SPEAK OUR MINDS

ENDING THE YOUTH MENTAL HEALTH CRISIS

YOUTH MENTAL HEALTH

Community Input Results

In February 2024, the State of Colorado announced a settlement in a groundbreaking class-action lawsuit brought by Medicaid-eligible youth who were unable to access needed mental health care.

The settlement gave the state one year to develop a comprehensive plan to address the crisis in youth mental health, and five years to fully implement the plan. The state's Health Care Policy and Finance (HCPF) division is responsible for developing the plan, and Speak Our Minds, a nonprofit advocacy organization, elected to gather extensive community and stakeholder input to inform that plan. The state's history of failing to listen and respond to the needs of our youth and their families has created a fragmented, ineffective youth mental health care system at a time when mental health challenges are escalating. It is imperative that HCPF understand the concerns of its constituents and incorporate their ideas and input into its forthcoming plan. Speak Our Minds seeks to partner with the state to ensure that those who will be most impacted by the rollout of the new youth mental health system of care are heard. We offer the recommendations in this report in the spirit of collaboration, but also intend to hold the state accountable for developing a responsive and inclusive plan.

METHODOLOGY

The recommendations included in this report were developed entirely through stakeholder engagement. Over a four-week period in June 2024, Speak Our Minds conducted 13 focus groups for mental health providers, school leaders, county officials, parents and other concerned leaders. The focus groups were conducted online, allowing participants from across the state to be part of the conversation. In addition, we conducted an online survey with similar questions to those posed in the focus groups. The focus group discussion guide is included as Appendix A and survey questions are found in Appendix B.

Community response to the call for input was tremendous. There were 229 individuals who registered to attend the focus groups. Participants were asked what connection they have to the issue of youth mental health, and responded as follows. (Note: participants could select more than one option.)

25% Mental health care provider

26% Parent

46% Advocate

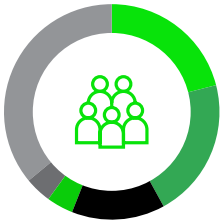
4% School personnel

13% Government official

8% Health system administrator

36% Other

28 individuals responded to the survey. The affiliations of those respondents included:



21% Mental health care provider

21% Parent

14% Advocate

4% Government official

4% Health system administrator

36% Other

Prior to soliciting participant input, focus group facilitators provided some background information on the lawsuit and the requirements of the settlement. They explained that the following elements must be part of the plan being developed by the state:

A definition of those who will be eligible for benefits

Prevention services

Individual care plans

Tiered care coordination

In-home and community-based services

Mobile crisis response

Provider outreach

Data and monitoring

The focus group discussions, as well as the survey, were designed to seek input on each of these topics. The recommendations offered in this report reflect the thinking of this broad group of concerned constituents.

RECOMMENDATIONS

DEFINE ELIGIBILITY BROADLY

INTRODUCTION

At the start of each focus group, participants were told that the plan being developed by the state must address the needs of Medicaid-eligible youth with complex mental health needs. They were then given the following common definition of complex mental health needs and asked for feedback:

Definition

"People with complex mental health needs experience significant, multiple, rare or persistent mental health challenges that impact their functioning in most areas such as in the home, school and community. Complex cases require individuals to access services and support from a wide variety of government and/or community services."

FEEDBACK

Importance of the Term "or"

Participants emphasized the significance of the word "or" in the definition. They noted that challenges might be persistent but not rare, or significant but not persistent. Thus, youth presenting with significant, or rare, or persistent challenges, or multiple challenges, should be eligible for services.

Diagnosis Not Required

The definition's reliance on demonstrated challenges in different settings, rather than a specific diagnosis, was valued by the community. Participants appreciated that the eligibility criteria did not mandate a diagnosis and emphasized the importance of recent legislation removing the requirement of a diagnosis as a prerequisite for care.

Scope of the Term “Most”

The use of “most” in describing the settings where youth may demonstrate challenges was criticized. Participants argued that youth might have significant challenges in only one setting, such as at home or school, and still have substantial needs. Hence, youth should be eligible for services regardless of the number of settings where challenges are observed.

Applicability to Very Young Children

Participants noted that the definition might not encompass very young children who may not yet be symptomatic but should be presumed to have mental health needs due to adverse experiences such as trauma. In such cases, there should be a presumption of eligibility.

Importance of Dyadic Care

The state must recognize the importance of dyadic care, especially for young children. Youth mental health and family mental health are interconnected. Therefore, if youth require care, the family should be included in the care plan.

Cultural Sensitivity

The definition might not be sufficiently broad to account for cultural differences. Participants raised concerns about the requirement for individuals to access services from government or community programs, as stigma surrounding mental health services is prevalent in many cultures. The state should consider supporting youth in various settings, including at home, to accommodate cultural sensitivities.

RECOMMENDATIONS

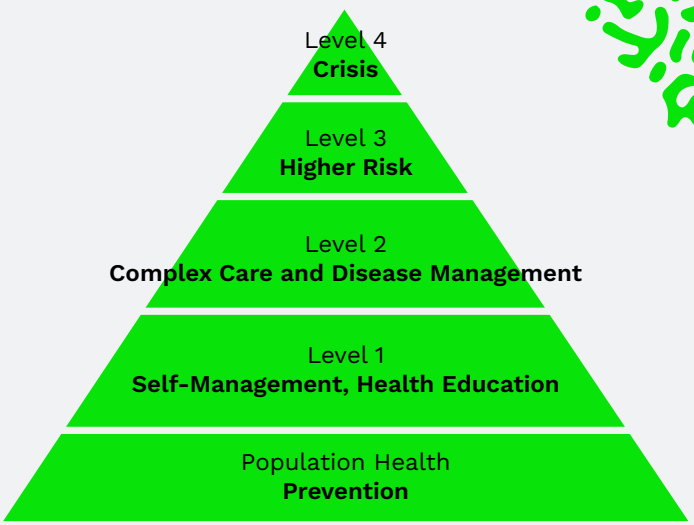
Based on the feedback, the following recommendations are proposed:

1. **Define eligibility broadly:** Ensure the definition includes multiple ways that youth might exhibit mental health challenges.
2. **Presume eligibility based on demonstrated need:** Avoid requiring a diagnosis to determine eligibility.
3. **Implement age-appropriate Identification methods:** Develop ways to identify young children who need services, particularly those who have had adverse experiences.
4. **Include caregivers in treatment plans:** Recognize the interconnectedness of youth and family mental health and include caregivers in the care plans.
5. **Adopt culturally responsive approaches:** Consider cultural differences in determining eligibility and support youth in diverse settings, including at home.

FOCUS ON PREVENTION

INTRODUCTION

Participants were presented with the following graphic depiction of tiers of care and were asked for feedback about the appropriate entry point for Medicaid. They were also asked about the role that Medicaid should play in youth mental health prevention.



FEEDBACK

In considering tiers of care, and the appropriate entry point for Medicaid, participants were adamant that care begins with prevention and that universal prevention is the goal.

Prevention reduces long- term expense

Participants recognized that there is a practical need for the state to contain costs and that there is a natural tendency to defer services until there is a demonstrated need. However, there was broad consensus that investment in prevention reduces the need for more acute and more frequent care downstream and this, in turn, reduces overall long-term costs.

Prevention services improve downstream outcomes

Participants also emphasized that the goal of the state should be to improve overall youth mental health, and that adequate investment is required to meet this goal. They agreed that preventative care improves mental health outcomes and therefor is an appropriate focus for the state.

Universal prevention is needed

There was valid debate about the role of Medicaid in universal prevention, and acknowledgment that the state's plan must address the needs of Medicaid-eligible youth, not all youth. The conclusion was that the state should provide universal preventive care for Medicaid-eligible youth through targeted outreach and by providing services in settings where there are larger concentrations of eligible youth.

Care giver education is key to prevention

Again, recognizing that the parent/care giver role is inextricably linked to youth mental health, participants urged the state to offer preventive services that include the entire family. They specifically recommended parent/care-giver education programs for targeted populations to help improve understanding of youth mental health and how to spot early warning signs of poor mental health. Educational programs should be offered in a variety of settings, including online and in person. Programs should be offered by a range of providers including licensed professionals, content experts who may not be licensed, and, importantly, peers who can credibly share their own experiences.

Integrated care is effective

The state has supported the integration of mental and physical health care in the past and should continue to support these models as an effective prevention and early detection strategy. Mental health consultation integrated into pediatric primary care can be particularly impactful because of the high utilization rate of pediatric primary care. People visit their pediatrician regularly, and when a mental health care provider is a regular part of those visits, parents are better educated about mental health and youth benefit from additional screening and early intervention. In addition, integrated can reduce stigma about mental health because it is just a routine aspect of regular well child visits.

Home visitation is a prevention strategy

Similarly, evidence-based home visitation programs with a focus on mental health can improve early detection and treatment of mental health challenges for young children. Home visitation also offers parent education and dyadic care as an integrated part of the model.

Screening should be offered in multiple settings

Mental health screening is an effective way to identify youth experiencing challenges and to intervene before those challenges become more complex. Screenings are generally easy to administer and cost effective. Focus group participants suggested offering screenings in multiple settings including pediatric primary care, early education centers and K-12 schools. The state should reimburse any provider for the cost of administering screenings. Importantly, there must also be a coordinated system of referral and case management for those who are identified as needing care.

Prevention is not just screening or education

Participants urged the state should think expansively about what qualifies as prevention. In addition to screening, education and consultation, prevention should include activities that increase youth sense of belonging and well-being. Structured participation in arts, athletics and community service has been shown to improve youth mental health and should be included in the state's prevention plan.

RECOMMENDATIONS

1. Offer universal prevention services to all Medicaid-eligible youth: Services should be offered in multiple settings and led by a variety of providers.
2. Include parents and caregivers in prevention services: Dyadic care is essential for youth, and parent education can improve early detection and treatment of mental health challenges.
3. Encourage integrated mental and physical care: Integrated care increases access to, and reduces stigma about, mental health care.
4. Support home visitation. Home based preventive services can improve parent education, support dyadic care, and improve early detection and intervention.
5. Offer screening in multiple settings. Screening should be offered in pediatric, educational and community settings, should be reimbursed, and should be followed up with appropriate referrals and case management.
6. Include a broad range of activities in prevention. Activities that help youth feel connected and engaged, including arts and athletic programs, are shown to improve youth mental health.

ALLOW FLEXIBILITY IN CARE COORDINATION

INTRODUCTION

Participants were asked about who should be responsible for the individual care plans of youth with complex mental health needs. They were given the following options for consideration and were also asked to offer additional suggestions.

Primary care providers

Specialty care providers

Medicaid Regional Accountability Entities

Others

FEEDBACK

Flexibility is important

Participants agreed that effective care coordination is essential to improving youth mental health. Ensuring referrals are made when needed, following up on referrals, and assisting with warm handoffs between providers are essential care management services. Because care coordination is so critical, the state should be flexible in determining how cases will be managed and should be responsive to individual needs. Options include:

- **School officials.** In some circumstances, youth mental health needs will be identified by school personnel and mental health care may be included in Individual Education Plans (IEP's.) If school personnel have capacity and expertise to do manage care, they should be eligible for reimbursement for these services.
- **Primary care.** These settings are often the first stop for youth and families seeking diagnosis and treatment. Referrals from primary care settings are common. Again, dependent on capacity and expertise, primary care providers should be one option for care coordination.
- **Specialty providers.** In some cases, therapists and other specialized behavioral health providers are best positioned to coordinate care across providers. Care coordination should be a reimbursable service.
- **Regional Accountability Entities (RAE's).** While the state is currently rebidding RAE's, it should reconsider the role they play in care coordination. There is significant potential for RAE's to take on increased cased management duties and this may be the most efficient and economical option. However, it is imperative that RAE's dramatically increase their capacity to take on care coordination and that they increase staff understanding of mental health care.

Care coordination must be a reimbursable service

Regardless of the setting for care coordination, Medicaid must provide adequate funding for this critical service. Making referrals, following up on referrals, and ensuring there is an appropriate exchange of information among providers requires a significant investment of time from highly trained professionals. This care must be reimbursed at rate that allows providers to recoup their costs.

There must be accountability for care coordination

During the focus groups, many participants shared their experiences with inadequate care coordination and frustrations with lapses in service. While increasing reimbursement for care coordination is part of the solution, those offering this service must also be held accountable, The state should monitor referral rates and follow through rates to assess coordinator effectiveness. It should also offer incentives for high quality care management and/or penalties for poor performance.

RECOMMENDATIONS

1. Allow flexibility with care coordination based on individual needs. The most appropriate setting for care coordination will vary by patient and by location and should be determined by individual circumstances.
2. Leverage the rebid of the RAE's to improve care coordination. The state has an opportunity to increase the impact of the RAE's by expanding care coordination capacity and increasing RAE accountability for this service.
3. Make care coordination a reimbursable service. High quality case management is time intensive and impactful and should be resourced appropriately.
4. Hold those providing care coordination accountable. As with any other reimbursable service, Medicaid should hold care coordinators accountable for ensuring patient access to services.

EXPAND CAPACITY FOR HOME AND COMMUNITY-BASED SERVICES

INTRODUCTION

Focus group participants were also asked to provide input on specialized services. More specifically, they were asked about the current availability of services, the quality of those services, and ways that the state might provider more accessible or impactful services.

FEEDBACK

There was broad consensus among participants that access to care is currently inadequate and that the lack of capacity is being primarily driven by below-market reimbursement rates and insufficient workforce. Lack of access is particularly pronounced in rural Colorado.

Reimbursement rates should reach parity with private insurance

Inadequate reimbursement rates were viewed as the number one barrier to having enough mental health providers to meet the needs of Medicaid-eligible youth. While increasing reimbursement rates alone might not ensure an adequate supply of providers, it is an essential first step. At a minimum, the state will have to reach parity with private insurers' reimbursement rates. This will immediately expand the pool of providers who are willing to accept Medicaid.

Bureaucratic barriers to participation must be reduced

Streamlining and improving procedures for becoming a Medicaid provider, and for billing, would also significantly expand the pool of participating providers. The current system for enrolling as a provider and for submitting claims is seen as overly cumbersome, particularly for providers who see both Medicaid and private insurance clients. Advances in technology should make provider participation easier.

Services should be reimbursed for a range of providers

Licensed professional counselors, licensed marriage and family counselors, social workers, nurse practitioners, psychologists, psychiatrists, and even peer mentors each have a place in a healthy system of care. While licensed providers are certainly needed in some cases, considering alternative providers, when appropriate, can increase the pool of caregivers. Services offered by less specialized providers should be reimbursed at rates that correspond to their level of expertise.

Alternative therapy should also be reimbursed

Therapies such as art, music and movement can be effective alternatives to traditional mental health care, and often come at a lower cost. The state should include alternative forms of therapy as reimbursement options for care. This will expand the availability of care and potentially increase impact and reduce cost.

Culturally appropriate care is needed

Participants believe the state should consider the unique cultural and linguistic needs of diverse populations. As a starting point, translation services should be offered to both youth and their caregivers as needed, and those services should be reimbursable. In addition, the state should offer incentives for multi-lingual providers and for providers with experience and expertise in diverse cultural practices.

Workforce development is key to expanding services

Focus group discussions included thinking about the role of the state in expanding the overall mental health workforce. While there was acknowledgment that workforce development might not traditionally be seen as the responsibility of Medicaid, there was agreement that if the state does not address workforce challenges, it will be difficult the meet the needs of youth. Suggestions included providing free training or reimbursing professional development for providers to better understand and support the needs of Medicaid eligible youth, and offering incentives, such as tuition reimbursement, for those entering the field to serve Medicaid-eligible youth.

Rural providers' unique needs must be considered

Serving rural populations is challenging. Patients are often geographically distant. There also may be only one or two providers in a setting, and those providers may not be able to address the range of youth needs. To address the unique needs of rural communities, the state should offer providers and patients reimbursement for travel time which is a significant cost not typically borne in urban settings. In addition, the state should expand the use of tele-health, particularly for older youth, in non-crisis situations.

RECOMMENDATIONS

1. Increase reimbursement rates. Colorado Medicaid should reach parity with private insurers for youth mental health which will expand the pool of participating providers.
2. Reduce bureaucratic barriers. Making it easier for providers to accept Medicaid and to submit for reimbursement will also increase the number of participants.
3. Reimburse for a range of providers. Including different levels of providers, including those who are not licensed, will also increase access to services.
4. Include alternative therapy. Providing reimbursement for therapies such as art, movement or music can both improve outcomes and increase access.
5. Provide culturally responsive care. Providers should be reimbursed for translation services and incentives should be offered for providers with experience in serving patients from diverse cultures.
6. Address workforce shortages. Medicaid should reimburse for appropriate professional development and should provide incentives for new providers to accept Medicaid patients.
7. Provide solutions for rural communities. Rural providers and patients should be reimbursed for travel expenses and telemedicine should be utilized when appropriate.

EXPAND CRISIS INTERVENTION AND STABILIZATION SERVICES

INTRODUCTION

Another topic of discussion for focus groups was crisis intervention. Participants were informed that the state is required to provide statewide, 24-hour, youth-oriented, mobile crisis intervention and stabilization services. They were asked to offer suggestions about how to meet this requirement.

FEEDBACK

Stakeholders acknowledged that crisis intervention is one of the more challenging requirements that the state's plan must address. Services are currently very limited and often not well suited for youth.

Currently available services are not youth oriented

Participants agreed that, currently, crisis services are more oriented toward adults than youth. Crisis providers are generally not trained in youth mental health.

Crisis services are not available when youth need them most

In addition, participants felt that crisis services are generally only available during normal business hours. Because youth are typically in school during these times, challenges that arise during business hours are often addressed by school personnel. When crisis situations occur at night or on the weekends, there are fewer resources available.

Crisis services are more available in urban settings

While there are general disparities in access to mental health care in rural locations, those disparities are even more pronounced when it comes to crisis intervention. Most participants agreed rural crisis services are extremely limited and that most rural communities rely on police as first responders.

Some programs are working and should be replicated

Participants pointed to proven programs such as the Support Team Assisted Response (STAR) program in Denver as potential models for replications. STAR is a civilian emergency response team that is dispatched by Denver's 9-1-1 to respond to low-risk calls when there are not significant safety concerns. The program engages behavioral health clinicians and paramedics to assist those experiencing mental health distress and substance use disorders.

The states' Crisis Resolution Teams should be expanded and better resourced

Several focus group participants encourage the state to leverage the existing Crisis Resolution Teams that are in 14 counties across Colorado. These teams are well positioned to support youth who have entered the system through some sort of crisis referral and are a logical partner to expand services to include crisis intervention and to become the first point of entry into the system.

Improved police training can complement other efforts

While there was consensus that police are generally not well equipped to respond to a mental health crisis, there was also recognition that building response capacity statewide will be challenging. One solution, to be pursued in tandem with efforts to build capacity, is to improve police training. Police should better understand de-escalation tactics and should have a clear way to hand off youth to receive care after a crisis.

Referrals and progress monitoring are essential

When a youth experiences a mental health crisis, responding immediately is important. However, follow up care is also important. The state should ensure that any youth who experiences a crisis is referred for additional services. There must also be progress monitoring and care coordination for those who enter the system because of a mental health crisis.

RECOMMENDATIONS

1. Leverage existing crisis response teams. The state should build on existing teams and ensure that they are adequately trained in youth mental health and that they offer round the clock care.
2. Expand the capacity of the Crisis Resolution. These teams could be expanded to offer crisis intervention in addition to follow up care. They should also have sufficient resources to manage referrals and care coordination.
3. Replicate proven models. The STAR program was consistently named as an impactful program that the state could replicate in other areas.
4. Improve police training. While the state should not rely on the police for crisis intervention it should recognize the role they play and improve training for responding to youth experiencing mental health challenges.
5. Improve referrals after a crisis intervention. Youth should be Immediately connected to case managers and should receive referrals for follow up care.

COLLECT AND ACT ON DATA TO CONTINUOUSLY IMPROVE IMPLEMENTATION

INTRODUCTION

Participants were informed that the state will be required to collect and analyze two different sets of data: one to evaluate the implementation of the new state plan and one to assess overall youth well-being. They were asked for suggestions on how to collect and use both sets of data.

FEEDBACK

Key indicators of success should be simple and easy to track

Most participants felt that the data the state should use to evaluate implementation of the plans should be simple to both collect and understand. They felt that key indicators would include wait times for appointments, number of visits, referral follow up rates and treatment plan completion rates. They suggested building data systems that facilitates collection and analysis of this information.

Patient experience is important

Participants also urged the state to consider patient and caregiver satisfaction when evaluating implementation of the plan. While they did not think it was necessary to collect satisfaction data after every point of contact, they encouraged periodically collecting this information. They also suggested including qualitative evaluation, including interviews or focus groups, in addition to using survey instruments. There should also be mechanisms for patients and caregivers to report any difficulties they have with accessing care or with the quality of care they receive.

Data should be public

The state should, at least annually, publicly disclose the evaluation data it collects. The data should be shared in a format that allows for third party validation and analysis. This will improve public accountability.

Analysis of overall youth wellbeing should draw on other publicly available data

Most participants felt that the state should not have develop new systems for monitoring overall youth mental health. They agreed that using other currently available population health indicators would be sufficient. Important indicators include attempted and completed suicides, substance use and abuse, and self-reported levels of anxiety and depression. Much of this data is already collected through the Healthy Kids Colorado survey and through public health agencies.

RECOMMENDATIONS

1. Agree on simple and meaningful indicators of success. The state should select a limited number of indicators, such as wait times, referral follow throughs, and treatment completion, to evaluate implementation of its plan. Data systems should be built to facilitate collecting and analyzing this data.
2. Include patient and caregiver voice. Satisfaction surveys, in person interviews and focus groups, and mechanisms for reporting challenges and are all important ways to gather end user input.
3. Data should be public. Sharing data will increase the state's accountability and will allow third parties to assess implementation of the state's plan.
4. Use current public health data to assess overall impact. The state does not need to create new public health surveillance systems but should use data to assess the impact of the new plan.

SHARE THE PLAN WITH DIVERSE AUDIENCES IN ACCESSIBLE FORMATS

INTRODUCTION

The final discussion topic during the focus group was about how the state should communicate its new plan once it is finalized. Participants were asked to share their thoughts on who the target audiences might be and the best way to reach those audiences.

FEEDBACK

Many audiences have a stake in the state's plan

Participants believed that there are several different stakeholder groups who should learn about the state's plan. Providers are clearly an important audience, but Medicaid-eligible youth, their caregivers, schools and community support organizations are also important audiences.

Simplicity is important

There was a shared belief among participants that Medicaid-related communication from the state tends to be legalistic and tailored toward those with prior knowledge of the system. They urged the state to develop communication about the new plan that is easy for the broader community to understand.

Multiple channels of communication are required

While the state has clear lines of communication with providers and others who are part of the Medicaid system, it will need to develop new ways to communicate with wider audiences. Participants suggested using multiple channels including traditional media, social media, in person gatherings, virtual meetings, direct mail, and email to reach constituents.

RECOMMENDATIONS

1. Communicate with many constituents. Providers, patients, caregivers, schools and community groups should all be targeted for outreach.
2. Communicate in simple language. The state should clearly communicate what it plans to do to address the requirements of the lawsuit without relying on jargon or legalese.
3. Communicate through multiple channels. Constituents receive their information from a wide range of sources and the state should leverage all those sources to share the plan.

CONCLUSION

The recommendations offered in this report reflect the thoughts and concerns of dozens of Colorado residents. They include mental health care providers, school personnel, government officials and families, all of whom have been impacted by Colorado's failure to provide adequate mental health services to Medicaid-eligible youth. The state has been forced to develop a plan to respond to this crisis because it has not previously listened to, nor responded to, the calls from constituents to do better by our youth. Now that the courts have required the state to fulfill its moral imperative to address this crisis, the state can and should be responsive to community input. Speak Our Minds is grateful to the many focus group participants and survey respondents who have shared their stories and offered their suggestions. We look forward to the state's response and intend to hold them accountable for creating a system that meets the needs of our youth.

APPENDIX A

FOCUS GROUP DISCUSSION GUIDE

- **The lawsuit settlement requires that the state address youth with complex mental health needs but does not define complex mental health needs. I am going to read a common definition, and then ask you what you agree or disagree with in this common definition. I will also put this definition into the chat:**

  "People with complex mental health needs experience significant, multiple, rare or persistent mental health challenges that impact their functioning in most areas such as in the home, school and community. Complex cases require individuals to access services and support from a wide variety of government and/or community services."

  - What do you like about this definition?
  - What do you dislike about this definition?
  - How do you think we can ensure the state does not define complex mental health needs too narrowly, thereby limiting service?

- **Let's talk about Tiers of Care. Please look at this graphic about Tiers of Care. At which level of this pyramid should HCPF start?**

  - What are some specific activities that the state should consider to improve prevention services?

- **Our next topic is individual care plans. Essentially there needs to be one owner of individual plans to make sure that care is being provided and that providers are coordinating with one another.**

  - What are your thoughts about who should be responsible for these plans?
  - One idea is that the Regional Accountability Entities or RAE's. What do you think about that idea?

- **Let's talk about the requirement to provide intensive home and community-based services. This is a broad requirement, so let's talk about what might fall under this umbrella.**

  - What is your assessment of what is available now? Tell me about how people access these services and the quality and safety of the services they receive
  - What are some ways that the state could do this better?

- **One of the more ambitious requirements of the settlement is that the state must provide youth-oriented mobile mental crisis intervention 24/7.**

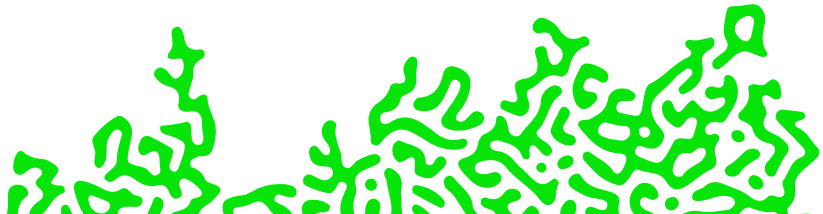
  - What mobile crisis services are you aware of in your community?
  - What entities might have the capacity or the skills to do this?
  - What ideas do you have about how the state might address this requirement?

- **Let's talk about data**

  - What data do you or your colleagues currently use to assess the status of youth mental health?
  - How should that data be collected? And who should collect it?
  - Who needs access to the data?

- **Finally, once the state has developed its plan, it will need to share this information.**

  - Who needs to know about this?
  - What is the best way to reach those audiences?



APPENDIX B

SURVEY QUESTIONS

1 Name

2 Email

3 What best describes your connections to youth mental health (check all that apply)

- Provider
- Parent
- Advocate
- School personnel
- Youth
- Government official
- Health system administrator
- Other (please specify)

4 The settlement in the lawsuit discussed in our focus group requires the state to address youth with complex mental health needs. How should the state define that population?

5 What is the role of Medicaid in youth mental health prevention services?

6 Who should be responsible for the individual care plans of youth with complex mental health needs:

- Primary care providers
- Specialty care providers
- Medicaid Regional Accountability Entities
- Other (please specify)

7 The state is also required to provide intensive home and community-based services. What is the current state of those services in your community? How can the state improve those services?

8 The state must also provide mobile crisis intervention services 24/7. What is the current state of those services and how can the state do better?

9 What data should be collected about youth mental health? Who should collect the data and who should be able to access it?

10 Who needs to know about the plan the state is developing? And what is the best way for the state to communicate about the plan?

11 What else would you like to add to the conversation to inform how the state will better address the mental health needs of Medicaid eligible youth?

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