Mercer

Government Human Services Consulting

2025 Service Capacity Assessment

Priority Mental Health Services

Arizona Health Care Cost Containment System

June 30, 2025

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Contents

Section 1

Executive Summary

The Arizona Health Care Cost Containment System, Arizona's Medicaid Agency (hereafter referred to as Arizona or State), engaged Mercer Government Human Services Consulting (Mercer) to perform a network sufficiency evaluation of four prioritized mental health services available to persons living with a serious mental illness (SMI) in Maricopa County, Arizona. This report represents the twelfth in a series of annual service capacity assessments.

The service capacity assessment includes evaluating the assessed need, availability, and provision of consumer-operated services (peer support and family support services), supported employment, supportive housing, and assertive community treatment (ACT) services. Mercer assesses priority mental health services capacity using the following methods:

- **Key informant surveys, interviews, and focus groups*:*** The analysis includes surveys and interviews with key informants, and focus groups with members, family members, case managers, and providers.
- **Medical record reviews:** Mercer identifies a random sample (n=200) of class members to support an in-depth analysis of clinical assessments, individual service plans, and progress notes. The review also examines each recipients' assessed needs and the timeliness of accessing priority mental health services.
- **Analysis of service utilization data and contracted capacity for each priority mental health service:** The analysis evaluates the volume of unique users, billing units, and rendering providers for select priority mental health services identified via administrative claims data. In addition to the percentage of recipients who received one or more of the prioritized services, Mercer completes an analysis to estimate "persistence" in treatment. The persistence calculation includes the proportion of recipients who received a priority service during a single month, as well as progressive time intervals (i.e., two to three months, three to four months, five to six months, seven to eight months, and nine months or longer), to determine the percentage of recipients who sustained consistent participation in the prioritized services during the review period.
- **Analysis of outcomes data:** Mercer analyzes outcome data for persons living with SMI, including employment status, criminal justice involvement, grievance data, and emergency room utilization.
- **Benchmark analysis:** The analysis evaluates priority mental health service prevalence and penetration rates in other states and local systems that represent relevant comparisons to Maricopa County.

Overview of Findings and Recommendations

See Table 1 for a service utilization summary of the priority mental health services during the review period. The current review period primarily targets calendar year (CY) 2024, although for some units of analysis that rely on service utilization data, the timeframe was adjusted to account for potential lags in processing administrative claims data.

Service Capacity Assessment Conclusions

Mercer's service capacity assessment found comparable percentages of members using the priority mental health services during CY 2024 when compared to CY 2023, as illustrated in the following tables. There was an overall increase of 1,379 members between CY 2024 and CY 2023.

Table 1 — Summary of Priority Mental Health Services Utilization, CY[1] 2024, CY 2023, and CY 2022

CY 2024 Service Capacity Assessment Time Period — Utilization

Data Source	Number of Recipients	Peer Support	Family Support	Supported Employment	Supportive Housing	ACT
Service Utilization Data	40,425	28%	4%	26%	15%	5.2%[2]

CY 2023 Service Capacity Assessment Time Period — Utilization

Data Source	Number of Recipients	Peer Support	Family Support	Supported Employment	Supportive Housing	ACT
Service Utilization Data	39,046	29%	3%	26%	14%	5.3%

CY 2022 Service Capacity Assessment Time Period — Utilization

Data Source	Number of Recipients	Peer Support	Family Support	Supported Employment	Supportive Housing	ACT
Service Utilization Data	37,107	31%	3%	30%	17%	5.7%

[1] Calendar year (CY) referenced in this context refers to the period October 1, 2023 through December 31, 2024.

[2] ACT services were not included as part of the service utilization file, but based on the current ACT roster, 5.2% of all active SMI recipients are assigned to ACT teams.

Opportunities to improve the identification of need, access to the priority mental health services, and sufficiency of the system to meet the needs of people with SMI, as well as system strengths, are noted below.

Consumer-Operated Services (Peer Support and Family Support)

Twenty-eight percent (28%) of all members living with a SMI received at least one unit of peer support from October 1, 2023, through December 31, 2024; a slight decrease from the prior review period, in which 29% of members received peer support services. During CY 2024, members accessed 96,516 fewer units of peer support than in CY 2023. In addition, 70 fewer recipients received peer support during this period, continuing a downward trend over the past three years. It appears that the reduction in peer support utilization between CY 2023 and CY 2024 is partially due to Arizona Health Care Cost Containment System's suspension of multiple service providers following credible allegations of inappropriate billing practices.

Peer support specialists are available within the health home clinics, through multi-disciplinary teams providing ACT team services, via participation in an expansive array of clinic-based education and support groups, and/or within the community by attending available consumer-operated peer support programs. Most members access peer support services via groups rather than individual 1:1 peer support.

Service utilization data demonstrates that 4% of members received at least one unit of family support services during 2024, one percentage point higher than last year. In addition, 425 more members received family support services during CY 2024 than CY 2023. Over the past three years, there has been an 88% increase in the volume of family support units, although utilization of the service remains minimal.

Family support utilization is significantly lower than the other priority mental health services. Several factors influence the utilization of family support services, including estranged family members, members' preferences not to have family involved in their treatment, and the health home staff's lack of familiarity regarding the potential benefits of the service, as well as failing to recognize circumstances in which to offer the service. In addition, Mercer's service capacity assessment suggests that there may be opportunities to expand the volume of providers who can deliver the service.

Supported Employment

Per the Centers for Medicare and Medicaid Services, "employment is a fundamental part of life for people with and without disabilities, provides a sense of purpose and how individuals contribute to their community, and it is associated with positive physical and mental health benefits. Meaningful work is part of building a healthy lifestyle as a contributing member of society and is essential to individuals' economic self-sufficiency, self-esteem, and well-being. All individuals, regardless of disability and age, can work and have

access to pre-vocational services, education, and training opportunities that build on strengths and interests, individually tailored and preference-based career planning, job development, job training, and job support, which recognize each person's employability and potential contributions to the labor market."[3]

Service utilization data demonstrates that 26% of members received at least one unit of supported employment during CY 2024, the same finding as last year. Fourteen more members received supported employment when comparing CY 2024 to CY 2023. However, there was a reduction of 151,959 units of the service delivered during this same period.

Provider focus group participants perceive that there is adequate capacity for community-based supported employment providers, stating that community employment specialists reach out within 24 hours of a referral, and services can start in about a week. Eighty-six percent (86%) of the survey respondents report that supported employment services can be accessed within 30 days of the identification of the service need. This compares to 69% during CY 2023.

There appears to be sufficient capacity for supported employment services, with six contracted supported employment providers offering 29 service locations and co-located at 18 health homes throughout Maricopa County. In addition, co-located vocational rehabilitation (VR) counselors continue to be available on a part-time basis at most health homes, and each serves multiple clinics. Providers reported high turnover among VR counselors and attributed this to "insufficient support, lack of training, and overwhelming caseloads". The provider focus group participants shared that some VR counselors reach out to health home rehabilitation specialists for guidance and resources and, in some cases, may need clarification regarding how each role interacts with the member to provide supported employment services and support.

Supportive Housing

Service utilization data reveals that 15% of members received at least one unit of supportive housing during the review period, slightly more when compared to last year (14%). There were 462 more members who received supportive housing between CY 2024 and CY 2023. In addition, there was an increase of 82,210 supportive housing units during this same period[4].

Permanent supportive housing providers share there are immediate openings available to members but report that some case managers appear unaware of the availability of supportive housing services. Case manager focus group participants confirm a lack of awareness regarding available permanent supportive housing providers in the community, opting to refer members to the assigned housing specialist at the health home or attempt to assist the member directly.

[3] Centers for Medicare and Medicaid Services, Medicaid Employment Initiatives | Medicaid

[4] Increases in supportive housing services reflect wrap-around services, not increases in housing subsidies or vouchers.

Previously, case manager focus group participants reported ongoing challenges in working with Arizona Health Care Cost Containment Services' contracted housing administrator. Although the referral process was reported to be easy to navigate, participants found it challenging to obtain any information or speak to a live person following the submission of a referral. This year, case manager focus group participants reported improvements in the process and that the housing administrator now has a point of contact that promptly responds to inquiries and questions.

Assertive Community Treatment

As a percentage of the total population with SMI, 5.2% of all members are assigned to an ACT team. There are 45 more members assigned to an ACT team when comparing CY 2024 to CY 2023. There has been a slight reduction of 12 ACT team members between CY 2024 and CY 2022.

Case manager focus group participants shared positive impressions of ACT, stating the service is "tailored more to each member," and they can "actually get to know a person" because they spend more time with each member. The case managers report that the success of ACT depends on management and how well the team implements the evidence-based model of ACT.

CY 2024 service utilization profiles for 2,078 ACT team members[5] who received a behavioral health service were analyzed. The analysis sought to identify the utilization of one or more priority mental health services (supported employment, supportive housing, peer support services, and/or family support services).

The analysis found:

- Sixty-eight percent (68%) of the ACT team members received peer support services during the review period.
- Twelve percent (12%) of the ACT team members received family support services.
- Fifty percent (50%) of ACT recipients received supported employment services.
- Forty-six percent (46%) of ACT recipients received supportive housing services.

Members assigned to ACT teams receive the priority services at a higher percentage than members assigned to supportive and connective levels of case management.

[55] This number of ACT team members differs from the total number of members assigned to ACT because not all ACT team members could be identified in the administrative claims data file.

General Findings and Recommendations

Mercer noted additional findings and recommendations to improve the appropriate identification and the provision of priority mental health services to members who may benefit from the services. Opportunities identified this year include:

- An in-depth medical record review activity included a case in which an intake specialist contacted health home team members to establish services to meet members' identified needs. This proactive approach appears to be a best practice to help ensure members are referred to and connected with service providers following the identification of needs. Mercer continues to observe case records in which the clinical teams do not follow up with initiating referrals for needed services after completing a member's service plan.
- When compiling the sample for medical record reviews, 6% of the cases (from a sample of 200) did not include current assessments or individual service plans, an improvement from last year, when 14% of the sample lacked current documentation.
- Focus group participants perceive that case managers lack familiarity with the priority mental health services and may need additional training and education to assist members with accessing the services.
- Multiple sources identified concerns with the reliability of the managed care contractor's non-emergency transportation provider. There were accounts of transportation not showing up to transport members to scheduled appointments, including meetings with case managers and providers to access the priority mental health services.

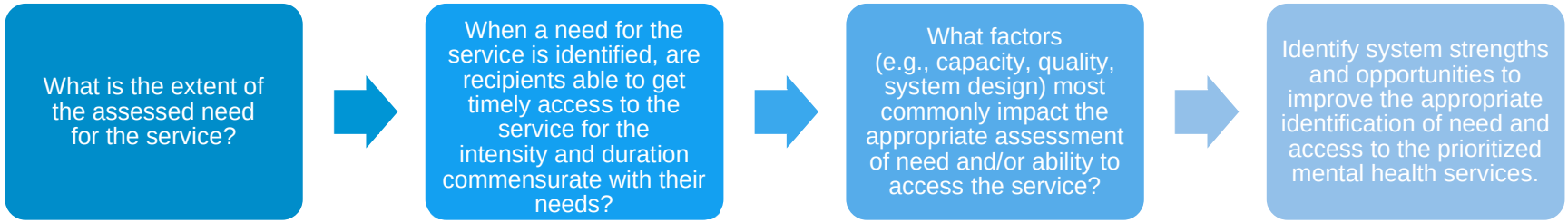
Additional and more detailed findings and recommendations for each of the priority services can be found in *Section 5, Findings and Recommendations.*

Section 2
Overview

The Arizona Health Care Cost Containment System (AHCCCS) (hereafter referred to as Arizona or State) retained Mercer Government Human Services Consulting (Mercer) to implement an annual network sufficiency evaluation of four prioritized mental health services available to persons determined to have a serious mental illness (SMI).[6] The service capacity assessment included a need and allocation evaluation of consumer-operated services (peer support services and family support services), supported employment, supportive housing, and assertive community treatment (ACT).

Goals and Objectives of Analyses

The primary objectives of the service capacity assessment were designed to answer the following questions regarding prioritized mental health services. For each of the prioritized services:



Limitations and Conditions

Mercer did not independently verify the accuracy and completeness of service utilization data, outcomes data, and other primary source information collected from AHCCCS and AHCCCS' contracted managed care organizations. Service utilization data includes encounter submission lag times that are known to impact the completeness of the data set, although some units of analysis were

[6] The determination of SMI requires both a qualifying SMI diagnosis and functional impairment as a result of the qualifying diagnosis.

adjusted to accommodate potential claims run-out limitations. Mercer performed an analysis of summary-level service utilization data related to the prioritized mental health services and aggregated available functional and clinical outcomes data.

Section 3

Background

AHCCCS serves as the single Arizona authority to provide coordination, planning, administration, regulation, and monitoring of all facets of the State public behavioral health system. AHCCCS contracts with managed care organizations to administer integrated physical health and behavioral health services throughout the state. AHCCCS administers and oversees the full spectrum of covered services to support integration efforts at the health plan, provider, and member levels.

History of *Arnold v. Sarn*

In 1981, a class action lawsuit was filed alleging that the State, through the Arizona Department of Health Services and Maricopa County, did not adequately fund a comprehensive mental health system as required by State statute. The lawsuit, referred to as *Arnold v. Sarn*, sought to enforce the community mental health treatment system on behalf of persons with SMI in Maricopa County.

On May 17, 2012, former Arizona Governor Jan Brewer, State health officials, and plaintiffs' attorneys announced a two-year agreement that included funding for recovery-oriented services, including supported employment, living skills training, supportive housing, case management, and expansion of organizations run by and for people living with SMI. The two-year agreement included activities aimed at assessing the quality of services provided, member outcomes, and overall network sufficiency.

On January 8, 2014, a final agreement was reached in the *Arnold v. Sarn* case. The final settlement extends access to community-based services and programs agreed upon by the State and plaintiffs, including crisis services, supported employment and supportive housing services, ACT, family and peer support, living skills training, and respite care services. The State was required to adopt national quality standards outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA), as well as annual quality service reviews conducted by an independent contractor, and an independent service capacity assessment, to evaluate the delivery of care to persons with SMI.

Service Delivery System

AHCCCS contracts with managed care organizations to deliver integrated physical health and behavioral health services in three geographic service areas (GSAs) across Arizona. Each contractor (also known as a managed care contractor) must manage a network of providers to deliver all covered physical health and behavioral health services to Medicaid-eligible persons living with a

SMI. The managed care organizations contract with behavioral health providers to provide the full array of covered physical health and behavioral health services, including the prioritized mental health services that are the focus of this assessment. In addition to Medicaid-eligible members, system administrators must ensure that all medically necessary, covered behavioral health services are available to enrolled adult individuals (i.e., non-Title XIX) who meet established criteria for persons living with a SMI.

For persons living with a SMI designation in Maricopa County, the designated managed care organization has contracts with multiple administrative entities that manage ACT teams and/or operate health homes throughout the GSA. Table 2 below identifies the administrative entities and assigned health homes.

Table 2 — Maricopa County Health Homes

Provider	Health Home
Alium	Shea Boulevard
Center for Health and Recovery	Heatherbrae
Chicano Por La Causa	Centro Esperanza
Community 43	16th Street
Community Bridges, Inc.	Mesa Heritage
Community Partners Integrated Healthcare, Inc.	Osborn
Copa Health	Arrowhead Campus East Valley Campus Gateway Campus Hassayampa Campus Metro Campus West Valley Campus
Horizon Health and Wellness	Plaza Queen Creek
Intensive Treatment Systems	West Clinic Access Point

Provider	Health Home
Jewish Family and Children Services	Michael R. Zent Healthcare Clinic East Valley Health Center
La Frontera/EMPACT	Apache Junction Comunidad San Tan
Resilient Health	Higley 1st Street
Southwest Behavioral and Health Services	Buckeye Outpatient Metro Outpatient
Southwest Network	Estrella Vista Northern Star Saguaro San Tan
Spectrum	Anywhere Care
Terros	Desert Cove 23rd Avenue 51st Avenue Mitchell Priest Oak South Mountain
Valle Del Sol	Red Mountain
Valleywise	First Episode Center Mesa Behavioral Health Specialty Clinic

Section 4

Service Capacity

The information presented below reflects the contracted capacity for each of the prioritized services during the period under review:[7]

Table 3: Consumer-Operated Services (Peer Support and Family Support)

Number of Unique Providers	Number of Provider Locations	Contracted Capacity
37	75	1,880 (multiple providers are not contracted for specific capacity)

Table 4: Supported Employment

Number of Unique Providers	Number of Provider Locations	Co-Located Health Homes	Contracted Capacity
6	29	18	305 (four providers are not contracted for specific capacity)

Table 5: Supportive Housing (Scattered Site and Community-Based Permanent Supportive Housing)

Number of Unique Providers	Number of Provider Locations	Contracted Capacity
10	10	835 (five providers are not contracted for specific capacity)

Table 5a: Supportive Housing (Temporary Housing Assistance Program)

Number of Unique Providers	Number of Provider Locations	Contracted Capacity
2	2	150 (one of the providers is not contracted for specific capacity)

[7] As reported by the Maricopa County Regional Behavioral Health Authority administering the AHCCCS contract in December 2024. Additional capacity exists across the system of care for most of the prioritized mental health services and is not reflected as contracted capacity.

Table 6: ACT Teams (24 teams serving 2,105 recipients)[8][9]

Health Home Clinic	Specialty	Capacity	Number of Recipients	Percent Below Full Capacity
Community Bridges: 99th Avenue	Primary care provider (PCP) partnership	100	82	18%
Community Bridges: Avondale	PCP partnership	100	86	14%
Community Bridges: Forensic Assertive Community Treatment (FACT) Team 1	Forensic team and PCP partnership	100	76	24%
Community Bridges: FACT Team 2	Forensic team and PCP partnership	100	71	29%
Community Bridges: Mesa Heritage	PCP partnership	100	85	15%
Copa Health: Gateway	PCP partnership	100	91	9%
Copa Health: Metro Campus — Omega Team	PCP partnership	100	93	7%
Copa Health: Metro Campus — Varsity Team	PCP partnership	100	96	4%
Copa Health: MACT	Medical team	100	83	17%
Copa Health: West Valley Campus	PCP partnership	100	95	5%
La Frontera/EMPACT: Tempe	PCP partnership	100	99	1%
La Frontera/EMPACT: Capitol Center	PCP partnership	100	93	7%
La Frontera/EMPACT: Comunidad	PCP partnership	100	98	2%
Southwest Network: Northern Star	PCP partnership	100	97	3%
Southwest Network: Saguaro	PCP partnership	100	89	11%
Southwest Network: San Tan	PCP partnership	100	89	11%

[8] As of December 1, 2024.

[9] ACT team capacity presented above may exclude ACT team participants if those members are assigned to managed care contractors that do not administer the Regional Behavioral Health Agreement and/or are assigned to the American Indian Health Plan.

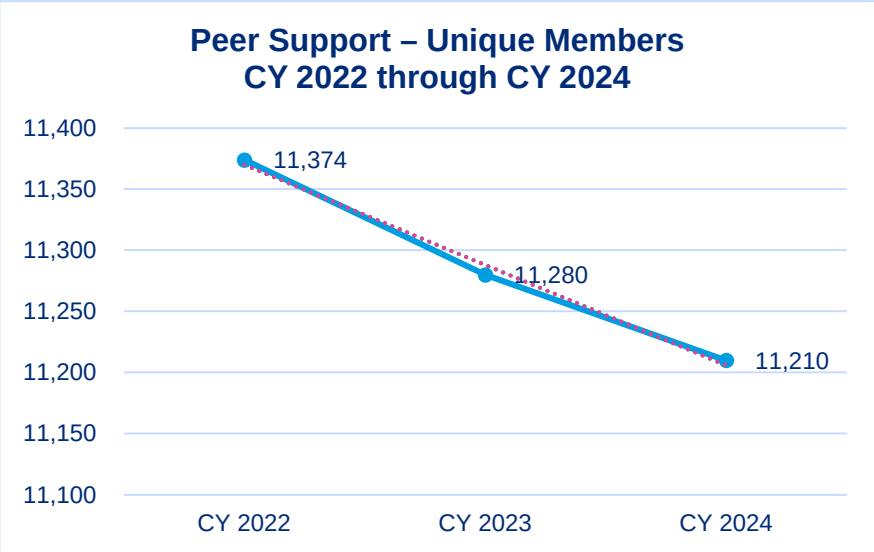
Health Home Clinic	Specialty	Capacity	Number of Recipients	Percent Below Full Capacity
Terros: 51st Avenue	PCP partnership	100	97	3%
Terros: Priest	None	100	91	9%
Terros: 23rd Avenue Team 1	PCP partnership	100	96	4%
Terros: 23rd Avenue Team 2	PCP partnership	100	97	3%
Terros/Lifewell: Desert Cove	PCP partnership	100	92	8%
Terros/Lifewell: South Mountain	PCP partnership	100	96	4%
Valleywise: Mesa Riverview	PCP partnership	100	88	12%
Valleywise: Maryvale ACT/FACT	Forensic team and PCP partnership	100	25	75%
Totals		**2,400**	**2,105**	**12%**

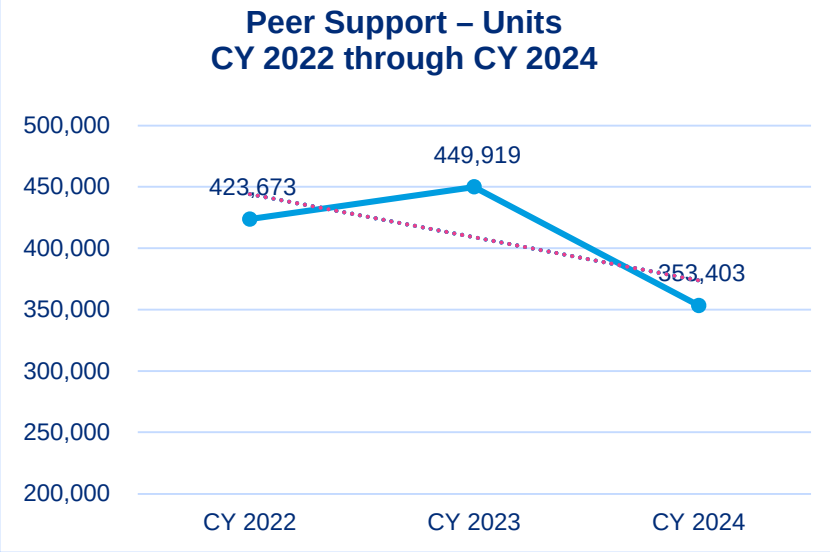
Service Utilization

Service utilization data is presented below to identify the volume of units and unique members affiliated with each priority mental health service over the most recent three years.

Table 7: Peer Support

CY 2022		CY 2023		CY 2024	
Members	Units	Members	Units	Members	Units
11,374	423,673	11,280	449,919	11,210	353,403

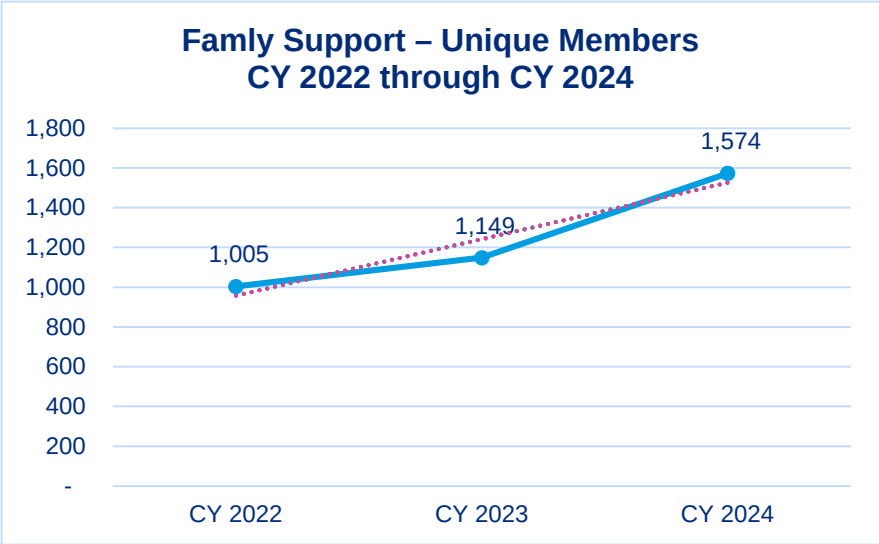


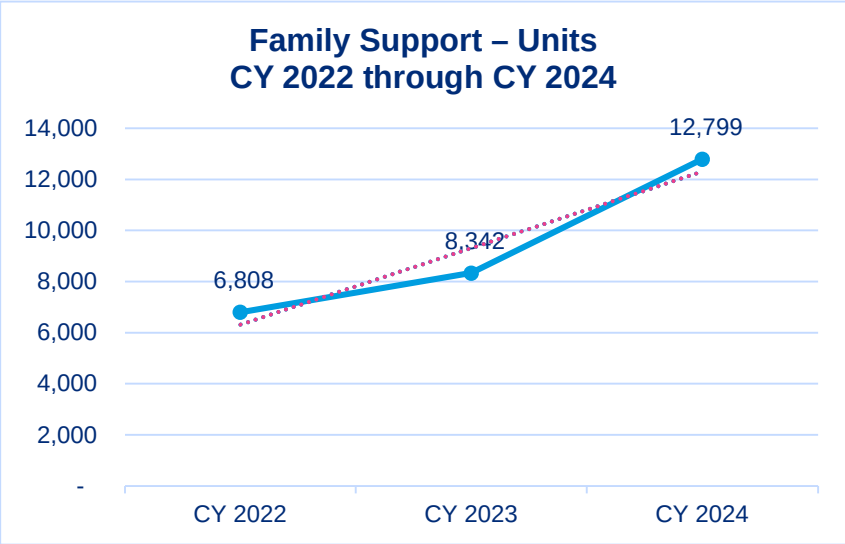


There were 96,516 less units of peer support delivered in CY 2024 when compared to CY 2023. In addition, 70 less recipients received peer support during this same period, continuing a downward trend over the past three years.

Table 8: Family Support

CY 2022		CY 2023		CY 2024	
Members	Units	Members	Units	Members	Units
1,005	6,808	1,149	8,342	1,574	12,799

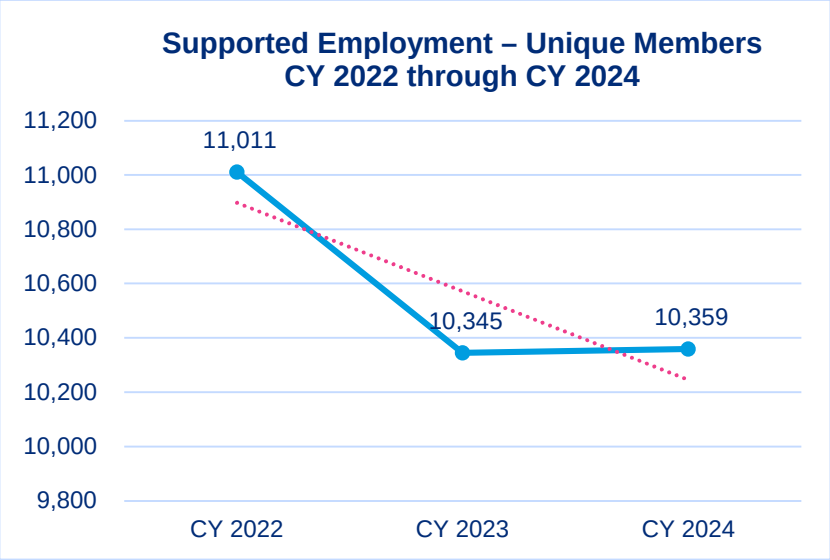


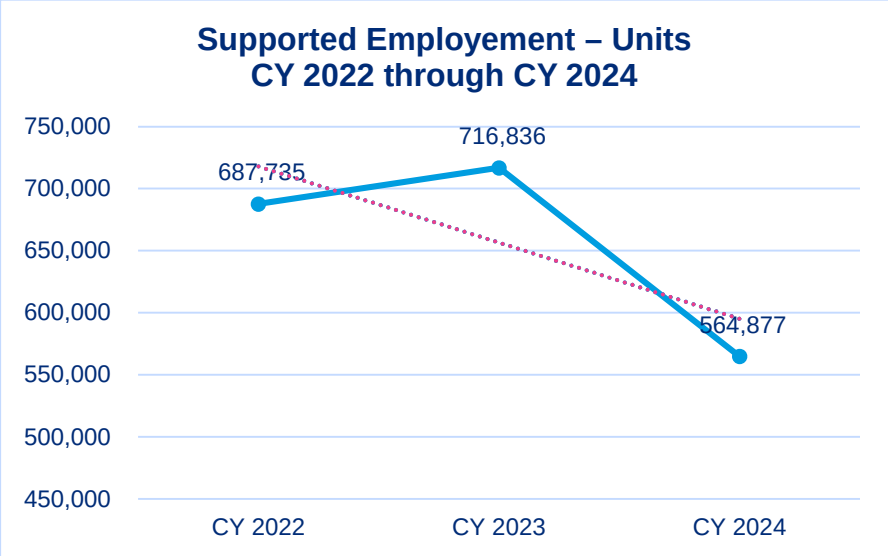


During CY 2024, there were 425 more members who received family support services when compared to CY 2023. Over the past three years, there is an 88% increase in the volume of family support units.

Table 9: Supported Employment

CY 2022		CY 2023		CY 2024	
Members	Units	Members	Units	Members	Units
11,011	687,735	10,345	716,836	10,359	564,877



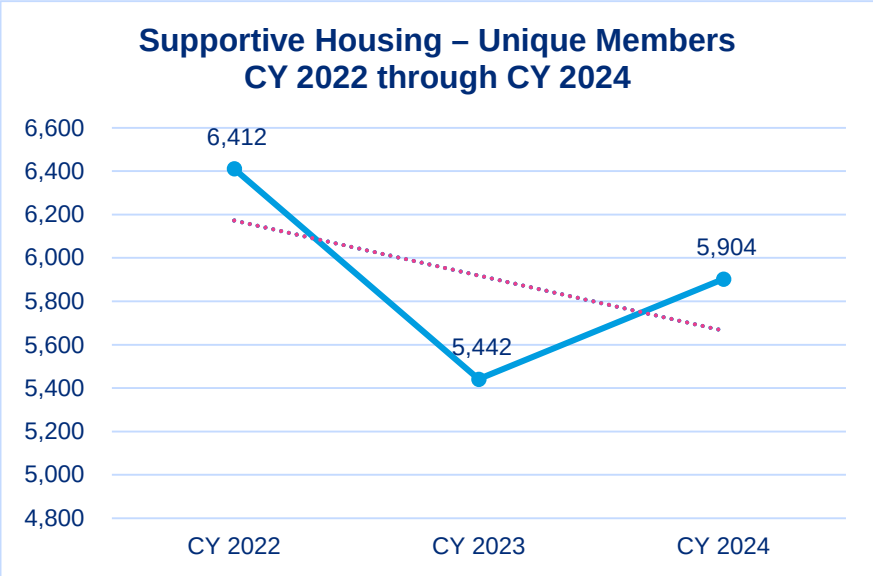


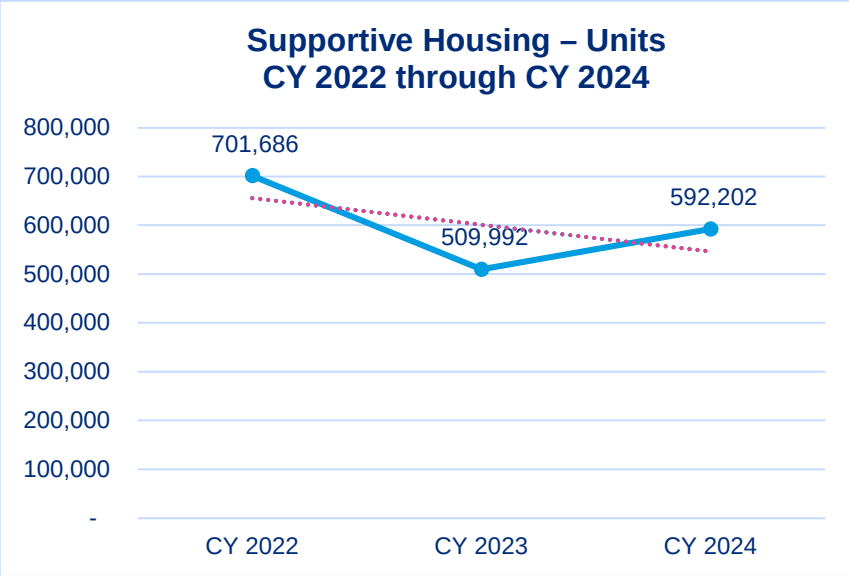
Fourteen more members received supported employment when comparing CY 2024 to CY 2023. However, there was a reduction of 151,959 units of the service delivered during this same period.

Table 10: Supportive Housing[10]

[10] Mercer queried the following codes to delineate supportive housing service utilization when provided by a contracted supportive housing provider: H0043 (Supportive Housing), H2014 (Skills Training and Development), H2017 (Psychosocial Rehabilitation Services), and T1019 and T1020 (Personal Care Services).

CY 2022		CY 2023		CY 2024	
Members	Units	Members	Units	Members	Units
6,412	701.686	5,442	509,992	5,904	592,202

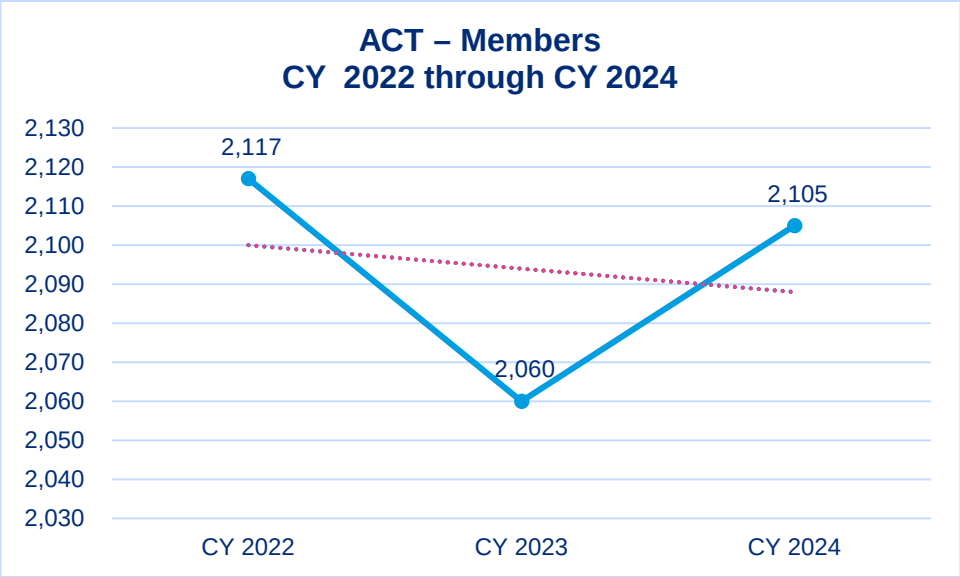




Between CY 2024 and CY 2023, there were 462 more members who received supportive housing. In addition, there was an increase of 82,210 supportive housing units during this same period.

Table 11: ACT Services

CY 2022	CY 2023	CY 2024
Members	Members	Members
2,117	2,060	2,105



There are 45 more members assigned to an ACT team when comparing CY 2024 to CY 2023. There has been a slight reduction of 12 ACT team members between CY 2024 and CY 2022.

Methodology

Mercer uses the following methods to perform a service capacity assessment of the priority mental health services:

- **Key informant surveys, interviews, and focus groups*:*** The analysis includes surveys and interviews with key informants and focus groups with members, family members, case managers, and providers.
- **Medical record reviews:** Mercer identifies a random sample (n=200) of class members to support an in-depth analysis of clinical assessments, individual service plans (ISPs), and progress notes. The review also examines each recipient's assessed needs and the timeliness of accessing the priority mental health services.
- **Analysis of service utilization data and contracted capacity for each priority mental health service:** The analysis evaluates the volume of unique users, billing units, and rendering providers for select priority mental health services identified via administrative claims data. In addition to the percentage of recipients who received one or more of the prioritized services, Mercer completes an analysis to estimate "persistence" in treatment. The persistence calculation includes the proportion of recipients who received a priority service during a single month as well as progressive time intervals (i.e., two to three months, three to four months, five to six months, seven to eight months, and nine months or longer) to determine the percentage of recipients who sustained consistent participation in the prioritized services during the review period.
- **Analysis of outcomes data:** Mercer analyzes outcome data for persons living with SMI, including employment status, criminal justice involvement, grievance data, and emergency room utilization.
- **Benchmark *analysis:*** The analysis evaluates priority mental health service prevalence and penetration rates in other states and local systems that represent relevant comparisons to Maricopa County.

A description of the methodology used for each evaluation component is presented below.

Focus Groups

As part of the service capacity assessment of the priority behavioral health services in Maricopa County, four focus groups were conducted with key informants. The focus groups were organized and managed to facilitate discussions with participants who have direct experience with the priority mental health services.

Participation in the focus groups was solicited by an invitation created by Mercer, which was reviewed and approved by AHCCCS.[11]

Notification of the annual service capacity assessment focus groups was communicated to key stakeholders in the community. This included email communications and electronic invitations sent to the administrative entities, providers of the priority mental health services, and to family and peer-run organizations. Mercer distributed the invitation multiple times to each set of key stakeholders to increase participant registration rates.

The focus groups targeted the following participants:

- Providers of supportive housing services, supported employment services, ACT team services, and peer and family support services
- Family members of adults with SMI and receiving behavioral health services
- Adults with SMI and receiving behavioral health services
- Health home clinic case managers

A total of 31 stakeholders participated in the four two-hour focus groups conducted on January 27, 2025, and January 28, 2025. All four focus groups were held in-person at the Burton Barr Library in Central Phoenix, Arizona. Invitations to voluntarily participate in the focus groups were distributed to a defined list of stakeholders, and the actual number of participants does not represent a statistically significant sample. As such, focus group results should be reviewed in the context of qualitative and supplemental data and should not be interpreted to be representative of the total population of potential focus group participants.

The methodology included the following approach:

- Definitions of each of the priority mental health services were communicated to each group of participants at the onset of the focus groups.
- Participants were prompted to discuss experiences related to accessing each of the priority services, including perceived system strengths and barriers.

[11] See Appendix A: Focus Group Invitation.

- Based on findings derived from the prior year's evaluation, participants were asked to share observations regarding any noted system changes, improvements, and/or ongoing and emerging concerns regarding the availability and capacity of the priority mental health services.

Key Informant Surveys and Interviews

One objective of the service capacity assessment was to obtain comprehensive stakeholder feedback regarding the availability of each of the priority mental health services. To meet this objective, a key informant survey was created using Qualtrics®. The survey tool includes questions with rating assignments related to accessing the priority mental health services, including the ease of access and timeliness of access to the services.[12]

The survey distribution approach targeted a defined list of key system stakeholders, and responses to the survey do not represent a statistically significant sample of all potential informants. As such, survey results should be reviewed in the context of qualitative and supplemental data and should not be construed to be representative of the total population of system stakeholders.

The survey was disseminated to key system stakeholders (e.g., service providers, administrators of health homes, etc.) via email, with a hyperlink to the online survey. A total of 18 respondents completed the survey tool.

In addition, targeted interviews were conducted with providers of the targeted services and other community stakeholders to gather information regarding system strengths and potential barriers to accessing the priority mental health services.

Medical Record Reviews

Mercer pulled a random sample of members and evaluated clinical assessments, ISPs, and clinical team progress notes to determine the extent to which needs for priority services were being considered in service planning and being met through service provision. The medical record sample consisted of adults living with SMI who were widely distributed across administrative entities, health home clinics, and levels of case management (i.e., assertive, supportive, and connective).

The final sample included 200 randomly chosen cases stratified by fund source, administrative entity, and clinic, and were selected using the following parameters:

[12] See Appendix B: Key Informant Survey.

- The recipient was identified living with a SMI and received a covered behavioral health service during October 1, 2023, and December 31, 2024.
- The recipient had an assessment and ISP date between January 1, 2024, and November 15, 2024.[13]

The medical record review seeks to answer the following questions regarding the assessment and provision of the priority mental health services:

- Is there evidence that the need for each of the priority mental health services was assessed by the clinical team?
- When assessed as a need, was the priority mental health service(s) identified on the recipient's ISP?
- When identified as a need and listed on the recipient's ISP, is there evidence that the recipient accessed the service, consistent with the prescribed frequency and duration and within a reasonable time?
- If the recipient was unable to access the recommended priority service, what were the reasons the service(s) was not delivered?

Medical record documentation was requested for each recipient identified in the sample. Requested documents included the recipient's current annual assessment update or initial assessment and/or a current psychiatric evaluation, the recipient's current ISP, and all clinical team progress notes following each recipients' assessment date. Accessing current assessments and ISPs has been a longstanding challenge in performing medical record reviews, as the audit methodology requires access to an assessment and ISP within the designated review period. During CY 2024, 6% of the final sample did not include current assessments and/or ISPs, an improvement from 14% during CY 2023.

Three licensed behavioral health professionals reviewed medical record documentation and record results in a data collection tool to complete the medical record audit. As applicable, additional comments may be added to the tool to clarify scoring and findings. Reviewer training, inter-rater reliability testing, and scoring guidelines help to ensure that each reviewer consistently applies the review tool.

[13] Cases for the sample were selected to ensure that sufficient time had elapsed to reasonably expect the delivery of recommended services following the completion of the recipient's assessment and ISP.

Analysis of Service Utilization Data

Mercer initiated a request to AHCCCS for a comprehensive service utilization data file. The service utilization data file includes all adjudicated service encounters for any person designated as SMI and assigned to the Maricopa County GSA, with dates of service between October 1, 2023, and December 31, 2024.

Specific queries identify the utilization of each prioritized mental health service. The analysis evaluates the volume of unique users, billing units, and rendering providers. In addition to the percentage of recipients who received one or more of the prioritized services, Mercer performs an analysis of recipients who sustained consistent participation in each of the prioritized services, including recipients who received the service in a single month versus those who continued participation in the service over consecutive months (i.e., two to three months, three to four months, five to six months, seven to eight months, and nine months).

To examine priority mental health service utilization for members assigned to an ACT team, Mercer reviews each ACT team member's service array and aggregates findings by priority service.

The service utilization data file supports the medical record review sample extraction. It also allows for an analysis of the service utilization profile for each selected recipient and supports an aggregated view of service utilization for the sample group.

Sample characteristics for CY 2022–CY 2024 of the service capacity assessment are illustrated in the following tables and are compared to the characteristics of the total population.

CY 2024 Service Capacity Assessment Time Period — Utilization

	Number of Recipients	Peer Support	Family Support	Supported Employment	Supportive Housing	ACT
Sample Group	200	35%	1%	38%	22%	7.5%
Service Utilization Data	40,425	28%	4%	26%	15%	5.2%[14]

[14] ACT services were not included as part of the service utilization file, but based on the current ACT roster, 5.2% of all active SMI recipients are assigned to ACT teams.

CY 2023 Service Capacity Assessment Time Period — Utilization

	Number of Recipients	Peer Support	Family Support	Supported Employment	Supportive Housing	ACT
Sample Group	200	37%	1%	27%	22%	7%
Service Utilization Data	39,046	29%	3%	26%	14%	5.3%

CY 2022 Service Capacity Assessment Time Period — Utilization

	Number of Recipients	Peer Support	Family Support	Supported Employment	Supportive Housing	ACT
Sample Group	200	37%	4%	46%	26%	8%
Service Utilization Data	37,107	31%	3%	30%	17%	5.7%[15]

Analysis of Outcomes Data

The service capacity assessment includes an analysis of member outcome data to correlate receipt of one or more of the priority mental health services with improved functional outcomes. Based on the available data, the review team selected the following outcome indicators to support the analysis:

- Employment data
- Criminal justice involvement
- Grievance data
- Emergency room utilization

[15] ACT services were not included as part of the service utilization file, but based on the current ACT roster, 5.7% of all active recipients with SMI are assigned to ACT teams.

Penetration and Prevalence Analysis

As part of the service capacity assessment, a review of utilization and penetration rates of the prioritized mental health services (ACT, supported employment, supportive housing, and peer support[16]) was conducted. Penetration rates were compared to benchmarks, as described below.

The following review process was completed by Mercer:

- Review of select academic publications
- Consultation with national experts regarding the prioritized services and benchmarks for numbers served
- Review of data from SAMHSA on evidence-based practice (EBP) penetration rates at the state and national levels

The intent of reviewing these sources was to identify average and best practice benchmarks for EBP penetration. *Average benchmarks* are drawn from national averages and other sources that do not necessarily represent a best practice level of effort, whereas *best practice benchmarks* are drawn from the highest performing systems in a study.

Please note that data for Maricopa County included in this report generally covers CY 2024. Although Mercer uses the most recent available data for comparison (including CY 2024), comparison states and communities have varying data available. In all cases, the analysis utilizes the most recent data available. In addition, Maricopa County's results are derived from administrative claims data, while many comparison communities present data submitted to SAMSHA, which may only reflect EBP utilization and/or be underreported in some circumstances.

[16] Peer support services are not currently reported on SAMHSA's National Outcome Measures interview tool.

Section 5

Findings and Recommendations

Findings and recommendations associated with each of the priority mental health services are summarized for each evaluation component that comprises the service capacity assessment. Key findings identify how effectively the overall service delivery system is performing to identify and meet member needs through the provision of the priority mental health services.

The service capacity assessment includes the following distinct evaluation components:

- Penetration and prevalence analysis
- Multi-evaluation component analyses of each priority mental health service:
  - Focus groups
  - Key informant survey data
  - Medical record reviews
  - Service utilization data
- Outcomes data analyses

Serious Mental Illness Prevalence and Penetration — Overview of Findings

Service system penetration represents the percentage of people who received services, among the estimated number of people considered eligible for services during a specified period. As detailed in Table 12, the publicly funded system served 16% of the estimated adults living with SMI in Maricopa County in 2024. This penetration rate is lower than the national (publicly funded) penetration rate of 28%; however, it is higher than some statewide rates and is comparable to rates of similar large counties in Texas. Within the Maricopa County Medicaid system, the penetration rate of adults with SMI (55%) exceeds the national average (28%) and the rates of similarly sized regions in Texas (i.e., Harris County [Houston] and Bexar County [San Antonio], which have penetration rates of 19% and 22% respectively). Thus, Maricopa County's lower overall penetration rate appears to result from the low penetration rate among people without Medicaid coverage (5%).

The Maricopa County system's utilization rates excel for certain EBPs. For example, supportive housing and supported employment are more available in Maricopa County (especially for Medicaid recipients) than for people living with SMI nationally. Maricopa County also provides access to peer support services in what could be considered a best practice benchmark. In addition, Maricopa County provides ACT to a greater percentage of the eligible population than most comparison communities included in this analysis. In Maricopa County, ACT teams served 2,105 individuals as of December 1, 2024. A study by ACT researchers estimated that 4.3% of adults with SMI served in a mental health system need an ACT level of care.[17] Few of the identified comparison communities provide ACT to 4.3% or more of their adults living with SMI, whereas 5.2% of adults with SMI residing in Maricopa County received ACT in 2024. Because some people receiving an ACT level of care in Maricopa County receive it from a forensic ACT team (FACT), 5.2% does not represent an overuse of ACT.

Maricopa County has 24 ACT teams, including specialty ACT teams that partner with PCPs, teams that have a specific medical specialty, and forensic teams. Some people in need of ACT-level services also live with chronic (and sometimes acute) physical health conditions. Maricopa County has 23 ACT teams that integrate medical professionals (medical ACT) or partner with PCPs (PCP partnership ACT teams). Three FACT teams serve adults living with SMI who have a history of high utilization of the criminal justice system (these teams include PCP partnerships). This allocation of resources for justice-involved people reflects responsiveness to the stated concerns of many system stakeholders to address the needs of people living with SMI who have histories of criminal justice system involvement. Maricopa County's array of ACT and FACT offerings is more comprehensive compared to those of select large counties nationally included in this analysis.

[17] Cuddeback, G. S., Morrissey, J. P., Meyer, P. S. (2006). How many assertive community treatment teams do we need? *Psychiatric Services, 57*, 1803–1806. The estimate of 4.3% was based on findings from an analysis of data of the services for people living with SMI in Portland, Oregon.

Table 12 — Service System Penetration Rates for Individuals with SMI

Region	Adult Population (≥ 18 Years Old)[18]	Estimated Rate of SMI in the Adult Population[19]	Estimated Number of Adults with SMI in the Population[20]	Number of Adults with SMI Served[21]	Penetration Rate Among Adults with SMI[22]
United States	266,978,268	5.8%	15,567,473	4,357,017	28%
Arizona:	5,994,209	7.2%	432,073	180,504	42%
Maricopa County:[23]	3,572,375	7.2%	257,503	40,425	16%
Adults with Medicaid	618,862	8.8%	54,460	29,987	55%
Non-Medicaid Adults	2,953,513	5.3%	224,417	10,438	5%
Texas:	23,625,608	4.9%	1,159,312	330,701	29%
Harris County (Houston)	3,595,915	4.9%	176,452	33,220	19%
Bexar County (San Antonio)	1,577,040	4.9%	77,386	16,862	22%
New York:	15,884,969	5.2%	820.610	551,763	67%
New York City[24]	6,776,005	5.2%	350,045	237,185	68%

[18] All state-level population estimates are based on the US Census Bureau, Population Division. *Estimates of the total resident population and resident population age 18 years and older for the United States, states, and Puerto Rico: July 1, 2023*.

[19] National and state-level SMI estimates: Substance Abuse and Mental Health Services Administration. (2023). *2021–2022 National Survey on Drug Use and Health: Model-based prevalence estimates (50 states and the District of Columbia)*. https://www.samhsa.gov/data/report/2021-2022-nsduh-state-prevalence-estimates

County-level SMI estimates: Substance Abuse and Mental Health Services Administration. (2022). *2016–2018 NSDUH substate region estimates – tables.* https://www.samhsa.gov/data/report/2016-2018-nsduh-substate-region-estimates-tables

[20] The estimated number of adults with SMI is calculated by multiplying the estimated rate of SMI in the adult population by the adult population in the region or state.

[21] The national and state-level percentages of people with SMI served were obtained from the Substance Abuse and Mental Health Services Administration. (2024). *2022 Uniform Reporting System (URS) output tables*. https://www.samhsa.gov/data/report/2022-uniform-reporting-system-urs-output-tables

[22] The penetration rate of people with SMI served among those with SMI in the community is calculated by dividing the number of adults with SMI served within the system (for states, see calculation note above) by the estimated number of adults with SMI in the adult population.

[23] The number of people with SMI served in Maricopa County is based on Arizona Health Care Cost Containment System's 2023 service utilization data file.

[24] Utilization data was obtained by personal communication with Marleen Radigan, Dr.PH, MPH, MS, Research Scientist VI and Director in the Office of Performance Measurement and Evaluation within the New York State Office of Mental Health, May 2019. No update is available since the COVID-19 pandemic began in 2020.

Region	Adult Population (≥ 18 Years Old)[18]	Estimated Rate of SMI in the Adult Population[19]	Estimated Number of Adults with SMI in the Population[20]	Number of Adults with SMI Served[21]	Penetration Rate Among Adults with SMI[22]
Colorado:	4,744,328	7.1%	337,943	67,646	20%
Denver City/County [25]	589,711	7.1%	42,006	19,704	47%
Nebraska	1,521,153	6.9%	104,649	9,469	9%
California	31,012,711	4.9%	1,511,093	411,458	27%
Illinois	10,012,697	5.1%	510,518	16,185	3%
Kansas	2,278,027	6.1%	140,083	9,648	7%
Minnesota	4,494,094	5.8%	262,417	182,731	70%
Wisconsin	4,719,976	6.5%	307,373	31,990	10%
Tennessee	5,645,233	7.6%	430,132	213,232	50%
Indiana	5,338,189	6.3%	334,027	87,740	26%
Delaware	838,204	5.5%	46,285	7,687	17%
New Hampshire	1,159,668	7.2%	83,755	16,922	20%
North Carolina	8,685,722	5.4%	467,434	60,192	13%
Washington:	6,303,143	7.4%	466,774	169,669	36%
King County[26]	1,836,529	7.4%	136,003	49,595[27]	36%

[25] Data is from MHCD, the largest community-based provider of services to people with SMI in Denver, Colorado. Personal communication with Clinical/Administrative Director, Kim Foust, and her staff at MHCD, April 25, 2025.

[26] Utilization data was obtained by personal communication with Christopher Mitchel, PPM II _ Diversion and Reentry at the Behavioral Health Recovery Division within King County Behavioral Health Recovery Division, April, 2024.

[27] Estimated using US Census Population Table B01003: Total Population and URS 2023 Reporting Tables for Washington.

Overview of EBP Utilization Benchmark Analyses

Table 13 — EBP Utilization Rates Among People with SMI Who Were Served in the System[28]

Region	ACT		Supported Employment		Supportive Housing	
	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
United States	86,467	2.0%	77,190	1.8%	107,274	2.5%
Arizona:	2,783	1.5%	16,366	9.1%	1,144	0.6%
Maricopa County (2024)[29, 30]	2,105	5.2%	10,359	25.6%	5,904	14.6%
Maricopa County — Medicaid	1,609	5.4%	7,881	26.3%	4,700	15.7%
Maricopa Co. — non-Medicaid	496	4.8%	2,478	23.7%	1,204	11.5%
Maricopa County (Supported Employment Ongoing)[31]	N/A	N/A	2,336	5.8%	Not Available	Not Available
Texas:	7,683	2.3%	4,622	1.4%	7,202	2.2%
Harris County (Houston)	1,134	3.4%	3,613	10.9%	1,380	4.2%
Bexar County (San Antonio)	141	0.8%	494	2.9%	2,743	16.3%
New York:	7,966	1.4%	700	0.1%	26,432	4.8%
New York City[32]	3,850	1.1%	Not Available	Not Available	Not Available	Not Available

[28] National and state-level data on the number of people using EBPs was obtained from SAMHSA. (2024). *2022 Uniform Reporting System (URS) output tables*. https://www.samhsa.gov/data/report/2022-uniform-reporting-system-urs-output-tables

[29] Supported employment services in Maricopa County are associated with seven billing codes: H2025, H2025 HQ, H2025 SE, H2026, H2027, H2027 HQ, and H2027 SE. Codes H2025 through H2026 are labeled as ongoing support to maintain employment. H2027, H2027 HQ, and H2027 SE are labeled as psychoeducational services (pre-job training and development). For this analysis, Mercer reports both the unduplicated number of people who received any service associated with supported employment and separately those who received "ongoing" supported employment. The ongoing billing codes are most likely to indicate high-fidelity supported employment. Mercer also does not know the extent to which the figures from other regions and states represent actual, evidence-based supported employment.

[30] The number served in Maricopa County with evidence-based services is based on AHCCCS's 2023 service utilization data file.

[31] Ongoing supported employment refers to the employment/vocational services associated with obtaining and maintaining employment and excludes people who only received pre-job training and development services.

[32] We know from a recent New York City hearing that the city has 77 ACT teams, six (6) of which are FACT teams. ((https://citymeetings.nyc/meetings/new-york-city-council/2024-09-23-1000-am-committee-on-mental-health-disabilities-and-addiction/chapter/assertive-community-treatment-act-program-for-serious-mental-illness/)) We also know that most of the most-recently created teams have 68 slots each.

Region	ACT		Supported Employment		Supportive Housing	
	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
Colorado:	11,742	17.4%	1,507	2.2%	Not Available	Not Available
Denver City/County (MHCD)[33]	570	1.4%	404	1.0%	1,667	4.0%
Nebraska	66	0.7%	782	8.3%	856	9.0%
California	11,874	2.9%	3,221	0.8%	3,663	0.9%
Illinois	558	3.4%	3,144	19.4%	Not Available	Not Available
Kansas	Not Available	Not Available	766	7.9%	1,771	18.4%
Minnesota	1,882	1.0%	Not Available	Not Available	1,167	0.6%
Wisconsin	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Tennessee	416	0.2%	1,061	0.5%	950	0.4%
Indiana	991	1.1%	905	1.0%	2,859	3.3%
Delaware	105	1.4%	3	0.0%	20	0.3%
New Hampshire	1,021	6.0%	13,598	80.4%	428	2.5%
North Carolina	3,097	5.1%	Not Available	Not Available	Not Available	Not Available
Washington:	1,540	0.9%	Not Available	Not Available	Not Available	Not Available
King County[34]	375	1%	Not Available	Not Available	Not Available	Not Available

(https://omh.ny.gov/omhweb/transformation/docs/omh-monthly-report-sep-2024.pdf). We therefore conservatively estimated that that the 77 ACT teams functioned like small ACT teams, serving an average of 50 clients per year.

[33] Data are from MHCD, the largest community-based provider of services to people with SMI in Denver, Colorado. Personal communication with Clinical/Administrative Director, Kim Foust, and her staff at MHCD, April 25, 2025.

[34] Utilization data were obtained by personal communication with Christopher Mitchel, PPM II _ Diversion and Reentry at the Behavioral Health Recovery Division within King County Behavioral Health Recovery Division, April, 2024.

Table 13 depicts utilization rates of ACT, supported employment, and supportive housing among adults with SMI served in the Maricopa County behavioral health system. Maricopa County has an ACT utilization rate of 5.2%, which exceeds researchers' best estimate of the percentage of people with SMI who need ACT (4.3%). The county's utilization rates for supportive housing and supported employment services also exceed the national average benchmarks. Maricopa County's supported employment utilization rate of 25.6% and ongoing supported employment utilization rate of 5.8% (considered closer to high-fidelity supported employment than the other supported employment codes) are among the highest in this benchmark analysis. For example, the national utilization rate for supported employment is less than 2%. Given that many people with SMI who are served in the public system are unemployed, supported employment is a vital EBP that is underutilized nationwide. The utilization rate for supportive housing (14.6%) in Maricopa County is also much higher than the national average (2.5%) and the utilization rates of all other regions in the analysis. The availability of supportive housing is essential in preventing chronic homelessness among people living with SMI.

Changes in EBP Utilization from 2013 through 2024

Table 14 compares the utilization of ACT, supported employment, and supportive housing in Maricopa County from 2013 through 2024. The following are highlighted findings of the analysis comparing utilization/penetration rates across those years:

- **ACT:** Between 2013 and 2020, Maricopa County experienced an increase each year in the total number of adults with SMI who received ACT services, consistently achieving penetration rates that ranged from 6.4% to 7.0%, which exceed the benchmark penetration rate for ACT services (4.3%). The ACT penetration rate decreased from 2021 (6.6%) to 2024 (5.2%). However, these decreases do not necessarily represent a decrease in the quality of care, as they indicate a penetration rate closer to the best estimate that Mercer currently has of the percentage of people with SMI served in a publicly funded system who need ACT.
- **Supported Employment*:*** From 2022 to 2024, Maricopa County experienced decreases in the overall penetration rates for supported employment (from 29.7% to 25.6%) and ongoing supported employment (from 6.5% to 5.8%). In 2020, the overall penetration rate for supported employment reached its highest percentage since 2013. The number of individuals who received *ongoing* supported employment during 2020 exceeded 3,200 unique individuals; this decreased to just over 2,400 in 2022 and 2,250 in 2023. However, the penetration rate for ongoing supported employment services in 2024 is more than double the rate in 2013 (5.8% versus 2.5%). Regardless, the penetration rate for supported employment in Maricopa County is high relative to those of most states, yet it is well below the level of need for supported employment, as is true nationally.
- **Supportive Housing*:*** A single supportive housing billing code (H0043) informed the initial years of the penetration rate analysis. Supportive housing providers used this code infrequently. As a result, Mercer could not accurately estimate supportive housing utilization between 2013 and 2014. In recognition that supportive housing services can incorporate many interventions and activities, an additional billing code (H2014: Skills Training and Development) was added in 2016 to capture the provision of

supportive housing services more accurately by contracted supportive housing providers. With the addition of the H2014 code, the supportive housing penetration rate increased from 3.7% in 2015 to 4.6% in 2016 and 6.6% in 2017. The following year (2018), Mercer expanded the analysis to include additional service codes (T1019 and T1020: Personal Care Services; and H2017: Psychosocial Rehabilitation Services) when contracted supportive housing providers rendered the services. As a result, the penetration rate for supportive housing more than doubled to 15.1% in 2018, and the total number of people served with supportive housing also increased significantly. The penetration rate for supportive housing increased substantially between 2019 (14.9%) and 2021 (21.8%) but decreased through 2023 (13.9%, 5,442 served). From 2023 to 2024, the penetration rate increased again to 14.6% (5,904 served).

Table 14 — Maricopa County EBP Utilization Rates Among People with SMI Served in the System: 2013 through 2023

Year	Number of Adults with SMI Served	ACT		Supported Employment (SE)		Supportive Housing	
		Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP[35]	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
Maricopa County (2024)	40,425	2,105	5.2%	10,359	25.6%	5,904	14.6%
SE Ongoing	-	-	-	2,336	5.8%	-	-
Maricopa County (2023)	39,046	2,060	5.3%	10,345	26.5%	5,442	13.9%
SE Ongoing	-	-	-	2,250	5.8%	-	-
Maricopa County (2022)	37,107	2,117	5.7%	11,011	29.7%	6,412	17.3%
SE Ongoing	-	-	-	2,423	6.5%	-	-
Maricopa County (2021)	36,718	2,265	6.2%	11,790	32.1%	7,988	21.8%
SE Ongoing	-	-	-	2,567	7.0%	-	-
Maricopa County (2020)	35,114	2,317	6.6%	11,890	33.8%	7,558	21.5%

[35] For additional information regarding ongoing supported employment, see footnotes 15 and 17.

Year	Number of Adults with SMI Served	ACT		Supported Employment (SE)		Supportive Housing	
		Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP[35]	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
SE Ongoing	-	-	-	3,265	9.2%	-	-
Maricopa County (2019)	34,451	2,278	6.6%	10,615	30.8%	5,149	14.9%
SE Ongoing	-	-	-	2,436	7.1%	-	-
Maricopa County (2018)	34,264	2,241	6.5%	9,861	28.8%	5,160	15.1%
SE Ongoing	-	-	-	2,376	6.9%	-	-
Maricopa County (2017)	31,712	2,233	7.0%	8,168	25.8%	2,098	6.6%
SE Ongoing	-	-	-	1,708	5.4%	-	-
Maricopa County (2016)	30,440	2,093	6.9%	7,930	26.1%	1,408	4.6%
SE Ongoing	-	-	-	1,544	5.1%	-	-
Maricopa County (2015)	24,608	1,693	6.9%	4,230	17.2%	902	3.7%
SE Ongoing	-	-	-	725	3.0%	-	-
Maricopa County (2014)	23,977	1,526	6.4%	5,634	23.4%	793	3.3%
SE Ongoing	-	-	-	657	2.7%	-	-
Maricopa County (2013)	20,291	1,361	6.7%	7,366	36.3%	Not Available	Not Available
SE Ongoing	-	-	-	515	2.5%	-	-

Chart 1 — Maricopa County ACT Utilization Rates: 2013 through 2024

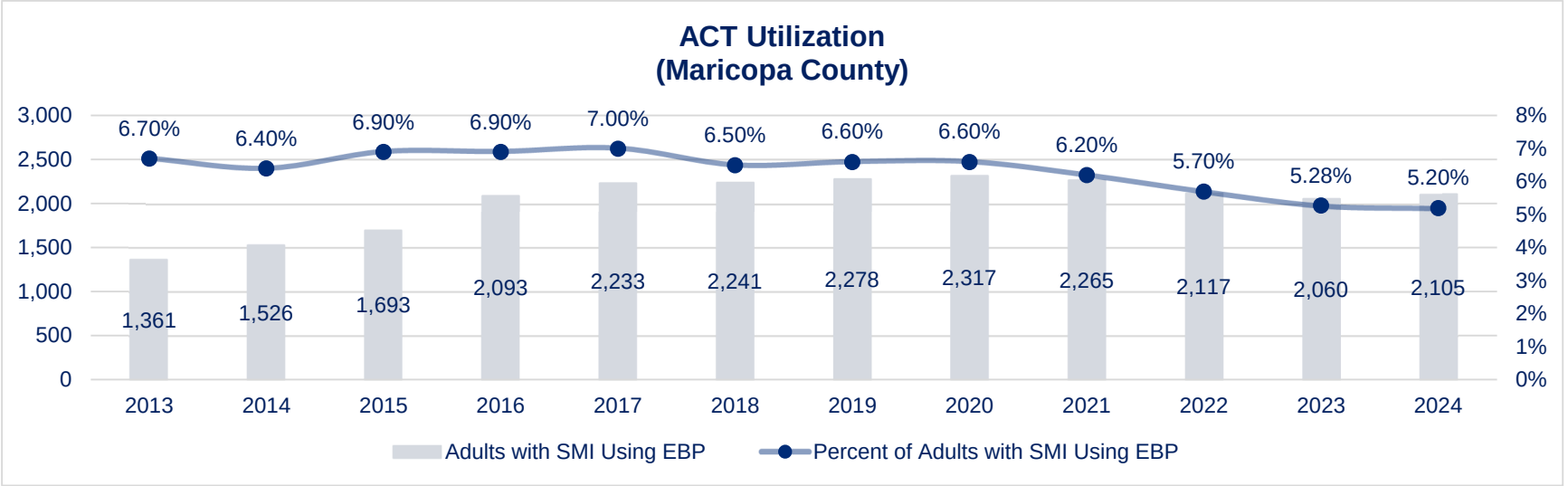


Chart 2 — Maricopa County Supported Employment Utilization Rates: 2013 through 2024

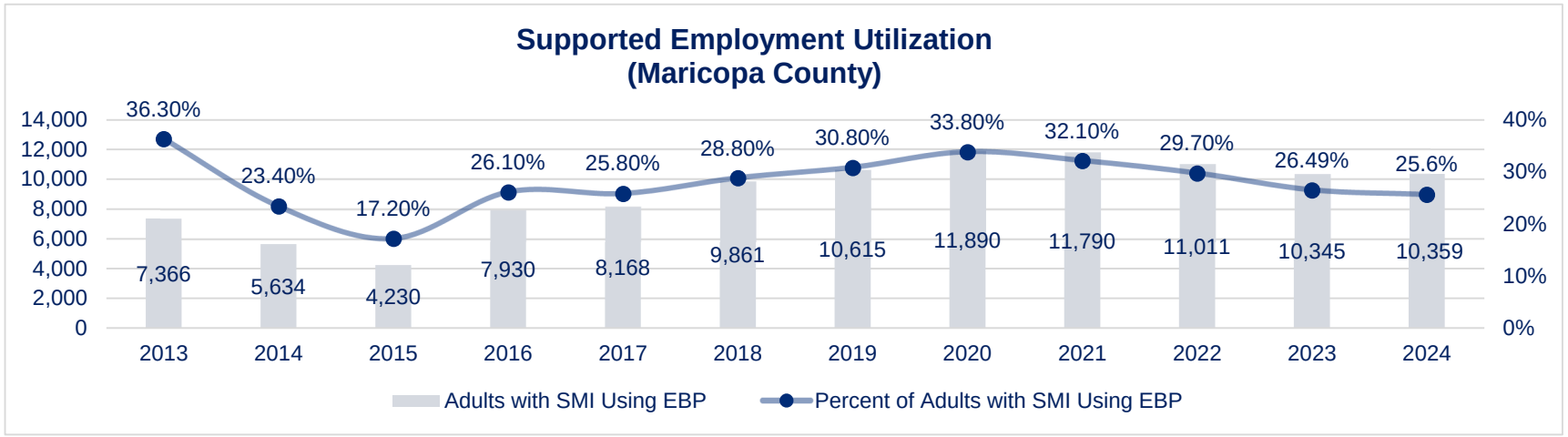


Chart 3 — Maricopa County Ongoing Supported Employment Utilization Rates: 2013 through 2024

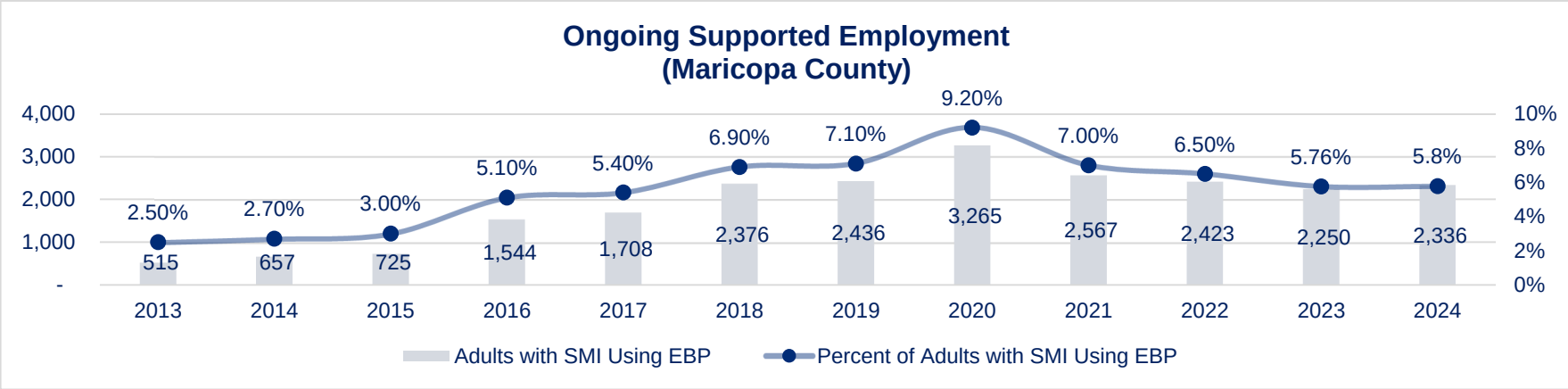
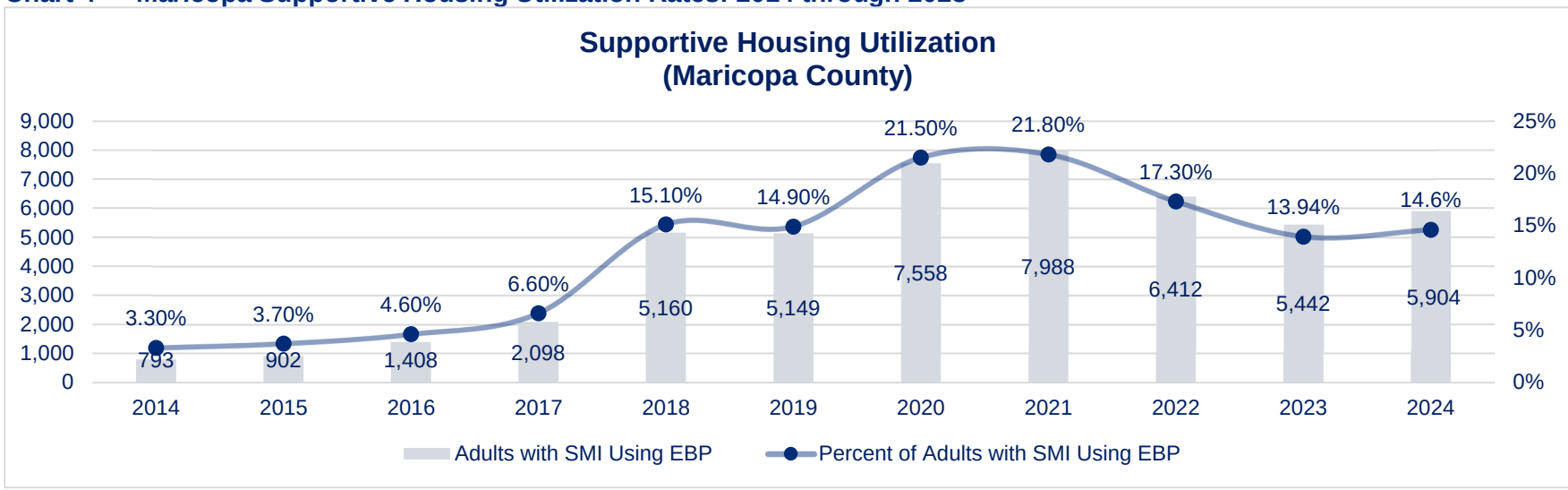


Chart 4 — Maricopa Supportive Housing Utilization Rates: 2014 through 2023



ACT Benchmarks

In an influential 2006 study, Cuddeback, Morrissey, and Meyer estimated that over 12 months, 4.3% of adults with SMI in an urban mental health system needed an ACT level of care. The Maricopa County ACT penetration rate is presented in Table 15 relative to all people with SMI served in the system (as well as relative to the 4.3% estimate provided by Cuddeback, et al.).[36]

Over the years, Maricopa County has made significant strides in bolstering its capacity to offer ACT services to individuals living with a SMI. The ACT penetration rate, standing at 5.2%, surpasses the benchmark set by the Cuddeback, et al. study (4.3%). This rate not only holds up well against those of other communities nationwide but also sets a high standard, particularly when considering that Maricopa County (a) incorporates FACT teams to cater to the needs of adults with SMI who have a history of involvement with the criminal justice system and (b) integrates physical health care into most of its teams.

Table 15 — ACT Utilization Relative to Estimated Need among People with SMI

Region	Number of Adults with SMI Served in Public System	Number of Adults Estimated to Need ACT	Number of Adults Who Received ACT	ACT Penetration	
				Percentage of All Adults with SMI Who Received ACT	Percentage of the Estimated Number in Need of ACT Who Received ACT
Ideal Benchmark[37]	-	-	-	*4.3%*	*100%*
United States	4,357,017	187,352	86,467	2.0%	46%
Arizona:	180,504	7,762	2,783	1.5%	36%
Maricopa Co.	40,425	1,738	2,105	5.2%	121%
Maricopa Co. — Medicaid	29,987	1,289	1,609	5.4%	125%
Maricopa Co. — non-Medicaid	10,438	449	496	4.8%	111%
Texas:	330,701	14,220	7,683	2.3%	54%
Harris County (Houston)	33,220	1,428	1,134	3.4%	79%

[36] Some readers might conclude from this analysis that Maricopa County provides ACT to too many people with SMI, given that its penetration rate of 5.3% exceeds the estimated percentage of people living with SMI needing ACT (4.3%). However, it is important to note that the 4.3% estimate Mercer uses in this analysis was derived from a study conducted in Portland, Oregon almost 20 years ago. That study is the only United States-based study of its kind that Mercer could find that would be pertinent to Maricopa County, and it did use well-accepted criteria concerning the number of psychiatric hospitalizations that would indicate that a given person needs ACT. However, since the Cuddeback et al. study, ACT has been extended to people living with SMI who have recurring involvement in the criminal justice system and who may or may not have enough hospitalizations to qualify for ACT. Maricopa County has extended ACT to these clients, and the overall penetration rate for ACT is likely very close to the actual level of need. A more in-depth study would be needed to verify that conclusion. However, the overall finding is that Maricopa County delivers a robust level of ACT and varying types of ACT to its clients who need that level of care.

[37] Cuddeback, G. S., Morrissey, J. P., Meyer, P. S. (2006). How many assertive community treatment teams do we need? *Psychiatric Services, 57*, 1803–1806.

Region	Number of Adults with SMI Served in Public System	Number of Adults Estimated to Need ACT	Number of Adults Who Received ACT	ACT Penetration	
				Percentage of All Adults with SMI Who Received ACT	Percentage of the Estimated Number in Need of ACT Who Received ACT
Bexar County (San Antonio)	16,862	725	141	0.8%	29%
New York:	551,763	23,726	7,966	1.4%	34%
New York County (New York City)[38]	237,185	10,199	3,850	1.6%	38%
Colorado:	67,646	2,909	11,742	17.4%	404%
Denver County (MHCD)[39]	19,704	847	592	3.0%	70%
Nebraska	9,469	407	66	0.7%	16%
California	411,458	17,693	11,874	2.9%	67%
Illinois	16,185	696	558	3.4%	80%
Minnesota	182,731	7,857	1,882	1.0%	24%
Wisconsin	31,990	1,376	N/A	N/A	N/A
Tennessee	213,232	9,169	416	0.2%	5%
Indiana	87,740	3,773	991	1.1%	26%
Delaware	7,687	331	105	1.4%	32%
New Hampshire	16,922	728	1,021	6.0%	140%
North Carolina	60,192	2,588	3,097	5.1%	120%
Washington:	169,669	7,296	1,540	0.9%	21%
King County[40]	49,595	2,133	393	0.8%	18%

[38] Utilization data was obtained from Marleen Radigan, D.Ph., MPH, MS, Research Scientist VI and Director in the Office of Performance Measurement and Evaluation within the New York State Office of Mental Health. Data reflect 2019 values.

[39] Data are from MHCD, the largest community-based provider of services to people with SMI in Denver, Colorado. Personal communication with Clinical/Administrative Director, Kim Foust, and her staff at MHCD, April 25, 2025.

[40] Utilization data was obtained by personal communication with Christopher Mitchel, PPM II _ Diversion and Reentry at the Behavioral Health Recovery Division within King County Behavioral Health Recovery Division, April, 2024.

Supported Employment Benchmarks

Maricopa County provides aspects of supported employment to a high percentage of those estimated to need this EBP: 25.6% of people with SMI in the public mental health system received at least one vocational assessment or other type of pre-vocational service. However, the best estimate of the percentage of individuals who received high-fidelity supported employment in Maricopa County is the percentage of individuals who received ongoing support to maintain employment (5.8%).

Table 16— Supported Employment Utilization Relative to Estimated Need among People with SMI

Region	Number of Adults with SMI Served in System[41]	Number of Adults in Need of SE[42]	Number of Adults Who Received SE[43]	SE Penetration	
				Percentage Served Among Adults with SMI	Percentage Served Among Adults Estimated to Need SE
Ideal Benchmark	-	-	-	*45.0%*	*100%*
United States	4,357,017	1,960,658	77,190	1.8%	4%
Arizona:[44]	180,504	81,227	16,366	9.1%	20%
Maricopa Co. — Total Served	40,425	18,191	10,359	25.6%	57%
SE Ongoing	40,425	18,191	2,336	5.8%	13%
Maricopa Co. — Medicaid	29,987	13,494	1,492	5.0%	11%
SE Ongoing	29,987	13,494	1,701	5.7%	13%
Maricopa Co. — non-Medicaid	10,438	4,697	2,478	23.7%	53%
SE Ongoing	10,438	4,697	635	6.1%	14%

[41] The number of people with SMI served at the national and state-level was obtained from the Substance Abuse and Mental Health Services Administration. (2024). *2022 Uniform Reporting System (URS) output tables*. Uniform Reporting System (samhsa.gov)

[42] Approximately 90% of people with SMI are unemployed. Consumer preference research suggests approximately 50% desire to work. These two percentages were applied to the estimated SMI population to determine the estimated number of people who need supported employment.

[43] The number of people who received supported employment at the national and state levels was obtained from the Substance Abuse and Mental Health Services Administration. (2024). *2022 Uniform Reporting System (URS) output tables*. Uniform Reporting System (samhsa.gov)

[44] The penetration rates for Arizona are likely comparable to the "total served" (including pre-vocational and assessment services rates for Maricopa County) and not ongoing supported employment penetration rates.

Region	Number of Adults with SMI Served in System[41]	Number of Adults in Need of SE[42]	Number of Adults Who Received SE[43]	SE Penetration	
				Percentage Served Among Adults with SMI	Percentage Served Among Adults Estimated to Need SE
Texas:	330,701	148,815	4,622	1.4%	3%
Harris County (Houston)	33,220	14,949	3,613	10.9%	24%
Bexar County (San Antonio)	16,862	7,588	494	2.9%	7%
New York	551,763	248,293	700	0.1%	0.3%
Colorado:	67,646	30,441	1,507	2.2%	5%
Denver County (MHCD)[45]	19,704	8,867	N/A	N/A	N/A
Nebraska	9,469	4,261	782	8.3%	18%
California	411,458	185,156	3,221	0.8%	1.7%
Illinois	16,185	7,283	3,144	19.4%	43%
Kansas	9,648	4,342	766	7.9%	18%
Wisconsin	31,990	14,396	1,327	4.1%	9%
Tennessee	213,232	95,954	1,061	0.5%	1%
Indiana	87,740	39,483	905	1.0%	2%
Delaware	7,687	3,459	3	0.0%	0.1%
New Hampshire	16,922	7,615	13,598	80.4%	179%

[45] Data are from MHCD, the largest community-based provider of services to people with SMI in Denver, Colorado. Personal communication with Clinical/Administrative Director, Kim Foust, and her staff at MHCD, April 25, 2025.

Peer Support Benchmarks

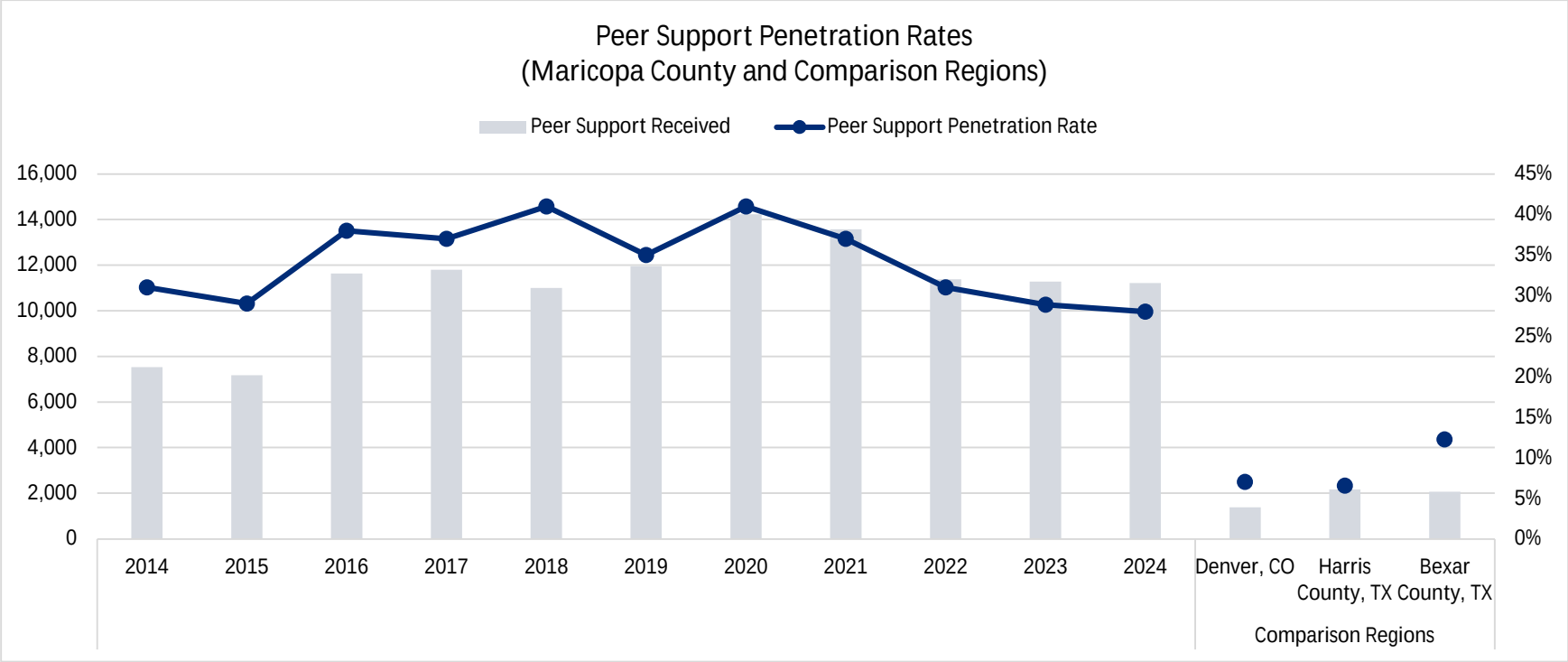
Maricopa County excels in making peer support services available to people in need. Its penetration rates for 2013–2024 are high and likely represent a best practice benchmark regarding access to peer support (see Table 17).

Table 17 — Peer Support Penetration Rates

Peer Support		
Region	**Peer Support Received**	**Peer Support Penetration Rate**
Arizona:		
Maricopa County (Total) — 2024	11,210	28%
Maricopa County (Total) — 2023	11,280	29%
Maricopa County (Total) — 2022	11,374	31%
Maricopa County (Total) — 2021	13,573	37%
Maricopa County (Total) — 2020	14,224	41%
Maricopa County (Total) — 2019	11,943	35%
Maricopa County (Total) — 2018	11,001	41%
Maricopa County (Total) — 2017	11,803	37%
Maricopa County (Total) — 2016	11,629	38%
Maricopa County (Total) — 2015	7,173	29%
Maricopa County (Total) — 2014	7,522	31%
Maricopa County (Total) — 2013	8,385	41%
Texas:		
Harris County (Houston)	2,172	7%
Bexar County (San Antonio)	2,062	12%

Peer Support		
Region	**Peer Support Received**	**Peer Support Penetration Rate**
Colorado:		
Denver City/County[46] (2023)	1,106	6%

Chart 5 — Peer Support Penetration Rates



[46] Data are from MHCD, the largest community-based provider of services to people with SMI in Denver, Colorado. Personal communication with Clinical/Administrative Director, Kim Foust, and her staff at MHCD, April 25, 2025. MHCD provides peer support services for adults with SMI using peer mentors and peer specialists. This figure may include some duplication of those served by both a peer mentor and a peer specialist.

Multi-Evaluation Component Analysis — Consumer-Operated Services (Peer Support and Family Support)

Service Descriptions[47]

Peer support services are delivered in individual and group settings by individuals who have personal experience with mental illness, substance use disorder, or dependence and recovery, to help people develop skills to aid in their recovery.

Family support services are delivered in individual and group settings and are designed to teach families skills and strategies for better supporting their family members' treatment and recovery in the community. Supports include training on identifying a crisis and connecting recipients in crisis to services, as well as education about mental illness and available ongoing community-based services.

Focus Groups

Mercer facilitated four focus groups with key system stakeholders as part of the service capacity assessment of the four priority behavioral health services in Maricopa County. Mercer convened the focus groups to facilitate discussion with participants with direct experience with priority mental health services. Readers should review focus group results in the context of qualitative and supplemental data and not interpret the feedback as representative of the total population of potential focus group participants.

Key findings derived from the focus groups regarding the delivery system's capacity to deliver peer support and family support services included:

- Most focus group participants continue to view peer support services as a valuable service. Members reported: "Every person who attends is so uplifting" and "As a person, I have changed; everything is going well. I am healthier and have more confidence." One family member reported that the change in their family member has been "magical" after having positive interactions with peers at the clinics and developing friendships.
- Adult members express satisfaction when describing the variety of groups and class topics available through peer-run organizations. These include classes on creative writing, grief and loss, relapse prevention, setting boundaries, and other topics that support individuals in their recovery.

[47] The definitions for the priority mental health services are derived from the *Stipulation for Providing Community Services and Terminating the Litigation,* which may not reflect the terminology used to currently describe these services.

- Adult members expressed familiarity with the peer warm line and believe it is an important option for crisis prevention. The peer-run organizations ensure members are aware of the availability of the warm line. Case managers highlighted concerns that calls to the warm line are limited to 15 minutes, and this may not be conducive to fully supporting a person needing assistance.
- Some family members expressed concerns that offering peer support as the only intervention during a crisis may not always be appropriate for members. One parent shared that her son is on an ACT team and during an “intense” nighttime crisis, the team only offered to send a peer support specialist to de-escalate the crisis. The parent expressed that this was the first and only time the peer support specialist interacted with her son, and she did not feel that the peer support specialist was adequately trained to address the crisis.
- Health homes deliver most peer support services in person, although virtual delivery was reported to be an option for some peer-run groups. Members receiving services through a peer-run organization reported services could be in person, virtual, or over the telephone. Providers reported that some peer support services are available on evenings and weekends through the health homes or ACT teams, but members stated this is not currently an option through peer-run organizations.
- Participants in all focus groups perceived that there are not enough peer support specialists available, particularly at the health homes. It is common for peer support specialists to serve multiple teams, with some health homes having only one to two peer specialists available across the entire site. Participants shared that some health homes are looking to expand the openings for more peer support staff. At the peer-run organizations, group classes are typically full, but some organizations are not expanding the groups due to concerns about available staffing resources.
- Case managers shared that peer support specialists primarily provide group sessions, but they believed that many members would also benefit from 1:1 peer support (including in-home peer support). However, given the lack of available peer support staff, 1:1 support is not a viable option.
- Family members shared that there is a lack of peer support specialists specializing in younger individuals experiencing first episode psychosis. One parent shared that her son would benefit from connecting with someone who shares his unique needs, and it is challenging to find peer support specialists who understand young adults with “arrested development”, or who can support transition-age youth experiencing challenges to develop healthy relationships and achieve age-appropriate milestones.
- Case managers and providers reported that turnover rates remain high among peer support specialists at the health homes, stating some staff may leave employment after a few weeks or months. Turnover rates were reported to be lower at peer-run organizations. As in previous years, one of the main contributing factors perceived by stakeholders to high turnover is ambiguity of the peer support specialist role. Due to the high turnover of case managers, peer support specialists are often asked to conduct case management or case aide tasks (e.g., picking up food boxes). Other contributors to turnover include low pay, high

caseloads, transportation challenges, exacerbated mental health symptoms or challenges with substance use, background check requirements, and a perceived lack of support from management.

- Case manager participants emphasized that progress note entry and billing requirements are leading contributors to peer support specialist turnover, sharing that progress note entry must be completed during regular business hours; therefore, overtime is not available for this task. Additionally, for client contacts to be billed, the duration of the encounter must last for eight minutes or more. This makes it more challenging for peer support specialists to achieve billable hours goals as some tasks are considered non-billable. Some health homes have also recently increased billable goals for staff. For peer support specialists, this expectation can contribute to higher turnover.
- Participants noted that health home management can play a large role in reducing turnover for peer support staff. In health homes with long-tenured peer support staff, participants noted that management has created incentives for staff, provide strong communication, allow the staff to feel heard, and place the staff in roles that match their interest and skills. One participant noted that when supervisors clearly value the role of the peer support specialist and clarify job expectations, turnover is reduced.
- Focus group participants noted it would be beneficial to educate the health homes about the role of the peer support specialist. Case managers participating in the focus group report receiving minimal training regarding peer support services during onboarding and new employee orientation, having, rather, to learn about the service and resource through word-of-mouth. It was suggested that management focus on the strengths and skills of peer support specialists, offer continuing education and support for career goals (such as offering opportunities for conference attendance), and help new staff to be more prepared for the expectations of the role.
- Adult members shared that access to peer support services at peer-run organizations is “smooth,” and case managers processed referrals for the service “quickly.” Participants in the case manager and provider focus groups expressed an understanding that members may self-refer to access services, and, typically, services can start immediately. Peer-run organizations often provide a 10-day pass that allows members to participate in services pending the referral and updated ISP. Some providers shared that there are times when it is a challenge to get an updated ISP from the health home, but they allow continued participation while they wait on the ISP.

Family Support Services

- As reported in prior years, there continues to be a lack of information about the availability and benefit of family support services. Most adult members and family members reported being unfamiliar with the service, and a member stated, “My family would be interested if this was offered, but it’s never been offered.” Most family member participants expressed they have not been offered this service by the clinical teams at the health homes.
- Family members shared there is a lack of marketing for family support services in the health homes. One family member reported asking the clinical team about family support services and received a “vague answer and I could not access the service.” Case managers reported the availability of family support services is not widely shared with members and families, but they will recommend it at times (such as when members feel unsupported by family members who may not understand the member’s mental health needs). Participants stated it is a regular referral for ACT but, outside of ACT, it is rarely added to an ISP. Case managers reported not receiving training regarding family support services, even during onboarding, and must learn about the service on the job.
- Only one family member reported receiving family support services in the past. She shared that she received a series of books from a family support specialist when her son was first diagnosed and described the resource as “invaluable.”
- Family members expressed that it would be “extremely helpful” to have family support services available during an initial hospitalization of their family member. Families often struggle to know what to do and/or what resources are available, and they believed that family support services would be particularly helpful with discharge planning. Other family members shared that a family support specialist may play a role in helping to develop safety plans and offer support and guidance to handle crises, particularly when someone is physically aggressive.
- Providers report that families would benefit from education, validation, co-dependency training, engagement, and support during a member’s first episode psychosis; help to navigate the system of care; assistance following hospitalization of a member; and support after members are released from incarceration. Provider participants advocated establishing telephonic support services for families as well.
- Last year, it was reported that when turnover occurs for family support positions, the health homes either elect not to re-hire for the position or struggle to find applicants. This year, one provider reported a family support specialist position is open, but it does not know if the vacancy will be filled. Most reported that there are no family support specialists at their health homes or provider settings, and there are no plans to hire for the role. Some case manager participants will refer out for family support services, but others reported that they would not know where to refer members to access the service.

- Providers report it is a challenge to provide family support services because it is “hard for members to rebuild relationships” with estranged family members. Providers report actively looking for ways to engage families, but the work is challenging. One health home offers a monthly family forum, but it has been difficult to get families to attend, and the activity is non-billable. Another health home offers quarterly parties for families to attend and another offers art events, literary events, and opportunities for families to engage through volunteering.

Key Informant Survey Data

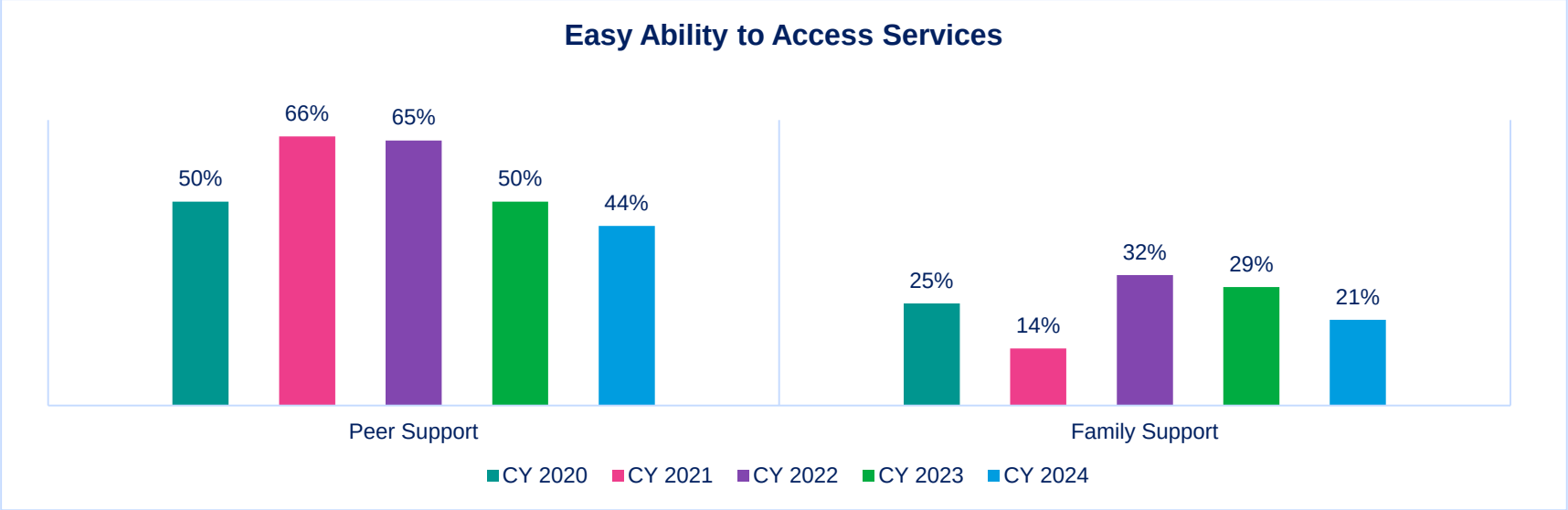
As part of an effort to obtain comprehensive input from key system stakeholders regarding availability, quality, and access to the priority services, Mercer administered a key informant survey. The survey tool included questions and rating assignments related to the priority mental health services. The survey distribution process targeted a defined list of system stakeholders, and responses to the survey did not represent a statistically significant sample of all potential informants. Readers should review survey results in the context of qualitative and supplemental data and avoid interpreting results to be representative of the total population of system stakeholders.

Level of Accessibility

Forty-four percent (44%) of survey respondents thought peer support services were easy to access, a decrease compared to the last two year’s findings (50% in CY 2023, 65% in CY 2022). Thirteen percent (13%) of survey respondents indicated peer support services were difficult to access.

Forty-three percent (43%) of survey respondents thought family support services were difficult to access, while 21% of the respondents indicated family support services were easy to access. Thirty-six percent (36%) of respondents rated access to family support services as “fair.”

Overall, respondents thought the ability to access peer support and family support services was more difficult during CY 2024 when compared to CY 2023.



Factors that Influence Access

The most common factors identified that negatively impact accessing peer support and family support services:

- Transportation barriers
- Clinical team unable to engage/contact member

Efficient Utilization

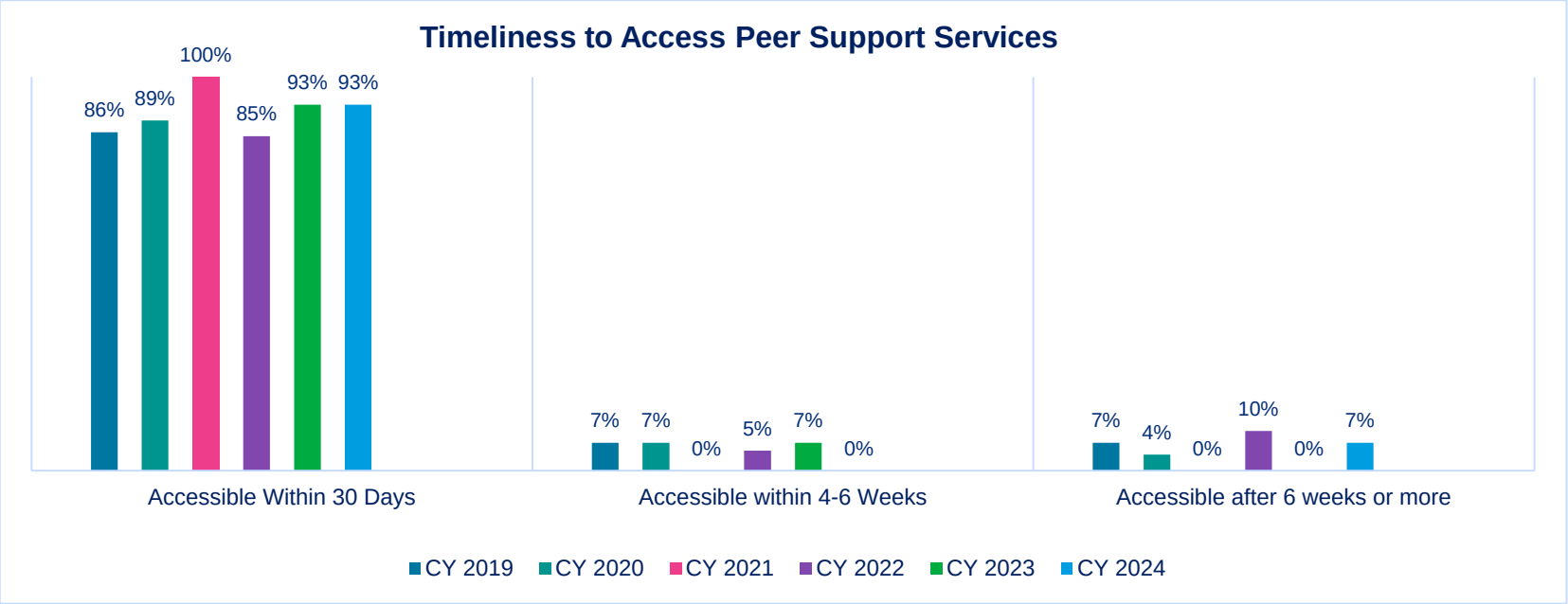
In terms of service utilization, 94% of the responses indicated peer support services were being used efficiently or were utilized efficiently most of the time. Six percent (6%) of respondents indicated that the peer support services were not utilized efficiently.

Eighty percent (80%) of the respondents indicated family support services were being utilized effectively or were utilized efficiently most of the time. Twenty percent (20%) of the respondents indicated family support services were not utilized efficiently.

Timeliness

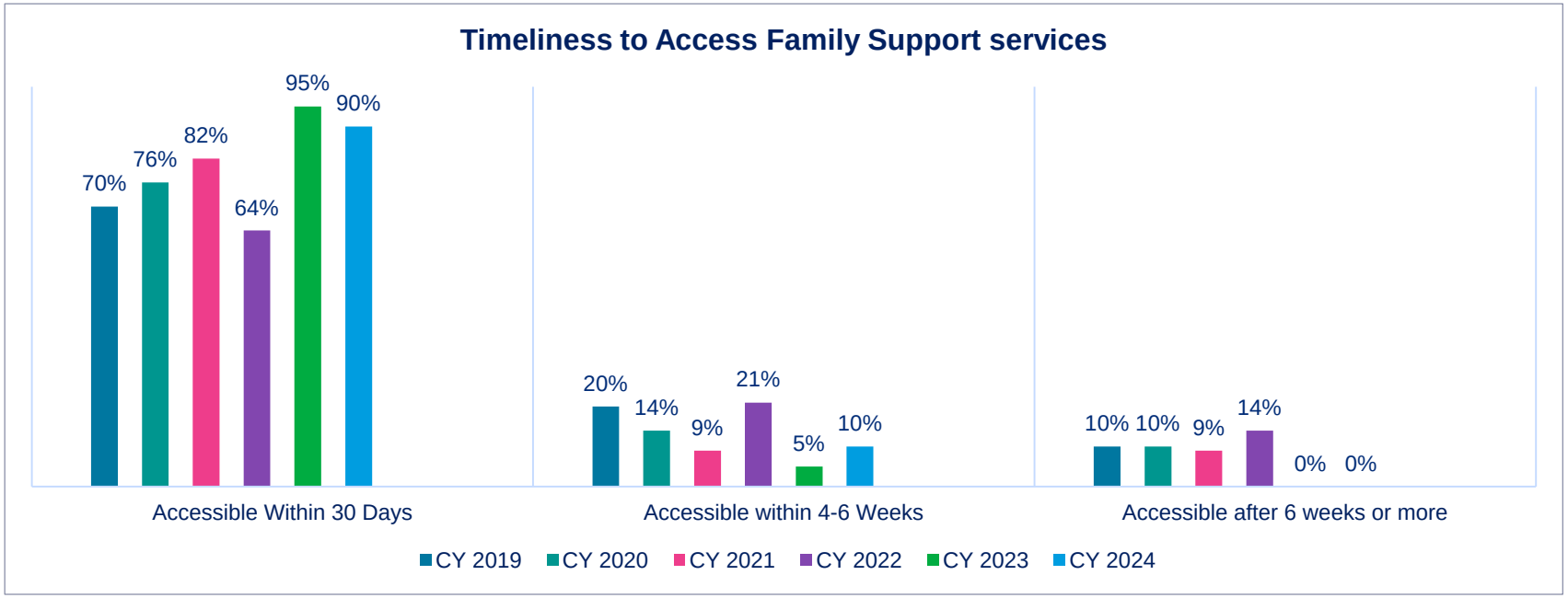
Regarding the duration of time to access peer support services and family support services after a need has been identified:

- Ninety-three percent (93%) of the survey respondents reported peer support services could be accessed within 30 days of the identification of the service need, the same finding as CY 2023.
- Seven percent (7%) of the survey respondents reported it would take an average of six weeks or longer to access peer support services.



- Ninety percent (90%) of the survey respondents reported family support services could be accessed within 30 days of the identification of a service need. This finding compares to 95% during CY 2023.

- Ten percent (10%) reported it taking four to six weeks to access family support services following the identification of need.
- None (0%) of the survey respondents reported that it would take an average of six weeks or longer to access family support services.

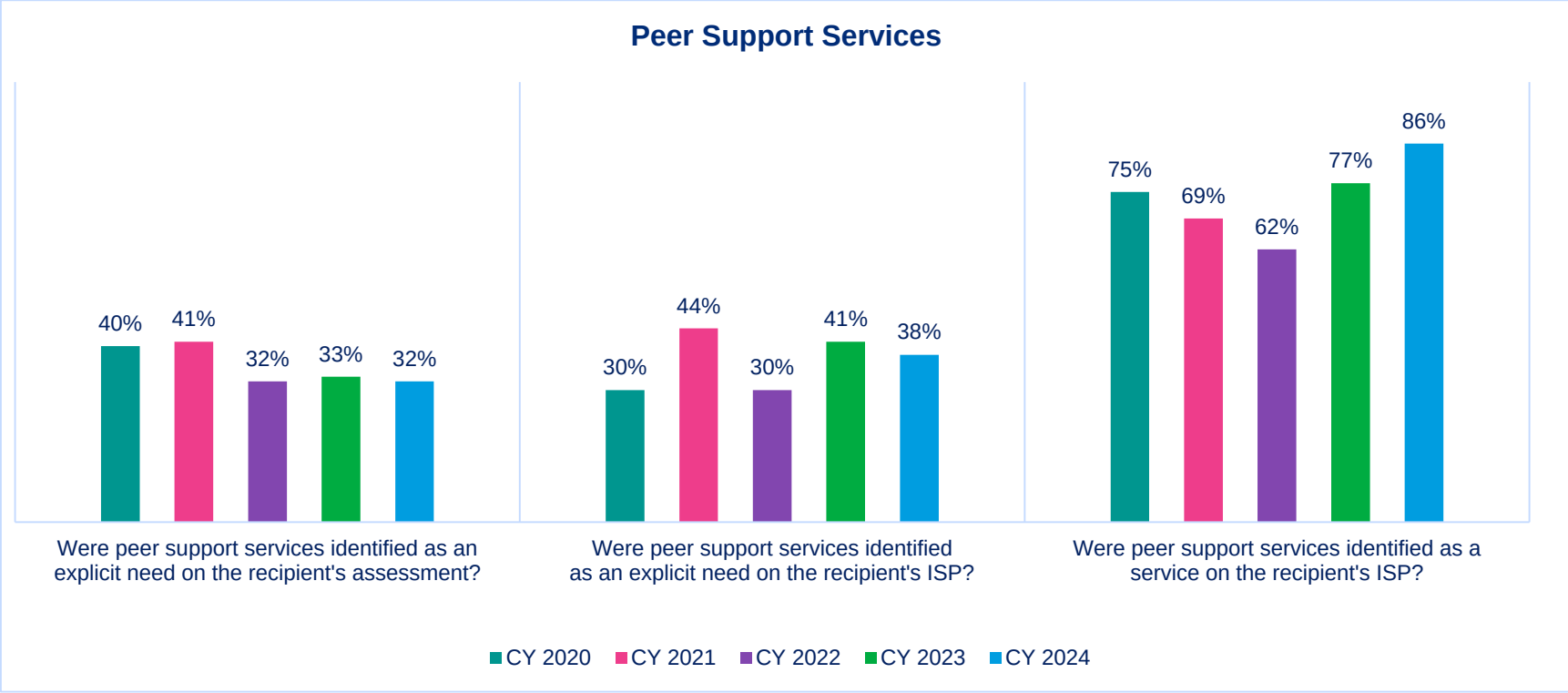


Medical Record Reviews

Mercer reviewed a random sample of 200 recipients' medical records documentation to evaluate the consistency in which peer support services and family support services were assessed by the clinical team, identified as a needed service to support the recipient, was included as part of the ISP, and, when applicable, was accessed promptly by the member.

Peer Support Services

- Eighty-six percent (86%) of the ISPs included peer support services when assessed as a need; an increase when compared to CY 2023 (77%).
- Thirty-five percent (35%) of the recipients included in the sample received at least one unit of peer support during CY 2024.



Reviewers review progress notes and record the reasons the person could not access peer support services when identified as a need by the clinical team. The most common finding is that the clinical team did not initiate a referral for the service.

Member-Specific Experiences

Mercer reviewers analyzed member-specific experiences with the care system to illustrate and reinforce key themes identified through the service capacity assessment. The two examples below pertain to members whose clinical team identified a need for peer support services and recommended the services as part of the person's individual service plan.

Case #1 – Peer Support Services

The member has a legal guardian, and, per the member's assessment, the member attends a peer-run organization several days during the week to participate in groups and be active in the community. The member lives independently with other family members. The member is not currently employed per the assessment.

The individual service plan includes an objective to meet with a peer support specialist 1 to 12 times a year and a separate objective to attend a day program at a peer-run organization. Health home progress notes include the following descriptions:

- The peer-run organization contacted the health home and requested a copy of the member's current ISP, indicating the ISP was requested previously and not sent, as well as noting that the prior assessment and ISP had expired over a year ago.
- The member experienced three case manager assignment changes over three months. When a family member expressed concern, the current case manager advised the family member not to get attached to the case managers because they change often, and the health home routinely re-assigns case managers to help manage caseload sizes across the teams. Another case manager informed the legal guardian that there would be another change with the member's assigned case manager.
- The member was scheduled to meet with a behavioral health medical professional, who noted in the progress note that the member was "new to the nurse practitioner." A family member became upset about the medication management appointment because the member had not taken psychotropic medications for an extensive period of time. The family member attributed the oversight to the new case manager not being familiar with the member's medical record. It was later noted that the member's legal guardian was advocating for a medication review based on feedback from the peer-run organization and disagreed with the family member's perception that the member did not need medication.
- The member attended groups at the peer-run organization, consistent with the clinical team's assessed need and the member's individual service plan. Separate meetings with a peer support specialist did not occur as identified on the individual service plan.

Case #2 – Peer Support Services

Per the assessment, the member's spouse is perceived by the member to be very supportive and helpful. A prompt on the assessment template states: ***Does the client want anyone involved in treatment at this time?*** The response is "No", followed by a table that identified family member's names, relationships, and "involvement." The member's spouse is listed with the term "all" entered in the "involvement" column. The Mercer review team regularly noted contradictory information in assessments for the sample of members. In addition, when members identify family members who may offer support, clinical teams rarely recommend family support services that may benefit individuals in meeting and sustaining their recovery goals. The clinical team did identify peer support services as a need for the member.

The member is not currently employed, per the assessment, and is not interested in pursuing work because the member perceives that employment income may jeopardize disability income that the family is currently receiving. The member may have benefited from education regarding available programs that allow individuals to work and retain benefits.

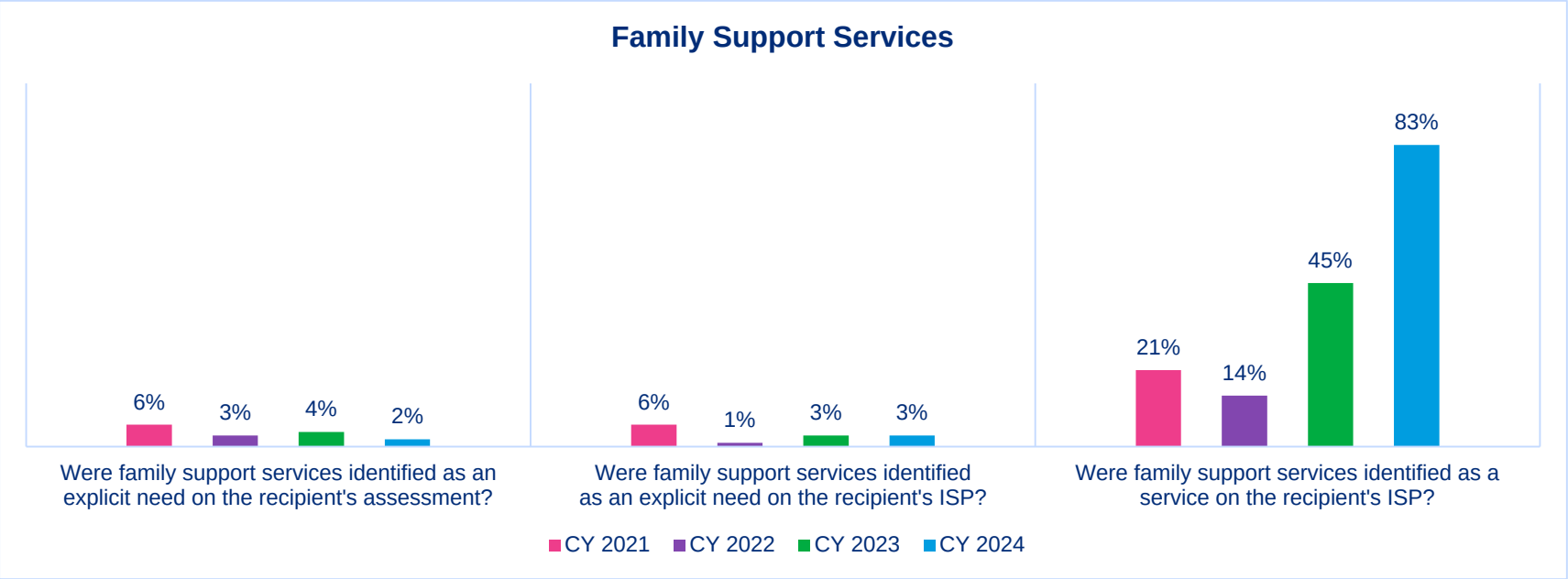
The member's individual service plan includes an objective to engage with a peer support specialist for further support at a frequency of one time per year. Although the need for peer support is consistent with the clinical team's assessed need, it is unclear how a one-time meeting with a peer support specialist each year will accomplish the accompanying measure found in the member's service plan (i.e., "Member and peer support to build rapport and supportive relationship").

A review of progress notes demonstrates minimal engagement between the member and the clinical team. There are two case management notes, each describing outreach to remind the member of an upcoming appointment. The member met with the behavioral health medical practitioner on three occasions (twice to monitor medications, one time for a psychiatric evaluation). The clinical team did not reference the member's individual service plan after completing it and the clinical team did not initiate a referral for peer support services as recommended per the member's service plan.

Family Support Services

As part of the clinical services assessment process, the clinical team regularly documents information regarding the natural and family support that is important to the recipient. However, clinical teams rarely leverage the opportunity to involve family members when the person desires to have family or significant others involved in their treatment services. In these circumstances, there may be opportunities to utilize family support services that may improve outcomes and/or offer additional support for people living with an SMI. One health home representative stated that most of the priority mental health services can be accessed directly at the health home, except for family support services, and thought that the need for a referral outside of the health home may be an impediment to members accessing the services. The health home representative added that many people living with SMI and participating in the public behavioral health system lack available family members, which may be contributing to lower utilization of family support services.

Three percent (3%) of the medical record review cases included an assessed need for family support services. Of these six cases, 83% of the ISPs included family support services, a noteworthy improvement compared to previous years. One percent (1%) of the recipients in the sample received at least one unit of family support during CY 2024, based on a review of service utilization data.



Service Utilization Data — Peer Support Services

Peer support services (i.e., self-help/peer services) are designated by two unique billing codes (H0038 – 15-minute billing unit and H2016 – per diem). During the period of October 1, 2023, through June 30, 2024, there were 39,273 unique users represented in the service utilization data file. Of those, 74% were Medicaid eligible (i.e., Title XIX) and 26% were non-Title XIX eligible.

- Overall, 24% of the recipients received at least one unit of peer support services during the period (a slight increase from last year, when 23% of recipients received peer support over a comparable period).

- Access to the service favored Title XIX eligible members (25%) over the non-Title XIX population (22%).

Persistence in Services

An analysis of the persistence in peer support services was completed by analyzing the sustainability of engagement in the service over consecutive monthly intervals:

- Overall, 58% of members who received at least one unit of peer support during the review period accessed the service during a single month, an increase when compared to CY 2023 (54%).
- Seventy-five percent (75%) of all members who received at least one peer support unit during the review period accessed the service for one or two months. During CY 2023, this result was 72%. Peer support services are widely accessible across the system of care. Members may have opportunities to attend a clinic-based peer support group or receive peer support services within or outside their assigned health home. The nature of the service can lead to episodic participation and is less dependent on sustained participation to provide adequate support and intervention.

Persistence in Peer Support Services October 2023–June 2024			
Consecutive Months of Service	**Medicaid Recipients**	**Non-Medicaid Recipients**	**All Recipients**
1	56.3%	62.4%	57.6%
2	17.8%	15.5%	17.3%
3–4	13.8%	11.3%	13.2%
5–6	4.6%	4.2%	4.5%
7–8	2.7%	2.2%	2.6%
9+	4.8%	4.4%	4.7%

Recipients may be duplicated based on multiple consecutive month periods of service within the time frame.

Targeted Interviews — Health Homes

Mercer conducted interviews with representatives of two of the administrative entities that manage multiple health homes, as well as ACT teams, throughout Maricopa County. During the interview, Mercer identified the following topics to address and gather stakeholder perspectives:

- Case manager turnover, caseload management, and available training regarding the priority mental health services

- Challenges with the non-emergency transportation vendor
- Implementing services after developing an individual service plan
- Utilization of family support services

One administrative entity employs case manager aides to provide support to case managers. Each health home employs four to five case manager aides, who assist by performing administrative tasks that allow the case managers to focus on monitoring caseloads and meeting with members. Caseloads are assigned to ensure continuity and relationship building with members. Mercer noted in medical record documentation that at least one of the health homes engages in frequent reassignments of members across case managers to manage caseload sizes. However, the administrative entities that Mercer met with do not utilize this approach.

Case manager turnover is high, vacancies exist agency-wide, and many existing case managers have limited experience. New case managers participate in a one-week new employee orientation and shadow case managers during home visits and hospital staffing meetings. One administrative entity has established weekly billable hour goals (at least 100 units or 25 hours) for case managers.

The interviewees acknowledge ongoing challenges with the current non-emergency transportation provider consistently showing up for scheduled pick-ups and describe recent changes to the process for prior authorization of transportation services. The contracted managed care organization previously applied mileage limitations to the service, but rescinded the requirement recently. For members assigned to ACT teams, team members may provide transportation to members on their caseloads.

The administrative entity expects clinical teams to review the member's ISP when meeting with members and initiate steps to help members access services. One clinical director utilizes an Excel spreadsheet to track when members' assessments and ISPs are due for an update. The ISP is formally reviewed with ACT team members at least every six months.

The stakeholders acknowledge that family support services are generally underutilized and observe that many of the members do not have available family members to provide support and/or have estranged relationships with family.

An additional interview was completed with a health home clinical leader who oversees five specialty outpatient clinics, including two centers that serve young adults experiencing a first episode of psychosis. These outpatient centers can serve 90 members each, with one currently operating at capacity and the other serving approximately 70 to 75 members. Families of these youth often struggle to provide care and support in their homes and may seek out-of-home placements to safeguard younger siblings and family members. The health home representative cited a need for expanded housing options for younger members and perceives that behavioral health residential facilities expose youth to substance use behaviors and are not always conducive to supporting their long-term recovery from mental illness.

The provider also manages two ACT teams, one of which is a forensic specialty team. Recruiting and retaining ACT team staff is an ongoing challenge, as the work is demanding and can lead to a high rate of “burnout.” In addition, there is a lack of licensed clinicians willing to accept below-market salaries and take on field-based positions. The agency representative believes there are opportunities to more efficiently coordinate care with criminal justice and hospital systems, as it can take significant time to locate assigned ACT team members following discharge from a hospital or jail setting. The managed care contractor recently clarified that jails can no longer execute courtesy releases to health home case managers following a legal opinion from the Maricopa County Attorney’s Office.

Recruitment for case manager positions is active, with multiple applicants seeking positions. The health home representative reports that turnover is most prevalent on teams with newer management and/or behavioral health medical practitioners. Clinical supervision is available to case managers via multiple forums, including weekly clinical staff meetings (for ACT team members), weekly high-risk meetings, and medical management meetings at each health home, approximately every two weeks.

The provider cited multiple issues over the past year with the current non-emergency transportation vendor, including reporting that members are in transport when they are not, claiming a telephone call to the member occurred when it did not, and dropping members off at the incorrect address.

Targeted Interview — Community Provider

A residential substance use disorder treatment agency provides support and services to women living with a SMI and experiencing co-occurring substance use disorders. The agency offers housing units for pregnant women and women and their dependents. In addition, the agency provides outpatient services, including group therapy. Most women participating in the residential treatment program stay for at least one year, though most continue services for at least two years. The agency coordinates care with the health homes and receives funding through various sources, including Medicaid, substance use and mental health block grants, and private donors.

The agency embeds up to 30 peer support specialists in each of the provider’s housing and outpatient programs. Although the peer support specialist position experiences the highest turnover within the organization, turnover rates are at or below 10% per year. The agency also trains and certifies individuals who want to pursue a career as a peer support specialist. The peer support certification classes consist of a 60-hour training curriculum, with approximately 25 graduates per year.

The provider also offers family support services, with staff functioning as parenting coaches and helping members enhance parenting skills. An agency representative describes low reimbursement rates and onerous reporting requirements dissuade the promotion of the services throughout the care system. The agency also employs benefit specialists who assist members with applying for and

retaining public benefits, such as the Supplemental Nutrition Assistance Program and food stamps. The agency representative describes the role of the benefit specialist as “a must” to appropriately support program participants.

The agency representative endorses reliability concerns with the current non-emergency transportation vendor, and program staff encourage members to utilize bus passes as an alternative mode of transportation.

Targeted Interview — Contracted Managed Care Organization

A peer navigator program will be implemented soon to help new members transition to the system of care for up to 90 days, assess the presence of social determinants of health, and offer support. A peer-run organization will oversee a health home focusing on engagement and outreach to members assigned to navigator levels of care/case management. To address ongoing education to health home case managers and peer-run organizations, the managed care organization host lunch and learn training sessions that promote professional development. The managed care organization collaborates with the Arizona Peer and Family Career Academy to further professional development and engagement of the peer support workforce. Oversight of the health homes includes tracking the number of full-time equivalents, site visits, and deliverables to monitor the ongoing sufficiency of the peer support workforce. In addition, the contracted managed care organization is piloting with a family-run organization to expand access to family support services.

Service Utilization Data — Family Support Services

Family support services (i.e., Home Care Training Family) are assigned a unique service code (S5110). The billing unit is 15 minutes in duration.

- Overall, 3.3% of the recipients received at least one unit of family support during the review period (1.8% over a comparable review period last year). The utilization of family support has consistently been between 2% to 5% since the inception of the service capacity assessment. Several factors may influence these results, including the absence of supportive family members, member choice of excluding family members from their treatment, and a need for more understanding by clinical teams regarding the appropriate application and potential benefits of the service.

Access to the service was split between Title XIX (3.3%) and non-Title XIX groups (3.5%).

Persistence in Services

An analysis of the persistence in family support services was completed by analyzing the sustainability of engagement in the service over consecutive monthly intervals.

- Sixty-five percent (65%) of the members who received at least one unit of family support during the review period accessed the service during a single month, a decrease from last year when 75% of the members accessed the service during a single month.
- Eighty-one percent (81%) of all members who received at least one unit of family support during the review period accessed the service for one or two months.

Persistence in Family Support Services October 2023–June 2024			
Consecutive Months of Service	**Medicaid Recipients**	**Non-Medicaid Recipients**	**All Recipients**
1	62.0%	71.7%	64.6%
2	17.9%	13.6%	16.7%
3–4	14.1%	10.3%	13.1%
5–6	3.7%	3.1%	3.5%
7–8	1.3%	<1.0%	1.1%
9+	1.0%	<1.0%	<1.0%

Recipients may be duplicated based on multiple consecutive month periods of service within the time frame.

Key Findings and Recommendations

Significant findings regarding the demand for and provision of peer support and family support services are presented below.

Key Findings: Peer Support

- Service utilization data reveals the volume of peer support services accessed during a defined review period. For the period of October 1, 2023, through December 31, 2024, 28% of all members living with SMI received at least one unit of peer support. During the prior year, 29% of members received peer support services.

- 96,516 less units of peer support were delivered in CY 2024 when compared to CY 2023. In addition, 70 less recipients received peer support during this same period, continuing a downward trend over the past three years. It appears that the reduction in peer support utilization between CY 2023 and CY 2024 is partially due to AHCCCS' suspension of multiple service providers following credible allegations of inappropriate billing practices.
- Most focus group participants continue to view peer support services as a valuable service. Members reported: "Every person who attends is so uplifting" and "As a person, I have changed; everything is going well. I am healthier and have more confidence." One family member reported that the change in their family member has been "magical" after having positive interactions with peers at the clinics and developing friendships.
- Case managers shared that peer support specialists primarily provide group sessions, but they believed that many members would also benefit from 1:1 peer support (including in-home peer support). However, given the lack of available peer support staff, 1:1 support is not a viable option.
- Participants in all focus groups perceived there are not enough peer support specialists available, particularly at the health homes. It is common for peer support specialists to serve multiple teams, with some health homes having only 1 to 2 peer specialists available across the entire site. Participants shared that some health homes are looking to expand the openings for more peer support staff. At the peer-run organizations, group classes are typically full, but some organizations are not expanding the groups due to concerns about available staffing resources.
- Forty-four percent (44%) of survey respondents thought peer support services were easy to access, a decrease compared to the last two year's findings (50% in CY 2023, 65% in CY 2022). Thirteen percent (13%) of survey respondents indicated peer support services were difficult to access.
- When evaluating a sample of medical record documentation, 86% of the ISPs included peer support services when assessed as a need; an increase when compared to CY 2023 (77%).

Key Findings: Family Support

- Service utilization data demonstrates that 4% of members received at least one unit of family support services during 2024 compared to 3% during 2023.
- 425 more members received family support services during CY 2024 when compared to CY 2023. Over the past three years, there has been an 88% increase in the volume of family support units.

- Three percent (3%) of the medical record review cases included an assessed need for family support services. Of these 6 cases, 83% of the ISPs included family support services, a noteworthy improvement compared to previous years.
- Forty-three percent (43%) of survey respondents thought that family support services were difficult to access, while 21% of the respondents indicated family support services were easy to access. Thirty-six percent (36%) of respondents rated access to family support services as “fair.”
- Last year, it was reported that when turnover occurs for family support positions, the health homes either elect not to re-hire for the position or struggle to find applicants. This year, one provider reported a family support specialist position is open, but they do not know if the vacancy will be filled. Most reported there are no family support specialists at their health homes or providers settings, and there are no plans to hire for the role. Some case manager participants will refer out for family support services, but others reported that they would not know where to refer members to access the service.
- Providers report it is a challenge to provide family support services because it is “hard for members to rebuild relationships” with estranged family members. Providers report actively looking for ways to engage families, but the work is challenging. One health home offers a monthly family forum, but it has been difficult to get families to attend, and the activity is non-billable. Another health home offers quarterly parties for families to attend, and another offers art events, literary events, and opportunities for families to engage through volunteering.

Recommendations: Peer Support

- Assess and expand capacity, as appropriate, to provide more opportunities for members to access 1:1 peer support while emphasizing peer support interactions during crisis events, as part of hospital discharge planning teams, and supporting young adults experiencing first episode psychosis.
- Per the AHCCCS Contractor Operations Manual, *Policy 407, Workforce Development*, overseeing the development of the provider workforce is a function of the managed care contractor’s network management responsibilities. As such, take actions to deploy a qualified and sufficiently staffed peer support workforce, and offer training and resources for providers to assist peer support workers in effectively managing stress and burnout.

Recommendations: Family Support

- Formally assess the current provider network’s capacity to offer family support services and recruit additional providers as appropriate.

- Continue efforts to provide training, supervision, and written materials to help ensure that health home clinical team members understand the appropriate application of family support services and to recognize the value of the services as an effective service plan intervention.

Multi-Evaluation Component Analysis — Supported Employment

Service Description[48]

Supported employment services are services through which recipients receive assistance in preparing for, identifying, attaining, and maintaining competitive employment. The services provided include job coaching, transportation, assistive technology, specialized job training, and individually tailored supervision.

Focus Groups

Mercer facilitated focus groups to promote discussion with participants with direct experience with priority mental health services. Readers should review focus group results in the context of qualitative and supplemental data and not interpret the feedback as representative of all system stakeholders.

Findings collected from focus group participants regarding supported employment services included the following:

- Members report they can talk to a case manager or supported employment specialist at their health home or peer-run organization if interested in work or engaging with a vocational rehabilitation (VR) specialist. One adult member reported that their case manager referred them to the in-house supported employment specialist when she expressed interest in finding employment. The referral was completed quickly, as was her referral for VR services. Members reported knowing several people who have been able to obtain jobs with the help of the peer-run organizations.
- Family members offered varied responses regarding their experiences with supported employment services. One family member participant reported the service was very effective and was happy with the process. Her daughter was able to obtain a job with supported employment support and the assistance provided by the health home. Another family member reported their son's experience was "great," as "he felt good about himself," but the service was time-limited and, without the ongoing support, his

[48] The definitions for the priority mental health services are derived from the *Stipulation for Providing Community Services and Terminating the Litigation,* which may not reflect the terminology utilized to currently describe these services.

progress stalled. Another family member reported their son was deemed “too sick” and was “blocked from getting VR.” One family member stated the service is needed because “having something to do daily is critical.”

- Co-located vocational rehabilitation counselors continue to be available on a part-time basis at most health homes, and each serves multiple clinics. VR orientation sessions are offered both virtually and individually. Case managers reported VR counselors attend monthly health home team meetings.
- Providers reported high turnover among VR counselors and attributed this to “insufficient support, lack of training, and overwhelming caseloads”. The provider focus group participants shared that some VR counselors reach out to health home rehabilitation specialists for guidance and resources and, in some cases, may need clarification regarding how each role interacts with the member to provide supported employment services and supports.
- Case managers and provider participants reported that wait times for VR referral processing varies depending on the VR counselor and can range from one to two weeks, 90 days, or up to six months before receiving a response.
- One supported employment provider reported receiving no response at all from the assigned VR counselor and that the VR counselor has not been to the health home in six months. The VR process was described as “slow, cumbersome, and with heavy paperwork burdens.” Additionally, provider participants were skeptical of VR referral requirements and questioned the need to require documentation, such as member medication lists.
- Provider focus group participants perceive there is adequate capacity for community-based supported employment providers, stating community employment specialists reach out within 24 hours of a referral, and services can start in about a week.
- Providers report there have been funding reductions for some non-Title XIX services, including supported employment. These funding limitations limit the number of non-Title XIX members who can enroll for supported employment services through supported employment agencies.
- Case manager focus group participants shared receiving limited training regarding the availability of supported employment providers or how to engage with the providers if an assigned member expresses a desire for supported employment services. The case managers acquire knowledge about the service and available providers from learning on the job and by word-of-mouth. Most case managers could not name any of the current community-based supported employment providers and were only familiar with work adjustment training programs. The case managers shared that referrals are made to health-home based employment specialists, when available, but most frequently to rehabilitation specialists. When health home employment specialists are available, the team members participate in weekly team huddles to offer support to members seeking employment opportunities.

- Providers agreed that case managers do not appear to receive training on supported employment and the availability of community-based providers. Providers reported conducting marketing and outreach to the case managers. One supported employment provider is co-located at 11 health homes and encourages the employment specialists to consistently conduct outreach and provide education to the case managers.
- Case managers and providers agreed that health homes have rehabilitation specialists available, and case managers concurred that a rehabilitation specialist is typically assigned to each case management team. In the provider focus group, some participants expressed that rehabilitation specialists need to receive more training about their role overall, and how it differs from VR. However, a rehabilitation specialist participating in the case manager focus group indicates receiving “plenty of training” and added his team regularly educates case managers on how they can engage with members to explore employment-related goals.
- Adult members and case managers report being familiar with the Disability Benefits 101 website, but participants in all focus groups stated members remain concerned about the impact working will have on eligibility for public benefits. Families expressed concerns about the “ups and downs” that an individual with a mental health condition may experience, and that benefits are not automatically reinstated when a member is suddenly unable to continue working. Family member focus group participants recommend suspending benefits and offering more flexibility to quickly reestablish eligibility when individuals’ circumstances change, and the person is unable to generate income.
- Case managers and provider focus group participants shared that benefit specialists are rarely employed by health homes, and there are “only maybe two or three benefit specialists left in the county.” Rehabilitation specialists have assumed the role of assisting members with applying for and maintaining eligibility for public benefits, although support is thought to be limited to helping individuals apply for AHCCCS health insurance and supplemental nutrition assistance programs. Provider focus group members indicate assistance is often needed with completing applications for Social Security Disability Insurance, but there are limited resources available.
- Case manager focus group participants attribute the turnover rate of benefit specialists to low salaries, and provider focus group attendees share that it has been difficult to hire benefit specialists due to established qualifications and training requirements, which limits the pool of available candidates.

Key Informant Survey Data

As part of an effort to obtain comprehensive input from key system stakeholders regarding availability, quality, and access to supported employment services, Mercer administered a key informant survey. The survey distribution process targeted a defined list of system stakeholders, and responses to the survey did not represent a statistically significant sample of all potential informants.

Readers should review survey results in the context of qualitative and supplemental data and avoid interpreting results to be representative of the total population of system stakeholders.

Level of Accessibility

Six percent (6%) of survey respondents believed that supported employment services were difficult to access, less than the finding in CY 2023 (13%). Ninety-four percent (94%) of respondents indicated supported employment services were easy to access or had "fair" access, higher than CY 2023 (84%).

Factors that Influence Access

Factors that negatively impact accessing supported employment services include:

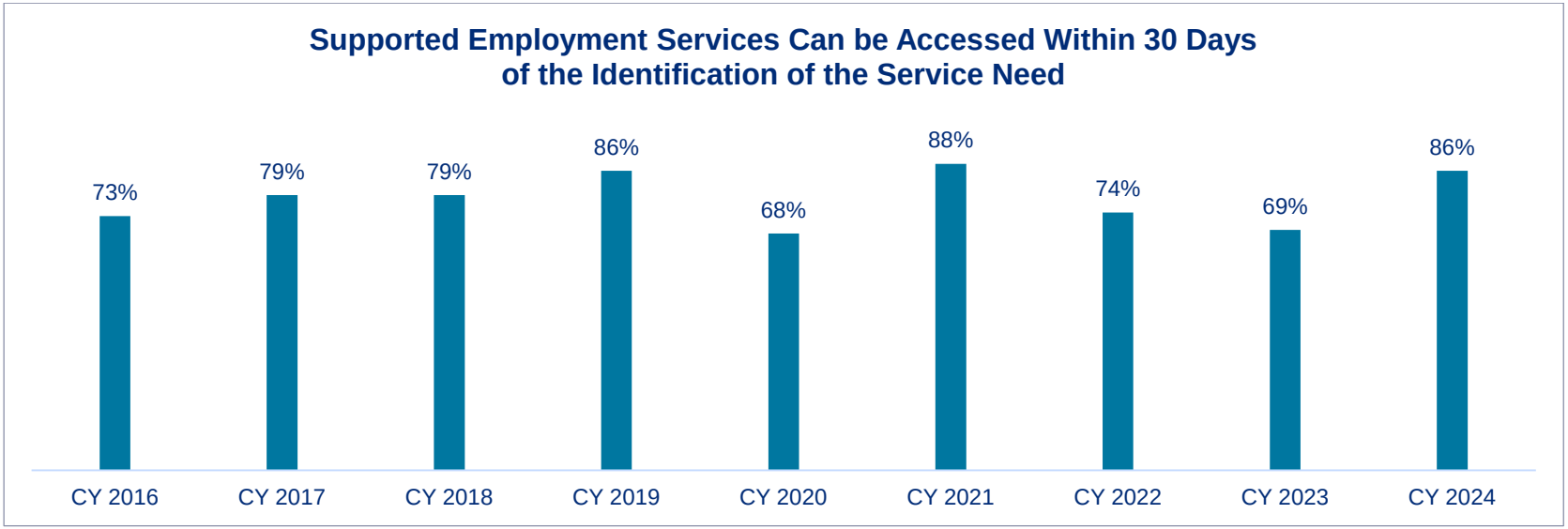
- Transportation barriers
- Clinical team unable to engage/contact member
- Staffing turnover

Efficient Utilization

Ninety-four percent (94%) of the responses indicated supported employment services were being used efficiently or were utilized efficiently most of the time, higher than last year (77%). Twenty-three percent (6%) of respondents indicated supported employment services were not utilized efficiently.

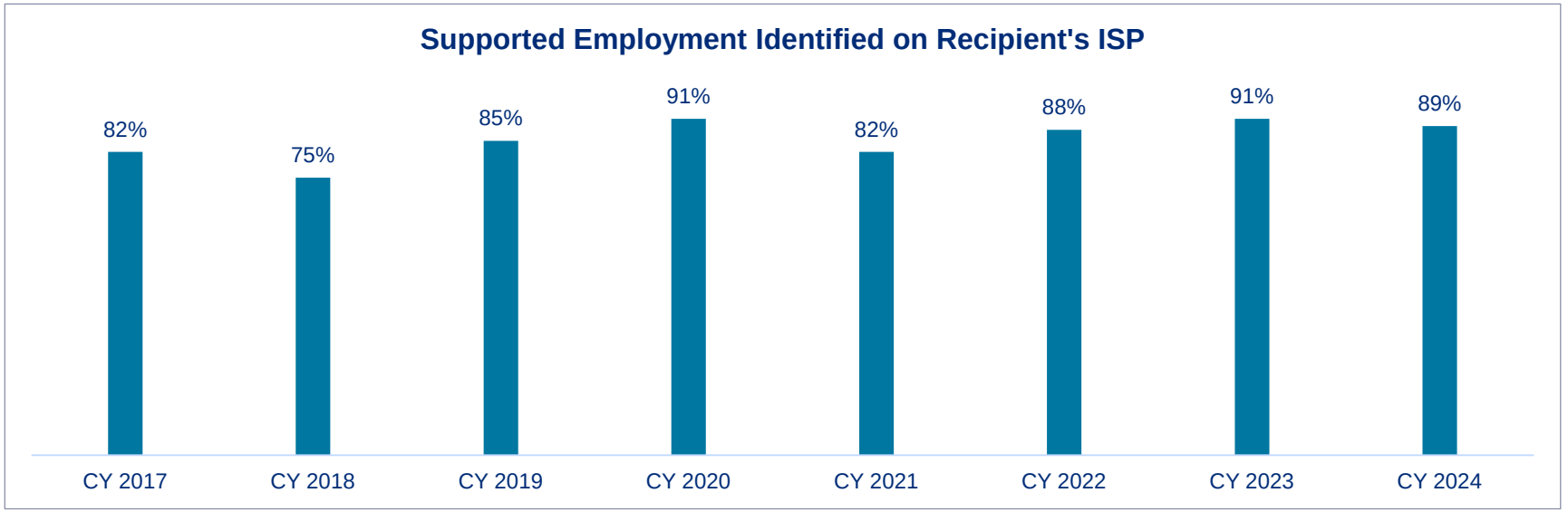
Timeliness

Eighty-six percent (86%) of the survey respondents report supported employment services can be accessed within 30 days of the identification of the service need. This compares to 69% during CY 2023. Fourteen percent (14%) of the survey respondents reported it would take an average of six weeks or longer to access supported employment services.



Medical Record Review

The results of the medical record review demonstrate supported employment services are identified as a need on either the recipient's assessment and/or ISP in 44% of the cases reviewed. Supported employment services were identified as a service on the recipient's ISP in 89% of the cases reviewed when assessed as a need (91% in CY 2023).



Thirty-eight percent (38%) of the recipients included in the medical record review sample received at least one unit of supported employment during CY 2023, based on a review of service utilization data. Several ISPs included supported employment services to reflect a one-time meeting with a health home-based rehabilitation specialist, regardless of any assessed need for the service.

In 33 cases, reviewers were able to review progress notes and record the reasons the person did not access supported employment services after a supported employment need was identified by the clinical team. A lack of evidence that the clinical team followed up with initiating a referral for the service was noted in 45% of the cases, in which the person did not access the service despite an identified need — less than the rate identified during CY 2023 (49%).

Consistent with prior annual reviews, the review team noted inconsistencies across the health homes regarding listing supported employment services on member ISPs to reflect a one-time annual vocational activity profile (VAP) through the health home assigned rehabilitation specialist (this activity is often identified as pre-job development and training, and commonly includes pre-job development and ongoing support to maintain employment billing codes). Some health homes include this intervention on virtually all ISPs, while other clinics do not necessarily follow this approach. The contracted managed care organization has promulgated expectations for the health homes that an assessment of vocational interests and capabilities occur during members' annual

assessment update and ISP development process. Several cases in the medical record review sample did not include evidence the member received a VAP after the clinical team identified the activity as an intervention on the member's ISP.

The managed care organization offers a webinar to orient new health home staff members to supported employment services, and an operations manual is available that outlines AHCCCS' policy and SAMHSA's evidence-based toolkits for many of the priority mental health services, including supported employment.

Service Utilization Data

Three distinct billing codes are available to reflect the provision of supported employment services. Available billing codes include:

- Pre-job training and development (H2027)
- Ongoing support to maintain employment:
  - Service duration 15 minutes (H2025)
  - Service duration per diem (H2026)

H2027 — Psychoeducational Services (Pre-Job Training and Development)

Services that prepare a person to engage in meaningful work-related activities may include, but are not limited to, the following: career/educational counseling, job shadowing, job training, assistance in the use of educational resources necessary to obtain employment; attendance to Vocational Rehabilitation/Rehabilitation Services Administration (VR/RSA) information sessions; attendance to job fairs; training in resume preparation, job interview skills, study skills, budgeting skills (when it pertains to employment), work activities, professional decorum, time management, and assistance in finding employment.

H2025 — Ongoing Support to Maintain Employment

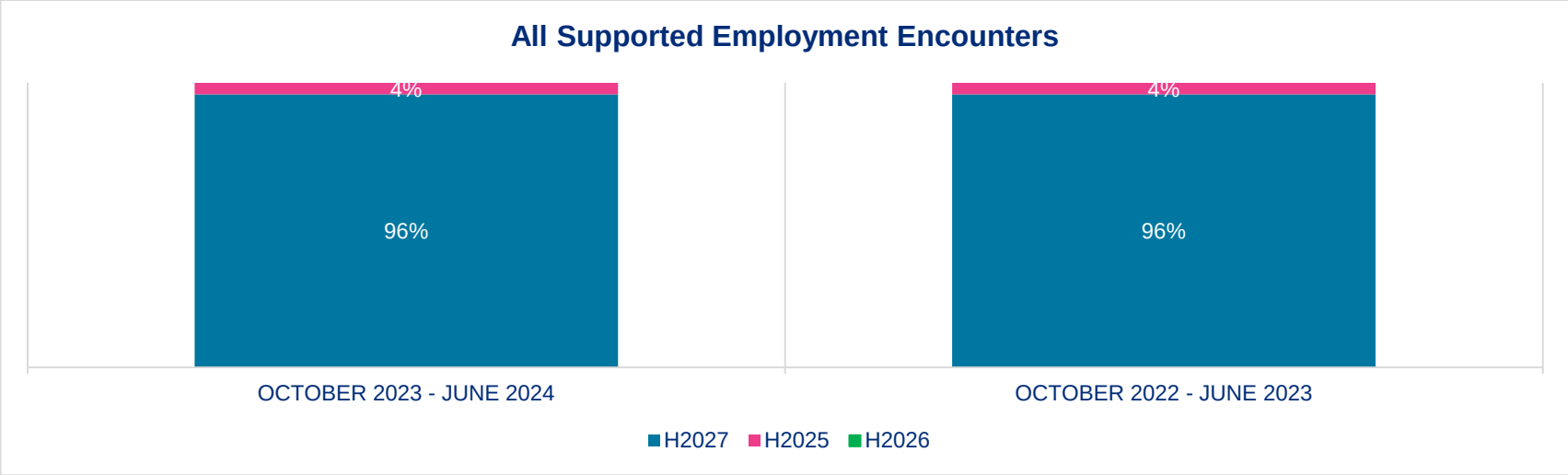
Includes support services that enable a person to maintain employment. Services may include monitoring and supervision, assistance in performing job tasks, and supportive counseling.

H2026 — Ongoing Support to Maintain Employment (per Diem)

Includes support services that enable a person to maintain employment. Services may include monitoring and supervision, assistance in performing job tasks, and supportive counseling.

Service Utilization Trends

For the period October 1, 2023, through June 30, 2024, H2027 (pre-job training and development) accounts for 96% of the total supported employment services. H2025 (ongoing support to maintain employment/15-minute billing unit) represents 4% of the supported employment utilization. H2026 (ongoing support to maintain employment/per diem billing unit) accounted for less than 1% of the overall supported employment utilization.



Challenges with providing ongoing support to maintain employment (H2025) include members opting out of supported employment services once competitively employed or the member's inability to attend meetings with job coaches due to commitments related to full-time employment. However, supported employment providers now offer virtual meetings, texting, and telephonic support in lieu of in-person meetings.

Despite a reduction of one supported employment provider, the managed care organization reallocated contracted capacity across the remaining providers and perceives that the network is sufficient to meet the current demand for supported employment services. The managed care organization recently began auditing a sample of medical records in coordination with a data validation review team to monitor for the completion of vocational activity profiles.

Additional findings from the service utilization data set are as follows:

- Overall, 22% of the recipients received at least one unit of supported employment during the October 2023–June 2024 review period, two percentage points more than last year (20%).
- Access to the service was split between Title XIX (22%) and non-Title XIX groups (21%).

Persistence in Services

An analysis of the persistence in supported employment services was completed by examining the sustainability of engagement in the service over consecutive monthly intervals.

Persistence in Supported Employment Services October 2023–June 2024			
Consecutive Months of Service	**Medicaid Recipients**	**Non-Medicaid Recipients**	**All Recipients**
1	60.9%	66.8%	62.4%
2	14.8%	12.3%	14.2%
3–4	11.8%	9.9%	11.3%
5–6	5.7%	4.8%	5.5%
7–8	2.3%	2.9%	2.4%
9+	4.4%	3.3%	4.1%

- Sixty-two percent (62%) of the recipients who received at least one unit of supported employment services during the review period accessed the service during a single month. This finding aligns with the low utilization of ongoing support to maintain employment, which leads to consistent participation over several months.
- Eleven percent (11%) of the recipients received supported employment services for three to four consecutive months during the review period.
- Four percent (4%) of the recipients received the service for at least nine consecutive months.

Coordinating With VR/RSA

The supported employment specialists associated with contracted supported employment providers, health home rehabilitation specialists, and health home employment specialists coordinate closely with staff employed with the Arizona Department of Economic Security (DES)/ RSA (aka “Vocational Rehabilitation”).

Twenty-nine full-time DES/RSA counselors are dedicated to persons with SMI and co-located at several health home clinic locations. Six vacancies were reported as of December 2024. VR counselors meet regularly with health home clinic rehabilitation specialists and contracted supported employment providers and work in coordination to meet the members’ supported employment needs.

The VR program for people with SMI is tracking targeted outcomes. Overall, there has been an increase across all metrics when compared to CY 2023. DES/RSA data secured from the contracted managed care organization includes the following:

- Members referred to VR/RSA: 1,297 between October 1, 2023, and September 30, 2024
- Members served in the VR program: 1,431 as of September 30, 2024
- Members open in the VR program: 1,221 as of September 30, 2024
- Members in service plan status with VR: 256 as of September 30, 2024
- Members successfully closed and employed: 118 between October 1, 2023, and September 30, 2024

AHCCCS, DES/RSA, and the three managed care contractors are updating an inter-agency protocol outlining entity roles and responsibilities. In addition, the managed care contractor actively coordinates with DES/RSA and meets monthly with representatives of the agency to improve coordination and outcomes for members. Every quarter, the managed care contractor meets with the health home rehabilitation specialists to share updates regarding supported employment services.

Key Findings and Recommendations

The most significant findings regarding the need for and delivery of supported employment services are presented below. Recommendations are included that should be considered as follow-up activities to address select findings.

Findings: Supported Employment

- Service utilization data demonstrates 26% of members received at least one unit of supported employment during CY 2024, the same finding as CY 2023.
- Fourteen more members received supported employment when comparing CY 2024 to CY 2023. However, there was a reduction of 151,959 units of the service delivered during this same period.
- Six percent (6%) of survey respondents believed supported employment services were difficult to access, less than the finding in CY 2023 (13%). Ninety-four percent (94%) of respondents indicated supported employment services were easy to access or had “fair” access, higher than CY 2023 (84%).
- Members report they can talk to a case manager or supported employment specialist at their health home or peer-run organization if interested in work or engaging with a VR specialist. One adult member reported their case manager referred them to the in-house supported employment specialist when she expressed interest in finding employment. The referral was completed quickly, as was her referral for VR services. Members reported knowing several people who have been able to obtain jobs with the help of the peer-run organizations.
- Adult members and case managers report being familiar with the Disability Benefits 101 website, but participants in all focus groups stated members remain concerned about the impact working will have on eligibility for public benefits. Families expressed concerns about the “ups and downs” an individual with a mental health condition may experience, and that benefits are not automatically reinstated when a member is suddenly unable to continue working. Family member focus group participants recommend suspending benefits and offering more flexibility to quickly reestablish eligibility when individuals’ circumstances change, and the person is unable to generate income.
- Provider focus group participants perceive there is adequate capacity for community-based supported employment providers, stating community employment specialists reach out within 24 hours of a referral, and services can start in about a week.
- Supported employment services were identified as a service on the recipient’s ISP in 89% of the cases reviewed when assessed as a need (CY 2023 — 91%).
- In 33 cases, reviewers were able to review progress notes and record the reasons the person did not access supported employment services after a supported employment need was identified by the clinical team. A lack of evidence that the clinical team followed up with initiating a referral for the service was noted in 45% of the cases in which the person did not access the service despite an identified need — less than the rate identified during CY 2023 (49%).

- Several cases in the medical record review sample did not include evidence the member received a VAP after the clinical team identified the activity as an intervention on the member's ISP. The contracted managed care organization does not currently monitor or track the completion of annual vocational-related assessments.

Recommendations: Supported Employment

- Ensure health home case managers receive training and clinical supervision to support members who express an interest in supported employment services, including awareness of community-based supported employment providers and how to access the services on behalf of members.
- Ensure integrated health homes are performing required vocational assessments during the annual assessment and ISP update process, and monitor and track recommended services on member's ISPs are delivered, including VAPs.
- Designate and expand staffing resources to serve as benefit specialists (e.g., use of peer support specialists, case managers) to address ongoing member concerns about securing employment without jeopardizing eligibility for public assistance programs (e.g., AHCCCS eligibility, SSDI).

Multi-Evaluation Component Analysis — Supportive Housing

Service Description[49]

Supportive housing is permanent housing, with tenancy rights and support services enabling recipients to attain and maintain integrated affordable housing. It allows recipients to have the choice to live in their own homes and with whom they wish to live. Support services are flexible and available, as needed, but not mandated as a condition of maintaining tenancy. Supportive housing also includes rental subsidies or vouchers and bridge funding to cover deposits and other household necessities, although these items alone do not constitute supportive housing.

Focus Groups

Mercer facilitated focus groups to promote discussion with participants with direct experience with priority mental health services. Readers should review focus group results in the context of qualitative and supplemental data and not interpret the feedback as representative of all system stakeholders.

[49] The definitions for the priority mental health services are derived from the *Stipulation for Providing Community Services and Terminating the Litigation,* which may not reflect the terminology utilized to currently describe these services.

Findings collected from focus group participants regarding the full continuum of supportive housing services included the following:

- As in previous years, there was consensus across all four focus groups that there are not enough stable, safe, and affordable housing options in Maricopa County. Additionally, there are still not sufficient subsidized vouchers available, waitlists remain excessively long (e.g., three to four years), if they are open at all, and finding landlords willing to accept vouchers at fair market value remains increasingly difficult.
- Providers and case manager focus group participants noted several common barriers to obtaining and/or maintaining housing. These challenges can include exhausting available flex funding for deposits and eviction prevention allocations early in the year, limited assistance available to members when moving residences, and the lack of new housing vouchers.
- Other barriers to obtain housing, as reported by focus group participants, include restrictions for individuals with prior evictions and members with criminal sex offenses. For the latter, select focus group participants shared that it is “virtually impossible” to find housing if a member has a sexual offense record.
- Case manager focus group attendees describe members expressing concerns about finding housing in safe neighborhoods and that available housing is often too far from members’ assigned health homes. Focus group participants believe that when housing vouchers become available, members often struggle to provide the long list of required documents, and for some members, the delay can result in the loss of the voucher.
- Family member focus group participants expressed this is a lack of affordable housing and the process of obtaining vouchers is challenging. One family member stated her son had been on the scattered-based housing list and was removed because he was not homeless for a time, and it took several years to get him back on the list.
- The lack of available and appropriate housing options led some family member focus group participants to feel that their family members are often “dumped” with the family as a housing option, particularly when there is an eviction or a discharge from an inpatient behavioral health setting. Family members participating in the focus group advocated for more appropriate options for temporary housing when members transition from hospital settings and other facility-based levels of care.
- Previously, case manager focus group participants reported ongoing challenges in working with AHCCCS’ contracted housing administrator. Although the referral process was reported to be easy to navigate, participants found it challenging to obtain any information or speak to a live person following the submission of a referral. This year, case manager focus group participants reported improvements in the process and that the housing administrator now has a point of contact that promptly responds to inquiries and questions.

- Permanent supportive housing providers share there are immediate openings available to members, but report that some case managers appear unaware of the availability of supportive housing services. Case manager focus group participants confirm a lack of awareness regarding available permanent supportive housing providers in the community, opting to refer members to the assigned housing specialist at the health home or attempting to assist the member directly. Provider focus group participants express that housing specialists are often too "bogged down" by the need to find housing for members and may not initiate referrals for permanent supportive housing services. Provider participants noted some health homes may not have an available housing specialist and believe there is an insufficient number of housing specialists to adequately assist members in need of housing support.
- During the focus groups, it was reported some health homes offer an overview of supportive housing services during new employee orientation, but most case manager focus group participants report not receiving training regarding the full continuum of available supportive housing services and how to assist members to access the services. Case manager focus group participants attributed the high rate of turnover among health home staff as a barrier to keeping the teams continuously informed. Adult member focus group participants report receiving rental subsidies, but all were unfamiliar with available permanent supportive housing services.
- Family member focus group participants shared that after members obtain housing, there is a lack of support to help maintain the housing on a long-term basis. One family member participant shared that her son's home can quickly transition from well-maintained to "needing to be condemned" if there is not regular, ongoing support. Another parent focus group participant, paying for her adult son's apartment, needs supportive housing assistance to help him learn to maintain it. The parent shared that she has asked for the service on behalf of her son, but has yet to receive it.

Key Informant Survey Data

As part of an effort to obtain comprehensive input from key system stakeholders regarding availability, quality, and access to supportive housing services, Mercer administered a key informant survey. The survey tool included questions and rating assignments related to the priority mental health services. The survey distribution process targeted a defined list of system stakeholders, and responses to the survey did not represent a statistically significant sample of all potential informants. Readers should review survey results in the context of qualitative and supplemental data and avoid interpreting results to be representative of the total population of system stakeholders.

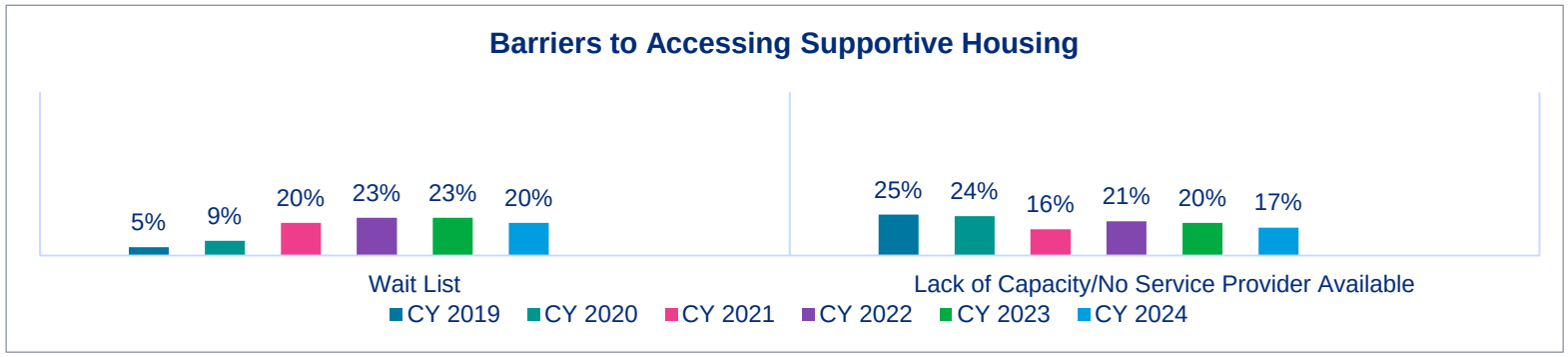
Level of Accessibility

Forty-seven percent (47%) of the survey respondents believed supportive housing services were difficult to access (48% in CY 2023). Fifty-three percent (53%) of respondents indicated supportive housing services had “fair access” or were easy to access; an increase from CY 2023 (45%).

Factors that Influence Access

When asked about the factors that negatively impact accessing supportive housing services, the most predominant responses include:

- Wait list exists for services[50]
- Lack of capacity/no service provider available
- Clinical team unable to engage/contact member

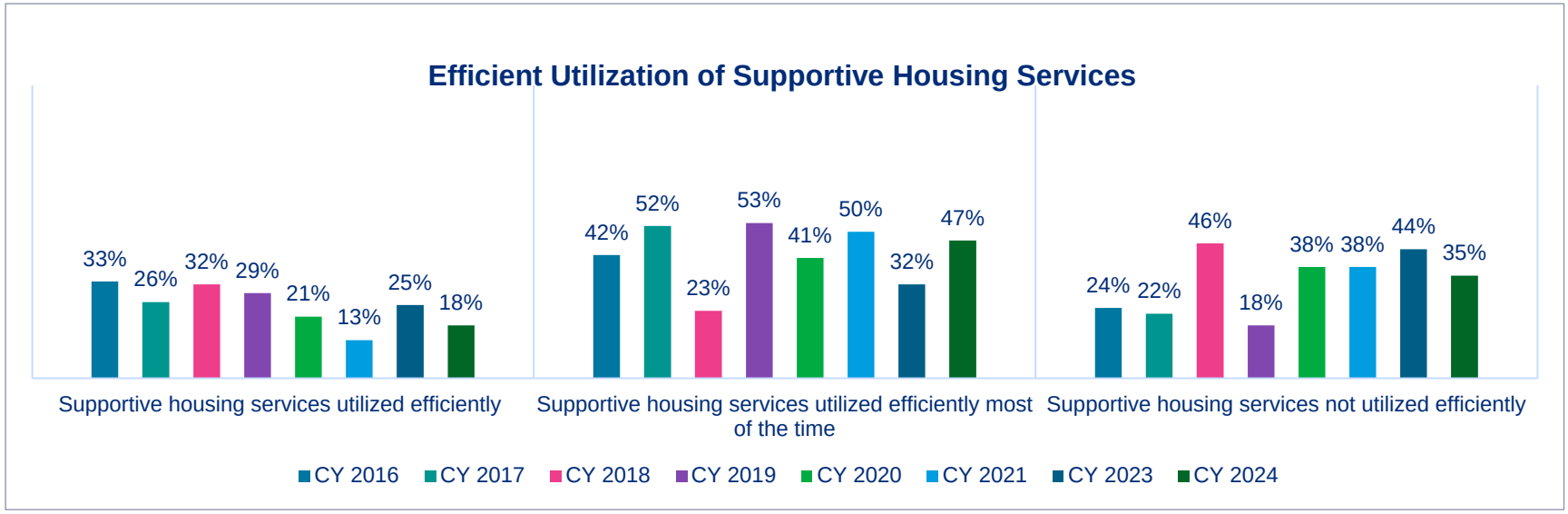


Efficient Utilization

In terms of efficient utilization of supportive housing services:

[50] Supportive housing services in this context refers to the full continuum of housing support available to persons living with a SMI. It is widely known wait lists exist for housing vouchers due to the limited supply versus demand. The responses on the key informant survey more than likely reflect stakeholder perceptions regarding wait lists for supportive housing vouchers, not permanent supportive housing services.

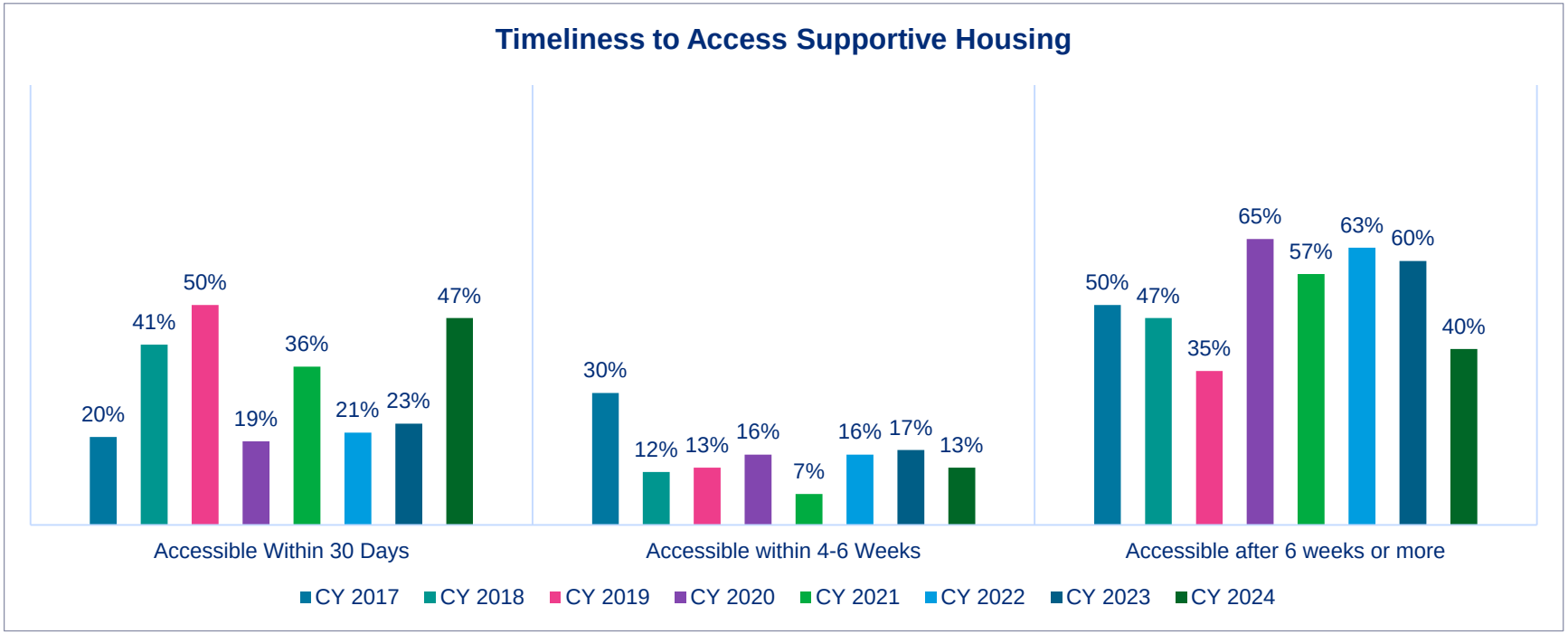
- Eighteen percent (18%) of the responses indicated the services were being utilized efficiently (25% in CY 2023).
- Forty-seven percent (47%) responded the services were utilized efficiently most of the time (32% in CY 2023).
- Thirty-five percent (35%) of the respondents indicated supportive housing services were not utilized efficiently (44% in CY 2023)



Timeliness

In terms of the amount of time to access supportive housing services:

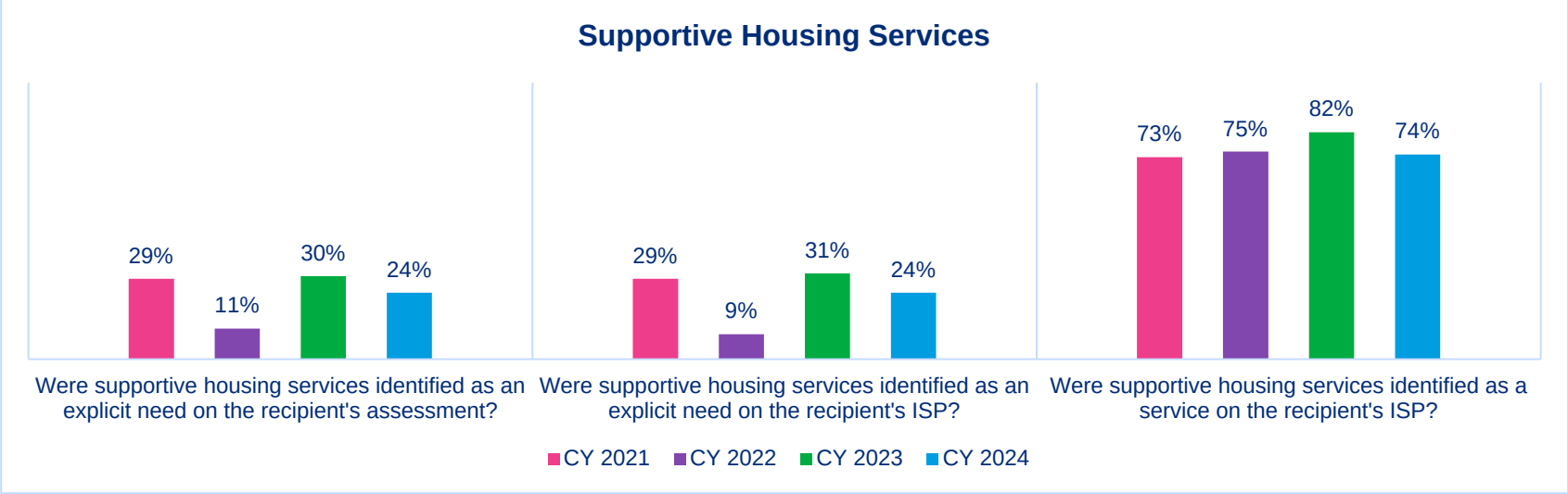
- Forty-seven percent (47%) of the survey respondents reported supportive housing services could be accessed within 30 days of the identification of the service need (23% in CY 2023).
- Thirteen percent (13%) of the respondents indicated the service could be accessed on average within four to six weeks (17% in CY 2023).
- Forty percent (40%) of the survey respondents reported it would take an average of six weeks or longer to access supportive housing services (60% in CY 2023).



Medical Record Review

The clinical teams at the integrated health homes consistently assess and document each recipient's living situation in the health home medical records.

- Supportive housing services were identified as a need on either the recipient's assessment or recipient's ISP in 31% of the cases reviewed, less than last year's finding (36%).
- Supportive housing was identified as a service on the recipient's ISP in 74% of the cases when identified as a need. A decrease from last year when 82% of the ISPs with a documented need included supportive housing.
- Twenty-two percent (22%) of the recipients included in the medical record review sample received a unit of supportive housing during CY 2024.



In 24 cases, reviewers were able to review progress notes and record the reasons the person was unable to access supportive housing services after housing-related assistance was included on the person's ISP. The most common reason was there was a lack of evidence the clinical team followed up with initiating a referral for the service.

Member-Specific Experiences

Mercer reviewers analyzed member-specific experiences with the care system to illustrate and reinforce key themes identified through the service capacity assessment. The two examples below pertain to members whose clinical teams identified a need for supportive housing services and recommended the services as part of the person's individual service plan.

Case #1 – Supportive Housing Services

The member has an assigned guardian to assist with accessing services and other administrative and programmatic support as needed. Due to the member's mental health symptoms, the member requires assistance with activities of daily living. At the time of the assessment, the member is living in a transitional and emergency housing program. The transitional living program allows the member to stay up to three months and requires the member to have income or be actively searching for employment. Prior to the current placement, the member resided in multiple different housing situations, including a homeless shelter. Per the assessment, the member is not currently employed but is looking for work. The member is agreeable to housing assistance through the clinical team.

The member's ISP includes an action step that states the housing specialist will actively work with the member to obtain permanent supportive housing, vouchers, or resources for housing and will send referrals that are needed.

The member recently transferred from a different administrative entity/health home. The receiving administrative entity employs an intake specialist that meets with new members and identifies service needs. In this case, the intake specialist proceeded to contact health home team members, including the housing specialist, to establish services to meet the person's identified needs. This proactive approach appears to be a "best practice" to help ensure members are referred in a timely manner to and connected with service providers following the identification of needs or following the development of the person's ISP. Mercer observed multiple case records in which the clinical teams do not follow-up with initiating referrals for needed services after completing a member's service plan.

Following completion of the assessment and ISP, the health home's assigned housing specialist reached out to the member to schedule an appointment. However, the appointment was rescheduled due to transportation barriers. A new appointment was scheduled, and transportation was arranged by the housing specialist. Prior to the appointment, the member was temporarily evicted from the transitional living program due to intoxication and an escalation of mental health symptoms. The member subsequently missed the appointment and the clinical team learned the member took shelter at a community park.

Another appointment with the housing specialist was arranged with the member. By this time, the member was accepted back into the transitional housing program. However, the member missed the appointment due to the transportation provider not showing up. Later, the member successfully met with the housing specialist, who reviewed housing options with the member and completed an application to the Arizona Housing Program. The member eventually met with a benefit specialist who supported the member with an AHCCCS health insurance renewal application just before the expiration of the member's eligibility. Later, the health home team

attempted to arrange transportation on behalf of the member through the contracted transportation vendor. However, the member's AHCCCS eligibility renewal was still pending, and the transportation vendor representative refused to schedule a ride, citing that the member's AHCCCS eligibility had expired.

The health home team proactively outreached the member and made concerted efforts to connect the person to needed services within reasonable timeframes, particularly the intake specialist and the housing specialist. The member was ultimately able to access supportive housing services despite an unstable living environment, challenges with mental health symptoms, substance use, and inconsistent access to transportation services.

Case #2 – Supportive Housing Services
Per the member's assessment, the member is homeless and in need of housing and housing-related support. The clinical team documented a housing recommendation to address the member's needs. The member is unemployed, is not seeking work, and declined assistance in finding a job. The member is unhoused and is residing in an unsheltered outdoor space..

The individual service plan includes the following intervention: "T1016 – Case Management, 1 to 1 times (sic) per annually" to address the member's housing needs.

Given the member's unhoused status, the assessed need for housing-related support, and the objectives and interventions contained in the individual service plan, the need for supportive housing services is clearly established for this member.

Following the annual assessment and individual service plan update, a housing provider working with the member contacted the member's assigned health home to report the member was in "crisis." The member was placed on a 72-hour "ban" and was temporarily not allowed to return to the premises. Afterwards, a health home case manager attempted to contact the member, but was unsuccessful, and they left a voice mail.

The housing provider contacted the health home again and reported the member physically assaulted another person on the property and requested the health home to send someone to meet with the member. The member then contacted the health home to request assistance with expediting a Social Security Insurance eligibility application. The health home case manager offered the member a meeting with a benefit specialist, as well as a referral for housing, but the member was not interested. The case manager then contacted the housing provider and informed the provider that the team had encouraged the member to come to the clinic, but the member refused. The housing provider asked what could be done to assist the member, and the health home case manager stated the member was appropriate when they spoke, and the health home is unable to petition the member unless they observe behaviors that indicate the member is a danger to self or others.

Later, the case manager met the member in the community. The member was described as calm and lucid, and was encouraged to come into the clinic for support. After meeting the member, the case manager met with the co-located provider, who described the

member as aggressive, suspected to be using illicit substances, and was at-risk of being evicted from the community. The member then presented at the health home to meet with the benefit specialist and the member's behavior was described as appropriate.

Some additional time elapsed until the housing provider contacted the health home and reported the member was incarcerated. The housing provider asked about the process to petition the member for court-ordered treatment. The case manager explained that the last time the member presented at the clinic, the member was cooperative and coherent, and the member must be exhibiting behavior deemed to be a danger to self or to others to be petitioned. An extended period passed without a progress note regarding the member's status. The next progress note described a rehabilitation specialist's attempt to contact the member to ascertain the member's preference to attend an advisory committee meeting at the health home.

More time passed with no additional progress notes until the housing provider contacted the health home to report the member was evicted from a homeless provider's program due to unsafe and unsanitary behaviors. The provider again asked for assistance with petitioning the member, and the case manager provided a similar explanation regarding the absence of observable behaviors that meet the criteria for involuntary treatment. The case manager offered to see the member at a homeless shelter. However, there was no additional documentation to indicate a visit was attempted.

Later, the member called the health home "demanding a bus pass." The member was described as agitated when the case manager refused to deliver the bus pass to the member and requested the member come into the clinic. A representative of the health home then attempted to contact the member and left a "detailed message" regarding an overdue vocational activity profile that needed to be completed.

No additional documentation was available in this case, as Mercer's medical record documentation protocol requests progress notes within three months of the member's last assessment date. Although the member's behaviors may be characterized as challenging, the health home demonstrated a lack of urgency to outreach and offer support and services that may have prevented evictions and the member's incarceration. In addition, the health home clinical team allowed extensive time to elapse before attempting any interventions with the member. It's unclear why the case manager did not seek clinical supervision or convene a treatment team meeting with the health home's clinical leadership and the housing provider to help identify interventions to support the member. Outreach attempts to contact the member were minimal, given the member's acute presentation and reported assaultive behaviors, and some of the contacts initiated by the care team lacked relevance and seemed disconnected from what the member was experiencing (e.g., inviting the member to an advisory committee, following up with an overdue vocational activity profile). As observed with other medical record review cases, the clinical team did not follow up with the member's individual service plan goals or objectives and assumed a passive role in supporting the member's stability and recovery.

Service Utilization Data

Permanent supportive housing utilization includes skills training and development services to help members obtain and maintain community-based independent living arrangements. In addition to these services, targeted services for contracted permanent supportive housing providers can include behavioral health prevention and education, peer support, case management, behavioral health screening and assessment, non-emergency transportation, medication training and support, counseling, personal care, and psychoeducational services.

Mercer utilizes a subset of these services to capture supportive housing services when rendered by a contracted permanent supportive housing provider.[51] The contracted managed care organization tracks supportive housing utilization through a roster of members affiliated with one of 10 contracted supportive housing providers. During the period of January 1, 2024–November 30, 2024, the roster of members receiving permanent supportive housing totaled 1,235, which is a reduction of 68 members over a comparable period last year.

As indicated within the service utilization data file, 4,700 (compared to 4,436 last review cycle) Title XIX eligible (Medicaid) recipients and 1,204 (compared to 1,006 last review cycle) non-Title XIX recipients were affiliated with the service during the period of October 1, 2023–December 31, 2024, from a total population of 40,425.

Key Findings and Recommendations

The following information summarizes key findings identified as part of the service capacity assessment of supportive housing.

Findings: Supportive Housing

- Service utilization data reveals 15% of members received at least one unit of supportive housing during the review period; 462 more members received supportive housing between CY 2024 and CY 2023. In addition, there was an increase of 82,210 supportive housing units during this same period.
- Permanent supportive housing providers share there are immediate openings available to members, but report some case managers appear unaware of the availability of supportive housing services. Case manager focus group participants confirm a lack of awareness regarding available permanent supportive housing providers in the community, opting to refer members to the assigned housing specialist at the health home or attempting to assist the member directly. Provider focus group participants express housing specialists are often too “bogged down” by the need to find housing for members and may not initiate referrals for

[51] Mercer queried the following codes to delineate supportive housing service utilization when provided by a contracted supportive housing provider: H0043 (Supportive Housing); H2014 (Skills Training and Development); H2017 (Psychosocial Rehabilitation Services); and T1019 and T1020 (Personal Care Services).

permanent supportive housing services. Provider participants noted some health homes may not have an available housing specialist and believe there is an insufficient number of housing specialists to adequately assist members in need of housing support.

- During the focus groups, it was reported that some health homes offer an overview of supportive housing services during new employee orientation, but most case manager focus group participants report not receiving training regarding the full continuum of available supportive housing services and how to assist members to access the services. Case manager focus group participants attributed the high rate of turnover among health home staff as a barrier to keeping the teams continuously informed. Adult member focus group participants report receiving rental subsidies, but all were unfamiliar with available permanent supportive housing services.
- Family member focus group participants shared that after members obtain housing, there is a lack of support to help maintain the housing on a long-term basis. One family member participant shared that her son's home can quickly transition from well-maintained to "needing to be condemned" if there is not regular and ongoing support. Another parent focus group participant, who is paying for her adult son's apartment, needs supportive housing assistance to help him learn to maintain it. The parent shared that she has asked for the service on behalf of her son, but has yet to receive it.
- Forty-seven percent (47%) of the survey respondents believed supportive housing services were difficult to access (48% in CY 2023). Fifty-three percent (53%) of respondents indicated supportive housing services had "fair access" or were easy to access; an increase from CY 2023 (45%).
- Forty percent (40%) of the survey respondents reported it would take an average of six weeks or longer to access supportive housing services (60% in CY 2023).
- Supportive housing was identified as a service on the recipient's ISP in 74% of the cases when identified as a need. A decrease from last year, when 82% of the ISPs with a documented need included supportive housing.

Recommendations: Supportive Housing

- Ensure health home case managers receive training and clinical supervision to support members who express an interest in supportive housing services, including awareness of the full continuum of available supportive housing services and how to access the services on behalf of members.
- Ensure health home clinical teams follow up and assist members in accessing timely supportive housing services when identified as a need on members' ISPs.

Multi-Evaluation Component Analysis — Assertive Community Treatment

Service Description[52]

An ACT team is a multi-disciplinary group of professionals including a psychiatrist, a nurse, a social worker, a substance abuse specialist, a vocational rehabilitation specialist, and a peer specialist. Services are customized to a recipient's needs and vary over time as needs change.

Focus Groups

Mercer facilitated focus groups to promote discussion with participants with direct experience with priority mental health services. Readers should review focus group results in the context of qualitative and supplemental data and not interpret the feedback as representative of all system stakeholders.

Findings collected from focus group participants regarding ACT services included the following:

- During the provider focus group, participants expressed that ACT team staff demonstrate passion and commitment to members. Provider focus group participants report, "ACT teams can do wonders" and emphasize that ACT teams optimally perform when the team possesses skills and has the support of management.
- Case manager focus group participants shared positive impressions of ACT, stating the service is "tailored more to each member" and you can "actually get to know a person" because you spend more time with each member. The case managers report the success of ACT depends on management and how well the team implements the evidence-based model of ACT.
- Some family member focus group attendees were personally familiar with ACT due to their adult children receiving the service and shared varying views about the service. One family member stated, "There are some good ACT team providers. Their teams work a lot of hours and are exhausted, but they are available, respect guardians, are good at engaging, communicate well with families, and understand medications and the importance of medication support." She added that other ACT teams are not this responsive and respectful of guardian involvement. Another family member reported ACT had been "the best thing to ever happen" to her son, but it was difficult to initially access the service.

[52] The definitions for the priority mental health services are derived from the *Stipulation for Providing Community Services and Terminating the Litigation,* which may not reflect the terminology utilized to currently describe these services Specifically, social work professionals are not recognized as a required ACT team member per SAMSHA's ACT Evidence-Based Practices Kit.

- Case manager and provider focus group participants shared perceptions that there are not enough ACT teams available and stressed the need for more ACT teams due to ongoing wait lists. Provider and case manager focus group attendees report ACT teams operate at full capacity for the most part, with the exception of when teams experience staff turnover. Case manager focus group participants share there is now a protocol in place to share information regarding openings in other health home ACT teams.
- Family member focus group participants shared ideas to expand the number of available ACT teams and expressed the need for more medical ACT teams. Case manager and provider focus group attendees agreed there is a need for more forensic and medical ACT teams and would also like to access teams specializing in geriatrics and transitional or college-age youth.
- Family member participants familiar with ACT admission criteria described scenarios in which the criteria may not have been followed and shared accounts of members who appeared to meet ACT admission criteria but were not approved for the service.
- Case manager and provider focus group participants reported being familiar with ACT admission criteria. Case managers do not experience many ACT service denials as the criteria is perceived to be specific enough to prevent members from not being accepted, however; providers believed denial rates are high for ACT. Case manager participants reference the criteria to determine whether to make an ACT team referral and, when there is a formal denial, case managers report members receive a notice of decision.
- An ACT provider participating in the focus group reports approximately 5% of ACT team members will graduate from the program, and members are evaluated annually to determine whether the member is ready for a lower level of care.
- ACT team provider and case manager focus group participants share turnover is high with ACT team staff. Case manager and provider attendees agree the workload for ACT team staff members can be overwhelming, and staff are not always prepared for the work. The participants perceive billable hour goals, long work hours, extensive documentation requirements, and on-call expectations make it difficult to recruit and retain team members.
- Provider and case manager focus group participants agree the support an ACT team receives is critical to prevent turnover. Case manager participants suggest having teams participate in clinical decisions, conduct team building opportunities, offer specific training days that offset billable hour goals, and add an additional team member who handles administrative tasks. Provider attendees recommend allowing ACT team staff to use dictation technology for note entry, adding no teams presently have this kind of support.

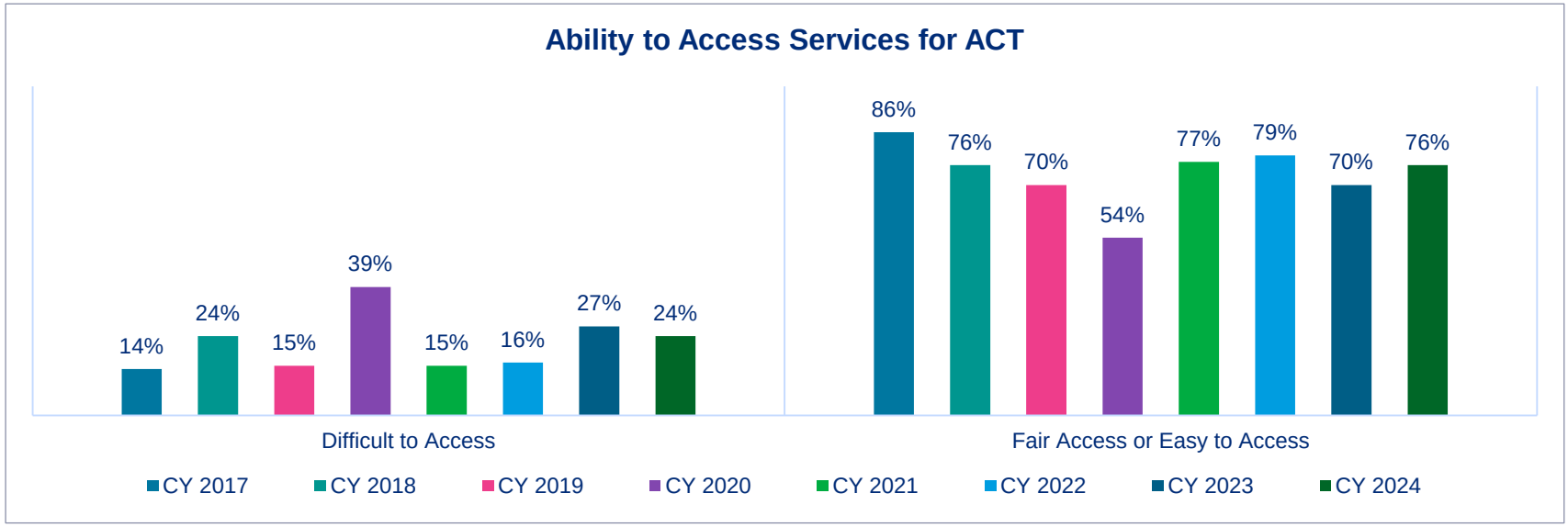
Key Informant Survey Data

As part of an effort to obtain comprehensive input from key system stakeholders regarding availability, quality, and access to ACT team services, Mercer administered a key informant survey. The survey tool included questions and rating assignments related to the priority mental health services. The survey distribution process targeted a defined list of system stakeholders, and responses to the survey did not represent a statistically significant sample of all potential informants. Readers should review survey results in the context of qualitative and supplemental data and avoid interpreting results to be representative of the total population of system stakeholders.

Level of Accessibility

Twenty-four percent (24%) of survey respondents reported ACT team services were difficult to access (27% in CY 2023).

Seventy-six percent (76%) of respondents indicated ACT team services had “fair access” or were easy to access (70% in CY 2023).



Factors that Influence Access

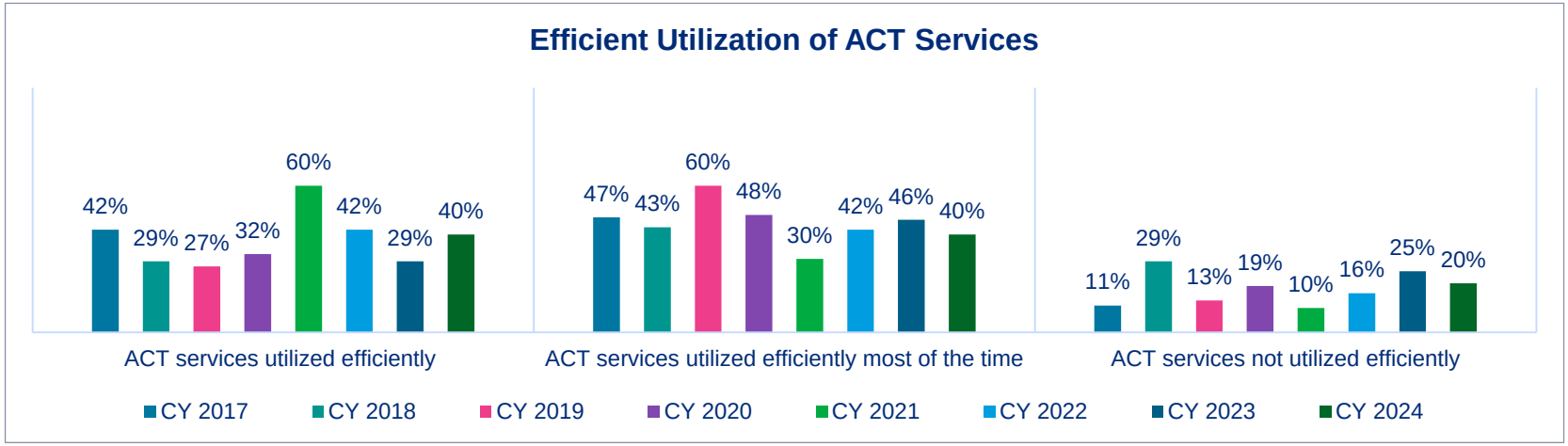
When asked about the factors that negatively impact accessing ACT team services, the CY 2024 responses are as follows:

- Clinical team unable to engage/contact member
- Staffing turnover
- Transportation barriers

Efficient Utilization

In terms of the efficiency of service utilization in CY 2024:

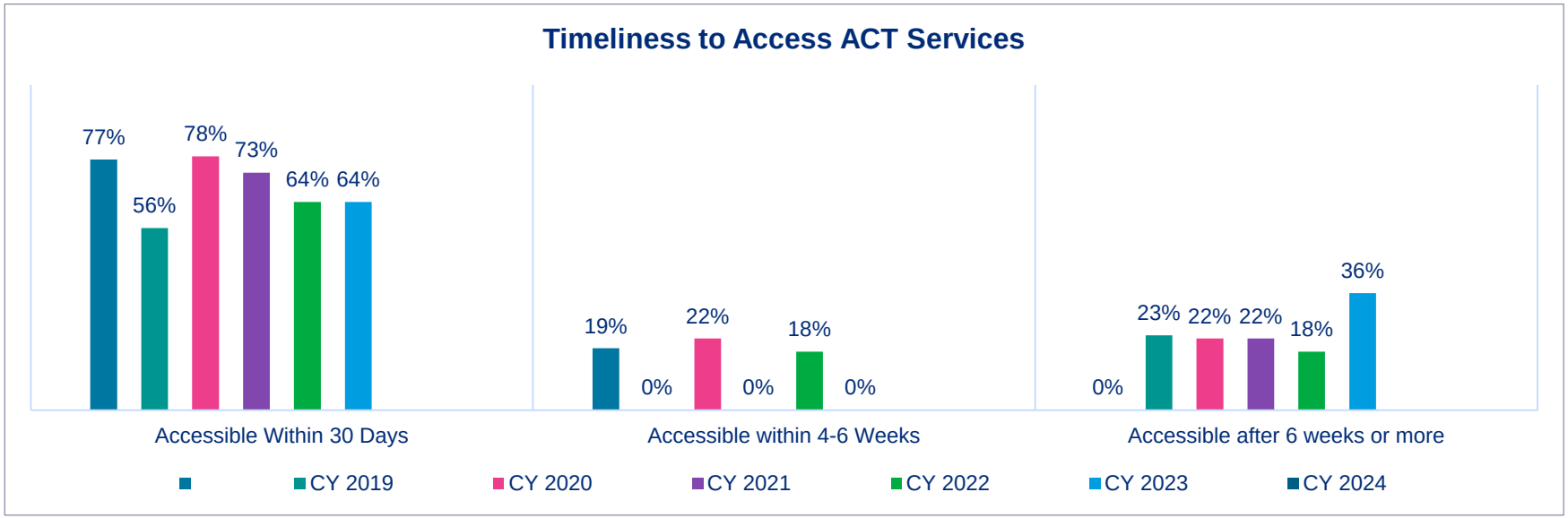
- Forty percent (40%) of the responses indicated the services were being utilized efficiently (29% in CY 2023).
- Forty percent (40%) responded the services were utilized efficiently most of the time (46% in CY 2023).
- Twenty percent (20%) of the respondents indicated ACT team services were not utilized efficiently (25% in CY 2023).



Timeliness

In terms of the amount of time to access ACT team services in CY 2024:

- Sixty-four percent (64%) of the survey respondents reported ACT team services could be accessed within 30 days of the identification of the service need (64% in CY 2023).
- None (0%) of the survey respondents indicated the service could be accessed on average, within four to six weeks (18% in CY 2023).
- Thirty-six percent (36%) of survey respondents reported it would take an average of six weeks or longer to access ACT team services (18% in CY 2023).

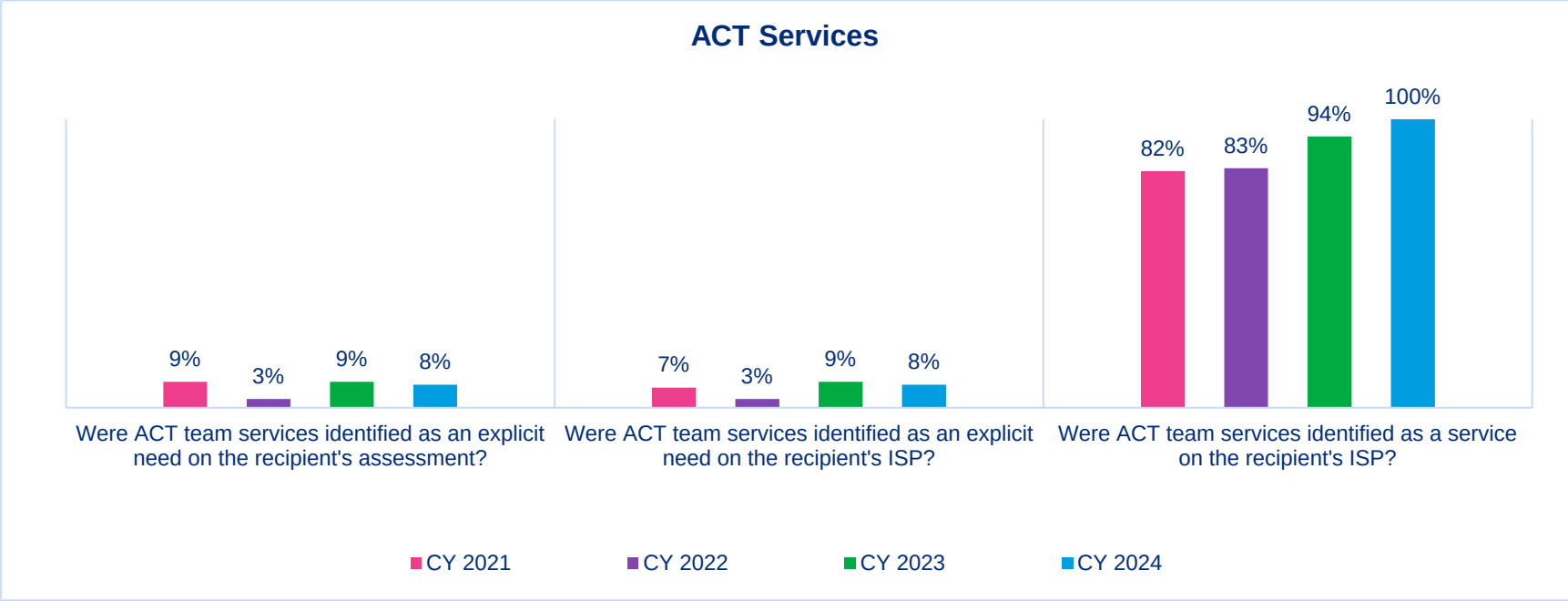


Medical Record Review

Mercer reviewed a random sample of 200 recipients' medical records documentation to evaluate the consistency in which ACT team services were assessed by the clinical team, identified as a needed service to support the recipient, was included as part of the ISP, and, when applicable, was accessed timely by the member.

In 16 cases (8%), ACT team services were identified as a need on recipients' assessments or ISPs. All of the cases with an assessed need for ACT included ACT or case management services on the ISP.

Seven and a half percent (7.5%) of the recipients included in the sample were assigned to an ACT team.



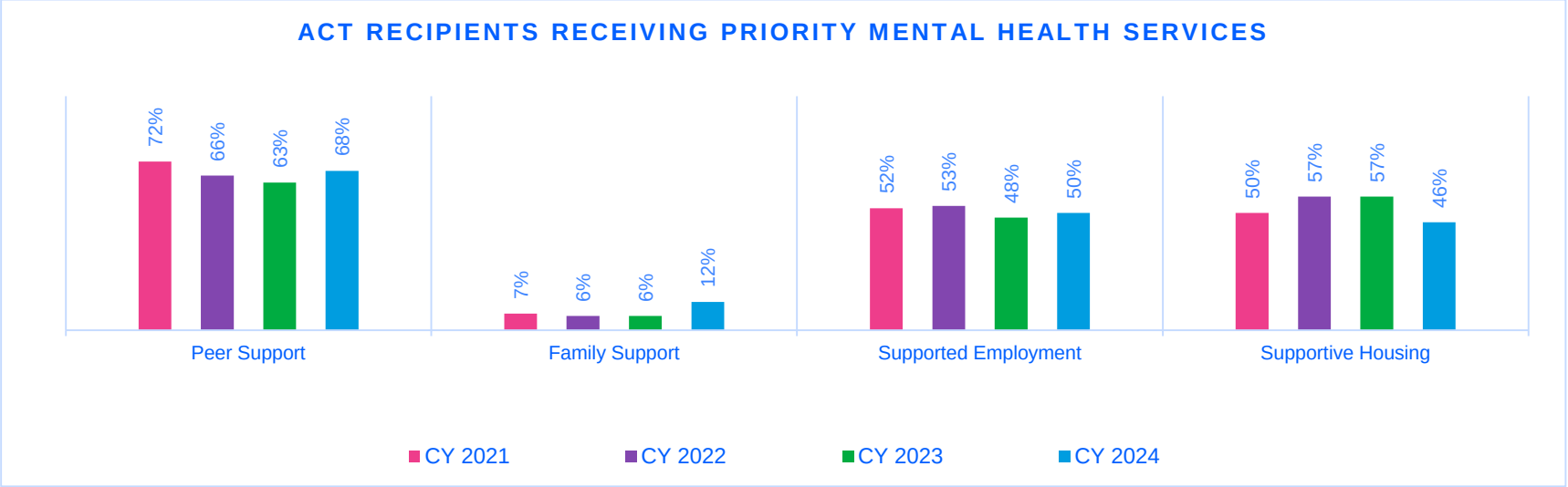
Service Utilization Data

ACT team services are not assigned a specific billing code. Therefore, ACT team services are not uniquely reflected in the service utilization data file. Mercer did complete an analysis of service utilization for recipients that were assigned to an ACT team. They

analyzed CY 2024 service utilization profiles for 2,078 ACT team members who received a behavioral health service. The analysis sought to identify the utilization of one or more of the priority services (supported employment, supportive housing, peer support services, and/or family support services).

The analysis found:

- Sixty-eight percent (68%) of the ACT team members received peer support services during the review period.
- Twelve percent (12%) of the ACT team members received family support services.
- Fifty percent (50%) of ACT recipients received supported employment services.
- Forty-six percent (46%) of ACT recipients received supportive housing services.



Analysis of Cost Data

To ensure the appropriate utilization of ACT services, entities involved in the clinical management of persons living with SMI should actively monitor and identify candidates for ACT team services by regularly analyzing relevant data sources. Examples include, but

are not limited to, service utilization trends, service expenditures, the review of jail booking data, quality of care concerns, and adverse incidents involving members living with SMI.

Mercer assessed 100 members living with SMI associated with the highest aggregate behavioral health service costs during CY 2024. The analysis found 20% of the members are assigned to an ACT team. This is a slightly higher percentage when the analysis was completed during CY 2023 (19%).

Of the 20 members assigned to ACT and included on the list of the top 100 members with the highest behavioral health service costs, 14 (70%) also reside in supervised behavioral health residential settings. During times of transition (admission or discharge from ACT team services), it may be appropriate to temporarily have a member assigned to ACT and placed in a supervised setting, but this should be time-limited due to the duplicative nature of the services. In other cases, placement in a supervised behavioral health residential setting and assignment to ACT may be appropriate for some high-acuity members (e.g., medical comorbidities, challenging behaviors).

Overall, 72% of the 100 members reside in a supervised behavioral health residential setting, which can contribute to higher service costs for those members and may dissuade clinical teams from considering or referring a member to an ACT team. When members placed in a supervised behavioral health residential setting are excluded from the analysis, 22 out of 28 (79%) members may benefit from assignment to an ACT team if determined clinically appropriate.

Key Findings and Recommendations

Findings: ACT Team Services

- As a percentage of the total population with SMI, 5.2% of all members are assigned to an ACT team. There are 45 more members assigned to an ACT team when comparing CY 2024 to CY 2023. There has been a slight reduction of 12 ACT team members between CY 2024 and CY 2022[53].
- Case manager focus group participants shared positive impressions of ACT, stating the service is “tailored more to each member” and you can “actually get to know a person” because you spend more time with each member. The case managers report the success of ACT depends on management and how well the team implements the evidence-based model of ACT.
- ACT team provider and case manager focus group participants share turnover is high with ACT team staff. Case manager and provider attendees agree the workload for ACT team staff members can be overwhelming, and staff are not always prepared for

[53] ACT team census may exclude ACT team participants if those members are assigned to managed care contractors that do not administer the Regional Behavioral Health Agreement and/or are assigned to the American Indian Health Plan.

the work. The participants perceive billable hour goals, long work hours, extensive documentation requirements, and on-call expectations make it difficult to recruit and retain team members.

- Provider and case manager focus group participants agree the support an ACT team receives is critical to prevent turnover. Case manager participants suggest having teams participate in clinical decisions, conduct team building opportunities, offer specific training days that offset billable hour goals, and add an additional team member who handles administrative tasks. Provider attendees recommend allowing ACT team staff to use dictation technology for note entry, adding no teams presently have this kind of support.
- Twenty-four percent (24%) of survey respondents reported ACT team services were difficult to access (27% in CY 2023).
- Sixty-eight percent (68%) of the ACT team members received peer support services, 50% received supported employment services, and 46% received supportive housing services during the review period.

Recommendations: ACT Team Services

- To address available capacity on many ACT teams, continue efforts to identify candidates for ACT and FACT team services through the regular analysis of service utilization trends, service expenditures, and the review of jail booking data, quality of care concerns, and adverse incidents involving members living with SMI. The contracted managed care organization should proactively alert clinical teams when key metrics suggest an assigned member may be appropriate for transition to an ACT team.
- Continue efforts to mitigate workforce challenges associated with the recruitment and retention of ACT team staff members. Consider offering flexible work schedules, incentives, and other innovative approaches to support workers and improve job satisfaction and retention.
- Provide ongoing training and supervision to help ensure health home case managers understand how to identify ACT team candidates and the established procedures to refer a member to an ACT team.

Section 6

Outcomes Data Analysis

The service capacity assessment included an analysis of recipient outcome data to link receiving one or more priority mental health services with improved functional outcomes. Relationships between outcomes and service utilization trends do not necessarily reflect causal effects. As such, observed outcomes may be contingent on several variables unrelated to the receipt of one or more of the priority mental health services.

Mercer reviewed the following data sources:

- Employment status
- Criminal justice involvement
- Emergency room utilization
- Grievance data

Employment Status

Employment stimulates self-reliance and leads to other valued outcomes, including self-confidence, respect for others, personal income, and community integration. It is not only an effective short-term treatment but also one of the only interventions that lessens dependence on the mental health system over time.[54]

The contracted managed care organization contracts with six specialty employment providers to implement evidence-based supported employment services. The provider network includes various provider types, including outpatient providers, peer-run organizations, and community service agencies. These providers may offer psychoeducational services, pre-job training and development, and ongoing support to maintain employment. A billing code modifier (H2027 SE) tracks employment services provided to members with an expressed interest and goal of obtaining employment in the next 45 days or are currently engaged in an active job search with a contracted supported employment provider. Services provided using H2027 SE are directly related to obtaining

[54] Robert E. Drake and Michael A. Wallach. Employment is a Critical Mental Health Intervention. *Epidemiology and Psychiatric Services*, November 5, 2020.

employment. From January 1, 2024, through December 31, 2024, there were 1,890 people living with SMI in Maricopa County who received at least one unit of H2027 SE, which is 21 additional members compared to CY 2023.

For people living with SMI, the following counts of employment are noted as of December 1, 2024:

- People competitively employed full-time: 3,156
- People competitively employed part-time: 3,018
- People with other employment: 1,337

Criminal Justice Involvement

Mercer analyzed jail booking data to identify members that have had multiple jail bookings over a defined period (i.e., 11 months — January 2024 through November 2024). Members with multiple incarcerations are then compared to ACT and FACT team rosters to determine the percentage accessing the evidence-based practice.

- There were 1,362 unique members incarcerated during the review period. The number of incarcerations per member ranged from one to nine.
- There were 289 members who experienced at least two jail bookings during the period under review (428 in CY 2023).
- Of these 289 members, 61 (21%) were assigned to an ACT team during the review period (13% in CY 2023).
- Of the 61 members assigned to an ACT team, 13 (21%) are assigned to a forensic specialty ACT team (21% in CY 2023).
- There were 19 members receiving ACT team services with three or more incarcerations over the review period, but they are not assigned to one of the three available forensic specialty ACT teams, an increase of two members when compared to last year.
- There are 180 members with three or more incarcerations that are not currently assigned to an ACT or forensic specialty ACT team.

Although individuals experiencing multiple incarcerations may be evaluated for assignment to an ACT or FACT team, the presence of repeated jail bookings may not necessarily be due to the person’s mental health acuity, but rather, can involve behaviors such as probation violations and missing court appearances.

Emergency Room Utilization[55]

Mercer analyzed emergency room utilization for members living with SMI in Maricopa County over the period of October 1, 2023–December 31, 2024. A summary of findings is presented below:

- Over the reporting period, there were 99,859 emergency department visits involving 14,406 unique members or 36% of the total population (40,425). Over a comparable period last year, there were 94,587 emergency department visits involving 14,184 unique members or 36% of the total population (39,047).
- There were 9,216 (23%) members who experienced three or more emergency room visits during the reporting period.
- For people assigned to an ACT team, there were 8,478 emergency room visits involving 922 unique members or 44% of the ACT team population (2,105). Last year, the same analysis found there were 8,818 emergency room visits involving 918 unique members or 45% of the ACT team population (2,060).
- There were 627 or 30% of ACT team members who experienced three or more emergency room visits during the reporting period.

Grievance Data

Mercer reviewed summarized grievance data collected by the contracted managed care organization over the following period: January 1, 2024–November 2024. Below is an overview of the types of complaints related to members living with SMI in Maricopa County.

- A total of 2,793 complaints were recorded over the reporting period (compared to 2,318 during CY 2023).
- There were 2,460 complaints noted as “closed” at the time of the report, with 31% of those cases involving issues found to be substantiated and an additional 9% being partially substantiated.

The tables below summarize counts by complaint category and sub-category:

[55] Mercer did not have access to diagnostic codes for members presenting to the emergency room; therefore, we cannot verify the visits involved assessment/treatment for behavioral health conditions.

Category	Count
Access to care	14
Attitude and service	2,422
Billing and financial issues	83
Quality of care	271
Quality of practitioner office site	3
TOTAL	**2,793**

Subcategory — Access to Care	Count
Access to appointments	12
Geographic availability of network practitioner or provider	1
Telephone access	1

Appendix A

Focus Group Invitation

Seeking Your Feedback — Service Capacity Assessment Stakeholder Sessions

Are you looking for a way to provide feedback about Priority Mental Health Services (PMHS)* in Maricopa County's behavioral health system ***and*****,** you are:

- An ***adult with a serious mental illness*** (SMI) living in Maricopa County and receiving at least one PMHS from the behavioral health system
- A ***family member of an adult with SMI*** living in Maricopa County, who is receiving at least one PMHS from the behavioral health system
- A ***health home case manager*** providing PMHS for adults with SMI in Maricopa County
- Or a provider of a priority mental health service (PMHS) in Maricopa County.

**PMHS includes Assertive Community Treatment (ACT), Supportive Housing or Permanent Supportive Housing (SH), Supportive Employment (SE), or Peer and Family Support Services.*

If so, consider registering for *one* of the in-person sessions below. *Attendees may only attend* **one** *session that best matches their role in the behavioral health system.*

Session One:
For ***Adults with SMI*** receiving at least one PMHS

Monday, January 27, 2025
10:00 am–Noon

Session Two:
For ***Health Home Case Managers*** providing PMHS to adults with SMI

Monday, January 27, 2025

Session Three:
For ***Family Members of Adults with SMI*** receiving at least one PMHS

Tuesday, January 28, 2025

Session Four:
For ***Providers of ACT, SH, SE, Peer and Family Support Services***

Tuesday, January 28, 2025

All sessions will be held *in person* at the following location:

Burton Barr Central Library, Meeting Room A
1221 N Central Ave, Phoenix, AZ 85004
RSVP with the name of the session you want to attend (for example, Group One) by January 24, 2025, to Liza Auterino at liza.auterino@mercer.com or via call or text at +1 480 238 9161.
Space is available for 15 participants per stakeholder group. All RSVPs will be confirmed by email.
Once capacity is reached, interested participants will be placed on a waiting list.

Si el Español es su idioma de preferencia y desea dar comentarios, por favor enviar correo a liza.auterino@mercer.com y nosotros agendaremos una llamada con un intérprete

Information gathered in these stakeholder sessions will be provided to the Arizona Health Care Cost Containment System (AHCCCS) as part of the annual Service Capacity Assessment of PMHS in Maricopa County. Information gathered helps to expand access to recovery-oriented services. Please note that all attendee names and information shared will be kept confidential.

Priority Mental Health Services – Definitions

Peer support services are delivered in individual and group settings by individuals who have personal experience with mental illness, substance abuse, or dependence and recovery to help people develop skills to aid in their recovery.

Family support services are delivered in individual and group settings and are designed to teach families skills and strategies for better supporting their family member's treatment and recovery in the community. Supports include training on identifying a crisis and connecting recipients in crisis to services, as well as education about mental illness and about available ongoing community-based services.

Supported employment services are services through which recipients receive assistance in preparing for, identifying, attaining, and maintaining competitive employment. The services provided include job coaching, transportation, assistive technology, specialized job training, and individually tailored supervision.

Supportive housing or permanent supportive housing is permanent housing with tenancy rights and support services that enable recipients to attain and maintain integrated affordable housing. It enables recipients to have the choice to live in their own homes and with whom they wish to live. Support services are flexible and available as needed but not mandated as a condition of maintaining tenancy. Supportive housing also includes rental subsidies or vouchers and bridge funding to cover deposits and other household necessities, although these items alone do not constitute supported housing.

An ACT team is a multi-disciplinary group of professionals, including a psychiatrist, nurse, social worker, substance abuse specialist, vocational rehabilitation specialist, and peer specialist. Services are customized to a recipient's needs and vary over time as needs change.

Appendix B
Key Informant Survey

Mercer AHCCCS Priority Mental Health Services: Key Informant Survey 2025

Q1. Please indicate if you provide the following behavioral health services to adults with a serious mental illness (SMI).

	Yes (1)	No (2)
Assertive Community Treatment (ACT) (1)	O	O
Family Support Services (2)	O	O
Peer Support Services (3)	O	O
Supported Employment (4)	O	O
Supportive Housing (5)	O	O

Q2. Based on your experience as a provider, rate the level of accessibility to each of the priority services.
1=No Access/Service Not Available, 2=Difficult Access, 3=Fair Access, 4=Easy Access, NA=I do not have experience with this service

	1 (1)	2 (2)	3 (3)	4 (4)	N/A (5)
ACT (1)	O	O	O	O	O
Family Support Services (2)	O	O	O	O	O
Peer Support Services (3)	O	O	O	O	O
Supported Employment (4)	O	O	O	O	O
Supportive Housing (5)	O	O	O	O	O

Q3. Please identify the factors that hinder access to each of the priority services (select all that apply).

	Member Declines Service (1)	Wait List Exists for Service (2)	Language or Cultural Barrier (3)	Transportation Barrier (4)	Clinical Team Unable to Engage/Contact Member (5)	Lack of Capacity/No Service Provider Available (6)	Admission Criteria for Services too Restrictive (7)	Staffing Turnover (8)	Other (9)
ACT (1)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Family Support Services (2)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Peer Support Services (3)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Supported Employment (4)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Supportive Housing (5)	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q4. If you checked other above, please specify:

_____

Q5. Are the priority services below being utilized efficiently?

	Yes (1)	Most of the Time (2)	No (3)	N/A (4)
ACT (1)	O	O	O	O
Family Support Services (2)	O	O	O	O
Peer Support Services (3)	O	O	O	O
Supported Employment (4)	O	O	O	O
Supportive Housing (5)	O	O	O	O

Q6. After a priority service need is identified by the clinical team, member, and family (as applicable), how much time elapses before the member accesses the service? Please respond for each priority service. NA = I do not have experience with this service.

	1-2 Weeks (1)	3-4 Weeks (2)	4-6 Weeks (3)	Longer than 6 weeks (4)	NA (5)
ACT (1)	O	O	O	O	O
Family Support Services (2)	O	O	O	O	O
Peer Support Services (3)	O	O	O	O	O
Supported Employment (4)	O	O	O	O	O
Supportive Housing (5)	O	O	O	O	O

Q7. Over the past 12 months, to what degree has access to each of the priority services changed? 1=easier to access, 2=more difficult to access 3=no change

	1 (1)	2 (2)	3 (3)
ACT (1)	O	O	O
Family Support Services (2)	O	O	O
Peer Support Services (3)	O	O	O
Supported Employment (4)	O	O	O
Supportive Housing (5)	O	O	O

Q8. Describe the most significant service delivery issue(s) for the persons with a SMI accessing behavioral health services in Maricopa County.

_____

Q9. What is your job role/title?

- O CEO (1)
- O Executive Management (2)
- O Clinical Leadership (behavioral health) (3)
- O Clinical Leadership (medical) (4)
- O Specialty Case Manager (5)
- O Direct Services Staff (BHP/BHT) (6)
- O Other (please specify) (7) _____

Q10. From the list below, please select which best describes * your organization.

- O ACT Team Provider (1)
- O Behavioral Health Provider for Adults with a SMI Only (2)
- O Behavioral Health Provider for Adults with a SMI, Children, General Mental Health/Substance Abuse (3)
- O Consumer Operated Agency (peer support services/family support services for adults) (4)
- O Crisis Provider (5)
- O Hospital (6)
- O Provider Network Organization or other Administrative Entity within the Maricopa County Regional Behavioral Health Authority System (7)
- O Supported Employment Provider (8)
- O Supportive Housing Provider (9)
- O Other (please specify) (10) _____

Appendix C
Medical Record Review Tool

Log-in screen [1]
Reviewer Name _____ Client ID _____ DOB ___/___/___
Date _____/_____/_____ Provider Network Organization _____ Direct Care Clinic_____
Date of most recent assessment ___/___/___ Date of most recent ISP___/___/___ Sample period: *January 1, 2024 – December 31, 2024*

Chart Review [2]						
	Functional Assessment Need (as documented by the clinical team) **[2A]**	ISP Goals Need (as documented by the clinical team) **[2B]**	Is the documented need consistent with other information (e.g., client statements, assessment documentation)? **[2C]**	ISP Services (record any relevant service(s) referenced on the ISP) **[2D]**	Evidence of Service Delivery Consistent with ISP **[2E]**	Reasons Service was not Delivered Consistent with ISP **[2F]**
ACT						
Supported Employment						
Supportive Housing						
Peer Support Services						
Family Support Services						

Appendix D
Summary of Recommendations

Service	Recommendations
Peer Support Services (PSS)	PSS 1: Assess and expand capacity, as appropriate, to provide more opportunities for members to access 1:1 peer support while emphasizing peer support interactions during crisis events, as part of hospital discharge planning teams, and supporting young adults experiencing first episode psychosis. PSS 2: Per the AHCCCS Contractor Operations Manual, *Policy 407, Workforce Development*, overseeing the development of the provider workforce is a function of the managed care contractor's network management responsibilities. As such, take actions to deploy a qualified and sufficiently staffed peer support workforce and offer training and resources for providers to assist peer support workers in effectively managing stress and burnout.
Family Support Services (FSS)	FSS 1: Formally assess the current provider network's capacity to offer family support services and recruit additional providers as appropriate. FSS 2: Continue efforts to provide training, supervision, and written materials to help ensure that health home clinical team members understand the appropriate application of family support services and to recognize the value of the services as an effective service plan intervention.
Supported Employment Services (SES)	SES 1: Ensure that health home case managers receive training and clinical supervision to support members who express an interest in supported employment services, including awareness of community-based supported employment providers and how to access the services on behalf of members. SES 2: Ensure that integrated health homes are performing required vocational assessments during the annual assessment and ISP update process, and monitor and track that recommended services on member's ISPs are delivered, including VAPs. SES 3: Designate and expand staffing resources to serve as benefit specialists (e.g., use of peer

Service	Recommendations
	support specialists, case managers) to address ongoing member concerns about securing employment, without jeopardizing eligibility for public assistance programs (e.g., AHCCCS eligibility, SSDI).
Supportive Housing Services (SH)	SH 1: Ensure that health home case managers receive training and clinical supervision to support members who express an interest in supportive housing services, including awareness of the full continuum of available supportive housing services and how to access the services on behalf of members. SH 2: Ensure that health home clinical teams follow up and timely assist members in accessing supportive housing services when identified as a need on members' ISPs.
Assertive Community Treatment (ACT)	ACT 1: To address available capacity on many ACT teams, continue efforts to identify candidates for ACT and FACT team services through the regular analysis of service utilization trends, service expenditures, and the review of jail booking data, quality of care concerns, and adverse incidents involving members living with SMI. The contracted managed care organization should proactively alert clinical teams when key metrics suggest an assigned member may be appropriate for transition to an ACT team. ACT 2: Continue efforts to mitigate workforce challenges associated with the recruitment and retention of ACT team staff members. Consider offering flexible work schedules, incentives, and other innovative approaches to support workers and improve job satisfaction and retention. ACT 3: Provide ongoing training and supervision to help ensure that health home case managers understand how to identify ACT team candidates and the established procedures to refer a member to an ACT team.
General Recommendations (GR)	GR 1: Perform an assessment of the workflows at the integrated health homes that focuses on the implementation of members' ISP interventions, with the goal of ensuring that clinical teams initiate timely referrals for needed services.

Service	Recommendations
	GR 2: Ensure that new employee orientation materials and ongoing training curricula for health home clinical team members (including case managers and clinical supervisors) address the appropriate application of the priority mental health services and how to assist members with accessing the services when medically necessary. GR 3: Enhance the availability of clinical supervision and ensure that case managers have regular opportunities (e.g., clinical rounds, group supervision) to review challenging cases with health home clinical leadership. GR 4: Improve monitoring and oversight of the contracted transportation vendor to ensure members receive reliable non-emergency transportation services to facilitate access to the priority mental health services.

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