Medicaid Section 1115 Serious Mental Illness and Serious Emotional Disturbance (SMI/SED) Demonstrations: State Actions to Integrate Supportive Housing and Supported Employment Services into Treatment

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RTI International

Introduction

Stable housing and meaningful employment are two of many social determinants of health that have a profound impact on people living with serious mental illness (SMI).[1,2,3] Supportive housing services help individuals access safe, affordable, community-based housing,[4] which has been shown to decrease emergency department visits and improve appropriate service use among homeless individuals with SMI.[5,6] Supported employment helps individuals achieve competitive employment in community-based settings and includes job development and career planning.[7] These employment services may contribute to a higher quality of life for individuals with SMI, a greater sense of meaning and belonging within the community and may lead to reduced psychiatric symptoms and recovery from mental illness.[8,9] Mental Health Treatment Study interventions, which include supported employment services, have been shown to reduce visits to the emergency room for people with SMI.[10] Additionally, patients who participated in the Recovery After an Initial Schizophrenia Episode (RAISE) Connection Program Implementation and Evaluation study reported that supported employment was correlated with engagement in the program.[11]

The Centers for Medicare & Medicaid Services (CMS) recognizes Medicaid's role in supporting states' efforts to address health-related social needs by providing supportive housing and supported employment services for individuals eligible for home- and community-based services, some of whom may have SMI.[12,13] To support social service and medical providers in delivering these services to Medicaid beneficiaries in need, CMS allows states to access federal Medicaid funds to provide supportive housing and supported employment services through 1915(c) waivers and 1915(i) state plan benefits and section 1115 demonstrations.[12-14] About 15 percent of mental health facilities participating in Medicaid reported offering supportive housing services in 2018 and 15 percent reported offering supported employment services.[7] Community-based social service and mental health providers also offer supportive housing and supported employment services, although the percentages that do so are unknown. In addition, states and local communities offer

[1] For the purposes of this report, SMI is used as shorthand for serious mental illness (SMI) and serious emotional disturbance (SED).
[2] National Alliance on Mental Illness (NAMI). (n.d.). *Social determinants of health: Housing*. https://nami.org/Advocacy/Policy-Priorities/Supporting-Community-Inclusion-and-Non-Discrimination/Social-Determinants-of-Health-Housing
[3] National Alliance on Mental Illness (NAMI). (n.d.). *Social determinants of health: Employment*. https://nami.org/Advocacy/Policy-Priorities/Supporting-Community-Inclusion-and-Non-Discrimination/Social-Determinants-of-Health-Employment
[4] U.S. Interagency Council on Homelessness. (n.d.). *Supportive housing*. https://www.usich.gov/solutions/housing/supportive-housing/
[5] Ly, A., & Latimer, E. (2015). Housing First impact on costs and associated cost offsets: A review of the literature. *Canadian Journal of Psychiatry, 60*(11), 475-487. https://doi.org/10.1177/070674371506001103
[6] McPherson, P., Krotofil, J., & Killaspy, H. (2018). Mental health supported accommodation services: A systematic review of mental health and psychosocial outcomes. *BMC Psychiatry, 18*, 128. https://doi.org/10.1186/s12888-018-1725-8
[7] MACPAC. (2022). Chapter 2. Access to mental health services for adults covered by Medicaid. In *Report to Congress on Medicaid and CHIP*. https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-2-Access-to-Mental-Health-Services-for-Adults-Covered-by-Medicaid.pdf
[8] Frederick, D. E., & VanderWeele, T. J. (2019). Supported employment: Meta-analysis and review of randomized controlled trials of individual placement and support. *PLoS One, 14*(2), e0212208. https://doi.org/10.1371/journal.pone.0212208
[9] Kern, R. S. (2019). Supported employment for patients with severe mental illness. *UpToDate*. https://www.uptodate.com/contents/supported-employment-for-patients-with-severe-mental-illness
[10] Salkever, D., Gibbons, B., & Ran, X. (2014). Do comprehensive, coordinated, recovery-oriented services alter the pattern of use of treatment services? Mental health treatment study impacts on SSDI beneficiaries' use of inpatient, emergency, and crisis services. *Journal of Behavioral Health Services and Research, 41*,434–446.
[11] Lucksted, A., Essock, S. M., Stevenson, J., Mendon, S. J., Nossel, I. R., Goldman, H. H., Goldstein, A. B., & Dixon, L. B. (2015). Client views of engagement in the RAISE Connection Program for early psychosis recovery. *Psychiatric Services, 66*(7), 699-704. https://doi.org/10.1176/appi.ps.201400475
[12] MACPAC. (2018). *The role of Medicaid in supporting Employment, InfoBrief*. https://www.macpac.gov/wp-content/uploads/2018/07/The-Role-of-Medicaid-in-Supporting-Employment.pdf
[13] MACPAC. (2021). *Medicaid's role in housing, InfoBrief*. https://www.macpac.gov/wp-content/uploads/2021/06/Medicaids-Role-in-Housing-1.pdf
[14] Centers for Medicare & Medicaid Services. (n.d.). *Employment & HCBS*. https://www.medicaid.gov/medicaid/long-term-services-supports/employment-initiatives/employment-hcbs/index.html

numerous housing and employment programs for individuals with SMI, such as permanent housing, rental assistance, and tailored employment services.

This report is part of a series of rapid cycle reports intended to share early findings and insights about section 1115 SMI/SED demonstrations. This report uses state program documents and interviews with state Medicaid agency and behavioral health agency officials to summarize the strategies states are implementing or plan to implement to integrate supportive housing and supported employment services into treatment plans for beneficiaries with SMI and to identify the enabling factors and challenges states experience during implementation.

Specifically, this report addresses the following three objectives:

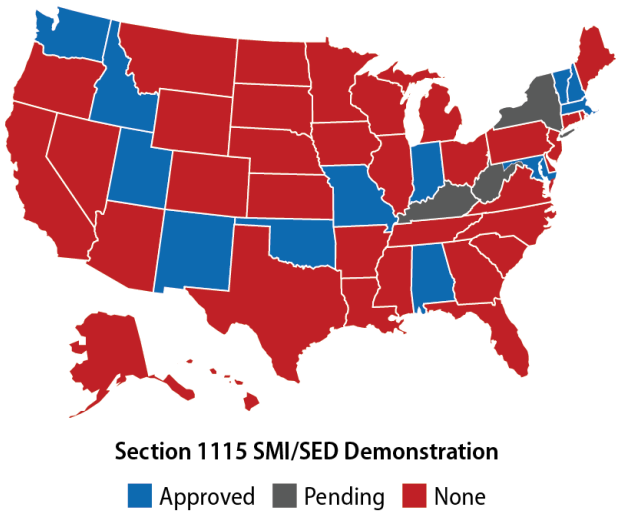
1. Describe state strategies to integrate supportive housing and supported employment services into treatment plans.
2. Describe state-reported policies, programs, and contextual factors that enable strategies to integrate supportive housing and employment services into treatment.
3. Describe state-reported challenges to integrating supportive housing and employment services into treatment, and how states are addressing or plan to address these challenges.

About Section 1115 SMI/SED Demonstrations

Improving care for Medicaid-enrolled adults with SMI and youth with SED through innovative service delivery is a priority for the Centers for Medicare & Medicaid Services (CMS). Section 12003 of the 21st Century Cures Act directed CMS to develop section 1115 demonstration projects for this population. Section 1115 SMI/SED demonstrations allow states to receive federal financial participation (i.e., federal Medicaid matching dollars) for care delivered during short-term stays in institutions for mental disease (IMDs) as long as the state is taking action to ensure quality of care in IMDs and to improve access to mental health care at all levels of intensity as well as recovery support services for Medicaid beneficiaries with SMI or SED. States must also commit to maintaining funding levels for outpatient community-based mental health services and monitor and evaluate demonstration performance.

Goals of section 1115 SMI/SED demonstrations include reducing utilization and length of stay in emergency departments; reducing readmissions to acute care hospitals and residential settings; improving availability of crisis stabilization, intensive outpatient, and acute short-term psychiatric hospital and residential treatment setting services; improving access to community-based services and integrated primary and behavioral health care; and improving care coordination and continuity of care after a hospitalization or residential treatment stay.

Figure 1. Section 1115 SMI/SED demonstration status as of February 2024



These demonstrations require the state to submit and carry out implementation plans that set forth how the state will meet four key milestones on its path to achieving demonstration goals:

1. Ensure quality care in psychiatric hospitals and residential settings.
2. Improve care coordination and transitions to community care.
    a. Including by "implementation of a process to assess the housing situation of individuals transitioning to the community from psychiatric hospitals and residential treatment settings and connect those who are homeless or have unsuitable or unstable housing with community providers that coordinate housing services where available"[15]
3. Increase access to a continuum of care and crisis care.
4. Support early identification and engagement in treatment
    a. Including by "implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with serious mental health conditions, in treatment sooner including through supported employment and supported education programs".[16]

[15] The state Medicaid Director Letter titled "Opportunities to Design Innovative Service Delivery for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance" can be found at https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18011.pdf.

[16] The state Medicaid Director Letter titled "Opportunities to Design Innovative Service Delivery for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance" can be found at https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18011.pdf.

Achieving these milestones is expected to lead to successful performance on demonstration goals.

As of February 2024, 12 states and the District of Columbia had received approval for section 1115 SMI/SED demonstrations; 3 states have a pending application (**Figure 1**).

Overview of Findings

As a part of these section 1115 SMI/SED demonstrations, states pursued common strategies to integrate into treatment supportive housing and supported employment services for beneficiaries with SMI:

- Revising state rules, policies, provider manuals, administrative codes, and contracts to assess housing during discharge from a psychiatric hospital or residential treatment facility.
- Supporting case management programs, which can connect Medicaid beneficiaries with SMI to supportive housing and supported employment services.
- Leveraging existing Medicaid benefits and waivers to provide supportive housing and supported employment services.

Numerous factors enabled states to pursue the strategies they did:

- Relying on community mental health centers to provide the case management that connects beneficiaries with SMI to housing and employment services.
- Using federal grants to increase the availability of supportive housing and supported employment services.
- Leveraging health information exchange to streamline the process of providing referrals to and tracking receipt of supportive services delivered by social service organizations.

State officials identified common challenges to integrate supportive services:

- Lacking integrated information systems between mental health and social service providers.
- Having difficulty establishing necessary partnerships to improve the referral process for supportive services.
- Experiencing complexities in covering supported employment services through the 1915(i) state plan benefit.
- Encountering limited employment options for beneficiaries because of business closures in the COVID-19 pandemic.

Approach

Findings in this report are based on interviews and a review of state documentation submitted to CMS by ten states with approved section 1115 SMI/SED demonstrations (Alabama, the District of Columbia, Idaho, Indiana, Maryland, New Hampshire, Oklahoma, Utah, Vermont, Washington) as of November 2022.[17] Videoconference interviews were conducted between August and November 2022 with 32 Medicaid and behavioral health agency officials in the ten states. Interviews with Alabama, Maryland, and New Hampshire were conducted soon after their demonstration implementation plans were approved, and the states had not yet started demonstration activities. As a result, these interviews focused on planned activities and anticipated facilitators and challenges. **Appendix A** provides more information about the data collection methods used.

Results

Milestone 2b for the section 1115 SMI/SED demonstrations guided states to ensure that psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with organizations to connect them to housing supports. Milestone 4a guided states to implement "strategies for identifying and engaging individuals, particularly adolescents and young adults with serious mental health conditions, in treatment sooner including through supported employment and supported education programs."[18] States' demonstration documents described a variety of strategies to connect individuals to supportive housing and supported employment services (**Exhibit 1**).[18] State officials noted that many of these strategies were in place prior to the demonstration because states' approaches to delivering mental health care already included assessing for housing and employment needs and referring beneficiaries to organizations that provide these services. However, some states did strengthen these policies as a result of this demonstration opportunity.

[17] For brevity, we refer to states and the District of Columbia as "states" and all respondents as "state officials."

[18] The state Medicaid Director Letter titled "Opportunities to Design Innovative Service Delivery for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance" can be found at https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18011.pdf.

Common State Strategies

Revising State Rules, Policies, Provider Manuals, Administrative Codes, and Contracts to Assess Housing during Discharge from a Psychiatric Hospital or Residential Treatment Facility. All states we interviewed had implemented or were implementing administrative policy changes requiring residential treatment facilities and psychiatric hospitals to assess beneficiary housing needs at the time of discharge from treatment. Because of this section 1115 SMI/SED demonstration, some states that already had policies in place revised their requirements to make them clearer. For example, in Indiana, state officials described plans to update the Medicaid provider manual to explicitly require hospitals to assess housing needs. Vermont will change its hospital licensing rules to ensure that IMDs assess their beneficiaries' housing needs. In Oklahoma, state officials had already revised their administrative code to require state hospitals to provide discharge planning that includes addressing housing supports. Some states also set guidelines for Medicaid managed care organizations. For example, Idaho plans to add language to their managed care contracts requiring network providers to assess housing needs during discharge planning; Alabama already requires its primary care case management entities' transitional care nurses to complete a housing assessment during discharge planning to identify housing-related needs.

Exhibit 1. Summary of state strategies to integrate supportive housing and employment services into treatment

- Making administrative policy changes that require providers and/or Medicaid managed care organizations to assess housing needs during discharge from a psychiatric hospital or residential treatment facility.
- Supporting case management programs with funding, training, and resources.
- Leveraging existing Medicaid benefits and/or waivers to provide supportive services to beneficiaries with SMI.

Supporting Case Management Programs. Given the complex needs of beneficiaries with SMI, officials from all states reported providing case management to those beneficiaries who meet the state's eligibility and clinical requirements for these services before the demonstration. In addition, some of the demonstration states used Medicaid's targeted case management benefit specifically for individuals with mental health disorders.[19] Case management encompasses a suite of activities designed to help Medicaid beneficiaries access needed medical, social, educational, housing, and employment services.[20] Case management has been associated with fewer psychiatric symptoms, improved quality of life, and the potential to improve treatment for individuals with SMI.[21,22] In state documentation, all states addressed the role that case managers and case management programs in psychiatric hospitals, community mental health centers (CMHCs), and Medicaid managed care organizations have in connecting Medicaid beneficiaries with SMI/SED to supportive housing and supported employment services. State support for case management included funding, training, and providing tools for case managers when meeting with clients. For example, Alabama provided funding to CMHCs (through its Stepping Up initiative, a program to prevent incarceration among individuals with SMI) to provide case management for individuals with SMI that includes linking them to housing support. Alabama also provided training for CMHC case managers. Oklahoma helped fund case managers at CMHCs to provide adults with mental health disorders with both employment and housing assistance. Lastly, to help case managers review housing options during the discharge process, Washington developed a discharge planning toolkit that includes guidance on navigating housing resources within the state.

> *"Care coordination has focused on those groups of folks [people with complex physical health and health-related social needs] and we have built recently into that team what we're calling an intensive care coordination team which is all about coordinating with the state health department and especially going out into the community to find people who are housing insecure and in shelters or in the encampments and trying to assess their mental health needs and help them assess their willingness to accept housing and once they get housing to help them succeed in their new home as part of their recovery journey."*
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> -State official

Leveraging Existing Medicaid Benefits and Waivers to Provide Supportive Housing and Supported Employment Services. In their demonstration documentation, several states referenced 1915(c) home- and community-based services (HCBS) waivers or the 1915(i) state plan HCBS benefit as avenues to provide supportive housing and supported employment services. For those eligible for HCBS, which may include beneficiaries with SMI, the 1915(c) HCBS waiver and the 1915(i) state plan benefit allowed states to use federal Medicaid funds to pay for housing transition and tenancy-sustaining services and habilitation services, which can include supported employment services. Six demonstration states have a 1915(c) HCBS waiver and/or 1915(i) state plan amendment (SPA), and state documentation and state officials in these states noted how the 1915(c) and 1915(i) benefits helped connect beneficiaries with SMI to those services. For example, New Hampshire used their 1915(i) supportive housing state plan benefit to provide transitional

[19] KFF. (n.d.). *Medicaid benefits: Targeted case management*. https://www.kff.org/medicaid/state-indicator/targeted-case-management/

[20] Social Security Administration. (n.d.). *Provisions respecting inapplicability and waiver of certain requirements of this title*. https://www.ssa.gov/OP_Home/ssact/title19/1915.htm

[21] Lim, C. T., Caan, M. P., Kim, C. H., Chow, C. M., Leff, H. S., & Tepper, M. C. (2021). Care management for serious mental illness: A systematic review and meta-analysis. *Psychiatric Services, 73*(2), 180-187. https://doi.org/10.1176/appi.ps.202000473

[22] Dietrich, M., Irving, C. B., Bergman, H., Khokhar, M. A., Park, B., & Marshall, M. (2017). Intensive case management for severe mental illness. *Cochrane Database of Systemic Reviews, 2017*(1), CD007906. https://doi.org/10.1002/14651858.CD007906.pub3

and/or sustained supportive housing services to eligible individuals who are homeless or at-risk of homelessness. Alabama's 1915(c) program included employment-related services that are available to eligible beneficiaries, and Utah used their existing comprehensive Medicaid section 1115 demonstration to provide housing-related services and supports to certain eligible individuals, including those with SMI.

State-Reported Policies, Programs, and Contextual Factors That Enable Integration of Housing and Employment Services in Treatment Plans

Relying on CMHCs to Provide Case Management Services. Several state officials reported that CMHCs (or Certified Community Behavioral Health Clinics [CCBHCs]) are the primary providers of mental health care for Medicaid beneficiaries with SMI. CMHCs and CCBHCs responded to these beneficiaries' complex needs by delivering complex case management that provided assistance with accessing medical care, mental health care, and social services that addressed beneficiaries' health-related social needs.[23] As such, CMHCs and CCBHCs were best positioned to provide social need assessments and connect beneficiaries to the social service agencies that could address their needs. Several state officials mentioned the critical role these community-based providers play in connecting Medicaid beneficiaries with SMI to supportive housing and supported employment services.

> *"We've had a pretty significant thrust towards improving our housing services and coordinating with hospitals, both IMDs and regular hospitals and other settings in the state. This aligns pretty easily with the implementation project."*
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> *-State official*

Using Federal Grants to Fund Supportive Housing and Supported Employment Services. Even though options are available for Medicaid programs to reimburse supportive housing and supported employment services (e.g., 1915(c) waivers and 1915(i) state plan benefits), demonstration states also relied on grant funding to pay for these services. As described in demonstration documentation, several states reported using the Community Mental Health Services Block Grant (MHBG) funds from the Substance Abuse and Mental Health Services Administration (SAMHSA). For example, one state (Oklahoma) reported using their MHBG to partially fund the Individual Placement and Support (IPS) program,[24] an evidence-based model that provides individuals with SMI with help in gaining competitive employment. Other states (e.g., Alabama, New Hampshire) also distributed SAMHSA's Projects for Assistance in Transition from Homelessness (PATH) funding[25] to CMHCs to provide outreach, mental health services, case management services, referrals for primary health care services, job training, educational services, and housing search services for individuals with SMI who are affected by housing instability.

Leveraging Health Information Exchange. Consistent with milestone two, which entails "implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers,"[26] all states' implementation plans noted the importance of collecting social service data, sharing that data within a care team, and improving information exchange between medical and social service providers to better track referrals to community-based supports, including housing and employment services. States used the demonstration period to plan and pilot initiatives to help them improve information exchange. For example, one state official mentioned that they are exploring options for combining medical, Medicaid eligibility, and social service data in their health information exchange so that all providers can more easily see what services a beneficiary is eligible for and if housing and employment services have been provided. Another state official shared the state's plans to incorporate referrals for housing and employment services into its health information exchange. One state planned to survey providers to better understand how they use referral capabilities within their electronic health records (EHRs), and they will also increase outreach to providers on how to use EHR referral capabilities to connect beneficiaries to social service providers.

State-Reported Challenges to Providing Supportive Housing and Supported Employment Services in Treatment Plans

Few state officials noted explicit challenges to implementing supportive housing and supported employment services. Those that were mentioned are noted here, with the acknowledgment that these should not be interpreted as generalizable to all states given the low response rate for this line of inquiry.

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[23] Everett, A. & Lee, S. U. (2012). Community and public mental health services in the United States: History and programs. In W. W. Eaton (Ed.), *Public mental health*. Oxford University Press. https://doi.org/10.1093/acprof:oso/9780195390445.001.0001

[24] SAMHSA. (2020 [updated]). *Transforming lives through supported employment.* https://www.samhsa.gov/grants/grant-announcements/sm-14-011

[25] SAMHSA. (2022 [updated]). *Projects for assistance in transition from homelessness (PATH)*. https://www.samhsa.gov/homelessness-programs-resources/grant-programs-services/path

[26] Centers for Medicare & Medicaid Services. (2018). *Opportunities to design innovative service delivery systems for adults with a serious mental illness or children with a serious emotional disturbance. SMD 18-011.* https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf

Lacking Integrated Information Systems between Mental Health and Social Service Providers. A few state officials noted that mental health providers and social service providers generally do not use the same health information systems to document care plans, referrals, and service delivery, which limits information sharing between the two delivery systems.

Having Difficulty Establishing Necessary Partnerships to Improve the Referral Process for Supportive Services. Medicaid providers need to establish relationships with social service providers that provide supportive housing and supported employment services. A few state officials noted that connecting with agencies that provide these services (e.g., agencies providing supported employment services) is not always easy, but they did not elaborate on why it was challenging.

Experiencing Complexities in Covering Supported Employment Services through the 1915(I) State Plan Benefit. A few state officials commented on exploring how to transition supported employment services for Medicaid beneficiaries to a state plan benefit through a 1915(i) SPA. One state official noted that the requirements to add the service to the state plan were too cumbersome to navigate. Another state did transition those services into the state plan but found that complying with the requirements (e.g., assessment and documentation procedures) necessary to receive reimbursement under the 1915(i) benefit was more challenging than anticipated.

Encountering Limited Employment Options for Beneficiaries Because of Business Closures during the COVID-19 Pandemic. One state official noted that business shutdowns and reduced staffing during the COVID-19 pandemic negatively impacted their ability to place individuals living with SMI/SED in employment. Although the services to help beneficiaries find employment were available, the jobs were not, as organizations that had provided employment to beneficiaries in the past could not hire.

Conclusions

This report summarizes the strategies states are implementing or planning to implement to integrate supportive housing and supported employment services in treatment (section 1115 SMI/SED demonstration Milestones 2b and 4a) and the enabling factors and challenges states experienced in doing so. Although states are pursuing different strategies to address these milestones, common themes emerged, including revising administrative documents and policies to require providers to assess housing needs at the time of discharge from a psychiatric hospital or residential stay; ensuring beneficiary case management includes referrals and connections to supportive housing and supported employment services; and relying on existing Medicaid coverage and funding pathways like the 1915(c) waiver and the 1915(i) state plan benefit to reimburse supportive housing and supported employment services for eligible beneficiaries with SMI. To support these strategies, states use case management services from CMHCs, existing funding streams, and health information exchanges.

Although state officials did not mention many challenges related to integration of these services into mental health treatment, the following themes emerged: lack of integrated information systems between mental health providers and social service providers; difficulty establishing necessary partnerships to link beneficiaries to supportive housing and supported employment services; complexities of covering services through the 1915(i) state plan benefit; and limited employment options for beneficiaries because of business closures during the COVID-19 pandemic. Interestingly, the pandemic did not surface as a major implementation challenge aside from one state official's reference to the limited employment options.

Most demonstration states noted in their implementation plans that they had met Milestones 2b and 4a by the time they began their demonstration activities because they were already engaged in connecting, referring, and providing supportive housing and supported employment. Therefore, states used the demonstration to strengthen their strategies. For example, because of the demonstration, most states made the changes to codify a requirement that institutional providers assess beneficiaries' housing needs and make appropriate referrals at the time of discharge. Moreover, a few state officials mentioned plans to test new approaches to connecting beneficiaries to services (e.g., innovations in health information exchange redesign to more easily track beneficiaries referred for these supportive services). Although states may have planned to test innovations or make changes regardless of the demonstration, the fact that the demonstration asks states to focus their energies in these areas was reported as a motivating factor to do so.

This report shares early insights about states' section 1115 SMI/SED demonstration efforts to integrate supportive housing and supported employment services into treatment for beneficiaries with SMI. As part of the meta-evaluation, we will continue to monitor changes in service delivery as the demonstrations mature. The findings from these interviews may help to contextualize state-specific results from the impact analysis and meta-analysis or may support operationalization of new variables for those analyses.

Authors and Acknowledgments

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The Federal Meta-Analysis Support Contract

In 2018, the Centers for Medicare & Medicaid Services (CMS) commissioned the Federal Meta-Analysis Support contract (HHSM-500-2014-00037I) to learn from each Medicaid section 1115 demonstration and the groups of such demonstrations with similar features. Under this contract, RTI International is conducting meta-evaluations of selected groups of Medicaid section 1115 demonstrations.

Rapid cycle reporting is central to the Federal Meta-Analysis Support contract, providing CMS with timely, practical findings, and supporting dissemination of findings to key stakeholder audiences. This report is one of several rapid cycle reports prepared by RTI International under the contract.

Appendix A: Data, Methods, and Limitations

Findings in this report are based on interviews with 10 states (Alabama, District of Columbia, Idaho, Indiana, Maryland, New Hampshire, Oklahoma, Utah, Vermont, Washington) and a review of the 10 states' implementation plans, of midpoint assessments for two states (District of Columbia and Vermont), and of quarterly monitoring reports for five states (District of Columbia, Idaho, Oklahoma, Utah, and Washington). Videoconference interviews were conducted between August and November 2022 with 32 Medicaid and behavioral health agency officials in the ten states. Respondents included state Medicaid directors, state Medicaid program staff, and state behavioral health agency staff familiar with the section 1115 SMI/SED demonstration. One interview was conducted per state, and almost all states had multiple program staff attending the interview.

Interviews with Alabama, Maryland, and New Hampshire were conducted soon after their demonstration implementation plans were approved, and the states had not yet started demonstration activities. As a result, interviews in these states focused on planned activities, enabling factors, and challenges.

Interviews used a common, semi-structured protocol that covered multiple topics, including perspectives on the state's most important demonstration activities and activities around SMI/SED Demonstration Milestones 1 through 4. This report drew upon interview questions and responses related to implementation of Milestone 2b, improving care coordination and transitioning to community-based care, and 4a, early identification and engagement in treatment. Interviews were 60 minutes in length.

Interviews were audio recorded with state officials' permission and transcribed. RTI analyzed the transcripts using NVivo 12.0. The initial analysis phase entailed a deductive coding process with prescribed codes for topics that aligned with the interview protocol. After this initial phase, the analysis team initiated an inductive coding process to identify and synthesize strategies, enabling factors, and challenges across states. The team held regular coding reviews and debriefings and conducted intercoder reliability assessments to ensure quality control.

In the report, we use quantifying language (e.g., "all state officials" or "some state officials") to give readers a sense of the number of state officials who mentioned a topic during an interview and therefore the prevalence of topics that state officials raised or addressed. We do not provide exact counts of state officials who mentioned a topic because the interviews were semi-structured in nature. Unlike the case of a structured survey with identical questions and response sets, we cannot conclude from semi-structured interviews that a particular topic was or was not relevant or meaningful to state officials who did not mention a particular topic. Also, when data come from publicly available documents, we provide state names and counts, as well as note that the documentary source. We avoid naming states when data come solely from interviews to minimize risk to confidentiality.

This analysis has several limitations. State officials may report strategies; state-reported policies, programs, and contextual factors, and challenges that are most important to them. As such, there may be some inherent bias in the information they report. Additionally, states' perspectives may have varied depending on how far along they were in implementation. At the time our interviews were conducted, some states had been engaged in demonstration implementation for close to 2 years while others were only recently approved to begin demonstration activities. Perspectives about the importance of a strategy in meeting a demonstration milestone may reasonably be expected to change over time. Moreover, this report is not designed to provide an exhaustive list of strategies, enabling factors, and challenges; we present those that were frequently mentioned. Finally, interviews lasted 60 minutes and covered multiple topics, which limited in-depth discussion on any one topic. Notably, discussion of challenges implementing supportive housing and supported employment services was infrequent, which limits the generalizability of the challenges discussed in this report.