Medicaid Advisory Committees: Best Practices for Effective Stakeholder Engagement

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Although Medical Care Advisory Committees (MCACs) have been federally required for nearly forty years, some states have seriously underutilized this opportunity to monitor and improve their Medicaid programs. In May 2024, the Centers for Medicare & Medicaid Services (CMS) updated regulations implementing MCACs.[1] New requirements for the renamed Medicaid Advisory Committees (MACs) and Beneficiary Advisory Councils (BACs) present an important opportunity to enhance the role of Medicaid enrollees and other stakeholders in state Medicaid policy development and oversight.

This paper describes key regulatory changes for MACs and BACs, as well as operational challenges and best practices to help ensure meaningful stakeholder engagement.[2]

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[1] Dep't of Health & Human Srvs., *Medicaid Program; Ensuring Access to Medicaid Services Final Rule*, 89 Fed. Reg. 40542 – 40874 (May 10, 2024), https://www.govinfo.gov/content/pkg/FR-2024-05-10/pdf/2024-08363.pdf (hereinafter "2024 Access Final Rule").

[2] The National Health Law Program (NHeLP) has long advocated for effective MCACs. In 2022, NHeLP, working with the North Carolina Justice Center and other advocates, developed training resources for member advisory committees as the state transitioned Medicaid enrollees to managed care plans. See Member Advisory Committee (MAC) Training for Medicaid Managed Care. See also, *e.g.*, Jane Perkins & Sarah Somers, Nat'l Health Law Prog., *Fact Sheet: Medicaid Medical Care Advisory Committees* (Jan. 2005), https://www.ndrn.org/images/Documents/Issues/Medicare_Medicaid/NDRN_medcare_advisory_committees.pdf; Wayne Turner, Nat'l Health Law Prog., Letter to Trina Dutta Special Projects Officer, DC Department of Health Care Finance, *Re: Proposed Medical Care Advisory Committee By-Laws* (Jul. 15, 2016), https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/NHeLP%20Comments%20Proposed%20DC%20Medical%20Care%20Advisory%20Committee%20By-Laws%2007.15.2016.pdf.

1. Why Medicaid enrollee engagement is important

In the 2024 Access Final Rule, CMS recognized the important role enrollees can and should play in Medicaid policy and program development:

> "We have concluded that beneficiary perspectives need to be central to operating a high-quality health coverage program that consistently meets the needs of all its beneficiaries."[3]

Including people with lived experience in the policy-making process can lead to a deeper understanding of the conditions affecting certain populations, facilitate identification of possible solutions, avoid unintended consequences of potential policy or program changes that could negatively impact the people the program aims to serve.[4] People who rely on Medicaid

[3] *Id.* at 40544.

[4] Centering the experiences of affected populations in program and policy development has long-standing antecedents. For example, in 1983, a group of people living with AIDS (PWAs) released The Denver Principles, which, in part, recommend that PWAs "be involved at every level of decision-making and specifically serve on the boards of directors of provider

for their health care are the best experts on how well or poorly a state's program performs. Medicaid members can serve as important voices for their communities by providing insight into issues or concerns they have about the care and service they receive. Their participation on the MAC and BAC allows them to communicate real experiences they are having and to offer input on potential solutions to problems.
Advocates must ensure that participants asked to serve on the MACs and BACs are being brought on because their lived experience is essential to the work of the committee.

Regulatory requirements for MACs and BACs, while promising, do not guarantee that Medicaid enrollees, members of enrollee support systems, and other stakeholders will fully participate in state Medicaid policy development and program implementation. Medicaid enrollees face numerous challenges. By definition, they are low income and may be living with a disability or chronic health conditions. They may be working one or more jobs and experiencing housing or food insecurity. They may have had negative experiences with the Medicaid program, including on stakeholder committees, or with providers. In short, people with lived experience relying on Medicaid may be highly skeptical and reluctant to participate in an advisory group.

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organizations." The Denver Principles (1983) **https://data.unaids.org/pub/externaldocument/2007/gipa1983denverprinciples_en.pdf**. They also recommended that people with AIDS be included in all AIDS forums with equal credibility as other participants, to share their own experiences and knowledge. Similarly, "Nothing about us, without us" is a guiding principle adopted by the Disability Rights movement that highlights the desire of people with disabilities to represent their own interests, especially when it comes to the development of policies and programs that will have a direct impact on their well-being and independence. *See* James I. Charlton, *Nothing About Us Without Us* (1 ed. 1998), **http://www.jstor.org/stable/10.1525/j.ctt1pnqn9** (last visited Jun 25, 2024). *See also* Judith Stevens & Barbara Ibañez, Center for Development and Disability Partnership Initiative Program, *Beyond Tokenism: Partnering with People with Diverse Abilities on Consumer Advisory Boards* (2004), **https://systems.aucd.org/docs/councils/coca/beyond_tokenism_unm2004.pdf**.

> "Efforts to engage meaningfully with beneficiaries should be mindful of historic distrust of health care systems and other institutions and the factors that affect beneficiaries' ability to provide feedback. This distrust from Medicaid beneficiaries, particularly those from marginalized communities, is the product of decades-long."[5]

It is incumbent on CMS, state officials, and health care advocates to establish and implement an accessible, inclusive framework that values the perspectives and insights of people who rely on Medicaid for their health care.

2. Medicaid Advisory Committee and Beneficiary Advisory Council authority

The Medicaid Act authorizes state agencies to establish advisory committees.[6] The purpose of the MACs and BACs is to "advise the state Medicaid agency on matters of concern related to policy development, and matters related to the effective administration of the Medicaid program."[7] Reflecting the broad scope of MAC and BAC advisory authority, the 2024 Access Final Rule establishes that the MAC and BAC determine, in collaboration with the state, the topics on which they will advise.[8] At minimum, MACs and BACs advise on issues concerning additions, changes, and access to services; coordination of care problems; quality of services; eligibility, enrollment, and renewal processes; beneficiary and providers; cultural competency, language access, health equity, disparities and bias; as well as other issues that impact provision of services or outcomes.[9]

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[5] Medicaid & CHIP Access & Payment Comm'n (MACPAC), *Report to Congress on Medicaid and CHIP, Ch. 1: Engaging Beneficiaries through MCACs to Inform Medicaid Policymaking* 4 (Mar. 2024), **https://www.macpac.gov/publication/engaging-beneficiaries-through-medical-care-advisory-committees-to-inform-medicaid-policymaking-2/** (hereafter "MACPAC 2024 Report").

[6] 42 U.S.C. § 1396a(a)(4); 42 C.F.R. § 431.12. See also 42 U.S.C. § 1396u-2(d)(2)(A)(ii) (requiring state consultation with MCAC to review Medicaid managed care marketing materials).

[7] 42 C.F.R. § 431.12(a). Some states have sought to limit the scope of MCACs to certain topics, such as managed care or the delivery of services. *See, e.g.,* discussion at 89 Fed. Reg. 40561. *See also Morabito v. Blum*, 528 F. Supp. 252, 263-67 (S.D.N.Y. 1981) (the scope of MCAC advisory authority extends to "the entire field of state decision-making with respect to the Medicaid program, and is not limited to discrete areas of concern."

[8] 42 C.F.R. § 431.12(g).

[9] *Id.*

Additional MAC responsibilities are specified in regulation, including:

- reviewing Medicaid managed care marketing materials;[10]
- reviewing the state's Medicaid managed care program report;[11]
- providing input on the state's managed care quality rating system;[12]
- drafting and revising the state's quality strategy;[13] and
- public notice and hearing requirements for § 1115 demonstration projects.[14]

Best practices: Bylaws for MACs and BACs can provide for standing and *ad hoc* subcommittees focusing on specific areas of concern. Although not required by the regulations, subcommittees can address issues such as behavioral health, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, eligibility, and home and community based services (HCBS).[15]

3. MAC and BAC composition

The 2024 Access Final Rule establishes minimum requirements for membership in MACs and BACs. Instead of stipulating a minimum or maximum number of members, MACs must include at least one member from each of the following categories:

- State or local consumer advocacy groups or other community-based organizations that represent the interests of, or provide direct service, to Medicaid beneficiaries;
- Clinical providers or administrators who are familiar with the health and social needs of Medicaid beneficiaries and with the resources available and required for their care. This includes providers or administrators of primary care, specialty care, and long-term care;
- Participating managed care plans or state associations representing plans (where applicable;

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[10] 42 U.S.C. § 1396u-2(d)(2)(A)(ii); 42 C.F.R. § 438.104(c).
[11] 42 C.F.R. § 438.66(e)(3)(ii).
[12] 42 C.F.R. § 438.344(c)(2)(i).
[13] 42 C.F.R. § 438.340(c)(1)(i).
[14] 42 C.F.R. § 431.408(a)(3)(i).
[15] As of March 2024, twenty-three states use topic based MCAC subcommittees or beneficiary-only subcommittees as ways to solicit beneficiary input on specific topics. MACPAC 2024 Report at 10.

- Other state agencies that serve Medicaid enrollees as ex officio members (non-voting).[16]

In addition, at least 25% of MAC membership must come from the BAC.[17] The BAC is composed of past or current Medicaid enrollees, family members, and paid or unpaid caregivers of enrollees.[18] States have three years to ramp up BAC membership in their MACs. In Year 1 the MAC membership must be 10% BAC members, 20% by Year 2 and 25% BAC members by Year 3.[19]

Best practices for BAC composition: The perspectives of Medicaid enrollees and their caregivers do not necessarily align, even though both may serve on the BAC. Experience in North Carolina with Consumer and Family Advisory Committees (CFAC) at the county and state level taught advocates important lessons on how these differences can inhibit enrollee participation. Family members and caregivers - even with best intentions – were often over-represented and drowned out the voices of actual beneficiaries. The committees where beneficiaries were most likely to have their opinions heard and valued were the ones in which at least 25% of the members were beneficiaries with lived experience.

Creating effective BACs should be done through bylaws to ensure membership requirements are consistent over time. BAC membership should further reflect the characteristics of the beneficiaries of the state's Medicaid program. This means that membership should have proportional representation of urban and rural residents, members who are representative of diverse demographic backgrounds, and the various Medicaid eligibility categories and service programs found in the state's Medicaid program.

Best practices for MAC composition: Providers, including medical professional organizations, hospital associations, etc. may push the state for their own slots on the MAC.[20]

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[16] § 431.12(d)(2).
[17] § 431.12(d)(1).
[18] § 431.12(e).
[19] § 431.12(d)(1).
[20] *See, e.g.*, Letter from Ronald Benner, President, American Optometric Association to Chiquita Brooks-LaSure, Administrator, CMS (Jun. 14, 2023), **https://www.regulations.gov/comment/CMS-2023-0070-0273** (calling on CMS to establish a mandatory MAC slot for optometrists).

However, if states were to carve out mandatory MAC slots for every key Medicaid provider type, it would bloat the size of the MAC and make it difficult to adhere to the 25% minimum for BAC members. However, in many states, efforts are underway to undermine access to evidence-based sexual and reproductive health care. Medicaid is an important provider of reproductive health services, covering more than 40% of U.S. women's births and 65% of Black women's' births. It is the leading source of family planning coverage in the U.S. Advocates should push states to require that MACs include *bona fide* reproductive health care providers.

Advocates should also push to include Protection and Advocacy (P&A) organizations and free legal services providers on the MAC.[21] Although P&As and legal aid could fill the slot slated for "consumer advocacy groups or community based organizations that represent the interest of Medicaid beneficiaries," legal advocates have important perspective that is different from provider-led advocacy, church organizations, condition-specific groups, or family support groups that may otherwise fill that category. Moreover, because legal services providers and P&As rely on outside funding streams, they do not have a pecuniary interest in a state's Medicaid policy.

> Legal and advocacy groups can engage in the MAC and BAC even if they are not members. Since the 1980s, the Pennsylvania Health Law Project has served as legal counsel to the Consumer Subcommittee of Pennsylvania's Medical Assistance Advisory Committee (MAAC), briefing enrollees on health issues, providing technical assistance, and identifying and interpreting legal issues.[22]

[21] 42 U.S.C. § 15041; *see also* Nat'l. Disability Rights Network, *About*, **https://www.ndrn.org/about/** (last visited Aug. 26, 2024).
[22] Pennsylvania Health Law Project, Our History, **https://www.phlp.org/en/about/our-history**. *See also* J.M. Zhu & R. Rowland, Oregon Health and Science University*, Increasing consumer engagement in Medicaid: Learnings from states* (2020), **https://www.ohsu.edu/sites/default/files/2020-12/Increasing%20Consumer%20Engagement%20in%20Medicaid%20-%20Learnings%20from%20States%2012.14.20.pdf**.

4. Member application and selection

The MAC and BAC members are selected by the director of the single state Medicaid agency under the 2024 Access Final Rule.[23] States must establish a process for recruitment and selection of members and must post this information on the state's website.[24] States determine member term length, and members are barred from serving consecutive terms.[25] Members serve on a rotating and continuous basis. The selection process for members and leaders of the MAC and BAC and any recruitment information must be posted and publicly available.[26] The 2024 Access Final Rule requires meeting agenda to include a time for MAC and BAC members to disclose conflicts of interest.[27]

Best practices for member applications: The application process for MAC and BAC membership should be simple. For example, Nebraska asks applicants their affiliation with the Medicaid program and why they want to serve on the state's MCAC.[28] Overly complicated processes akin to employment applications, and requiring sensitive information such as background checks may discourage some people from applying. Online-only applications may also pose a barrier to some applicants. States should allow prospective MAC and BAC members to apply online, on paper/in person, or by phone, similar to the single streamlined application for insurance affordability programs.[29] The application process must be accessible to persons with disabilities and persons with limited English proficiency (LEP).

Best practices for terms and member selection: The prohibition on consecutive terms will ostensibly allow new voices to participate in the MAC and BAC. However, one term may limit some members' ability to gain expertise in Medicaid policy matters and effectively advocate for change, especially enrollees and other BAC members. Committee members should have terms that are longer than one or two years so they can familiarize themselves with bureaucratic processes, especially since there are only a few meetings a year. This allows them to serve a sufficient period of time to learn how to become effective committee members

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[23] § 431.12(c).
[24] *Id.*
[25] *Id.*
[26] *Id.*
[27] § 431.12(f)(3). Some states may have requirements and processes for conflict of interest disclosures for state advisory boards and committees.
[28] Nebraska Department of Health and Human Services, *Medical Care Advisory Committee (MCAC) Application Form,* **https://dhhs.ne.gov/Documents/MLTC-39.pdf**.
[29] 42 U.S.C. 1396w-3(b); 42 C.F.R. §§ 435.907(b); 435.909.

without immediately having to give up their seat on the MAC and BAC. States should set terms for MAC and BAC members at no less than two years.

Another best practice, which can be codified in the MAC bylaws, is to establish a Nominations Committee that includes representation of BAC members. This provides advocates a way to influence on who gets on the committees, as well as builds a bench of potential candidates to serve in future years. This bench of committee candidates will be needed due to the rotating and continuously evolving nature of the committee's makeup. Continually recruiting potential committee members will be extremely important to the ongoing success of the MAC and BACs.

Finally, bylaws should specify that members serve for the duration of their appointments and allow only "for cause" removal, including written notice and explanation of the ground for removal. Such a requirement would allow MAC and BAC members to proffer advice and constructive criticism of the state Medicaid agency without fear of retribution or loss of their position.[30]

5. Agency support

Successful committee implementation and MACs and BACs depends on the state Medicaid agency. The agency is responsible for creating standardized processes that are available for the public to review.[31] The agency must provide appropriate planning and execution of advisory group meetings, as well as support personnel to ensure "meaningful participation" from MAC and BAC members.[32] The agency must support recruitment and facilitate member engagement.[33] A member of the single state agency executive staff must present at each MAC

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[30] *See, e.g.*, Letter from Jennifer Meazy, Supervising Attorney, Legal Aid Society of the District of Columbia, to Trina Dutta Special Projects Officer DC Department of Health Care Finance (Jul. 15, 2016), **https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Legal%20Aid%20Society%20of%20DC%20Comments%20on%20Proposed%20MCAC%20By-Laws.pdf** (opposing a DC MCAC bylaws change declaring that members serve "at the pleasure of the Director," who may be removed at any time and for any reason, following a purge of members that publicly criticized the Agency.

[31] § 431.12(f).

[32] § 431.12(f)(7), (h)(3).

[33] § 431.12(c), (h)(3)(i).

and BAC meeting.[34] Additionally, the state must post meeting times and locations at least 30 days in advance, and provide financial support, if necessary, "to facilitate Medicaid beneficiary engagement in the MAC and the BAC."[35]

Best practices: Financial support can take the form of stipends and reimbursement to encourage committee members to participate and attend meetings. Participation in these meetings can be challenging and time consuming for Medicaid beneficiaries, who typically have limited resources and may also have health complications or disabilities.

Reimbursements for expenses such as travel, parking, meals, overnight lodging, make these meetings easier to attend, more worthwhile for people, and more likely to participate.[36] States should also provide additional supports, including free childcare and food during meetings.

> Compensation received that is at least $600 during one calendar year must be reported to the IRS.[37]

However, financial support for MAC and BAC participation may affect a participant's Medicaid eligibility. For example, honoraria, stipends, and compensation for missed wages could be viewed as income or resources. Therefore it is important that the amounts of these do not impact a committee member's financial eligibility for Medicaid.[38]

6. MAC and BAC meetings

There is no limit on how many times a year the MAC and BAC can meet, but they are required to meet at least once per quarter. At least two MAC meetings per year must be open to the public.[39]

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[34] § 431.12(h)(3)(iii).
[35] § 431.12(f), (g).
[36] Reimbursement for expenses are not considered income. *See generally*, IRS Pub. 525, *Taxable and Nontaxable Income* (2023), **https://www.irs.gov/pub/irs-pdf/p525.pdf**.
[37] IRS, *Instructions for Forms 1099-MISC and 1099-NEC* (01/2024), **https://www.irs.gov/instructions/i1099mec**.
[38] *See, e.g.*, 42 U.S.C. § 1396a(e)(14); 42, C.F.R. § 435.603, requiring states to use Modified Adjusted Gross Income (MAGI) methodologies to determine financial eligibility in many Medicaid categories.
[39] § 431.12(f)(3), (4).

States must offer a variety of meeting modalities – in-person, virtual, hybrid options – and all meetings must have a call-in, telephone option.[40] Finally, states must ensure that the meeting times and locations for MAC and BAC meetings are selected to maximize member attendance.[41]

The BAC must meet separately and in advance of MAC meetings.[42] BAC meetings are not required to be open to the public unless the BAC decides otherwise.[43]

The meeting times and locations, meeting minutes, member list, bylaws for governance, recruitment process, and administrative processes must all be posted publicly on the state's website.[44] BAC members have the option to have their names on the membership list and in meeting minutes posted publicly. [45]

Best practices: Although not required by the 2024 Access Final Rule, the Director of the state's Medicaid agency should meet directly with the BAC members on at least a quarterly basis. In addition, representatives from the CMS regional office should meet with BAC.

See **Trainings and additional Strategies for Effective Stakeholder Engagement**

7. Accessibility

Meetings, whether they are in-person, virtual, or hybrid, need to be accessible for people with disabilities. By law they must comply with Americans with Disabilities Act (ADA), Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act, and Section 1557 of the ACA.[46] Ensuring meetings are accessible to people with disabilities means not only complying with the laws and making sure that the meeting space is physically accessible for those attending events in person, but also that people with disabilities are able to effectively communicate, understand the meeting materials, and have the necessary support to participate in the meeting discussions. Meetings must also provide meaningful access for persons with limited English

[40] § 431.12(f)(5).
[41] § 431.12(f)(6).
[42] § 431.12(e)(2).
[43] § 431.12(f)(4).
[44] § 431.12(f)(1).
[45] § 431.12(f)(1).
[46] § 431.12(f)(7).

proficiency (LEP). State Medicaid agencies must ensure that programs and services are accessible, including MACs and BACs, making reasonable modification where needed.

Best practices: States should take action beyond minimum compliance with ADA and Section 504 standards to ensure that MAC and BAC meetings and operations are truly inclusive. This means making inclusive approaches to meetings the expectation of all people going into a meeting, even if no one requests accommodations. Accessibility is required, and inclusivity should not be something that people have to worry about or ask for in advance.

Inclusive design would include, for example that all attendees are supplied with all of the necessary materials and information on the agenda at least forty-eight hours in advance to allow for those with cognitive or information processing disabilities time to look over the material. These materials should use accessible fonts and font size, limited use of graphics and pictures (unless properly formatted for accessibility), and be formatted for screen reader accessibility.[47] Materials that go out before the meeting should also list all communication accommodations that will be automatically provided to ensure accessibility without the need for a request (*e.g.,* captioning, translation). In addition, participants should always be able to contact the meeting host with additional accommodation requests.
For all meeting attendees, support staff familiar with the meeting topics, yet neutral and unaffiliated with industry stakeholders, should be available prior to the meeting to answer questions and explain the topics so attendees are prepared and able to participate in the discussion. Staff should also follow up with attendees after the meetings to ask for feedback, make sure attendees felt heard, had their participation needs met, if there are more ways their participation could be supported, and if they have more questions.[48]

Physical meeting space accessibility requirements include making sure attendance is accessible from getting to the venue, parking and drop-off areas, to getting inside and participating in the meeting. This starts with ensuring the meeting takes place in a location on an accessible public transit route for those without their own transportation and has sufficient accessible parking and entrances for those with transportation. This may require creating additional, temporary accessible parking based on the needs of the attendees expected to show up for

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[47] Nat'l Health Law Program, NC Justice Center, et al., *How to Plan and Run an Accessible and Inclusive Meeting* (2022) **https://www.ncjustice.org/wp-content/uploads/2022/07/MAC-Plan-Run-Meeting.pdf**

[48] California Health Care Foundation, *Medi-Cal Member Advisory Committee* (2023) **https://www.chcf.org/publication/medi-cal-member-advisory-committee-design-recommendations-ca-dhcs/** (last visited Aug 27, 2024).

the meeting. The path of travel from the parking into the building and the meeting space must be accessible, which includes ensuring there is proper signage designating the accessible route and that equipment like elevators and power-assisted door openers, where required, are working properly.

Meeting rooms should be large enough to accommodate attendees with mobility devices like walkers and wheelchairs so they can freely move around the meeting space, conference tables, and into breakout sessions. Accessible restrooms should be not only on the premises but also near to the meeting space so attendees do not have far to travel. However, note that although physical accessibility is important, it is not the only component of accessibility of a meeting space.

During the meeting, captioning and translation services should be available for both in-person and virtual attendees. This includes using live ASL interpreters who are able to stand in a prominent, well-lit space. Other communication supports should be available as needed depending on the needs of committee members and attending public, if applicable. In the course of the proceedings it is important to identify speakers, amplify voices, and describe all images that appear during presentations.[49]

8. Virtual and hybrid meetings

Virtual and hybrid meetings pose accessibility challenges that can be quite different from in-person meetings and need to be planned for accordingly. Any meetings with a virtual component need to be conducted on platforms that are compatible with assistive technologies used by disabled persons (*e.g.,* screen readers, screen enlargement applications, closed-captioning, cognitive aids including computer devices). When access issues arise like the captioning not working or interpreters are not visible on screen, these problems should be responded to by a staff person assigned to handle issues in real time. This person or another should be assigned to observe the chat and Q&A functions and provide attendees the option to have their comments and questions read aloud.

[49] *Id* at 14.

Best practices:

How to Plan and Run an Accessible and Inclusive Meeting

The strategies mentioned above on running an accessible meeting are just the tip of best practices that can be implemented to ensure people with disabilities are able to effectively participate in meetings.

We strongly recommend that before facilitating any stakeholder meeting, meeting organizers and attendees read through the guide *How to Plan and Run an Accessible and Inclusive Meeting*. The guide includes extensive checklists for meeting planning and checklists for members on what they can do to be ready to effectively attend and participate in meetings. It covers both in-person and virtual meetings.

9. Transparency

The 2024 Access Final Rule includes robust transparency requirements for MACs and BACs. The state must publish on its website information on the process for recruiting and selecting new members and the process for selecting MAC and BAC leadership.[50] The state must develop and publicly post bylaws for the governance of the MAC and BAC.[51] In addition, the state must post:

- Administrative processes and practices of the MAC and BAC;[52]
- The list of MAC and BAC members, as well as meeting minutes and attendees, with the opportunity for BAC members to opt out;[53]
- The schedule for MAC and BAC meetings, and the date, time, and location, of each public MAC and BAC meeting at least thirty calendar days in advance of the meeting; [54]
- Minutes for each meeting, which must be posted within thirty calendar days following the meeting;[55]

[50] § 431.12(c), (f)(2).
[51] § 431.12(f)(1).
[52] § 431.12(f).
[53] § 431.12(f)(1).
[54] § 431.12(f)(3), (4).
[55] § 431.12(h)(2).

- An annual report describing the MAC's activities and topics, including recommendations from the BAC and the state's responses.[56]

Best practices: The 2024 Access Final Rule requires states to publicly post past meeting minutes, but does not specify how long they must be posted and publicly available. States should maintain a publicly accessible archive of past MAC and BAC meeting minutes and other information. Being able to review past activities will help advocates track progress on specific issues. In addition, the requirement to publicly post past meeting minutes does not distinguish between public and closed meetings. Advocates should insist that state Medicaid officials publicly post the minutes of closed meetings to help ensure transparency and accountability.

States should post draft versions of meeting minutes to provide participants and other stakeholders the opportunity to review and suggest edits prior to final adoption. Minutes should be sufficiently detailed, describing proceedings and perspectives shared, in addition to public comments. Written comments, testimony, reports, and other materials provided to MAC and BAC members should also be publicly posted.

10. Bylaws

The 2024 Access Final Rule requires states to develop and publicly post bylaws for the governance of MACs and BACs.[57] Most, if not all states will be required update any current bylaws governing MCACs to reflect new regulatory requirements for MACs and BACs. In addition, some states established their MCACs through legislation.[58] For example, Mississippi authorizes the State's Governor, Lieutenant Governor, and Speaker of the House to appoint MCAC members.[59] States may need to amend state statutes when they conflict with new federal requirements.

Best practices: Advocates should reach out to their state Medicaid agency to participate in the bylaws review and updating process. Bylaws can provide for many of the suggestions and best practices described herein, including length of terms, for cause removal, subcommittees on specific topics (behavioral health, EPSDT) and MAC and BAC operations like nominations, as

[56] § 431.12.
[57] § 431.12(f)(1).
[58] See, *e.g.*, C.R.S. § 25.5-4-203 (Colorado).
[59] MS Code § 43-13-107(3)(b)(2023).

well as trainings and meeting norms that center the experiences of Medicaid enrollees. MAC and BAC bylaws should also provide for periodically reviewing and updating the bylaws.

In addition, the MAC and BAC bylaws should require coordination with other state-level advisory groups for Medicaid stakeholders. These include the member advisory committees required for states when long term services and supports (LTSS) are delivered through a managed care program, and of managed care entities providing LTSS.[60] The MAC and BAG should also consult with the Interested Parties Advisory Group that consults on rate reviews for home and community-based services.[61] The MAC and BAG should also coordinate with the state's Drug Utilization Review Board and Medicaid Pharmacy and Therapeutics Committees.[62]

> Advocates should reach out to their state Medicaid agency to help develop and update bylaws governing MACs and BACs. Many of the best practices to maximize effective Medicaid stakeholder engagement, which exceed the minimum regulatory requirements, can be codified through the bylaws governing MACs and BACs.

11. Trainings and additional strategies for effective stakeholder engagement

Bringing people onboard as members of the MAC and BAC and being an effective advocate during the meetings requires training and support. Medicaid is complicated, with agencies, plans, regulations, and acronyms that can be overwhelming, even for experienced advocates. Although not required by the 2024 Access Final Rule, states should provide training for all MAC and BAC members.

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[60] 42 C.F.R. §§ 438.70, 110.
[61] 42 C.F.R. § 447.203(b)(6).
[62] *See* 42 U.S.C. § 1396r-8(g)(3), authorizing the Drug Utilization Review Board; 42 U.S.C. § 1396r-8 (d)(4)(A), providing for the establishment of formularies. States may also have Pharmacy and Therapeutics (P&T) committees to develop preferred drug lists. *See* National Academy for State Health Policy (NASHP), *State Experience in Creating Effective P&T Committees* (March 2006), **https://eadn-wc03-6094147.nxedge.io/cdn/wp-content/uploads/sites/default/files/medicaid_pandt.pdf**. *See also* 45 C.F.R. § 156.122(a)(3), requiring P&T Committees for plans subject to Essential Health Benefits.

CMS, working with states, should provide training and resources for new MAC and BAC members describing the fundamentals of the Medicaid program.[63]

However, all MAC and BAC members, including state officials and support staff, should receive training on effective stakeholder engagement. *Using Enrollee Experiences to Improve Medicaid Plans*, developed by NHeLP, NC Justice Center, and others, is a helpful resource on how to share and listen to personal experiences of Medicaid enrollees with to improve services.

Best practices: Participating in stakeholder engagement meetings requires a certain set of skills that may not be intuitive for members new to the committees. In order for the meetings to yield impactful results all of the participants should receive training on effective engagement skills. The trainings need to involve more than new members to the MAC and BAC, and should also include agency staff and continuing members. There can be significant differences in power dynamics between new members, community members, and agency staff due to differences in experience, familiarity with policy proposals, and comfort with participating in large group discussions. All participants should be able to recognize and name those power dynamics and have the necessary skills to mitigate imbalances. These trainings should incorporate skill building on active listening and centering and understanding enrollee perspectives and experience. As CMS states in the preamble to the 2024 Access Final Rule, the enrollee experience should be central to the goals and workload of the committee.

Active listening: Active listening requires clearing the mind in order to take in the information that other members are sharing.[64] Writing down thoughts or questions that need to be answered during the meeting is a tool that can help clear headspace in order to focus on what others are saying. Then when the conversation begins, the person who is speaking has the right to be heard without interruption. Writing down notes, thoughts, and questions that come while a speaker is speaking helps keep attention focused on the speaker. When the speaker finishes, listeners should respond to what they hear through the facts of what was said, the feelings that were expressed and stated by the speaker, and the listener should

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[63] See, *e.g.*, training materials developed by the Health Resources Services Administration (HRSA) for participants in the Ryan White Part A Planning Councils EGM Consulting, LLC, *Training Guide for RWHAP Part A Planning Councils/Planning Bodies: A Member's First Planning Cycle* (Feb. 2020), https://targethiv.org/planning-chatt/training-guide (last visited June 25, 2023).
[64] *Id.* at 11.

name and reflect the values the speaker believes or holds strongly. The speaker must then be given space to clarify or correct any misunderstood facts, feelings or values.

Active listening requires asking questions instead of assuming intentions of the speaker and judging. Lastly, the listener must be generous and understand that the speaker harbors no bad intentions, even if the details of what they are saying may be uncomfortable to hear. Medicaid enrollees and their caregivers may share personal stories about their experiences accessing the program. Agency officials and other MAC members should work to understand these experiences within the context of the broader legal and policy framework. Using active listening techniques can foster open communication between MAC members which include state health officials, health industry representatives, Medicaid enrollees, caregivers, and family members. Training should also bring together state representatives and Medicaid enrolled to cover the shared goals and objectives of the group itself.

Establishing meeting norms: Ensuring meeting accessibility is only one part of facilitating effective meetings. The groups should collectively create and affirm holding onto a set of group norms and community agreements for how meetings will be conducted and how the meeting attendees will relate to one another. It is a helpful practice to post the norms and agreements publicly and to reaffirm them frequently at the group's meetings.

Effective meetings promote participation from the multiple voices in the room. The same people should not repeatedly dominate the conversation across multiple meetings. In order to facilitate an open dialogue, attendees should have opportunities to contribute in the way they feel most comfortable. This can be done by establishing meeting norms like encouraging attendees to participate and hearing from participants. MAC and BAC should allow members and public commenters multiple ways to provide feedback, including pre-recorded and written testimony, as well as smaller groups where participants may feel more comfortable speaking. In addition, participants should be encouraged to leave their camera off if they want to or letting them dial in from a phone instead of using a computer if that makes participation easier.

12. Resources

Federal

- **Dep't of Health & Human Srvs., *Medicaid Program; Ensuring Access to Medicaid Services Final Rule*, 89 Fed. Reg. 40542 – 40874 (May 10, 2024)**

- **Medicaid and CHIP Access and Payment Commission (MACPAC), *Report to Congress on Medicaid and CHIP, Ch. 1: Engaging Beneficiaries through MCACs to Inform Medicaid Policymaking* 4 (March 2024)**
- **HHS Office the Assistant Secretary for Planning and Evaluation (ASPE), *Engaging People with Lived Experience to Improve Federal Research, Policy, and Practice* (2022)**

Advocacy groups

Training materials developed by NHeLP and the NC Justice Center:

- **Using Enrollee Experiences to Improve Medicaid Plans (2022)**
- **How to Plan and Run an Accessible and Inclusive Meeting (2022)**

Overview of 2024 Access Final Rule

- **NHeLP Webinar - Medicaid Advisory Committees: Regulatory Changes and Challenge (May 2024)**
- **SHVS, Engaging Medicaid Members: New Requirements in the Medicaid Access Rule (June 2024)**

Additional resources

- **Georgetown Center for Children and Families, Beneficiary Advisory Councils, Historic Opportunity for State Medicaid Programs (May 2024)**
- **CHCS: Building State Capacity for Community-Informed Policymaking Learning and Action Series: Implementing a Medicaid Beneficiary Advisory Council (April 2024)**
- **CHCF Medi-Cal Member Advisory Committee: Design Recommendations for the California Department of Health Care Services (2023)**
- **Community Catalyst: Listening to Dually Eligible Individuals: Person-Centered Enrollment Strategies for Integrated Care (2021)**