CHCF

# Designing Medi-Cal Consumer Advisory Committees

## Insights from a Survey of Medi-Cal Managed Care Plans

JULY 2023

AUTHORS
Madeline Steward, Courtney Roman, and Kelly Church,
Center for Health Care Strategies

## About the Authors

Madeline Steward, MPH, CAPM, is program officer; Courtney Roman, MA, is senior program officer; and Kelly Church, MPH, is program associate at the Center for Health Care Strategies.

The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. CHCS supports partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit www.chcs.org.

## About the Foundation

The California Health Care Foundation (CHCF) is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities that have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system. CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

# Contents

# Executive Summary

In February 2023, the California Department of Health Care Services (DHCS) announced the launch of its Medi-Cal Member Advisory Committee (MMAC) to make sure people enrolled in Medi-Cal, including many from historically marginalized communities, have an active voice in shaping DHCS policies and programs. The DHCS MMAC will operate alongside existing advisory groups within the agency, such as the Stakeholder Advisory Committee. However, DHCS MMAC participants will all be Medi-Cal enrollees and caregivers of Medi-Cal enrollees.

To help inform the design of the MMAC, the California Health Care Foundation and DHCS commissioned the Center for Health Care Strategies to survey all 23 Medi-Cal managed care plans (MCPs) in the state to understand their practices, learn from their experiences, and identify promising approaches. This report presents findings from the 14 MCPs that responded to the survey. This survey is part of a larger effort to identify lessons and promising practices that could inform the design of the MMAC. A companion report, *Medi-Cal Member Advisory Committee: Design Recommendations for the California Department of Health Care Services*, presents results of a landscape assessment and literature review of the experiences of consumer advisory committees (CACs) in California and other states as well as design recommendations for the MMAC.

Historically, Medi-Cal MCPs are required to maintain a CAC to inform each plan's cultural and linguistic services program. Recently announced Medi-Cal managed care plan contracts for 2024 have sought to elevate the CAC by clarifying its role and member composition and prescribing the plan's role in providing support for CAC members to maximize participation. MCPs will be expected to make sure their CAC membership reflects that of the health plan and the county being served.

## Key Findings

Following is a summary of findings about CAC design based on insights from 14 MCP survey respondents:

- **Composition and size.** It is important to ensure the composition of CACs reflects the Medi-Cal population and that the groups are manageable in size. CAC members represent Medi-Cal enrollees from diverse backgrounds, locations, and experiences. CAC group sizes are between four and 185. CAC group size varies based on geographic region, county, and health plan.
- **Recruitment, onboarding, and term limits.** MCPs need a multipronged approach to effectively recruit Medi-Cal enrollees for participation in CACs. Plans reported using (1) direct outreach to enrollees and through providers and community partners, (2) presentations to community-based partners, (3) the member handbook, (4) Medi-Cal member newsletters and/or direct mailings, (5) the MCP website and social media, and (6) referrals by current CAC members. Fifty-seven percent of survey respondents institute term limits for CAC members, with one and two years being the most common. MCPs use various methods to onboard new CAC members, ranging in effort, scope, and resources. Members should be provided with clear information regarding the CAC's purpose; roles and responsibilities; what to expect before, during, and between meetings; a list of key terms; how the CAC will influence policy; how to reach the CAC contact; and other key details.
- **Compensation.** Participating members are entitled to fair compensation for their time and participation. All responding MCPs compensate participating CAC members. Stipend payments are the most popular (71%) method of compensation for Medi-Cal enrollees among the surveyed health plans, followed by travel/mileage reimbursement (50%), gift cards (43%), and meals (43%).

- **Meeting structure.** Consistency regarding meeting format, length, and cadence can go a long way in supporting members and accommodating their needs. Before the COVID-19 pandemic, all responding MCPs held in-person CAC meetings. CACs have since pivoted to virtual meetings only or a combination of in-person and virtual meetings. CAC meetings tend to occur on a quarterly (63%) or bimonthly (25%) basis for 90 (43%) or 120 (29%) minutes.
- **Meeting facilitation and support.** Meeting materials should be easy to understand, free from jargon and acronyms, written at a sixth-grade reading level to ensure readability, and translated into CAC members' primary languages. Of the responding MCPs, 86% share accessible meeting materials at least one week before the meeting, and 93% have staff available to discuss questions or concerns ahead of each meeting. MCPs' CACs use a variety of stakeholders as meeting facilitators, including internal staff, board members, committee chairs, community-based organization representatives, and CAC members. Meeting agenda topics are created by both staff and CAC participants to make sure items important to all parties are represented.
- **Building trust.** MCPs recognize that they must earn the trust of CAC participants, and there are numerous ways trust can be built right away and strengthened over time. MCPs relayed the importance of building meaningful relationships, setting ground rules, and valuing member voices as integral to their approach.

CACs benefit from customization and tailoring to the unique needs of the populations served. While this customization is beneficial to reflecting the preferences of CAC participants (on features such as meeting length and time of day), there are also opportunities for MCPs to learn from one another and adopt best practices (e.g., making sure members can speak at meetings in their preferred language, materials are written at appropriate reading level, etc.). Ultimately, these survey findings can help DHCS (1) increase awareness among MCPs, DHCS, and Medi-Cal stakeholders regarding MCP CAC practices; (2) add to stakeholders' understanding of promising practices highlighted in *Medi-Cal Member Advisory Committee: Design Recommendations for the California Department of Health Care Services*; and (3) inform DHCS's approach to setting expectations and providing oversight for MCP CAC activities.

Overall, the survey findings make it clear that most responding MCPs are committed to leading and sustaining meaningful CACs. Responses illustrate that MCPs understanding Medi-Cal enrollees is key to ensuring MCPs make patient-centered decisions around policy and procedures, and center their enrollees' unique perspectives and experiences. However, there are still elements of the CACs that could continue to be strengthened, including treating CAC members with respect and dignity, and focusing on recruiting diverse CAC members (e.g., rural populations, LGBTQIA+ communities, indigenous communities, people with intellectual/developmental disabilities, etc.). Going forward, MCPs should continue to challenge themselves in their recruitment strategies and invest staff time and resources into recruitment, facilitation, and CAC member support and compensation.

# Introduction

To help inform the design of the Department of Health Care Services (DHCS) Medi-Cal Member Advisory Committee, the Center for Health Care Strategies surveyed Medi-Cal managed care plans (MCPs) in the state to understand Medi-Cal MCP Consumer Advisory Councils. The survey was conducted between September and November 2022. The goals of the survey were to:

- Gather information about the MCPs' advisory groups with Medi-Cal enrollees
- Identify approaches, lessons learned, and promising/best practices
- Unearth potential unique needs of Medi-Cal members to consider when creating a DHCS Medi-Cal Member Advisory Committee (MMAC)

This work was supported by the California Health Care Foundation (CHCF) and is part of a larger effort to identify lessons and promising practices that could inform the design of the MMAC. A companion report, *Medi-Cal Member Advisory Committee: Design Recommendations for the California Department of Health Care Services*, presents results of a landscape assessment and literature review of the experiences of consumer advisory committees (CACs) in California and other states as well as design recommendations for the MMAC.

# Methods

## Questionnaire

The Center for Health Care Strategies (CHCS) developed the survey instrument with feedback from CHCF and DHCS regarding question content, wording, order, clarity, and other issues pertaining to questionnaire quality. The survey was fielded online in English using Survey Monkey. The survey included a mix of 27 qualitative and quantitative questions (see appendix).

## Data Collection

DHCS Director Michelle Baass emailed all 23 Medi-Cal MCPs asking them to complete the survey, and sent a second email to those that did not respond to the first request within six weeks. Only full-service MCPs that contract with DHCS received the survey. Special needs plans, Cal Medi-Connect plans, PACE plans, and special projects were not included.

MCPs received no incentive to complete the survey.

Survey responses were received from 14 of the 23 Medi-Cal MCPs. The average time to complete the web survey was one hour and 16 minutes per respondent.

The MCPs that completed the survey were:

- Aetna
- Anthem Blue Cross
- Blue Shield Promise Health Plan
- CalOptima Health
- CalViva Health
- CenCal Health
- Health Plan of San Joaquin
- Inland Empire Health Plan
- L.A. Care Health Plan
- Kaiser Foundation Health Plan – North Medi-Cal Operations
- Kaiser Foundation Health Plan – South Medi-Cal Operations
- Molina Healthcare of California
- Partnership HealthPlan of California
- San Francisco Health Plan

The MCPs that did not complete the survey were Alameda Alliance for Health, California Health and Wellness/HealthNet, Central California Alliance for Health, Community Health Group, Contra Costa Health Plan, Gold Coast Health Plan, Health Plan of San Mateo, Kern Family Health Care, and Santa Clara Family Health Plan. A few of these, however, participated in interviews and provided useful information that informed the larger effort to identify promising practices and lessons that could inform the design of the MMAC.

## Data Processing and Analysis

Before launching data collection, testing of the survey was completed to ensure it worked as expected. After the launch, survey data were carefully checked for accuracy, completeness, and nonresponse to specific questions so any issues could be identified and resolved. All respondents answered 100% of survey questions they received. CHCS conducted data analysis using Microsoft Excel, including creating constructed variables, running additional testing for statistical significance, and coding responses to open-ended questions.

# Findings

## Composition and Size

### Composition

Given the diversity of the 15 million Californians enrolled in Medi-Cal, it is important to ensure MCPs are as inclusive as possible and fully representative of the population. It is also important to make sure the CACs are manageable in size. Generally, the MCP CACs that responded to the survey have members from diverse backgrounds, locations, and experiences. The survey revealed that some MCPs do not ask participants to disclose information such as sexual orientation or incarceration status. So, it is difficult to determine whether specific groups, including many of those listed in Table 1, are sufficiently represented among the MCP CACs.

**Table 1. CAC Member Demographics of Surveyed MCPs (*n* = 14)**

| POPULATION | PERCENTAGE OF RESPONDING MCPS WITH KNOWN REPRESENTATION |
|---|---|
| **MEMBER RACE/ETHNICITY** | |
| African American or Black | 86% |
| Latino/a | 86% |
| Asian American | 57% |
| Pacific Islander | 29% |
| Tribal Nations | 14% |
| **ADDITIONAL MEMBER IDENTITIES/EXPERIENCES** | |
| Individuals with Disabilities (e.g., I/DD) | 93% |
| Individuals with Chronic Conditions | 86% |
| Guardians/Families with Children | 71% |
| Seniors | 71% |
| Geographic Representation | 64% |
| Individuals Experiencing Behavioral Health Issues | 64% |
| Guardians/Families/Caregivers with Children Who Have Special Health Care Needs | 57% |
| Individuals Experiencing Homelessness | 43% |
| LGBTQIA+ | 43% |
| Rural Residents | 43% |
| Teens/Youth | 36% |
| Formerly Incarcerated Individuals | 29% |
| Former Foster Youth | 14% |

Source: *Survey of Medi-Cal Managed Care Plans*, Center for Health Care Strategies, 2022.

### Size

Medi-Cal CAC size varies based on geographic region, county, and health plan. Responding MCPs recorded CAC group sizes between 4 and 185. The 14 responding MCPs did not share more details regarding structure and frequency that would enable a calculation of CAC size average. For example, one MCP shared that their 13 advisory councils included participation from 185 Medi-Cal enrollees but did not specify how these enrollees are distributed among their councils. Another plan recorded that CACs included five to eight members but varied by region. When managing group size, it is important for MCP CACs to find a balance between including as many enrollees as possible without creating an unmanageable group.

In addition to Medi-Cal enrollees, one responding MCP noted including providers and community-based organizations. These stakeholders are meant to act on behalf of enrollees but are not necessarily enrolled in Medi-Cal themselves. While diverse stakeholder input is an important consideration for MCPs seeking input, this CAC structure can present unique challenges and power dynamics that may limit Medi-Cal enrollees' ability to build trust and share honest, open feedback.

## Recruitment, Onboarding, and Term Limits

CAC recruitment is a critically important part of the process and is necessary for sustainability and keeping CAC composition representative of the Medi-Cal population. All 14 of the MCPs responding to the survey reported that every CAC member participates in an orientation/onboarding process to become acclimated to the group and to start off on a solid foundation. While some MCPs institute term limits, the length of the terms is not consistent across MCPs.

### Recruitment

MCPs need a multipronged approach to effectively recruit Medi-Cal enrollees for participation in their CACs. MCPs reported recruiting Medi-Cal enrollees for participation in their CACs in a variety of ways using staff from various areas within the organization to support recruitment, including those working within health education, case management, member services, and community engagement. Responding plans promote recruitment through:

- Direct outreach to members and through providers and community partners
- Presentations to community-based partners (e.g., *promotores* groups, community clinics, etc.)
- Member handbooks
- Medi-Cal member newsletters and/or direct mailings
- MCP websites and social media
- Referrals by current CAC members

### Onboarding

MCPs use various methods to onboard new CAC members, ranging in effort, scope, and resources. Onboarding may take place either before or during a member's first CAC meeting. Members should be provided with clear information regarding the CAC's purpose; roles and responsibilities; what to expect before, during, and between meetings; a list of key terms; how the CAC will influence policy; how to reach the CAC contact; and other key details. See Table 2 for examples of onboarding approaches.

**Table 2. Sample Onboarding Approaches**

| STRATEGY | EXAMPLES |
|---|---|
| Premeeting Orientation | ▸ CalViva Health's director of community relations, who oversees the CAC, sets up a phone call with each member and provides an informal orientation.<br>▸ Health Plan of San Joaquin schedules calls with the CAC coordinator to orient members to the CAC's purpose, participant expectations, and meeting frequency. |
| Orientation as a Part of CAC Meeting | ▸ At the beginning of each meeting, the Anthem Blue Cross CAC meeting facilitator reminds the attendees of the purpose of the CAC. |

Source: *Survey of Medi-Cal Managed Care Plans*, Center for Health Care Strategies, 2022.

### Term Limits

Eight of the 14 MCPs responding to the survey institute term limits for their CAC members. One- and two-year CAC term limits are the most common. CAC members can pursue more terms depending on the needs of the CAC and the health plan. There seems to be interest in exploring term limits further by MCPs who do not currently use them.

## Compensation

Participating members are entitled to fair compensation for their time and participation. All 14 MCPs that responded to the survey offer compensation for CAC members. Stipend payments are the most popular method of compensation for Medi-Cal enrollees among the surveyed health plans and vary in amount, as shown in Table 3. Stipends for CAC members range between $40 and $150. MCPs with stipends noted that this payment is often *in addition* to other forms of compensation, including mileage reimbursement, meals, and childcare. L.A. Care Health Plan shared that it is exploring an all-inclusive stipend that reduces the administrative burden of offering multiple types of reimbursement.

A limitation of the survey is that it did not account for differences between virtual and in-person meetings. Two MCPs noted that their members who joined by telephone received a smaller stipend than those who attended in person. Additionally, it is unclear from the survey whether MCPs that do not compensate for mileage, travel, food, or a combination of the three are holding meetings in a virtual or in-person format. Future analysis would benefit from stratifying compensation based on delivery method.

**Table 3. Types of CAC Compensation (*n* = 14)**

| TYPE OF COMPENSATION | PERCENTAGE |
|---|---|
| Stipends | 71% |
| Travel/Mileage Reimbursement | 50% |
| Gift Card | 43% |
| Meals | 43% |

Source: *Survey of Medi-Cal Managed Care Plans*, Center for Health Care Strategies, 2022.

## Meeting Structure

### Format

As possible, consistency regarding meeting format, length, and cadence can go a long way in supporting members and accommodating their needs. Before the COVID-19 pandemic, all responding MCPs held CAC sessions in person. CACs have since pivoted to virtual meetings only or to a combination of in-person and virtual meetings. At least one MCP still structures in-person meetings to enable virtual participation for those unable to join in person. If the meeting is virtual, two health plans shared that they reduce the meeting time by 30 minutes

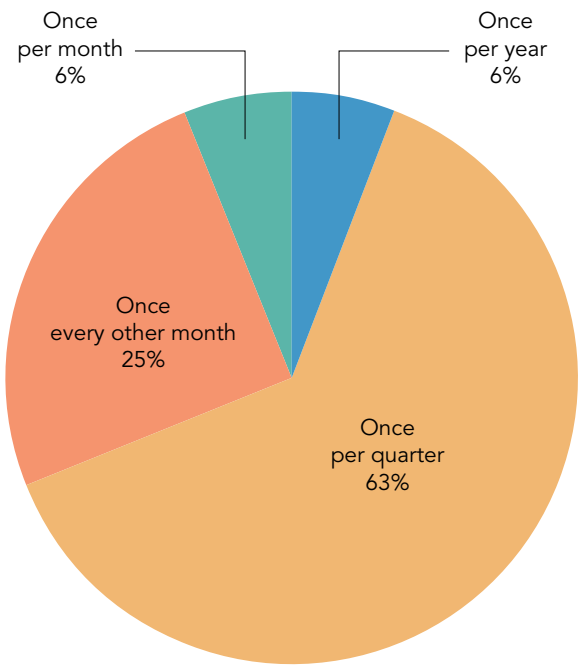
to accommodate virtual fatigue. Respondents also indicated that participating CAC members appreciate the opportunity to meet virtually but note the value of in-person meetings for building and strengthening relationships among the group.

In its response, one plan noted the unique challenges presented by the virtual delivery method, sharing that while virtual meetings may offer enhanced flexibility, especially amid COVID-19, the virtual setting presents barriers for participants who do not have access to Wi-Fi.

## Frequency

Overwhelmingly, MCPs reported a preference for holding CAC meetings quarterly, as shown in Figure 1. However, some MCPs noted that subsets and combined groups may hold meetings less frequently. For example, one MCP reported that it has three CACs that include Medi-Cal members and that these groups meet at different frequencies ranging from bimonthly to yearly. It is unclear, however, the extent of overlap among recorded group frequencies.

**Figure 1. Frequency of CAC Meetings Reported by MCPs Surveyed (*n* = 16)**




Note: Two plans reported frequencies for two meetings.

Source: *Survey of Medi-Cal Managed Care Plans*, Center for Health Care Strategies, 2022.

### Duration

About 43% of CAC meetings for the MCPs surveyed are 90 minutes long, as shown in Table 4. L.A. Care Health Plan reported holding the longest CAC meetings at two and a half hours.

**Table 4. CAC Meeting Duration (*n* = 14)**

| MEETING LENGTH | PERCENTAGE |
|---|---|
| 60 min | 21% |
| 90 min | 43% |
| 120 min | 29% |
| 2.5 hours | 7% |

Source: *Survey of Medi-Cal Managed Care Plans*, Center for Health Care Strategies, 2022.

### Time of Day

CAC meetings are held primarily during the lunch hour (64%), but mornings (21%) and afternoons (29%) are fairly common. Scheduling is influenced by CAC member preference. Only one MCP (L.A. Care Health Plan) holds meetings in the evening.

## Meeting Facilitation and Support

### Meeting Materials

Meeting materials should be easy to understand, free from jargon and acronyms, written at a sixth-grade reading level to ensure readability, and translated into CAC members' primary languages. The following are approaches of the surveyed MCPs to preparing and distributing CAC meeting materials to Medi-Cal members:

- 93% of the 14 MCPs responding to the survey share materials and invite CAC members to ask questions via phone or email ahead of the meeting.
- 86% share materials before the meeting to allow ample prep time for CAC members.
- 57% confirmed that materials are written at no more than a sixth-grade level.
- 50% translate materials into members' native language before dissemination.
- Blue Shield Promise Health Plan highlighted the value of prep meetings with members once materials are shared as a strategy to increase attendance and engagement during CAC meetings.

### Language Supports and Accommodations

Surveyed MCPs offered a robust set of supports for participating CAC members. These accommodations are typically implemented by request of the CAC member and include:

- Real-time language translation (93%)
- American Sign Language interpretation (57%)
- Translated meeting materials (57%)
- Opportunities for members to speak their preferred language (57%)
- Closed captioning (50%)

While this survey did not probe on accommodations outside of language supports, Partnership HealthPlan of California shared that they record CAC meetings for a member with a disability that prevents the member from taking traditional notes.

### Facilitation

Strong meeting facilitation is vital for effective meetings. CACs use a variety of stakeholders to facilitate the meetings, including internal staff, board members, committee chairs, community-based organization representatives, and CAC members. The meeting agenda is driven by both staff and CAC participants to make sure items important to all parties are represented.

- Health Plan of San Joaquin uses a template to develop its CAC meeting agendas. The agenda template includes at least one relevant public health/community topic, one presentation from the MCP, and one conversation with a community partner on a topic that members have requested.
- Anthem Blue Cross has a designated County Account Management Team responsible for overseeing all CAC activities including recruiting members, developing meeting agendas, and recording meeting notes. The County Account Management Team member is responsible for obtaining information updates from internal Anthem Medi-Cal teams to add to the meeting agenda. Also, CAC members are asked for topics of interest they would like to learn more about or if there is a particular community-based organization they would like to have present.
- CAC meetings for Blue Shield Promise Health Plan are cochaired by a community-based representative and health plan representative. Health plan representatives, and the CAC itself, provide input on the agenda.

## Building Trust

To support active participation, CAC members need to feel safe and supported. CAC members may be somewhat distrustful of health plans and could have significant trauma and frustration, making them wary to participate. MCPs recognize that trust needs to be earned, and there are numerous ways trust can be built right away and continue to strengthen. When asked to name strategies that are key to these efforts, MCPs relayed the importance of building meaningful relationships, setting ground rules, and valuing member voice.

- For example, a staff member from the Partnership HealthPlan of California meets with CAC members individually, noting that it is important to invest time to get to know CAC members as individuals so their needs can be better supported. The MCP works to ensure everyone on the CAC has a voice, feels heard, and all comments are acknowledged. Also, Partnership aims to develop agendas that cover topics relevant to the needs of CAC members, showing an understanding of the CAC members' priorities and interests.
- L.A. Care Health Plan uses ground rules that ensure confidentiality within meetings to support honest dialogue.
- Molina Healthcare regularly reminds CAC members they are important and valued. Key people from various departments attend meetings to show CAC members that all teams are committed to listening and helping with the needs of the Medi-Cal population.
- Anthem Blue Cross highlighted accessible meetings as a key element for building and sustaining a safe and trusting environment. This means making sure meeting facilities and materials are accessible to all CAC members, including those with a disability or limited English proficiency. Their approach includes:
  - Providing language interpreters on-site and virtually
  - Making meeting materials (paper and electronic) available in any language or alternative formats as requested before the meeting
  - Arranging and paying for transportation
  - Offering childcare support via financial reimbursement or on-site childcare
  - Holding meetings face-to-face with virtual participation options
  - Arranging convenient meeting dates and times

## Feedback Loop

Clear and consistent communication with CAC members is important to build trust. MCPs use a variety of approaches to communicate with Medi-Cal CAC members on how their input in being used. Responding MCPs reported that this information is shared before, during, and after CAC meetings. For example:

- At the beginning of each meeting, Blue Shield Promise Health Plan reviews action items, what is in progress, and what has been implemented since the last meeting.
- San Francisco Health Plan follows up with members between meetings via email and phone, both individually and as a group, to discuss how input is being used.
- Inland Empire Health Plan emphasized the importance of being up front regarding feedback. Meeting speakers often start their presentations explaining how they use member feedback. This helps set the meeting tone and gives participants the confidence to fully express their opinions.

## Meeting Debriefs

Following up after meetings in a timely and responsive way shows CAC members that their feedback is important. Debrief methods vary across MCPs and may include post-meeting surveys, ad hoc support, and scheduled phone or email follow-up. See Table 5 for examples from responding MCPs.

**Table 5. Examples of Meeting Debrief Strategies**

| STRATEGY | EXAMPLES |
|---|---|
| Surveys | ▸ The Blue Shield Promise Health Plan distributes a survey following each CAC meeting to ask follow-up questions, gather feedback, and address any member concerns. |
| Ad Hoc Support | ▸ Inland Empire Health Plan's CAC has a dedicated contact that members may reach out to regarding their participation, including any meeting follow-up.<br>▸ Following a meeting, CalViva Health CAC members will receive communications if there are questions that could not be answered in the meeting. |
| Structured Support | ▸ CenCal Health's staff will proactively check in with CAC members to see if there are questions and concerns before and after the meeting.<br>▸ Partnership HealthPlan of California debriefs with CAC members through at least one phone and/or email communication between meetings. |

Source: *Survey of Medi-Cal Managed Care Plans*, Center for Health Care Strategies, 2022.

# Conclusion

This survey of Medi-Cal MCPs finds that while there are similarities among MCPs' approaches to their CACs, there is also wide variation across several dimensions including composition and size, logistics and accessibility, meeting facilitation requirements, trust building, language considerations, member preparation and support, and compensation and other forms of support. At their core, CACs benefit from customization and tailoring to the unique needs of the populations served. While this customization helps to reflect the preferences of CAC participants (on features such as meeting length and time of day), there are also opportunities for MCPs to learn from one another and adopt best practices (e.g., making sure members can speak in their preferred language, materials are written at appropriate reading level, etc.). Ultimately, these survey findings can help DHCS (1) increase awareness among MCPs, DHCS, and Medi-Cal stakeholders regarding MCP CAC practices; (2) add to stakeholders' understanding of promising practices highlighted in *Medi-Cal Member Advisory Committee: Design Recommendations for the California Department of Health Care Services*; and (3) inform DHCS's approach to setting expectations and providing oversight for MCP CAC activities.

Overall, the survey findings make it clear that most responding MCPs are committed to leading and sustaining meaningful CACs. Responses illustrate that MCPs understand Medi-Cal enrollees are key to ensuring that MCPs make patient-centered decisions around policy and procedures, and centers their unique perspectives and experiences. However, there are still elements of the CACs that could continue to be strengthened, including treating CAC members with respect and dignity, and focusing on recruiting diverse CAC members (e.g., rural populations, people with intellectual/developmental disabilities, LGBTQIA+ people, indigenous communities, etc.). Going forward, MCPs should continue to challenge themselves in their recruitment strategies, and invest staff time and resources into recruitment, facilitation, and CAC member support and compensation.

## Appendix. DHCS Medi-Cal Consumer Advisory Committee Design Survey

The California Department of Health Care Services (DHCS) is deeply committed to strengthening approaches to engage Medi-Cal members and people with lived experience to drive policy change. To that end, the agency has identified the need for a DHCS Consumer Advisory Committee (CAC) to be led by DHCS, and is aiming to convene its first meeting by the end of 2022. The Center for Health Care Strategies (CHCS) received support from the California Health Care Foundation to support DHCS in conducting research and developing a proposed design for a DHCS CAC of Medi-Cal members.

As part of the research and design phase of the project, CHCS is surveying all Medi-Cal managed care plans (MCPs) to gather information about their advisory groups with Medi-Cal consumers; to identify approaches, lessons learned, and promising/best practices; and to expose their efforts toward greater transparency.

The below survey notes and terminology were shared as a part of the survey effort to increase participation and standardize terminology across responding plans.

### Survey Notes

| | |
|---|---|
| Audience | MCP staff who coordinate advisory groups with Medi-Cal consumers. |
| Contact Information | Individual survey responses are confidential; responses will be reported in the aggregate. If you are willing to participate in an interview to provide more detail and/or clarification, please provide your contact information. |
| Completion Time | 10–15 minutes |

### Survey Terminology

| | |
|---|---|
| Community Engagement | Integrating Medi-Cal members and other people with lived experience and expertise of navigating public benefit programs, like Medi-Cal, into all aspects of state agencies to shape and drive policy change. |
| DHCS Consumer Advisory Committee* | To date, DHCS has done well integrating advocates into its stakeholder process but now would like to focus more intentionally on Medi-Cal member voices. Thus, DHCS plans to launch a CAC made up of diverse Medi-Cal members from across the state who will advise on DHCS policy and programs. The CAC will focus on the priorities cited by the members and will coordinate and inform existing groups such as the current Stakeholder Advisory Committee. |
| Medi-Cal Consumer Advisory Committee | MCPs are required to have a diverse CAC to implement and maintain community partnerships with stakeholders, including Medi-Cal members. Duties of a CAC include providing feedback on culturally appropriate services or program design, priorities for health education and outreach programs, member satisfaction survey results, findings on health education and cultural linguistic needs, health plan marketing materials and campaigns, and community resources and information. MCPs may operate their Medi-Cal CAC under different names. |

* The DHCS CAC has since been renamed the DHCS Medi-Cal Member Advisory Committee.

**The following questions focus on how MCPs organize, structure, and operate Medi-Cal member Consumer Advisory Councils.**

**1.** Please enter your contact information (name, organization, email address, phone number).

**2.** How many of your organization's advisory councils include Medi-Cal members?

- **a.** 1
- **b.** 2
- **c.** 3
- **d.** 4
- **e.** 5
- **f.** Other (please specify)

**3.** How many members make up your Medi-Cal enrollee CAC? *(open-ended)*

**4.** What groups/populations are represented in your Medi-Cal enrollee CAC?

- **a.** Tribal nations
- **b.** African American/Black
- **c.** Asian American
- **d.** Pacific Islander
- **e.** LGBTQIA+
- **f.** Latinx
- **g.** Seniors
- **h.** Guardians/families with children
- **i.** Guardians/families with children who have special health care needs
- **j.** Individuals with disabilities (e.g., I/DD)
- **k.** Individuals with chronic conditions
- **l.** Individuals experiencing homelessness
- **m.** Teens/youth
- **n.** Former foster youth
- **o.** Formerly incarcerated individuals
- **p.** Rural residents
- **q.** Geographic representation
- **r.** Other (please specify)

**5.** How does your organization recruit Medi-Cal enrollees to join the Medi-Cal CAC? *(open-ended)*

**6.** How does your organization onboard Medi-Cal enrollees to fully participate in the Medi-Cal CAC (e.g., orientation, assigning a mentor, etc.)? *(open-ended)*

**7.** Are Medi-Cal CAC members subjected to any term limits? If so, how long is a term?

- **a.** Yes; 1 year
- **b.** Yes; 2 years
- **c.** Yes; 3 years
- **d.** Yes; 4 years
- **e.** No
- **f.** Other (please specify)

**8.** How many times does your Medi-Cal member CAC meet per calendar year?

- **a.** Once per year
- **b.** Twice per year
- **c.** Once per quarter
- **d.** Once per month
- **e.** Other (please specify)

**9.** How long are your Medi-Cal CAC meetings?

- **a.** 30 min
- **b.** 60 min
- **c.** 90 min
- **d.** 120 min
- **e.** Other (please specify)

**10.** Who facilitates and drives the agenda for your organization's Medi-Cal CAC meetings?

- **a.** Medi-Cal enrollees
- **b.** Internal staff
- **c.** External facilitators / outside organization
- **d.** Other (please specify)

**11.** Do your Medi-Cal members meet virtually, in-person, or a combination of both?

- **a.** Virtual (e.g., Zoom, WebEx, etc.)
- **b.** In person
- **c.** A combination of both
- **d.** Other (please specify)

**12.** What time of day are Medi-Cal CAC meetings held?

- **a.** Early morning (before work hours)
- **b.** Morning
- **c.** Noon/lunchtime
- **d.** Afternoon
- **e.** Late afternoon (post work hours)
- **f.** Late evening (post work hours)
- **g.** Weekend
- **h.** Other (please specify)

**13.** What language-related meeting supports do you offer for Medi-Cal enrollees during CAC meetings?

- **a.** Real-time language interpretation
- **b.** American Sign Language interpretation
- **c.** Translated meeting materials
- **d.** Closed captioning
- **e.** Opportunities for members to speak in their native language
- **f.** Other (please specify)

**14.** How do you, if at all, compensate Medi-Cal enrollees for their CAC participation?

- **a.** Gift cards
- **b.** Stipends (checks)
- **c.** Travel/mileage reimbursement
- **d.** Meals
- **e.** Other (please specify)

**15.** If your answer included "stipends" in the previous question, can you please elaborate on what this stipend entails? For example, is there a standard monetary compensation amount for Medi-Cal enrollees? How was this amount chosen? Why? *(open-ended)*

**16.** How does your organization prep and disseminate CAC meeting materials to Medi-Cal members?

- **a.** Materials are shared in advance of the meeting to allow ample prep time for CAC members.
- **b.** Materials are translated into members' native language prior to dissemination.
- **c.** Materials are written at no more than the sixth-grade level.
- **d.** Members have the opportunity to speak with staff ahead of the meeting to further orient themselves to the materials.
- **e.** Other (please specify).

**17.** How does your organization debrief with Medi-Cal members between/following CAC meetings? *(open-ended)*

**18.** From your experience operating CACs with Medi-Cal enrollees, what would you identify as the most important lessons your organization has learned? *(open-ended)*

**19.** How does your organization communicate with its Medi-Cal members on how their input is being used? *(open-ended)*

**20.** What has been most important for you to consider in designing your Medi-Cal CAC that ensures participants feel safe and supported?

**21.** Is there a Medi-Cal CAC policy or practice of yours that has been shaped by consumer input that you would want to highlight?

**The following questions ask for recommendations on how DHCS should design, structure, and operate its Medi-Cal CAC.**

**22.** Are there design considerations unique to Medi-Cal that DHCS should consider? *(open-ended)*

**23.** How would you define a strong and effective Medi-Cal Consumer Advisory Committee? What strategies seem to work well? *(open-ended)*

**24.** What types of challenges most negatively impact the effectiveness of a Medi-Cal Consumer Advisory Committee? What strategies haven't worked? *(open-ended)*

**25.** Do you have consumer contacts (e.g., Medi-Cal members participating on a CAC) that you would recommend DHCS consider for its Consumer Advisory Council? If you select yes, we will follow up with you via email. Thank you.

- **a.** Yes
- **b.** No
- **c.** Other (please specify)

**26.** Do you have any other comments, thoughts, and/or recommendations? *(open-ended)*

Are there any documents or resources (e.g., application, Charter, written meeting procedures, written CAC member roles/responsibilities, etc.) that you'd like to share at this time? *(option to attach files)*