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Government Human Services Consulting

June 30, 2026
Arizona Health Care Cost Containment System

2026 Service Capacity Assessment

Priority Mental Health Services

Contents

Section 1

Executive Summary

The Arizona Health Care Cost Containment System (AHCCCS), 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 thirteenth 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 of the priority mental health services.
- **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 recipient's 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 priority mental health services during the review period.
- **Analysis of outcomes data:** Mercer analyzes outcome data for people 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) 2025, 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.

Mercer's service capacity assessment identified increases in the percentages of members using most of the priority mental health services during CY 2025 when compared to CY 2024, except for supported employment and ACT services, as illustrated in the following tables. There was an overall increase of 902 members between CY 2025 and CY 2024.

Table 1 — Summary of Priority Mental Health Services Utilization[1], CY[2] 2025, CY 2024, and CY 2023

Data Source	Number of Recipients	Peer Support	Family Support	Supported Employment	Supportive Housing	ACT
CY 2025 Service Capacity Assessment Time Period — Utilization						
Service utilization data	41,327	31%	5%	24%	26%	5.1%[3]
CY 2024 Service Capacity Assessment Time Period — Utilization						
Service utilization data	40,425	28%	4%	26%	15%	5.2%
CY 2023 Service Capacity Assessment Time Period — Utilization						
Service utilization data	39,046	29%	3%	26%	14%	5.3%

System strengths, as well as 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 living with SMI, are noted below.

[1] Mercer did not limit service utilization queries and outputs to service providers recognized as providers of evidence-based services.

[2] Calendar year (CY) referenced in this context refers to the period October 1, 2024 through December 31, 2025.

[3] ACT services were not included as part of the service utilization file, but based on the current ACT roster, 5.1% of all active SMI recipients are assigned to ACT teams.

Consumer-Operated Services (Peer Support and Family Support)

Thirty-one percent (31%) of members living with an SMI received at least one unit of peer support from October 1, 2024 through December 31, 2025; an increase from the prior review period in which 28% of members received peer support services. During CY 2025, there was a substantial increase (128%) in the number of peer support units when compared to CY 2024, which is partially attributed to community peer-run organizations resuming programming analogous with pre-COVID operations. In addition, over 1,500 more recipients received peer support during this period, reversing a downward trend of the past three years.

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. Based on an analysis of peer support prevalence and penetration rates in other states and local systems, Maricopa County excels in making peer support services available to people in need. Penetration rates for the service are high and likely represent a best practice benchmark regarding access to peer support.

Service utilization data demonstrates that 5% of members received at least one unit of family support services during 2025; one percentage point higher than last year. In addition, over 400 more members received family support services during CY 2025 than CY 2024. Over the past three years, there has been a 73% increase in the number of individuals accessing family support services.

Overall, family support utilization is lower than the other priority mental health services. Several factors influence the utilization of family support services, including members with no or estranged family relationships, members' preferences not to have family involved in their treatment, and evidence that some health home staff lack familiarity of the potential benefits of the service. AHCCCS' managed care contractor is taking steps to promote the availability of family support services, including, but not limited to, expansion of the network by leveraging family-run organizations to provide the services. Mercer also noted that some first episode psychosis programs offer family support services as a core intervention for families of young adults, which seems to be an especially relevant population that may benefit from the services.

Supported Employment

Service utilization data demonstrates that 24% of members received at least one unit of supported employment during CY 2025, a reduction of two percentage points compared to last year. There were 286 less members that received supported employment when comparing CY 2025 to CY 2024. However, there was an increase of nearly 80,000 (79,431) units of the service delivered during this same period.

Adult members and case managers report being familiar with the "Disability Benefits 101" (DB 101) website, and an adult member expressed that it is a "helpful" program. Supported employment providers complete DB 101 with all members and agreed that the

website is “awesome.” Supported employment providers shared they were not hearing as many concerns about the impact of work on benefits, but peer-run organization representatives and family members believe that there is still apprehension about the impact of working on eligibility for public benefits.

There continues to appear to be sufficient capacity for supported employment services, with six contracted, supported employment providers offering multiple service locations and co-located at 19 health homes throughout Maricopa County. In addition, co-located vocational rehabilitation counselors continue to be available on a part-time basis at most health homes, and each serves multiple clinics.

Supportive Housing

Service utilization data reveals that 26% of members received at least one unit of supportive housing during the review period, significantly more when compared to last year (15%). Between CY 2025 and CY 2024, there was an 81% increase in the number of members who received supportive housing. In addition, there was an increase of 87,505 supportive housing units during this same period.

During the review period (CY 2025), four permanent supportive housing providers terminated contracts with AHCCCS’ contracted managed care organization, reducing the number of available providers of supportive housing services. Existing providers temporarily expanded capacity and accepted additional referrals, as members were reallocated across the remaining supportive housing provider network. One additional permanent supportive housing provider was added to the managed care contractor’s network during the same period. A targeted interview with one supportive housing provider revealed that there are no current wait lists to access supportive housing services, although initial intakes for services can be delayed a few weeks during busy periods. Current utilization is described as being at approximately 50% of the provider’s maximum operating capacity.

During medical record reviews performed by Mercer, reviewers identified the reasons a person was unable to access a priority mental health service after the service was included on the person’s individual service plan (ISP). For supportive housing services or housing-related assistance, the most common reason was a lack of evidence that the clinical team followed up with initiating a referral for the service, occurring in almost three-fourths (74%) of the applicable cases.

Assertive Community Treatment

As a percentage of the total population with SMI, 5.1% of all members are assigned to an ACT team. There are 19 more members assigned to an ACT team when comparing CY 2025 to CY 2024. There has been an increase of 64 ACT team members between CY 2023 and CY 2025.

Case manager familiarity with ACT admission criteria varied among focus group attendees. Some case managers reported receiving minimal training regarding the referral process and ACT admission criteria and expressed a desire to receive more detailed training. One case manager shared, “a general overview is not sufficient to understand if a member would be appropriate for ACT” and another stated, “I am not confident with knowing the criteria.” Other case managers expressed feeling “very familiar with the criteria” and added “the process is simple if you know it.” AHCCCS’ managed care contractor is working on education to supportive teams and inpatient hospital teams to understand ACT admission criteria and how to assess the appropriateness of the service, including forensic assessments initiated through the criminal justice system.

To ensure the appropriate utilization of ACT services, entities involved in the clinical management of people 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 an SMI. Mercer assessed 100 members living with an SMI and associated with the highest aggregate behavioral health service costs during CY 2025. The analysis found 34% of the members are assigned to an ACT team. This finding is significantly higher than the percentage when the analysis was completed during CY 2024 (20%).

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:

- Medical record reviews illustrate that treatment plan services and interventions identified by the clinical team frequently lack consistent follow-up to ensure that the services are put in place and made available to members. The provision of priority mental health services would likely increase substantially if clinical teams acted more intentionally to secure services within days of identifying members’ treatment interventions.
- When compiling the sample for medical record reviews, 11% of the cases (from a sample of 200) did not include current assessments or individual service plans, which is an increase from last year when 6% of the sample lacked current documentation.
- Consistent with prior service capacity assessments, Mercer noted annual assessment update and ISP templates vary across health homes. Each administrative entity that oversees a health home adopted unique electronic medical record formats to support the organization’s clinical documentation, billing records, and reporting needs. In some cases, the assessment and ISP templates lack important information, such as identifying specific services on the member’s ISP or summarizing the clinical team’s recommendations. Mercer recommends that the contracted managed care organization reiterate existing requirements and

monitor that basic elements, such as service interventions, are represented as part of the assessment and ISP templates utilized by the health homes.

- Several record reviews, focus group comments, and interviews with providers of the priority mental health services cite high turnover rates with health home case managers. This has the potential to disrupt continuity of care and presents ongoing challenges with ensuring new staff are familiar with the application, availability, and procedures 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.”

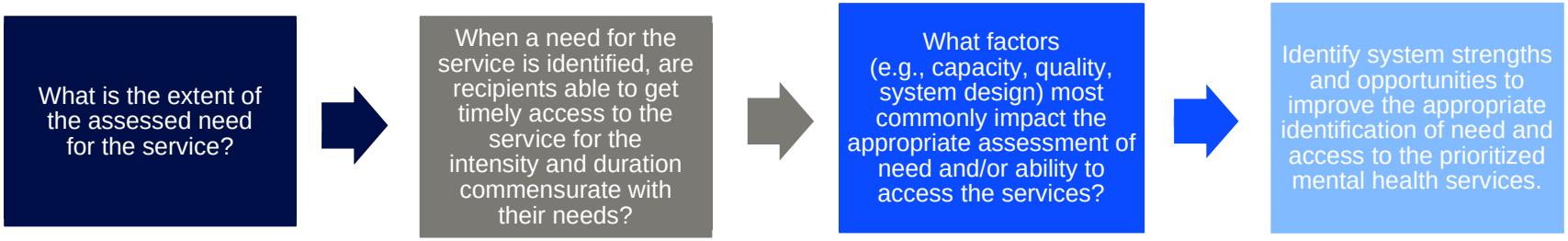
Section 2

Overview

The Arizona Health Care Cost Containment System (AHCCCS) 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).[4] 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:



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

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 organization. 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 adjusted to accommodate potential claims run-out limitations. Mercer performed an analysis of summary-level service utilization data related to the priority 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 people living with an 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, 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 people living with an 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 an 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 an SMI.

For persons living with an 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 Southern Avenue (Mesa, AZ)
Center for Health and Recovery	Heatherbrae
Chicano Por La Causa	Centro Esperanza
Choice Health Integrated	Centennial Way 19th Avenue
Community Bridges, Inc.	Mesa Heritage
Community Partners Integrated Healthcare, Inc.	Osborn

Provider	Health Home
Copa Health	Arrowhead Campus East Valley Campus Gateway Campus Metro Campus West Valley Campus
Horizon Health and Wellness	Plaza Queen Creek
Intensive Treatment Systems	West Clinic Access Point
Jewish Family and Children Services	Michael R. Zent Healthcare Clinic East Valley Health Center West Valley Healthcare 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
Terros	Desert Cove 23rd Avenue 51st Avenue

Provider	Health Home
	Mitchell Priest Oak South Mountain
Valle Del Sol	Red Mountain
Valleywise	First Episode Center (Avondale) First Episode Center (Mesa) 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:[5]

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

Number of Unique Providers	Number of Provider Locations	Contracted Capacity
37	77	2,095 (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	13	19	305 (four of the six 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
11 (four providers terminated permanent supportive housing services during calendar year (CY) 2025. One provider was	11	1,025 (five providers are not contracted for specific capacity, three providers also offer 1:1 staff to member ratios)

[5] As reported by the Maricopa County Regional Behavioral Health Authority administering the AHCCCS contract in December 2025. Additional capacity exists across the system of care for most of the prioritized mental health services and is not reflected as contracted capacity.

Number of Unique Providers	Number of Provider Locations	Contracted Capacity
added during CY 2025)		

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

Number of Unique Providers	Number of Provider Locations	Contracted Capacity
2 (one provider terminated temporary housing assistance during CY 2025)	2	150 (one of the two providers is not contracted for specific capacity)

Table 6: ACT Teams (24 teams serving 2,124 recipients)[6][7]

Health Home Clinic	Specialty	Capacity	Number of Recipients	Percent Below Full Capacity
Community Bridges: 99th Avenue	Primary care provider (PCP) partnership	100	71	29%
Community Bridges: Avondale	PCP partnership	100	69	31%
Community Bridges: Forensic Assertive Community Treatment (FACT) Team 1	Forensic team and PCP partnership	100	82	18%
Community Bridges: FACT Team 2	Forensic team and PCP partnership	100	65	35%
Community Bridges: Mesa Heritage	PCP partnership	100	73	27%
Copa Health: Gateway	PCP partnership	100	97	3%
Copa Health: Metro Campus — Omega Team	PCP partnership	100	97	3%
Copa Health: Metro Campus — Varsity Team	PCP partnership	100	92	8%

[6] As of December 1, 2025.

[7] 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 (RBHA) and/or are assigned to the American Indian Health Plan (AIHP). As of December 1, 2025, the number of ACT members assigned to other non-RBHA managed care contractors and the AIHP was 14.

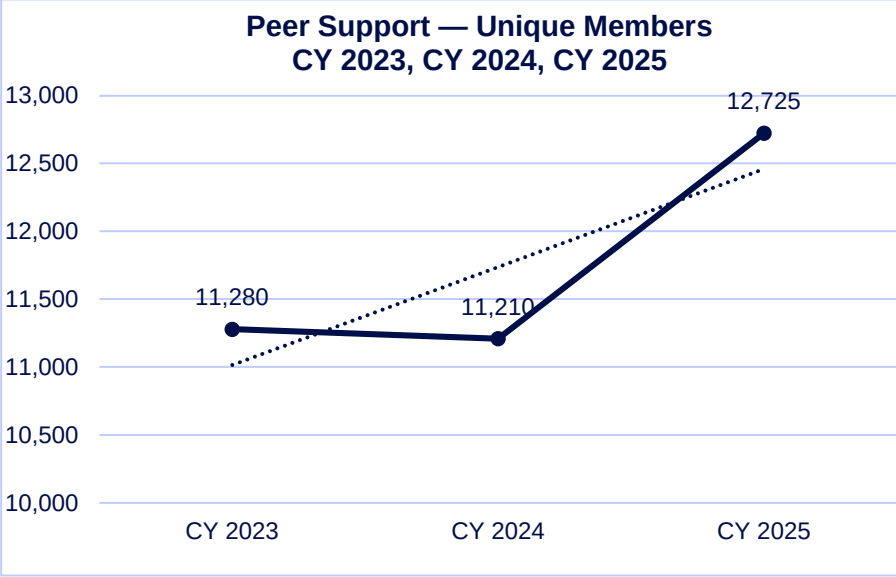
Health Home Clinic	Specialty	Capacity	Number of Recipients	Percent Below Full Capacity
Copa Health: Medical Assertive Community Treatment	Medical team	100	92	8%
Copa Health: West Valley Campus	PCP partnership	100	93	7%
La Frontera/EMPACT: Tempe	PCP partnership	100	96	4%
La Frontera/EMPACT: Capitol Center	PCP partnership	100	95	5%
La Frontera/EMPACT: Comunidad	PCP partnership	100	97	3%
Center for Health and Recovery: Resilience	PCP partnership	100	96	4%
Southwest Network: Northern Star	PCP partnership	100	91	9%
Southwest Network: Saguaro	PCP partnership	100	88	12%
Southwest Network: San Tan	PCP partnership	100	91	9%
Terros: 51st Avenue	PCP partnership	100	98	2%
Terros: Priest	N/A	100	97	3%
Terros: 23rd Avenue Team 1	PCP partnership	100	91	9%
Terros: 23rd Avenue Team 2	PCP partnership	100	99	1%
Terros: South Mountain	PCP partnership	100	96	4%
Valleywise: Mesa Riverview	PCP partnership	100	89	11%
Valleywise: Maryvale ACT/FACT	Forensic team and PCP partnership	100	69	31%
Totals		**2,400**	**2,124**	**11.5%**

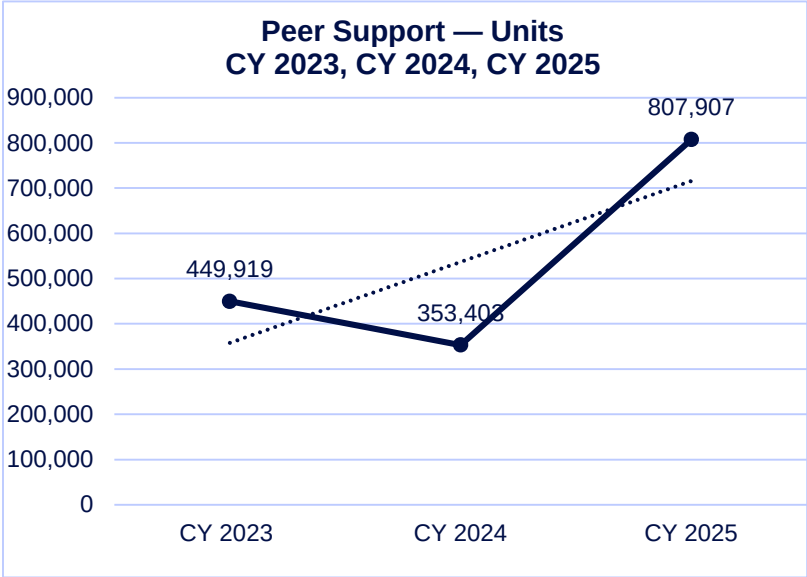
Service Utilization

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. Please note that during CY 2024, service utilization rates for some priority mental health services may be influenced by inappropriate billing practices identified and subsequently addressed by AHCCCS.

Table 7: Peer Support

CY 2023		CY 2024		CY 2025	
Members	Units	Members	Units	Members	Units
11,280	449,919	11,210	353,403	12,725	807,907

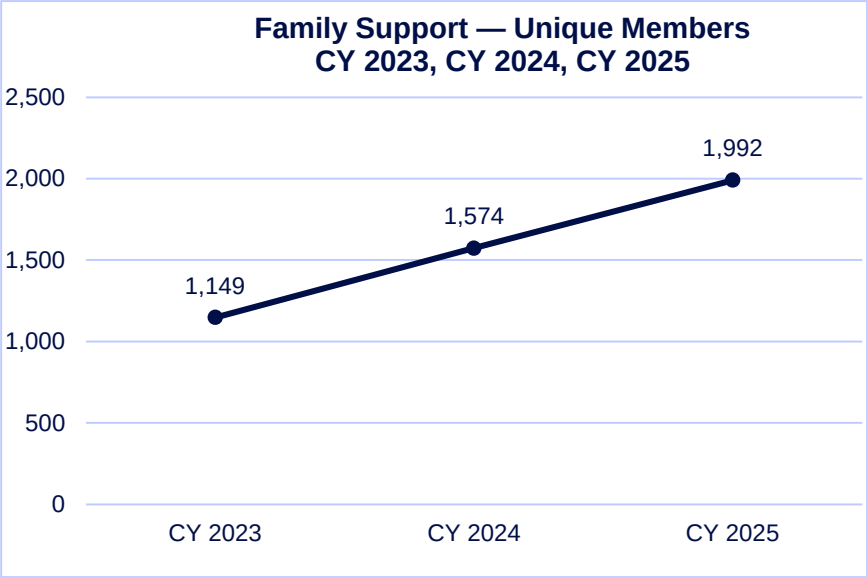


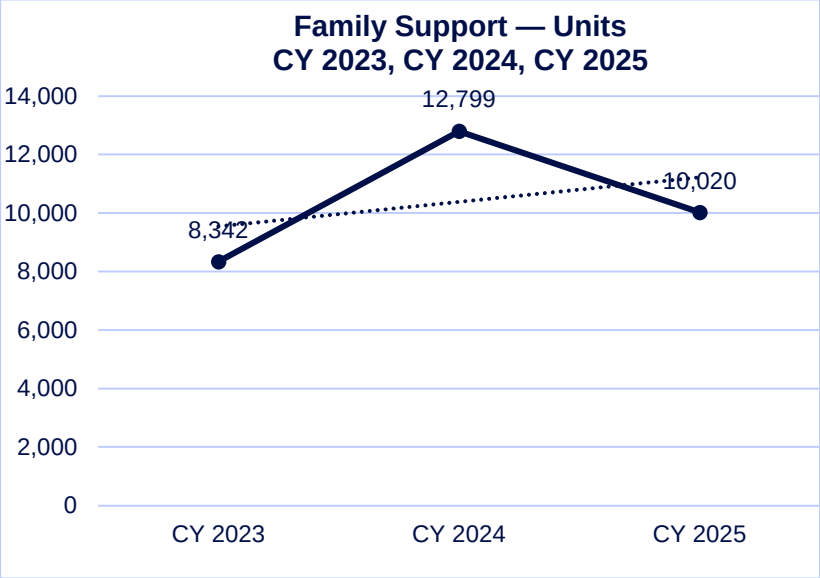


Units of peer support increased over 128% in CY 2025 compared to CY 2024 and included 1,515 more unique members served over the same period.

Table 8: Family Support

CY 2023		CY 2024		CY 2025	
Members	Units	Members	Units	Members	Units
1,149	8,342	1,574	12,799	1,992	10,020

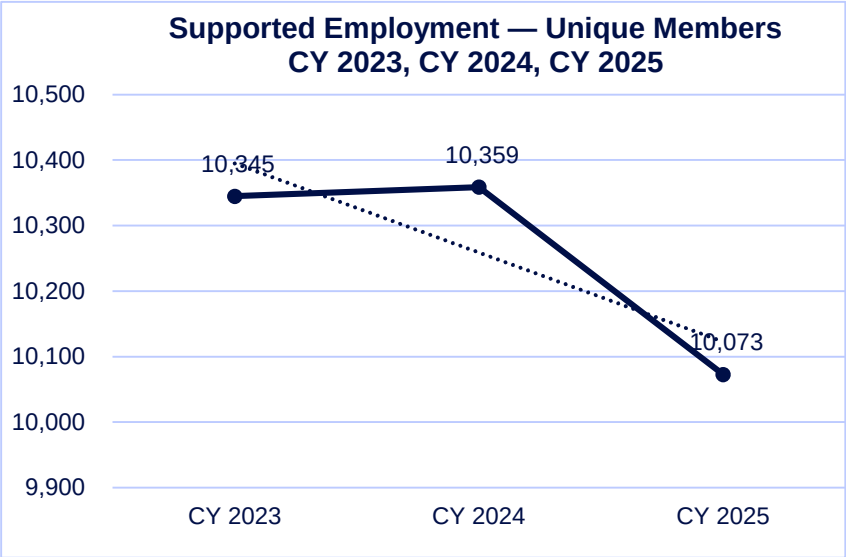


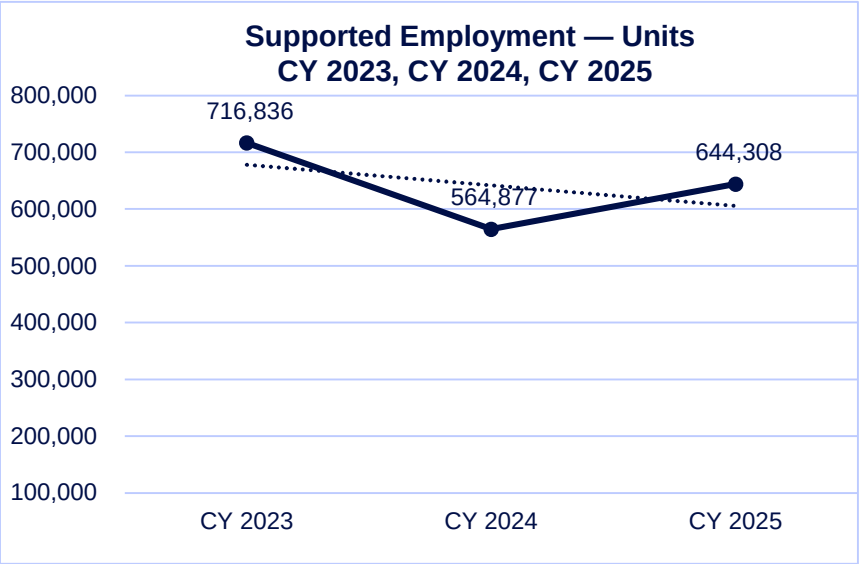


During CY 2025, there were 418 more members who received family support services when compared to CY 2024 and 843 more than CY 2023 (an increase of over 73%). However, units of family support decreased by 2,779 between CY 2024 and CY 2025.

Table 9: Supported Employment

CY 2023		CY 2024		CY 2025	
Members	Units	Members	Units	Members	Units
10,345	716,836	10,359	564,877	10,073	644,308

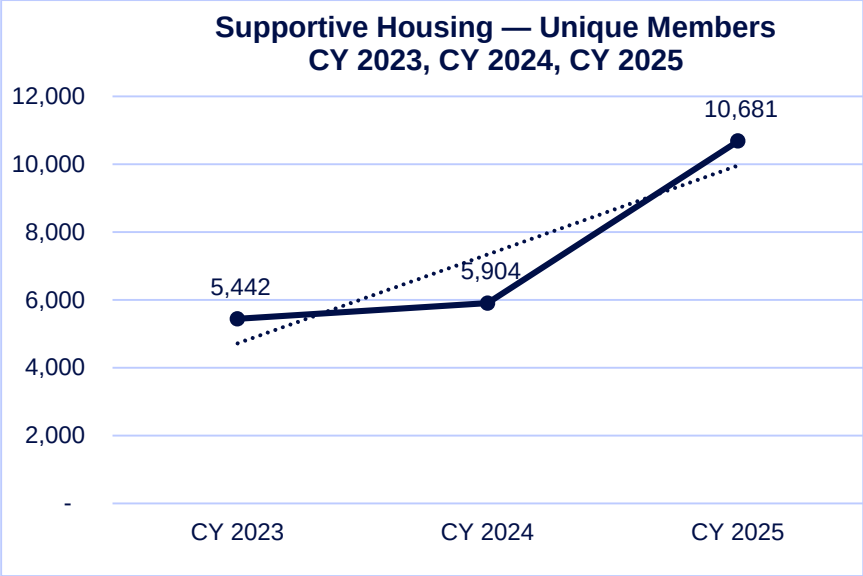


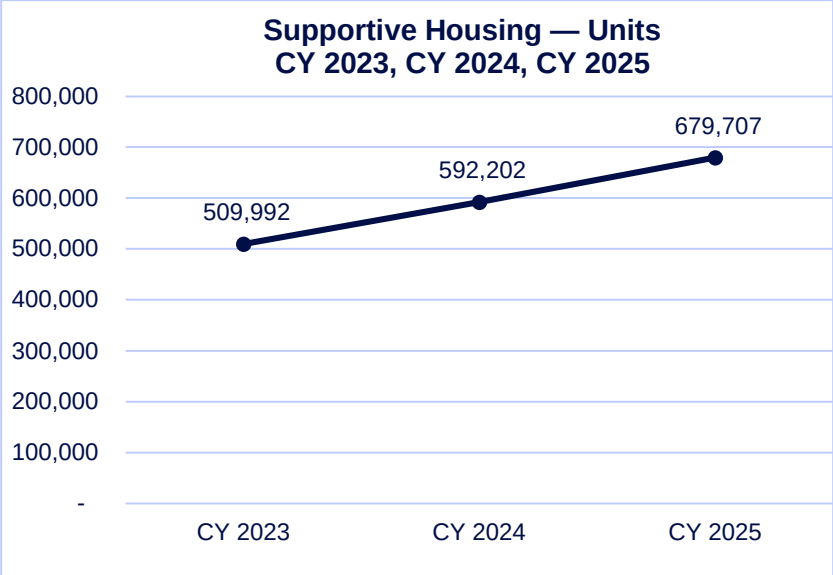


There were 286 less members that received supported employment when comparing CY 2025 to CY 2024. However, there was an increase of nearly 80,000 (79,431) units of the service delivered during this same period.

Table 10: Supportive Housing[8]

CY 2023		CY 2024		CY 2025	
Members	Units	Members	Units	Members	Units
5,442	509,992	5,904	592,202	10,681	679,707



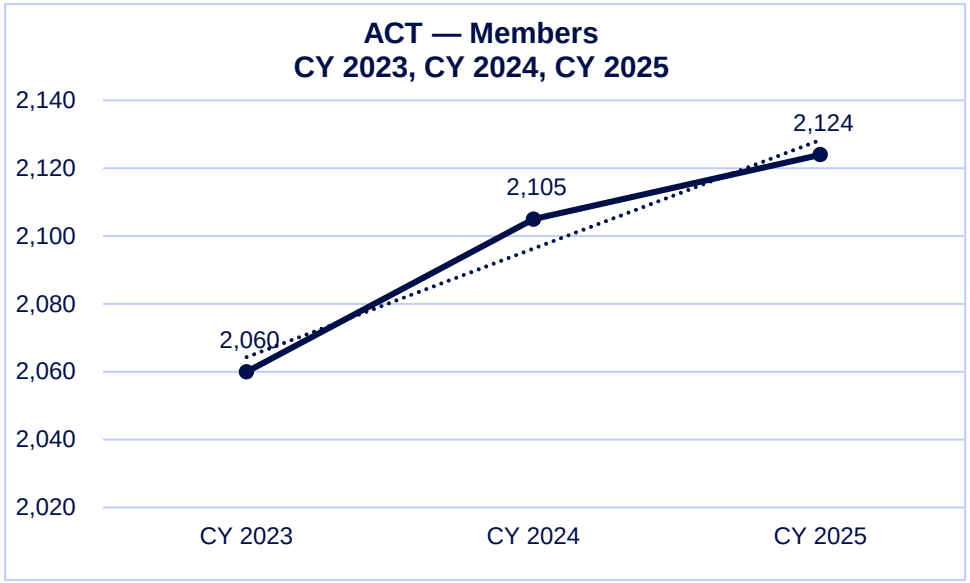


Between CY 2025 and CY 2024, there was an 81% increase in the number of members who received supportive housing. In addition, there was an increase of 87,505 supportive housing units during this same period.

[8] 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).

Table 11: ACT Services

CY 2023	CY 2024	CY 2025
Members	Members	Members
2,060	2,105	2,124



There are 19 more members assigned to an ACT team when comparing CY 2025 to CY 2024. There has been an increase of 64 ACT team members between CY 2023 and CY 2025.

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 of the priority mental health services.
- **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[9] 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 priority mental health services during the review period.
- **Analysis of outcomes data:** Mercer analyzes outcome data for people 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.

[9] Mercer did not limit service utilization queries and outputs to service providers recognized as providers of evidence-based services.

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 priority mental health services.

Participation in the focus groups was solicited by an invitation created by Mercer, which was reviewed and approved by AHCCCS.[10]

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 24 stakeholders participated in the four two-hour focus groups conducted on January 26, 2026, and January 27, 2026. All four focus groups were held in person at the Center for Health and Recovery in 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:

[10] See Appendix A: Focus Group Invitation.

- 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.
- 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 priority mental health services.

Key Informant Surveys and Interviews

One objective of the service capacity assessment is 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.[11]

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 16 respondents completed the survey tool.

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

Medical Record Reviews

Mercer extracted a random sample of members and evaluated clinical assessments, individual service plans (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

[11] See Appendix B: Key Informant Survey.

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 health home, and were selected using the following parameters:

- The recipient was identified living with an SMI and received a covered behavioral health service during October 1, 2024 and December 31, 2025.
- The recipient had an assessment and ISP date between January 1, 2025 and November 15, 2025.[12]

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 recipient's 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 2025, 11% of the final sample did not include current assessments and/or ISPs, an increase from 6% during CY 2024.

Consistent with prior service capacity assessments, Mercer noted annual assessment update and ISP templates vary across health homes. Each administrative entity that oversees a health home has adopted unique electronic medical record formats to support the

[12] 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.

organization's clinical documentation, billing records, and reporting needs. In some cases, the assessment and ISP templates lack important information, such as identifying specific services on the member's ISP or summarizing the clinical team's recommendations. Mercer recommends that the contracted managed care organization requires and monitors to ensure that basic elements, such as service interventions, are represented as part of the assessment and ISP templates utilized by the health homes.

Three licensed behavioral health professionals reviewed medical record documentation and recorded 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.

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, 2024 and December 31, 2025.

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 reviewed each ACT team member's service array and aggregated 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 2023–CY 2025 of the service capacity assessment are illustrated in the following tables and are compared to the characteristics of the total population.

Table 12: CY 2025 Service Capacity Assessment Time Period — Utilization

Data	Number of Recipients	Peer Support	Family Support	Supported Employment	Supportive Housing	ACT
Sample group	200	33%	5%	28%	28%	5.5%
Service utilization data	41,327	31%	5%	24%	26%	5.1%[13]

Table 13: CY 2024 Service Capacity Assessment Time Period — Utilization

Data	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%

Table 14: CY 2023 Service Capacity Assessment Time Period — Utilization

Data	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%

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

[13] ACT services were not included as part of the service utilization file, but based on the current ACT roster, 5.1% of all active SMI recipients are assigned to ACT teams.

- Criminal justice involvement
- Grievance data
- Emergency room utilization

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 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

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[14]) was conducted. Penetration rates were compared to benchmarks, as

[14] Peer support services are not currently reported on the Substance Abuse and Mental Health Services Administration's National Outcome Measures interview tool.

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 of people served
- Review of data from the Substance Abuse and Mental Health Services Administration on evidence-based practice (EBP) penetration rates at the state and national levels

The intent in 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 cover CY 2025. Although Mercer uses the most recent available data it has for comparison (including CY 2025), comparison states and communities have varying data availability. In all cases, the most recent data available were applied.

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 18% of the estimated adults living with SMI in Maricopa County in 2025. This penetration rate is lower than the national (publicly funded) penetration rate of 25%; however, it is higher than some statewide rates and is comparable to rates of other large counties in the State of Texas. Within the Maricopa County Medicaid system, the penetration rate of adults living with SMI (99.8%) exceeds the national average (25%) and the rates of similarly sized regions in Texas (i.e., Harris County [Houston] and Bexar County [San Antonio]). Thus, Maricopa County's lower overall penetration rate appears to result from the low penetration rate among people without Medicaid coverage (6%).

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 at a level that 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 2,124 individuals[15] as of December 1, 2025. 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.[16] Few of the identified comparison communities provide ACT to 4.3% or more of their adults living with SMI, whereas 5.1% of adults with SMI residing in Maricopa County received ACT in 2025. Because some people receiving an ACT level of care in Maricopa County receive it from a forensic ACT team (FACT), 5.1% does not represent an overuse of ACT.

Maricopa County has 24 ACT teams, including specialty ACT teams that partner with primary care providers (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), one team that serves members with comorbid chronic medical conditions, and 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.

[15] ACT team membership may exclude ACT team participants if those members are assigned to managed care contractors that do not administer the Regional Behavioral Health Agreement (RBHA) and/or are assigned to the American Indian Health Plan (AIHP). As of December 1, 2025, the number of ACT members assigned to other non-RBHA managed care contractors and the AIHP was 14.

[16] Cuddeback, G. S., Morrissey, J. P., Meyer, P. S. (2006). "How many assertive community treatment teams do we need?" *Psychiatric Services, 57*, pp. 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 15 — Service System Penetration Rates for Individuals with SMI

Penetration Rates					
Region	**Adult Population (≥ 18 Years Old)[17]**	**Estimated Rate of SMI in the Adult Population[18]**	**Estimated Number of Adults with SMI in the Population[19]**	**Number of Adults with SMI Served[20]**	**Penetration Rate Among Adults with SMI[21]**
United States	269,763,509	5.8%	15,729,880	3,992,099	25%
Arizona:	6,026,503	7.2%	434,401	167,120	38%
Maricopa County:[22]	3,658,366	6.3%	230,118	41,327	18%
Adults with Medicaid	550,802	5.5%	30,036	29,962	99.8%
Non-Medicaid Adults	3,107,564	5.5%	200,082	11,365	6%
Texas:	24,109,307	4.9%	1,183,047	330,110	28%
Harris County (Houston)[23]	3,736,684	5.0%	186,268	33,220	18%
Bexar County (San Antonio)[24]	1,614,025	6.0%	96,740	16,862	17%
New York:	16,097,036	5.2%	831,565	551,823	66%

[17] 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, 2024*.

[18] 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. (2026). *2021–2023 NSDUH substate region estimates – tables.* https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/substate-releases

[19] 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.

[20] The national and state-level percentages of people with SMI served were obtained from Substance Abuse and Mental Health Services Administration. (2025). *2024 Uniform Reporting System (URS) output tables*. https://www.samhsa.gov/data/report/2024-uniform-reporting-system-urs-output-tables

[21] 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.

[22] The number of people with SMI served in Maricopa County is based on Arizona Health Care Cost Containment System's 2024 service utilization data file.

[23] The Meadows Mental Health Policy Institute. (2025). Patients served at The Harris Center for Mental Health and IDD and The Center for Healthcare Services LMHAs – FY 2024. Available upon request.

[24] Ibid..

Penetration Rates					
Region	**Adult Population (≥ 18 Years Old)[17]**	**Estimated Rate of SMI in the Adult Population[18]**	**Estimated Number of Adults with SMI in the Population[19]**	**Number of Adults with SMI Served[20]**	**Penetration Rate Among Adults with SMI[21]**
New York City[25]	6,776,005	5.2%	350,045	237,185	68%
Colorado:	4,792,358	7.1%	341,365	55,413	16%
Denver City/County[26]	600,540	7.3%	43,634	19,704	45%
Nebraska	1,538,757	6.9%	105,860	9,720	9%
California	31,180,511	4.9%	1,519,269	376,543	25%
Illinois	10,100,540	5.1%	514,997	16,883	3%
Kansas	2,294,452	6.1%	141,093	7,871	6%
Minnesota	4,547,092	5.8%	265,512	134,012	50%
Wisconsin	4,750,680	6.5%	309,372	31,632	10%
Tennessee	5,739,349	7.6%	437,303	200,220	46%
Indiana	5,397,168	6.3%	337,718	82,467	24%
Delaware	849,963	5.5%	46,934	5,971	13%
New Hampshire	1,170,277	7.2%	84,521	17,072	20%
North Carolina	8,838,026	5.4%	475,630	47,679	10%

[25] 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 recently created teams have 68 slots each. (https://omh.ny.gov/omhweb/transformation/docs/omh-monthly-report-sep-2024.pdf). We, therefore, conservatively estimated that that the 77 ACT teams functioned similar to small ACT teams, serving an average of 50 clients per year.

[26] 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.

Penetration Rates					
Region	Adult Population (≥ 18 Years Old)[17]	Estimated Rate of SMI in the Adult Population[18]	Estimated Number of Adults with SMI in the Population[19]	Number of Adults with SMI Served[20]	Penetration Rate Among Adults with SMI[21]
Washington	6,366,184	7.4%	471,443	167,838	36%
King County[27]	1,898,790	6.6%	125,884	49,595[28]	39%

Overview of EBP Utilization Benchmark Analyses

Table 16 — EBP Utilization Rates Among People with SMI Who Were Served in the System[29]

EBP Utilization Rates						
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	73,032	1.8%	76,489	1.9%	108,653	2.7%
Arizona:	2,918	1.7%	14,542	8.7%	926	0.6%

[27] 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.

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

[29] National and state-level data on the number of people using EBPs were obtained from Substance Abuse and Mental Health Services Administration. (2025). *2024 Uniform Reporting System (URS) output tables*. https://www.samhsa.gov/data/report/2024-uniform-reporting-system-urs-output-tables

EBP Utilization Rates						
Maricopa County (2025)[30,31]	2,124	5.1%	10,073	24.4%	10,681	25.8%
Maricopa County — Medicaid	1,635	5.5%	7,450	24.9%	8,086	27.0%
Maricopa Co. — non-Medicaid	489	4.3%	2,623	23.1%	2,595	22.8%
Maricopa County (Supported Employment Ongoing)[32]	N/A	N/A	2,537	6.3%	N/A	N/A
Texas:	7,630	2.3%	4,396	1.3%	6,121	1.9%
Harris County (Houston)[33]	1,134	3.4%	3,613	10.7%	1,380	4.1%
Bexar County (San Antonio)[34]	141	0.9%	494	3.3%	2,743	18.4%
New York	8,280	1.6%	635	0.1%	27,011	4.9%
New York City[35]	4,887 – 6,158	1.5% – 1.9%	N/A	N/A	4,717	1.5%
Colorado:	784	1.4%	438	0.8%	395	0.7%
Denver City/County (MHCD)[36]	592	1.4%	N/A	N/A	1,674	3.8%
Nebraska	73	0.8%	461	4.7%	891	9.2%
California	11,668	3.1%	3,291	0.9%	4,108	1.1%
Illinois	626	3.7%	3,060	18.1%	N/A	N/A

[30] 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.

[31] The number served in Maricopa County with evidence-based services is based on Arizona Health Care Cost Containment System's 2024 service utilization data file.

[32] 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.

[33] The Meadows Mental Health Policy Institute. (2025). Patients served at The Harris Center for Mental Health and IDD and The Center for Healthcare Services LMHAs – FY 2024. Available upon request.

[34] Ibid.

[35] Data on the number of adults enrolled in ACT in New York City were obtained through personal communication with the New York State Office of Mental Health, Office of Population Health and Evaluation (May 2026). Because these data reflect current enrollment, rather than the total number of individuals receiving services over time, the estimated number served was calculated as a range using turnover rates reported in prior literature, available at: https://psychiatryonline.org/doi/10.1176/appi.ps.201700127.

[36] 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.

EBP Utilization Rates						
Kansas	N/A	N/A	545	6.9%	925	11.8%
Minnesota	1,476	1.1%	1,821	1.4%	865	0.6%
Wisconsin	N/A	N/A	N/A	N/A	N/A	N/A
Tennessee	361	0.2%	1,316	0.7%	972	0.5%
Indiana	704	0.9%	623	0.8%	2,042	2.5%
Delaware	383	6.4%	2	N/A	26	0.4%
New Hampshire	1,031	6.0%	13,255	77.6%	528	3.1%
North Carolina	1,644	3.4%	N/A	N/A	N/A	N/A
Washington	1,681	1.0%	N/A	N/A	N/A	N/A
King County[37]	375	0.3%	N/A	N/A	N/A	N/A

Table 17 depicts utilization rates of ACT, supported employment, and supportive housing among adults living with an SMI served in the Maricopa County behavioral health system. Maricopa County has an ACT utilization rate of 5.1%, which exceeds researchers' best estimate of the percentage of people with SMI who need ACT (4.3%). Although the penetration rate among non-Medicaid adults is low, overall, the county appears to have prioritized ensuring those non-Medicaid adults with the greatest behavioral health needs have access to ACT services. 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 24.3% and ongoing supported employment utilization rate of 6.1% (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 2.0%. Given that many people living with an 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 (25.8%)[38] in Maricopa County is also higher than

[37] 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.

[38] Mercer did not limit service utilization queries and outputs to service providers recognized as providers of evidence-based services and included service code H0043, which is now designated for AHCCCS' Housing and Health Opportunities Demonstration. As such, CY 2025 data over represents the actual utilization of supportive housing services.

the national average (2.7%) and the utilization rates of most other regions in the analysis. The availability of supportive housing is essential in preventing chronic homelessness among people living with a SMI.

Changes in EBP Utilization from 2013 through 2025

Table 18 compares the utilization of ACT, supported employment, and supportive housing in Maricopa County from 2013 through 2025. 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 2025 (5.1%). However, these decreases do not necessarily represent a decrease in the quality of care, as they indicate a penetration rate that is closer to the best estimate that Mercer currently has of the percentage of people with an SMI served in a publicly funded system who need ACT.
- **Supported Employment*:*** From 2022 to 2025, Maricopa County experienced decreases in the overall penetration rates for supported employment (29.7% to 24.4%), and ongoing supported employment decreased from 2022 to 2024 (6.5% to 5.8%) but increased again in 2025 (6.1%). 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 an average of 2,400 between 2021 and 2025. However, the penetration rate for ongoing supported employment services in 2025 is more than double the rate in 2013 (6.1% versus 2.5%). Regardless, although the penetration rate for supported employment in Maricopa County is high relative to those of most states, it is well below the level of need for supported employment, as is true nationally.
- **Supportive Housing*:*** A single supportive housing billing code (H0043)[39] 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),

[39] Service code H0043 is now designated for use under AHCCCS' Housing and Health Opportunities Demonstration. The goal of the demonstration is to enhance and expand housing services and interventions for AHCCCS members living with a SMI and homeless or at risk of being homeless. Criteria for referral to the demonstration includes individuals who are experiencing homelessness, and are designated as a person living with a serious mental illness, and is diagnosed with a chronic medical condition or is placed in a correctional facility with a scheduled release date within 90 days or was released from correctional facility in the past 90 days.

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%) and continued to increase significantly through 2025 (25.8%,10,681 served)[40].

Table 17 — Maricopa County EBP Utilization Rates: 2013 through 2025

Maricopa County EBP Utilization Rates Among People with SMI Served in the System							
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[41]	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
Maricopa County (2025)	41,327	2,124	5.1%	10,073	24.4%	10,681	25.8%
SE Ongoing				2,537	6.1%		
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%

[40] Mercer did not limit service utilization queries and outputs to service providers recognized as providers of evidence-based services and included service code H0043, which is now designated for AHCCCS' Housing and Health Opportunities Demonstration. As such, CY 2025 data over represents the actual utilization of supportive housing services.

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

Maricopa County EBP Utilization Rates Among People with SMI Served in the System							
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[41]	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
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%
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%

Maricopa County EBP Utilization Rates Among People with SMI Served in the System							
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[41]	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
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 2025

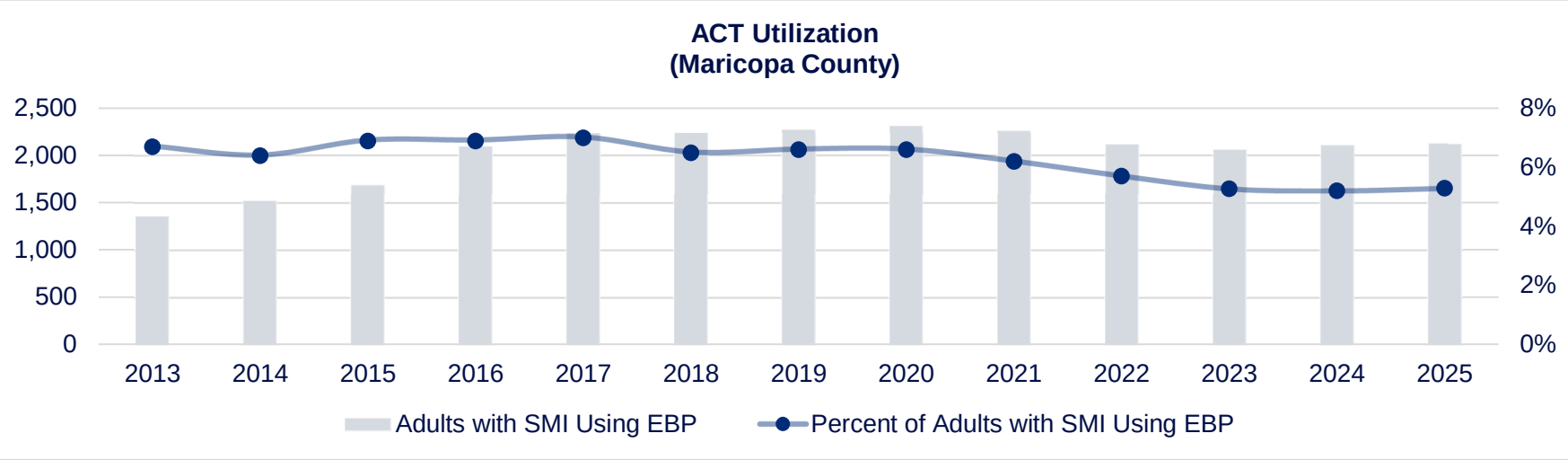


Chart 2 — Maricopa County Supported Employment Utilization Rates: 2013 through 2025

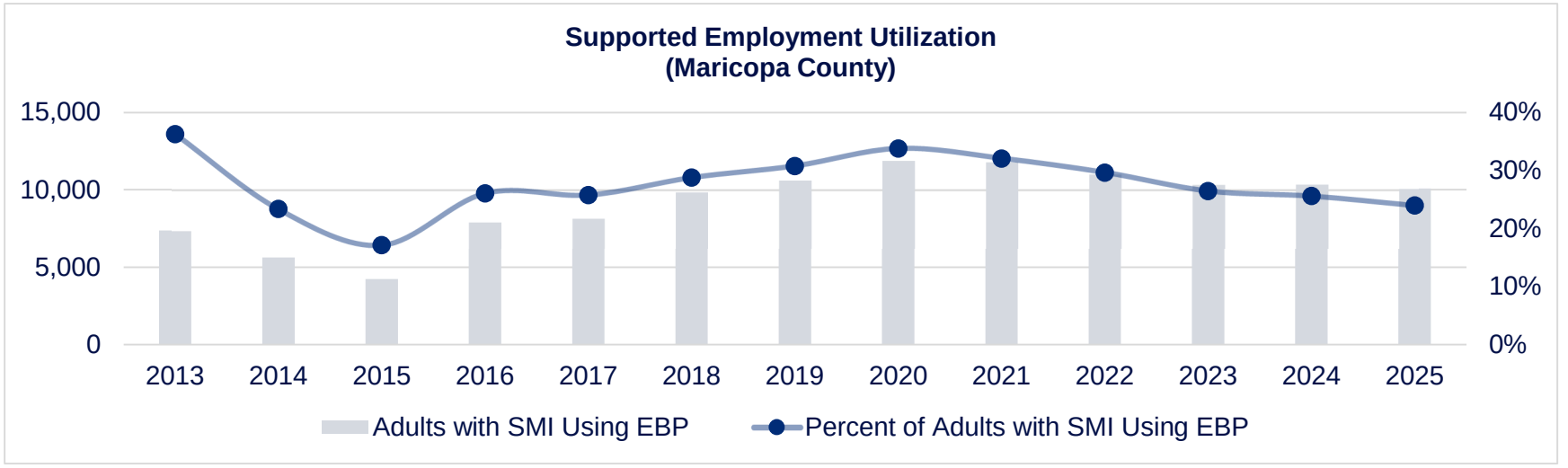


Chart 3 — Maricopa County Ongoing Supported Employment Utilization Rates: 2013 through 2025

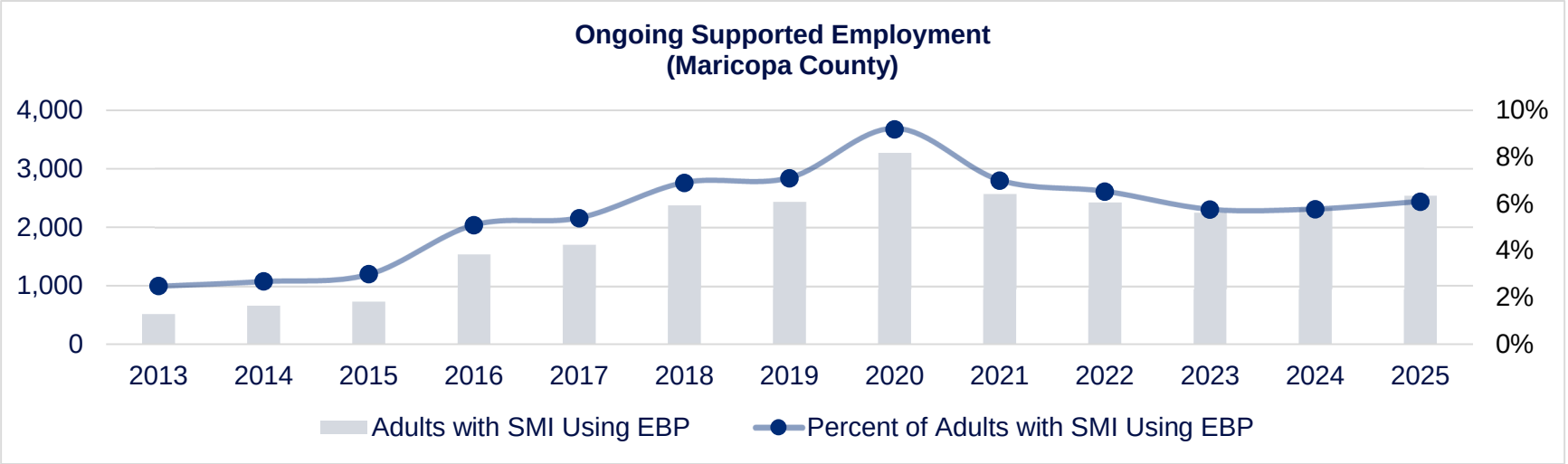
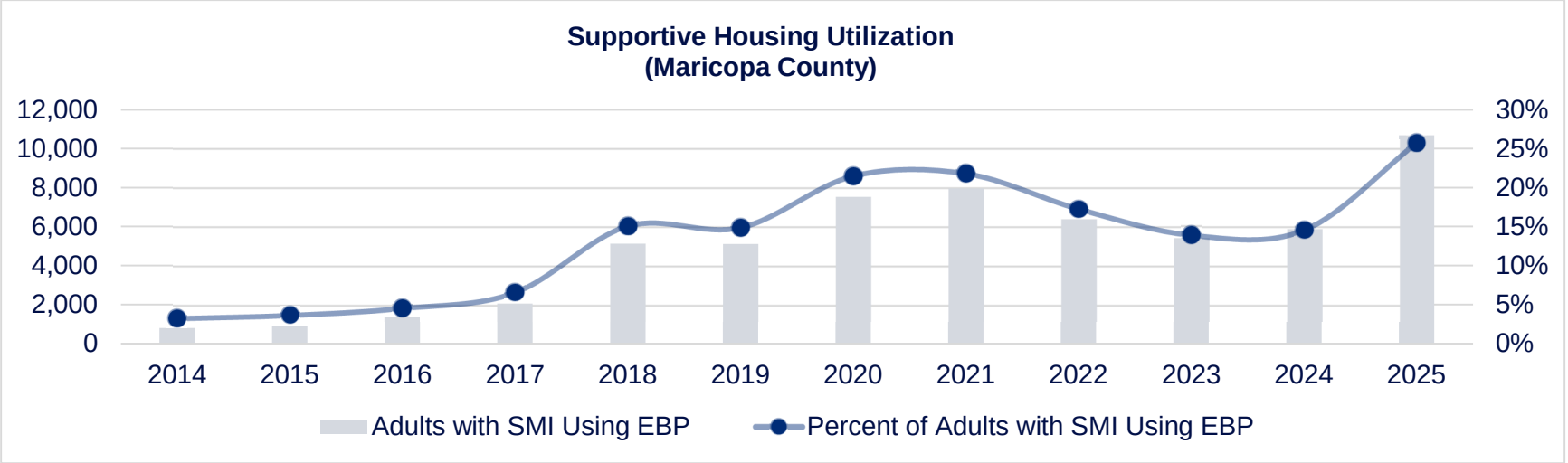


Chart 4 — Maricopa Supportive Housing Utilization Rates: 2014 through 2025



ACT Benchmarks

In an influential 2006 study, Cuddeback, Morrissey, and Meyer estimated that over 12 months, 4.3% of adults living with an SMI in an urban mental health system needed an ACT level of care. The Maricopa County ACT penetration rate is presented in Table 18, relative to all people living with an SMI served in the system (as well as relative to the 4.3% estimate provided by Cuddeback et al.).[42]

Over the years, Maricopa County has made significant strides in bolstering its capacity to offer ACT services to individuals with SMI. The ACT penetration rate, standing at 5.1%, 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 almost all teams.

Table 18 — 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[43]	-	-	-	*4.3%*	*100%*
United States	3,992,099	171,660	73,032	1.8%	43%
Arizona:	167,120	7,186	2,918	1.7%	41%
Maricopa Co.	41,327	1,725	2,124[44]	5.1%	123%
Maricopa Co. — Medicaid	29,962	1,256	1,635	5.5%	130%
Maricopa Co. — non-Medicaid	11,365	469	489	4.3%	104%

[42] 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.

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

[44] ACT team membership may exclude ACT team participants if those members are assigned to managed care contractors that do not administer the Regional Behavioral Health Agreement (RBHA) and/or are assigned to the American Indian Health Plan (AIHP). As of December 1, 2025, the number of ACT members assigned to other non-RBHA managed care contractors and the AIHP was 14.

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
Texas:	330,110	14,195	7,630	2.3%	54%
Harris County (Houston)[45]	33,220	1,428	1,134	3.4%	79%
Bexar County (San Antonio)[46]	16,862	725	141	0.8%	19%
New York:	553,221	22,929	8,280	1.6%	3%
New York City[47]	229,214	9,856	4,887 – 6,158	2.1% – 2.7%	50% – 62%
Colorado:	55,413	2,383	784	1.4%	33%
Denver County (MHCD)[48]	19,704	847	592	3.0%	70%
Nebraska	9,720	418	73	0.8%	17%
California	376,543	16,191	11,668	3.1%	72%
Illinois	16,883	726	626	3.7%	86%
Minnesota	134,012	5,763	1,476	1.1%	26%
Wisconsin	31,632	1,360	N/A	N/A	N/A
Tennessee	200,220	8,609	361	0.2%	4%
Indiana	82,467	3,546	704	0.9%	20%
Delaware	5,971	257	383	6.4%	149%
New Hampshire	17,072	734	1,031	6.0%	140%
North Carolina	47,679	2,050	1,644	3.4%	80%
Washington	167,838	7,217	1,681	1.0%	23%

[45] The Meadows Mental Health Policy Institute. (2025). Patients served at The Harris Center for Mental Health and IDD and The Center for Healthcare Services LMHAs – FY 2024. Available upon request.

[46] Ibid.

[47] Data on the number of adults enrolled in ACT in New York City were obtained through personal communication with the New York State Office of Mental Health, Office of Population Health and Evaluation (May 2026). Because these data reflect current enrollment rather than the total number of individuals receiving services over time, the estimated number served was calculated as a range using turnover rates reported in prior literature, available at: https://psychiatryonline.org/doi/10.1176/appi.ps.201700127

[48] 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.

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
King County[49]	49,595	2,133	375	0.8%	18%

Supported Employment Benchmarks

Maricopa County provides aspects of supported employment to a high percentage of those estimated to need this EBP: 24.4% 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 (6.1%).

Table 19 — Supported Employment Utilization Relative to Estimated Need among People with SMI

Region	Number of Adults with SMI Served in System[50]	Number of Adults in Need of SE[51]	Number of Adults Who Received SE[52]	SE Penetration	
				Percentage Served Among Adults with SMI	Percentage Served Among Adults Estimated to Need SE
Ideal Benchmark	-	-	-	*45.0%*	*100%*
United States	3,992,099	1,796,445	76,489	1.9%	4%

[49] 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.

[50] The number of people with SMI served at the national and state-level was obtained from the Substance Abuse and Mental Health Services Administration. (2025). *2024 Uniform Reporting System (URS) output tables*. Uniform Reporting System (samhsa.gov)

[51] 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.

[52] 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. (2025). *2024 Uniform Reporting System (URS) output tables*. Uniform Reporting System (samhsa.gov)

Region	Number of Adults with SMI Served in System[50]	Number of Adults in Need of SE[51]	Number of Adults Who Received SE[52]	SE Penetration	
				Percentage Served Among Adults with SMI	Percentage Served Among Adults Estimated to Need SE
Arizona:[53]	167,120	75,204	14,542	8.7%	19%
Maricopa Co. — Total Served	41,327	18,052	10,073	24.4%	56%
SE Ongoing			2,537	6.1%	14%
Maricopa Co. — Medicaid	29,962	13,140	7,450	24.9%	57%
SE Ongoing			1,754	5.9%	13%
Maricopa Co. — non-Medicaid	11,365	4,912	2,623	23.1%	53%
SE Ongoing			783	6.9%	16%
Texas:	330,110	148,550	4,396	1.3%	3%
Harris County (Houston) [54]	33,220	14,949	3,613	10.9%	24%
Bexar County (San Antonio)[55]	16,862	7,588	494	2.9%	7%
New York	533,221	239,949	635	0.1%	0.3%
Colorado	55,413	24,936	438	0.8%	2%
Denver County (MHCD)[56]	19,704	8,867	N/A	N/A	N/A
Nebraska	9,720	4,374	461	4.7%	11%
California	376,543	169,444	3,291	0.9%	1.9%
Illinois	16,883	7,597	3,060	18.1%	40%
Kansas	7,871	3,542	545	6.9%	15%

[53] 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.

[54] The Meadows Mental Health Policy Institute. (2025). Patients served at The Harris Center for Mental Health and IDD and The Center for Healthcare Services LMHAs – FY 2024. Available upon request.

[55] Ibid.

[56] 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.

Region	Number of Adults with SMI Served in System[50]	Number of Adults in Need of SE[51]	Number of Adults Who Received SE[52]	SE Penetration	
				Percentage Served Among Adults with SMI	Percentage Served Among Adults Estimated to Need SE
Wisconsin	31,632	14,234	0	0.0%	0%
Tennessee	200,220	90,099	1,316	0.7%	1%
Indiana	82,467	37,110	623	0.8%	2%
Delaware	5,971	2,687	2	<0.1%	0.1%
New Hampshire	17,072	7,682	13,255	77.6%	173%

Peer Support Benchmarks

Maricopa County excels in making peer support services available to people in need. Its penetration rates for 2013–2025 are high and likely represent a best practice benchmark regarding access to peer support (see Table 20).

Table 20 — Peer Support Penetration Rates

Region	Peer Support Received	Peer Support Penetration Rate
Arizona:		
Maricopa County (Total) — 2025	12,725	31%
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%

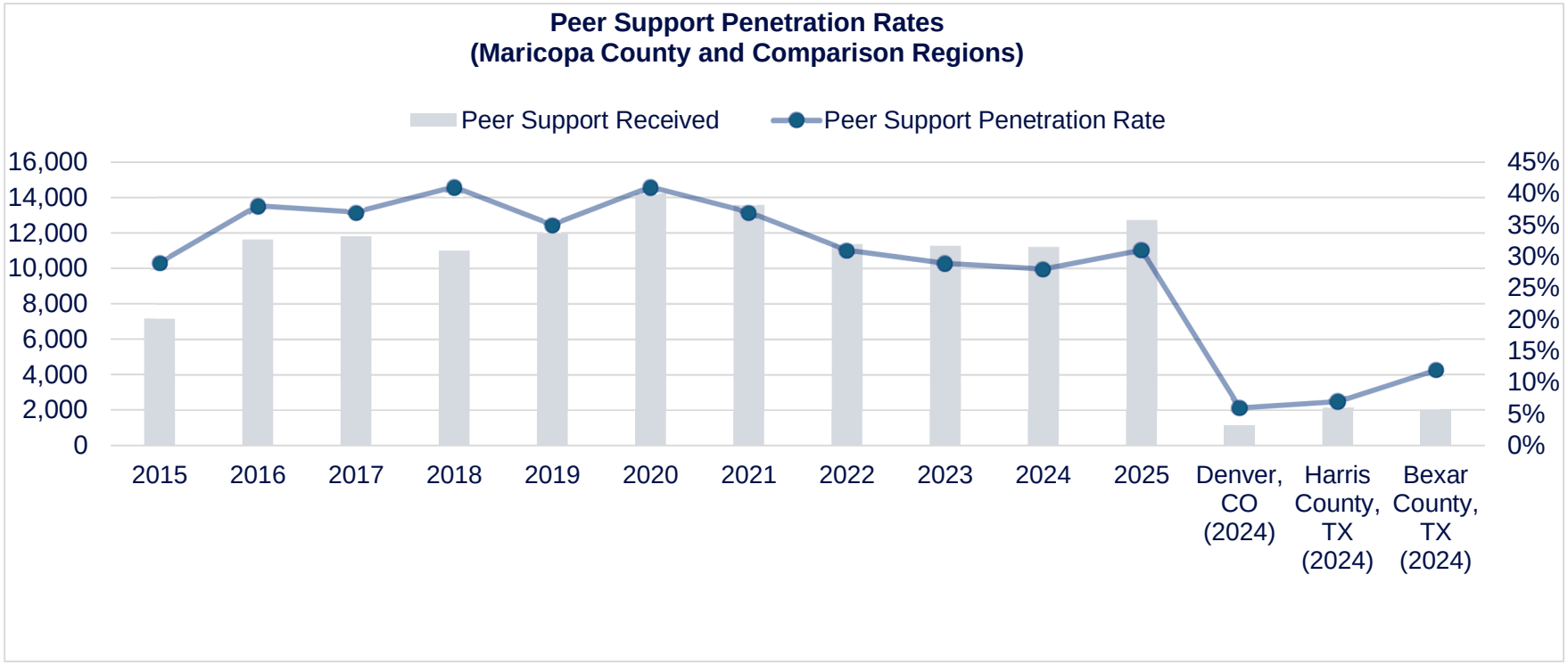
Region	Peer Support Received	Peer Support Penetration Rate
Maricopa County (Total) — 2018	11,001	41%
Maricopa County (Total) — 2017	11,803	37%
Maricopa County (Total) — 2016	11,629	38%
Maricopa County (Total) — 2015	7,173	29%
Maricopa County (Total) — 2014	7,522	31%
Maricopa County (Total) — 2013	8,385	41%
Texas:		
Harris County (2024)[57]	2,172	7%
Bexar County (2024)[58]	2,062	12%
Colorado:		
Denver City/County (2024)[59]	1,106	6%

[57] The Meadows Mental Health Policy Institute. (2025). Patients served at The Harris Center for Mental Health and IDD and The Center for Healthcare Services LMHAs – FY 2024. Available upon request.

[58] The Meadows Mental Health Policy Institute. (2025). Patients served at The Harris Center for Mental Health and IDD and The Center for Healthcare Services LMHAs – FY 2024. Available upon request.

[59] 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.

Chart 5 — Peer Support Penetration - Maricopa County 2015 through 2025 and Comparative Regions (2024)



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

Service Descriptions[60]

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 the 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:

Peer Support Services

- Most focus group participants continue to view peer support services as a valuable service. Case managers shared that "peer support specialists are able to connect with members in a special way because of their lived experience" and that peer support specialists are "passionate about communicating and connecting with others." A member shared, "They are there for you when you have something going on in your head that you can't figure out. They will listen until you sort it out." And another member stated, "I've been coming to my peer-run organization for about five years, and it has been life-changing for me. I was always

[60] 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.

isolated, and I needed community support to turn my life around. I was invited to serve on the advisory council and then their board of directors. It is invaluable to the people who need it."

- Not all members and family members were aware of peer support as an available service, and providers noted that many "people do not become aware of the service." One member reported that at a prior health home, where she received services for two years, she was never offered peer support during that time. She then transferred to a peer-run health home and stated, "Once I got in the door — everyone was so helpful, there were so many choices of groups, and I said 'wow.' The services are helpful. I've learned so much." A family member and guardian reported that they "never knew the service existed."
- Adult members expressed satisfaction when describing the variety of groups and class topics available through peer-run organizations. One member shared, "My peer run has done a major overhaul of the offering of services, and they have increased the focus on health and wellness. One of the classes is about laughter, and we all need laughter to be well." Another member reported, "My peer run offers personal medicine classes twice per day. We take a daily hour-long scheduled walk, and now, I've signed up for a 5k. That's how I know they care — they want to keep us alive."
- Some family members expressed concerns about peer support. One parent noted that the "the service was sporadic, inconsistent, and doesn't seem like an effective service to offer." Other family members stated that the training for peer support specialists focuses too heavily on working with individuals with general mental health needs and substance use disorders. One family member had taken the training and reported that only "1%" focused on individuals living with an SMI. According to another family member, the perceived lack of focus on SMI, "results in services that are inappropriate to our families." Another family member stated, "I know a peer support specialist cannot be successful with my son because he needs someone who is professionally trained to work with someone with schizophrenia."
- Adult members reported familiarity with the peer warm line and believe it is an important option for crisis prevention. One member stated, "I used it when I needed someone to talk to, and it really helped."
- Peer-run organizations and health homes largely deliver individualized peer support services in person, but it can also be offered virtually or by phone if preferred by a member. Members continue to have access to in-person peer support groups at peer-run organizations, and some health homes also offer group peer support in person. Case managers shared that the peer-run groups are "popular" among members. Providers reported that some peer-run organizations offer late afternoon and evening services, but weekend peer support was only reported as available from one provider. Adult members shared that their peer-run organization used to offer more evening and weekend peer support, but their organization wanted to encourage members to engage in activities and with natural supports outside of their organization on weekends. The decision to eliminate peer support during these times was viewed as a positive decision.

- Some family members believed that the format of peer support groups at the clinics is “unapproachable for individuals with SMI.” They noted barriers such as “transportation to the clinics, which requires a two-hour trip on both ends for a 45-minute group.”
- Participants in all focus groups perceived there are not enough peer support specialists available, particularly at the health homes. Most health homes reportedly have one peer support specialist per site, and providers shared that “it’s not possible for one person to serve an entire site.” Case managers believe that the number of peer support specialist positions at health homes should be increased to respond to the demand. One case manager shared they view peer support as a “stepping-stone to counseling for those who are not quite ready to engage in counseling, but there aren’t enough peer support specialists to support members in this process.” Another case manager shared “My clinic used to have two, but now we only have one, and it’s not enough.”
- Family members expressed a need for peer-run organizations that can “cater to certain subsets of the population such as for younger individuals.” Some believed that peer-run organizations are “not appropriate for people who aren’t stable enough to achieve a certain level of independence.”
- Providers of peer support services reported concerns about their ability to sustain their peer-run organizations. The providers shared that they have had to reduce their workforce because reimbursement rates for peer support have been reduced, peer support is now capped at five hours per day (most programs provide peer support seven hours per day), and peer-run groups have been capped at 20 people. If the group exceeds 20 people, it requires a second staff person, which is difficult to plan for in a staffing model. Providers believe that peer-run organizations should be offered a special modifier and rate to support delivery of this service.
- Members, case managers, and providers reported that turnover rates remain high among peer support specialists at the health homes, and an ACT provider noted that they experience higher turnover of peer support specialists specifically assigned to forensic ACT teams. Turnover rates were reported to be lower at peer-run organizations. Leading causes of turnover included the lower pay scale for peer support specialists, demands of the position, ambiguity of the peer support specialist role, and asking peer support specialists to take on case management or case aide tasks (e.g., picking up food boxes), a lack of training and ongoing support, a requirement to have a vehicle or to meet an agency’s insurance requirements, and exasperated mental health symptoms or challenges with substance use faced by some peer support specialists. Providers also shared that peer support specialists often actively seek promotions into other roles, but some find that they may not meet the minimum requirements for positions, such as behavioral health technicians (BHTs), leading to attrition.
- Providers reflected on how adequate training and support during onboarding and beyond may address turnover rates. The providers reported that a previous managed care organization provided mandatory six-month training for new health home staff and then ongoing training for at least the first year of hire. This training is no longer available, and health homes are responsible for all onboarding trainings. Providers expressed that, “Things are too fast paced at the clinics, and there isn’t the time or manpower to provide this sort of training at the clinics. Most training is provided through RELIAS (online training platform), which

is perceived as not engaging." Like last year, focus group participants noted it would be beneficial to educate health home staff 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, and learn about the service through word-of-mouth.

- To address turnover, an ACT provider shared that once a peer support specialist meets the requisite requirements for a BHT, they raise their salary to the BHT level to encourage them to remain in the peer specialist role. A peer-run organization offers promotional career paths for peer support specialists, so staff can remain in professional peer support roles. Another provider shared that they were aware of a health home that "disconnected" their peer support specialist from their clinical team to keep them focused on peer support-specific tasks (such as running groups), noting that "it's important to use peer support specialists in the right way." Another health home has implemented case aide positions to remove peers from clinical tasks. Providers also suggested the use of "peer ambassadors" or "employee support partners," who can provide individualized support to new and seasoned peer support specialists. There was a continued perception that peer support specialists do not feel adequate support once they are on the job.
- Case managers largely believed that access to peer support services at peer-run organizations is "smooth," and referrals are processed "quickly." On average, it takes approximately a week for services to begin. Providers of peer support services reported they were more flexible in the past with self-referrals that preceded a formal referral but found that clinical teams were not following up with the appropriate referrals. They now offer a 10-day maximum pass for self-referrals and shared that they continue to receive "a lot of expired documentation." Providers believed this is due to the turnover at the health homes and staff who do not understand the requirements for referrals.
- A family member and guardian shares that he wanted to access peer support for his adult child from a peer-run organization, stating, "Clinics are refusing to refer to peer-run organizations" because they prefer that members utilize clinic-based peer support services. The family member added, "for my adult child, I specifically requested that they refer to a peer-run organization, and they refused. I filed a quality-of-care concern with AHCCCS."
- For clinic-based peer support services, case managers reported that members can access groups "immediately and hop in right away, but it can take a little more time to access 1:1 peer support." The case managers explained that this is due to the lack of available peer support specialists and, for available staff, it can take time to fit a new member into their schedule. A family shared that it "took four years for peer support to be provided," and another reported that they "requested it multiple times and could not obtain a referral."

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, “I am not aware of this service. It’s too bad that more people don’t take advantage of this service.” Family member participants were largely unfamiliar with family support services, and one family member shared, “My son is in flex care, and for the first time, a person called to ask me if I was interested in this service.” Another stated, “…our son was hospitalized in another county. They provided us with a 30-minute family support session before and after every visit with them. It was tremendously helpful, and I have never received it again."
- Several family members, who were also guardians to their adult children, expressed interest in the service but shared that health homes do not honor their legal rights as guardians. The family members reported that they are frequently told by health home staff that they do not have the right to request and engage in services despite being legal guardians.
- Several family members described Maricopa County’s behavioral health system as “anti-family.” One family member stated, “We used to take care of families until about 10 years ago. There used to be a person in the clinics who would walk families through the system and how to care for their children. But something shifted about 10 years ago, and the system is now anti-family.” Another family member shared, “We have all experienced the ‘anti-family-ness’ of this system. When a family has a loved one in a hospital, we cannot even get through the front door to get to the service.” Another stated, “The most broken part of our system is how the system engages with our families.”
- Case managers also reported they were largely unaware of family support services and stated, “There is a lack of ongoing knowledge of the service, and we are not taught about the importance of the role,” and “I wasn’t aware that this is an available service or position.” Some case managers shared they “received an overview [of family support services] in the new employee training, and training [is] also available on RELIAS,” and one believed, “there needs to be more training. I can think of ways that it could be utilized more, but there is a general lack of understanding of the service.” Other case managers viewed family support as “really important” for members and will refer to the National Alliance on Mental Illness (NAMI) when indicated.
- Provider and case manager participants agreed that most health homes do not have a family mentor on staff. Only one case manager reported that they have a family mentor at their site. This family mentor provides mostly 1:1 service on site and in family member homes. They also offer on-site groups, and they are focused on helping members who want to improve relationships with their family members. One provider reported they have an open family mentor position at their site, but they are prioritizing the hiring of case managers over this position. Another provider has a family mentor who is active in helping families understand the court order process, how to navigate the behavioral health system, what they should expect from the clinical team, and how they can help their family members when at home. Referrals to this family mentor are typically processed within a day. Providers without family mentors on site will also refer to NAMI when needed.

- Providers shared that a previous managed care organization mandated they have a family mentor at the health homes. The providers described that the family mentors “were instrumental in offering a weekly family support group. Family mentors offered opportunities for families to get together (outings, dinners), helped families to navigate the system, and to understand symptomology. The family mentors served as the “first face for families” and “it was amazing” to experience that support provided. “This piece has been lost and should return as a mandate. Especially at hospitalizations.”
- Case managers familiar with family support services shared they will recommend the service when a member reports challenges within their family, but it is rarely initiated by a member or family member. Providers shared that they would like to “see more universal encouragement of discussing the benefits with members, to increase family involvement and connection to families.”

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 mental health 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. As such, responses to the survey do 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.

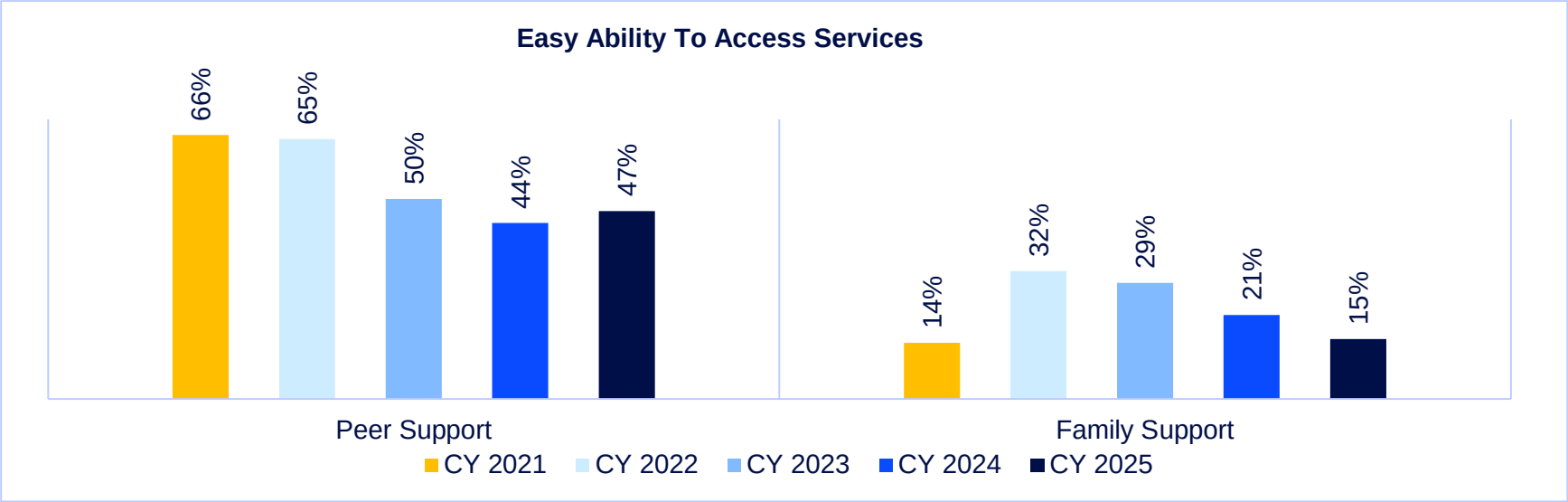
Level of Accessibility

Forty-seven percent (47%) of survey respondents thought peer support services were easy to access, a slight increase compared to last year’s findings (44% in CY 2024). None (0%) of the survey respondents indicated peer support services were difficult to access.

Thirty-one percent (31%) of survey respondents thought family support services were difficult to access, while 15% of the respondents indicated family support services were easy to access. Fifty-four percent (54%) of respondents rated access to family support services as “average.”

Overall, respondents thought the ability to access peer support was easier during CY 2025 when compared to CY 2024, while stakeholders indicated it was more difficult to access family support services over this same period.

Chart 6 – Ability to Access Services



Factors that Influence Access

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

- Staffing turnover
- Lack of capacity/no service provider available

Efficient Utilization

In terms of service utilization, 100% of the responses indicated peer support services were being used efficiently or were utilized efficiently most of the time. None (0%) of respondents indicated that the peer support services were not utilized efficiently.

Ninety-two percent (92%) of the respondents indicated family support services were being utilized effectively or were utilized efficiently most of the time. Eight percent (8%) 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 the past two years.
- All survey respondents reported that peer support services could be accessed within 45 days.
- Seventy percent (70%) 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 90% during CY 2024.
- Ninety percent (90%) of the survey respondents reported that family support services could be accessed within 45 days.
- Ten percent (10%) of the survey respondents reported that it would take longer than 45 days to access family support services.

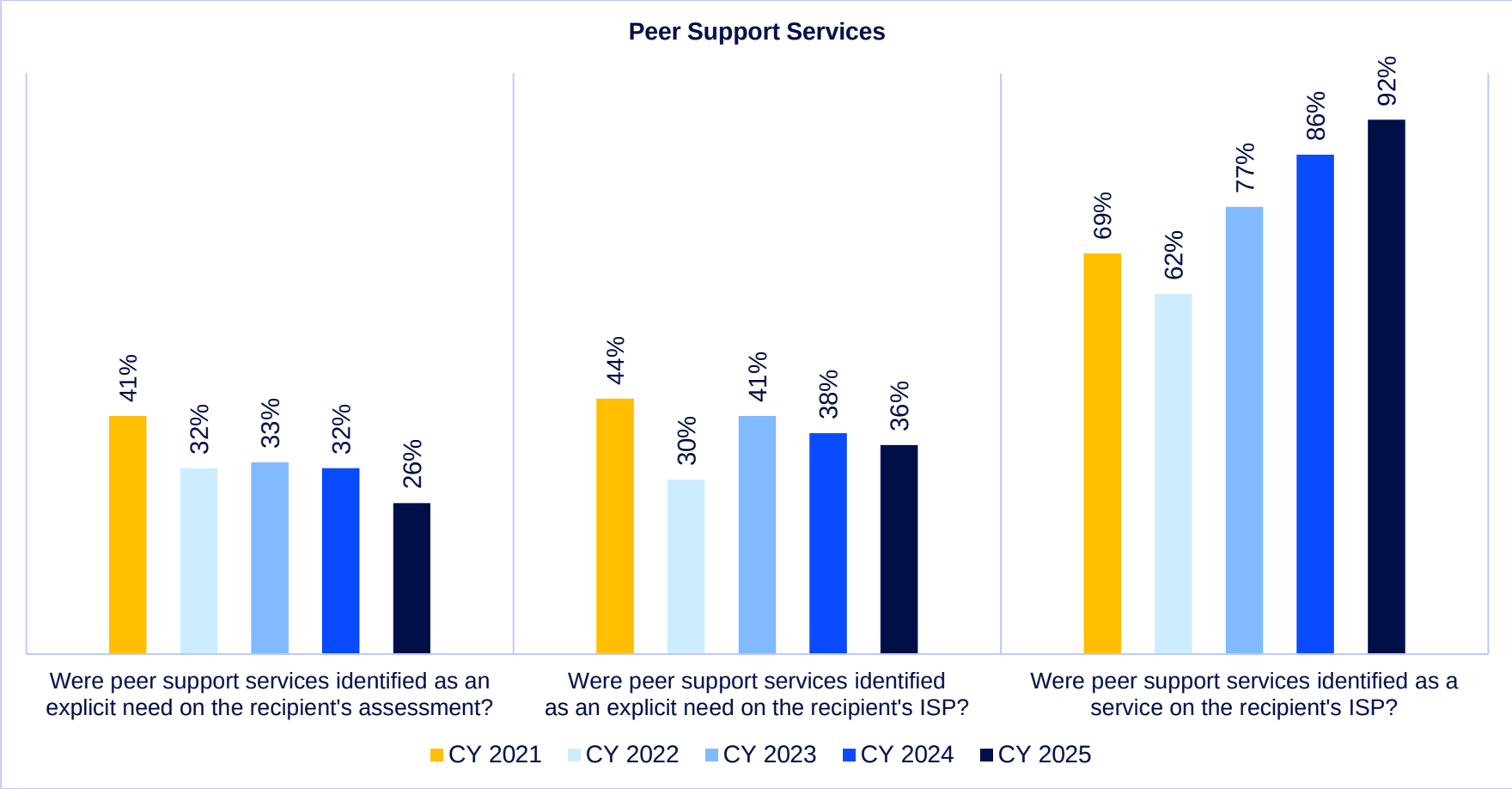
Medical Record Reviews

Mercer reviewed a random sample of 200 recipients' health home medical records 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

- Ninety-two percent (92%) of the ISPs included peer support services when assessed as a need; an increase when compared to CY 2024 (86%) and CY 2023 (77%).
- Thirty-three percent (33%) of the recipients included in the sample received at least one unit of peer support during CY 2025.

Chart 7 – Peer Support Services



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, occurring two thirds (67%) of the time the service was not provided.

Mercer assessed the timeliness of receiving peer support services once the service was identified as a need. During CY 2025, the timeframe was modified to within 45 days as opposed to within 30 days (per AHCCCS policy). For the subset of members who

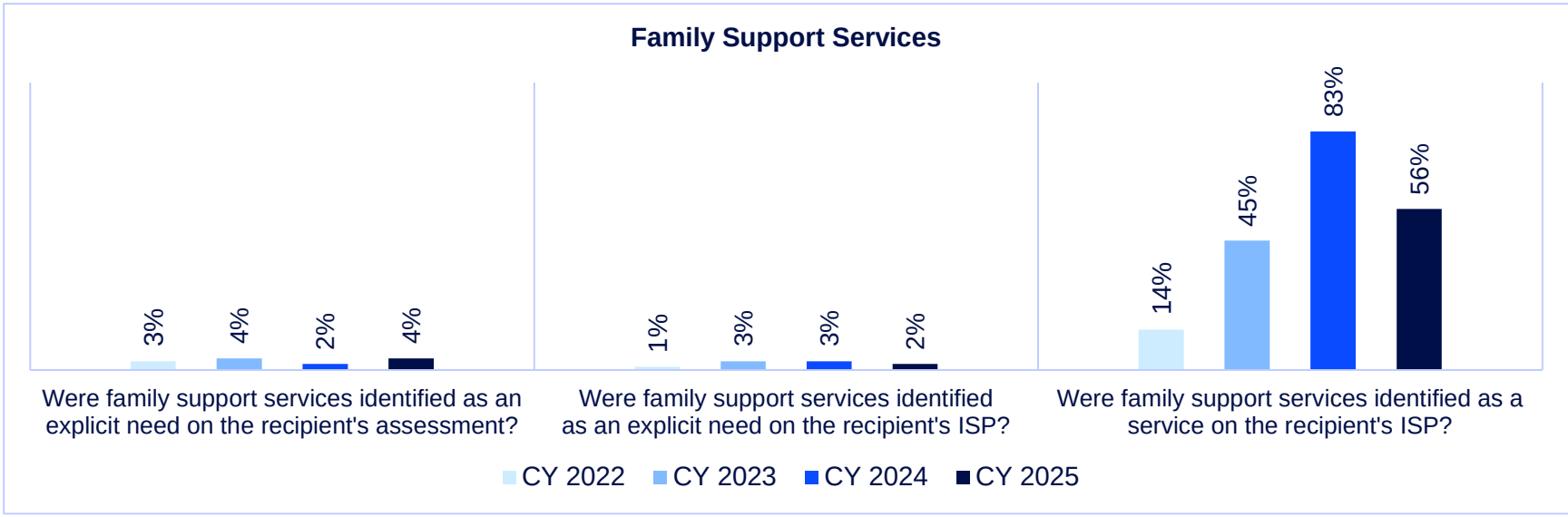
received peer support services within 45 days of the identification of need, most (91%) received the service between days 0 through 30.

Family Support Services

As part of the clinical services assessment process, the clinical team regularly documents information regarding the natural and family support that are important to the recipient. However, clinical teams rarely leverage the opportunity to involve family members when the person expresses interest with having 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 and/or people important to their recovery.

Five percent (5%) of the medical record review cases included an assessed need for family support services. Of these nine cases, 56% of the ISPs included family support services, a decrease from CY 2024, but higher than CY 2023 and CY 2022. Five percent (5%) of the recipients in the sample received at least one unit of family support during CY 2025, based on a review of service utilization data.

Chart 8 – Family Support Services



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 family support services and recommended the services as part of the person's ISP.

Case #1 – Family Support Services

The member is a young adult, who is currently residing at home with family. The member is not currently in school and is unemployed. The client's family is actively involved in the member's treatment and reports that the current living situation is unsustainable. Per the assessment and treatment plan, the member's stated preference for goals and interventions include housing assistance, vocational support, medication management, and family support services for the member's mother.

- Within a few days of the assessment and treatment planning meeting, the assigned case manager reaches out via email to a colleague to refer the family for family support services. The family support services provider contacts the family, who requests a call back later in the week. Ultimately, the service provider is unable to reach the family and leaves a message for a call back in the event they would like to follow up with services.
- Over a month passes before the next progress note, which describes an appointment with the health home nurse practitioner for medication management services. The nurse practitioner documents that the member needs housing assistance and that the member is not in school and is unemployed. The nurse practitioner notes that the member is spending extended periods engaged in social media.
- Following the medication management appointment with the nurse practitioner, there is no substantive clinical team documentation regarding the member's treatment progress or services for several weeks. The next progress note describes a meeting between the case manager and a clinical coordinator/supervisor at the health home. The clinical coordinator is inquiring about the member's treatment status. The case manager explains that the member had expressed a disinterest in any services other than medication management. The clinical coordinator advises the case manager to reach out to the member and offer support.

This case illustrates a common occurrence across the medical records reviewed by Mercer. Treatment plan services and interventions are identified by the clinical team, but there is a lack of consistent follow-up to ensure that the services are put in place

and made available to members. The action by the case manager to almost immediately initiate a referral for family support services following completion of the treatment plan is a best practice that has not been widely implemented across the system of care.

It is unclear, based on the clinical documentation available, that the member expressed a disinterest in services following the development of their treatment plan (as reported by the case manager). The member clearly expressed an interest in housing assistance and vocational support during the treatment plan meeting, and the nurse practitioner restated the member's needs in these areas when documenting the disposition of a medication management appointment.

The clinical coordinator's intervention with the case manager to ascertain the status of the member's treatment progress is a promising practice, but it occurred almost three months following the establishment of the member's treatment goals. The provision of priority mental health services would likely increase substantially if clinical teams acted more intentionally to secure services within days of identifying members' treatment interventions.

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, 2024 through June 30, 2025, there were 40,116 unique users represented in the service utilization data file. Of those, 73% were Medicaid eligible (i.e., Title XIX) and 27% were non-Title XIX eligible.

- Overall, 23% of the recipients received at least one unit of peer support services during the period (a slight decrease from last year, when 24% 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 (20%).

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, 56% of members who received at least one unit of peer support during the review period accessed the service during a single month, a slight decrease when compared to CY 2024 (58%).
- Seventy-three percent (73%) 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 2024, this result was 75%. 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.

Table 21 – Persistence in Peer Support Services October 2024–June 2025

Consecutive Months of Service	Medicaid Recipients	Non-Medicaid Recipients	All Recipients
1	53.9%	61.8%	55.7%
2	18.0%	15.9%	17.5%
3–4	14.5%	10.2%	13.5%
5–6	5.6%	5.7%	5.6%
7–8	2.5%	2.6%	2.5%
9+	5.6%	3.8%	5.2%

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

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, 3.1% of the recipients received at least one unit of family support during the review period (3.3% 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 (3.2%) and non-Title XIX groups (2.8%).

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.

- Seventy-seven percent (77%) of the members who received at least one unit of family support during the review period accessed the service during a single month, an increase from last year, when 65% of the members accessed the service during a single month.
- Ninety-two percent (92%) of all members who received at least one unit of family support during the review period accessed the service for one or two months.

Table 22 – Persistence in Family Support Services October 2024–June 2025

Consecutive Months of Service	Medicaid Recipients	Non-Medicaid Recipients	All Recipients
1	75.6%	81.0%	76.9%
2	16.0%	11.8%	15.0%
3–4	6.4%	4.6%	5.9%
5–6	1.1%	1.0%	1.0%
7–8	<1.0%	<1.0%	<1.0%
9+	<1.0%	1.3%	<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, 2024 through December 31, 2025, 31% of all members living with SMI received at least one unit of peer support. During the prior year, 28% of members received peer support services.
- There were 454,504 more units of peer support delivered in CY 2025 when compared to CY 2024, an increase of 128%. In addition, 1,515 more recipients received peer support during this same period, reversing a downward trend over the past three years.

- Adult members expressed satisfaction when describing the variety of groups and class topics available through peer-run organizations. One member shared, “My peer run has done a major overhaul of the offering of services, and they have increased the focus on health and wellness.”
- Peer-run organizations and health homes largely deliver individualized peer support services in-person, but it can also be offered virtually or by phone if preferred by a member. Members continue to have access to in-person peer support groups at peer-run organizations, and some health homes also offer group peer support in person. Case managers shared that the peer-run groups are “popular” among members.
- Not all members and family members were aware of peer support as an available service, and providers noted that many “people do not become aware of the service.” One member reported that, at a prior health home where she received services for two years, she was never offered peer support during that time.
- Forty-seven percent (47%) of survey respondents thought peer support services were easy to access, a slight increase compared to last year’s findings (44% in CY 2024). None (0%) of the survey respondents indicated peer support services were difficult to access.
- Ninety-two percent (92%) of the ISPs included peer support services when assessed as a need; an increase when compared to CY 2024 (86%) and CY 2023 (77%).
- 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, occurring two thirds (67%) of the time the service was not provided.

Key Findings: Family Support

- Service utilization data demonstrates that 5% of members received at least one unit of family support services during CY 2025 compared to 4% during 2024.
- During CY 2025, there were 418 more members who received family support services when compared to CY 2024 and 843 more than CY 2023 (an increase of over 73%). However, units of family support decreased by 2,779 between CY 2024 and CY 2025.
- Five percent (5%) of the medical record review cases included an assessed need for family support services. Of these nine cases, 56% of the ISPs included family support services, a decrease from CY 2024, but higher than CY 2023 and CY 2022.

- Thirty-one percent (31%) of survey respondents thought family support services were difficult to access, while 15% of the respondents indicated family support services were easy to access.
- Case managers reported that they were largely unaware of family support services and stated, “There is a lack of ongoing knowledge of the service, and we are not taught about the importance of the role,” and “I wasn’t aware that this is an available service or position.” Some case managers shared they “received an overview [of family support services] in the new employee training and [it is] also available on RELIAS,” and one believed “there needs to be more training. I can think of ways that it could be utilized more, but there is a general lack of understanding of the service.” Other case managers viewed family support as “really important” for members and will refer to NAMI when indicated.
- Case managers familiar with family support services shared they will recommend the service when a member reports challenges within their family, but it is rarely initiated by a member or family member. Providers shared that they would like to “see more universal encouragement of discussing the benefits with members, to increase family involvement and connection to families.”

Recommendations: Peer Support

- Collaborate with health homes to ensure that ISP interventions are immediately initiated following completion of a member’s ISP, including securing needed services, such as peer support, when recommended as a need and a service on the person’s ISP. Leverage active clinical supervision and repeated member engagement attempts to ensure recommended services are implemented as soon as possible.

Recommendations: Family Support

- Continue efforts to promote family support services, regularly assess the sufficiency of the provider network, 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.
- Identify and target conditions and populations that may be particularly amenable to benefiting from family support services such as young adults transitioning to adulthood and members experiencing first episode psychosis.

Multi-Evaluation Component Analysis — Supported Employment

Service Description[61]

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 that they can talk to a case manager or supported employment specialist at their health home or peer-run organization if interested in work or in engaging with a vocational rehabilitation (VR) specialist. One adult member reported that their team “offers them the opportunity to regularly talk about their options for employment.” Another adult member shared they used VR services in the past and found it to be “helpful, but slow moving.” The participant added that they were able to get back to work and get the services they needed.
- Family members offered varied responses regarding their experiences with supported employment services. One family member participant reported that their son “went to a supported employment provider for a year, and he loved it. But when he moved into a more independent setting, he relapsed and dropped out of the program.” Another family member shared that their son “used VR services and got a job that included a job coach for ongoing support. It didn’t end up being the right environment for him because he can get a bit loud when he is responding to his delusions. I felt they didn’t place him correctly.”
- Other family members believed that supported employment services would be beneficial if provided to their adult child. One family member shared that their son was recently fired from their job after getting into an argument with a customer. The family member

[61] 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.

believes that their son would have been able to keep this and other jobs if they had a job coach or other ongoing supported employment services.

- Case managers shared that co-located VR counselors are available on a part-time basis at most health homes, and each serves multiple clinics. Unlike previous years, some case managers were unclear whether they still had a VR counselor specifically assigned to their clinic. One reported, “I have never met our VR counselor.”
- Case managers reported that VR orientation sessions are now primarily offered in person, but virtual sessions remain available. Providers reported that VR orientation sessions are offered every two weeks.
- Some case manager participants were not aware that VR services were available to their members, including a case manager supervisor with long tenure in the field.
- Case managers and provider participants reported varied wait times for VR referral processing, from two weeks to months before receiving a response. Providers believed that the referrals are taking “way too long” to get processed, and one provider will refer to a work adjustment program instead of VR because “it takes too long.” They described this as a “nice bridge, which has been successful for many individuals.”
- Case managers shared that referrals to clinic-based rehabilitation specialists are typically processed within 10 days. Processing time depends on the caseload size of the rehabilitation specialist. Some case managers have seen an increase in the number of rehabilitation specialists available in their clinics, which has expedited the referral process. The case managers have also seen longer tenure among rehabilitation specialists, which they attributed to lower caseloads and higher pay rates than in previous years.
- Case managers indicated that it takes about two weeks for community-based employment providers to process requests for services.
- Supported employment providers report non-Title XIX members no longer have access to supported employment services due to funding cuts for these services. Non-Title XIX members may still access supported employment services from community-based providers if referred by VR, but not from the health homes.
- Provider focus group participants reported that case managers do not receive sufficient training about the availability of supported employment services and that the training is limited to virtual options available on RELIAS (an online learning management system). The provider participants believe that case managers would benefit from “bootcamp” training that would cover employment services in more detail.

- Case managers shared they will include supported employment on a member's ISP "if someone expresses an interest" and noted a monthly requirement that 85% of all members have a vocational assessment profile completed.
- Providers expressed a concern about a reduction in the number of referrals to community-based employment providers. The participants believed that this may be because supported employment is a potential revenue source for health homes, and the health homes may be opting to keep the services in house.
- Providers would like more access to the health homes to provide presentations to the clinical teams and to remain visible and engaged. Some employment providers share that they no longer attend weekly team meetings at the health homes and are no longer publicizing their available employment options at the clinics. These providers expressed that the constant turnover in health home staff and rehabilitation specialists has impacted system-wide knowledge of community-based supported employment services.
- Adult members and case managers report being familiar with the "Disability Benefits 101" (DB 101) website, and an adult member expressed that it is a "helpful" program. Supported employment providers complete DB 101 with all members and agreed that the website is "awesome." Supported employment providers shared they were not hearing as many concerns about the impact of work on benefits, but peer run organization representatives and family members continue to hear concerns about the impact of working on eligibility for public benefits. Providers added that increasing rental costs are pushing more members to work, despite the potential impact on their benefits.
- Case managers and providers indicated that there is different employment options offered to members, including part-time, gig work, and work adjustment options. However, both case managers and providers shared that it is hard for the workforce to "meet members where they are at" and to find compatible jobs. Providers noted that the job "market is very soft, and there's not a lot of hiring. This limits opportunities available for members." Supported employment providers will lean towards gig work or help members to ease into employment through temporary job agencies.
- Families continued to express 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.
- Case managers and provider focus group participants shared that there are a limited number of benefit specialists available in the system. One member had worked with a benefit specialist at their site and found them to be helpful to clarify how benefits may be impacted by working. Providers reported that benefits specialists are largely limited to helping individuals apply for AHCCCS health insurance and supplemental nutrition assistance programs, but some can assist with Social Security disability insurance applications. Family members believed that "benefit specialists no longer exist and state, "this has disappeared from the clinics."

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

Seven percent (7%) of survey respondents believed that supported employment services were difficult to access, slightly higher than the finding in CY 2024 (6%). Ninety-three percent (93%) of respondents indicated supported employment services were easy to access or had “average” access, about the same as CY 2024 (94%).

Factors that Influence Access

Factors that negatively impact accessing supported employment services include:

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

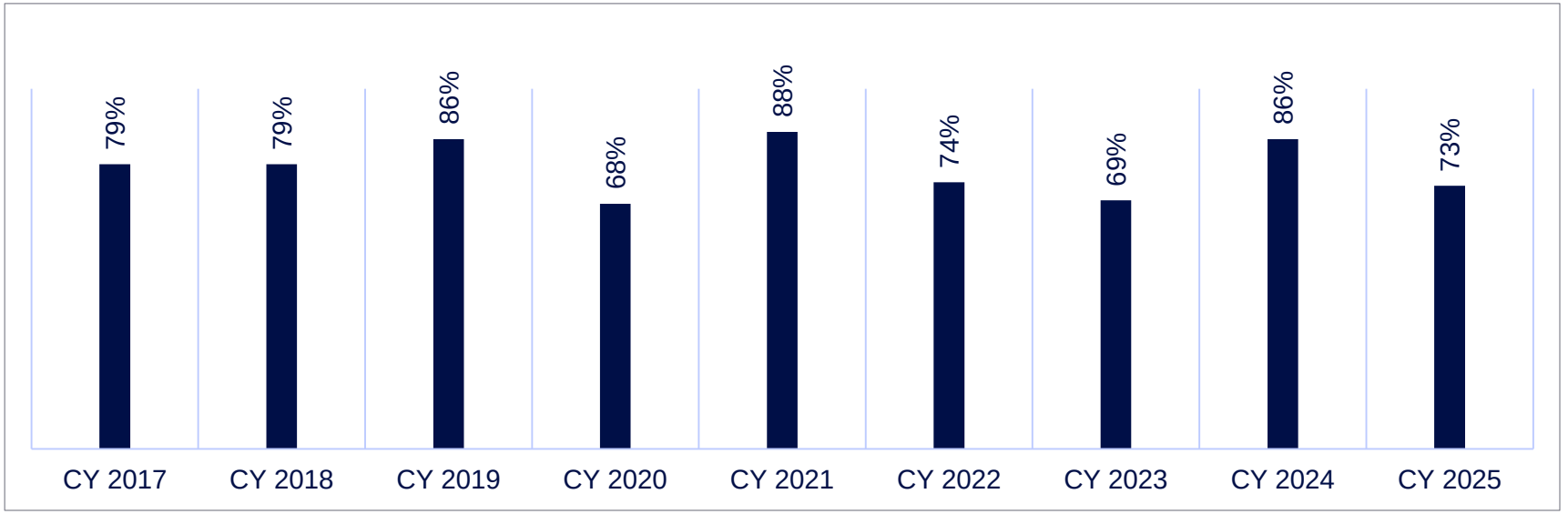
Efficient Utilization

Ninety-two percent (92%) of the responses indicated supported employment services were being used efficiently or were utilized efficiently most of the time, slightly less than last year (94%). Eight percent (8%) of respondents indicated that supported employment services were not utilized efficiently.

Timeliness

Seventy-three percent (73%) of the survey respondents report supported employment services can be accessed within 30 days of the identification of the service need. This compares to 86% during CY 2024. One hundred percent (100%) of the survey respondents reported access to supported employment services would occur within 45 days.

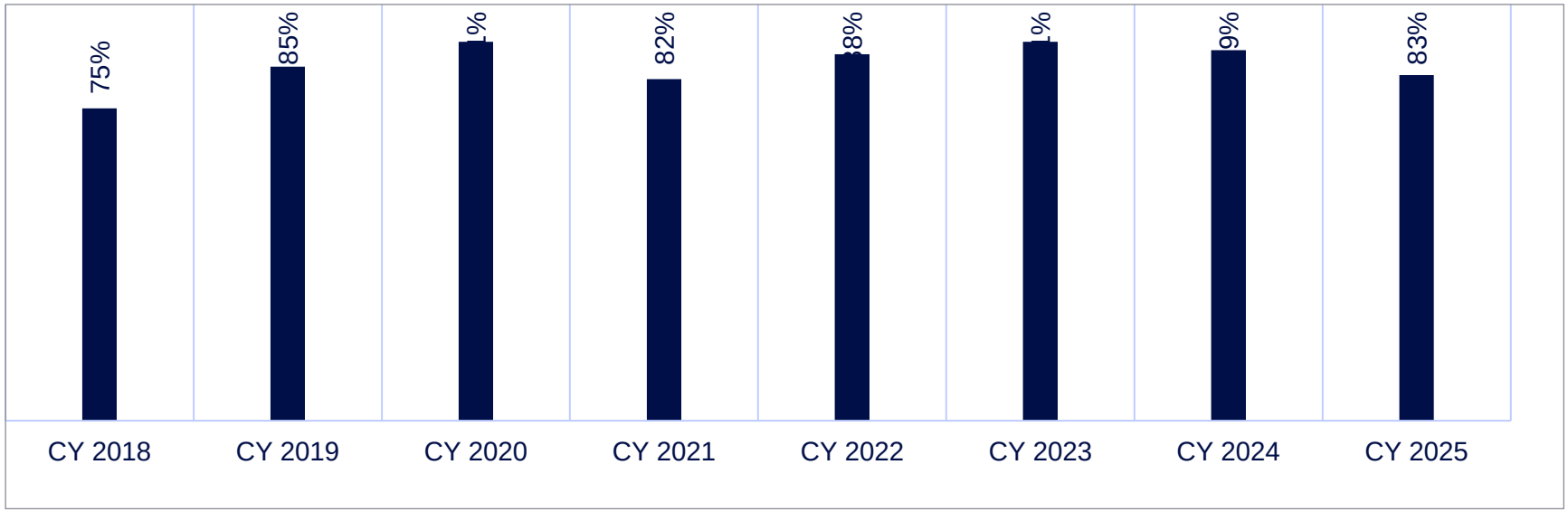
Chart 9 – Supported Employment Services Accessed within 30 Days of Identification of Service Need



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 36% of the cases reviewed. Supported employment services were identified as a service on the recipient's ISP in 83% of the cases reviewed when assessed as a need (89% in CY 2024).

Chart 10 – Supported Employment Identified on Recipient's ISP



Based on a review of service utilization data, 28% of the recipients included in the medical record review sample received at least one unit of supported employment during CY 2025.

In forty-four 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 cases, the same rate identified during CY 2024.

Mercer also assessed the timeliness of receiving supported employment once the service was identified as a need. During CY 2025, the timeframe was modified to within 45 days as opposed to within 30 days (per AHCCCS policy). For the subset of members who received supported employment services within 45 days of the identification of need, over half (57%) received the service between days 0 through 30.

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 VR/Rehabilitation Services Administration (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)

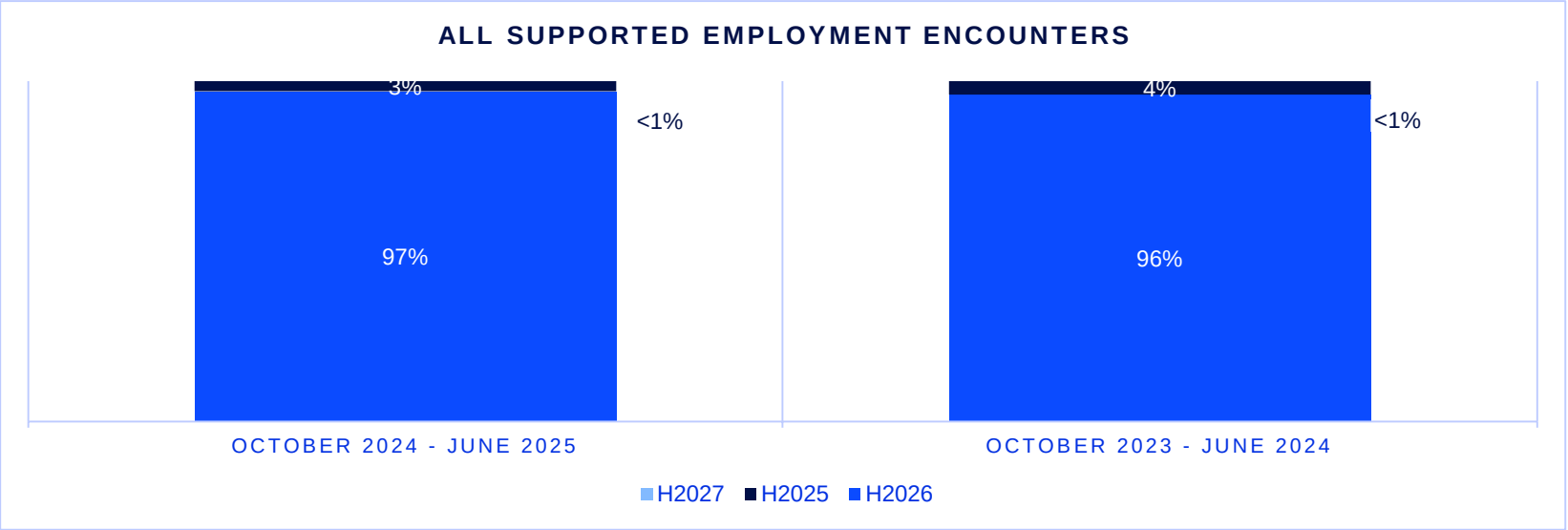
Includes support services that enable a person to maintain employment. Services may include monitoring and supervision, assistance in performing job tasks, and supportive counseling.

Service Utilization Trends

For the period October 1, 2024 through June 30, 2025, H2027 (pre-job training and development) accounts for 97% of the total supported employment services. H2025 (ongoing support to maintain employment/15-minute billing unit) represents 3% 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.

Chart 11 – All Supported Employment Encounters



As documented in prior years, 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.

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

- Overall, 19% of the recipients received at least one unit of supported employment during the October 2024–June 2025 review period, three percentage points less than last year (22%).
- Access to the service was split between Title XIX (19%) and non-Title XIX groups (18%).

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.

Table 23 – Persistence in Supported Employment Services October 2024–June 2025

Consecutive Months of Service	Medicaid Recipients	Non-Medicaid Recipients	All Recipients
1	60.1%	67.2	62.0%
2	15.4%	12.0%	14.5%
3–4	12.2%	9.8%	11.6%
5–6	5.2%	4.7%	5.1%
7–8	2.3%	2.9%	2.4%
9+	4.8%	3.5%	4.5%

- 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 can lead to consistent participation over several months.
- There were 11%–12% of the recipients that received supported employment services for three to four consecutive months during the review period.
- There were 4%–5% of the recipients that 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 (29) full-time DES/RSA counselors are dedicated to people living with SMI and are co-located at several health home clinic locations. Thirty-one percent (31%) of VR/RSA staff are assigned to more than one health home. Eight vacancies were reported as of December 2025. VR counselors meet regularly with health home clinic rehabilitation specialists and contracted supported employment providers and work in coordination to meet members’ supported employment needs.

The VR program for people living with SMI is tracking targeted outcomes. Per the managed care organization, RSA adopted a new information system in July 2025. As such, available data is limited and unable to be compared to outcomes reported in prior review cycles:

- Members referred to VR/RSA: 722 between October 1, 2024 and June 30, 2025
- Members served in the VR program: 1,426 as of quarter ending June 30, 2025
- Members open in the VR program: 1,167 as of quarter ending June 30, 2025
- Members in service plan status with VR: 261 as of quarter ending June 30, 2025
- Members successfully closed and employed: 121 between October 1, 2024 and June 30, 2025

An inter-agency protocol outlining roles and responsibilities across AHCCCS, the managed care organization, and DES/RSA was updated in September 2025. 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 demonstrate 24% of members received at least one unit of supported employment during CY 2025, two percentage points less than CY 2024 (26%).
- There were 286 less members that received supported employment when comparing CY 2025 to CY 2024. However, there was an increase of nearly 80,000 (79,431) units of the service delivered during this same period.
- Seven percent (7%) of survey respondents believed that supported employment services were difficult to access, slightly higher than the finding in CY 2024 (6%). Ninety-three percent (93%) of respondents indicated supported employment services were easy to access or had “average” access, about the same as CY 2024 (94%).

- Focus group members report that 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 that their team "offers them the opportunity to regularly talk about their options for employment." Another adult member shared they used VR services in the past and found it to be "helpful, but slow moving." The participant added that they were able to get back to work and get the services they needed.
- Adult members and case managers report being familiar with the "Disability Benefits 101" (DB 101) website, and an adult member expressed that it is a "helpful" program. Supported employment providers complete DB 101 with all members and agreed that the website is "awesome." Supported employment providers shared they were not hearing as many concerns about the impact of work on benefits, but peer-run organization representatives and family members continue to hear concerns about the impact of working on eligibility for public benefits.
- Case managers and providers indicated that there are different employment options offered to members, including part-time, gig work, and work adjustment options. However, both case managers and providers shared that it is hard for the workforce to "meet members where they are at" and to find compatible jobs. Providers noted that the job "market is very soft, and there's not a lot of hiring. This limits opportunities available for members." Supported employment providers will lean towards gig work or help members to ease into employment through temporary job agencies.
- Supported employment services were identified as a service on the recipient's ISP in 83% of the cases reviewed when assessed as a need (89% in CY 2024 and 91% in CY 2023).
- In 44 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, the same rate identified during CY 2024 (45%).

Recommendations: Supported Employment

- Due to high turnover and the need to continuously recruit and onboard staff, ensure that health home case managers receive training and clinical supervision to support members who express an interest in supported employment services, including available resources within the health home and across the network of available supported employment providers.
- Collaborate with health homes to ensure that ISP interventions are immediately initiated following completion of a member's ISP, including securing needed services, such as supported employment, when recommended as a need and a service on the person's ISP. Leverage active clinical supervision and repeated member engagement attempts to ensure recommended services are implemented as soon as possible.

Multi-Evaluation Component Analysis — Supportive Housing

Service Description[62]

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.

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, sufficient subsidized vouchers are still unavailable, waitlists remain excessively long (e.g., three to four years), and finding landlords willing to accept vouchers at fair market value remains increasingly difficult. One family member participant shared, “In three years, I only know of one family who has received a voucher.” Providers of peer services reported they “are not seeing a lot of people getting into housing.”
- Permanent supportive housing providers reported that documentation and administrative requirements are barriers to receiving housing, which includes the requirement that all documents are color-copied and double-sided. The providers also report that turnover of properties is slow, which increases waitlist times. Providers perceive that turnover times have become slower under the current housing administrator.

[62] The definitions for 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.

- Family members continued to express concerns about the lack of available and appropriate housing options and housing support following a discharge from an inpatient behavioral health setting. One family member stated, “During a hospitalization, my child was on the cusp of a lease expiring. We were lucky, because we could assist with renewing the lease. But if not, she would have lost her housing. It would have been helpful for someone to advocate with the rental company to preserve the lease.”
- 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 cannot get information about a member’s location on the waiting list, especially when the referral was completed by another case manager or it had been several years since the referral was submitted. Case managers expressed that it is difficult to navigate the process, particularly if you are a new case manager. Case managers stated it would be helpful to have dedicated points of contact available from the housing administrator.
- Permanent supportive housing providers believed that case managers need more training on how to work with the vendor that processes housing referrals before they are submitted to the housing administrator. The providers described the training as “minimal.”
- Provider and case manager participants noted that some health homes may not have an available housing specialist and believe that there is an insufficient number of housing specialists to adequately assist members in need of housing support. For those sites with housing specialists, responsibilities differ depending on the site. Some housing specialists focus on applying for vouchers and help with locating housing, and the clinical team provides the in-home permanent supportive housing services. For other sites, the housing specialists provide the full range of permanent supportive housing services. The providers reported there is only one health home in which the housing specialist is readily available on a walk-in basis to members.
- Case manager participants appeared to be more familiar with the full continuum of supportive permanent housing services than in previous years (beyond vouchers and housing subsidies). The case managers shared that they most commonly refer members for assistance with learning to maintain their homes and how to adhere to housing provider requirements.
- Adult member participants reported that their clinical teams ask them about the status of their housing, with questions such as “Do you feel safe?” and “Do you have enough money to buy food?” One adult member shared that she was homeless for two years and would couch surf or stay on a friend’s front porch. She also lived out of her car for a period. Her clinic eventually helped her to get into housing, although she was unaware for some time that they could provide housing supports. Now she lives independently without any housing support or subsidies.
- Family members were not familiar with the range of permanent supportive housing services available (other than vouchers) and expressed that their clinical teams do not have discussions with them about housing options and available services.
- Some family members expressed frustration in trying to navigate the system to obtain assistance with housing. One family member shared, “My husband and I are not going to be around forever, and I need to make sure my son has housing before we

are gone. When I call [the managed care organization] and AHCCCS, they tell me that the clinics are responsible for housing." Other family member participants sought assistance with completing housing applications but could not obtain this assistance from their health homes.

- Providers expressed they would like to see more supportive housing services provided to members who are already in housing, which they believed aligned with the Housing First Model. Case managers reported there are less housing resources and support available to non-Title XIX members.

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

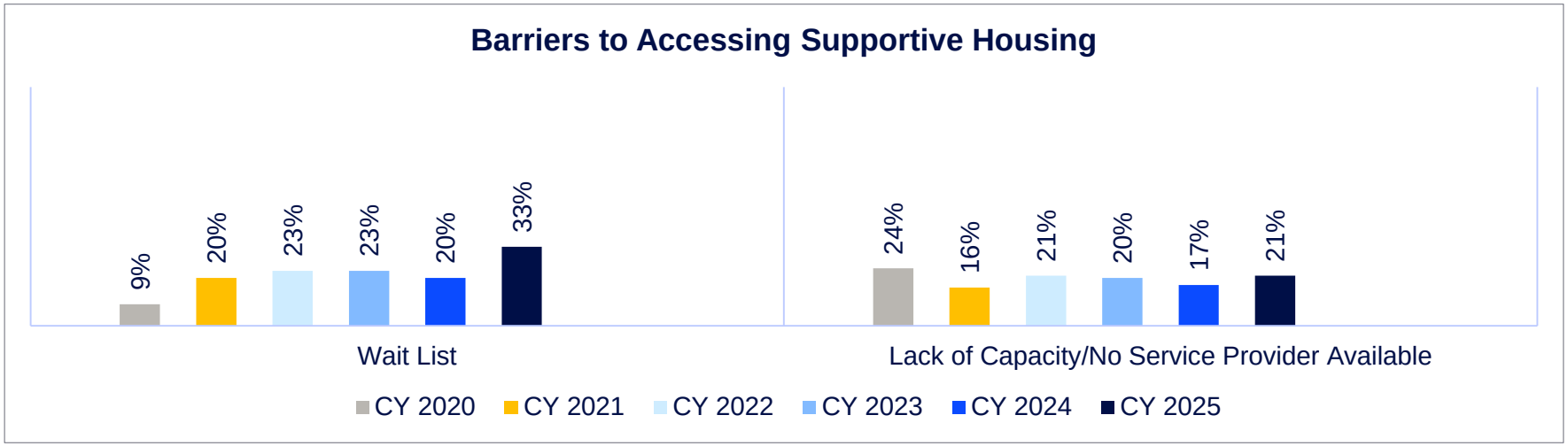
Fifty-seven percent (57%) of the survey respondents believed supportive housing services were difficult to access (47% in CY 2024). Forty-three percent (43%) of respondents indicated supportive housing services had "fair access" or were easy to access, a decrease from CY 2024 (53%).

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[63]
- Lack of capacity/no service provider available
- Staffing turnover

Chart 12 – Barriers to Accessing Supportive Housing CY 2020–CY 2025



Efficient Utilization

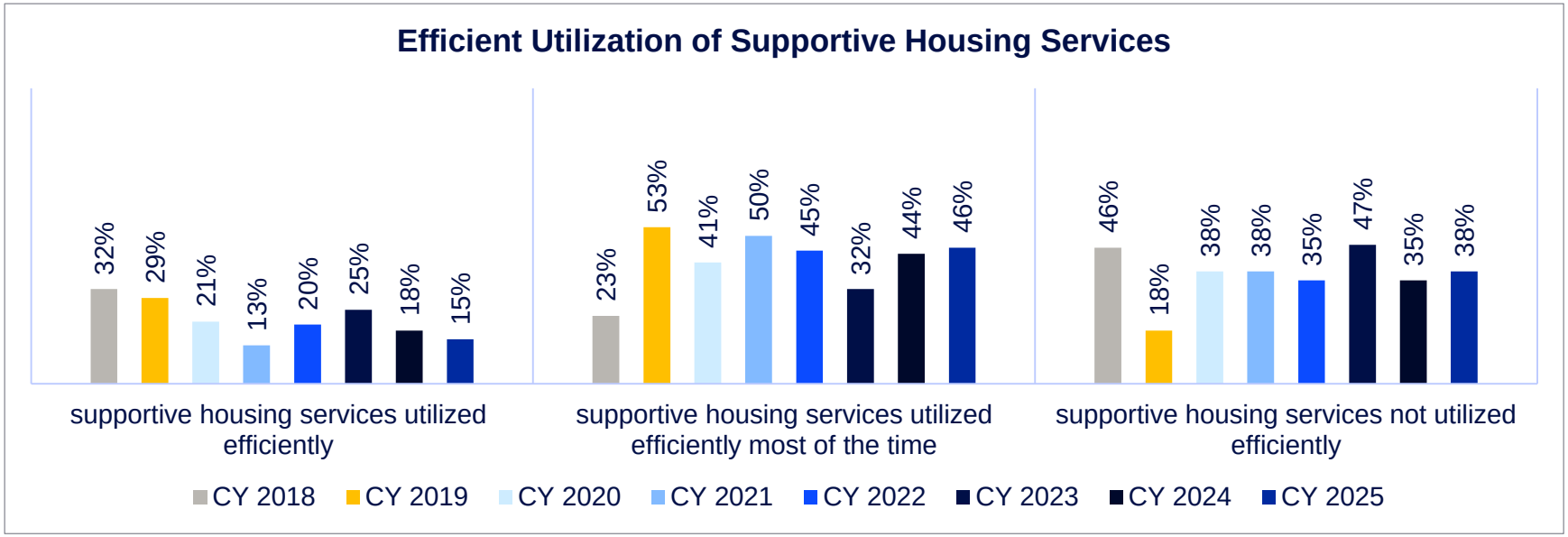
In terms of efficient utilization of supportive housing services:

- Fifteen percent (15%) of the responses indicated the services were being utilized efficiently (18% in CY 2024).
- Forty-six percent (46%) responded that the services were utilized efficiently most of the time (47% in CY 2024).

[63] Supportive housing services in this context refer to the full continuum of housing support available to persons living with an 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.

- Thirty-eight percent (38%) of the respondents indicated supportive housing services were not utilized efficiently (35% in CY 2024)

Chart 13 – Efficient Utilization of Supportive Housing Services



Timeliness

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

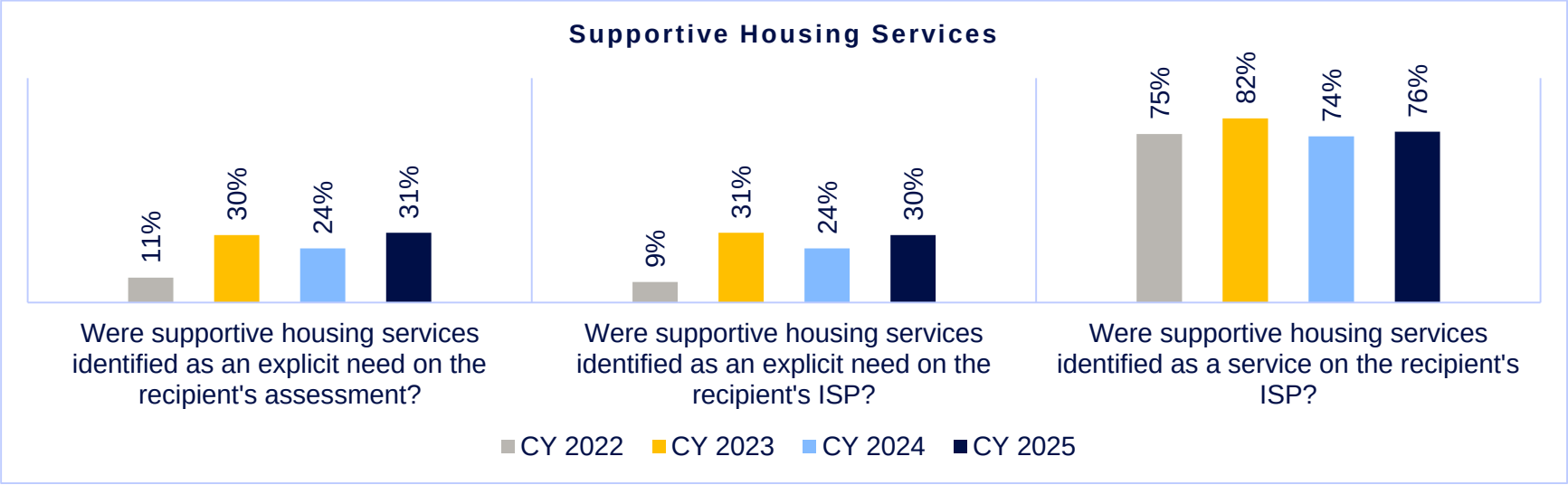
- Fourteen percent (14%) of the survey respondents reported supportive housing services could be accessed within 30 days of the identification of the service need (47% in CY 2024).
- Thirty-six percent (36%) of the respondents indicated the service could be accessed within 45 days.
- Sixty-four percent (64%) of the survey respondents reported it would take longer than 45 days to access supportive housing services.

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 37% of the cases reviewed, more than last year's finding (31%).
- Supportive housing was identified as a service on the recipient's ISP in 76% of the cases, when identified as a need. This is an increase from last year, when 74% of the ISPs with a documented need included supportive housing.
- Twenty-eight percent (28%) of the recipients included in the medical record review sample received a unit of supportive housing during CY 2025.

Chart 14 – Supportive Housing Services



In 27 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 a lack of

evidence that the clinical team followed up with initiating a referral for the service, occurring in almost three fourths (74%) of the applicable cases.

Mercer also assessed the timeliness of receiving supportive housing services once the service was identified as a need. During CY 2025, the timeframe was modified to within 45 days as opposed to within 30 days (per AHCCCS policy). For the subset of members who received supportive housing-related services within 45 days of the identification of need, most (92%) received the service between days 0 through 30.

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 related services and recommended the services as part of the person's individual service plan.

Case #1 – Supportive Housing Services

The member was recently determined to meet criteria for a person living with an SMI and presents to a health home for an initial assessment and treatment plan. Per the assessment, the member has a child, is pregnant, and was "recently" hospitalized. Prior to the hospitalization, the member was without housing and acknowledged struggling with an ongoing substance use disorder. At the time of the assessment at the health home, the member is temporarily residing with a family member, although she states she does not believe the current living arrangement is sustainable in the long term. The member has no income and expresses concern for housing. During the treatment planning process, she identifies needs for stable housing and vocational support in consultation with the clinical team.

- The health home provides an extensive number of assessments and treatment services to the member during her visit to the clinic for her assessment and treatment planning meeting. Services, in addition to the psychosocial assessment and treatment plan, include a nursing assessment with vital sign monitoring, a daily living activity functional assessment, a depression screening questionnaire, an hour-long psychotherapy session, and a psychiatric evaluation.
- There has been no additional documentation in the health home record regarding the member's status following the assessment and treatment planning meeting. The next progress note, dated over several weeks since the initial meeting with the member, indicates that the member "no showed" for a scheduled telemedicine appointment with the health home's nurse practitioner. The clinical team does not follow up with the member for another several calendar days, when an email is sent to the member from the health home's newly assigned case manager, introducing herself and offering to meet with the member, with the goal of getting to know each other and learning how the case manager could support the member.

- Additional time passes with no progress notes. The next note is a description of a telephone call with a community provider offering services to the member. The staff member is contacting the health home to coordinate care and discuss current services on behalf of the member. The case manager explains that a face-to-face appointment will need to be scheduled for the following week to complete a full assessment of the member's needs and goals.
- Several days later, the staff member from the agency contacts the case manager and attempts to reschedule and align appointments on behalf of the member so that the member can meet with the health home nurse practitioner and the case manager on the same day. An appointment is scheduled for the following week for the member to meet with the clinical team.
- It is unclear from the medical record documentation whether the member attended the next scheduled appointment. The next two progress notes describe unsuccessful member outreach attempts by the case manager. The final progress note in the review cycle is an email invitation by the case manager to the member to attend a non-profit community event for Thanksgiving dinner.

This case exemplifies themes identified through the service capacity assessment, including the negative impact of case manager turnover on the continuity of services, delays with implementing service plan interventions for at-risk members in need of immediate support and services, and questionable clinical team decision making (i.e., the case manager's expectation to duplicate assessments and treatment planning after the member underwent comprehensive screenings, assessments, evaluations, and service recommendations at the health home just weeks earlier).

Case #2 – Supportive Housing Services

The member presents at their annual assessment and treatment plan update meeting. The member describes their current housing arrangement as temporary and unsustainable. The member has limited financial resources and expressed fear about their future housing. The stress associated with their housing arrangement is exacerbating their mental health symptoms. The member requests support to access housing with a corresponding treatment plan objective to find permanent safe housing.

- The day following the assessment, the member's assigned case manager meets face-to-face with the member and provides support for housing referrals and moving assistance research. When service plan interventions are acted upon relatively soon after identification, members are much more likely to access needed services.
- While taking steps to assist the member to find safe, affordable housing, the clinical team is concurrently engaged with the member's pharmacy to bridge medications and follow up to refer the member to a specialist, to assess an identified medical condition. The team worked effectively to address all the member's needs simultaneously and seamlessly.
- Relatively quickly following the individual service plan date, a benefits and housing specialist initiated multiple referrals for low-income housing and helped the member qualify for social security disability insurance. The member finds temporary housing,

sharing an apartment with other individuals. Several weeks later, the member maintains stable housing and is effectively managing their mental health symptoms.

The clinical team's quick response to the member's pending homelessness, through efforts to secure temporary housing, actively exploring affordable housing options, and assisting the member to apply and qualify for cash assistance, contributed to the member's ongoing stability and recovery. The case manager recognized that the member was at risk and worked expeditiously across the clinical team to secure resources to avoid homelessness, address gaps in medication, and promote financial independence.

Targeted Interview – Supportive Housing Provider

During the review period (CY 2025), four permanent supportive housing providers terminated contracts with AHCCCS' contracted managed care organization, reducing the number of available providers of supportive housing services. Existing providers temporarily expanded capacity and accepted additional referrals as members were reallocated across the remaining supportive housing provider network. One additional permanent supportive housing provider was added to the managed care contractor's network during the same period. A targeted interview with one supportive housing provider revealed that there are no current wait lists to access supportive housing services, although initial intakes for services can be delayed a few weeks during busy periods. Current utilization is described as being at approximately 50% of the provider's maximum operating capacity.

The permanent supportive housing provider also manages up to 40 beds under a transitional living placement program, which is intended to house individuals for up to 30 days (e.g., temporary housing following an inpatient hospitalization). The transitional living placement beds turn over quickly, as demand for the resource is high and the provider's program is consistently operating at or near full capacity.

Another supportive housing program, referred to as "flex care", includes up to 72 beds, with varied lengths of stay between six months and 12 months. Flex care beds include housing and living skills training groups that program participants must attend. The program is currently only accessible to people living with an SMI and meeting Medicaid eligibility requirements. The service provider owns and rents the housing units, which include one- and two-bedroom living arrangements, with some placements being able to accommodate members with criminal backgrounds and/or sexual offender histories.

AHCCCS' contracted managed care organization administers the referral process for the temporary housing assistance program, while contracted providers directly process referrals from health homes, hospitals, members, and other sources, to access permanent supportive housing services.

The supportive housing provider reports periodically "re-educating" health home case managers on how the permanent supportive housing program is intended to serve members and may need to clarify the level and appropriateness of support the provider can

offer. For example, the permanent supportive housing provider often must inform case managers that the agency does not have direct access to housing resources or funding for members with insufficient income. Housing options are limited for members with limited or no income and may be restricted to shelters until the member can find employment and/or apply and qualify for cash assistance programs. The provider observed that health home housing specialists are less prevalent and that many health homes may not have a designated housing specialist available, as the positions have been phasing out over the past few years.

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.[64] The contracted managed care organization tracks supportive housing utilization through a roster of members affiliated with one of 11 contracted supportive housing providers. During the period of January 1, 2025–November 30, 2025, the roster of members receiving permanent supportive housing totaled 1,498, which is an increase of 263 members over a comparable period last year.

As indicated within the service utilization data file, 8,086 (compared to 4,700 last review cycle) Title XIX eligible (Medicaid) recipients and 2,595 (compared to 1,204 last review cycle) non-Title XIX recipients were affiliated with the service during the period of October 1, 2024–December 31, 2025, from a total population of 41,327.

Key Findings and Recommendations

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

[64] 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).

Findings: Supportive Housing

- Service utilization data reveals 28% of members received at least one unit of supportive housing during the review period. Between CY 2025 and CY 2024, there was an 81% increase in the number of members who received supportive housing. In addition, there was an increase of 87,505 supportive housing units during this same period.
- Case manager participants appeared to be more familiar with the full continuum of supportive permanent housing services than in previous years (beyond vouchers and housing subsidies). The case managers shared that they most commonly refer members for assistance with learning to maintain their homes and how to adhere to housing provider requirements.
- Family members continued to express concerns about the lack of available and appropriate housing options and housing support following a discharge from an inpatient behavioral health setting.
- Permanent supportive housing providers reported that documentation and administrative requirements are barriers to receiving housing, which includes the requirement that all documents are color-copied and double-sided. The providers also report that turnover of properties is slow, which increases waitlist times. Providers perceive that turnover times have become slower under the current housing administrator.
- Fifty-seven percent (57%) of the survey respondents believed supportive housing services were difficult to access (47% in CY 2024). Forty-three percent (43%) of respondents indicated supportive housing services had “average access” or were easy to access; a decrease from CY 2024 (53%).
- Sixty-four percent (64%) of the survey respondents reported it would take longer than 45 days to access supportive housing services.
- Supportive housing was identified as a service on the recipient’s ISP in 76% of the cases when identified as a need. This is an increase from last year, when 74% of the ISPs with a documented need included supportive housing.
- In 27 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 a lack of evidence that the clinical team followed up with initiating a referral for the service, occurring in almost three fourths (74%) of the applicable cases.

Recommendations: Supportive Housing

- Continue efforts to 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.
- Collaborate with health homes to ensure that ISP interventions are immediately initiated following completion of a member's ISP, including securing needed services, such as permanent supportive housing and housing-related services, when recommended as a need and a service on the person's ISP. Leverage active clinical supervision and repeated member engagement attempts to ensure recommended services are implemented as soon as possible.

Multi-Evaluation Component Analysis — Assertive Community Treatment

Service Description[65]

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:

- Case manager participants expressed positive views regarding ACT services. Case managers shared that ACT "is such a great resource," "Our clinic has a spectacular ACT team," and "It's nice to be able to cater to where the member is at, particularly when

[65] The definitions for 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 the Substance Abuse and Mental Health Services Administration's ACT EBP kit.

the member needs to be met in the community." Adult member focus group participants had not used the service themselves but shared "it's so helpful to so many people" and "for those who need a little bit more care, they get the care they need." The adult members added, "It would be good to tell others about ACT so they could get the service."

- 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 shared they had a "really good" experience with their son's ACT team. Another family member reported that their ACT team was "overly sensitive and retaliatory with our family." They added, "If the service were wraparound, comprehensive services, the team would respond proactively.
- One family member described attempting to obtain ACT services and their experiences once the service was initiated: "Despite being the legal guardian, I got an email from the [managed care organization] stating that ACT is a voluntary program, and your son must agree to receive the service. Once he got on an ACT team, there has never been a psychiatrist on the team. The team initially was not going into his apartment, stating that they needed to have his consent to enter the apartment. I had to coordinate between the ACT team and the housing organization to get them to go into the apartment."
- Provider focus group participants shared that there are not enough ACT teams available and believed that members often continue to need the support of ACT following discharge. Provider focus group participants also reported that not all ACT teams operate at full capacity, and case managers agreed that "generally, there are openings" on ACT teams.
- Case managers perceive that there is a need for more forensic ACT teams, and providers agreed that FACT teams have the lowest census compared to other ACT teams. Providers reported that referrals for FACT must come through the [managed care organization] and the criminal justice system, and would like more flexibility to refer directly to FACT teams.
- Case manager familiarity with ACT admission criteria varied among focus group attendees. Some case managers reported receiving minimal training regarding the referral process and ACT admission criteria and expressed a desire to receive more detailed training. One case manager shared, "a general overview is not sufficient to understand if a member would be appropriate for ACT," and another stated, "I am not confident with knowing the criteria." Other case managers expressed feeling "very familiar with the criteria" and added "the process is simple if you know it."
- Family member participants familiar with ACT admission criteria agreed that some case managers do not appear to be aware of ACT criteria and believed that there may be many people who are eligible for ACT but are not assessed or offered the service.
- Providers shared that there is a universal screening process and established timelines for processing referrals, but some providers have instituted additional requirements for referrals (such as requiring doctor-to-doctor transfers between ACT teams at different health homes). Providers recommended that the [managed care organization] work to standardize requirements for ACT transfers. Similarly, providers of ACT services would like more "transparency" in the referral process, so ACT teams receive all necessary information about the member.

- Case managers reported that referral processing times for ACT varies and depends on the provider. If a case manager does not have access to an ACT team at their site, the referral takes approximately three weeks to be processed by the external provider. Providers of ACT services reported that the biggest barrier to initiating services is obtaining all the required paperwork from the clinical teams.
- An ACT provider participating in the focus group reports members are evaluated “regularly” to determine whether the member is ready for a lower level of care, but there is no average tenure for ACT.
- ACT team providers shared that turnover rates have improved for ACT team staff and are lower than supportive teams at health homes. The provider participants attribute the improvement in turnover rates to strategies such as using transcription specialists who help to reduce administrative burden by entering progress notes, providing active and ongoing support to ACT team members, and offering team-building opportunities to build morale.

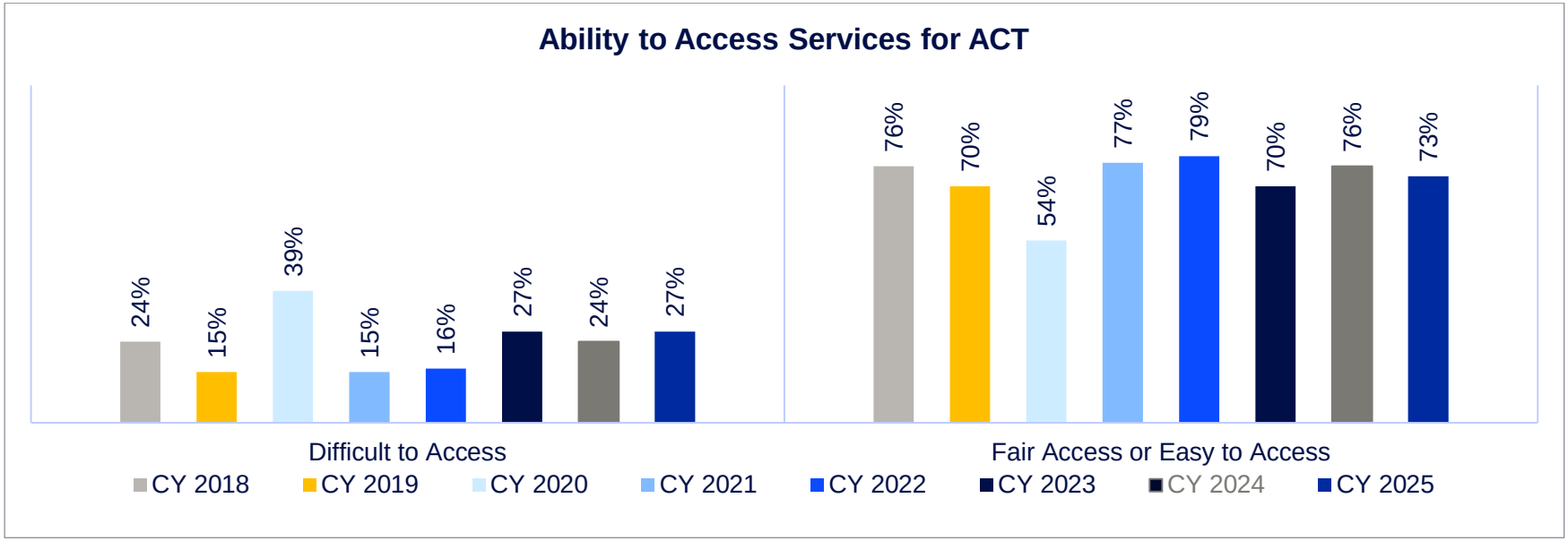
Key Informant Survey Data

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-seven percent (27%) of survey respondents reported ACT team services were difficult to access (24% in CY 2024).
- Seventy-three percent (73%) of respondents indicated ACT team services had “fair access” or were easy to access (76% in CY 2024).

Chart 15 – Ability to Access Services for ACT CY 2018–CY 2025



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
- Lack of capacity/No service provider available
- Wait list exists for service

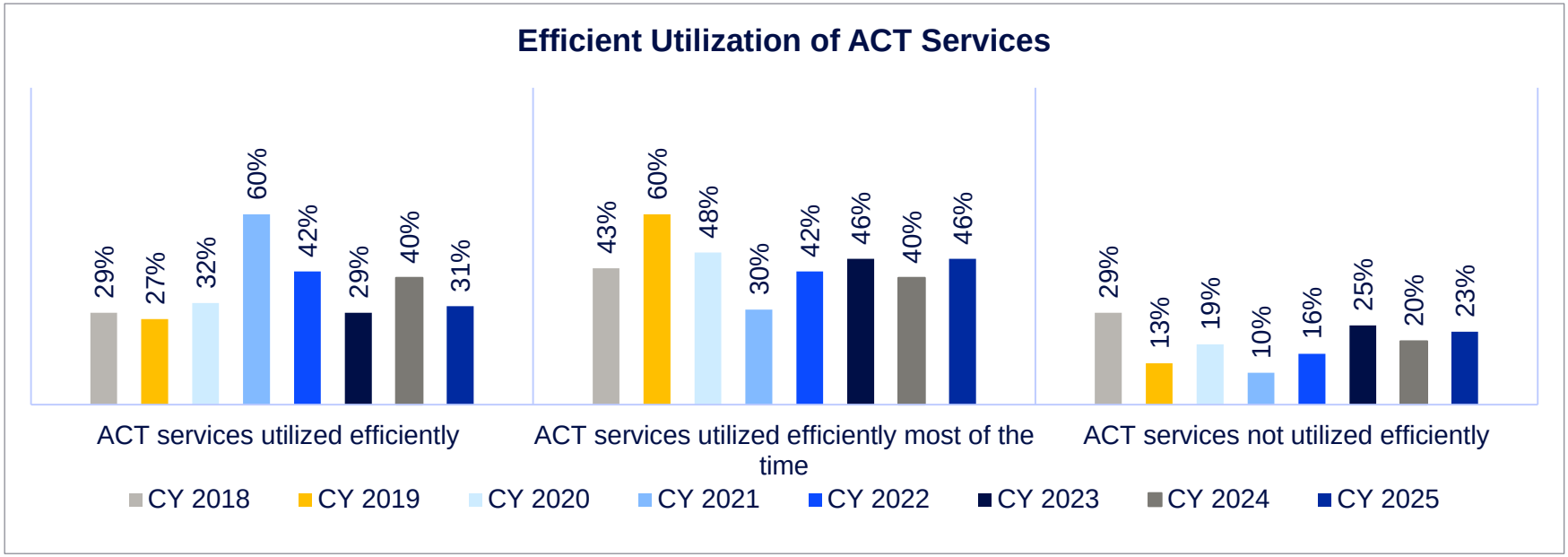
Efficient Utilization

In terms of the efficiency of service utilization in CY 2025:

- Thirty-one percent (31%) of the responses indicated the services were being utilized efficiently (40% in CY 2024).

- Forty-six percent (46%) responded that the services were utilized efficiently most of the time (40% in CY 2024).
- Twenty-three percent (23%) of the respondents indicated ACT team services were not utilized efficiently (20% in CY 2024).

Chart 16 – Efficient Utilization of ACT Services CY 2018–CY 2025



Timeliness

In terms of the amount of time to access ACT team services in CY 2025:

- Seventy-five percent (75%) of the survey respondents reported ACT team services could be accessed within 30 days of the identification of the service need (64% in CY 2024).
- Eighty-three percent (83%) of the survey respondents indicated the service could be accessed within 45 days.
- Seventeen percent (17%) of survey respondents reported it would take longer than 45 days to access ACT team services.

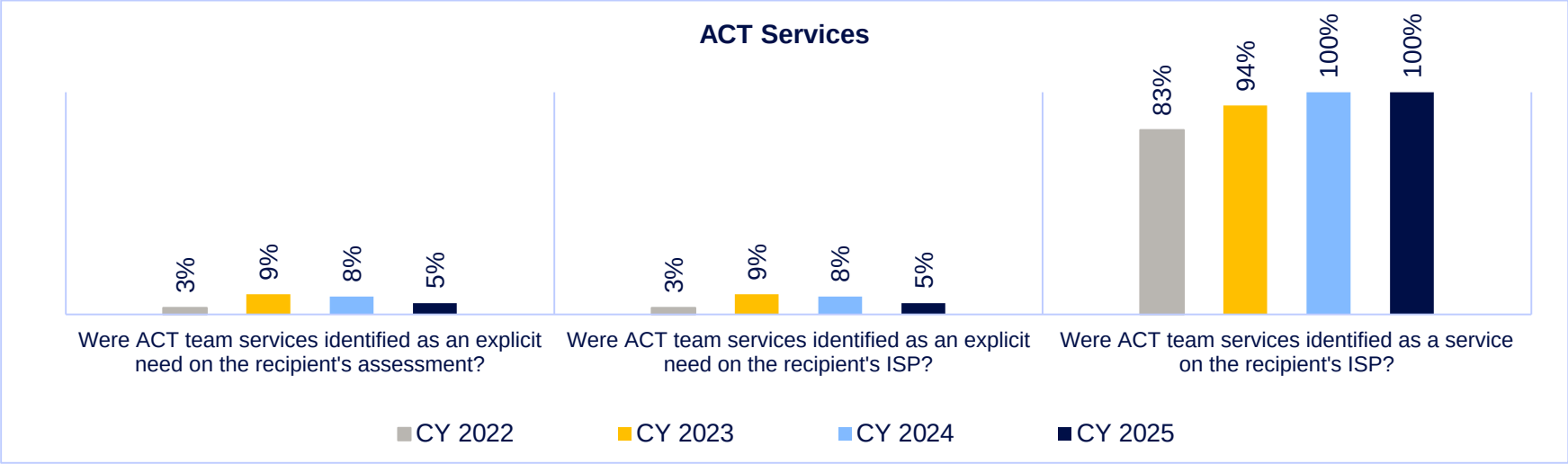
Medical Record Review

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 in a timely manner by the member.

In 10 cases (5%), ACT team services were identified as a need on recipients' assessments or ISPs. All the cases with an assessed need for ACT included ACT or case management services on the ISP.

There were 5.5% of the recipients included in the sample that were assigned to an ACT team.

Chart 17 – ACT Services CY 2022–CY 2025



Targeted Interview – ACT Providers

Mercer interviewed two separate providers to gain additional insights regarding the availability and accessibility of ACT services. One provider manages multiple ACT teams and utilizes a weekly census report to monitor the ongoing capacity of each team. The organization's ACT teams usually operate near or at full capacity, and clinical coordinators manage wait lists for the teams. Referrals

originate from within the organization's health home network as well as outside of the agency, such as inpatient hospitals and transfers from other health homes.

Another provider expressed concerns about the appropriateness of referrals, citing that many stakeholders across the system of care do not appear to understand ACT admission criteria. The provider must respond to referrals from health homes and hospitals and reports that, in some situations, coordination is lacking between the hospital treatment team initiating the referral and the members assigned health home. The provider reports that evaluating new ACT referrals requires significant clinical and administrative time investments and that a large proportion of ACT referrals ultimately do not meet clinical admission requirements. Other challenges include an inability to locate members once referred and members not consenting to being placed on an ACT team. A recent change instituted by AHCCCS' contracted managed care organization now requires hospital-based referrals to include an authorized release of information from the potential ACT candidate as part of the referral packet, which has removed that responsibility from the receiving ACT team. The managed care contractor reports that efforts are underway to provide education regarding ACT admission criteria to case management and hospital staff.

The providers describe robust clinical supervision and oversight, which includes daily meetings to review every member assigned to the team, weekly clinical oversight meetings, complex case meetings, regular training opportunities for ACT team staff, access to medical directors for consultation, and a monthly meeting with AHCCCS' contracted managed care organization to address administrative and case-specific challenges. One provider promotes an integrated, dual disorder treatment, multi-disciplinary approach and other evidence-based practices, such as motivational interviewing.

Members' ongoing clinical appropriateness for ACT services is reviewed on an ongoing basis, and is guided by outcomes the member may achieve, such as employment, ability to live independently, and the absence of hospitalizations for an extended period. Decisions to "graduate" from ACT services occur minimally during annual assessment updates and treatment planning meetings and, for one provider, must be approved by the team's assigned behavioral health medical practitioner.

Many of the ACT teams enjoy stable staffing, with long-tenured staff members and minimal turnover. Certain specialties on the team experience higher turnover and include peer support specialists, rehabilitation specialists, and licensed substance use disorder specialists[66].

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. The

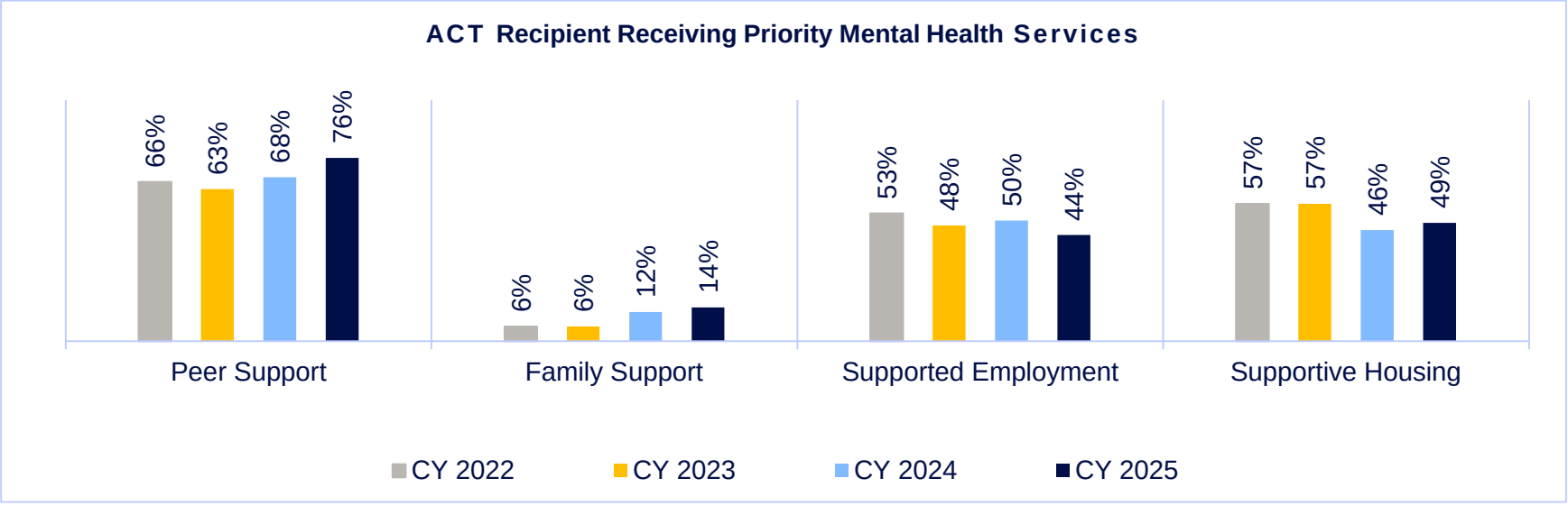
[66] The contracted manage care organization strongly encourages that two substance use disorder specialist be part of each ACT team but does not mandate that each team include licensed substance use disorder specialists.

analysis included CY 2025 service utilization profiles for 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:

- Seventy-six percent (76%) of the ACT team members received peer support services during the review period.
- Fourteen percent (14%) of the ACT team members received family support services.
- Forty-four percent (44%) of ACT recipients received supported employment services.
- Forty-nine percent (49%) of ACT recipients received supportive housing services.

Chart 18 – ACT Recipients Receiving Priority Mental Health Services CY 2022–CY 2025



Analysis of Cost Data

To ensure the appropriate utilization of ACT services, entities involved in the clinical management of people 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 an SMI.

Mercer assessed 100 members living with SMI associated with the highest aggregate behavioral health service costs during CY 2025. The analysis found 34% of the members are assigned to an ACT team. This finding is significantly higher than the percentage when the analysis was completed during CY 2024 (20%).

Of the 34 members assigned to ACT and included on the list of the top 100 members with the highest behavioral health service costs, 21 (62%) 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, 62% 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, 25 out of 38 (66%) 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, 5.1% of all members are assigned to an ACT team. There are 19 more members assigned to an ACT team when comparing CY 2025 to CY 2024. There has been an increase of 64 ACT team members between CY 2023 and CY 2025.
- Case manager participants expressed positive views regarding ACT services. Case managers shared that ACT “is such a great resource,” “our clinic has a spectacular ACT team,” and “it’s nice to be able to cater to where the member is at, particularly when the member needs to be met in the community.”

- ACT team providers shared that turnover rates have improved for ACT team staff and are lower than supportive teams at health homes. The provider participants attribute the improvement in turnover rates to strategies such as using transcription specialists, who help to reduce administrative burden by entering progress notes, providing active and ongoing support to ACT team members, and offering team-building opportunities to build morale.
- Providers shared that there is a universal screening process and established timelines for processing referrals, but some providers have instituted additional requirements for referrals (such as requiring doctor-to-doctor transfers between ACT teams at different health homes). Providers recommended that the [managed care organization] work to standardize requirements for ACT transfers. Similarly, providers of ACT services would like more “transparency” in the referral process, so ACT teams receive all necessary information about the member.
- Twenty-seven percent (27%) of survey respondents reported ACT team services were difficult to access (24% in CY 2024).
- Seventy-six percent (76%) of the ACT team members received peer support services, 44% received supported employment services, and 49% received supportive housing services during the review period.
- Mercer assessed 100 members living with SMI associated with the highest aggregate behavioral health service costs during CY 2025. The analysis found 34% of the members are assigned to an ACT team. This finding is significantly higher than the percentage when the analysis was completed during CY 2024 (20%).

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 continue efforts to proactively alert clinical teams when key metrics indicate an assigned member may be appropriate for transition to an ACT team.
- Continue efforts to offer ongoing training and supervision to health home case managers regarding ACT admission criteria, ACT referral expectations, including required documentation, and how to identify members who may be appropriate for ACT services.

Section 6

Outcomes Data Analysis

The service capacity assessment included an analysis of recipient outcome data to assess linkages with receiving one or more priority mental health services and improved functional outcomes. Relationships between outcomes and service utilization trends do not necessarily reflect causal effects. As such, observed outcomes may be contingent upon several variables unrelated to the receipt of 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.[67]

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

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

to members with an expressed interest and goal of obtaining employment in the next 45 days or who are currently engaged in an active job search with a contracted supported employment provider. Services provided using H2027 SE are directly related to obtaining employment. From January 1, 2025 through December 31, 2025, there were 2,178 people living with SMI in Maricopa County who received at least one unit of H2027 SE, which is 288 additional members compared to CY 2024.

For people living with SMI, the following counts of employment are noted, as of December 1, 2025:

- People competitively employed full-time: 3,032 (December 1, 2024 – 3,156)
- People competitively employed part-time: 2,853 (December 1, 2024 – 3,018)
- People with other employment: 1,276 (December 1, 2024 – 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., January 2025 through November 2025). Members with multiple incarcerations were then compared to ACT and FACT team rosters to determine the percentage accessing the EBP:

- There were 1,549 unique members incarcerated during the review period. The number of incarcerations per member ranged from one to 12.
- There were 519 members who experienced at least two jail bookings during the period under review (289 in CY 2024).
- Of these 519 members, 63 (12%) were assigned to an ACT team during the review period (21% in CY 2024).
- Of the 63 members assigned to an ACT team, 20 (32%) were assigned to a FACT team (21% in CY 2024).
- There were 20 members receiving ACT team services with three or more incarcerations over the review period, but they are not assigned to one of the available FACT teams (19 in CY 2024).
- There are 165 members with three or more incarcerations that are not currently assigned to an ACT or FACT 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[68]

Mercer analyzed emergency room utilization for members living with SMI in Maricopa County over the period of October 1, 2024–December 31, 2025. A summary of findings is presented below:

- Over the reporting period, there were 95,760 emergency department visits involving 14,470 unique members or 35% of the total population (41,327). Over a comparable period last year, there were 99,859 emergency department visits involving 14,406 unique members or 36% of the total population (40,425).
- There were 8,931 (22%) members who experienced three or more emergency room visits during the reporting period.
- For people assigned to an ACT team, there were 9,896 emergency room visits involving 1,042 unique members or 49% of the ACT team population (2,124). Last year, the same analysis found there were 8,478 emergency room visits involving 922 unique members or 44% of the ACT team population (2,105).
- There were 683 or 32% 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, 2025–November 2025. Below is an overview of the types of complaints related to people living with SMI in Maricopa County. A total of 2,874 complaints were recorded over the reporting period (compared to 2,793 during CY 2024).

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

[68] 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.

Table 24 – Counts by Complaint Category

Category	Count
Access to care	8
Attitude and service	2,540
Billing and financial issues	83
Quality of care	242
Quality of practitioner office site	1
Total	**2,874**

Table 25 – Counts by Complaint Subcategory

Subcategory – Access to Care	Count
Access to appointments	3
Geographic availability of network practitioner or provider	1
Telephone access	2
Total	**6**

Appendix A

Focus Group Invitations

Seeking Your Feedback — Service Capacity Assessment Stakeholder Sessions

Are you looking for a way to provide feedback about Maricopa County's behavioral health system ***and*****,** you are:

- An ***adult living with a serious mental illness*** (SMI) residing in Maricopa County and actively receiving, or have received, at least one of the services listed below from the behavioral health system. *
- A ***family member of an adult living with SMI*** residing in Maricopa County, who is actively receiving, or has received, at least one service from the behavioral health system. *
- A ***health home case manager*** supporting adults living with SMI in Maricopa County.
- A ***provider of one of the services listed below******** in Maricopa County.

****Services include Assertive Community Treatment (ACT), Supportive Housing or Permanent Supportive Housing (SH), Supportive Employment (SE), or Peer and Family Support Services.*** These services are also known as "Priority Mental Health Services" or PMHS.

If so, consider registering for <u>one</u> 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 ***Health Home Case Managers*** supporting adults with SMI

Monday, January 26, 2026
9:00 am–11:00 am

Session Two: For ***Adults living with SMI*** actively receiving, or has received, at least one of the identified services

Monday, January 26, 2026
2:00 pm–4:00 pm

Session Three: For ***Family Members of Adults living with SMI*** actively receiving, or has received, at least one of the identified services

Tuesday, January 27, 2026
10:00 am–12:00 pm

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

Tuesday, January 27, 2026
2:00 pm–4:00 pm

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

Center for Health and Recovery (CHR), Group Room 7A
1950 W Heatherbrae Dr, Phoenix, AZ 85015

RSVP with the name of the session you want to attend (for example, Group One) by January 23, 2026, to Liza Auterino at liza.auterino@govmercer.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@govmercer.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 behavioral health services 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 (PMHS) – 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 2026

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=Average 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).

	Wait List Exists for Service (1)	Language or Cultural Barrier (2)	Transportation Barrier (3)	Clinical Team Unable to Engage/Contact Member (4)	Lack of Capacity/No Service Provider Available (5)	Admission Criteria for Services too Restrictive (6)	Staffing Turnover (7)	Other (8)
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)	Within 45 days (3)	Longer than 45 days (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 an 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 an SMI Only (2)
- O Behavioral Health Provider for Adults with an 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, 2025 – December 31, 2025*

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: Collaborate with health homes to ensure that ISP interventions are immediately initiated following completion of a member's ISP, including securing needed services, such as peer support, when recommended as a need and a service on the person's ISP. Leverage active clinical supervision and repeated member engagement attempts to ensure recommended services are implemented as soon as possible.
Family Support Services (FSS)	FSS 1: Continue efforts to promote family support services, regularly assess the sufficiency of the provider network, 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. FSS 3: Identify and target conditions and populations that may be particularly amenable to benefiting from family support services such as young adults transitioning to adulthood and members experiencing first episode psychosis.
Supported Employment Services (SES)	SES 1: Due to high turnover and the need to continuously recruit and onboard staff, ensure that health home case managers receive training and clinical supervision to support members who express an interest in supported employment services, including available resources within the health home and across the network of available supported employment providers. SES 2: Collaborate with health homes to ensure that ISP interventions are immediately initiated following completion of a member's ISP, including securing needed services, such as supported employment, when recommended as a need and a service on the person's ISP. Leverage active clinical supervision and repeated member engagement attempts to ensure recommended services are implemented as soon as possible.

Service	Recommendations
Supportive Housing Services (SH)	SH 1: Continue efforts to 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. SH 2: Collaborate with health homes to ensure that ISP interventions are immediately initiated following completion of a member's ISP, including securing needed services, such as permanent supportive housing and housing-related services, when recommended as a need and a service on the person's ISP. Leverage active clinical supervision and repeated member engagement attempts to ensure recommended services are implemented as soon as possible.
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 continue efforts to 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 offer ongoing training and supervision to health home case managers regarding ACT admission criteria, ACT referral expectations, including required documentation, and how to identify members who may be appropriate for ACT services.
General Recommendations (GR)	GR 1: Ensure that all members have current assessments and ISPs through ongoing monitoring, periodic medical record reviews, and health home reporting. GR 2: Reiterate minimum requirements for assessment and ISP templates to ensure important data fields are included, such as a summary of clinical team recommendations and specific services to address identified behavioral health needs and perform ongoing monitoring of contracted health homes to ensure compliance.

Service	Recommendations
	GR 3: Perform or delegate a formal assessment of the causative factors influencing high turnover rates for case managers and implement improvement 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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Mercer Health & Benefits LLC
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
www.mercer-government.mercer.com