



# “THE BIGGEST VALUE IS GETTING THE VOICE OF THE MEMBER”

*An Exploration of Consumer Advisory Councils  
within Medicare-Medicaid Plans Participating in  
the Financial Alignment Initiative*

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## Authors

Rachel Isaacson, Leena Sharma, Marc Cohen, Renée Markus Hodin

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# Introduction

Nationally, [10.7 million](#) people are “dually eligible” for both Medicare and Medicaid benefits. Dual-eligible individuals are typically low-income older adults or people with disabilities. They tend to have very complex health and social needs and account for a disproportionately high share of both of these programs’ costs.

To improve dual eligible individuals’ health outcomes and to stabilize costs, the Centers for Medicare and Medicaid Services (CMS) launched the [Financial Alignment Initiative](#) (FAI) in 2011. The FAI was designed to fix the financial misalignment between Medicare and Medicaid by improving care coordination and integration between the two programs. The FAI removed the ‘financial fence’, or separation of Medicare and Medicaid funding streams, which long prevented health plans and providers from viewing dual-eligible individuals through a comprehensive lens.

[Thirteen states](#) opted into the FAI with two different alignment models.<sup>1</sup> Most of these states – California, Texas, Illinois, Michigan, Ohio, South Carolina, Virginia, New York, Massachusetts and Rhode Island – implemented a capitated model. In the capitated model, the state, CMS and Medicare-Medicaid Plans (MMPs) in that state entered a ‘three-way contract,’ through which the health plan receives a prospective blended per-capita payment to provide comprehensive, coordinated care for the dual eligible individuals they enroll. Today, nearly [390,000 dual eligible individuals](#) are enrolled in health plans participating in the capitated model.

Although each state’s capitated model is unique, all share some common features including the mandate that participating MMPs establish consumer advisory councils (CACs). And while there is some variation across states in this mandate, the function of CACs is “[to obtain beneficiary and community input on issues of program management and enrollee care.](#)” At advisory council meetings, enrollees have the opportunity to provide their MMP with feedback on their care experience and suggestions on how that experience could be improved. MMPs can then use enrollees’ feedback to improve health plan operations and provide better care, which may translate into improved health outcomes for enrollees.

Consumers<sup>2</sup> who participate on these advisory councils may experience one additional personal benefit: becoming more engaged or activated in their own health care. While this study does not explore that area, there is [research which suggests](#) there is an association between activation and health, with activated consumers experiencing improved health outcomes. Activated consumers are more likely to adhere to their medication regimes and self-manage chronic conditions. They are also more likely to engage in healthy behaviors, such as regular exercise or healthy eating. Due to these benefits, MMPs may see an improvement in health outcomes or a decrease in costs related to care for consumers participating on their CACs.

<sup>1</sup> Two states, Washington and Colorado, implemented a managed fee-for-service model. In this model, states partner with CMS and benefit if they save money through specified initiatives designed to improve quality and reduce costs within Medicare and Medicaid. One state, Minnesota, implemented an administrative alignment program where the state contracts with a selection of health plans that act as Medicaid managed care organizations and contract with CMS as Medicare Advantage Special Needs Plans for Dual Eligibles (D-SNPs).

<sup>2</sup> In this paper, we use the terms “consumer,” “enrollee,” “member” and “beneficiary” interchangeably.

## Purpose and Methods

The purpose of this research was to systematically collect and analyze information on the composition, function, and impact of the Consumer Advisory Councils operating within MMPs participating in the FAI's capitated demonstrations. To accomplish this objective, we used a mixed methods approach which included (1) an online survey distributed to Medicare-Medicaid Plans with 5,000 or more consumers enrolled, and (2) telephone interviews with consumers, consumer advocates, health plan representatives and officials from the CMS Medicare-Medicaid Coordination Office (MMCO). This study was conducted between April 2018 and November 2018.

In the first phase, the online survey was distributed by email to 35 MMPs, identified through the Integrated Care Resource Center's [Monthly Membership of Medicare-Medicaid Plans \(MMP\) by Plan and by State, April 2017 to April 2018](#). Follow-up contacts were made by phone, email, and through the Association for Community Affiliated Plans and the SNP Alliance, two trade organizations whose memberships include MMPs. The online survey can be found in Appendix 1.

In the second phase, researchers conducted semi-structured telephone interviews with six health plan representatives, four consumers, seven consumer advocates and two CMS officials. The health plans were selected for interviews according to a [purposive sample method](#), with selection based on factors that include non-profit/for-profit plan status, geographic location and size of enrollee population. Consumer advocates and consumers were selected based on a [snowball sampling method](#), in which initial interviewees introduced us to additional interviewees. The qualitative interview protocol can be found in Appendix 2.

[This mixed methods approach](#) uses an explanatory sequential design. Survey data were used to design the semi-structured interview guide. The qualitative and quantitative data were integrated using the weaving approach, with findings presented together by topic.

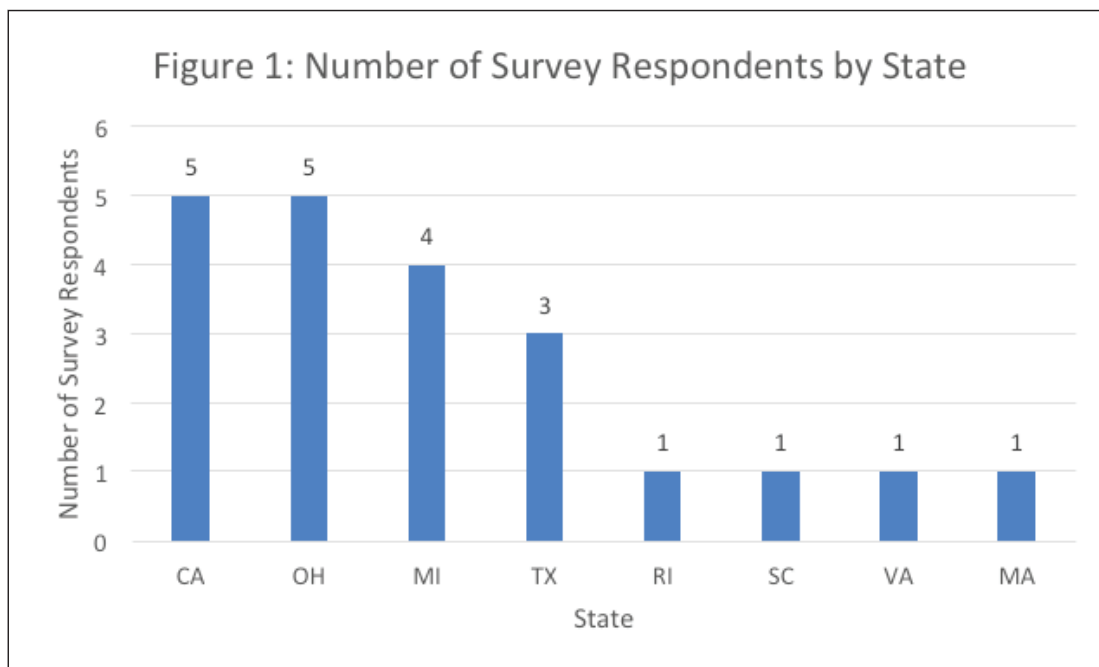
We tested correlations between different survey questions to determine if there is a relationship between certain survey answers. We characterize the strength of correlation as follows: strong (coefficient ( $r$ )  $\geq 0.7$  and  $\leq 1$ ), moderate ( $\geq 0.5$  and  $< 0.7$ ), weak ( $\geq 0.3$  and  $< 0.5$ ), and no correlation ( $< 0.3$ ).

The interviews were conducted by one or two researchers who took detailed notes throughout the interview. [Qualitative data was then analyzed](#) using an immersion/crystallization approach, wherein the transcripts were read multiple times to identify emerging themes and topics. Once themes and topics emerged, researchers created codes, formed a code book, and then coded the interview notes. Interview notes were then sorted into segments, with related pieces of text grouped together. This information was then presented to corroborate the quantitative data.

# Findings

## Survey Responses

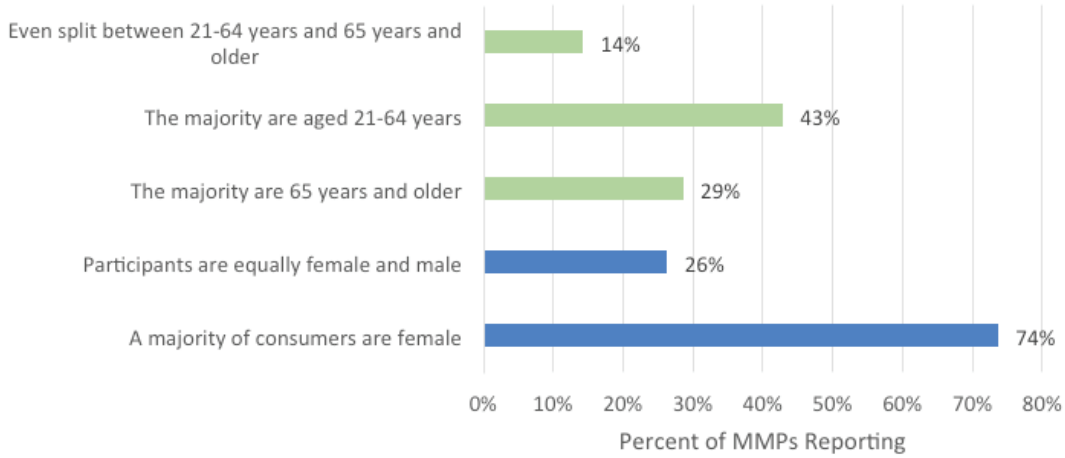
Representatives from 21 MMPs completed the online survey, a 60 percent response rate. These MMPs collectively enroll 244,480 dual eligible individuals, approximately 60 percent of all consumers enrolled in MMPs participating in the FAI. Figure 1 shows the distribution of responding plans by state. While most states participating in the FAI are represented in the sample, none of the participating plans in New York or Illinois responded to the survey. National plans operating in multiple states were contacted through either advocacy partners who have a connection or through their corporate office.



## Overview of Consumer Advisory Councils

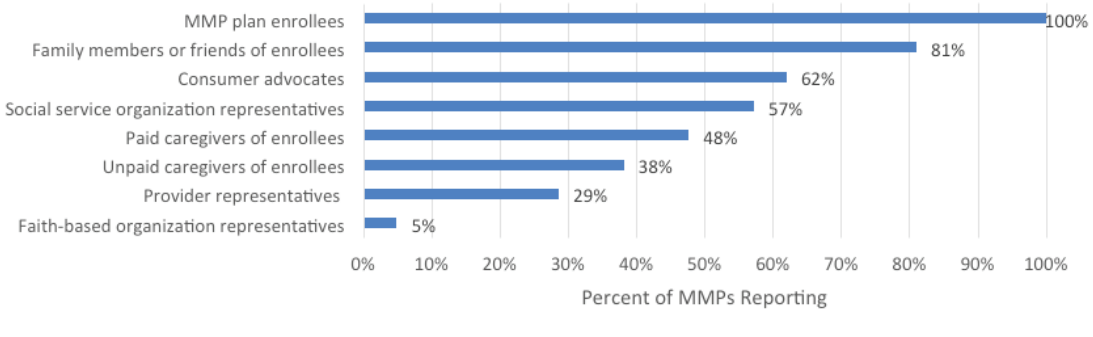
86 percent of MMPs reported that their advisory councils were newly created to ensure MMP compliance with the FAI mandate. The remaining plans reported that they created their advisory council by repurposing an existing committee. All CACs meet on either a monthly or quarterly basis. Figure 2 shows the reported gender (in blue) and age (in green) distribution of MMP enrollees who participate on advisory councils. As noted in the chart, 43 percent of plans report that the majority of their consumer participants are aged 21-64. Seventy-four percent of plans reported that majority of consumers participating are female.

Figure 2: Reported Gender and Age Distribution of Consumer Participants in CACs



In terms of attendees at CAC meetings, 100 percent of respondents indicated that both enrollees and health plan staff attend. Some advisory council meetings are open to any enrollees who wish to attend. Other advisory councils have a set membership, with meetings closed to non-members. Some MMPs invite additional stakeholders to attend or to participate, as displayed in Figure 3.

Figure 3: Consumer Advisory Council Meeting Attendees



## Consumer Recruitment & Training

Most MMPs do not have a formal process for recruiting enrollees to participate on their CAC. To recruit enrollees, MMPs commonly:

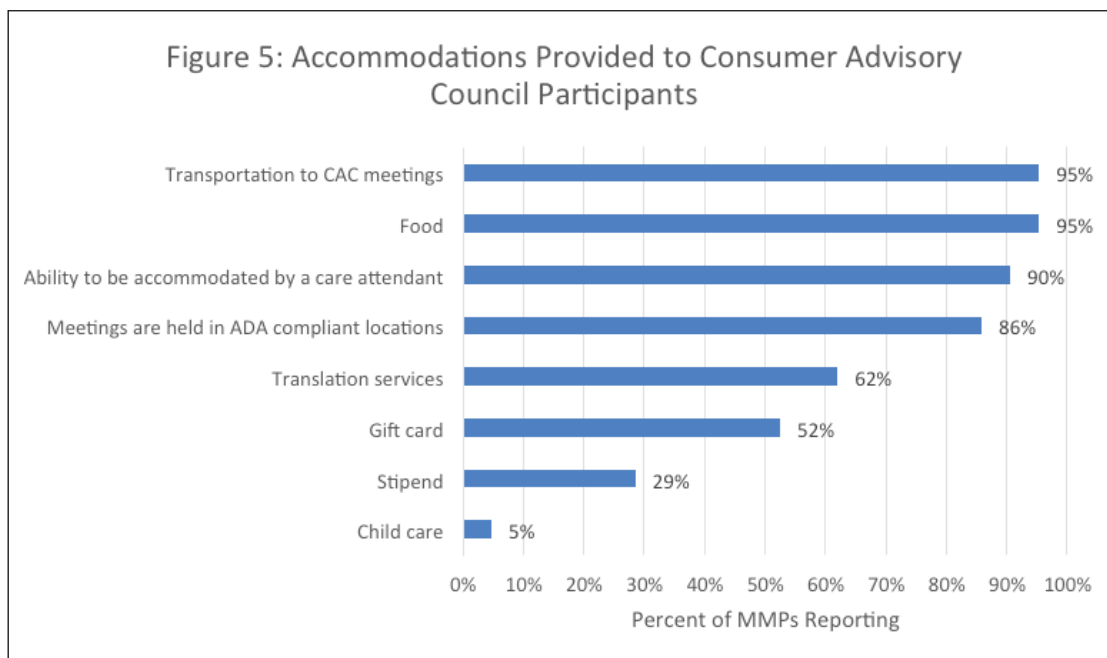
- Use their Care Management or Member Services departments to identify potential participants.
- Invite enrollees with whom they or other members of the advisory council have prior relationships.
- Outreach to enrollees at community events or through community-based groups.
- Perform direct outreach to enrollees, typically through cold calls or flyers.

When asked about the type of consumer MMPs look to recruit, one MMP representative replied, “We look for people who are vocal, who offer suggestions when talking to the health plan. We want people who will tell us what we can do better, who are assertive, articulate, and communicative, [and] who look at things from a global perspective.” This description of the ideal consumer participant was typical among the MMPs that we interviewed.

65 percent of survey respondents report that they train consumers on how to work effectively on their advisory council. These trainings range from formal orientations that feature mock advisory council meetings, which simulate what occurs during actual meetings, to a causal overview of the purpose of the advisory council and the consumer’s role. MMPs that do not train consumers may not believe that training is necessary for consumers to become effective advisory council members. This sentiment was expressed by one health plan representative, who said “we don’t have formal training about sitting on the advisory council. When people come on board, they’re good at getting into the flow.”

## Accommodations

MMPs provide a variety of accommodations to help a diverse group of consumers participate on advisory councils, as displayed on Figure 5.



Not all accommodations work well. For example, MMP representatives and consumers alike expressed frustration with the transportation vendors employed to give consumers rides to CAC meetings, as vendors are frequently late or may even skip pickups. To mitigate this problem, some MMPs have invited transportation vendor staff to attend advisory council meetings. This allows the transportation vendor to see firsthand every time a consumer is late and serves to foster more positive relationships between the vendor and advisory council participants.

- We found a moderate correlation ( $r=0.52$ ) between the number of accommodations a health plan offers and if the plan reports difficulty recruiting or retaining consumers, suggesting that health plans that offer more accommodations tend to have less difficulty recruiting and retaining consumers.

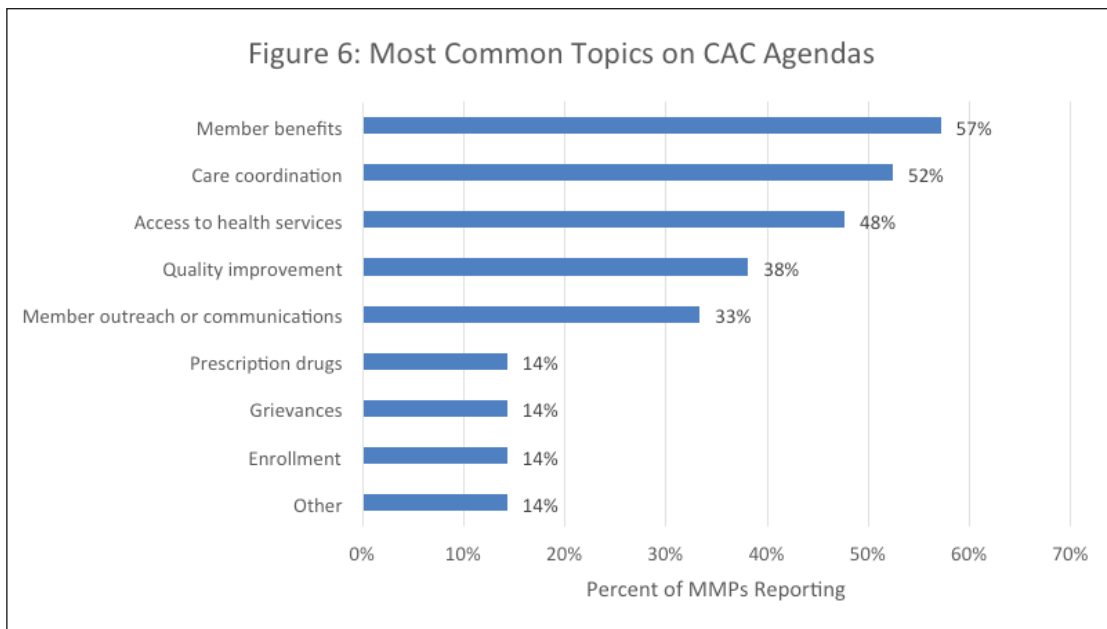
### Consumer Advisory Council Meeting Agendas

MMPs vary in how they determine which items get included on CAC meeting agendas and in the type of items that they commonly discuss. Nearly all (88 percent) MMPs report that their staff and consumers work together to set the agenda. At one health plan, the respondent indicated that *“agenda items naturally develop through conversations with members.”* Other health plans choose agenda items through a more formal process that involves designating time during each meeting to set agenda items for subsequent meetings. The most commonly reported agenda items are displayed in Figure 6.

Discussions during CAC meetings tend to focus on two areas – questions that MMP staff would like consumer feedback on and the problems that consumers experience with their MMP. Questions from MMP staff commonly involve: asking consumers about potential initiatives or projects, such as the rollout of an online portal for members; asking consumer members for their insights into the behavior of the wider member body, such as why enrollees utilize certain preventative services but not others; or input on communications materials, which could include workshopping the layout or wording of member notification or educational materials. One MMP staff member noted, *“What’s most important for us to want to hear about is what’s not working for them and about problems and issues. That’s the voice of the member [that we want to hear] in terms of problems and how to improve them.”*

Most MMPs designate time during advisory council meetings to report on progress on previously-discussed agenda items. When MMPs report back to consumers, consumers know that their MMP is listening to them and is accountable to them. This sends the message to consumers, as noted by MMP staff, that *“their feedback makes a difference”* and *“that their concerns matter.”* For MMPs, reporting back to consumers focuses their attention on the issues most salient to their members, which allows MMPs to make the correct improvements to their enrollees’ care experience.





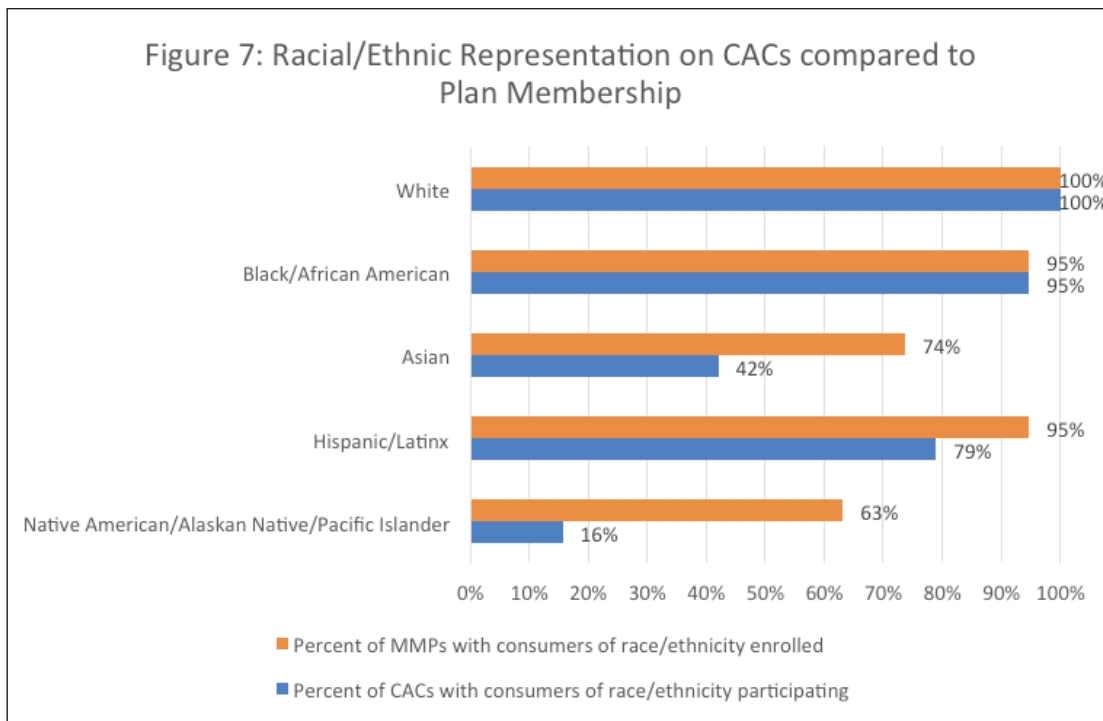
### Diversity & Representation

Having diverse consumer representation is necessary to ensure that the needs and voices of different communities served by an MMP are considered within advisory council discussions, that changes to health plan operations are made in culturally sensitive ways, and that underserved communities have access to high quality health services. Most states' Three-Way Contracts ([CA](#), [MA](#), [IL](#), [MI](#), [NY](#), [OH](#), [RI](#), [SC](#), [TX](#), [VA](#)) state that CAC membership should reflect the diversity of a MMP's member body. To our knowledge, MMCO has not provided guidance on what constitutes diversity, how to recognize diversity, or how to recruit consumers from diverse backgrounds.

The survey asked respondents to report on the race/ethnicity, gender and age distribution of consumers participating on consumer advisory councils and within MMP membership.

21 survey respondents (91 percent) were aware of the race/ethnicity of the consumers within their membership and of those who participate on their advisory council. Figure 7 displays the racial/ethnic representation of consumers within an MMP's advisory council and enrollee population. We obtained information on whether or not certain race/ethnicities are represented, but not on the proportion of races/ethnicities participating on an advisory council or within a member body.

The information collected suggests that there are disparities between the reported race/ethnicity profiles of MMP membership and that of associated consumer representation on CACs. Asians and Native American/Alaskan Natives/Pacific Islanders are the most under-represented. Of the 12 MMPs that enroll Native American/Alaskan Natives/Pacific Islanders, only three have consumers from this community who participate on their CAC.



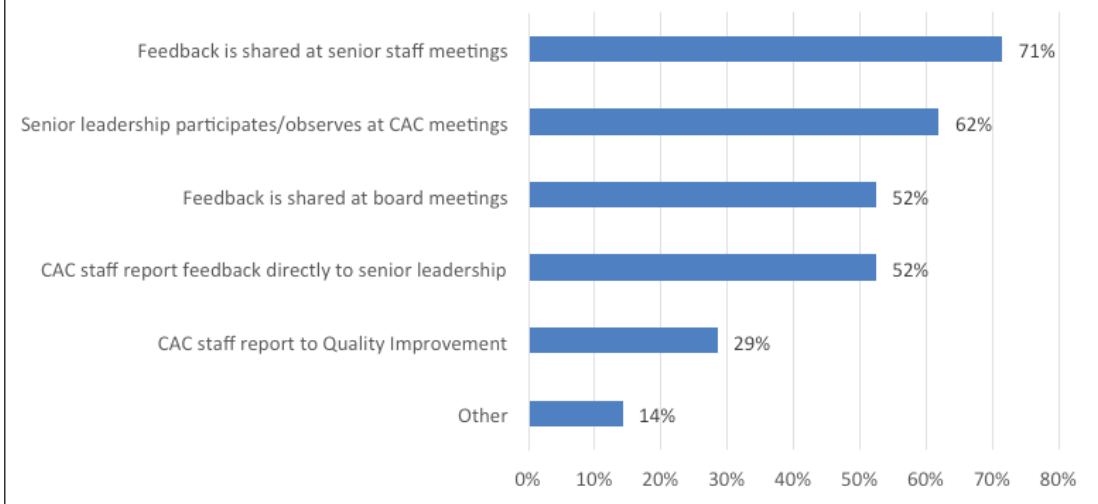
- We found a moderate association ( $r=0.53$ ) the number of race/ethnicities within a MMP’s membership and the number of race/ethnicities among the same plan’s consumer advisory council participants. This suggests that MMPs with more diverse enrollee memberships are also likely to have more diverse advisory councils.
- Additionally we examined the relationship between having a more diverse advisory council or member body and using more language inclusion strategies. Language inclusion strategies included conducting meetings in languages other than English all or some of the time; speaking languages other than English or offering translation services when recruiting consumers for the CAC; and offering translation services during CAC meetings. We found a moderate correlation ( $r=.60$ ) between the number of race/ethnicities participating on a CAC and the number of language inclusion strategies MMPs use.

### Feedback Loops

Bi-directional flows of information between CACs and MMPs are necessary to ensure that advisory councils can create meaningful change. These channels allow consumers to communicate feedback to health plan leadership. Health plan leadership can then make decisions based on this feedback and communicate progress back to advisory council participants. The most common methods used to communicate information from advisory councils to MMP leadership is to share feedback at senior staff meetings (71 percent) and/or to have senior leaders attend advisory council meetings (62 percent). The most common methods of communicating from the CAC to MMP leadership and the percent of MMPs who use each method is shown in Figure 8.

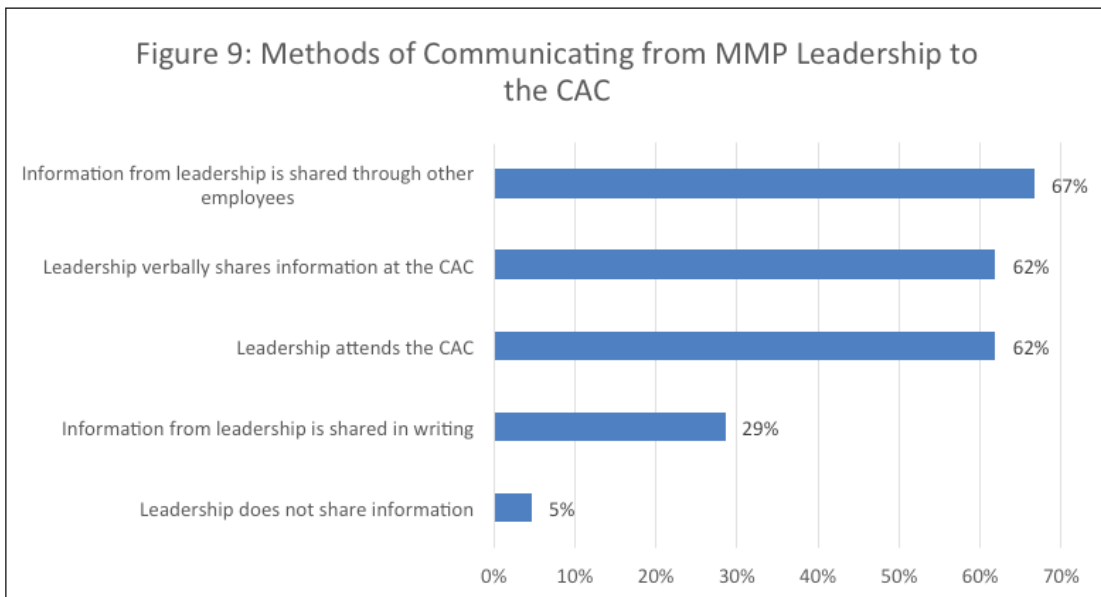
*“Our relationship with members is really important and has developed. They come back, and we invest in them by sharing how their feedback makes a difference.”*

Figure 8: Methods of Communicating from the CAC to MMP Leadership



When health plan leadership communicates back to their advisory council, they most often share information through other health plan representatives (67 percent), attend advisory council meetings in person or remotely (62 percent), and/or share information themselves at consumer advisory meetings (62 percent). Figure 9 shows the most common methods of communicating from MMP leadership to the CAC.

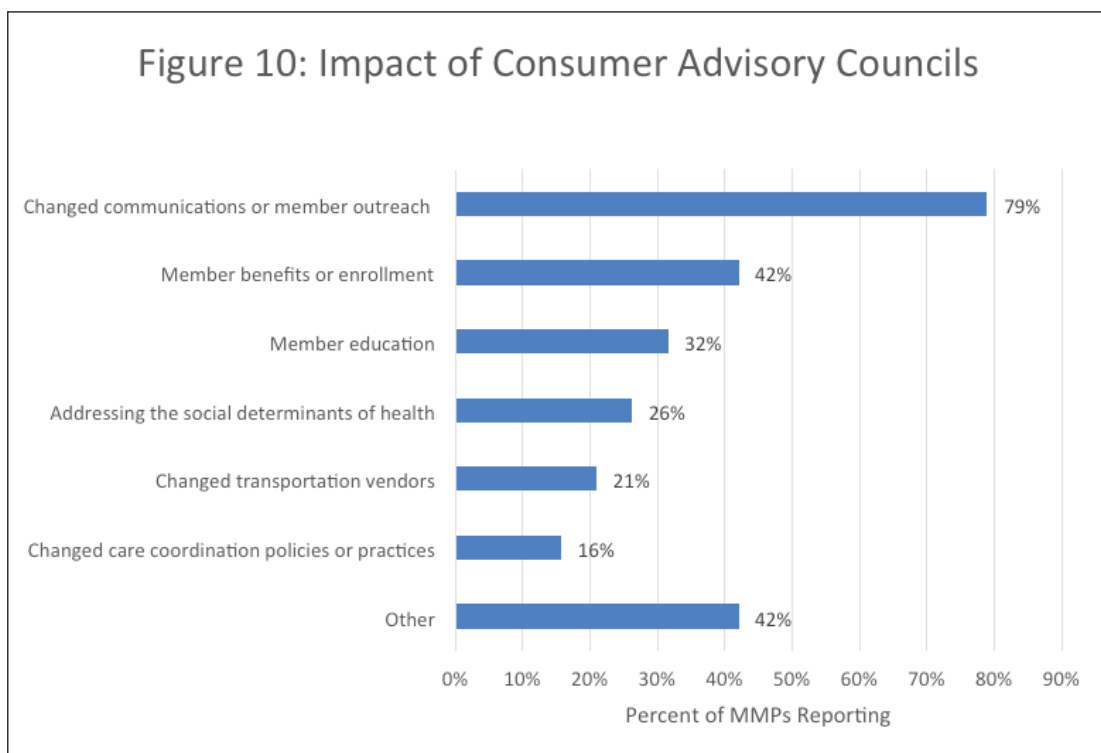
Figure 9: Methods of Communicating from MMP Leadership to the CAC



We expected that MMPs that utilize multiple methods to communicate in one direction, either from the CAC to leadership or from leadership to the CAC, would also utilize multiple methods to communicate in the other direction. We found a strong correlation ( $r=0.71$ ) between the number of methods used to communicate from the CAC to leadership with the number of methods used to communicate from leadership to the CAC.

### Consumer Advisory Council Impact

Survey respondents report that CAC deliberations have changed how MMPs perform member outreach, structure or deliver benefits, and have altered how non-medical challenges for members are addressed. Figure 10 summarizes the specific actions that survey respondents report as having resulted from CAC activity.



In the interviews, MMP staff elaborated on how CAC discussions resulted in policy change and on the impact of that policy change.

For example, through CAC discussions, one MMP realized that their members did not know where to go to access care or what points of care were available. This MMP wanted to educate their members on what options were available to them via a flyer. The MMP brought this idea to their CAC, who informed them that this information would be useful but should be presented on a refrigerator magnet in order to make it more easily accessible for members. During the magnet creation process, the marketing team attended CAC meetings to solicit feedback about proposed designs directly from consumers. The final product was well received by leadership, field representatives and members, ultimately becoming so popular that it was modified for other product lines.

*CAC members recommended and co-designed a magnet that explained how and when members should access various points of care.*

## A DESIRE TO ELEVATE THE CONSUMER VOICE DRIVES HOW MMPS APPROACH CACS

*“We measure success, first, by if our members return each quarter. There is a large drive for people to come and they look forward to the meetings. It’s easy to get them to come back because they find value. Second, by the level of value that internal stakeholders have found within CAC feedback. Each quarter, there’s so many requests for feedback that we can’t fit it all in. So, there’s a lot of internal engagement.”*

*“We limit the staff who participate because the staff was dominating. We want consumers to drive the meeting.”*

*“We have a well-functioning CAC and continue to make it better. We have a lot of passionate people who help to make it fun. We have minutes and approve minutes, but have eliminated a lot of formality so it can be free flowing and energetic. We all laugh at ourselves.”*

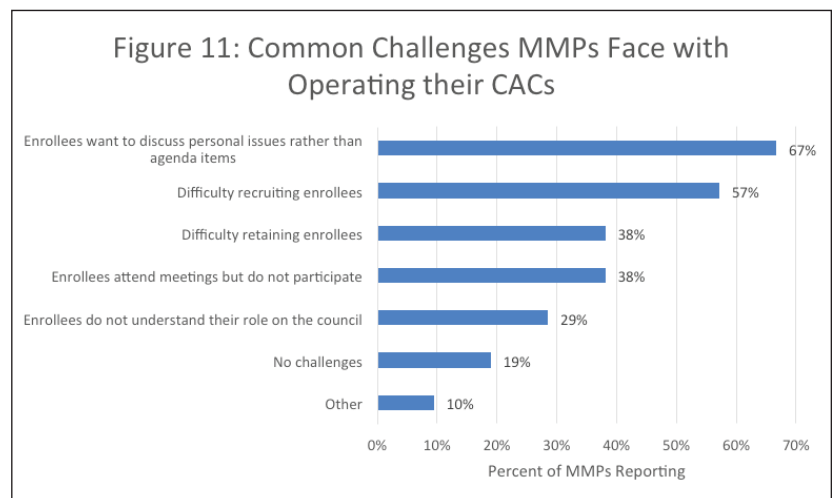
*“Really focusing on getting all the feedback that you can from members is what makes this successful. If you make it member focused, members understand what their role is on the council. If you make it a high-level meeting with only ‘those people’ talking, the meeting isn’t relevant for the members. Keep it in a place where consumers are able to give input and drive the meeting.”*

At another MMP, CAC participants expressed concern that their 90-day supply of prescription medication by mail had been changed to dispense only a 30-day supply. Staff brought this concern to the Quality Improvement team, who confirmed what consumers were reporting, and the plan reinstated the 90-day supply of medications.

Based on feedback provided at their CAC, a third MMP became aware that their consumers were having difficulty with the non-emergency medical transportation vendor. Health plan staff provided feedback to the vendor and worked to create and implement a robust confidential member complaint process.

### Challenges & Areas for Improvement

MMPs have faced a number of challenges with operating their CACs. Results from the survey suggest that MMPs’ most common challenges include that enrollees want to discuss personal issues rather than agenda items (67 percent); and/or difficulty recruiting consumers (57 percent). Figure 11 displays common challenges and the percentage of MMP respondents who report experiencing each.



## Discussion & Conclusion

Dual-eligible individuals face a host of challenges related to managing their health. MMPs can be key players in decreasing consumers' burdens if they can better understand the experience of their members. Operating an effective CAC is an important (see best practices list in Appendix 3), though certainly not the sole, means of understanding consumers' care experience and needs. The importance and value of CACs was demonstrated by the mandate placed on MMPs participating in the FAI demonstrations to utilize them.

While there were some suggestions from consumer advocate interviewees that MMPs operate their CACs solely to fulfill contractual obligations ("plans are afraid of negative publicity"), our research found that the vast majority of plans operate CACs with respect for the value they provide for both the plan and their member body. Representatives from several MMPs stated that a desire to elevate the consumer voice into their operations was at the core of why and how they operate their CAC.

Creating and maintaining CACs is a serious undertaking that require staff, time, resources and a dedication to listening to consumers (see Appendix 3 for more on best practices utilized by MMP). It requires ongoing engagement with CAC members to develop meaningful meeting agendas, to overcome physical, financial and language barriers and to be intentional about creating efficient and reliable feedback loops.

Where MMPs have dedicated time and resources to their CACs, there have been tangible, positive impacts. Our research uncovered MMPs that changed their operations in several arenas as a result of CAC discussions. These arenas include, but are not limited to, improving marketing materials, educating members on health issues, and expanding their benefit packages. These wide-ranging impacts show the potential CACs have to help MMPs better meet the needs of their member body.

More work is necessary, however, to understand the value of these impacts. For example, the MMP that partnered with its CAC to create refrigerator magnets (aimed at getting members to the right point of care at the right time) plans to examine if care utilization changed following distribution of the magnets. Furthermore, it would be important to understand the impact that the existence of a meaningful CAC has on MMP enrollees. For instance, MMPs that place the most value on soliciting consumer input and responding to the needs of their member body may see the most individual consumer activation, which in turn, may translate to the most significant improvement in consumer health outcomes.

Ultimately, Medicare-Medicaid enrollees should be engaged in the systems that serve them. They bring a unique and critical voice that help MMPs better serve their members and achieve the goals of the Financial Alignment Initiative. Our research findings are encouraging signs that CACs may be an effective way to improve Medicare-Medicaid enrollees' care experience and potentially improve their health outcomes.

*"The value of asking members is that when members talk about it and that feedback goes to leadership, it brings more weight to the idea than when staff suggest it. If the vision is to have members at the center of the health plan, there are ways to prove it. Hearing what members have to say is one way of proving it."*

*"CACs are a lot of work. They take time to plan and a lot of energy. The team feels exhausted but they're very worthwhile activities for a health plan because at the center of a health plan's mission should be its members. I think it's easy for a health plan to say that, but it's harder to walk that talk every day. CACs are a means to that end."*

## Limitations

This study has two primary limitations. First, our results may only be generalizable to larger MMPs, as only MMPs that enroll 5,000 or more individuals were eligible to take the survey. There may be systemic differences in the ways that larger and smaller MMPs approach CACs. Also important to note, all of the data reported here by plans is self-reported. Secondly, there may have been selection bias in the MMPs that filled out the online survey and self-selected to participate in the interviews. While the response rate to the on-line survey was robust, it is unlikely to fully mitigate selection bias. The interviews were likely very highly skewed toward MMPs that feel most passionately about incorporating the consumer voice. Similarly, consumer interviews may also have selection bias given the consumers interviewed were chosen by the plans. Finally, we recognize that our survey was limited in its assessment of diversity (capturing only race/ethnicity, age and gender and not capturing proportionality of representation) and we believe that a fuller assessment of CAC diversity is an important area for further research.

## Directions for Future Research & Practice

In the interviews, MMPs expressed a desire to have a way of sharing best practices and lessons learned. A national learning community could provide MMPs with this opportunity. We have hypothesized that by utilizing CACs to provide better care, MMPs can reduce their health care costs and improve their members' health outcomes. An evaluation of costs and outcomes pre- and post-CAC implementation on a plan, state or federal level could determine if CACs do have this effect. Additionally, MMPs may find value in quantifying the impacts of their CACs. Future research could determine if consumers' health outcomes have changed following the implementation of a CAC, or could even measure if service utilization or health behavior changes after new policy is implemented.

## Appendix 1: Online Survey

Dear Medicare-Medicaid Plan (MMP):

As you know, there is a growing emphasis on better understanding the consumer experience in health care. Research now recognizes patients as key decision-makers and partners in improving care and their care experience<sup>3</sup>. Furthermore, our literature review suggests that engaged patients have better health outcomes and reduced healthcare costs.

The Center for Consumer Engagement in Health Innovation is surveying health plans participating in the Financial Alignment Initiative (FAI) to learn about their consumer advisory councils. *[Note: Your MMP's CAC may operate under a different name, such as stakeholder advisory council, consumer advisory board, or enrollee advisory committee.]*

Nearly all plans participating in the FAI were required to create a consumer advisory council. The Center is aware that these councils are in different stages of development and that some may not be fully operational. The Center's goal is to capture best practices, challenges, and opportunities for improvement.

This survey is voluntary and will take no more than 15 minutes to complete. Please answer each question to the best of your abilities and submit only one survey per MMP. Please note that your answers are **confidential** and no individual plan's results will be shared. All results will be aggregated for presentation purposes. This survey will be supplemented with brief qualitative interviews – please indicate below if you would be willing to participate. Your contact information is requested so we can email you the final report.

If you have questions, please reach out to Leena Sharma, Project Manager/Senior Policy Analyst at [lsharma@communitycatalyst.org](mailto:lsharma@communitycatalyst.org). Thank you for your participation.

Name:

Name and State of Medicare-Medicaid Plan:

Title:

Email:

Would you be willing to participate in a brief follow-up telephonic interview?: Yes/No

### 1. How was/is your MMP's consumer advisory council created/being created?

- We use an advisory committee that existed before the Financial Alignment Initiative
- We created a new advisory committee for the Financial Alignment Initiative
- We are currently recruiting members for a new consumer advisory committee
- We are currently modifying an existing committee to become a consumer advisory committee
- We do not operate a consumer advisory council (if checked, use skip logic to take respondent to question 17).
- Please include any additional comments here:

<sup>3</sup> Greene, et al, 2018; National Academies of Medicine: A Guiding Framework for Patient and Family Engaged Care, 2017



**2. How often does your consumer advisory council meet?**

- We have not yet met
- Every 1 to 3 months
- Every 4 to 6 months
- Every 7 to 12 months
- On an ad-hoc basis
- Other, please specify:

**3. Does your consumer advisory council train new members on how to work on the council?**

- Yes
- No
- Please include any additional comments here:

**4. Who are the members of the council? Please select all that apply.**

- Enrollees of your MMP plan
- Representatives of providers employed by your plan or under contract with your plan
- Consumer advocates
- Faith based organization representatives
- Family members or friends of enrollees
- Paid caregivers of enrollees
- Unpaid caregivers of enrollees
- Social service organization representatives
- Other, please specify:

**5. What racial minorities are represented in your health plan? Please check all that apply.**

- Native American/Alaskan Native/Pacific Islander
- Hispanic/Latino
- Asian
- Black or African American
- White
- Other
- I do not know (if checked, use skip logic to take to question 6).

**5a. What racial minorities are represented in your consumer advisory council? Please check all that apply.**

- Native American/Alaskan Native/Pacific Islander
- Hispanic/Latino
- Asian
- Black or African American

- White
- Other
- I do not know

**6. How would you describe the gender of your council members?**

- More males than females
- More females than males
- Even number of males and females
- I am not sure

**7. How would you describe the age of your council members?**

- Majority are aged 21-64 years
- Majority are 65 years of age or older
- Even number under and over 65 years old
- I am not sure

**8. What type of impact, if any, has your consumer advisory council made? For example, feedback from consumers resulted in a policy change or the establishment of a new initiative. Please be specific.**

- Open-ended question

**9. Does your consumer advisory council use any of the following strategies? Please select all that apply.**

- Meetings are conducted in languages other than English all of the time
- Meetings are conducted in languages other than English some of the time
- When recruiting members for the council, languages other than English are spoken
- When recruiting members for the council, translation services are available
- Enrollee availability is considered when scheduling meetings
- Enrollee have input in drafting the agenda
- Enrollee(s) chair the meetings
- None of the above
- Please include any additional comments here:

**10. Are any of the following accommodations offered to help health plan enrollees attend consumer advisory council meetings? Please select all that apply.**

- Transportation
- Food
- Stipend
- Gift card
- Ability to be accommodated by a care attendant
- Translation services

- Meetings are held in ADA compliant locations
- No accommodations are offered
- Other, please specify:

**11. What are the most common topics on the agenda at consumer advisory council meetings? Please select the three most common topics.**

- Care coordination
- Enrollment
- Member benefits
- Member outreach or communications
- Prescription drugs
- Grievances
- Quality improvement
- Access to health services
- Other, please specify:

**12. Who sets the agenda at consumer advisory council meetings?**

- Enrollees set the agenda in its entirety
- Health plan representatives set the agenda in its entirety
- Enrollees and health plan representatives work together to set the agenda
- Other, please specify:

**13. Which of the following methods, if any, are used to share feedback generated during consumer advisory council meetings with health plan leadership? Please select all that apply.**

- Feedback is shared at senior staff meetings
- Feedback is shared at board meetings
- Consumer advisory council staff report feedback directly to senior leadership
- We do not share feedback with health plan leadership
- Senior leadership is invited to participate or observe at advisory council meetings
- Other, please specify:

**14. Which of the following methods, if any, does health plan leadership use to communicate with the consumer advisory council? Please select all that apply.**

- Leadership attends consumer advisory council meetings in person or remotely
- Leadership verbally shares information at consumer advisory council meetings
- Information from leadership is shared through other health plan representatives
- Information from leadership is shared in writing, such as through memos or emails
- Health plan leadership does not share information with the council
- Other, please specify:

**15. Has your health plan experienced any of the following challenges in operating your consumer advisory council? Please select all that apply. If your council has faced no challenges, please write “none” in the space provided. If there has been no attempt to create a council, please write “no attempt”.**

- Difficulty recruiting enrollees for the consumer advisory council
- Difficulty retaining enrollees on the consumer advisory council
- Enrollees do not understand their role on the council
- Enrollees attend meetings but do not participate
- Other, please specify:
- Please write additional comments on challenges here:

**16. What would you find most helpful in improving the quality of your consumer advisory council? Please select all that apply.**

- Ideas for recruiting additional members
- Strategies for ensuring that the membership of the consumer advisory council represents the diversity of the enrollee population
- Suggestions for how to effectively operate a consumer advisory council
- Access to educational and skill-building opportunities for council members
- Recommendations on additional strategies to receive input from enrollees or other stakeholders
- Examples of resources or tools that other consumer advisory councils have used
- Strategies for sharing consumer advisory council feedback with health plan leadership
- Strategies for sharing health plan leadership feedback with the consumer advisory council
- Other, please specify:

**17. Is there anything else you would like us to know about your experience with your consumer advisory councils?**

- Open ended

Thank you for your participation!

# Appendix 2: Qualitative Interview Protocol

## General Questions:

- Please introduce yourself.
- How did you become involved with the consumer advisory council (CAC)?
- To date, what has been the CAC's greatest accomplishment in helping to address/understand a particular problem?
- What one best practice/strategy contributed to this success?

## Health Plan Staff

- How has the plan used feedback from the advisory committee to improve operations? Or can you talk a little bit more about your answer from the survey?
- Does your council have dedicated staff and budget?
- How do you communicate decisions made on the CAC to other members in your plan?
- How are CAC decisions implemented?
- What are the top changes the plan intends, or would like to make, to the consumer advisory committee process moving forward?
- What measures do you utilize to evaluate CAC success?
- Do you ever talk with other CACs to share best practices? If so, what was shared?
- Are there others you think we need to talk to?

## State Based Advocates

- What is your role with the CAC?
- Depending on role, what are your perceptions of the council?
  - Effective?
  - Could use more work?
- Are there any areas/opportunities for the CAC to work more closely with consumers, community-based partners and/or the consumer advocate community?
  - What are those areas/opportunities?
- Has your advocacy work connected you to the CAC and the health plan? How have you worked with the plan?
- Can you put us in touch with consumer(s) on the council that we can interview?
- Are there others you think we need to talk to?

## Consumers Sitting on the Councils

- How were you recruited?
- How diverse is the group of consumers who sit on the CAC?
- What are your perceptions of the council?
- How do the accommodations provided by the health plan impact your ability to participate on the CAC? Could the health plan do anything else to help you participate? If so, what?

- What type of training did you receive when you started participating on the CAC? Was it helpful? what else would you have wanted to be trained on?
- What issues related to your health plan are most important to you?
  - How does the CAC address these issues?
- What has been positive about sitting on the CAC? What has been challenging?
- Who talks more at meetings – the health plan or the consumers? (e.g., is more time spent on plan “business”/presentations or on consumer feedback and recommendations for improvement?)
- Can you put us in touch with other consumer(s) on the council that we can interview?
- Are there others you think we need to talk to?

### **Federal Officials**

- Since CAC were a requirement that CMS incorporated into the demonstration, what were your hopes/expectations?
- Where have CACs fallen short?
- What else would you say about the CACs?

# Appendix 3: Best Practices Identified from MMP Interviews

## Dedicated Time at Meetings

- Designate time during advisory council meetings to report back to consumers regarding the issues they have raised, even if those issues are not resolved. Issues can be tracked through an ‘issue log,’ a place to document the feedback consumers provide and the status that has been made to address those issues. Reporting back should be done both for projects that are complete and that are still in progress – the intention is to let consumers know that the health plan heard their complaints and is working on a solution. If feedback or a discussion cannot be resolved during one meeting, that issue can be tabled and brought up during subsequent meetings.

## Consumer Trainings Are Essential

- Provide consumers with training on how to work effectively on advisory councils. This training could include explanations on how meetings are run, how to stay on topic, how to be respectful of other participants, and how to solicit feedback from their community. Consumers should set ‘rules of engagement,’ or rules that govern behavior during each advisory council meeting.

## Address Systemic Issues

- Advisory councils are most effective when they can address systemic issues that many enrollees face, as opposed to focusing on individual issues that a handful of consumers face. To decide if an issue is a systemic or individual, health plan staff can poll other consumers to see if they have experienced it. If it is a systemic issue, solutions can be discussed at future advisory council meetings. If it is an individual issue, health plan staff should connect the consumer who raised the issue with a care manager. The issue can then be resolved outside of the advisory council setting.

## Be Intentional with Diverse Recruitment

- Recruit a diverse selection of consumers to sit on the advisory council. Health plan staff should be aware of the demographics of their enrollee population, should set a benchmark of what representative advisory council membership should look like, and implement intentional recruiting practices to achieve that goal. To encourage shy members to speak out during meetings, health plans could consider alternative meeting formats or the use of small group or breakout sessions.

## Engage Plan Leadership

- Have health plan leadership attend advisory council meetings. This lets consumers know that the health plan is serious about their feedback and provides decision makers with unfiltered information as to the realities of the care experience in their plan.

## Engage Consumers at the Board Level

- Promote effective consumer advisory council participants to be members of the health plan’s board. This will allow the consumer voice to strategically inform business decisions.



**@CCEHI**  
**healthinnovation.org**

COMMUNITY CATALYST  
ONE FEDERAL STREET, 5TH FLOOR  
BOSTON, MA 0211  
617.338.6035