencing symptoms of depression after the sudden loss of her husband. She was admitted to Crisis Stabilization 5 weeks after his death. She had to move in with her parents due to no financial support. When the recovery navigator first met the GAP member she was tearful, depressed, unsure of herself and unable to make simple decisions. She was trying to cope with the recent loss and having to move back home. She created a Wellness Recovery and Action Plan with Recovery Navigation and decided to go back to school. She continued to make improvements and expressed interest in becoming a Peer Recovery Specialist. She was accepted into the Peer Specialist Training program did exceptionally well, even sharing her own story with peers. She has graduated from the training and is looking forward to employment and helping others on their own path to recovery.

Recovery Navigator Vignette

During the demontration, there were an average of 116 members enrolled in Recovery Navigation monthly. There is an average of 25 new enrollees per month to Recovery Navigation. The average number of days in Recovery Navigation is 138. There was an average of 29 calls to the Warmline each month, an evening and weekend support line, which is staffed by the Recovery Navigators. Of the supports delivered to GAP members by Recovery Navigation, emotional support, empathy, caring, concern, were the primary types of support provided followed by informational, and providing

knowledge and information about skills and training. GAP members using the Warmline may not necessarily be enrolled in Recovery Navigation Services.

Recovery Navigators offer support framed around the eight dimensions of wellness. Wellness means overall well-being. It includes the mental, emotional, physical, occupational, intellectual, and spiritual aspects of a person's life. The Eight Dimensions of Wellness, as defined by Substance Abuse, Mental Health Services Administration (SAMHSA) may also help people better manage their condition and experience recovery. The figure below describes each dimension in greater detail.

8 Dimensions of Wellness:	
	Emotional—Coping effectively with life and creating satisfying relationships
	Environmental—Good health by occupying pleasant, stimulating environments that support well-being
	Financial–Satisfaction with current and future financial situations
	Intellectual—Recognizing creative abilities and finding ways to expand knowledge and skills
	Occupational—Personal satisfaction and enrichment from one's work
	Physical—Recognizing the need for physical activity, healthy foods and sleep
	Social—Developing a sense of connection, belonging, and a well-developed support system
	Spiritual—Expanding our sense of purpose and meaning in life

5) Have GAP participants utilized Care Coordination?

GAP Demonstration Scores on Utilization of Care Coordination

Measure: Number of GAP participants with a record of Care Coordination.

Data Source: Magellan

Discussion: In Year 4, 686 (4%) members were referred for care coordination, 562 members enrolled in care coordination, 1,116 discharged, 42 inactive/other, and 234 were pending enrollment. Overall, for all categories the data showed an average of 2.54 successful contacts per member in 2018.

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:** This type of care coordination includes all supports of community wellness at a higher frequency. It is 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 because of contacting Magellan. DMAS is working with Magellan to review reporting processes to ensure better accuracy.

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

GAP Demonstration Scores on Care Coordination by Medical Doctor

Measure: Follow-up after Hospitalization for Mental Illness. The measure identifies 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:

- Seven days of discharge
- 30 days of discharge

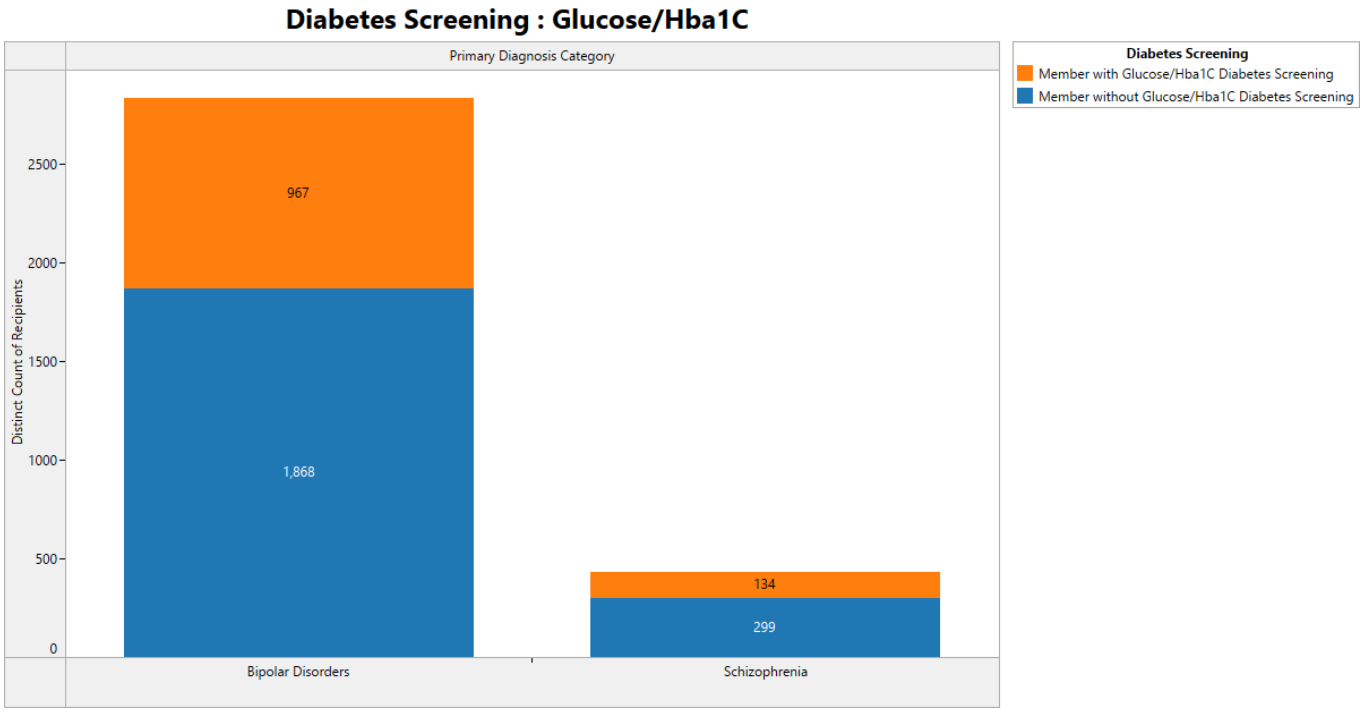
Data Source: MMIS, DBHDS and VHI

Discussion: In previous submissions of evaluation drafts, DMAS had recommended this measure be deleted as this data was initially intended to be accessed via VHI and DBHDS that is not available as DMAS thought. DMAS attempted to achieve this data from self reporting by members to the Recovery Navigators, but the self reportring was intermittent and not all GAP members participated in Recovery Navigation services.

Measure: Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications. The measure identities the percentage of members 21 to 64 years of age with schizophrenia or bipolar disorders, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Data Source: MMIS

Figure 15: Frequency of Diabetes Screening for the Members Diagnosed with Schizophrenia and Bipolar Disorders-2018

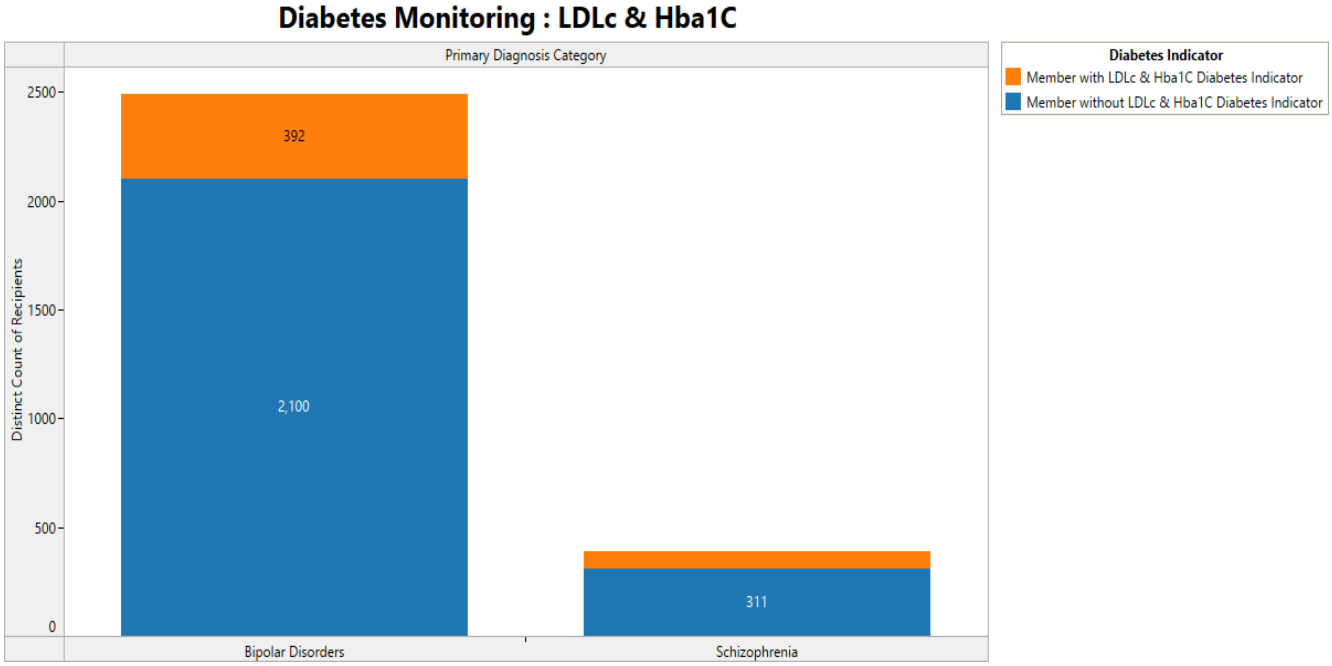


Discussion: The total numbers of reported members with Bipolar Disorder and Schizophrenia screened for diabetes via Glucose or HbA1c testing were 3,268 (19.1% of population) during 2018, which is a steady increase over the time of the demonstration.

Measure: Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD). The measure identifies the percentage of members 21 to 64 years of age with schizophrenia and diabetes, who had both an LDLc test and an HbA1c test during the measurement year.

Data Source: MMIS

Figure 16: Frequency of Diabetes Screening via LDLc and Hb1ac for the Members Diagnosed with Schizophrenia and Bipolar Disorders-2018

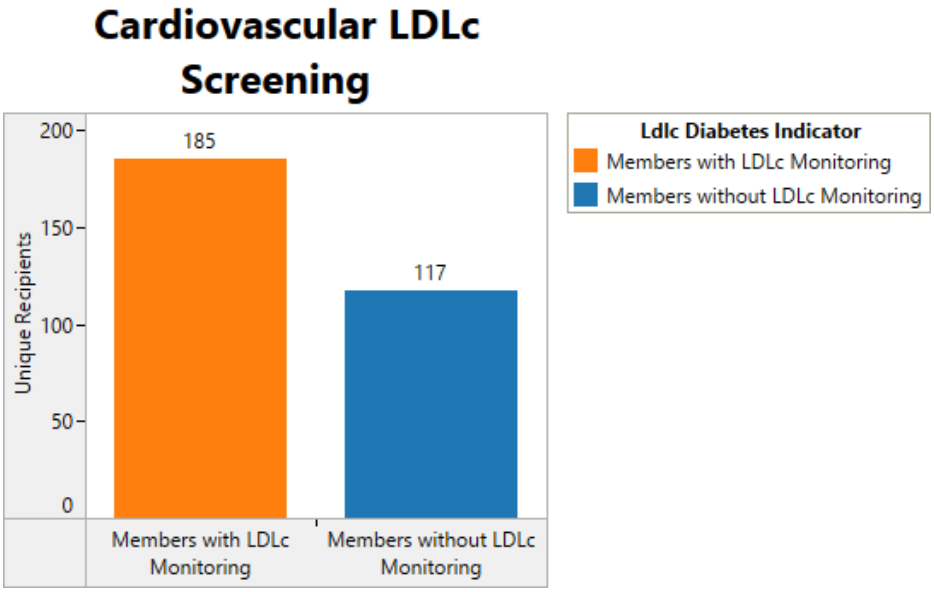


Discussion: According to Khalil, Radwa small dense low density lipoprotein (LDLc) has recently been suggested as a strong predictor of cardiovascular disease.[11]In Year 1 of the Demonstration, 1,501 members with Bipolar Disorders and 543 with Schizophrenia had LDLc monitoring and 1,618 members with 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. Note that in the Year 2 report, DMAS indicated a technical error occurred with the data regarding the number of members with Schizophrenia who received the Hba1c screening. In 2018, the total numbers of reported members with Bipolar Disorder and Schizophrenia screened for diabetes via LDLc and HbA1c testing were only 592, down from 1,893 during Year 3 of the demonstration, which was a 17.8% point increase from the 1,555 cases in Year 2 of the demonstration. The overall trend of the data showing decreases is not indicative of the other services where utilization shows increases. This suggests error in the data and the lesson learned identified in the final evaluation report is the need to build in more quality checks on data.

Measure: Cardiovascular Health Screening for People with Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications. The measurement identifies the percentage of members 18 to 64 years of age with schizophrenia and cardiovascular disease, who had an LDLc test during the measurement year.

Data Source: MMIS

Figure 17: Frequency of Cardiovascular Health Screening via LDLc for the Members Diagnosed with Schizophrenia and Bipolar Disorders-2018



Discussion: In 2018 , the total numbers of reported members with Bipolar Disorder and Schizophrenia screened for Cardiovascular Health Screening via LDLc testing were 302, less than half as many as in Year 3 which had 701, which was an 86.5% point increase from the 94 cases in Year 2 of the demonstration.

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

GAP Demonstration Scores on Reduction in Cost

Measure: Cost analysis of program accessed by age group, diagnosis category and service type. Measure is used to determine the trending cost for the program.

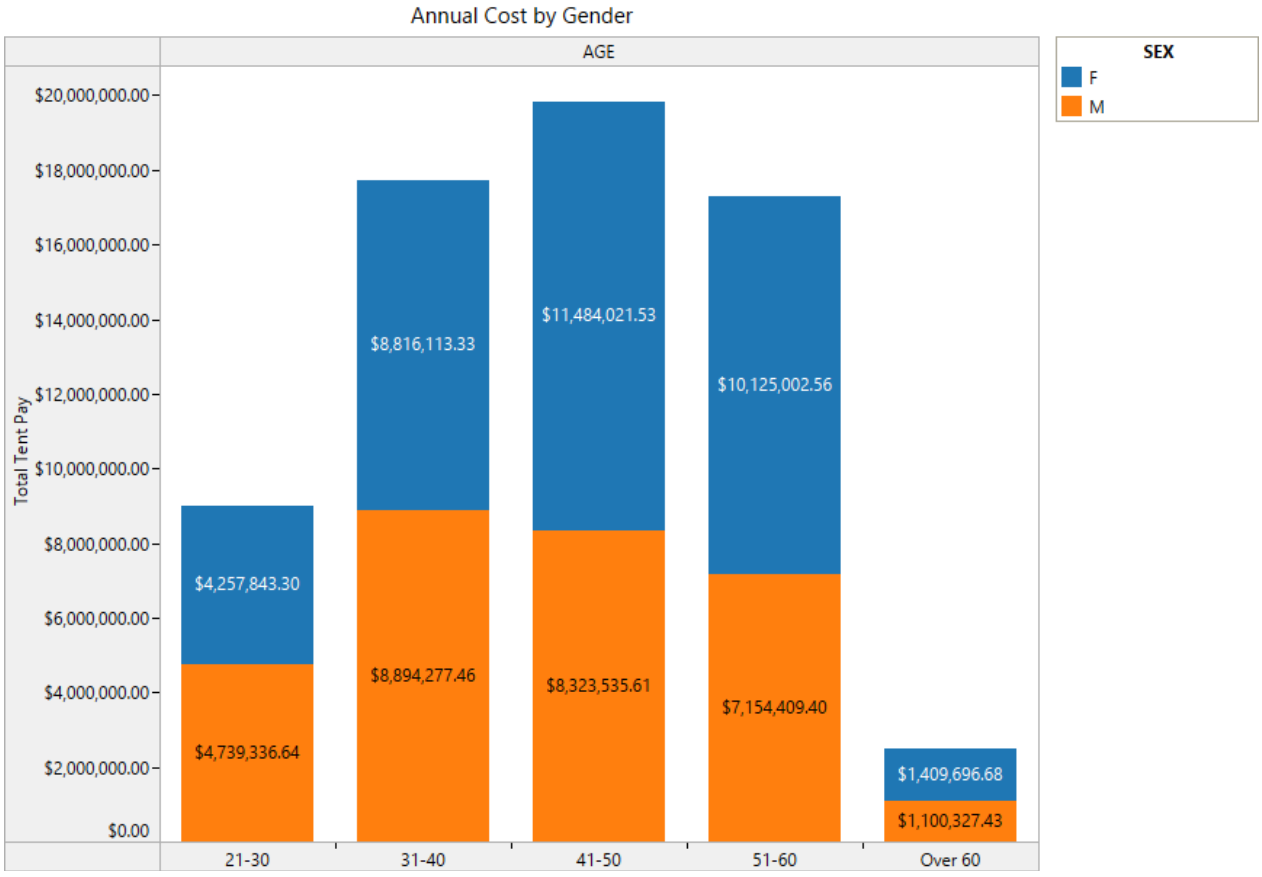
Data Source: MMIS and Claims Data

In the following Figures 18-20, the data represents expenditures during the evaluation period of 2018. Please note that the primary diagnosis category "Other Disorders" in Figure 19 only includes Obsessive-Compulsive Disorder (OCD), Panic Disorder, Agoraphobia, Anorexia Nervosa and Bulimia Nervosa, GAP eligible diagnoses.

Annual Cost by Age Group

In concordance with frequency of enrollment, the vast majority of cost derives from recipients aging from 41 to 60. This is consistent with the GAP membership in 2017.

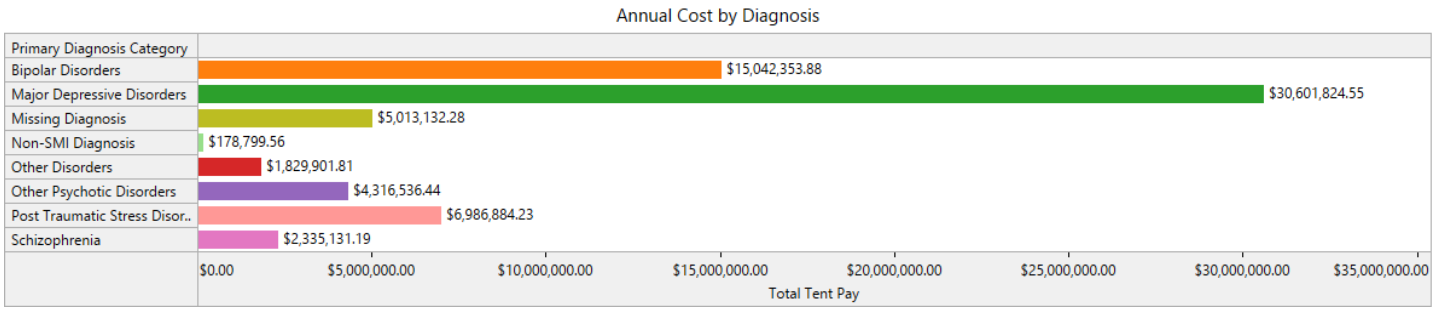
Figure 18: Annual Cost by GAP Recipient's Age-2018



Annual Cost by Diagnosis Category

The total costs for the Demonstration by diagnosis category estimated the approximately 50% of the expenditures derives from members with a major depressive disorder and these members comprise roughly 48% of the GAP membership. These numbers are very similar to our findings in 2017.

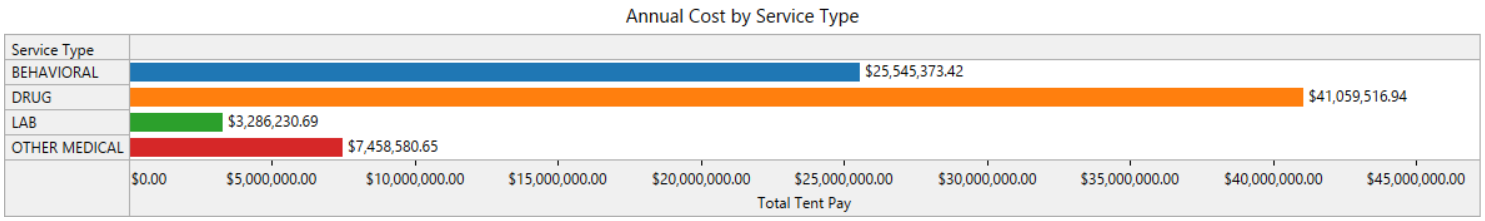
Figure 19: Annual Cost by Diagnosis Category-2018



Annual Cost by Service Type

The total costs for the Demonstration by service types estimated the approximately 53% of the expenditures derives from pharmacological treatment. In 2017, pharmacological services comprised nearly 75% of the total costs.

Figure 20: Annual Cost by Service Type-2018



Waiver Goal 3

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

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

Data Analysis: Annual assessment of the GAP Demonstration program and the quality data presented in the report are quality care surrounding the integration of medical and behavioral health services, Coordinated Care, which concentrates on communication and evidence-based peer support provided by Recovery Navigators. Reporting will capture performance measures to evaluate, provide an episode of care benchmarks and report the access to healthcare for GAP enrollees.

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

GAP Demonstration Scores on Integration of Care

Measure: Reduction in the number of interactions with the criminal justice system for GAP Participants. The measure will display the Reduction in/no change in number of incarcerations/arrests in the past 30 days from date of first service to date of last service.

Data Source: Department of Corrections (DOC)

Discussion: : In previous submissions of evaluation drafts, DMAS had recommended this measure be deleted as this data was initially intended to be accessed via DOC that is not available as DMAS thought. DMAS attempted to achieve this data from self reporting by members to the Recovery Navigators, but the self reportring was intermittent and not all GAP members participated in Recovery Navigation services. Self reports of involvement in the criminal justice system were not of a significant number.

Measure: Reduction in Temporary Detainment Order (TDOs) Claims

Data Source: MMIS

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.

By evaluating claims data, the frequency of TDOs in the GAP population serves as one way to track and monitor the effectiveness of the GAP waiver. If TDOs decrease subsequent to a member's enrollment, this shows that GAP members have access to the behavioral health, substance abuse, and medical care that they need. TDOs may occur during GAP enrollment as a sign that the member requires more attention to their behavioral health needs, and therefore, care coordinators and Recovery Navigators from the Behavioral Health Administrator (BHSA) serve to track and meet those needs throughout the member's enrollment in GAP. ~~GAP Team Analyst examined whether the mean frequency of TDO encounters decreased because of GAP enrollment.~~

Please see the table below comparing Year 1 and Year 2 of the Demonstration regarding number of TDOs by diagnostic category reflecting a 27% point increase in TDOs. However, the GAP membership increased by over 130% points 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 12% of the GAP membership in Year 2 experiencing 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

Temporary Detention Orders (%)	Female (N=549)	Male (N=874)	All GAP Recipients (N=1423)
Before Enrollment	19.4	28.11	47.51
During Enrollment	18.62	32.54	51.16
After Enrollment	0.56	0.77	1.34

The table above provides descriptive demographic statistics for our GAP Recipients with TDOs before, during and after GAP enrollment.

Our analysis sample of 8.81% (1,423 of 16,152) generated a total of 8,219 TDO claims dating back to 2013. When comparing occurrence of TDOs before and during enrollment, a decrease of 10.0% points in TDO frequency after transitioning into the GAP Program was noted.

Based on our analysis using t-tests, there is enough statistical evidence to conclude that the mean frequency of TDO encounters significantly improves for the group based on TDO claims generated

during the enrollment period from 2015 to 2018 ($p < 0.05$, $t = 30.47$, $df = 668$). Because of enrollment, TDO claims amounts decreased for the recipients that had TDOs during their enrollment period. When examining the change in the average of number TDO encounters after GAP disenrollment, we concluded that the mean number of TDO encounters significantly increases after GAP eligibility has ended ($p < 0.05$ $t = 85.5$). With respect to inpatient hospitalization, we found that GAP individuals who have transitioned into Medicaid are more likely to be hospitalized; DMAS is reviewing this finding. Overall, enrollment into the GAP program has the potential to improve the health for individuals with SMI.

Further analysis of Medicaid claims data across the evaluation timeframe concluded that 13.75% of the variation among GAP recipients with decreased TDO frequencies after enrollment compared to GAP recipients with increased or equivalent TDO frequencies can be explained by variation in the average amount of recipient eligibility days, followed by the total number of behavioral health services (Crisis Intervention, Crisis Stabilization and GAP Case management) acquired during enrollment ($F = 79.56$, $df= 2$, $p < .001$). From this analysis, DMAS concludes that enrollment in the GAP waiver has helped members to decrease their TDO encounters compared to their TDO encounters prior to enrollment.

GAP Demonstration Scores on Better Quality of Life and Psychosocial Outcomes

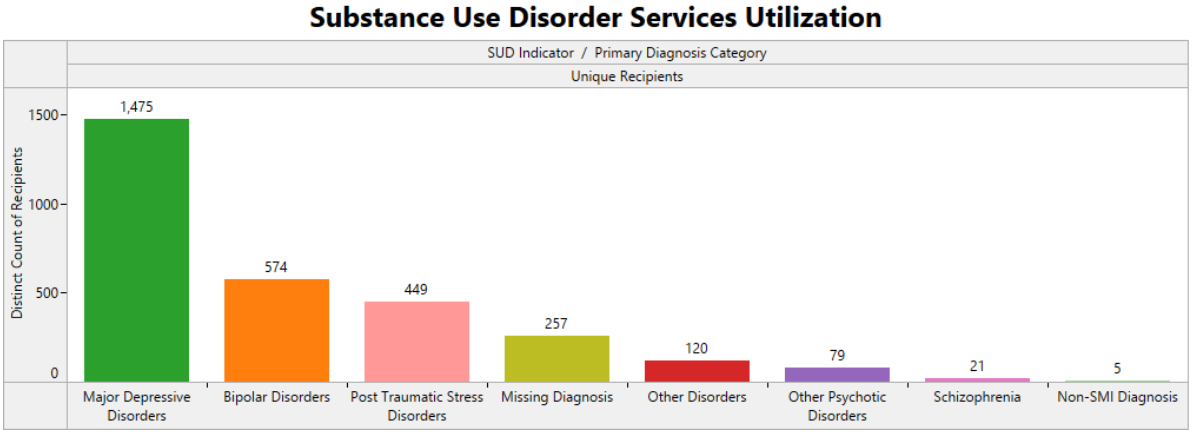
Measure: Show Reduced or No Substance Use

Data Source: MMIS

Discussion: Although the GAP program included some limited substance use treatment services at the inception of the program, there was very little use of the services; similarly to the Medicaid program. In 2017, the waiver was amended to include a full array of substance use treatment services with a better reimbursement methodology and enhanced provider network.

With this, the GAP members were able to access substance use treatment more easily.
Figure 21 reflects utilization for 2018 based on SMI diagnosis.

Figure 21-Substance Use Disorder Services Utilization-2018



Measure: Are Not Homeless

Data Source: Magellan

Discussion: During the evaluation Year 3, 3,138 unduplicated members enrolled in Recovery Navigation self-reported that they were homeless or at risk of homelessness 467 times. This data is only collected on GAP members who are enrolled in Recovery Navigation. Because of higher enrollment rates, there was an increase of 89.8% in GAP members receiving Recovery Navigation services self-reporting as homeless compared to evaluation Years 1 and 2. In Year 4, 1,267 GAP members were enrolled in Reocvery Navigation Services and about 21% noted they were either homeless or at risk of homelessness. This could be an underestimation as often the GAP members could not be located by mail or phone to assist with care coordination or eligibility renewals.

DMAS had recommended 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: Are Employed Full or Part-Time?

Data Source: Cover Virginia

While Cover Virginia gathers data that would identify full or part-time employment status for eligibility purposes, their contract did not include developing reporting to DMAS about the GAP applicants/population. DMAS did not have financial resources to amend their contract to include this reporting. DMAS had recommended in previous draft evaluation reports that this measure be deleted. DMAS has sought other avenues including DHBDS, Magellan and CSBs, but it would require manually counting/reporting and it is not data that they currently collect.

2) Has the integration of physical and behavioral health services resulted in better health outcomes of Demonstration participants?

GAP Demonstration Based on Health Outcomes

Measure: 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.

Data Source: MMIS, Cover VA

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%
2017	13,857	1712	12%
2018	17,089	832	4%

Discussion: In 2015 and 2016, only 4% of the GAP population moved from GAP to full Medicaid benefits based on a disability determination.. In 2017, 1,712 individuals, three times as many as previous years, disenrolled from GAP and transferred to full coverage Medicaid blind and disabled groups. In 2018 the figures reverted to the early years. These numbers are based on eligibility at "point in time."

Measure: Has there been a reduction in the number of emergency department visits for GAP Participants?

Data Source: DBHDS, VHI

Discussion:. DMAS had previously recommended this measure be deleted as the data was initially intended to be accessed via VHI which is not as available as DMAS thought. DMAS attempted to achieve this data from self reporting by members to the Recovery Navigators, but the self reportring was intermittent and not all GAP members participated in Recovery Navigation services. Self reports of emergency room visits were not of a significant number.

Measure: Has there been a reduction in the number of hospital admissions for GAP Participants?

Data Source: DBHDS and VHI

Discussion: DMAS had previously recommended this measure be deleted as the data was initially intended to be accessed via VHI which is not as available as DMAS thought. DMAS attempted to achieve this data from self reporting by members to the Recovery Navigators, but the self reportring was intermittent and not all GAP members participated in Recovery Navigation services. Self reports of hospital admissions were not of a significant number.

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.

Results 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 services the indigient or uninsured populations accessed more traditional health care providers.

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 influences our ability to better analyze and demonstrate cost effectiveness and measure psychosocial outcomes.

Implementation Successes

The greatest success of the GAP program continues to be that individuals with SMI are accessing health and behavioral health care. The data demonstrates that enrollment has increased since the demonstration's inception. Increased enrollment and growth in the GAP program has positively contributed to the third goal of the GAP demonstration: closing the insurance coverage gap in Virginia.

In 2017, DMAS received approval from CMS to add to the GAP benefit package substance use disorder (SUD) services such as partial day hospitalization (ASAM Level 2.5), residential treatment (ASAM Level 3.1, 3.3, 3.5, and 3.7) and withdrawal management. The added SUD benefits serve current as well as prospective GAP members in a more robust way.

DMAS continued to see success with its multi-faceted approach to educate potential members, families, advocates, providers, and other stakeholders about GAP. In 2017, DMAS made great progress with focusing on increasing access to healthcare for the criminal justice system is returning citizens who have significant behavioral and medical needs. DMAS was involved with House Bill 2183 Workgroup whose primary focus is coordination of applications and benefit start dates for incarcerated individuals who need access to behavioral and medical services immediately after release from incarceration. These discussions and planning helped to lay the groundwork for the Medicaid Expansion effort for incarcerated individuals eligibility application process.

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. Raising the percentage to above 80% positively affected the number of members who now have access to health and behavioral health care services via GAP. As

stated above, DMAS has seen increased enrollment and growth in the GAP program, and continued growth since the increase in October 2017 to 100% below FPL.

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. Because of these efforts, peer support was added to Substance Use Disorder and mental health benefits as a reimbursable service for all Medicaid members, not limiting it to only GAP members. This has allowed 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.

Since inception, DMAS has only received positive feedback regarding Recovery Navigation efforts. There are five Recovery Navigators located around the state: Northern Virginia/Central Virginia, Roanoke/Lynchburg, Far Southwest Virginia, and two in Tidewater. The Recovery Navigators provided in person outreach and education at crisis stabilization facilities operated by community services boards (CSBs). GAP members are automatically referred for Recovery Navigation services at the time of crisis stabilization request. This increased the ability for the Recovery Navigator to initiate support while the member is still in the facility, to assist with the member's transition back into the community, and assist with putting supports in place to make the member's discharge successful.

Challenges and Methodological Limitations

While having access to data from Cover Virginia, Magellan, and DMAS data sources, there were challenges 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. The evaluation panel was on hiatus as the challenges accessing adequate data to conduct a true evaluation continued. With the CMS approval of the evaluation design, the panel disbanded.

When interpreting the concordance between pharmacy claims-derived measures and adherence, it is important to understand that measures reflect drug availability to GAP members and not actual prescription taking behaviors. So a true measure of compliance adherence requires more resources.

Lessons Learned and Recommendations

DMAS continues to evaluate how processes and procedures can be refined and strengthened. For the demonstration as a whole, DMAS invested significant effort to increase the awareness and provide outreach about the benefit plan. DMAS continues to acknowledge 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, DBHDS, and BHSA. 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.

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, Interpretations, and Interactions with Other State Initiatives

Policy Implications and Interpretations

Since the benefit package for GAP is a subset of the overall Medicaid benefit package, there are few strategies that could 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 also 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 is a covered service as of 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 to avoid selling 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 demonstration 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 emergencies 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 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 collaborated with the Virginia Department of Corrections around GAP and explored strategies for making applications while an inmate is still incarcerated. Similar efforts were explored with the Department of Criminal Justice and local/regional jails. While these efforts didn't come to realization for GAP, they were a basis for eligibility application processing for incarcerated individuals for Medicaid Expansion.

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.

Conclusion

Even with limited and challenges to the data, one can conclude that the Demonstration was of benefit to the GAP members and ultimately to Virginia. The GAP Demonstration increased access to care for a segment of Virginians who have significant behavioral and medical needs, improved health and behavioral health outcomes of participants, and served as a bridge for the uninsured prior to implementation of Medicaid Expansion. 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 influence 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.

Appendix A – GAP Benefit Package

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	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**
		readmissions, improve community tenure and meaningful participation in communities of their choice. The scope of services provided through Recovery Navigation will 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.	

GAP Benefits, Scope of Service, and Provider Qualifications			
Benefit	**Provider Qualifications**	**Scope and Limitations**	**Differences from current VA Medicaid Program**
		• 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. • 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	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	No emergency room or inpatient coverage. Outpatient hospital

GAP Benefits, Scope of Service, and Provider Qualifications			
Benefit	**Provider Qualifications**	**Scope and Limitations**	**Differences from current VA Medicaid Program**
radiology services electrocardiogram, authorized CAT and MRI scans.		of coverage is within current Virginia Medicaid coverage guidelines.	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
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

GAP Benefits, Scope of Service, and Provider Qualifications			
Benefit	**Provider Qualifications**	**Scope and Limitations**	**Differences from current VA Medicaid Program**
			• $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 guidelines.	Service authorization 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.)

Appendix B – Measures for GAP Evaluation

Research Questions	Measure	Details	Data Source	Comparisons	Frequency
Goal 1. Serve as a bridge to closing the insurance coverage gap forVirginians					
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

Research Questions	Measure	Details	Data Source	Comparisons	Frequency

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

Research Questions	Measure	Details	Data Source	Comparisons	Frequency
Has the GAP Demonstration impacted access to care, through access to primary care, medications, and behavioral health supportive services?	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

Research Questions	Measure	Details	Data Source	Comparisons	Frequency

How many GAP Participants have utilized their GAP Coverage?	Number of approved applicants who have a behavioral health services claim		Magellan/MMIS	Compare it to service utilization of control group population	Annually
	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	Percentage of claims denied because the service was not covered	MMIS	Compare the denied claims to approved claims and identify what services are not covered that are necessary for recovery.	Annually

Research Questions	Measure	Details	Data Source	Comparisons	Frequency
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/ percentage of GAP participants with a claim for Care Coordination	Number/percentage of GAP participants with a claimforcare 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	MMIS, DBHDS, TBD		Annually

Research Questions	Measure	Details	Data Source	Comparisons	Frequency
Have GAP participants had their care coordinated with a Medical Doctor?		the member received follow-up within: ⧫ seven days of discharge ⧫ 30 days of discharge			
	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		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

Research Questions	Measure	Details	Data Source	Comparisons	Frequency

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

Research Questions	Measure	Details	Data Source	Comparisons	Frequency
Has the integration of physical and behavioral health services resulted in **better health outcomes** of demonstration participants?*	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
	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

*DMAS is exploring whether we can acquire the historical data (prior to GAP enrollment) for these measures.

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