



The Hilltop Institute UMBC

Annual Review:
Assistance in Community
Integration Services (ACIS),
CY 2020 to CY 2024

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report



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Introduction

Health-related social needs (HRSN) and their impact on individuals' health have become the focus of national attention. It is well known that homelessness and housing instability negatively affects an individual's physical and mental health.¹ This is especially true for those individuals covered by Medicaid, whose social needs are often both causes of chronic conditions and barriers to their treatment. Homeless individuals often have disabilities and suffer from chronic conditions such as diabetes, heart disease, HIV/AIDS, and mental health and substance abuse disorders. Those experiencing homelessness are nearly twice as likely to develop mental health conditions than those who were never homeless.² Access to treatment and preventive care are more difficult for those experiencing homelessness, which often leads to the overuse of emergency departments (EDs) and other inpatient settings.³ During interviews conducted with Medicaid recipients considered to be *high-risk users* (i.e., those with frequent ED and hospital visits), over half reported the ED as their regular source of care.⁴ While it has since been rescinded⁵, a 2023 directive by the Centers for Medicare & Medicaid Services (CMS) encouraged state Medicaid agencies to develop innovative housing support services to address housing instability among Medicaid beneficiaries.⁶ The Maryland Department of Health's (the Department's) Assistance in Community Integration Services (ACIS) pilot is on the forefront of this type of innovation.

¹ 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>

² Oppenheimer, S.C., Nurius, P.S., & Green, S. (2016). Homelessness history impacts on health outcomes and economic and risk behavior intermediaries: New insights from population data. *Families in Society: The Journal of Contemporary Social Sciences*, 97(3), 230-242. <https://journals-sagepub-com.proxy-bc.researchport.umd.edu/doi/pdf/10.1606/1044-3894.2016.97.21>

³ Sadowski, L.S., Kee, R.A., VanderWeele, T.J., & 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/>

⁴ Raven, M.C., Billings, J.C., Goldfrank, L.R., Manheimer, E.D., & Gourevitch, M.N. (2009, March). Medicaid patients at high risk for frequent hospital admission: Real-time identification and remediable risks. *Journal Urban Health: Bulletin of the New York Academy of Medicine*, 86(2):230-241. <https://doi.org/10.1007/s11524-008-9336-1>

⁵ Centers for Medicare & Medicaid Services. (2025, March 4). Rescission of Guidance on Health-Related Social Needs. *CMCS Informational Bulletin*. <https://www.medicaid.gov/federal-policy-guidance/downloads/cib03042025.pdf>

⁶ Centers for Medicare & Medicaid Services. (2023, November 16). Coverage of services and supports to address health-related social needs in Medicaid and the Children's Health Insurance Program. *CMCS Informational Bulletin*. <https://www.medicaid.gov/sites/default/files/2023-11/cib11162023.pdf>

The ACIS Program

ACIS is a pilot program that is operated under Maryland's §1115 HealthChoice demonstration, which authorizes the state's Medicaid managed care program, alongside other innovative programs and was launched in 1997. Under this pilot, Maryland provides a set of home- and community-based services (HCBS) to a population that meets the needs-based health and housing eligibility criteria detailed 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 Special Terms and Conditions (STCs) approved by CMS on June 16, 2017, that specifies eligibility criteria, service definitions, provider qualifications, and payment methodology.⁷

The ACIS pilot was initially approved for inclusion in the state's §1115 demonstration in 2017. CMS extended Maryland's demonstration for the five-year period of January 1, 2017, through December 31, 2021. CMS authorized ACIS beginning on July 1, 2017, after approving the state's ACIS protocol. Enrollment was initially capped at 300 individuals annually.⁸

The state then requested an amendment to the §1115 demonstration that included expansion of annual enrollment in ACIS to 600 individuals, which CMS approved on April 25, 2019.⁹ On February 7, 2022, CMS approved a five-year renewal of the §1115 demonstration (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, 2026.¹⁰

The Department invited local jurisdictions (referred to as lead entities, or LEs) in Maryland to apply to participate in the pilot program. Over the five-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 varies and can be found in a program summary written by the Department.¹¹

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

⁷ See Attachment F in <https://www.medicaid.gov/sites/default/files/2022-05/md-healthchoice-appvl-04262022.pdf>

⁸ See <https://health.maryland.gov/mmcp/Documents/HealthChoice%20Community%20Pilots/ACIS/FINAL%20MD%20HealthChoice%20STCs%20with%20Approved%20ACIS%20protocol%2006162017.pdf>

⁹ See [https://health.maryland.gov/mmcp/Documents/MD%20HealthChoice%20Amendment%20Approval%20\(updated%20April%2025,%202019\).pdf](https://health.maryland.gov/mmcp/Documents/MD%20HealthChoice%20Amendment%20Approval%20(updated%20April%2025,%202019).pdf)

¹⁰ See <https://www.medicaid.gov/sites/default/files/2022-05/md-healthchoice-appvl-04262022.pdf>

¹¹ See <https://health.maryland.gov/mmcp/Documents/HealthChoice%20Community%20Pilots/ACIS/ACIS%20Exec%20summary%20draft%207.7.22.pdf>

participate in the intergovernmental transfer process whereby each LE uses local dollars to submit 50% of its total estimated yearly ACIS budget to the Department and—once those local funds are matched with federal funds—the Department reimburses the LEs the full amount, on a quarterly basis.¹² CMS requires the Department to assess pilot programs operating under the state’s §1115 demonstration using both quantitative and qualitative approaches. At the request of the Department, 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) 2020 to CY 2024.¹³ Notably, the study period includes two years in which the state of Maryland was in a public health emergency as a result of the COVID-19 pandemic (CYs 2020 and 2021). Service utilization may have been impacted in those years and the years following.

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

Program Goals

The goals of the ACIS program are to reduce unnecessary health services use including ED utilization, increase housing stability, and improve health outcomes for Medicaid participants at risk of institutional placement or homelessness.¹⁴

Eligibility

To enroll in ACIS, individuals must meet the following criteria:¹⁵

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

¹² 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>

¹³ LEs began submitting ACIS program data in CY 2018.

¹⁴ See ACIS press release at <https://health.maryland.gov/newsroom/Pages/Maryland-Medicaid-Announces-Community-Health-Pilot-Selections.aspx>

¹⁵ See ACIS pilot description at <https://mmcp.health.maryland.gov/Pages/Assistance-in-Community-Integration-Services-Pilot.aspx>

LEs have considerable flexibility with program enrollment after determining that 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).

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.

ACIS Data

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 the Department and for program monitoring and assessment. ACIS data analyzed for this review includes:

- ACIS services delivered
- Discharge reason/destination of ACIS participants
- ACIS billing review
- General living situation at time of enrollment
- Specific living situation at time of enrollment
- ACIS participants stably housed
 - Number of months to stable housing from ACIS enrollment date
 - Type of first stable housing obtained

Services

ACIS provides Housing Case Management Services and Tenancy-Based Case Management Service/Tenancy Support 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/Tenancy Support Services 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.”¹⁶ The LEs may either provide ACIS Housing/Tenancy-Based Case Management Services directly to participants or contract with local providers, called participating entities (PEs), to do so. In CY 2024, 67.4% of ACIS services delivered were Housing Case Management services (Table 1).

Table 1. ACIS Services Delivered, CY 2024

Type of ACIS Service	Frequency	Percentage
Housing Case Management	20,127	67.4%
Intake/Assessment	156	0.5%
Separation from Program, with and without Service	78	0.3%
Tenancy-Based Case Management	9,494	31.8%
Total	29,855	100.0%

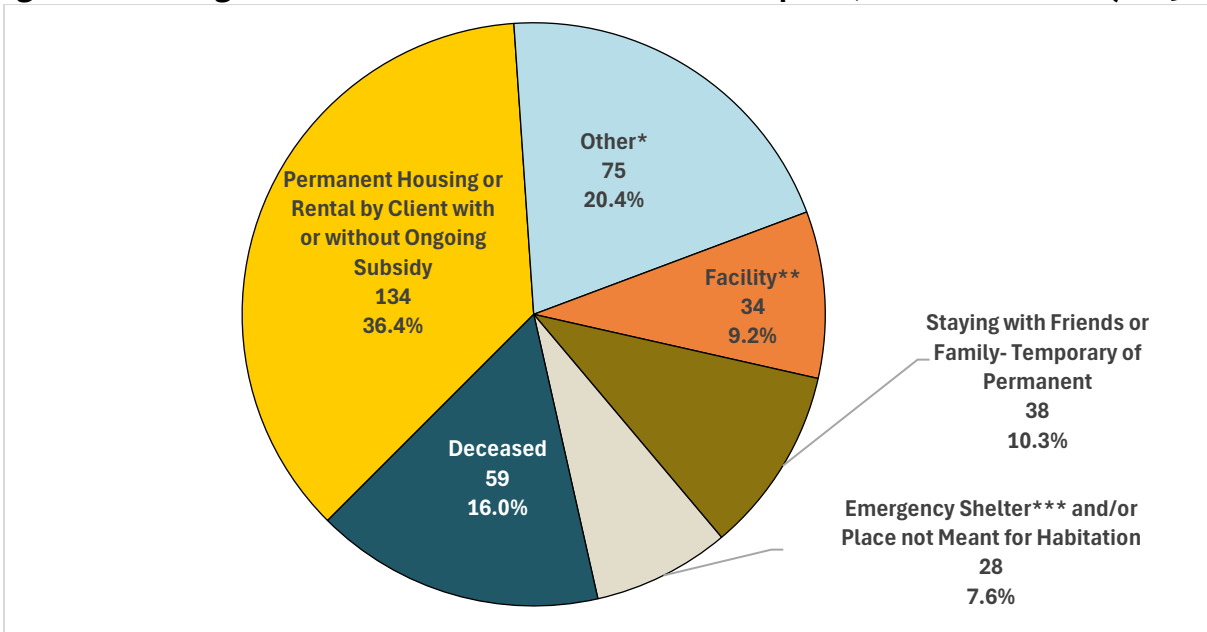
Disenrollment

Criteria for disenrollment varies 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 into the program. Some LEs disenroll participants from ACIS 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.

Of the 976 ACIS participants enrolled between CY 2020 and CY 2024, 368 left the program by the end of CY 2024. Those obtaining permanent housing (PH) or renting with or without a housing subsidy accounted for the highest percentage of discharge destinations: 36.4% (Figure 1).

¹⁶ 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>

Figure 1. Discharge Destination of Disenrolled ACIS Participants, CY 2020–CY 2024 (N = 368)



Notes: *Other includes no exit interview completed, other, client refused, and client does not know. **Facility includes jail or prison, nursing home, substance abuse treatment center, hospital or other non-psychiatric facility, psychiatric facility, halfway house, or safe haven. ***Emergency shelter includes hotels/motels paid for with or without an emergency voucher.

ACIS Billing Summaries

LEs are reimbursed only for ACIS services delivered when a participant is Medicaid-eligible and the LE has provided three or more ACIS services to that participant in a given month. This is a per member per month (PMPM) reimbursement model.

During the four quarters of CY 2024, Prince George’s County had the highest average number of participants served that were PMPM eligible: 94% (Figure 2). Baltimore City and Montgomery County had the lowest PMPM-eligible participants: 87%.

Figure 2. Average Percentage of ACIS Participants Served by PMPM Eligibility Status, by LE and CY 2024 Quarter

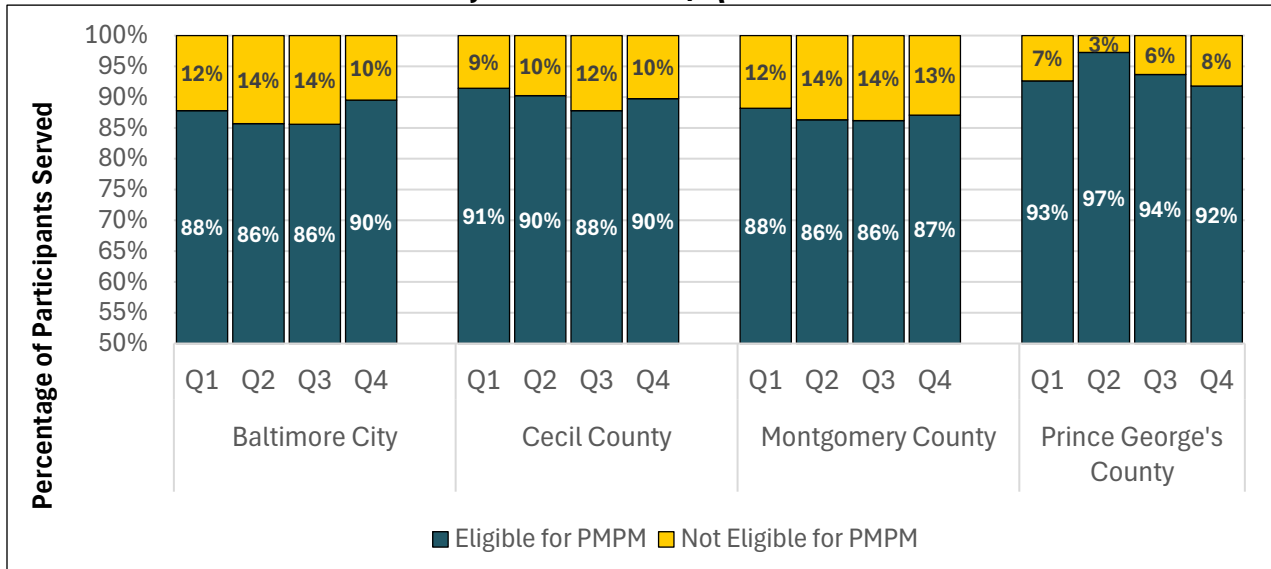
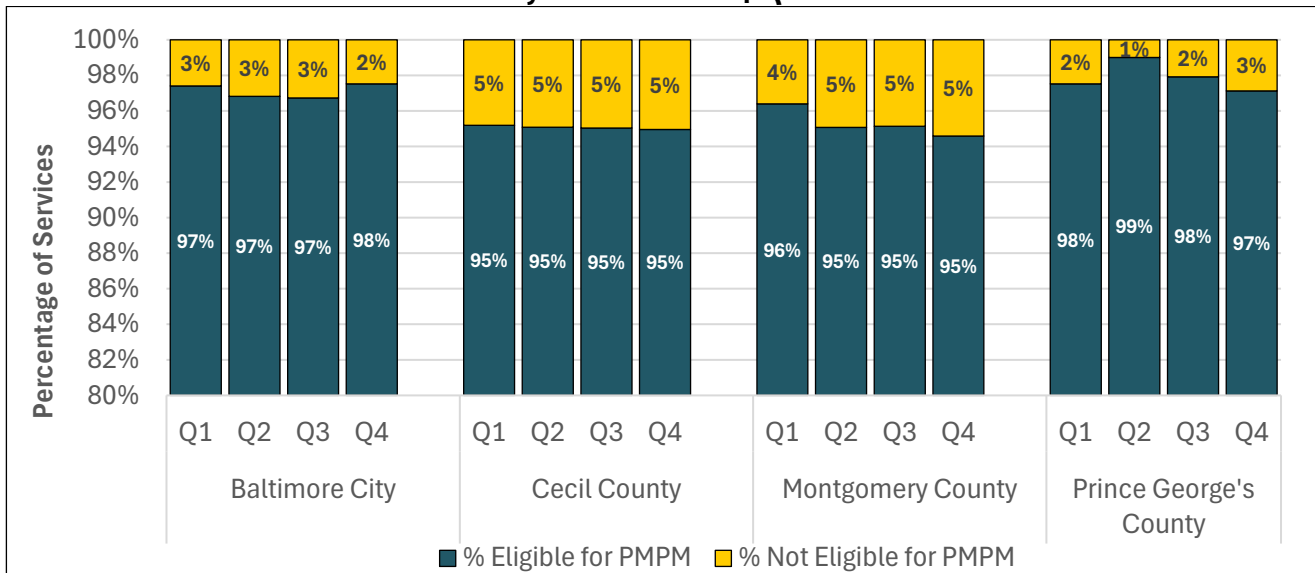


Figure 3 shows that Prince George's County had the highest average number of services delivered that were PMPM eligible (98%), while Cecil County and Montgomery County had the lowest (95%).

Figure 3. Average Percentage of ACIS Services Delivered by PMPM Eligibility Status, by LE and CY 2024 Quarter



Baltimore City delivered the highest average number of eligible ACIS services PMPM for CY 2024 (8.7), followed by Montgomery County (5.0). See Table 2.

Table 2. Average Eligible ACIS Services per Person by PMPM Eligibility Status, CY 2024

Lead Entity	Average Eligible Services per Person	Average Non-Eligible Services per Person
Baltimore City	8.7	1.8
Cecil County	3.2	1.2
Montgomery County	5.0	1.6
Prince George's County	3.4	1.1

Assessment Objectives and Methodology

Objectives

This report examines the utilization of Medicaid health services by individuals enrolled in ACIS in CY 2020 to CY 2024. Research questions include the following:

- Is the ACIS program serving the intended population?
- To what extent did participants receive stable housing? Where were they first housed?
- What health services did ACIS participants utilize during the study period?
- What percentage of ACIS participants had any substance use or mental health disorder diagnosis during the study period?

Study Population

This population includes ACIS participants¹⁷ enrolled during the five-year period of January 1, 2020, to December 31, 2024.

Data Sources

ACIS Service Data

As noted earlier, LEs submit ACIS data to Hilltop on a quarterly basis. The data analyzed below include the following:

- General living situation at time of enrollment

¹⁷ 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.

- Specific living situation at time of enrollment
- ACIS participants stably housed
 - Number of months to stable housing from ACIS enrollment date
 - Type of first stable housing obtained

MMIS2 Data

Hilltop used Medicaid Management Information Systems (MMIS2) 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.¹⁸ 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 admissions¹⁹
 - Defined using the International Classification of Diseases, Tenth Edition (ICD-10) psychiatric diagnoses once an inpatient admission had been identified and the psychiatric diagnosis was the primary diagnosis.²⁰

¹⁸ 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

¹⁹ Substance use disorder inpatient admissions were not reported due to small cell sizes.

²⁰ 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-F3178, 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.

- 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 substance use disorder (SUD) services in the community
 - Defined using outpatient, home health, physician, pharmacy, 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 COMAR 10.09.70.02 definition of an SUD.²¹
- Participants with ANY diagnosis of an MHD
 - Defined using the same ICD-10 psychiatric codes used for inpatient psychiatric stays.

Analysis

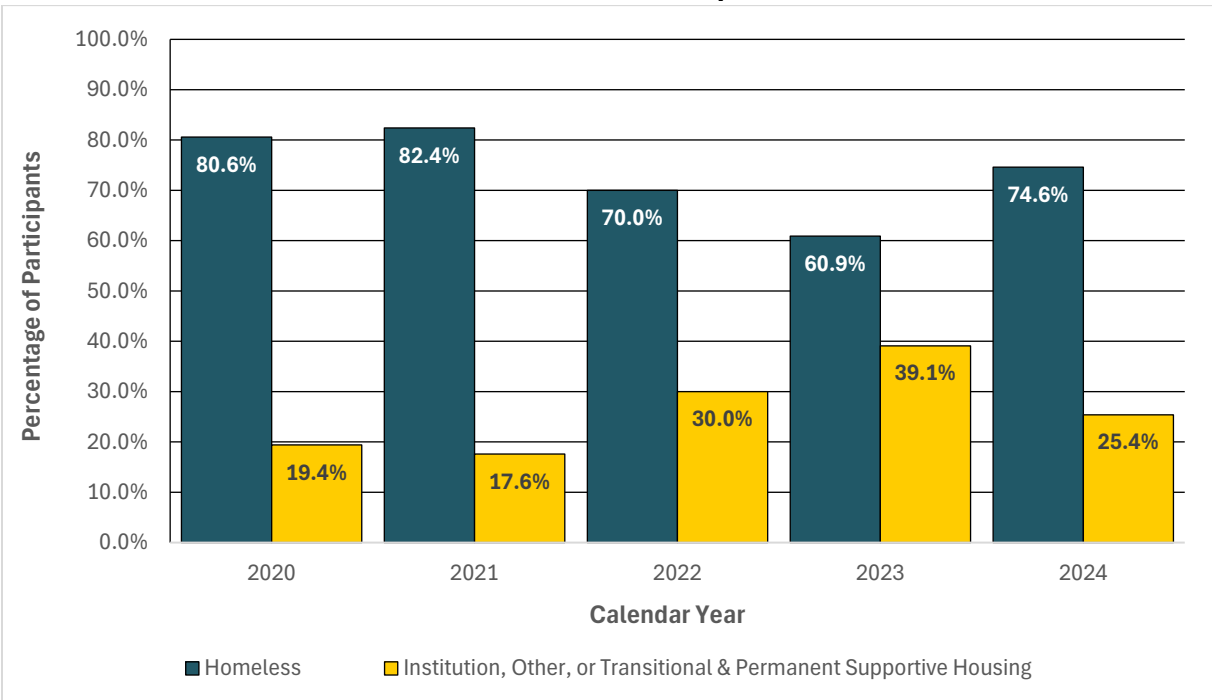
Hilltop summarized both the ACIS service data and health service utilization data with frequencies. The analysis of ACIS service utilization is based on a participant having received at least one ACIS service that occurred either on the date of enrollment, up to and including the date of discharge, or through December 31, 2024. The health service utilization analysis is based on health services utilized by ACIS participants during their ACIS enrollment span, broken out by each calendar year as appropriate.

Key Findings

At the time of ACIS enrollment, an average of 73.7% of ACIS participants were experiencing homelessness, and the remainder (26.3%) were residing in institutions or other transitional housing (Figure 4).

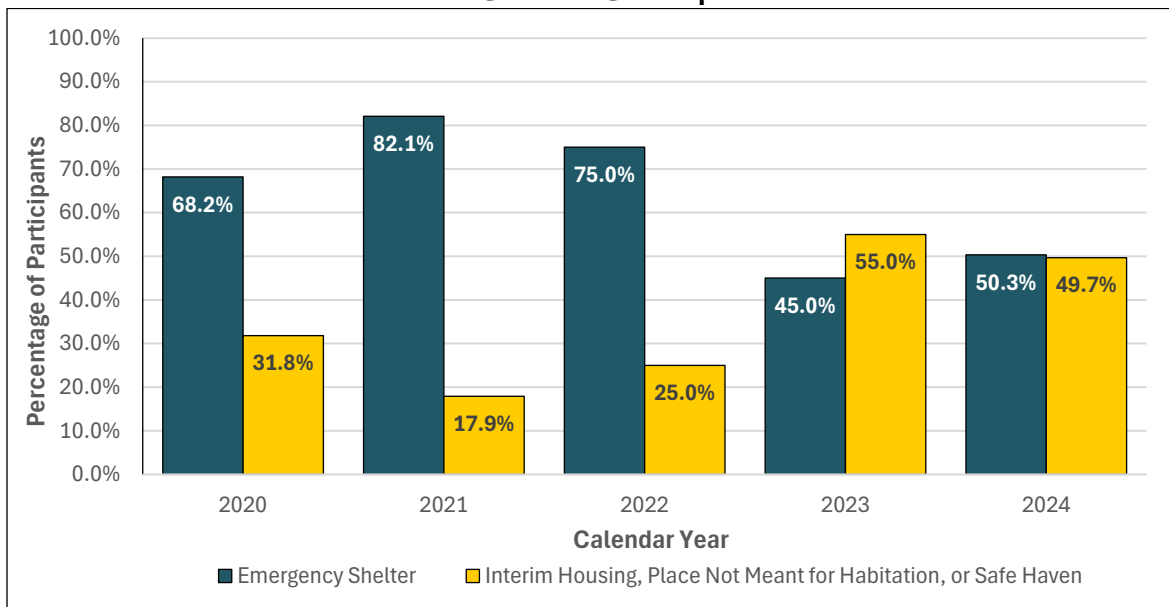
²¹ COMAR10.09.70.02 defines an SUD diagnosis as the inclusion of one of the following: ICD-10 diagnosis codes: F10-19, O99310-99315, O99320- 99325, R780-785 with Revenue codes 0114, 0116, 0124, 0126, 0134, 0136, 0154, 0156, 0762, 0900, 0905, 0906, 0911-0916, 0918, 0919, 0944, 0945, 0450- 0452, 0456, 0459 OR procedure codes 99.201-99.205, 99.211-99.215, J8499, J2315.

Figure 4. General Living Situations of ACIS Participants at the Time of Enrollment, CY 2020–CY 2024



Of those homeless at the time of enrollment, an average of 64.1% were residing in an emergency shelter and 35.9% were living in a place not meant for habitation, safe haven, or interim housing (Figure 5).

Figure 5. Specific Living Situation of Homeless ACIS Participants at the Time of Enrollment, CY 2020–CY 2024



Across all calendar years, the percentage of males exceeded that of females (55.8% to 44.2% respectively), the percentage of Black participants exceeded that of all other race categories (63.5%), and participants aged 51 to 60 years made up the largest percentage of participants (30.2%) (Table 3).

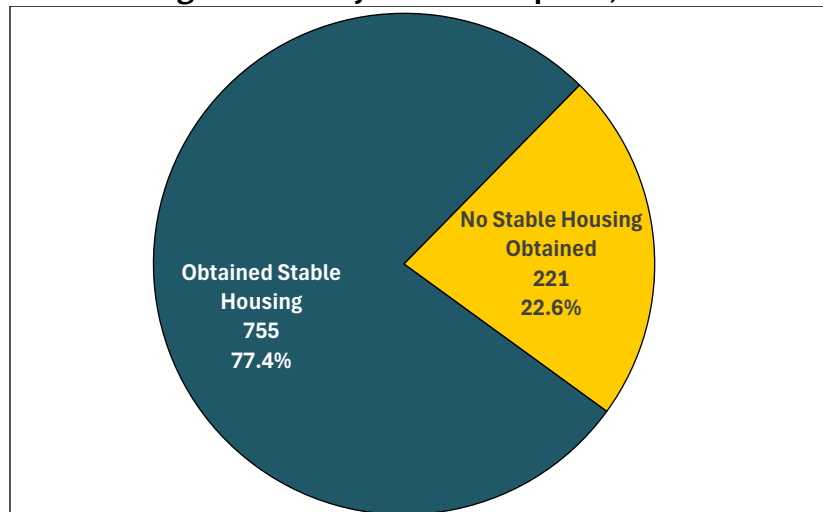
Table 3. Demographics of Newly Enrolled ACIS Participants, CY 2020–CY 2024

Demographic Characteristic	CY 2020 N=160 #	CY 2020 N=160 %	CY 2021 N=176 #	CY 2021 N=176 %	CY 2022 N=120 #	CY 2022 N=120 %	CY 2023 N=179 #	CY 2023 N=179 %	CY 2024 N=156 #	CY 2024 N=156 %	Total N=791 #	Total N=791 %
Sex												
Female	44	27.5%	67	38.1%	53	44.2%	106	58.6%	80	51.3%	350	44.2%
Male	116	72.5%	109	61.9%	67	55.8%	73	40.3%	76	48.7%	441	55.8%
Race/Ethnicity												
Black	98	61.3%	128	72.7%	64	53.3%	110	60.8%	102	65.4%	502	63.5%
Other*	23	14.4%	18	10.2%	26	21.7%	33	18.2%	29	18.6%	129	16.3%
White	39	24.4%	30	17.0%	30	25.0%	36	19.9%	25	16.0%	160	20.2%
Age Category at Enrollment												
30 & under	19	11.9%	22	12.5%	16	13.3%	42	23.2%	29	18.6%	128	16.2%
31–40	35	21.9%	37	21.0%	24	20.0%	33	18.2%	37	23.7%	166	21.0%
41–50	30	18.8%	36	20.5%	19	15.8%	43	23.8%	32	20.5%	160	20.2%
51–60	56	35.0%	63	35.8%	40	33.3%	37	20.4%	43	27.6%	239	30.2%
61+	20	12.5%	18	10.2%	21	17.5%	24	13.3%	15	9.6%	98	12.4%

Note: *Other may include Asian, Hispanic, Native American, or Pacific Islander/Alaskan.

Figure 6 shows the proportion of ACIS participants who obtained stable housing. Overall, 755 of the 976 ACIS participants (77.4%) obtained stable housing during their participation in the program.

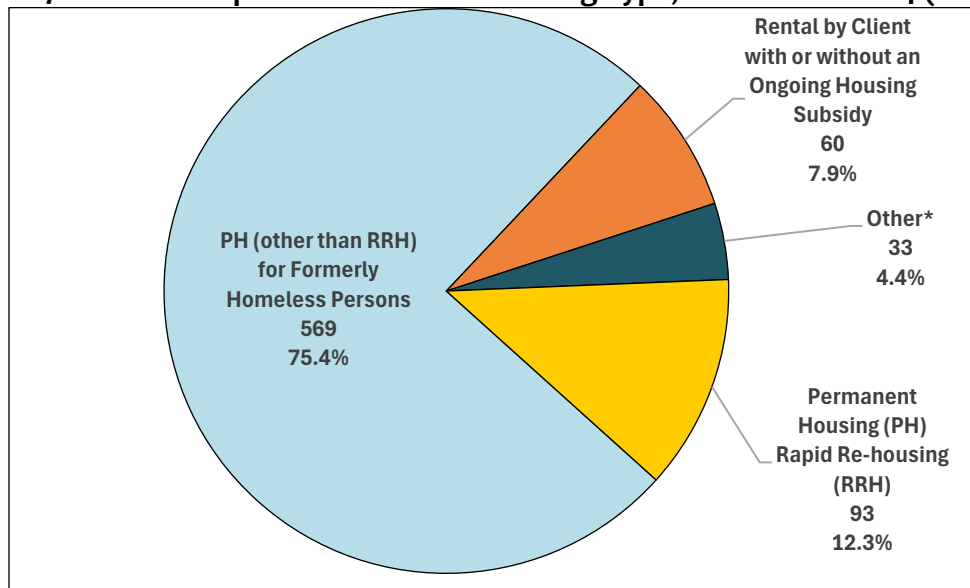
Figure 6. Stable Housing Obtained by ACIS Participants, CY 2020–CY 2024 (N = 976)



Note: Based on ACIS service data through CY 2025 for ACIS participants enrolled during CYs 2020 to CY 2024.

Figure 7 presents the first stable housing arrangement secured by ACIS participants during the study period. Most participants who achieved stable housing initially moved into permanent housing for formerly homeless individuals, excluding rapid re-housing programs.

Figure 7. ACIS Participants' First Stable Housing Type, CY 2020–CY 2024 (N = 755)



Notes: Based on ACIS service data through CY 2025 for ACIS participants enrolled during CYs 2020 to CY 2024.

*Other includes host home (non-crisis), owned by client, no ongoing housing subsidy, rental by client in a public housing unit, or rental by client with housing choice voucher.

Table 4 illustrates the average, median, maximum, and minimum number of weeks it took participants to obtain stable housing by LE. The time for ACIS participants to become stably housed varied by LE. It took an average of 10 weeks for an ACIS participant in Montgomery

County to become stably housed, whereas it took an average of 27 weeks in Prince George's County.

Table 4. Average, Median, and Maximum Number of Weeks to Obtain Stable Housing for ACIS Participants, by Lead Entity, CY 2020–CY 2024 (N = 755)*

Lead Entity	Average # of Weeks	Median # of Weeks	Maximum # of Weeks	Minimum # of Weeks
Baltimore City	14	9	121	0
Cecil County	18	12	91	0
Montgomery County	10	7	69	0
Prince George's County	27	21	111	0

Note: Based on ACIS service data through CY 2025 for ACIS participants enrolled during CY 2020 to CY 2024.

There was also significant variation across the LEs for the percentage of participants obtaining stable housing, with nearly 95% of participants in Montgomery County obtaining stable housing and approximately 82% participants in Baltimore City obtaining stable housing, while 57% or less of participants obtained stable housing in both Prince George's and Cecil Counties (Figure 8). This is 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. Even if a housing voucher is available, it may still take some time to get a participant physically housed due to waitlists, housing stock issues, etc. In comparison, both Cecil and Prince George's Counties allow participants to enroll in ACIS without a secured housing placement.

Figure 8. ACIS Participants Achieving Stable Housing, by Lead Entity, CY 2020–CY 2024

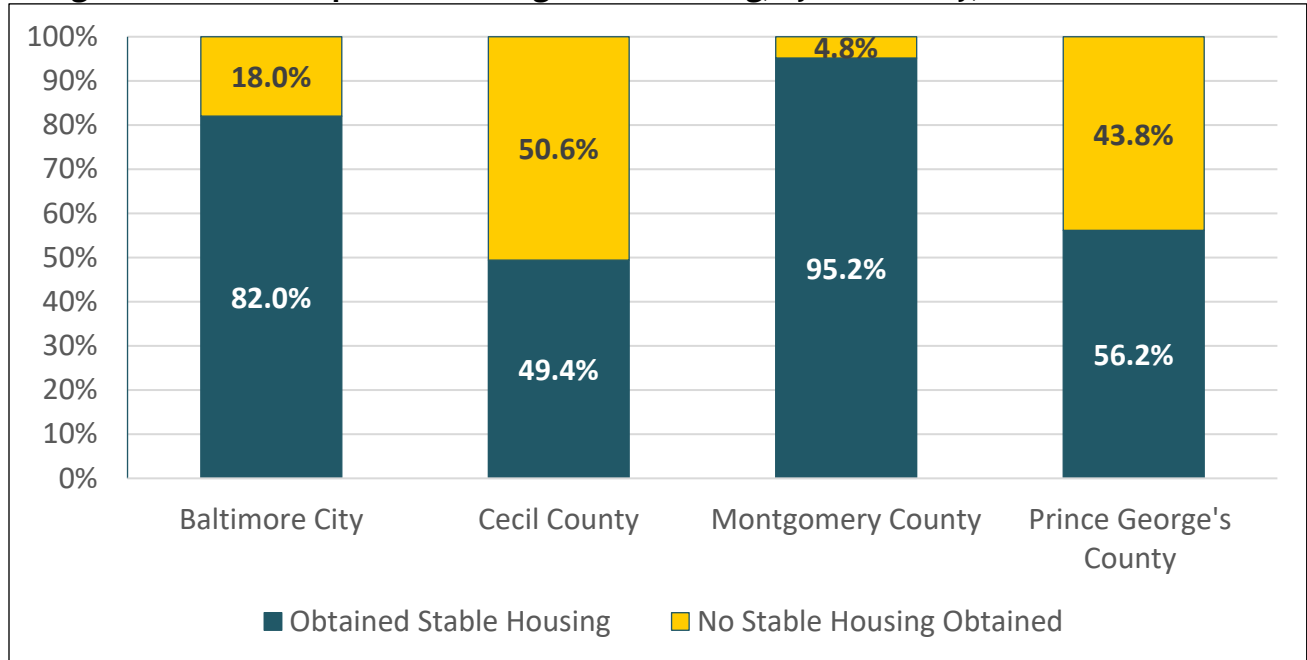


Table 5 shows the health care utilization of ACIS participants from CY 2020 to CY 2024. Across all study years, approximately 51.9% of ACIS participants had at least one ED visit, while approximately 30.3% had at least one avoidable ED visit. On average, almost 19.6% of ACIS participants had at least one inpatient stay, while 81.1% of participants had at least one ambulatory care visit across the study period.

Table 5. Health Service Utilization of ACIS Participants, CY 2020–CY 2024

Health Service Utilization	CY 2020 N = 406 #	CY 2020 N = 406 %	CY 2021 N = 483 #	CY 2021 N = 483 %	CY 2022 N = 520 #	CY 2022 N = 520 %	CY 2023 N = 611 #	CY 2023 N = 611 %	CY 2024 N = 634 #	CY 2024 N = 634 %
Ambulatory Care Visits										
At Least One Visit	336	82.8%	387	80.1%	418	80.4%	485	79.4%	524	82.6%
No Visits	70	17.2%	96	19.9%	102	19.6%	126	20.6%	110	17.4%
Inpatient Admissions										
At Least One Visit	109	26.9%	91	18.8%	85	16.4%	102	16.7%	121	19.1%
No Visits	297	73.2%	392	81.2%	435	83.7%	509	83.3%	513	80.9%
MDH Inpatient Admissions										
At Least One Visit	33	8.1%	22	4.6%	17	3.3%	26	4.3%	21	3.3%
No Visits	373	91.9%	461	95.5%	503	96.7%	585	95.7%	613	96.7%
ED Visits										
At Least One Visit	223	54.9%	261	54.0%	269	51.7%	310	50.7%	306	48.3%
No Visits	183	45.1%	222	46.0%	251	48.3%	301	49.3%	328	51.7%
Avoidable ED Visits										
At Least One Visit	129	31.8%	141	29.2%	158	30.4%	179	29.3%	194	30.6%
No Visits	277	68.2%	342	70.8%	362	69.6%	432	70.7%	440	69.4%
Nursing Facility Admissions										
At Least One Visit	19	4.7%	19	3.9%	15	2.9%	15	2.5%	*	*
No Visits	387	95.3%	464	96.1%	505	97.1%	596	97.5%	*	*

* Cells with values under 11 and those that can be used to calculate them have been suppressed

Table 6 shows the proportion of participants each year who had a SUD diagnosis, as well as those who also had outpatient visits. Nearly 47% of ACIS participants in CY 2024 had a SUD diagnosis; of those, 36.5% had at least one outpatient visit.

Table 6. ACIS Participants with Any SUD Diagnosis and SUD Outpatient Visit, CY 2020–CY 2024

Any Substance Use Disorder Diagnosis and Outpatient Visits	CY 2020 N = 406 #	CY 2020 N = 406 %	CY 2021 N = 483 #	CY 2021 N = 483 %	CY 2022 N = 520 #	CY 2022 N = 520 %	CY 2023 N = 611 #	CY 2023 N = 611 %	CY 2024 N = 634 #	CY 2024 N = 634 %
Any SUD Diagnosis										
Yes	208	51.2%	248	51.4%	241	46.4%	297	48.6%	293	46.2%
No	198	48.8%	235	48.7%	279	53.7%	314	51.4%	341	53.8%
SUD Outpatient Visits										
At Least One Visit	62	29.8%	82	33.1%	81	33.6%	90	30.3%	107	36.5%
No Visits	146	70.2%	166	66.9%	160	66.4%	207	69.7%	186	63.5%

On average, nearly 64% of ACIS participants enrolled between CY 2020 and CY 2024 had an MHD diagnosis (Table 7). Of ACIS participants with an MHD diagnosis across all study years, almost 55.7% had at least one MHD outpatient visit on average.

Table 7. ACIS Participants with Any MHD Diagnosis and MHD Outpatient Visits, CY 2020–CY 2024

Any Mental Health Disorder Diagnosis and Outpatient Visits	CY 2020 N = 406 #	CY 2020 N = 406 %	CY 2021 N = 483 #	CY 2021 N = 483 %	CY 2022 N = 520 #	CY 2022 N = 520 %	CY 2023 N = 611 #	CY 2023 N = 611 %	CY 2024 N = 634 #	CY 2024 N = 634 %
Any MHD Diagnosis										
Yes	292	71.9%	294	60.9%	300	57.7%	384	62.8%	423	66.7%
No	114	28.1%	189	39.1%	220	42.3%	227	37.2%	211	33.3%
MHD Outpatient Visits										
At Least One Visit	153	52.4%	159	54.1%	164	54.7%	229	59.6%	244	57.7%
No Visits	139	47.6%	135	45.9%	136	45.3%	155	40.4%	179	42.3%

The average number of ED visits per participant during CY 2024 was 2.0, while the median was 0 (Table 8). The average number of avoidable ED visits was lower at 1. The average number of ambulatory visits was 10, while the median was 6 for CY 2024.

Table 8. Average, Median, and Maximum Number of ED, Avoidable ED Visits, and Ambulatory Visits of ACIS Participants, CY 2024 (N = 634)

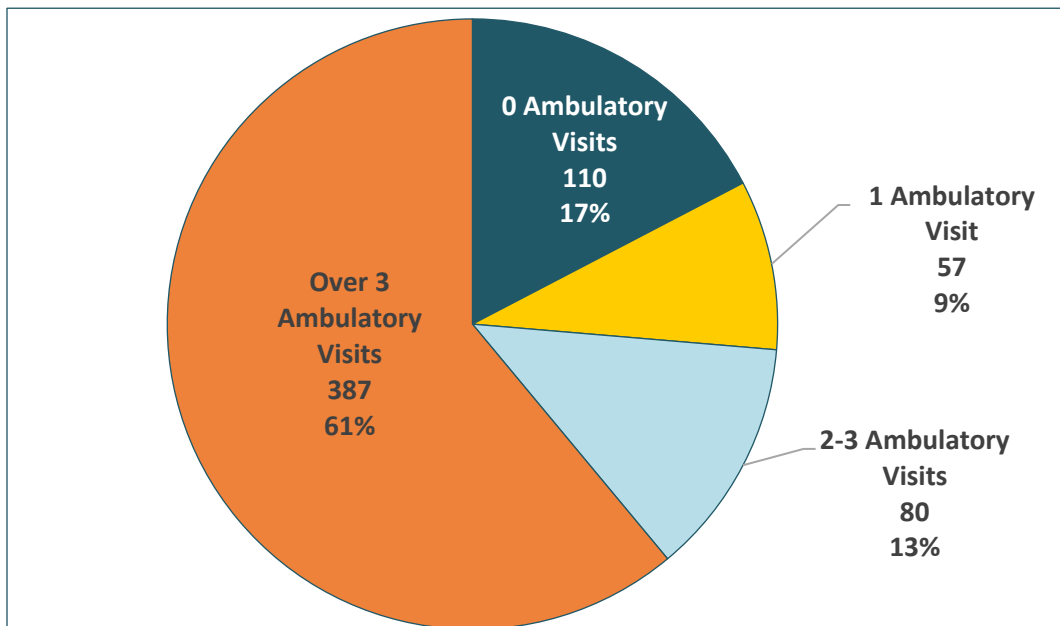
Type of Visit	Average	Median	Maximum
ED Visit	2	0	47
Avoidable ED Visit	1	0	26
Ambulatory Visit	10	6	69

Approximately 16% of participants had over three ED visits in CY 2024, while just 5% had over three avoidable ED visits (Table 9).

Table 9. Frequency of ED and Avoidable ED Visits of ACIS Participants, CY 2024 (N = 634)

Number of Visits	ED Visit #	ED Visit %	ED Visit Cumulative %	Avoidable ED Visit #	Avoidable ED Visit %	Avoidable ED Visit Cumulative %
0 Visits	328	52%	52%	440	69%	69%
1 Visit	98	15%	67%	94	15%	84%
2-3 Visits	108	17%	84%	68	11%	95%
Over 3 Visits	100	16%	100%	32	5%	100%
Total	634	100%	N/A	634	100%	N/A

Figure 9 shows that, in CY 2024, 61% of participants had over three ambulatory visits and 17% had zero ambulatory visits.

Figure 9. Frequency of Ambulatory Visits of ACIS Participants, CY 2024 (N=634)

Health Service Utilization before and after ACIS Enrollment

This section of the report includes ACIS participants who were enrolled in Medicaid during the one-year period immediately prior to *and* after their enrollment in ACIS.

A total of 504 participants (64% of the 791 participants newly enrolled between CY 2020 and 2024) 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. Hilltop used data from MMIS2 to conduct a pre/post comparison of service utilization during the one-year period prior to ACIS enrollment (pre-enrollment) and for the one-year period following

enrollment (post-enrollment). The following section highlights Medicaid health care service utilization for the 504 participants in the pre- and post-enrollment periods.

Table 10 shows health service utilization by the 504 ACIS participants with Medicaid eligibility in the one year before and after ACIS enrollment. With the exception of ambulatory care visits—which increased by 2.2%—service utilization decreased in the post-ACIS enrollment period in relation to pre-ACIS enrollment. The largest decrease (6.3%) was observed in the proportion of participants who had at least one avoidable ED.

**Table 10. Health Service Utilization of ACIS Participants before and after Enrollment
(N = 504)**

Frequency	Frequency Before	Percentage Before	Frequency After	Percentage After
Ambulatory Care Visits				
At Least One Visit	287	56.9%	298	59.1%
No Visits	217	43.1%	206	40.9%
Inpatient Admissions				
At Least One Visit	60	11.9%	33	6.6%
No Visits	444	88.1%	471	93.5%
MHD Inpatient Admissions				
At Least One Visit	36	7.1%	19	3.8%
No Visits	468	92.9%	485	96.2%
ED Visits				
At Least One Visit	241	47.8%	216	42.9%
No Visits	263	52.2%	288	57.1%
Avoidable ED Visits				
At Least One Visit	162	32.1%	130	25.8%
No Visits	342	67.9%	374	74.2%
Nursing Facility Admissions				
At Least One Visit	16	3.2%	12	2.4%
No Visits	488	96.8%	492	97.6%

Table 11 shows visits decrease in the number of participants with at least one SUD diagnosis and SUD outpatient visits in the post-period. The proportion of participants with an MHD diagnosis decreased slightly, as did the proportion of participants with at least one MHD outpatient visit.

Table 11. SUD and MHD Diagnoses and Utilization of ACIS Participants before and after Enrollment (N = 504)

Frequency	# Before	% Before	# After	% After
Any SUD Diagnosis				
Yes	203	40.3%	187	37.1%
No	301	59.7%	317	62.9%
SUD Outpatient Visits				
At Least One Visit	83	16.5%	80	15.9%
No Visits	421	83.5%	424	84.1%
Any MHD Diagnosis				
Yes	236	46.8%	231	45.8%
No	268	53.2%	273	54.2%
MHD Outpatient Visits				
At Least One Visit	139	27.6%	132	26.2%
No Visits	365	72.4%	372	73.8%

Over a quarter (27.4%) of the ACIS participants had at least one ED visit in the pre-enrollment period, which remained the same post-enrollment (Table 12). The largest decrease (5%) was observed in those with 4 to 9 ED visits in the year. The proportion of ACIS participants with no ED visits increased 52.2% to 57.1% post-enrollment.

Table 12. Frequency of Participants by Number of ED Visits before and after Enrollment (N = 504)

Number of ED Visits	Participants Before	Percentage Before	Cumulative Percentage Before	Participants After	Percentage After	Cumulative Percentage After
1-3	138	27%	27.4%	139	28%	27.6%
4-9	65	13%	40.3%	47	9%	36.9%
10-19	23	5%	44.9%	18	4%	40.5%
20+	15	3%	47.8%	12	2%	42.9%
No visits	263	52%	100.0%	288	57%	100.0%

Table 13 shows the frequency of health care visits for participants before and after enrollment. Also shown are results from a Wilcoxon Signed-Ranks statistical test comparing the difference in the mean number of visits for participants who had at least one visit.²²

With the exception of MHD outpatient visits, the average number of visits decreased from the pre- to post-enrollment period across six of the seven service environments. This decrease in

²² The Wilcoxon Signed-Ranks Test is a statistical method used to compare two sets of related data, such as the health care utilization of the sample group of individuals at two points in time (e.g., pre- and post-ACIS enrollment). See <https://www.sciencedirect.com/topics/medicine-and-dentistry/wilcoxon-signed-ranks-test>.

service utilization was statistically significant—at the conventional $p \leq 0.05$ level—for inpatient admissions, ED visits, and avoidable ED visits.

Table 13. Frequency of Health Service Visits of ACIS Participants before and after Enrollment (N = 504)

Health Service Visit	Maximum Pre	Maximum Post	Median Pre	Median Post	Mean Pre	Mean Post	Mean Difference (p-value)
Ambulatory Care Visits	124	94	2	2	8.46	8.36	-0.10 (p = 0.6520)
Inpatient Admissions	1	1	0	0	0.11	0.06	-0.05 (p = 0.0003*)
ED Visits	89	129	0	0	3.06	0.43	-2.63 (p = 0.0009*)
Avoidable ED Visits	40	59	0	0	1.18	0.84	-0.34 (p = 0.0002*)
Nursing Facility Admissions	5	4	0	0	0.05	0.04	-0.01 (p = 0.4902)
SUD Outpatient Visits	60	73	0	0	1.56	1.51	-0.05 (p = 0.7173)
MHD Outpatient Visits	153	139	0	0	4.53	5.49	0.96 (p = 0.4365)

Note: P-values based on Wilcoxon Signed-Ranks Test. *The difference between the pre and post mean is statistically significant at $p < .05$ or below

Considerations

1. Ideally, this 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 population, the ability to perform robust testing to determine statistical significance of outcomes was limited.
2. 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 five 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.

3. The study period is CY 2020 to CY 2024, which includes two years in which the state of Maryland was in a public health emergency as a result of the COVID-19 pandemic (CYs 2020 and 2021). Service utilization may have been impacted in those years and the years following.



The Hilltop Institute

UMBC

Sondheim Hall, 3rd Floor
1000 Hilltop Circle
Baltimore, MD 21250
410-455-6854

www.hilltopinstitute.org