ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

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KATIE HOBBS
GOVERNOR

VIRGINIA ROUNTREE
DIRECTOR

December 30, 2025

The Honorable Katie Hobbs
Governor of Arizona
1700 West Washington
Phoenix, Arizona, 85007

The Honorable Warren Petersen
President of the Arizona State Senate
1700 W Washington
Phoenix, Arizona 85007

The Honorable Steve Montenegro
Speaker of the Arizona House of Representatives
1700 W Washington
Phoenix, Arizona 85007

Dear Governor Hobbs, President Petersen, and Speaker Montenegro,

AHCCCS is providing the following report pursuant to Laws 2024, Chapter 163, Sec. 8 which requires the Administration to file a report regarding the development of recommendations for opportunities to improve the availability and transparency of information related to members with a serious mental illness designation with the Governor, the President of the Senate, and the Speaker of the House of Representatives.

If you have any questions regarding the attached report, please feel free to contact Damien Carpenter, Chief Legislative Liaison, at (602) 396-0767.

Sincerely,

Virginia Rountree

Virginia Rountree
Director

cc:
Meaghan Kramer, Health Policy Advisor, Office of the Governor

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Data Gap Recommendations Report[1]

October 2025

[1] Microsoft Copilot was utilized during the drafting process of this report to assist with document structuring, statutory cross-reference and professional language review. All content was reviewed and finalized by AHCCCS personnel.

Background

This report is submitted pursuant to Laws 2024, Chapter 163, Sec. 8:

A. The director of the Arizona health care cost containment system administration shall develop recommendations on opportunities to improve the availability and transparency of information related to members with a serious mental illness designation, including how to facilitate the extraction of data in clinical records for reporting, including:

1. Screening, evaluation and services provided under title 36, chapter 5, articles 4 and 5, Arizona Revised Statutes, including information about members receiving services whose court-ordered treatment is not renewed after completion, members receiving amendments to court-ordered treatment and members who were determined to be adherent or not adherent to court-ordered treatment.

2. The reasons that members with a serious mental illness designation receiving services from the administration or its contractors are discharged from inpatient psychiatric or residential services.

3. Deaths in an incarcerated setting of individuals with a serious mental illness designation, by manner of death.

4. Employment status of members with a serious mental illness designation, by supported or not supported employment.

B. In the development of these recommendations, the director shall convene and seek the advice of a representative group of stakeholders, including screening, evaluation and treatment agencies, contractors, hospitals and physicians providing behavioral health services, family members and persons who have received screening, evaluation or treatment services pursuant to title 36, chapter 5, article 4 or 5, Arizona Revised Statutes, persons who have or who have had in the past a serious mental illness designation and who have received behavioral health services, attorneys with experience in title 36, chapter 5, Arizona Revised Statutes, or title 13, Arizona Revised Statutes, processes for persons with mental illness, counties and the courts.

C. On or before October 1, 2025, the administration shall report to the governor, the president of the senate and the speaker of the house of representatives on the stakeholder recommendations, including any statutory changes necessary to improve the availability of information.

D. This section is repealed from and after June 30, 2026.

E. For the purposes of this section, "member" has the same meaning prescribed in section 36-2901, Arizona Revised Statutes.

The Arizona Health Care Cost Containment System (AHCCCS) has engaged stakeholders to formulate recommendations intended to enhance the availability and accessibility of data pertaining to individuals designated with a serious mental illness (SMI). This report respectfully presents the identified limitations and corresponding recommendations.

Title 36 Process

Arizona's Court-Ordered Evaluation (COE) and Court-Ordered Treatment (COT) processes, governed by Title 36 of the Arizona Revised Statutes, establish a legal framework for intervening when an individual is suspected of having a mental disorder and, due to symptoms of that disorder, is unwilling or unable to voluntarily seek treatment. These processes are initiated when there is concern that the individual poses a risk to themselves or others and may meet one or more statutory criteria: Danger to Self (DTS), Danger to Others (DTO), Persistently or Acutely Disabled (PAD), or Gravely Disabled (GD).

Counties have the authority and responsibility to designate pre-screening and evaluation agencies and are the payor for all services provided to individuals related to the COE process. To fulfill these responsibilities, counties may choose to:

- Directly contract with prescreening and evaluation agencies,
- Contract with an AHCCCS contracted Managed Care Organization (MCO), or
- Enter into an Intergovernmental Agreement (IGA) with AHCCCS.

Currently, Maricopa County is the only county with an IGA in place with AHCCCS. However, this agreement does not delegate the authority to designate prescreening or evaluation agencies to AHCCCS; that authority remains with the county.

This structure reflects the decentralized nature of the Title 36 process, where counties retain significant control over implementation and capacity, while AHCCCS supports coordination and system-level oversight. Continued collaboration between counties, AHCCCS, and ADHS is essential to ensure consistency, quality, and accountability in the delivery of court-ordered behavioral health services.

Court Ordered Evaluation Services

The Court-Ordered Evaluation (COE) process in Arizona may be initiated through one of two pathways: non-emergent or emergent. The non-emergent pathway begins with the completion of an *Application for Involuntary Evaluation*, which is reviewed by a designated screening agency contracted by the county to conduct pre-petition screening. If the screening agency determines that the proposed patient meets criteria for COE, it is required to file a *Petition for Court-Ordered Evaluation (PCOE)* with the court, along with the *Application for Involuntary Evaluation* and the *Pre-Petition Screening* form.

The emergent pathway is initiated through the completion of an *Application for Emergency Admission for Evaluation*, which allows for the immediate apprehension and admission of the individual to a designated facility for assessment. This pathway is appropriate when the individual is believed to pose an imminent risk of harm to themselves and/or others.

Both pathways require use of forms prescribed in Arizona Administrative Code, Title 9, Chapter 21, which stakeholders have reflected lack sufficient detail and contextual relevance, limiting their effectiveness in supporting the Title 36 petition/COE process. Additionally, over time, various counties and agencies have independently modified the forms to fit their needs, resulting in a lack of standardization and barriers to consistent data collection. To address this, AHCCCS intends to initiate the formal rulemaking process by the end of the current calendar year to revise the forms by updating Arizona Administrative Code, Title 9, Chapter 21, Article 5. While AHCCCS holds the responsibility and statutory authority to adopt rules and prescribe forms, it does not have the ability to monitor the use of altered forms when submitting to the applicable court, an

authority which resides with the courts. As such, it is recommended that AHCCCS work in partnership with the courts to mandate the utilization of the standardized forms prescribed in rule statewide, which will permit collection of consistent data points across all counties.

Oversight, management, and authority over designated prescreening and evaluation providers reside with each individual Arizona county. Counties are responsible for determining system capacity and identifying providers to meet the involuntary evaluation needs of their residents, including contracting with screening agencies to carry out the responsibilities outlined in Arizona Revised Statutes, Title 36, Chapter 5. As a result, there are significant differences in how counties operationalize their processes and assess capacity needs. There is no consistency in standard procedures or methodology for measuring capacity needs, provider expectations, or data collection, tracking, and reporting practices. Specifically, stakeholders have raised concerns that a substantial number of individuals are discharged from screening facilities before evaluations can be completed due to insufficient capacity at designated evaluation agencies preventing completion of the COE and filing of the PCOT with the court within the timeframes specified in Title 36, Chapter 5. Because there are no requirements for counties to evaluate their capacity to provide COE services, determine whether their capacity is meeting the needs of their population, or address any identified deficiencies in their capacity, there is currently no avenue to formally identify or address this concern identified by stakeholders.

It is therefore recommended that Arizona Revised Statutes, Title 36, Chapter 5 be amended to clarify that counties must adhere to a standardized process for evaluating screening and evaluation agency capacity and whether that capacity is meeting the needs of the population served. It is further recommended that this chapter be amended to include formal reporting requirements that capture the results of capacity evaluation and document efforts to minimize the number of PCOEs meeting time constraints before COE can be performed. These reports should be submitted to the Arizona State Legislature and made available to the public to promote transparency and accountability. In instances in which a county is found to be unable to meet the COE needs of its population, AHCCCS will explore exercising its authority as described in ARS 36-545.07.

Further, AHCCCS intends to add additional reporting requirements to Arizona Administrative Code, Title 9, Chapter 21, Article 5 through the formal rulemaking process. These updates will specify the data collection and reporting expectations for all screening and evaluating agencies. By incorporating these requirements into rule, AHCCCS, working in partnership with counties, will be better positioned to evaluate and improve COE services throughout the state by identifying system inefficiencies and deficits that require targeted intervention to meaningfully improve the experiences and outcomes for individuals requiring COE services.

Based on recommendations received and areas of inconsistent data collection identified by AHCCCS, Managed Care Organizations (MCOs), and other stakeholders, AHCCCS intends to, via rulemaking, require consistent data collection at each screening and evaluation agency. The data collected will be submitted to each county and to AHCCCS through the ACC-RBHA. Having these data points will ensure that AHCCCS, and subsequently the public, has visibility into how successfully each county is fulfilling its statutory obligations to provide COE to the individuals who require it, within the timeframes required by state law, and provide the opportunity to identify pain points and deficiencies that must be addressed. Data points collected will provide insights into volume of applications and petitions being submitted, timeliness of services, outcomes of those applications and petitions, and contributing factors to unintended outcomes.

Court Ordered Treatment Services

AHCCCS currently receives data on a monthly basis from contracted Managed Care Organizations (MCOs) regarding individuals subject to COT. This dataset encompasses a comprehensive range of variables, including but not limited to: individual identifiers (name and date of birth), Serious Mental Illness (SMI) designation status, start and expiration dates of COT order, and the legal basis for the order, categorized as Danger to Self (DTS), Danger to Others (DTO), Persistently or Acutely Disabled (PAD), Gravely Disabled (GD), or any combination thereof.

Additionally, MCOs report on the status and progression of court orders (e.g., new, continued, renewed, expired, amended), compliance metrics, tolling status, judicial reviews, and critical events such as hospitalizations and incarcerations. Each report identifies the provider organization responsible for coordinating services and ensuring adherence to the court order for each member, along with contact information for the reporting entity. MCOs also submit aggregate data reflecting the total number of individuals under COT at both the beginning and end of each reporting period, as well as those removed from the report due to status changes (e.g., expired orders, plan transfers, judicial terminations AHCCCS intends to add additional reporting requirements including reasons for not renewing COT including missed deadlines, inability to locate member, member incarcerated or hospitalized during the statutorily required timeframe for renewal evaluation, or member determined to no longer be in need of COT, as well as outcome data following the end of a COT order, including adherence to treatment, and subsequent need for re-petition within six months of the court order expiring or patient being released from COT via the judicial review process to be collected and reported to AHCCCS).

It is recommended that a standing advisory committee be established to determine metrics to be evaluated, operationalized, and continue to evaluate and improve the Court Ordered Evaluation and Court Ordered Treatment processes throughout the state. This committee should be given statutory authority to receive and review records from the counties and from AHCCCS.

Discharges from Inpatient Psychiatric or Residential Services Effective discharge and transition planning for individuals with a Serious Mental Illness (SMI) designation from higher levels of care—such as inpatient psychiatric units or Behavioral Health Residential Facilities (BHRFs)—is a critical component of recovery-oriented care. AHCCCS policy (AMPM 320-O) requires that discharge planning begin at admission and be fully integrated into the member's service and treatment plan. These plans must reflect the members' voice and choice, include measurable goals, and ensure coordination across all involved providers.

Additionally, Arizona Administrative Code Title 9, Chapter 10 outlines discharge planning requirements for licensed healthcare institutions. These include:

- Developing and implementing written discharge policies and procedures
- Basing discharge planning on the individual's clinical needs and recovery goals
- Coordinating with outpatient providers, community supports, and family members as appropriate
- Documenting the reason for discharge, referrals made, and follow-up instructions
- Providing discharge summaries to support continuity of care

Despite these requirements, AHCCCS does not have direct authority over provider-level decisions regarding discharge timing or criteria, which are often determined by clinical judgment and facility-specific protocols. This limits AHCCCS's ability to enforce consistency or evaluate discharge effectiveness across settings.

Discharges from Inpatient Psychiatric or Residential Services

Stakeholder feedback has highlighted concerns that transitions to lower levels of care may occur prematurely or without adequate linkage to community-based services. These gaps in care increase the risk of readmission, crisis episodes, and poor outcomes. In response, AHCCCS will partner with ADHS and work toward implementing the following recommendations to strengthen discharge practices:

- Standardize discharge planning protocols across inpatient and residential settings to align with AHCCCS and ADHS licensing requirements
- Mandate documentation of discharge rationale, post-discharge referrals, and member engagement in planning.
- Require reporting on discharge outcomes, including readmission rates, emergency department utilization, crisis system involvement, arrests/incarceration, service engagement within 30 days, and member satisfaction.
- Establish centralized oversight to monitor discharge practices and identify patterns of ineffective transitions.
- Develop data infrastructure within PMMIS to capture discharge-related metrics for members with an SMI designation, enabling longitudinal analysis and system-level improvement.
- Promote cross-sector collaboration among AHCCCS, providers, and courts to ensure discharge decisions are clinically appropriate, recovery-oriented, and compliant with Medicaid and licensing standards.

These recommendations aim to reduce inappropriate or ineffective discharge practices and promote continuity of care for individuals with SMI transitioning from higher to lower levels of care.

Deaths in an Incarcerated Setting for Individuals with a Serious Mental Illness Designation

Pursuant to ARS §36-3415, AHCCCS obtains mortality data for individuals with a Serious Mental Illness (SMI) designation through an interagency agreement with the Arizona Department of Health Services (ADHS). The data is derived solely from death certificates, which limits the scope of information available. Notably, the Arizona death certificate form includes location options such as Hospital, Residence, or Other; however, deaths occurring in carceral settings are typically reported under the "Other" category. This classification is inconsistently applied, resulting in incomplete data and the exclusion of carceral-related deaths from AHCCCS's current mortality reporting.

To address this gap, AHCCCS recommends legislation requiring carceral facilities to directly report deaths and incidents resulting in the death of individuals with an SMI designation. Direct reporting from these facilities would enhance data accuracy and support more comprehensive mortality trend analysis.

In parallel, AHCCCS is exploring opportunities to leverage existing data systems to improve mortality tracking. Since 2017, AHCCCS has implemented an Enrollment Suspension process for incarcerated members, maintaining their Medicaid eligibility in a suspended status rather than terminating coverage. This approach allows for potential linkage between vital records and suspended enrollment data, which may help identify deaths occurring in carceral settings as well as those deaths that occur in alternative settings following incidents in carceral environments—such as emergency medical transfers.

While this method would not yield a complete statewide dataset and lacks specificity regarding the type or location of the carceral setting, it may still provide valuable insights into system-level impacts on individuals with an SMI designation. AHCCCS continues to evaluate data integration strategies to strengthen mortality surveillance and inform policy development.

Employment Status of Members with a Serious Mental Illness Designation

AHCCCS currently collects and reports claims-based data on the number of members with a Serious Mental Illness (SMI) designation receiving supported employment services in Maricopa County. This same data is also collected statewide and will be incorporated into future legislative reports, as required.

However, AHCCCS faces significant limitations in accessing comprehensive employment data beyond the scope of supported employment services funded through the AHCCCS program. This data gap is driven by several factors. For example, members with an SMI designation may obtain competitive, integrated employment independently and choose not to disclose this information to their clinical teams. Additionally, some members may participate in vocational rehabilitation services offered through the Arizona Department of Economic Security (DES), which are not currently integrated into AHCCCS data systems.

Despite ongoing education efforts by AHCCCS and its contracted Managed Care Organizations (MCOs) to inform members and families about employment opportunities, utilization of supported employment services remains low. A persistent barrier is the concern among members, families, and guardians that employment may jeopardize eligibility for critical benefits, including healthcare and housing supports.

To address these gaps, AHCCCS is actively exploring collaborative opportunities with DES to improve data sharing and track participation in vocational rehabilitation programs among members with an SMI designation. Additionally, AHCCCS is evaluating the use of self-reported employment data collected during enrollment and re-enrollment processes to develop a more accurate and comprehensive understanding of employment status across this population.

Improving the accuracy and scope of employment data is essential to identifying systemic and policy-level barriers and informing targeted interventions. These efforts aim to enhance employment outcomes and overall quality of life for members with an SMI designation by ensuring that services are responsive to their needs and aligned with their recovery goals.

Summary

This report outlines critical data gaps and systemic barriers affecting the availability, accuracy, and transparency of information related to individuals with a Serious Mental Illness (SMI) designation in Arizona. Through stakeholder engagement and internal analysis, AHCCCS has identified inconsistencies in data collection across counties, limited oversight of Title 36 processes, and fragmented reporting practices that hinder the ability to evaluate system performance and member outcomes.

Key challenges include:

- Decentralized oversight of Court-Ordered Evaluation (COE) and Court-Ordered Treatment (COT) services, resulting in varied procedures and limited standardization.
- Inconsistent use of prescribed forms, which impedes reliable data aggregation and comparison.
- Limited visibility into discharge practices from inpatient and residential settings, raising concerns about

continuity of care and risk of readmission.

- Incomplete mortality data for individuals with an SMI designation who die in carceral settings due to reporting limitations.
- Restricted employment data, particularly for members engaged in work outside of AHCCCS-supported programs or through external agencies such as the Arizona Department of Economic Security (DES).

To address these gaps, AHCCCS is pursuing a multi-pronged strategy that includes:

- Initiating formal rulemaking to revise and standardize Title 36 forms and establish clear data reporting requirements for prescreening and evaluation agencies.
- Recommend legislative action to establish a centralized advisory committee with statutory authority to oversee COE and COT system performance.
- Strengthening discharge planning protocols and developing infrastructure to monitor post-discharge outcomes.
- Recommend legislative action to require direct reporting of deaths in carceral settings.
- Enhancing partnerships and utilizing alternative data collection resources to improve employment data collection methods.

These efforts are designed to improve the quality and consistency of data, inform policy and operational decisions, and enhance outcomes for individuals with an SMI designation. By advancing transparency, accountability, and cross-sector collaboration, AHCCCS aims to build a more responsive and equitable behavioral health system for Arizona's most vulnerable populations.