Medicaid and health equity

The Medicaid program and its role in advancing health equity through consumer engagement

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Introduction

Consumer engagement is a critical strategy for identifying health system challenges and opportunities, advancing more equitable health policies, and helping to build trust between consumers of health care and those delivering or managing that care.[1] Medicaid is now the single largest source of public health insurance in the United States, covering 72 million children, older adults, people with disabilities, and low-income populations. Those accessing their health care coverage through the Medicaid program are the most affected by policy and programmatic changes and therefore have the most significant expertise on how specific policies could impact and have impacted them and their communities.

Given the importance of the Medicaid program in supporting the health care of millions of individuals, UnitedHealthcare Community and State, in partnership with its independent National Health Equity Advisory Board (Board), chose to examine how meaningful consumer engagement is a critical pathway for advancing health equity in the Medicaid program.

For purposes of this paper, consumer means a Medicaid eligible individual served by an MCO.

Consumers' families and community stakeholders that interact with consumers may be counted by some as engaging consumers. While engaging these groups may involve overlapping strategies, they are not the same.

57 million
Medicaid consumers (72%) receive their care through risk-based manage care organizations (MCOs)

5.2 million
Individuals eligible for Medicare and Medicaid are enrolled in Dual-Eligible Special Needs Plans (D-SNPs)

In light of these statistics, it is important to focus on the ways in which health plans specifically can support and advance engagement of the members they serve. However, consumer engagement by Medicaid health plans does not exist in a vacuum. State Medicaid agencies, public health organizations, and many others are seeking to learn from, engage with, and respond to consumers. While well intentioned, without thoughtful design and coordination, these engagement efforts can fall flat, and worse, further disenfranchise individuals who already experience lack of trust in the system.

The paper begins by exploring different definitions of consumer engagement. From there, we examine current regulations around consumer engagement specifically related to those served by the Medicaid program, share insights from the UnitedHealthcare current consumer engagement journey, and discuss opportunities for policy and practice reform that help move from current state to a more ideal consumer engagement approach in Medicaid.

The recommendations included in the paper were written with health plans, state Medicaid agencies, and other stakeholders that influence Medicaid policy and program design in mind.

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[1] Engaging Consumers in Medicaid Program Design: Strategies from the States - PMC (nih.gov)

Defining consumer engagement

The federal regulator of the Medicaid program, the Centers for Medicare and Medicaid Services (CMS), defines consumer engagement as: "patients and families [being] partners in defining, designing, participating in and assessing the care practices and systems that serve them to assure they are respectful of and responsive to individual patient preferences, needs, and values. This collaborative engagement allows patient values to guide all clinical decisions and drives genuine transformation in attitudes, behavior, and practice."[2]

Community Catalyst, a national non-profit advocacy organization, refers to consumer engagement in health care as "a term of art used to describe anything from reaching people through mobile apps [to] involving stakeholders in advisory groups to inform new program development."[3] They go on to describe three levels of consumer engagement in the health care eco-system[4]:

Policy — When an individual(s) engages during the federal or state level policymaking process

Organizational — When an individual engages with a health plan or other health system stakeholder

Individual — When an individual makes a decision about their own health care

The organization notes that the term has many supporters, but its definition and application are not entirely clear or standard across the health care system.

At UnitedHealthcare, we currently define member (or consumer) engagement as any touchpoint or interaction that a member has throughout the entire arc of their enrollment experience with the health plan. With our work with the Board, we are reevaluating how the business measures and defines member engagement to better reflect the difference between engagement, outreach, and education.

Through its support from the Robert Wood Johnson Foundation, State Health & Value Strategies (SHVS), and Health Equity Solutions, note that engagement of community (or consumers) can range from transactional to transformational.

• **Transactional engagement –** characterized by narrow engagement or single interactions, seeking input on a near-final product or a discrete set of questions, and results that are superficial or only involve technical changes, changes that exacerbate inequities, or no change at all. It is characterized more as a 'check the box' exercise.

• **Transformational engagement –** the more ideal state involving sustained engagement, results that involve policy, practice, or culture changes, and includes transparency and feedback loops to ensure understanding of how or if input provided was incorporated and why.[5]

[2] Person-and-Family-Engagement-Strategy-Summary.pdf (cms.gov)
[3] Consumer Engagement: A Call for Tools that Measure Organizational and Policy Level Engagement - Community Catalyst
[4] Consumer Engagement: A Call for Tools that Measure Organizational and Policy Level Engagement - Community Catalyst
[5] SHVS_Transformational-Community-Engagement-to-Advance-Health-Equity.pdf

In order to move from consumer engagement being defined and operationalized as an individual exercise involving discrete engagements to a more ideal, and ultimately more impactful construct, which helps to shift policies and business practices, it is important to understand the regulations and contractual frameworks driving consumer engagement in the Medicaid program. The following section details examples of mandatory and voluntary consumer engagement-related regulations and contract requirements specific to actions required of health plans.

Consumer engagement – regulatory and contractual environment

To begin to explore how engagement of Medicaid and D-SNP consumers can be improved upon to move from transactional to transformational, an understanding of the current regulatory landscape that governs consumer engagement standards for Medicaid MCOs is helpful. Appendix B details consumer engagement regulations specifically relevant to MCOs and state Medicaid agencies, which though not the primary focus of this paper, are also useful to be aware of when considering alternative approaches for supporting more authentic and actionable consumer engagement.

Below is a snapshot of the content in Appendix B, which illustrates the layers of engagement requirements that exist today. Most of these regulations around consumer engagement for health plans are broad and more transactional in their focus—discrete committees and surveys—versus focusing on flexible, sustained engagement that supports a more transformational impact.

State Medicaid Agency Requirement	MCO Requirement (Federal)	MCO Requirement (State Contract)
• Medicaid Advisory Committee (MAC) • Beneficiary Advisory Council (BAC)	• Enrollee Advisory Committee • Long-Term Services and Supports (LTSS) Member Advisory Committee • Medicare Advantage STAR ratings – CAHPS focus	• Member Advisory Committee (MAC) • Governance Committee • National Committee for Quality Assurance (NCQA) Accreditation • Culturally and Linguistically Appropriate Standards (CLAS)

The comprehensive example of engagement requirements that begin to establish a deeper bi-directional engagement is found as part of the National Committee for Quality Assurance (NCQA) Health Equity Accreditation process.

National Committee for Quality Assurance (NCQA) Accreditation

In health care, accreditation is an official, external review process that allows organizations, like MCOs, to demonstrate their ability to meet regulatory requirements and standards.[6] [1] The National Committee for Quality Assurance (NCQA) is a not-for-profit organization, established in 1990, tasked with managing accreditation programs for individual physicians, health plans, and medical groups. The Health Plan Accreditation is based on standards related to quality management and improvement, population health management, network management, and member experience. It measures and ranks accreditation performance of health plans through the administration and submission of the Healthcare Effectiveness Data and Information Set (HEDIS) and the CAHPS survey. Twenty-six states require Medicaid health plans to obtain NCQA Health Plan accreditation to operate in their state.[7]

NCQA also has other accreditation programs such as the Health Equity Accreditation and the Health Equity Accreditation Plus programs. For a health plan to gain one of the NCQA health equity accreditation designations, they must demonstrate how they are engaging members and incorporating their feedback on possible solutions and interventions to improve member health. The two programs build on each other with the Plus program placing greater emphasis on structured process requirements. One of the factors needed to earn Health Equity Accreditation Plus designation is communicating the health plan's actions that resulted from stakeholder feedback back to consumers.

12 states
Currently, 12 states require Health Equity Accreditation

2 states
Only Georgia and Kansas require Medicaid health plans to earn Health Equity Accreditation Plus designations

There are additional dynamics that health plans and other stakeholders will have to overcome to advance consumer engagement in the Medicaid program to move from current state to a more impactful, ideal state.

- **Lack of trust –** There is a prevalence of mistrust for many consumers served by the health care system, including Medicaid. Demonstrating the trustworthiness of the system takes time and requires actions to help consumers feel comfortable to engage and share their experiences with both state Medicaid agencies and health plans.

- **Life commitments –** Many consumers may want to be engaged, but other factors, such as unstable living conditions or childcare, are concerns and priorities that take precedence.

- **Complexity of Medicaid program design –** States decide which services to carve in and out of MCO contracts, which may lead to member confusion on which services a consumer should engage their health plan on and the impact their engagement may have in shifting policies and practices.

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[6] Impact of accreditation on quality in healthcare (powerdms.com)
[1] Impact of accreditation on quality in healthcare (powerdms.com)
[7] States Using NCQA Programs

UnitedHealthcare consumer engagement focus

At UnitedHealthcare, we have historically defined member (or consumer) engagement as any touchpoint or interaction that a member has throughout the entire arc of their enrollment and care experience with the health plan. In so doing, we have sought to put the consumer at the center of the work we do every day. We have embraced human-centered design principles and moved to consider every interaction with the members we serve as an opportunity to learn, improve, and connect.

In assessing our own consumer engagement approach, we started first with capturing the various pathways by which we communicated, engaged, and/or gathered a member's care experience. At UnitedHealthcare, as is true in many health plans, we conduct outreach to members regularly. We disseminate information about available services and benefits and/or collect data about their experience through member advisory committees, national and member surveys, and the health plan accreditation process. Health plans may also collect data on consumer engagement through standard health plan operations, including the appeals and grievances process.

These outreach activities are part of our strategic member engagement and communications strategy and contribute to consumers' understanding of their health coverage and improving health plan operations. However, these various engagement pathways are largely characterized by single interactions and point in time capture of information. The information collected ensures a broad sampling of members from across our plans has opportunity to provide feedback with relatively low barriers to engagement.

> While all of these are helpful data points that can be used to inform areas of focus and opportunity, our leadership teams have sought to enhance our approach to consumer engagement. As such, we have begun a journey toward more transformative engagement.

To date, UnitedHealthcare has taken the following steps to deepen our engagement:

- **Training** leaders on consumer insights and best practices
- **Identifying** opportunities to understand consumer preferences and needs from the outset of their engagement with our health plans
- Advancing our consumer feedback and insight pathways including our member **advisory** committees
- **Implementing** a community of practice through the establishment of a market-based member advisory committee playbook
- **Exploring** new strategies to support consumer engagement

Health plan highlight: UnitedHealthcare Community Plan of Wisconsin

The UnitedHealthcare Community Plan of Wisconsin has prioritized consumer engagement and sought to diversify the engagement they have with their members. They have turned point in time feedback into bi-directional engagement, used data to inform community collaborations, and made continued refinements to their MACs.

Consumer experience collection pathways within a Medicaid MCO and D-SNP*

National Committee for Quality Assurance (NCQA) Accreditation	Culturally and Linguistically Appropriate Services (CLAS)	Net Promoter Score (NPS)	Operations Data	Medicare Advantage STAR Ratings**
Healthcare Effectiveness Data and Information Set (HEDIS)	Member Advisory Committees (MACs)	Member Verbatims	Enrollee Advisory Committees (EAC)**	HEDIS
The Consumer Assessment of Healthcare Providers and Systems (CAHPS)	CAHPS	Closed Loop Process	Complaints to Medicare**	HOS
	Language Lines	Member Call Centers	Appeals and Grievances	CAHPS
	Medicaid Performance Improvement Plans (PIPs)		Disenrollment	Operations Data

During the Net Promoter Score (NPS) survey process, UnitedHealthcare members can indicate if they would like a UnitedHealthcare representative to reach out to them. These "closed loop calls" give UnitedHealthcare the opportunity to learn more about what the member may have detailed in their member verbatim, close gaps in care, and identify areas of opportunity to improve the plan's operations. A similar survey process is used when members call into our member call center for assistance. The UnitedHealthcare Community Plan of Wisconsin implemented a Wisconsin customer experience forum for all staff to increase awareness and understanding of member experience, its measurement tools, metrics, and priorities, and to cultivate ownership. In addition, an Exceptional Member Experience Workgroup reviews monthly feedback from a variety of surveys and platforms to analyze any trends.

The health plan has also expanded its approach to engaging members through the creation of their Member and Community Advisory Board (MCAB). Comprised of members and community-based organizations from across the state, MCAB members are provided information on a number of topics including but not limited to Medicaid benefits, health plan operations, and clinical innovations. Questions and items for improvement derived from MCAB meetings are socialized across the health plan and the broader organization to either inform or to create solutions. At future MCAB meetings, health plan staff will provide updates about the progress being made on their feedback. This ensures accountability and demonstrates continuous process improvement.

*The shaded boxes indicate pathways where health plans collect consumer experience data.
**Pathway is specific to a D-SNP.

Opportunities to move from transactional to transformational consumer engagement

Transforming the Medicaid program's approach to consumer engagement to one that creates sustainable relationships and changes to policies and practices requires time, commitment, and action at all levels of the health care ecosystem. The following recommendations serve both as potential modifications to current federal and state regulations and contractual requirements related to health plan consumer engagement as well as considerations as policymakers and key stakeholders work to support more authentic, effective, and actionable consumer engagement.

Fostering trust

Strategies to build trust will have to consider how power dynamics play a role in how comfortable consumers are sharing their experiences in spaces with state and health plan leadership. Below are policy, program design, and practice recommendations that can help build trust to advance meaningful consumer engagement.

Partner with outside organizations – Partnering with organizations that already have the community's trust can help make members more comfortable sharing their feedback. These entities should be from the primary communities and/or populations served by the health plan and be trained to use affirming and trauma-informed language free of industry jargon and bias. Additionally, consultants and community-based organizations (CBOs) can help when some topics may benefit from separate sessions to target affected audience members, such as LGBTQ+ groups, caregivers, LTSS members, immigrant/refugee populations, and others.

- **Specific recommendation –** Health plans should consider the expertise of outside, independent consultants and/or CBOs to facilitate consumer engagement activities such as leading MAC meetings.
- **Specific recommendation –** NCQA should consider publishing guidance on how health plans can partner with CBOs for recruitment and facilitation of their MACs while still meeting the delegation requirements for accreditation.

Allow flexible touchpoints for consumer engagement – Some states only require health plans to meet with their MACs annually and/or mandate that they recruit and meet with a different group of members for each MAC meeting. This impacts the ability to build trust and ultimately relationships that do not feel transactional with members, establish an ongoing dialogue with members, and set up a feedback loop to follow up with how members' input is utilized.

- **Specific recommendation –** States should support health plans in establishing a standing committee with members, support multi-year engagement of consumers on individual health plan MACs, and ensure that they do not put limiting criteria around how frequently health plans can convene their MACs.
- **Specific recommendation –** States should allow health plans to adjust modalities by which consumers are engaged in MACs. Telephonic, virtual, and in-person meetings have benefits and drawbacks when engaging consumers and need to be weighed with the local engagement preferences and experience of health plans.

Provide stipends to consumers for their time – In the Medicaid and CHIP Payment and Access Commission's (MACPAC's) March 2024 Report to Congress, the Commission highlighted that consumers often cite the lack of compensation and lost income from taking time off work as barriers to participation in state level MCACs. The Commission also noted that other experts are often compensated for providing their expertise and that consumers, who are experts in their lived experience, should be treated similarly. The same barriers and needed adjustments exist for health plan MAC meetings.

- **Specific recommendation –** Health plans and other stakeholders should advocate for states to change their regulations to allow health plans to provide stipends to members for participating in MACs, if their state currently does not allow for such support. We encourage the state to establish guardrails or consistent processes to ensure that processes and reimbursement is consistent across plans.

MACPAC also highlighted that some consumers do not use the offered financial arrangements because they fear that it might affect their Medicaid eligibility or status with other entitlement programs.

- **Specific recommendation –** CMS should consider further guidance on how states and health plans can offer financial support for engagement activities without affecting members' eligibility.

Resource consumer engagement activities – As noted in Community Catalyst's 2020 Meaningful Engagement Toolkit, transformational engagement "requires a team that is funded by a dedicated budget and comprised of individuals with skills and experience who are devoted to the process of facilitating ongoing, open, and honest exchanges with members, caregivers and the community" outside of the annually or quarterly MAC meetings."

- **Specific recommendation –** Since meaningful consumer engagement is resource intensive, states should consider any consumer engagement requirements within the context of the administrative requirements and funding for the program. Additionally, states should support consumer engagement efforts focused on targeted quality improvement goals as an allowable expense in the numerator of the medical loss ratio calculation. Discerning community and member experience, feedback, and barriers that need targeted improvement should consistently be treated as part of a quality improvement program.

Ensure consumer representation on NCQA advisory council – NCQA's accreditation standards guide health plan operations. NCQA's Consumer Advisory Council includes representatives from consumer organizations, but no individual consumers.

- **Specific recommendation –** NCQA should prioritize individual consumer representation on the Consumer Advisory Council, along with consumer representative organizations, to ensure that the current measures are capturing both important clinical measures and also the direct concerns of consumers.

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[8] https://www.macpac.gov/wp-content/uploads/2024/03/Chapter-1-Engaging-Beneficiaries-through-Medical-Care-Advisory-Committees-to-Inform-Medicaid-Policymaking.pdf
[9] https://nhchc.org/wp-content/uploads/2020/01/Community-Catalyst-Consumer-Engagement.pdf

Support member self-advocacy education – A majority of the CAHPS survey measures are directly impacted by the member experience in a provider's office. This provides health plans with the opportunity to learn about members' interactions with providers and provide guidance on how to effectively advocate for their needs in a health care setting. Consistently creating opportunities and venues for members' voices to be heard and feedback loops that demonstrate those consumer voices are valued not only improves health plan performance but may also contribute to a member's confidence and comfort engaging with any health care system stakeholder.

- **Specific recommendation –** Health plans should make available at all MAC meetings a range of high-quality advocacy resources to bolster individuals' self-advocacy and aide in general health literary.

Utilizing data

Every health plan is at a different stage of advancing consumer engagement. Some health plans could be collecting consumer experience data, but not using it to inform their consumer engagement strategy. Some D-SNPs had a robust consumer engagement committee before CMS required each D-SNP to establish an EAC, while others implemented one for the first-time last year. Below are policy, program design, and practice recommendations on how health plans can utilize data to improve their consumer engagement strategy.

Use data to inform MAC meeting agendas – Given the variety of data collected and mechanisms used for collecting that data by health plans, they are well positioned to use data to help inform their overall consumer engagement strategy, including execution of their MACs.

- **Specific recommendation –** Use de-identified and HIPPA appropriate member experience data already collected to inform future MAC meetings to ensure that agendas can drive the most impact for members.

- **Specific recommendation –** Implement debrief meetings between MAC facilitators, health plan leaders, and other internal subject matter experts to help those across the health plan understand member issues, identify any possible trends, determine best next steps, and identify predicted timeline and process for providing feedback to members on the questions and challenges they raised to promote transparency and trust.

Define success metrics – Health plans create many business goals each year to track what was accomplished and where there are areas of improvement. Work around consumer engagement should be approached the same way as other business goals. Goals specific to consumer engagement across relevant teams will help to reinforce prioritization as well as support accountability.

- **Specific recommendation –** Health plans should consider including performance measures in annual business plans and/or individual employee performance reviews to measure consumer engagement activities and how they have impacted business operations. Development and/or review of these metrics should be included in consumer engagement activities.

Highlighting the importance of self-advocacy

In 2023, the UnitedHealthcare National Advisory Board (NAB) identified self-advocacy as its top priority. The NAB launched a video series featuring conversations about why self-advocacy is important and how it evolves throughout the different stages of life.

Partnering to advance consumer engagement

In a recent study, researchers interviewed 14 state leaders on their efforts to engage consumers in their Medicaid program design. While nearly all the states in the study cited "contractual requirements for their Medicaid MCOs to engage consumers, only two states captured input obtained through MCOs for use by agency leadership."[10] This finding highlights the need for health plans and state Medicaid agencies to facilitate more conversations around the consumer feedback received and if and when feedback can be best addressed at the health plan level or if a state Medicaid programmatic change needs to be considered. Below are policy, program design, and practice recommendations that can help increase collaboration between states and health plans related to consumer engagement in Medicaid program design.

Implement feedback loop between states, health plans, and consumers – There should be consistent communication between a state and their MCO partners on the feedback received through member/consumer experience efforts.

- **Specific recommendation –** States should consider requesting materials such as meeting minutes from MCOs' MACs and/or dedicate time during state and health plan meetings to discuss any consumer feedback themes and next steps.

- **Specific recommendation –** In the Medicaid Access Services Final Rule, CMS requires the new state level MCAC to include representatives from participating Medicaid managed care plans or the state health plan association. If applicable to a state's managed care market, requiring plans to attend the state level MCAC would provide an opportunity for MCOs to report out on trends and next steps to solve any member identified challenges.

Provide clear communication about the multiple channels for engagement – Providing consumers with multiple avenues for them to engage with their state Medicaid agency or health plan will increase the likelihood that they will be able to participate based on their interests and comfortable level. However, it could also lead to "engagement fatigue" if consumers are unaware and confused on how their feedback is being used.

- **Specific recommendation –** States and health plans should provide clear documentation on the different ways consumers can be involved, remove barriers for participation, and implement a clear feedback loop when changes are made as a result of their feedback.

Balance the use of data with consumers' everyday experience

While a data driven approach is vital for improving MACs and other consumer engagement strategies, it is important to acknowledge that much of the data health plans collect is collected at one point of time and should not be the only thing that drives MAC meeting agendas. Instead, the data should be a part of the strategy to listen to the concerns of members and create the ongoing dialogue and relationship building that is required to address issues.

Collaborate on consumer engagement recruiting efforts – Health plans cite challenges with recruiting and engaging members to serve on an advisory committee over an extended period. And with so many different required and available opportunities for consumers to engage with both their health plans and state Medicaid agencies, there is an opportunity for streamlining recruitment efforts to decrease the potential for consumer burnout or worse an inability for either stakeholder to effectively engage consumers.

- **Specific recommendation –** As states work to meet new federal regulations and establish a consumer selection process for the state-level MACs and BACs, states and health plans should collaborate to highlight the opportunities both have to serve on advisory committees. For example, if a consumer is not selected to serve on a state's BAC, the state could include information on how to join a health plan MAC in their selection notification.

- **Specific recommendation –** As states update their websites to improve accessibility of advisory board information, states may want to consider also including health plan contact information for those interested in participating in the MAC meetings led by Medicaid MCOs.

- **Specific recommendation –** States may also explore opportunities to consolidate the work of the state-level MACs, BACs, and health plan level MACs through a coordinated and facilitated structure. For example, all health plans could be required to be present and host an advisory board meeting immediately following the state-level BAC. If operationalized in this manner, consumers could participate in both, the state could have a high level of transparency to the engagement with plans, and there would be increased clarity on which level of system actions need to be taken to address member-identified opportunities – program design by state or health plan operation changes.

Conclusion

Health plans are strategically positioned to support and advance consumer engagement, and both health plans and state Medicaid programs must work together to incorporate member voice and ensure that consumer engagement opportunities are meaningful. Together states and health plans must consistently seek to gain honest, valuable, and actionable feedback that improves the member experience, ensure a feedback loop with members that demonstrates action and follow up, and create opportunities for members to co-create and co-lead initiatives.

> Addressing health disparities is predicated on fully appreciating and understanding the drivers of inequities and what is required to remove the obstacles inhibiting a fair and just opportunity to achieve one's full health potential.

All of the recommendations included in this paper aim to move how the Medicaid program overall advances consumer engagement. With incremental policy, program, and business practice changes, it is possible to shift many of the current transactional constructs into transformational practices that help to advance more equitable and effective services and supports for those accessing their health care coverage through Medicaid.

Appendix

Appendix A – defining terms

Health disparities – Avoidable differences in health status that can be linked to social, economic, and/or environmental disadvantages.[11]

Health Equity – Health equity means everyone has a fair and just opportunity to achieve their full health potential and be as healthy as possible. This requires reducing obstacles such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, and health care.[12]

Health-Related Social Needs – Health-related social needs (HRSNs) (also referred to as social determinants of health or social drivers of health) are "social and economic needs that individuals experience that affect their ability to maintain their health and well-being. These include needs such as employment, affordable and stable housing, healthy food, personal safety, transportation, and affordable utilities.[13]

-Isms – The behavioral manifestation of bias, conscious or unconscious, that reinforce oppression and inequities in our culture. Examples include racism, sexism, ageism, ableism, etc.[14]

Lived experience – Individuals with lived experience are those directly affected by social, health, public health, or other issues and by strategies that aim to address those issues. This gives them insights that can inform and improve systems, research, policies, practices, and programs. When we say lived experience, we mean knowledge based on someone's perspective, personal identities, and history, beyond their professional or educational experience.[15]

Shared-decision making – Helping patients evaluate all available options—weigh their personal values, goals and priorities against unbiased medical evidence—in order to make informed decisions at every stage of their care.[16]

Systemic racism – A complex system, rooted in historical and current realities of differential access to power and opportunity for different racial groups. This system is embedded within and across laws, structures, and institutions in a society or organization. This includes laws, inherited disadvantages (e.g., the intergenerational impact of trauma) and advantages (e.g., intergenerational transfers of wealth), and standards and norms rooted in racism.[17]

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[11] Health Equity Language Guide for State Officials (shvs.org)
[12] What is Health Equity? (rwjf.org)
[13] https://aspe.hhs.gov/sites/default/files/documents/3e2f6140d0087435cc6832bf8cf32618/hhs-call-to-action-health-related-social-needs.pdf
[14] Institutionalized "-isms" and Healthcare Disparities (brownemblog.com)
[15] What Is Lived Experience? (hhs.gov)
[16] MSDMCRoadmap.pdf
[17] Medicaid and Social Determinants of Health (rwjf.org)

Appendix B – consumer engagement regulations specific to state medicaid agencies and medicaid health plans

State Medicaid Agencies

Medical Care Advisory Committees (MCACs) – State Medicaid agencies are required to establish and maintain a Medical Care Advisory Committee (MCAC) that includes beneficiaries or consumer group representatives, as a way for individuals with lived experience within the Medicaid program to advise the state Medicaid agency about health and medical care services.[18] The current MCAC regulations include high-level requirements related to committee membership but provide states with a lot of flexibility in how their MCAC is implemented. Additionally, current regulations limit MCAC discussions to topics about health and medical services, which excludes other topics of importance for consumers, such as, strategies to address SDOH.[19]

The Centers for Medicare & Medicaid Services (CMS) acknowledged that the "current MCAC requirements [were] insufficient in ensuring that the beneficiary perspective [was] meaningfully represented on the MCAC"[20] and finalized provisions in the **Ensuring Access and Eligibility in Medicaid Final Rule** that revised MCAC regulations to emphasize beneficiary engagement and increase transparency between the Medicaid agency and beneficiaries.[21] The table below from CMS provides a summary of the MCAC provisions that were included in the Final Rule.[22]

Topic	Final Rule
Medicaid Advisory Committee and Beneficiary Advisory Council	Renames and expands the scope of states' Medical Care Advisory Committees. The renamed Medicaid Advisory Committees (MAC) will advise states on an expanded range of issues.
	Requires states to establish a Beneficiary Advisory Council (BAC) comprised of Medicaid beneficiaries, their families, and/or caregivers.
	Establishes minimum requirements for MAC membership, including a requirement that 25% of the MAC members will be drawn from the BAC.
	Requires states to make information about the MAC and BAC activities publicly available including bylaws, meeting schedules, agendas, minutes, and membership lists.
	Requires states to make at least two MAC meetings per year open to the public. These meetings must include a public comment period.
	Requires states to provide staff to support the planning and execution of the MAC and BAC activities.
	Requires states to create and publicly post an annual report summarizing MAC and BAC activities.
Interested Parties Advisory Group	Requires states to establish an advisory group for interested parties to advise and consult on certain current and proposed Medicaid provider payment rates to ensure the relevant Medicaid payment rates are sufficient to ensure access to homemaker services, home health aide services, and personal care services for Medicaid beneficiaries. CMS encouraged states to use this group as part of a process to conduct rate reviews and encourage eligible participants (including direct care workers, beneficiaries, beneficiaries' authorized representatives, and other interested parties impacted by the services rates in question, as determined by the State) to join their State's interested parties advisory group once established to bring their concerns directly to States that are setting the payment rates for HCBS.

Tribal council consultation[23] – State Medicaid agencies are required to consult with American Indian and Alaska Natives (AIAN) tribes and be responsive to their issues and concerns when making changes to the Medicaid program that have tribal implications.[24] Section 5006 of the American Recovery and Reinvestment Act of 2009 requires states to consult with tribes, designees of Indian health programs, and urban Indian organizations on matters related to Medicaid and the State Children's Health Insurance Program (CHIP) that affect the populations.[25] For example, states are required to consult with tribes before submitting Section 1115 waiver requests to CMS.

Public comment for medicaid waivers – Medicaid waivers give states permission to waive certain federal Medicaid program requirements. The Affordable Care Act (ACA) strengthened a number of consumer-centric processes relevant to Medicaid, such as adopting a new public comment process for Section 1115 Medicaid waiver applications to allow for greater transparency and public engagement. Additionally, all home and community-based services (HCBS) authorities must comply with federal regulations requiring states to issue a public notice of proposed changes in its methods and standards for setting Medicaid payment rates and implementing a 30-day public comment period for Section 1915(c) waivers and amendments.

New federal regulations to increase transparency and consumer engagement – States are required to have "robust systems to monitor their managed care programs and utilize the monitoring results to make program improvements."[26] Specifically, states are required to use the results of any enrollee or provider satisfaction survey conducted to improve the performance of their managed care programs. In the Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule, CMS updated the regulations to explicitly require states to conduct an annual enrollee experience survey, so states can receive "direct and candid input from enrollees" on topics such as if managed care networks are meeting their enrollees' needs.[27] Additionally, CMS published regulations to make state Medicaid websites easier for consumers to find important information related to eligibility, quality, and benefits. Overall, the recent regulations published by CMS have highlighted their commitment to promote meaningful beneficiary engagement in the Medicaid program.

[18] 42 Code of Federal Regulations (CFR) 431.12
[19] Federal Register: Medicaid Program; Ensuring Access to Medicaid Services
[20] Ibid.
[21] Ibid.
[22] Ensuring Access to Medicaid Services Final Rule (CMS-2442-F) | CMS
[23] Chapter 1-Engaging Beneficiaries through Medical Care Advisory Committees to Inform Medicaid Policymaking (macpac.gov)
[24] 42 CFR 431.408(b)
[25] Section 5006 of the American Recovery and Reinvestment Act of 2009
[26] Federal Register: Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality
[27] Ibid.

Medicaid health plans – federal requirements

Enrollee Advisory Committees (EACs) – Dually eligible individuals are eligible for Medicare and Medicaid services and as a result face many challenges while navigating the two systems. Dual eligible special needs plans (D-SNPs) are a type of Medicare Advantage (MA) plan tailored to serve the dually eligible population. To ensure that health plans are addressing the needs of this population, CMS required the development of EACs in the Calendar Year (CY) 2023 MA and Part D Final Rule (CY23 MAPD).[28] Beginning in 2023, all D-SNPs had to establish and maintain one or more EACs for each state in which the D-SNP is offered.[29] The EAC must have a "reasonably representative sample of enrollees of the population enrolled in the D-SNP ... [and] solicit input on ways to improve access to covered services, coordination of services, and health equity among under-served populations."[30] When CMS published the CY23 MAPD, they declined to include prescriptive requirements of the EAC (i.e., no definition of a reasonable sample of D-SNP enrollment), but noted that they would consider more prescriptive requirements based on how MA organizations implemented and complied with the requirement.

Long-Term Services and Supports (LTSS) Member Advisory Committees – Medicaid managed care plans that cover LTSS are required to solicit active member and other stakeholder input through the use of a member advisory committee.[31] Similar to the EAC regulation, MCOs must include at least a reasonably representative sample of the LTSS populations covered under their contract, but a definition of "reasonably representative sample" is not detailed.

Medicare Advantage STAR ratings – Medicare Advantage plans, including D-SNPs, are awarded a Star rating based on performance on a set of quality performance ratings. CMS developed the Medicare Star Ratings program to help consumers compare MA health plans based on quality and performance. CMS rates the relative quality of services delivered by health plans, care delivered by providers, member experience, and operational measures based on a five-star rating scale, where five stars indicate the highest score. A major component of the member experience measures in the Star ratings come from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The CAHPS survey was developed by the Agency for Healthcare Research and Quality to evaluate the experiences consumers have with their health plans, providers, and healthcare facilities.[32]

Medicaid health plans – state requirements

Member Advisory Committees (MACs) – Many states contractually require MCOs to implement a MAC to operate in their state. State regulations vary widely surrounding the use of MACs by Medicaid MCOs. For example, some states require Medicaid MCOs to have MACs for each of the different populations they serve in their state.

Governance committees – In addition to requiring MACs, some states, like Arizona, require MCOs to operate a Governance Committee. Similar to the MAC, the Governance Committee membership includes consumers that are enrolled with the MCO, however, they also meet with MCO leadership to "direct strategic planning, process improvement, and decision making" for the MCO.[33] Additionally, Oregon's Medicaid contract requires MCOs' (referred to as Coordinated Care Organizations (CCOs) in Oregon) governing boards to include two members of the community, at large, and two members of their community advisory council.

[28] Calendar Year (CY) 2023 MA and Part D Final Rule
[29] 42 CFR 422.107(f)
[30] Federal Register: Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency
[31] 42 CFR 438.110
[32] About the CAHPS Program and Surveys | Agency for Healthcare Research and Quality (ahrq.gov)
[33] Accessed through HMA Health Information Services.

National Committee for Quality Assurance (NCQA) Accreditation – In health care, accreditation is an official, external review process that allows organizations, like MCOs, to demonstrate their ability to meet regulatory requirements and standards.[34][35] The National Committee for Quality Assurance (NCQA) is a not-for-profit organization, established in 1990, tasked with managing accreditation programs for individual physicians, health plans, and medical groups. The Health Plan Accreditation is based on standards related to quality management and improvement, population health management, network management, and member experience. It measures and ranks accreditation performance of health plans through the administration and submission of the HEDIS and the CAHPS survey. Twenty-six states require Medicaid health plans to obtain NCQA Health Plan accreditation to operate in their state.[36]

NCQA also has other accreditation programs such as the Health Equity Accreditation and the Health Equity Accreditation Plus programs. For a health plan to gain one of the NCQA health equity accreditation designations, they must demonstrate how they are engaging members and incorporating their feedback on possible solutions and interventions to improve member health. The two programs build on each other with the Plus program placing greater emphasis on structured process requirements. One of the factors needed to earn Health Equity Accreditation Plus designation is communicating the health plan's actions that resulted from stakeholder feedback back to consumers. Currently, 12 states require Health Equity Accreditation and only Georgia and Kansas require Medicaid health plans to earn Health Equity Accreditation Plus designations.

Culturally and Linguistically Appropriate Services (CLAS) Standards – The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to do so. Health plans use feedback from member advisory board members, CAHPS, feedback on their translation services (also known as language lines), and Medicaid performance improvement plans (PIPs) to understand where they can improve services to better meet cultural and linguistic needs.

[34] Impact of accreditation on quality in healthcare (powerdms.com)
[35] Impact of accreditation on quality in healthcare (powerdms.com)
[36] States Using NCQA Programs

Appendix C – UnitedHealthcare Community & State Member Advisory Committee (MAC) Playbook (abridged version)

Why Create a Playbook?

Creating structures and policies that encourage members to feel welcome to participate and share their experience is essential to a successful Member Advisory Committee (MAC). UnitedHealthcare created a MAC Playbook to provide health equity informed guidance to all health plans to ensure best practices were consistently being utilized across the organization. The following playbook highlights the organization's process of developing and implementing MACs across UnitedHealthcare and provides a framework for other health plans to build the necessary structure and policies to advance consumer engagement through their MACs.

Assessing Where to Begin with MACs

1
Build relationships with external partners to gain support and inform strategy
- State regulators and other experts can help clarify MAC expectations.
- Meeting with local providers and health and social service organizations can aid in relationship building and gaining insight on the best way to engage members.

2
Engage a wide range of health plan staff to help with MAC planning, roll-out, and analysis
- Member and community engagement staff (i.e., community health workers, outreach specialists) will be able to provide important member insights and support recruitment.
- Staff responsible for quality metrics or clinical operations will be able to provide data on initiatives, member inquiries, and patterns in utilization/feedback.
- Health plan leadership should be actively involved in planning, roll-out, and analysis to ensure actions are taken to embed member voice into business priorities.

3
Establish data analysis, evaluation plan, and feedback structures
Define for your health plan:

The role of data for your MACs	Priority populations & desired market insights	Key performance indicators for year

4
Consider these strategies for roll out of your first MAC meeting(s)
- Partner with a locally trusted community-based organization to host and support recruitment
- Focus first meeting agendas on establishing group norms, setting expectations, identifying health equity priorities, and getting member input on what motivates them to participate
- Vary the days of the week and time of day for first meetings to see what works best for your members
- Consider planning meetings more frequently to start in order to gain visibility and opportunities for participation

5
Establish internal processes to share learnings and themes across your organization to develop best practices for consumer engagement, including the incorporation of consumer engagement in business goals.

Getting Started: Foundational Steps To Achieve Inclusive Recruitment

Composing a Representative Member Advisory Committee
A four-step process to strategize and execute a thorough recruitment strategy.

STEP 1 – Know the health plan
Purpose: Taking time to understand what's required increases efficiency in the long-term.

1. Know the history of member engagement in your organization/health plan.

2. Review the local contract to determine any requirements on meeting cadence, attendance targets, and reporting requirements.

3. Review existing charter documents, previous meeting agendas, meeting minutes, and action items.

4. If this is a new market, review request for proposal (RFP) documents, early focus group findings, and accreditation documents.

Key considerations:
- ✓ Contracts may stipulate term commitments, charter language, recruitment metrics, reporting timelines, meeting frequency, or documentation templates
- ✓ **Connect with the state to get clarity on the specifics of the local plan's engagement with members**

STEP 2 – Know the membership base
Purpose: Set goals for committee member composition and outline priorities for impacting member experience.

1. Review membership demographics to identify key populations and health priorities. Identify how outreach to different populations may differ.

2. Connect with subject matter experts to review NPS and CAHPS survey data for trends in member experience.

3. Connect with call center representatives and outreach teams to gain their insights on member experience.

4. Consider member barriers to participation and consider strategies for supporting their engagement.

Key considerations:
- ✓ How do demographics and population health insights vary across the state?
- ✓ Consider advantages to integrating multilingual meetings versus scheduling separate meetings for different targeted linguistic groups
- ✓ What CBO partnerships and advocacy groups exist in the community?
- ✓ Analysis of the membership base will allow you to identify priority member perspectives to target with recruitment efforts

Getting Started: Foundational Steps of Recruitment (cont.)

STEP 3 – Develop Communication Methods for Recruitment
Purpose: Communications about the MAC should center the value of health equity, diversity, and consumer voice.

1. Review local contract for stipulations on member contact regulations, acceptable channels/circumstances, and compensation regulations.

2. Consider the language ability and cultural context of members when designing recruitment materials (aim for communication at an acceptable grade level).
   • Pull member lists by language preference and update messaging for target languages across member-facing materials (mailings, phone calls, outreach events).

Key considerations:
✓ Contracts may stipulate how the plan is able to interact with members
✓ Keep member materials direct: who is invited, what will be discussed, when is the meeting, where is it (format), why attend?
✓ Engage trusted community partners to share meeting notices

STEP 4 – Coordinate Member Engagement
Purpose: Creating an environment that is welcoming and responsive to member's needs.

1. Maintain an attendance list with updated contact information for members.

2. Prepare member-facing materials before meeting. Consider how to provide paper/digital copies to all attendees for review beforehand or during meeting.

3. Consider logistics for attending virtual and in-person meetings.

Key considerations:
✓ Connect with translators ahead of meetings to review the agenda, key questions for the participants, and how you would like to work together to ensure member understanding.
✓ What kinds of meeting reminders do members expect?
✓ Are your meetings in person or virtual?
✓ Are your meetings state-wide or regional? Do locations rotate?
✓ Invite members who have benefitted from local health plan community services

Communication Templates
Have consistent communication tools and track response rates for different channels, such as: New Member Inserts, brochures, social media posts, scripts for call center staff, flyers for participants of programming through the health plan, etc.

Topic Analysis from Meetings

Convene to discuss themes from MAC:
These meetings should include at minimum:
MAC facilitators, Health Plan leaders, Quality & Clinical experts, and the market's Health Equity Director (as applicable)
Timeframe: Ideally 1-3 weeks after a MAC meeting

For each theme, ask:

➢ How would we characterize this issue? (Possibilities include workforce error, internal procedural barrier, member awareness, communication)
➢ What steps have we taken to understand the issue on an individual level and Macro level?
➢ Does our health plan assess/track this particular issue?
➢ What additional steps can we take to understand this issue?

1

Understanding the issue from individual and macro perspectives:

What information did you learn from member about the issue?
What steps have been taken to resolve the concern?
What steps remain? Who will address and how?

Has this issue been documented before?
What are the upstream factors that led to this scenario?
What assumptions do we have about this situation?

2

The role of data collection:

- Is this an issue that we track already?
- What does the data tell us?
- What questions do we still have?
- What do we want to learn?
- What would we like to do with the data we collect?

3

Action Plan

What can we commit to do today?
What do we want to share at the next MAC meeting?
What resources do we need to be prepared to address this issue?

Prioritization:
Once you have discussed the themes, what will be your first priority? Second? Does your prioritization match what MAC members would rank?
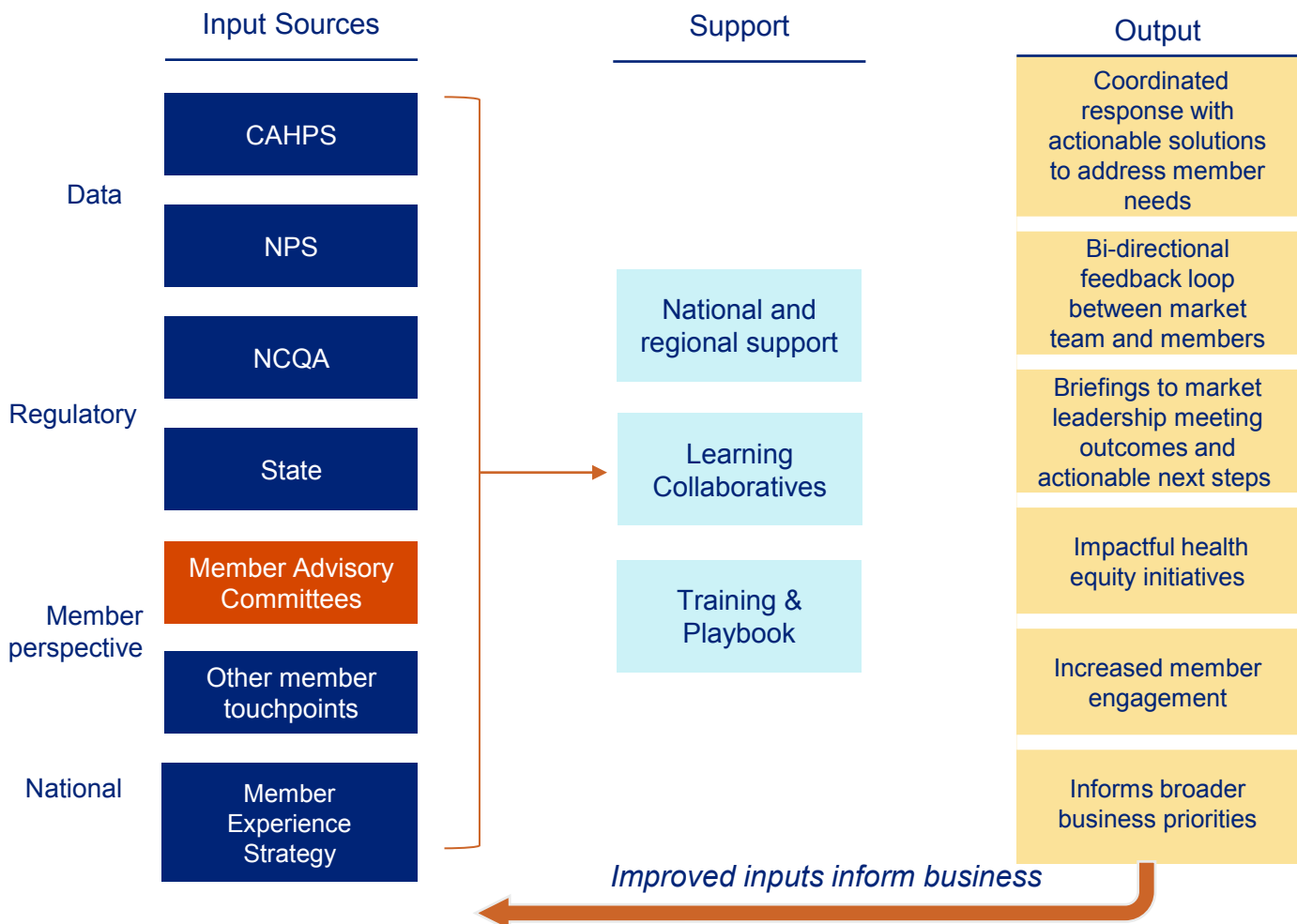
Next Steps:
1. Share plan with teams and MAC participants
2. Share out themes/lessons learned across the organization

Incorporating MACs into Your Organization's Health Equity Strategy

Member Advisory Committees are just one way to gain insight on member experience. Additional opportunities include member surveys, customer service lines, participant feedback on health plan programs, convening focus-groups, structured interviews with community organizations that reflect the targeted member demographics, and hosting community events.

Insights from member touchpoints, data, and regulatory guidance should be analyzed by health plan leadership to implement changes and address trends at the health plan level. Equally, it is important for health plans to share lessons learned and themes from their analysis to inform the business' overarching member engagement strategy and business priorities, as detailed by the graphic below.

Input Sources	Support	Output
Data		Coordinated response with actionable solutions to address member needs
CAHPS		
NPS		Bi-directional feedback loop between market team and members
Regulatory	National and regional support	
NCQA		Briefings to market leadership meeting outcomes and actionable next steps
State	Learning Collaboratives	
Member perspective		Impactful health equity initiatives
Member Advisory Committees	Training & Playbook	
Other member touchpoints		Increased member engagement
National		Informs broader business priorities
Member Experience Strategy		

Improved inputs inform business