The Hilltop Institute
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report

Summary Report: Assistance in Community Integration Services (ACIS) Program Assessment, CY 2018 to CY 2021

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The Hilltop Institute

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Summary Report: Assistance in Community Integration Services (ACIS) Program Assessment, CY 2018 to CY 2021

Introduction

Assistance in Community Integration Services (ACIS) is a pilot program that is operated under Maryland's §1115 demonstration waiver for HealthChoice, the state's Medicaid managed care program launched in 1997. Under this pilot, the state provides a set of home and community-based services (HCBS) to a population that meets the needs-based health and housing eligibility criteria detailed below in this report. Services provided through the pilot include HCBS that could otherwise be provided under a 1915(i) state plan amendment. The pilot operates in accordance with the protocol submitted by the state and approved by CMS on June 16, 2017, that specifies eligibility criteria, service definitions, provider qualifications, and payment methodology.[1]

The ACIS pilot was initially approved for inclusion in the state's §1115 demonstration waiver when CMS extended the waiver for the four-year period of January 1, 2017, through December 31, 2021. CMS approved expenditures for ACIS beginning on July 1, 2017, after approving the state's protocol. Enrollment was initially capped at 300 individuals[2] annually.

The state then requested an amendment to the §1115 demonstration waiver that included expansion of annual enrollment in ACIS to 600 individuals, which CMS approved on June 16, 2017.[3] On April 26, 2022, CMS approved a four-year renewal of the §1115 demonstration waiver (January 1, 2022, through December 31, 2026). The renewal included approval for a further increase in the ACIS enrollment cap to 900 individuals annually and operation of the pilot through December 31, 2026.[4]

MDH invited local jurisdictions (referred to as lead entities or LEs) in Maryland to apply to participate in the pilot program. Over the four-year pilot, four LEs were selected: Baltimore City, Cecil County, Montgomery County, and Prince George's County. Start dates and approved capacity for each of the four LEs varied as reported in this Maryland Department of Health (MDH) program summary.

[1] See Attachment F in https://www.medicaid.gov/sites/default/files/2022-05/md-healthchoice-appvl-04262022.pdf
[2] See https://health.maryland.gov/mmcp/Documents/HealthChoice%20Community%20Pilots/ACIS/FINAL%20MD%20HealthChoice%20STCs%20with%20Approved%20ACIS%20protocol%2006162017.pdf
[3] See https://health.maryland.gov/mmcp/Documents/MD%20HealthChoice%20Amendment%20Approval%20(updated%20April%2025,%202019).pdf
[4] See https://www.medicaid.gov/sites/default/files/2022-05/md-healthchoice-appvl-04262022.pdf

To receive Medicaid reimbursement for ACIS services provided to program participants, LEs are required to provide a minimum of three ACIS services per month to each individual. LEs participate in the intergovernmental transfer process (IGT) whereby each LE uses local dollars to submit 50% of its total estimated monthly ACIS budget to MDH and—once those local funds are matched with federal funds—MDH reimburses the LEs the full amount.[5] CMS requires MDH to assess pilot programs operating under the state's §1115 demonstration waiver using both quantitative and qualitative approaches. At the request of MDH, The Hilltop Institute used program data submitted by LEs and Medicaid eligibility data, claims, and encounters to conduct a quantitative analysis of participant characteristics and service utilization for individuals enrolled in ACIS during calendar year (CY) 2018 to CY 2021.[6] To supplement Hilltop's quantitative analysis, researchers from John Hopkins University (JHU) received approval from MDH to conduct semi-structured interviews with ACIS stakeholders to learn more about the experience with program implementation. Summary findings from these interviews are included in this report.[7]

The following sections of this report discuss ACIS program goals, eligibility criteria, services, and participating LEs, followed by the study objectives, research methodology, key findings, and study limitations.

The ACIS Program

The pilot program comes at a time when the focus on social determinants of health has received national attention. Homelessness negatively impacts an individual's physical and mental health.[8] Additionally, homelessness is a strong predictor of poor health outcomes.[9] Access to treatment and preventive care is more difficult for those experiencing homelessness, which often leads to the overuse of emergency departments (EDs) and other inpatient settings.[10] CMS has encouraged state Medicaid agencies to develop innovative programs to address homelessness.[11]

[5] See FAQ #3.f-h in https://health.maryland.gov/mmcp/Documents/HealthChoice%20Community%20Pilots/ACIS/2c.%20ACIS%20Pilot%20Frequently%20Asked%20Questions%20%28FAQs%29%20%28Round%203%29.pdf

[6] LEs began submitting ACIS program data in CY 2018.

[7] For the complete report, see Appendix B in the Evaluation of the Maryland Medicaid HealthChoice Program, CY 2017 to CY 2021: https://health.maryland.gov/mmcp/healthchoice/Documents/HealthChoice%20Monitoring%20and%20Evaluation/HealthChoice%20Post-Award%20Forum/2023/EvaluationOfTheHealthChoiceProgram-June2023%20Final.pdf

[8] National Health Care for the Homeless Council. (2019, February). *Homelessness & Health: What's the Connection?* https://nhchc.org/wp-content/uploads/2019/08/homelessness-and-health.pdf

[9] https://www.kff.org/report-section/linking-medicaid-and-supportive-housing-issue-brief/

[10] Sadowski LS, Kee RA, VanderWeele TJ, Buchanan D. (2009). Effect of a housing and case management program on emergency department visits and hospitalizations among chronically ill homeless adults: a randomized trial. *JAMA. 301*(17), 1771-1778. https://pubmed.ncbi.nlm.nih.gov/19417194/

[11] See https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf

Program Goals

The goals of the ACIS program are to reduce unnecessary health services use, increase housing stability, and improve health outcomes for Medicaid participants at risk of institutional placement or homelessness.[12]

Eligibility

To enroll in ACIS, individuals must meet the following criteria:[13]

1. Health Criteria (must meet at least one)
    a. Repeated incidents of emergency department (ED) use (defined as more than four visits per year) or hospital admissions
    b. Two or more chronic conditions as defined by §1945(h)(2) of the Social Security Act
2. Housing Criteria (must meet at least one)
    a. Will experience homelessness upon release from the settings defined in 24 CFR 578.3
    b. Be at imminent risk of institutional placement

LEs have considerable flexibility with enrollment after determining whether an individual meets these eligibility criteria. For example, some LEs enroll participants and then assist them with obtaining housing vouchers and finding housing (e.g., Cecil County). Other LEs enroll participants only if the LE has already procured a housing voucher/housing for that individual (e.g., Baltimore City).

Services

ACIS provides housing and tenancy-based case management services. Housing case management includes assisting participants in connecting with health care and social service providers and supporting the acquisition of independent living skills. Tenancy-based case management refers to "assisting participants in obtaining the services of state and local housing programs to locate and support the individual's medical needs in the home."[14] The LEs may either provide ACIS housing/tenancy case management services directly to participants or contract with local providers, called participating entities (PEs), to do so.

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[12] See ACIS press release at https://health.maryland.gov/newsroom/Pages/Maryland-Medicaid-Announces-Community-Health-Pilot-Selections.aspx

[13] See ACIS pilot description at https://mmcp.health.maryland.gov/Pages/Assistance-in-Community-Integration-Services-Pilot.aspx

[14] See Final HealthChoice Special Terms and Conditions (STCSs) with Approved ACIS protocol at https://health.maryland.gov/mmcp/Documents/HealthChoice%20Community%20Pilots/ACIS/Attachment%20E%20-%20FINAL%20MD%20HealthChoice%20STCs%20with%20Approved%20ACIS%20protocol%2006162017.2.pdf

Length of Program Participation and Disenrollment

The average enrollment span for participants who enrolled in the program between CY 2018 and CY 2021 was 372 days.

Criteria for disenrollment vary across the LEs. Some LEs "graduate" participants from the program once participants have stable housing and medical and social supports have been established. This allows the LE to enroll new individuals. Some LEs disenroll participants if the case management provider has been unsuccessful in engaging the participant for a specified length of time. Across the program, if a participant becomes ineligible for Medicaid and the case management service provider is not able to assist the participant in regaining eligibility, the LE disenrolls the participant.

Lead Entities

LEs are responsible for the administration of the pilot program in their jurisdiction. Three LEs were initially approved to participate in the ACIS pilot program: the Baltimore City Mayor's Office of Homeless Services (Baltimore City), the Cecil County Health Department (Cecil County), and the Montgomery County Department of Health and Human Services (Montgomery County). In April 2018, the Prince George's County Health Department (Prince George's County) was approved as the fourth LE.

Program Participation

Table 1 details each LE's average number of participants served, their approved participant capacity, and percentage participants served of their approved capacity for CY 2021.
CY 2021.

Table 1. Approved Capacity and Average Number of Participants Served, by LE, CY 2021

Average Number of Participants Served and Approved Capacities	CY 2021			
	Baltimore City	Cecil County	Montgomery County	Prince George's County
Average Number of Participants Served	162.4	13.3	103.7	42.2
Approved Capacity	200	15	130	75
Percentage of Approved Capacity Served	**81.2%**	**88.9%**	**79.7%**	**56.2%**

Assessment Objectives and Methodology

Objectives

This analysis examines program implementation and utilization of ACIS services and Medicaid health services by individuals enrolled in ACIS in CY 2018 to CY 2021. Research questions are as follows:

- Is the ACIS program serving the intended population?
- Did the LEs meet their enrollment goals?
- To what extent did participants receive stable housing? Did participants exit the program during the study period?
- Did ED visits, inpatient admissions, and nursing home admissions decline for ACIS participants after enrolling in the program? Did participants access other services?
- To what extent did ACIS participants receive treatment for substance abuse disorders (SUDs) or mental health disorders (MHDs) in the year following enrollment in ACIS?
- What are stakeholders' perceptions of program implementation?

Study Populations

Population 1: Analysis of ACIS Service Utilization

This population includes 615 ACIS participants[15] enrolled during the four-year period of January 1, 2018, to December 31, 2021. To be included in this population, participants must have received at least one ACIS service that occurred on the date of enrollment, or up to and including the date of discharge, or through December 31, 2021. The analyses of ACIS service utilization in this assessment includes these 615 participants.

Population 2: Pre-/Post- Analysis of Medicaid Service Utilization

This population includes ACIS participants in Population 1 who were enrolled in Medicaid during the one-year period immediately prior to their enrollment in ACIS. A total of 467 (76% of the 615 participants enrolled during the study period) participants met this requirement and are included in the analyses of Medicaid service utilization. The pre-ACIS period is defined as the one-year period prior to the individual's enrollment date. The post-ACIS period begins on the individual's enrollment date and extends for one year.

Data Sources

Participant Data Collected by LEs

The LEs submit data on ACIS participants to Hilltop on a quarterly basis using a standardized template. These data are used for both quarterly billing reports that Hilltop submits to MDH and program monitoring and assessment. Data points include:

- General living situation at time of enrollment
- Specific living situation at time of enrollment

[15] The study population may include a small number of participants who are dually eligible for Medicare and Medicaid. The study design does not include analysis of Medicare claims so service utilization may be understated for dually-eligible individuals.

- Discharge reason/destination of ACIS participants
- ACIS participants stably housed
- ACIS LE participant capacity

MMIS2

Hilltop used Medicaid claims and encounters to develop these measures for ACIS participants:

- ED visits
  - Defined as inpatient and outpatient institutional claims and encounters with revenue codes starting with "045" or "0981."
- Avoidable ED visits
  - Defined using the avoidable ED visit New York University algorithm.[16] Three categories from the algorithm were used to identify avoidable ED visits: non-emergent, emergent but primary care treatable, and emergent ED care needed-preventable/avoidable. If the value of these three variables was equal to or greater than 51%, then an ED visit was flagged as avoidable.
- Inpatient admissions
  - Defined as an institutional claim or encounter with a claim type of "I" (inpatient hospital claim) or a claim type of "M" (Medicare crossover inpatient claim).
- Mental health disorder (MHD) inpatient admissions
  - Defined using ICD-10 psychiatric diagnoses once an inpatient admission had been identified and the psychiatric diagnosis was the primary diagnosis.[17]
- Substance use disorder (SUD) inpatient admissions
  - Defined using the COMAR 10.09.70.02 definition of SUD once an inpatient admission had been identified and the substance use diagnosis was the primary diagnosis.[18]

[16] See https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2000_nov_emergency_room_use__the_new_york_story_billings_nystory_pdf.pdf

[17] Any diagnosis with the following ICD-10 codes: Codes that begin with F200-F205, F2081, F2089, F209, F21-F24, F250, F251, F258, F259, F28, F29, F3010-F3013, F302-F304, F308-F310, F3110-F3113, F312, F3130-F3132, F314, F315, F3160-F3164, F3170-3178, F3181, F3189, F319-F325, F328-F333, F3340-F3342, F338-F341, F348, F349, F39, F4000-F4002, F4010, F4011, F40210, F40218, F40220, F40228, F40230-F40233, F40240-F40243, F40248, F40290, F40291, F40298, F408-F413, F418, F419, F42, F430, F4310-F4312, F4320-F4325, F4329, F438-F442, F444, F446, F4481, F4489, F449-F451, F4520-F4522, F4529, F4541, F458, F459, F481, F488, F489, F5000-F5002, F502, F508, F509, F53, F54, F600, F601, F603-F607, F6081, F6089, F609, F630-F633, F6381, F6380, F639, F641, F642, F648-F654, F6550-F6552, F6581, F6589, F66, F6811, F6813, F688, F69, F843, F900-F902, F909-F913, F918, F919, F930, F938-F942, F948, F949, F980, F984, F988, F989, F99, G2111, G2402, G2589, G259, G244, G251, G210, R457, R45850, R45851, O93340-O99345, Z046 according to the COMAR definition of MHD.

[18] COMAR10.09.70.02 defines an SUD diagnosis as the inclusion of one of the following: ICD-10 diagnosis codes: F10-19, O99310-99315, O99320- 99325, R780-785 with Revenue codes 0114, 0116, 0124, 0126, 0134, 0136, 0154,

- Ambulatory care visits
  - Defined as contact with a doctor or nurse practitioner in a clinic, physician's office, or hospital outpatient department.
- Nursing facility admissions
  - Defined as a claim having a provider type of nursing facility.
- Participants receiving outpatient SUD services in the community
  - Defined using outpatient, home health, physician, or special services claims files with a provider type of substance use disorder program or clinic.
- Participants receiving outpatient MHD services in the community
  - Defined using outpatient, home health, physician, or special services claims files with a provider type of psychologist, nurse psychotherapist, mental health group therapy, social worker, certified professional counselor, mental health case management, outpatient community health clinic, community-based partial hospitalization program, or mobile treatment program.
- Participants with ANY diagnosis of an SUD
  - Defined using the same ICD-10 codes, revenue codes, and procedure codes for inpatient SUD stays.
- Participants with ANY diagnosis of an MHD
  - Defined using the same ICD-10 psychiatric codes used for inpatient psychiatric stays.

Analysis

For Population 1, Hilltop summarized the data provided by the LEs on ACIS program enrollment and participant characteristics using frequencies. For Population 2, Hilltop used data from MMIS2 to conduct a pre/post comparison of service utilization during the one-year prior to ACIS enrollment (Pre-ACIS) and for the one-year period following enrollment (Post-ACIS). Aggregate frequencies and descriptive statistics are presented where appropriate, as well as the results of the *Wilcoxon Signed-Ranks*[19] statistical test.

Key Findings

Key findings are presented below. The tables and figures referenced below can be found in the Appendix.

0156, 0762, 0900, 0905, 0906, 0911-0916, 0918, 0919, 0944, 0945, 0450- 0452, 0456, 0459 OR Procedure codes 99.201-99.205, 99.211-99.215, J8499, J2315.

[19] See https://libguides.library.kent.edu/SAS/PairedSamplestTest

Is the ACIS program serving the intended population?

- At the time of enrollment, 79.8% of ACIS participants were experiencing homelessness and the remainder (20.2%) were residing in institutions or other transitional housing (Figure 1).
- Of those homeless at the time of enrollment, 62.7% were residing in an emergency shelter and 37.3% were living in a place not meant for habitation, safe haven, or interim housing (Figure 2).
- Across all calendar years, an average of 47.4%of participants had an SUD and 70.2% had an MHD diagnosed (Table 2).
- Across all calendar years, the percentage of males exceeded that of females (60.7% to 39.3%, respectively), the percentage of Black participants exceeded that of all other race categories (57.9%), and participants aged 51 to 60 years made up the largest percentage of participants (34.3%) (Table 3).

Did the sites meet enrollment goals?

- Approved participant capacity varied by LE, and LEs had varying success in serving up to their approved participant capacity. Baltimore City, Cecil County, and Montgomery County served almost 80% or more of their capacity by CY 2021 (Table 4).

Key Findings: Program Enrollment and Implementation

- Almost 80% of ACIS participants were homeless at time of enrollment
- Approximately 47% of ACIS participants had an SUD, while 70% had an MHD
- LEs varied in their success in serving up to their allotted participant capacity
- 77% of ACIS participants obtained stable housing

To what extent did participants receive stable housing? Did participants exit the program during the study period?

- Overall, 474 of the 615 ACIS participants (77%) obtained stable housing during their participation in the program (Figure 3).
- There was significant variation across the four LEs, with more than 90% of participants in Baltimore City and Montgomery County obtaining housing, but only 45% in Prince George's County and 32% in Cecil County (Figure 4), likely because LEs approach housing placements differently. Baltimore City obtains housing placements as part of the enrollment process and Montgomery County is able to provide housing vouchers for most enrollees.

- Between CY 2018 and CY 2021, 203 of the 615 (33%) ACIS participants were discharged or disenrolled from the program; some had permanent or temporary housing at the time of exit and others were in institutional or unstable housing situations at the time they exited the program (Figure 5).[20]

Key Findings: Service Utilization Pre/Post-ACIS Enrollment

- There was a statistically significant decline in the mean number of ED visits and inpatient admissions
- ACIS participants with four or more ED visits declined approximately 37%

Did ED visits, inpatient admissions, and nursing home admissions decline for ACIS participants after enrolling in the program? Did participants access other health services?

- There was a statistically significant decline in the average number of ED visits, avoidable ED visits, and inpatient admissions for ACIS participants in the year following enrollment in the program (Table 5).
- ACIS participants with four or more ED visits in the pre- versus post-ACIS year declined 36.8%, from 95 to 60 participants (Tables 6 and 7). While small, the number of participants with frequent ED use should be addressed by the LEs and PEs in future phases of the program.
- ACIS participants experienced no statistically significant change in nursing home admissions and ambulatory visits in the year after ACIS enrollment (Table 5).

To what extent did ACIS participants receive treatment for SUD or MHD in the year following enrollment in ACIS?

- ACIS participants experienced no statistically significant change in MHD and SUD inpatient admissions and MHD community visits in the year after ACIS enrollment (Table 8).
- There was a statistically significant decrease in the mean number of SUD community visits for ACIS participants in the year following enrollment. This finding warrants further examination given the extent of SUD diagnoses among ACIS participants (Table 8).

[20] Program implementation varied across the LEs, including criteria and protocols for discharging/disenrolling participants.

What are stakeholders' perceptions of the program?

Interviews with a diverse group of stakeholders including individuals employed by LEs, PEs, state and local government officials, and case managers from local hospitals[21] identified these key themes:

- Finding housing for ACIS participants remains challenging.
- A key benefit of the ACIS program was leveraging existing resources and encouraging collaboration across the housing and health care service arenas, eliminating silos.
- Improved communications among ACIS referral sources, LEs, and PEs was an important factor in program success.
- Data collection was a key challenge in program implementation.

Stakeholders urged consideration of the following as the ACIS program continues to evolve:

- LEs should develop standard operating procedures for referrals and communication among local partners to ensure connectivity and coordination.
- Institute efficiencies in the standardized data collection process.
- Provide access to the statewide Homeless Management Information System (HMIS) so that a comparison group can be created using propensity score matching for more robust statistical analysis.

Study Limitations

1. The study population was small, consisting of a total of 615 individuals enrolled at different points in time over four years and across four ACIS LEs. The comparison of service utilization one-year pre- and one-year post-ACIS enrollment was further limited to the 467 individuals in the study population who were continuously enrolled in Maryland Medicaid in the one year prior to ACIS enrollment. For these 467 individuals, the study was limited to examining just one year of service utilization and outcomes post-ACIS enrollment.

2. Ideally the study would have included a comparison group of Medicaid-enrolled individuals similar to those Medicaid-enrolled individuals participating in the ACIS program using propensity score matching techniques. However, Medicaid MMIS2 data do not include reliable indicators for homelessness or risk of homelessness, which is a criterion for enrollment in ACIS. Thus, the study is a descriptive analysis of ACIS participants only. Because of the lack of a comparison group and the small study

[21] Stakeholder interviews were conducted by a team of researchers from Johns Hopkins University as part of the study protocol.

population, the ability to perform robust testing to determine statistical significance of outcomes was limited.

3. Some participants were enrolled in ACIS for more than one year during the four-year study period. However, the study did not include an examination of the experience of longer-enrolled participants versus those who were enrolled for shorter periods of time.

4. This study presents findings in aggregate for the four ACIS sites. The sites were given considerable flexibility in implementing the program resulting in notable variations in program implementation, management, and operations across each of the four ACIS LEs. In addition, because the study spanned four years including both start-up and full implementation years, there were variations in program management and operations from year to year, as each of the LEs evolved. Hence, the findings presented should be interpreted with caution and may not be applicable to individual LEs.

5. The study period is CY 2018 to CY 2021, which includes two years of the COVID-19 pandemic (CYs 2020 and 2021). Service utilization may have been depressed in those years.

6. The study does not include estimates of Medicaid expenditures for the study population. Participants were enrolled in Maryland's HealthChoice managed care program and reliable pricing information was not available for reported encounters in the MMIS2.

Appendix. Tables and Figures

Figure 1. General Living Situations of ACIS Participants at the Time of Enrollment, CY 2018-CY 2021

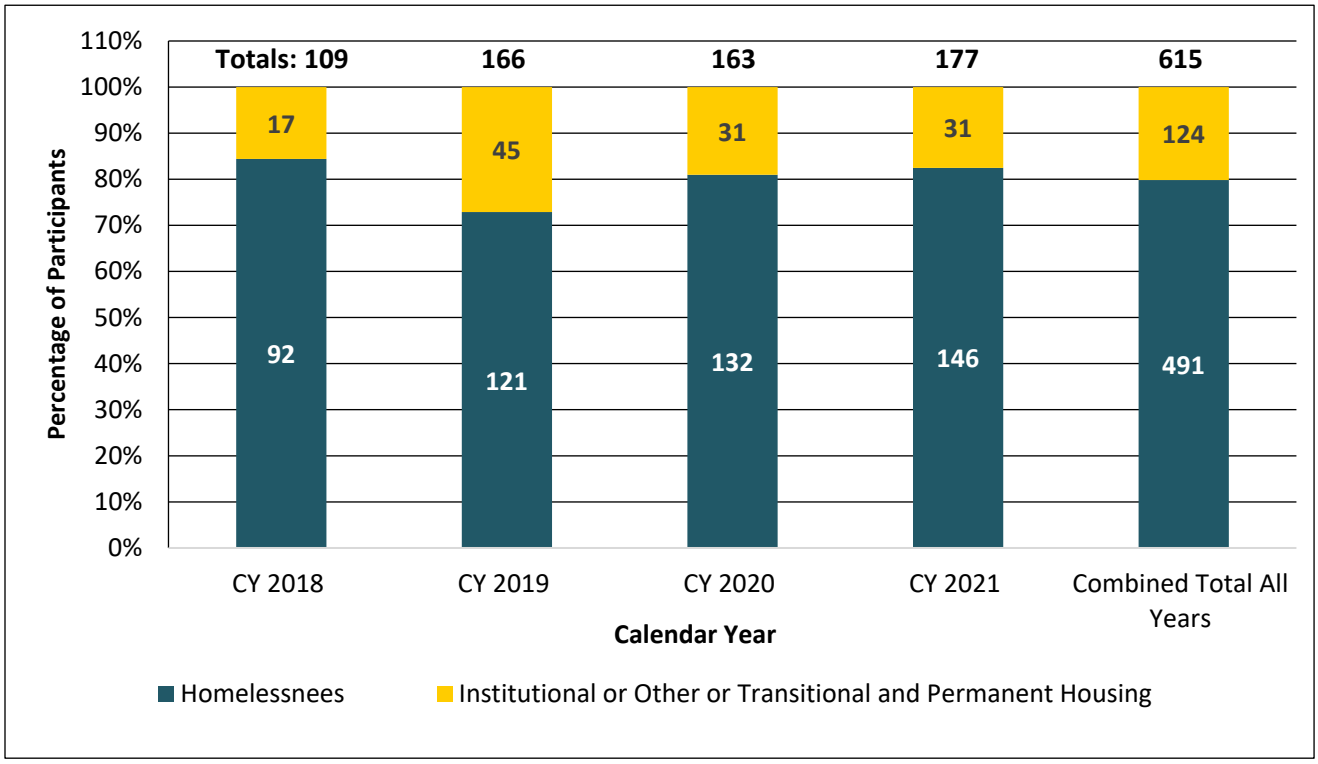


Figure 2. Specific Living Situation of Homeless ACIS Participants at the Time of Enrollment, CY 2018-CY 2021

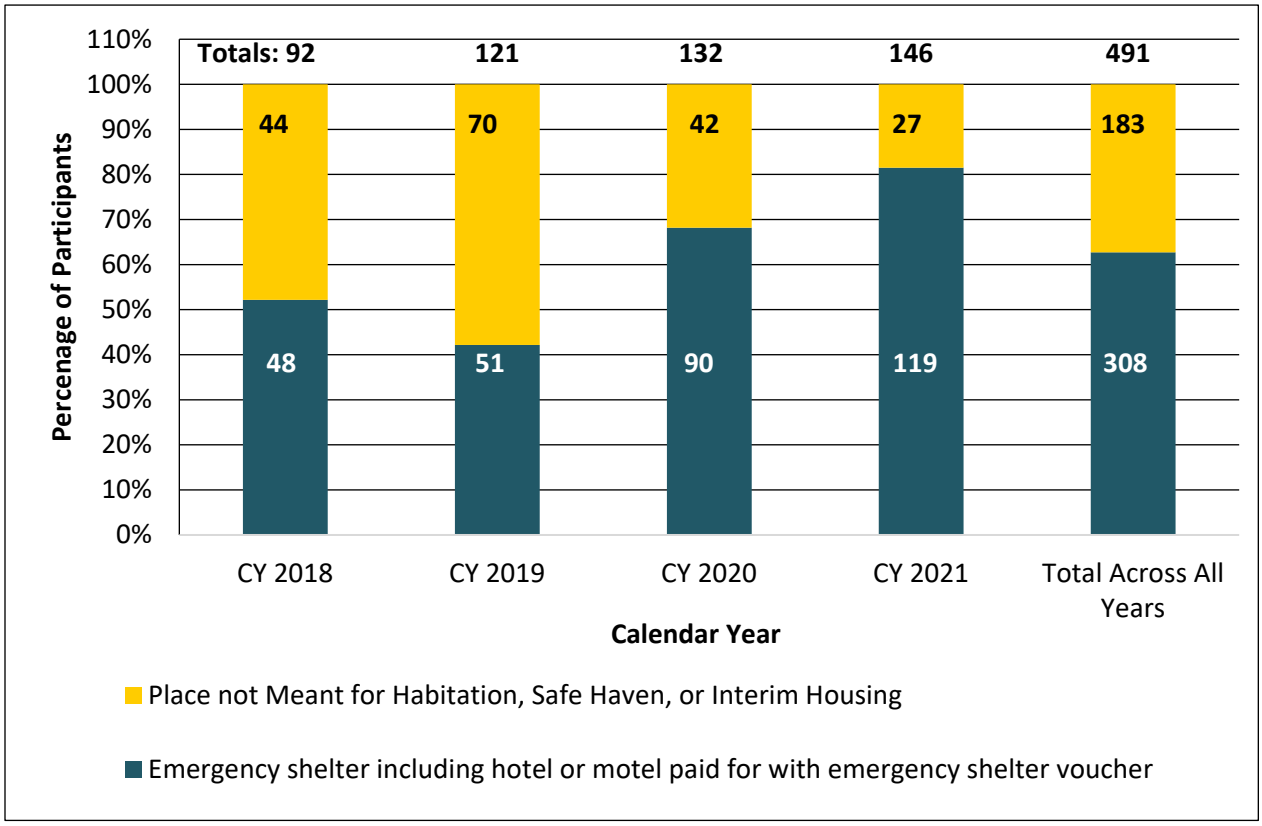


Figure 3. ACIS Participants Stably Housed, CY 2018-CY 2021

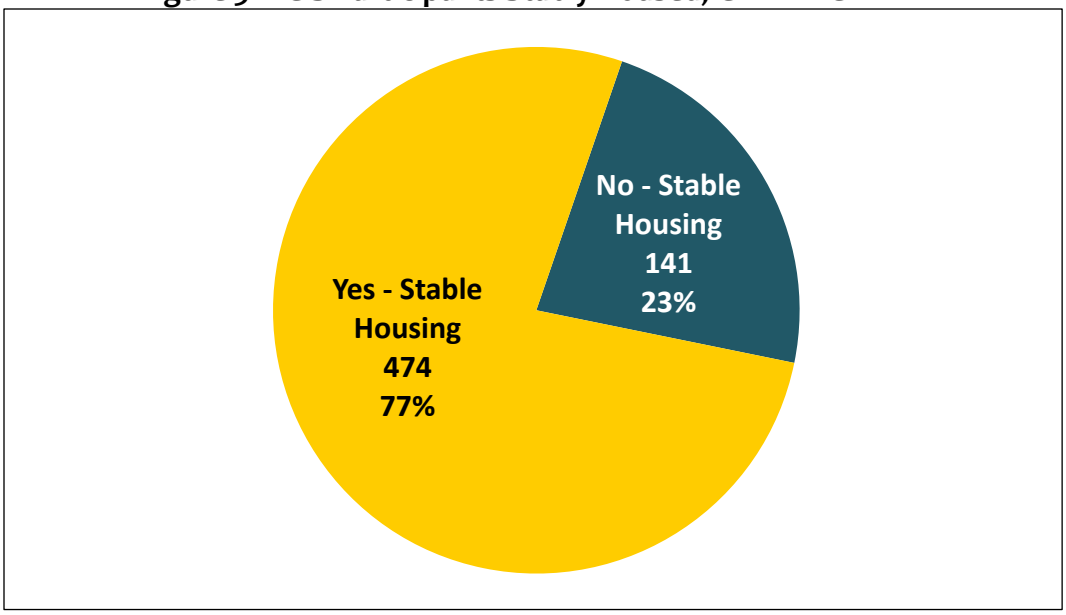


Figure 4. ACIS Participants Achieving Stable Housing, by Lead Entity

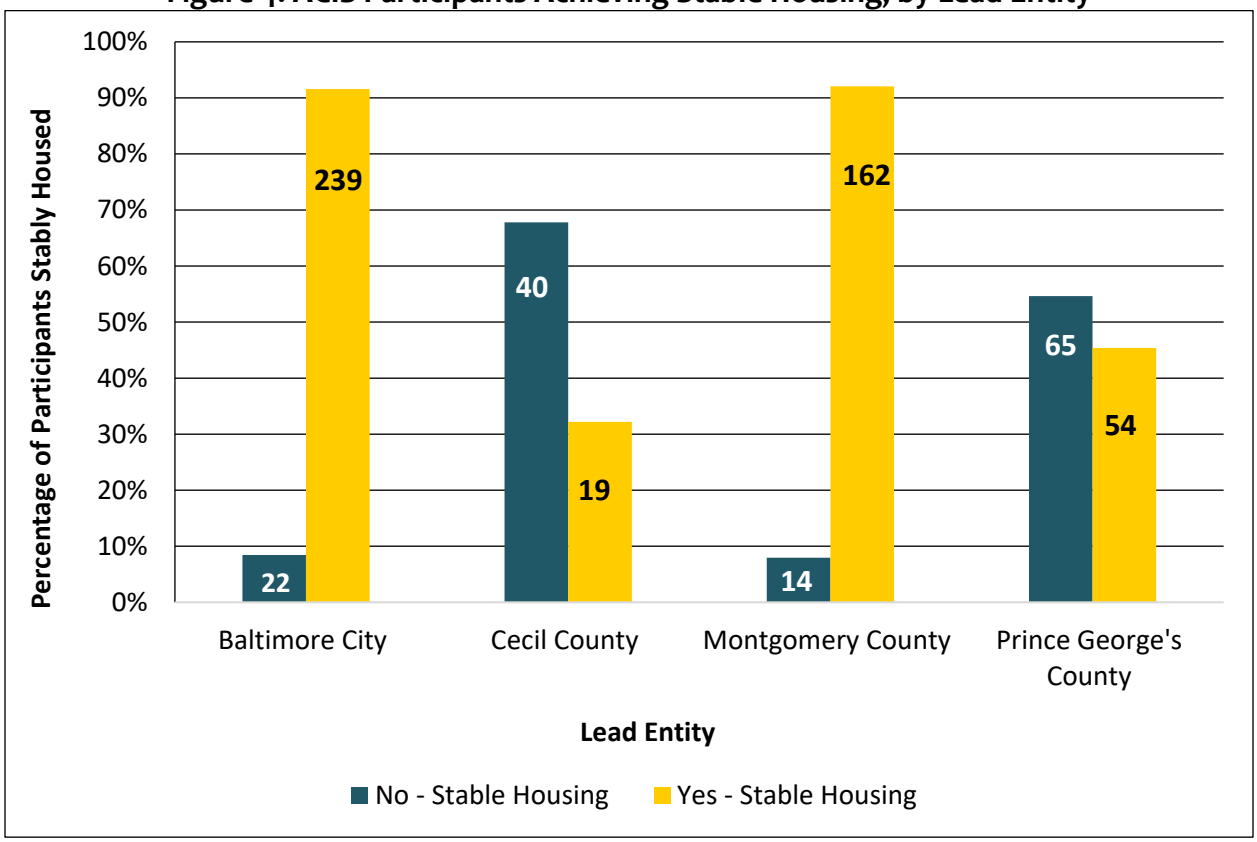
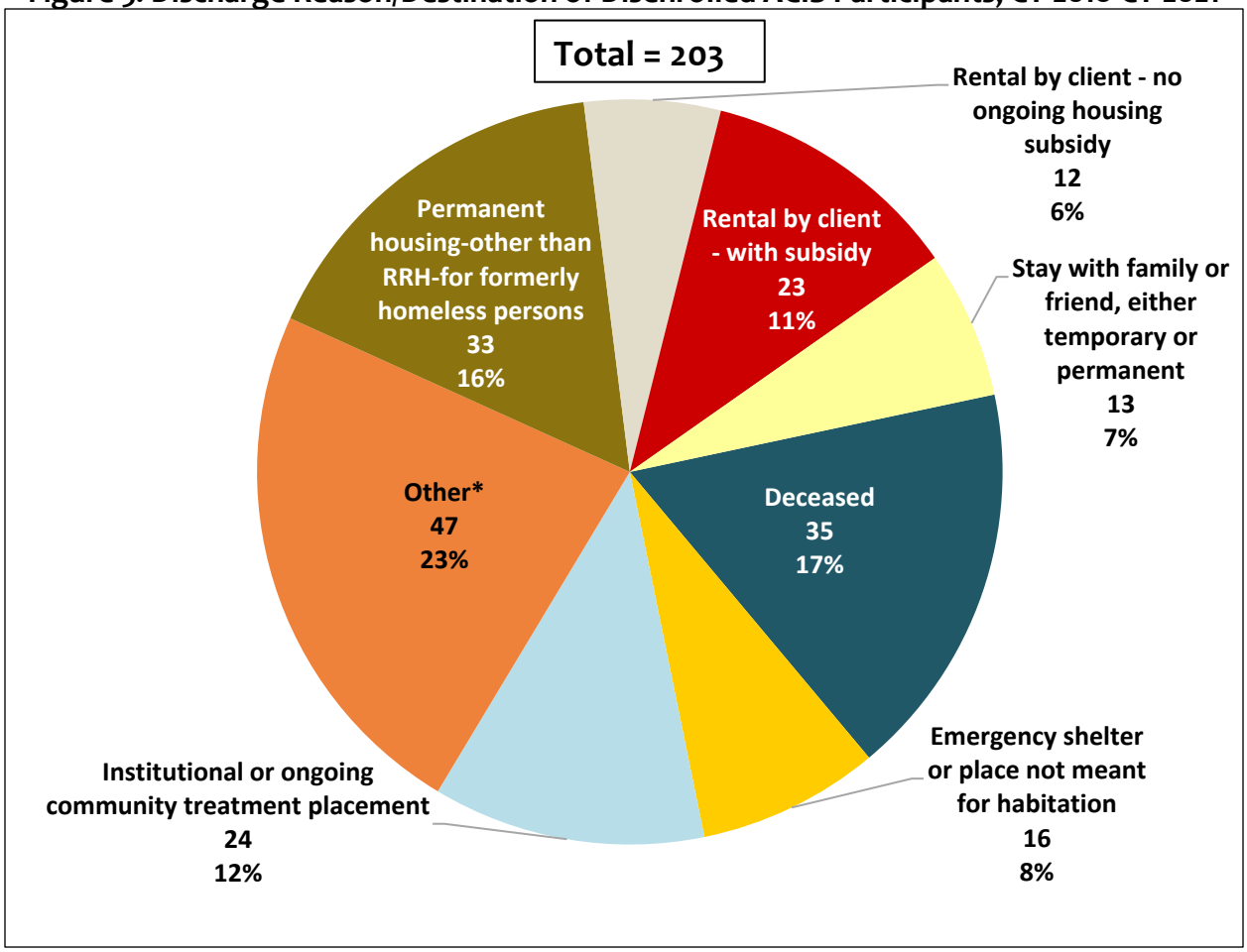


Figure 5. Discharge Reason/Destination of Disenrolled ACIS Participants, CY 2018-CY 2021



*" Other" includes: Client does not know, Client refused, No exit interview completed, and Other.

Table 2. ACIS Participants with Any SUD or MHD Diagnoses, CY 2018-CY 2021

Diagnosis	CY 2018 N = 100		CY 2019 N = 235		CY 2020 N = 329		CY 2021 N = 434		Average Across All Years	
	#	%	#	%	#	%	#	%	#	%
SUD Diagnosis										
Yes	48	48.0%	108	46.0%	146	44.4%	219	50.5%	130	47.4%
No	52	52.0%	127	54.0%	183	55.6%	215	49.5%	144	52.6%
MHD Diagnosis										
Yes	79	79.0%	179	76.2%	246	74.8%	267	61.5%	193	70.2%
No	21	21.0%	56	23.8%	83	25.2%	167	38.5%	82	29.8%

Table 3. Demographics of Newly Enrolled ACIS Participants, CY 2018-CY 2021

Demographic Characteristic	CY 2018 N=109		CY 2019 N=166		CY 2020 N=163		CY 2021 N=177		Total N=615	
	#	%	#	%	#	%	#	%	#	%
Sex										
Female	44	40.4%	85	51.2%	44	27.0%	69	39.0%	242	39.3%
Male	65	59.6%	81	48.8%	119	73.0%	108	61.0%	373	60.7%
Race**										
Black	66	60.6%	92	55.4%	88	54.0%	110	62.1%	356	57.9%
Hispanic/Other/ Unknown	15	13.8%	37	22.3%	38	23.3%	40	22.6%	130	21.1%
White	28	25.7%	37	22.3%	37	22.7%	27	15.3%	129	21.0%
Age Category										
> 30	19	17.4%	26	15.7%	20	12.3%	21	11.9%	86	14.0%
31 to 40	*	*	33	19.9%	36	22.1%	38	21.5%	121	19.7%
41 to 50	26	23.9%	41	24.7%	30	18.4%	36	20.3%	133	21.6%
51 to 60	41	37.6%	49	29.5%	57	35.0%	64	36.2%	211	34.3%
61+	*	*	17	10.2%	20	12.3%	18	10.2%	64	10.4%

*Small cell sizes (less than 11) have been excluded.

**Racial data in MMIS2 is limited to a single race and should be viewed cautiously.

Table 4. Average Percentage of Approved ACIS Participant Capacity Met, by Lead Entity, CY 2020-CY 2021

Average Number of Participants Served and Approved Capacities	All CY 2020*				All CY 2021			
	Baltimore City	Cecil County	Montgomery County	Prince George's County	Baltimore City	Cecil County	Montgomery County	Prince George's County
Average Number of Participants Served	112.2	13.2	73.3	24.3	162.4	13.3	103.7	42.2
Approved Capacity	200	15	120	75	200	15	130	75
Percentage of Approved Capacity Served	**56.1%**	**87.8%**	**61.1%**	**32.4%**	**81.2%**	**88.9%**	**79.7%**	**56.2%**

*CY 2019 is not shown due to small cell sizes (less than 11). Montgomery County's capacity changed from 110 to 130 mid-year 2020; this was accounted for by using an average capacity of 120 for CY 2020.

Table 5. Pre- and Post-ACIS Maximum, Median, and Mean Number of Health Service Visits

Health Service	Pre and Post Maximum Visits		Pre and Post Median Visits		Pre and Post Mean Visits		Mean Difference & Statistical Significance: p-value	
	Pre	Post	Pre	Post	Pre	Post	Mean Difference	p-value*
All ED Visits	192	166	2	1	4.65	3.61	-1.04	p <.0001*
Avoidable ED Visits	81	63	0	0	1.93	1.33	-0.59	p <.0001*
All Inpatient Admissions	12	13	0	0	0.68	0.56	-0.12	p = .0157*
Nursing Facility Admissions	5	4	0	0	0.07	0.06	-0.01	p=.3868
Ambulatory Visits	97	105	9	9	13.11	13.31	0.19	p = .07554

*The difference between the pre and post visit means are statistically significant at p < .05 or below.

Table 6. Frequency of Participants by Number of ED Visits, Pre-ACIS

Number of ED Visits	Participants	Percentage	Cumulative Percentage
0	147	31.5%	31.5%
1 to 3	179	38.3%	69.8%
4 to 9	95	20.3%	90.1%
10 to 22	30	6.4%	96.6%
23 to 192	16	3.4%	**100%**
Total	**467**	**100%**	

Table 7. Frequency of Participants by Number of ED Visits, Post-ACIS

Number of ED Visits	Participants	Percentage	Cumulative Percentage
0	204	43.7%	43.7%
1 to 3	163	34.9%	78.6%
4 to 9	60	12.8%	91.4%
10 to 22	29	6.2%	97.6%
23 to 166	11	2.4%	**100%**
Total	**467**	**100%**	

Table 8. Pre- and Post-ACIS Maximum, Median, and Mean Number of SUD- and MHD-Related Services

Health Service	Pre and Post Maximum Visits		Pre and Post Median Visits		Pre and Post Mean Visits		Mean Difference & Statistical Significance: p-value	
	Pre	Post	Pre	Post	Pre	Post	Mean Difference	p-value*
MHD Inpatient Admissions	9	7	0	0	0.15	0.13	-0.17	p = 0.2343
SUD Inpatient Admissions	2	2	0	0	0.01	0.01	0.00	p = 1.0000
MHD Community Visits	68	102	0	0	6.12	6.72	0.59	p = .9489
SUD Community Visits	113	89	0	0	8.46	6.80	-1.67	p = <.0001*

*The difference between the pre and post visit means are statistically significant at p < .05 or below.

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