CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MEETING SUMMARY

MEDI-CAL MEMBER ADVISORY COMMITTEE (MMAC)

MEETING SUMMARY

Date: Wednesday, December 11, 2024

Time: 5:30 p.m. – 7:30 p.m.

Type of Meeting: Virtual

Number of Members Present: 12 of 16 members were present.

DHCS Staff Present: Michelle Baass, Director; Sarah Brooks, Chief Deputy Director, Health Care Programs; Tyler Sadwith, State Medicaid Director; Lindy Harrington, Assistant State Medicaid Director; Tracy Arnold, Assistant Director; Anastasia Dodson, Deputy Director, Office of Medicare Innovation and Integration; Hatzune Aguilar, Stakeholder and Community Engagement Manager; Maria Romero-Mora, Community Engagement; Kiran Poonia, Stakeholder Outreach; Brian Hansen, Policy Advisor to the Directorate; Erika Cristo, Branch Chief, Woodland, CA; Joseph Billingsley, Assistant Deputy Director.

Meeting Materials: Meeting Presentation

Introduction and Summary of Content

- Members were informed about the DHCS's director updates, Centers for Medicare and Medicaid Services (CMS) Access Rule, the transitioning of Medi-Cal Members Advisory Council (MMAC): the Beneficiary Advisory Council (BAC) and Medicaid Committee Council (MAC), and milestones for 2025.
- There was a 20-minute discussion after the presentation, where all members responded to the following questions: (1) What are your immediate reactions, (2) What interests you about sharing space with other health care partners, and (3) what would you want to have continued in the MMAC and new combined partner meeting.
- Members were then divided into three breakout rooms, where they also discussed the following questions: (1) how long should a member's term be, (2) what time of day works best for meetings, (3) what is the longest a meeting should last, and (4) what topics would you be interested in the MMAC and new advisory group addressing?

Topics Discussed

Director's Updates: DHCS Director Michelle Baass provided updates on how the Department is actively preparing for the Governor's budget release on January 10, 2025, which will detail resources for Medi-Cal programs. Key efforts include advancing mental health, focusing on policy development, infrastructure improvements, and local engagement to optimize the use of funding under the Behavioral Health Services Act. Additionally, the Department is collaborating with CMS on critical policy initiatives, including the Managed Care Organization tax, the Behavioral Health Connect (BH Connect) waiver, and new Medicaid services like transitional rent.

Discussion:

- One member asked the Director whether she has budgeted for partnerships between mental health services and the ten (10) new counties, to which she replied that partnerships are built into these new counties and that no funding or budgets would be affected.
- Members also shared that they worried about mandates and laws not being enforced and how DHCS would hold people accountable. The Director replied that in the past few months, they have done an audit on their Medi-Cal managed care plans, and all the findings have been posted online for the public to view. They found issues and deficiencies and have issued corrective action plans. According to the Behavioral Health Services Act, they are committed to accountability and transparency.

CMS Access Rule: Hatzune Aguilar, Stakeholder and Community Engagement Manager, and Maria Romero-Mora, Community Engagement, provided updates on the new CMS Rule. The "Access Rule" aims to improve transparency, accountability, and engagement in Medi-Cal services. It mandates DHCS to establish two advisory groups:

- Beneficiary Advisory Council (BAC): Comprising Medi-Cal members, their families, and caregivers, this group offers a private forum for feedback on Medi-Cal policies and services.
- Medicaid Advisory Committee (MAC): A new advisory body to include representatives from the BAC, healthcare organizations, and stakeholders. Membership will be public, and meetings will partially be open to the public.

- Both groups are designed to enhance member engagement and provide input on Medi-Cal services. The MMAC will fulfill the BAC's requirements, while the MAC will ensure diverse representation, including clinical providers and community organizations, by July 2025. DHCS will develop bylaws, share materials in advance, and align meeting agendas with CMS standards. These efforts reflect a commitment to incorporating lived experiences and professional insights into policy recommendations and program development.
- The difference between the MMAC and the new MAC under Access Rule is that the MMAC, a member-only group, will meet quarterly and precede MAC meetings, and at least two public sessions annually. Recruitment will prioritize diverse representation, with fixed terms and term limits. DHCS will establish bylaws, require annual reports for CMS, and address topics like care coordination, service quality, and access. The MMAC will fulfill CMS's BAC requirement starting quarter three (summer) of 2025, with MAC recruitment beginning in quarter two (spring) of 2025 and with implementation of the new MMAC and MAC in quarter three (summer) of 2025. The focus remains on co-design, transparency, and accountability.

Discussion:

- Members inquired about workforce development and the potential for in-person meetings.
- A member also mentioned that they would be "out of a job" and that they enjoy being a member of the MMAC. Members felt that they can share their experience with Medi-Cal users, and this results in more trust.
- A member raised concerns about how term limits would affect long-standing members, with suggestions to allow termed-out members to rejoin.
- Members emphasized the importance of continuity, accountability, and maintaining the trust built within the group.
- Two members highlighted the need to ensure vulnerable populations are meaningfully represented by their voices being used to empower those alike while remaining protected and not having their voices used just to check off a list. and that new members are adequately prepared to contribute effectively. Another member mentioned needing time to process everything.

- Two members raised concerns about DHCS's accountability in supporting members during and after their terms. Suggestions included ensuring public meetings balance transparency with privacy to protect members.
- A member expressed concern about the future support for members after their terms end but appreciated the shared space and mutual support. She also looked forward to the new initiatives planned for 2025-2027.
- One member shared that she enjoys the committee we currently have. People would like to participate in this because they have different experiences and that is good for everyone.
- While many welcomed the inclusion of new voices, some members emphasized the value of retaining experienced participants to guide discussions and provide historical context.
- Member comments also touched on challenges in integrating physical and mental health care, workforce capacity, and the potential impact of broader policy changes, including previous federal policies.
- The discussion underscored a shared commitment to collaboration, inclusivity, and trust as the committees evolve. Members appreciated the space to voice concerns and looked forward to shaping a more effective and equitable advisory process.
- One member commented on the importance of creating a safe space for disclosing members' identities to the new administration.

All three breakout rooms addressed the following four questions and responses:

- **Key questions discussed:**
    1. How long should a member's term be?
    2. What time of day works best for meetings?
    3. What is the longest a meeting should last?
    4. What topic would you be interested in the MMAC and new advisory group addressing?
- **Member Responses:**

- Term Lengths: Most members suggested 2-to-3-year terms, with flexibility for rejoining after a break. They discussed whether past members could stay involved in non-voting advisory roles. Members debated optimal term lengths for advisory groups, suggesting longer terms of up to 4 years to build trust and continuity while balancing flexibility for new members. Concerns were raised about aligning term lengths with the implementation timelines of DHCS projects to allow members to see the outcomes of their contributions.
- Committee Size and Structure: The idea of grandfathering experienced members into the new structure was discussed.
- Leave of Absence: Members were supportive of the idea that members could request a leave of absence in the case that a health event occurred. They supported the idea that a member could choose to add time to their term length to make up for the time away.
- Compensation and Participation: Concerns about whether longer or shorter meeting durations would affect compensation were highlighted. Members emphasized the need for staggered term limits to maintain continuity when members cycle out.
- Meeting Timing: Members emphasized the importance of flexible meeting structures to accommodate diverse schedules and ensure adequate discussion time. Ideas included extending meetings when necessary and allowing virtual or hybrid participation. The current schedule (5:30-7:30 p.m.) was considered suitable by many.
- Meeting Duration/Structure: A two-hour limit was generally supported, with some suggesting a maximum of 2.5 hours. The idea of having a 10-minute break was discussed, and for longer meetings (4+ hours), a lunch break would be necessary. While 2-hour meetings were preferred, it was noted that currently, not everyone can ask questions or comment due to time constraints. DHCS staff asked members how they felt about submitting questions in advance after receiving meeting materials, allowing speakers to incorporate them into their presentations. Members thought this approach could be helpful in saving time and addressing initial questions in advance.

- Topics of Interest: Members expressed interest in the future around policies, mental health integration with physical health, climate change, gerontology, autism disorder, and anything that affects Medicaid and Medi-Cal.
- Recruitment and Onboarding: Participants emphasized the importance of transparent recruitment processes and clearer communication about the committee's purpose, roles, and time commitments. Suggestions included outreach via community-based organizations (CBOs) and word-of-mouth, as well as sharing committee successes to encourage participation.
- Transparency and Engagement: Members called for more transparency in how their feedback is translated into DHCS actions and policy changes. Updates on the progress of DHCS projects and the decision-making process were seen as crucial for keeping members engaged and informed.
- Trust-Building: Longer terms could foster trust, enabling members to share personal experiences and address systemic inequities.
- Members emphasized the importance of meaningful discussions around health care delivery, equity, and program integration. Feedback loops were encouraged for ongoing development of topics and structure.
- Federal Guidelines and Creativity: DHCS staff explained the balance between adhering to federal rules and customizing meeting formats to maximize participation and effectiveness.
- Feedback from DHCS Representatives: DHCS representatives acknowledged the value of members' input and emphasized their commitment to centering their efforts on member experiences.

Member Comments Highlights Shared: Following the breakout room discussions, members provided open comments and shared common themes, and discussion highlights below.

Discussion:

- Peer Support Specialist Certification: There were concerns about barriers to billing peer support specialists, particularly in integrating them with community health workers to address both physical and behavioral health challenges. Efforts are ongoing to resolve these issues.

- Access to Resources: A member emphasized the importance of improving access to healthcare resources, especially for vulnerable populations. He highlighted the challenges faced by youth experiencing homelessness, where basic needs often take precedence over healthcare. Suggestions included outreach in shelters and other community spaces to make healthcare services more accessible.
- Resource Guides to Educate Members: Members proposed creating a resource guide to help people navigate available services, especially for those with lived experiences of homelessness, foster care, juvenile justice and other hardships. Meeting people where they are and providing clear guidance on accessing services was emphasized.
- Flex Funds and Innovative Solutions: One member suggested exploring flex funds, which provide small but impactful amounts of money to help people in difficult situations, such as homelessness (support with deposits) or financial instability. He also advocated for considering evidence-based practices and creative solutions, like supplements or gym memberships, for individuals with specific needs.
- Enhanced Care Management (ECM) and Community Supports (CS): A member pointed out the need for greater awareness of ECM and CS programs under the California Advancing and Innovating Medi-Cal (CalAIM) initiative.
- Shallow Subsidy for Homelessness Prevention: One other member shared her positive experience with the shallow subsidy program, emphasizing the importance of funding prevention services for homelessness, rather than just addressing the issue after it occurs.
- Communication and Future Changes: Several members expressed concerns about the potential changes in healthcare policy under the new administration, particularly regarding disability benefits and housing. Other members highlighted the importance of clear and timely communication to address misinformation and ensure community trust in healthcare policies.

Next Steps: MMAC members were informed that they will be engaging in group evaluation discussions in January 2025, led by a third-party evaluation consultant.

The discussions and key findings will help inform the establishment and recommendations of the Beneficiary Advisory Council and the Medicaid Advisory Committee.

Closing Remarks: Director Baass closed the meeting, thanking the members for their comments that this committee has been valuable and acknowledging the time commitment. She asked the members to think about what questions they would want to ask health plans and health care providers so DHCS can start developing agenda topics.