CHCF

Pioneering Participation

Lessons from the First Medi-Cal Member Advisory Committee

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About Bright Research Group

Bright Research Group is a community-centered design, research, and capacity-building firm based in Oakland, California. They partner with public agencies, philanthropies, and nonprofits. Our mission is to support social impact and community health efforts to become more responsive to the needs, preferences, behaviors, strengths, and voices of consumers and communities. For more information, visit www.brightresearchgroup.com.

Acknowledgments

Bright Research Group would like to acknowledge the time, insights, and expertise of the MMAC members, the Planning Team, and DHCS staff who contributed to the evaluation. We are greatly appreciative and are honored to be lifting up the experiences and insights of the MMAC members. Thank you for the contributions you have made to improve Medi-Cal so that it benefits the health and well-being of all Medi-Cal members.

About the Foundation

The California Health Care Foundation is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Contents

Executive Summary

In the fall of 2021, under the leadership of Director Michelle Baass, the California Department of Health Care Services (DHCS) established the Medi-Cal Member Advisory Committee (MMAC), the first-ever mechanism for a diverse group of Medi-Cal members to directly engage with and provide feedback to DHCS staff on Medi-Cal programs, policies, and practices. The MMAC was officially launched in May 2023 after a yearlong design and planning phase by the MMAC Planning Team. The Planning Team consists of DHCS; two funders, the Californian Health Care Foundation (CHCF) and the Lucile Packard Foundation for Children's Health (LPFCH); an external consultant, Everyday Impact Consulting (EIC); and the California Pan-Ethnic Health Network (CPEHN). The Planning Team supports and guides the implementation of the MMAC.

Bright Research Group (BRG) evaluated the value, experience, and impact of the MMAC through December 2024 and informed recommendations for the transition of the MMAC to the Beneficiary Advisory Council (BAC) under the Centers for Medicaid & Medicare Services (CMS) "Ensuring Access to Medicaid Services" rule (the "Access Rule"). BRG reviewed key MMAC documentation and conducted interviews and small-group conversations with DHCS staff, the Planning Team, and MMAC members. This report consists of key findings and recommendations that emerged based on a thematic analysis of data.

Key Findings

What was needed to implement the MMAC?

The evaluation found that three facilitating factors led to the successful launch of the MMAC: (1) championship of the MMAC by DHCS leadership, (2) external philanthropic investment, and (3) strong collaboration and values alignment among the Planning Team. The engagement of a third-party consultant, EIC, helped operationalize the MMAC and increased the capacity of DHCS to authentically engage members. EIC offered thought partnership and expertise in community engagement to DHCS while also acting as a bridge between MMAC members and DHCS.

What has been the influence of the MMAC on DHCS?

As a result of being a part of the design and implementation of the MMAC, DHCS staff and leaders are shifting the culture and practice of the agency to be more member centered. They are learning to build authentic relationships and communicate with members, taking the time needed to build trust and rapport with members during and between MMAC meetings. Importantly, Director Baass's championing of the MMAC supports a culture shift in DHCS, which has led to an increased desire to engage and consult with Medi-Cal members directly.

In the year and a half of the MMAC, members have provided valuable feedback on member-facing communication materials. Through their input, DHCS has more insight into how to develop member-facing materials that are written in plain language, easy to understand, and easy to act upon by Medi-Cal members. Two examples are the member-facing communications on how to file a complaint and how to submit an appeal and obtain a state hearing.

What is the experience and value of the MMAC for members?

MMAC members are highly satisfied and value their experience with the MMAC. None of the members who participated in this evaluation shared a negative perspective or experience. Members reported feeling heard, welcomed, and respected in their relationships with DHCS and EIC within the meeting space and between meetings. Members were proud of their ability to directly educate and influence DHCS leadership to improve the Medi-Cal system for themselves and other consumers. They described the MMAC as a platform for sharing their experiences and challenges with the Medi-Cal system directly to leaders of DHCS, who are the decision makers and can change Medi-Cal policies and practices. They also valued having the ability to learn about their peers' diverse experiences with Medi-Cal, which keeps them informed and motivates them to advocate for their own communities. An unexpected ripple effect of the MMAC is that some members took on an advocate-ambassador role, formally and informally, by bringing information to their own community and relaying community challenges back to DHCS.

What are the strengths of the MMAC? How can the MMAC be strengthened to meet its objectives and influence DHCS?

The evaluation found that the implementation of the MMAC largely adhered to the design recommendations of the Center for Health Care Strategies (CHCS) for the MMAC. The learning posture of DHCS and the Planning Team also generated real-time changes to ensure that the MMAC was member centered and effective in influencing DHCS. Three key elements that contributed to the effectiveness of the MMAC were: (1) the participation of DHCS leadership at all meetings; (2) the diversity of MMAC members, which reflects the Medi-Cal member population; and (3) the human-centered design and facilitation of the MMAC.

The majority of MMAC members, DHCS leaders, and Planning Team informants were highly satisfied and provided positive feedback. They also shared suggestions on how to strengthen the MMAC so that it can better meet its objectives, including encouraging DHCS to improve transparency and consistently close the feedback loop. MMAC members expressed enthusiasm for and hopefulness about the next phase of the MMAC under the CMS Access Rule, encouraging DHCS to maintain and strengthen the existing MMAC design.

Conclusion

The MMAC is the first platform by which Medi-Cal members can directly influence the policies, programs, and practices of DHCS. The evaluation found that MMAC members were proud of the ways they have influenced DHCS, citing concrete examples of how they changed member-facing communications so that all Medi-Cal members can understand and use them. Through collaborative implementation of the MMAC and direct engagement with members, DHCS is shifting its organizational culture and practices to be more member centered. The MMAC members were highly satisfied and valued their experience with the MMAC. For a successful transition of the MMAC to the BAC under the CMS rule, DHCS should maintain the integrity of the MMAC design and the three components that enabled MMAC members' ability to influence the policies and practices of DHCS. The design of the MMAC should be shared with other Medicaid system actors so that Medicaid members can strengthen Medicaid health care delivery systems across the country and ultimately improve health outcomes.

Introduction

Impetus and Vision for the Medi-Cal Member Advisory Committee

In the fall of 2021, under the leadership of Director Michelle Baass, the California Department of Health Care Services (DHCS) established the Medi-Cal Member Advisory Committee (MMAC), the first-ever mechanism for a diverse group of Medi-Cal members to directly engage with and provide feedback to DHCS staff on Medi-Cal programs, policies, and practices. Historically, DHCS convened advisory groups with stakeholders, such as consumer advocacy groups and health care providers with limited Medi-Cal member participation. The MMAC is the first advisory committee made up solely of Medi-Cal members and caregivers.

The MMAC was founded on the belief that authentic engagement with a diverse body of Medi-Cal members who can provide consultation on Medi-Cal policies, programs, and practices would improve the ability of DHCS to respond to the priorities and needs of its members throughout California. The creation of the MMAC by DHCS contributes to the DHCS 2022 Comprehensive Quality Strategy goal — "Engaging Members as Owners of Their Own Care" — and ultimately aligns with the 10-year vision of DHCS for members to have longer, healthier lives through a whole-system, person-centered approach. Read more about the MMAC purpose and member roles in the MMAC Charter.

Design and Planning of the MMAC

The one-year planning phase of the MMAC began in the summer of 2022 and included both design and planning. In partnership with DHCS, CHCF commissioned the Center for Health Care Strategies (CHCS) to conduct research and interviews to identify best practices and lessons learned from other member advisory boards and community engagement efforts. This planning phase was guided by a technical advisory group composed of consumer advocates, Medi-Cal members, and subject matter

The Design, Planning, and Implementation of the Medi-Cal Member Advisory Committee, 2021–25

Design of the MMAC

- California Department of Health Care Services (DHCS) committed to establishing the MMAC in the fall of 2021.
- The Center for Health Care Strategies conducted a landscape scan and interviews that generated recommendations for the MMAC design, which included 10 core elements.
- CHCF and the Lucile Packard Foundation for Children's Health (LPFCH) committed three years of funding for 2023–25.
- DHCS committed staff to oversee implementation.
- Everyday Impact Consulting (EIC) was selected as an external consultant to collaborate on and support implementation.

Planning of the MMAC

- The MMAC Planning Team, consisting of DHCS staff, EIC, CHCF, LPFCH, and the California Pan-Ethnic Health Network, was formed to guide implementation.
- The MMAC infrastructure and charter were developed.
- Two rounds of recruitment and onboarding of Medi-Cal members were conducted to yield diverse statewide representation among MMAC members.

Implementation

- The first MMAC meeting launched with 15 MMAC members in May 2023.
- Eight MMAC meetings convened between May 2023 and April 2025.

For more information, see the DHCS MMAC website.

experts. The final report by CHCS provided recommendations, including 10 core elements to guide the design, effectiveness, and sustainability of the MMAC.

For the launch of the MMAC, LPFCH joined CHCF as a funder. The two foundations have committed three years of funding from 2023 to 2025 and served as thought partners for DHCS. DHCS dedicated staff from the Office of Communications and the Director's Office to oversee implementation. Through a competitive request for proposals (RFP) process, an external consultant, Everyday Impact Consulting (EIC), was selected to collaborate and support implementation of the MMAC. DHCS staff and EIC were responsible for recruiting and onboarding new members, preparing meeting agendas and materials, facilitating MMAC meetings, providing stipends and other support to members during and between meetings, and summarizing member feedback. The California Pan-Ethnic Health Network (CPEHN) and other subject matter experts provided a technical advisor role for the MMAC. Together, staff from DHCS, CHCF, LPFCH, EIC, and CPEHN constituted the MMAC Planning Team to support and guide the MMAC.

Prior to implementation, the Planning Team developed the MMAC infrastructure, including the membership application, onboarding materials, and an evaluation framework. To ensure that the MMAC represented the Medi-Cal membership and varied experiences on an advisory committee, two rounds of recruitment were conducted. The first round of recruitment through the existing community advisory committees of managed care plans (MCPs) yielded experienced advocates but fell short of the Planning Team's goals for membership that better reflected the diversity of the Medi-Cal population. DHCS and EIC staff conducted a second round of recruitment that drew upon the knowledge and relationships of a variety of ethnic-specific and community-based organizations across the state to achieve a more diverse MMAC membership. The current MMAC members are predominantly adults age 21 and older, represent 10 different counties, and are diverse users of Medi-Cal services. More than half of the members identify as female. White, Latino/x, and Asian, Native Hawaiian, and Pacific Islander members each represent 30% of the MMAC committee. See Appendix A for the MMAC member demographics.

Implementation of the MMAC

The MMAC held its inaugural meeting in May 2023 with 15 members and 8 senior staff from DHCS in attendance, including Director Baass. Between May 2023 and February 2025, the MMAC has convened eight quarterly meetings with 16–18 members. The MMAC quarterly meetings are held virtually on Wednesdays from 5:30 – 7:30 PM (PT) and are closed to the public. The meeting agenda and summaries are public information that can be found on the DHCS MMAC web page. To support a confidential space, members' identities are not public information.

About the Evaluation

The Planning Team, with funding from CHCF, engaged Bright Research Group (BRG) to evaluate the value, experience, and impact of the MMAC through the end of 2024. DHCS will use the evaluation results to inform the implementation of a Beneficiary Advisory Council (BAC) and the Medicaid Advisory Committee (MAC) required by the "Access Rule"* of the Centers for Medicare & Medicaid Services (CMS). DHCS will be implementing the MMAC to fulfill the requirements of the BAC. The MMAC members will also receive

* In April 2024, CMS released an "Ensuring Access to Medicaid Services" rule that included national standards to engage members by creating two bodies: the BAC and MAC. The BAC consists solely of members, while the MAC membership must consist of Medi-Cal members from a BAC along with MCP representatives, patient advocates, and providers. States must establish a BAC and MAC by July 2025.

a presentation of these key findings. Other state Medicaid programs, MCPs, and other stakeholder groups can also benefit from the recommendations and lessons learned in the design of member-centered strategies and advisory committees.

Methods

Between October 2024 and January 2025, BRG conducted a total of eight key informant interviews with the MMAC Planning Team, DHCS staff who presented at the MMAC meetings, and Spanish-speaking members, as well as two small-group conversations in English with a total of 12 MMAC members. MMAC members received a stipend of $50 for their participation. BRG conducted a thematic analysis of qualitative data and a descriptive analysis of post-MMAC meeting member surveys to answer the evaluation questions.

Evaluation Questions

The evaluation was designed to address the following questions:

1. **Experience:** What was the experience of Medi-Cal members on the MMAC and with respect to DHCS staff who participated in the meetings? How valuable was participation in the MMAC for them? How satisfied were they with their overall participation? To what extent did it meet their expectations and hopes for participation and influence?

2. **Impact:** To what extent is the MMAC influencing DHCS mindsets, practices, program design, and policies? What signals of progress are there toward operationalizing and adopting changes? How meaningful is this progress toward change?

3. **Variation:** Were there any significant differences with regard to perceived value and outcomes among advisory members, DHCS, and other partners?

4. **Lessons:** What was needed to implement the MMAC? How can the MMAC design, structure, and role be strengthened to meet its objectives and influence DHCS? What are the lessons learned from the MMAC implementation and member experience that can inform the next phase of the MMAC, considering the federal Access Rule requirements to sustain a BAC?

Table 1. Evaluation Methods and Sample Size

METHOD	TOTAL NUMBER OF INFORMANTS
Key informant interviews with the Planning Team and DHCS staff	12
Key informant interviews with Spanish-speaking MMAC members	2
Two small-group conversations with English-speaking MMAC members	12
Document review of the MMAC meeting agendas, summaries, surveys, and other background materials	NA

Source: Bright Research Group analysis of MMAC post-meeting surveys from May 2023 to May 2024.

Notes: *DHCS* is California Department of Health Care Services. *MMAC* is Medi-Cal Member Advisory Committee.

Evaluation Findings

Through interviews, small group conversations, and document review, BRG evaluated the MMAC implementation and influence on DHCS, experience and value for MMAC members, MMAC strengths and opportunities to deepen impact, and considerations for MMAC's next phase under CMS guidance.

What was needed to implement the MMAC?

The evaluation found that championship of the MMAC by DHCS leaders, external philanthropic investment, and strong collaboration and values

alignment among the Planning Team members were facilitating factors that led to the successful launch and implementation of the MMAC.

Interviews with the Planning Team and DHCS staff underscored the importance of Director Baass's championing of the MMAC as a vehicle for member-centered input. Her consistent leadership and presence in meetings were seen as critical to the development and effectiveness of the MMAC. Planning Team informants also pointed to the dedicated external funding from CHCF and LPFCH as critical to building the capacity of DHCS and to the effective implementation of the MMAC with fidelity to the design recommendations. They also agreed that their strong collaboration, trust, and clear roles, along with their shared value for learning, iteration, and improvement, allowed them to make mid-course corrections to strengthen the MMAC as a member-centered committee.

The engagement of a third-party consultant, EIC, increased the capacity of DHCS to authentically engage members. EIC offered thought partnership and expertise in community engagement to DHCS while also acting as a bridge between MMAC members and DHCS.

Informants underscored the importance of a third-party consultant that serves as a bridge between DHCS and members, creating deeper understanding and dampening power dynamics that naturally exist between a powerful unit of government and its program members. They explained the ways that EIC contributed to the success of the MMAC with respect to being member centered and inclusive. The EIC consultant team is composed of people of color who have lived experience with the Medi-Cal system, strong expertise with community engagement, and deep partnerships with community-based organizations across the state. Their lived and learned expertise with the community and Medi-Cal systems enabled them to play a bridging role. MMAC members and DHCS informants described EIC's ability to "translate" between the system perspective of DHCS and the firsthand experience of Medi-Cal members as essential for facilitating and supporting a member advisory committee. The DHCS staff and funders who were interviewed valued the EIC team's ability to navigate a large, complex public system like Medi-Cal. Member informants described how EIC gave them confidence and ease in participating in MMAC meetings with DHCS, minimizing formality and any feelings of intimidation. For the first year, a bilingual Spanish-speaking EIC staff also translated and supported monolingual Spanish-speaking MMAC members.

The evaluation also found that the external consultant group supported DHCS and the Planning Team's readiness and ability to learn and iterate on the design and implementation so that the MMAC could be member centered. The collaboration between DHCS and EIC facilitated a number of changes in response to emergent learnings during the MMAC implementation, including:

- **Member recruitment:** recruiting Medi-Cal members through community partnerships and other venues to ensure that the MMAC represents the diverse Medi-Cal member population
- **Stipends:** increasing the member stipend amount to $200 per quarter to honor members' time and expertise
- **MMAC meeting facilitation:** developing MMAC meeting agendas that increase the participation and input of members, including reducing the number of DHCS agenda items, bringing in ice-breaker activities and creative arts, and providing technical support before and after the meeting time
- **Pre- and post-meeting sessions with members:** offering small-group sessions to prepare before, and debrief members after, MMAC meetings.

These sessions are another touchpoint for DHCS staff to build trusting relationships with members, respond to their questions and feedback, and gather insight into how to strengthen MMAC meetings.

"It was helpful to have EIC with DHCS. They make the process feel — I don't feel like I have to be formal or a certain way. If it were with a different government entity, I would be more shy to reach out. EIC made it easy to reach out without feeling anxious."

—MMAC member

"What we've learned from the consultant group is that some members are very vocal — they talk a lot in the sessions — while others are quiet. We worked to do round-robins. We may call on people. And we will first start with this person to hear their feedback."

—DHCS staff

"DHCS leadership participation [at MMAC meetings] is really important. Amazing that Michelle Baass and the whole senior team is there — goes a long way for making it successful."

—Planning Team

What has been the MMAC's influence on DHCS?

MMAC members provided valuable feedback on member-facing communication materials, encouraging DHCS to create materials that are written in plain language, easy to understand, and easy to act upon.

The Planning Team and MMAC members alike cited the member-facing communications on how to file a complaint and how to submit an appeal and obtain a state hearing as examples of how the MMAC influenced the practices of DHCS. In January 2024, DHCS presented the appeals and complaint process to MMAC members to gain input on how to make its member-facing information helpful and clear. In response, members shared their experience with filing a complaint and how to change the information so that it is written in plain language, understandable for consumers, and translatable to different languages. One member shared their story of providers retaliating after the member filed a Medi-Cal complaint, while others shared their fears of provider retaliation. They believe that clear communications from DHCS about member rights after filing a complaint will enable members to have more confidence to file a grievance and get the care and services they deserve.

The MMAC members also explained how the terms "ombudsman" and "grievance" were unfamiliar and challenging for people to understand and act on. One member shared that through what they learned about the complaint process in the MMAC meetings, they were able to file a complaint of their own. See the text box on page 11 for examples of how the member-facing material changed through member feedback.

A few members also cited other examples of how they provided input to member-facing communications, including a television ad with misinformation about reenrollment processes for Medi-Cal, Medi-Cal eligibility of people with unsatisfactory immigration status, and information on Medi-Cal specialty mental health services.

"The MMAC has set [the] foundation of understanding [how to communicate with members]. Now DHCS can say across different spaces that members like to see infographics. They don't like or understand jargon like 'ombudsman' — terminology needs to be translated for meaning. We can say those things because it is grounded in feedback and in the committee."

—DHCS staff

"One change they might have made was a flyer about appeals. We all chimed in that we didn't understand the word 'ombudsman' and that [that] word would not translate to other languages. I feel like they heard us, because we were very vocal."

—MMAC member

As a result of being a part of the design and implementation of the MMAC, DHCS staff and leaders are shifting the culture and practice of the agency to be more member centered.

DHCS leaders and staff informants shared that through direct engagement with Medi-Cal members, they have more empathy for and accountability to Medi-Cal members. Through members' experiences and concerns brought up during MMAC sessions, DHCS leaders were alerted to and able to monitor potential systemic issues across the Medi-Cal health care delivery system throughout the state. They have gained a better understanding of how Medi-Cal policies and programs affect members directly, how these may be experienced differently based on region, and the difficulty members experience when navigating complex systems with bureaucratic jargon, predominantly in English. DHCS staff also directly responded to and helped address issues faced by individual MMAC members. For example, when one member shared that they had a delay in receiving a wheelchair, DHCS

Example of Changes in the "How to File a Complaint" and "How to File Appeal" Communications

Before

Not happy with your medical care? Think the service was bad or have medical bills that your plan should be covering?

As a Medi-Cal member, you have rights, regardless of your immigration status. You will not lose your benefits if you file a complaint.

After

Not happy with your medical care? Was the service bad, or do you have medical bills your plan should be covering?

As a Medi-Cal member, you have rights. You will not lose your benefits if you file a complaint, regardless of your immigration status or if you have complained before.

Before

The Ombudsman service is free and can help you file a complaint, an appeal, and a State Fair Hearing. The Ombudsman is an impartial individual to help Medi-Cal members resolve "issues" with their health plan.

Phone: (888) 425-8609
Email: MCDObudsmanOffice@dhcs.ca.gov

After

You can get free information on how and where to file a complaint, an appeal, and/or a State Hearing by contacting:

Phone (888) 425-8609
Email: MemberHelp@dhcs.ca.gov

Sources: "Not happy with your medical care?" DHCS, October, 2024 and "Medi-Cal Member Advisory Committee Meeting Presentation" DHCS, May 15, 2024.

promptly resolved the issue so that they received their Medi-Cal-covered durable medical equipment. This type of responsiveness is important for building trust between DHCS and MMAC members.

The Planning Team and DHCS staff informants also shared that through the MMAC implementation, DHCS is learning to build authentic relationships and communicate with members. DHCS is improving how it shows up with a posture of listening and learning in MMAC meetings and other meetings with members, communicating in plain language rather than jargon and acronyms, and slowing down and being responsive to members' needs. Informants explained that EIC's coaching and modeling have supported the capacity and growth of DHCS.

Informants also emphasized that Director Baass's championing of the MMAC supports a culture shift in DHCS, which has led to an increased desire to engage and consult with members directly. DHCS staff informants cited the following examples, which demonstrated the shift in DHCS: more DHCS departments are interested in presenting and gaining guidance from MMAC members, DHCS leaders are conducting listening tours with members across the state, and DHCS is planning to conduct focus groups to receive member feedback on member-facing materials.

"DHCS is looking at whether a member's issue is something we are hearing across the state or region. They are getting a systemic view. The agency is talking to specific departments and teams that are working at specific part[s] of the agency to resolve some of those issues and doing a deeper dive. We know it's happening because we develop[ed] a member issue tracker — we put it in the tracker, [and it] goes internal to the agency."

—Planning Team member

"[The] hardest for DHCS is this general concept of 'moving at speed [of] trust' and slowing down. We tend to move fast, talk fast, and cover lots of stuff. We are learning to cover 1–1.5 topics in [a] two-hour meeting. We need time for rapport building and relationship. . . This is an ongoing challenge with our culture. EIC as an intermediary has helped us slow down to [the] speed of trust. We have [a] mutual relationship where they are learning about what we have to deal with and [how to] speak Medi-Cal. We [DHCS] are learning how to work with members."

—DHCS staff

What is the experience and value of the MMAC for members?

MMAC members are highly satisfied with their experience with the MMAC.

The MMAC members in small-group conversations and interviews spoke positively about their experience with the MMAC. None of the members who participated in the evaluation shared a negative perspective or experience. Members reported feeling heard, welcomed, and respected by DHCS and EIC within the meeting space and between meetings. Specifically, they appreciated the responsiveness of both DHCS and EIC with respect to their questions and concerns.

This finding aligns with post-MMAC meeting surveys that were disseminated to members after the first five meetings from May 2023 to May 2024. On average, 96% of member respondents across all surveys strongly agreed or agreed that the meetings were well facilitated (See Appendix B). The Planning Team and DHCS leaders who were interviewed also perceived that members were satisfied overall with their experience in the MMAC thus far.

"On a scale of 1–10, [I] rate it a 10. DHCS and EIC [have] been responsive within hours — I get a response via email. They listen to my concerns, from mental health to my status as [a] DACA recipient. The one-on-ones have been great and . . . [attentive] to detail as to what I share with them. I am very satisfied."

—MMAC member

"With the things that come up between meetings, I was able to connect with EIC staff. That piece was very valuable to see them as a liaison and go-to person to DHCS."

—MMAC member

Members are proud of their ability to directly educate and influence DHCS leadership to improve the Medi-Cal system for themselves and other consumers.

In the small-group conversations and interviews, members described the MMAC as a platform for sharing their experiences and challenges with the Medi-Cal system directly to leaders of DHCS, who are the decision makers and can change Medi-Cal policies and practices. In post-meeting surveys, MMAC member respondents also raised this as the most valuable aspect of the MMAC meeting. Members emphasized that by sharing their stories to the top leaders of DHCS, they are "closing the gap" between the understanding of the Medi-Cal health care delivery system by DCHS and the consumer's experience at a regional and individual level. They strongly believe that participation in the MMAC will create improvements for themselves and other Medi-Cal members. The Planning Team members also expressed similar sentiments about what they believe is the value of the MMAC for members.

The evaluation also uncovered the implicit expectation that MMAC members will have their Medi-Cal issues and concerns addressed by the leadership of DHCS. In interviews and group conversations, the Planning Team and members described how the "air space" in MMAC meetings can easily be taken up by members' concerns. Member respondents expressed gratitude that DHCS staff directly resolved the individual issues they raised during MMAC meetings. However, some member informants expressed frustration that their challenges have yet to be resolved directly. In small-group conversations, members shared concerns regarding access to health care, such as long wait times for primary care appointments and traveling to another county to receive services.

"The individuals who are hearing us at DHCS are the decision makers and their leaders. The director comes to our meetings, and it is powerful and shows they are invested and want to see changes being made. They are not waiting for information to trickle up."

—MMAC member

"There is a clear gap between our understanding of the health care system and

those developing it. The only way to make [a] solution is by closing the gap — [DHCS is only] able to connect care to members by hearing from people themselves. The advisory board is doing just that."

—MMAC member

"I would give it . . . five star[s] if I had more of a direct connection to someone who can address my concerns outside of the meeting."

—MMAC member

A majority of the members who engaged in the evaluation highly valued the ability to learn about their peers' diverse experiences with Medi-Cal, which keeps them informed and motivates them to advocate for their own communities.

An unexpected ripple effect of the MMAC is that some members take on an advocate-ambassador role, formally and informally, by bringing information to their own community and relaying community challenges back to DHCS. Some members have formal roles as advocates or community health workers/*promotores*, in which they liaise between community members and agencies, providing fellow members with information about Medi-Cal and bringing community concerns to decision makers. A few MMAC members described themselves as "career advocates" who have participated in different advisory groups. Other members do not have formal roles but informally educate and advocate for their community. For example, a Spanish-speaking member who is part of a larger network explained that she shared information that she learned through the MMAC to other Medi-Cal members in her community. MMAC members expressed that they feel empowered to share information and updates on Medi-Cal policies, programs, and practices, because they have a direct connection to DHCS leaders. They also shared that participating in the MMAC validated their personal experience in navigating complex systems and the negative impact of systemic barriers on their or their family members' health. This helped them move from seeing the Medi-Cal system from a personal perspective to seeing it from a systemic point of view. Post-meeting survey responses also highlighted this as a key value of MMAC meetings for members.

"Learning about everyone's struggles with the system helped me to understand . . . [the challenges of people with disabilities] with Medi-Cal."

—MMAC member

"I am going to go back to the groups, committees, and boards I am on and share information. I have gone back after these meetings and shared what I heard — and [asking '[Are these Medi-Cal changes] happening here[?'] and if not, why not?"

—MMAC member

"I work with many community members. This group has been extremely valuable because I have an opportunity to voice my own personal Medi-Cal challenges as well as other community members' Medi-Cal issues. It's a great group to problem-solve Medi-Cal issues for the larger community. . . By learning how the enrollment and appeal[s] process works, I was able to educate other community members."

—MMAC member

What are the strengths of the MMAC?

The evaluation found that DHCS and the Planning Team largely adhered to the design recommendations from the research phase in the implementation of the MMAC.

In interviews and small-group conversations, the Planning Team, DHCS staff, and members alike described the implementation of the MMAC as being consistent with the original design recommended in the research phase. In addition, the learning posture of DHCS supported DHCS's ability to avoid (or work toward addressing) common pitfalls of advisory committees and make design changes that benefited members. There was consensus across the different groups — MMAC members, DHCS leaders, and the Planning Team — that three critical elements contributed to the effectiveness and value of the MMAC:

1. **Participation of DHCS directors and senior leaders in all MMAC meetings.** This was raised as one of the most important aspects of the MMAC design. Leadership presence signaled to members the agency's investment in member engagement and feedback. MMAC members valued the direct line to the top leaders and decision-makers of Medi-Cal's policies, programs, and practices. Additionally, the director's commitment and actions demonstrated to DHCS staff the value of being member centered, which subsequently influenced the mindset, culture, and practices of the DHCS.

2. **Diversity of MMAC members.** The diversity of MMAC members, which reflects the diverse Medi-Cal membership, supports the MMAC's ability to broaden and deepen DHCS leaders' and members' understanding of the varied experiences and challenges with the Medi-Cal system across the state.

3. **Human-centered design and facilitation of MMAC meetings.** Human-centered activities during MMAC meetings created authentic connection and fostered dialogue among Medi-Cal members and DHCS leaders in a way that a traditional didactic presentation and member response format could not. MMAC members and the Planning Team alike pointed to EIC staff's ability to employ different participant-engagement structures (e.g., round-robins and breakout groups) and bring in creative arts and meditation to open and close each MMAC meeting.

The majority of MMAC members, DHCS leaders, and Planning Team informants were satisfied and provided positive feedback on how they experienced the different elements of the MMAC design.

Table 2 (see following page) lists the elements of the MMAC design that multiple informants valued and recommended that DHCS continue.

"They have the eyes and ears of DHCS. All directors and deputies and leadership attend committee meetings. Right in the room with the members. This is a culture shift and power-dynamic shift."

—Planning Team

"I really like that someone comes in to do poetry or meditation to get into a mindset of getting into the groove of what we would cover. I love those meditation practices. They are really helpful, needed, and significant."

—MMAC member

Table 2. Informants' Positive Feedback on the MMAC Design

DESIGN ELEMENT	INFORMANTS' AREAS OF SATISFACTION
Composition and size	➤ 15–18 Medi-Cal members composing the MMAC ➤ Family members and caregivers representing Medi-Cal members who may have challenges with accessing and participating in MMAC meetings
Compensation	➤ Offering a $200 stipend per quarter and other supports to value the expertise and time of members ➤ Options for the type of stipend (e.g., check, gift card)
Meeting logistics	➤ Technology support for members to participate in virtual meetings (e.g., webcam, speaker) ➤ Interpretation and translation for monolingual non-English speakers ➤ Virtual quarterly sessions for the MMAC
Meeting facilitation	➤ Utilizing breakout groups and "calling in" groups of members to support the equitable and meaningful contribution of all members ➤ Bringing the creative "human" elements of arts and meditation into the meeting to foster authentic connection
Meeting materials	➤ Mailing meeting agendas and materials to participants prior to the meeting session
Building trust	➤ Treating MMAC members respectfully ➤ Responding to their requests in a timely manner
Preparing and supporting Medi-Cal members	➤ Responding to and resolving MMAC members' challenges with accessing and receiving Medi-Cal health care services ➤ Holding "in-between sessions" to prep MMAC members to support their ability to contribute their perspectives in meetings and to facilitate debriefing conversations so that members can offer additional feedback or ideas after the meetings

Source: Bright Research Group analysis of MMAC post-meeting surveys from May 2023 to May 2024. *MMAC* is Medi-Cal Member Advisory Committee.

"The facilitation of the meetings . . . [is] straightforward and easy to follow. I enjoy being able to have the presentation in advance. I appreciate the beforehand information."

—MMAC member

"There are members with different disabilit[ies], language[s], have kids, different socioeconomic status. [They can] hear how this service [Medi-Cal] is adversely affecting us."

—MMAC member

How can the MMAC be strengthened to meet its objectives and to influence DHCS?

While all informants were highly satisfied with the MMAC thus far, they shared some ideas on how to improve the MMAC, including encouraging DHCS to strengthen transparency and consistently close the feedback loop.

All stakeholder groups interviewed expressed high satisfaction with the implementation of the MMAC to date. Informants also provided suggestions on how to strengthen the MMAC so that members can more effectively inform the policies and practices of DHCS. Their suggestions are listed in Table 3.

Table 3. Informants' Suggestions to Strengthen the MMAC

DESIGN ELEMENT	INFORMANTS' SUGGESTIONS
Composition and size	➤ Strengthen the diversity of members to reflect the Medi-Cal population by ensuring diverse representation among language/ethnic groups; people with disabilities; and people with varying immigrant backgrounds, ages, and geographic representation.
Recruitment	➤ Dedicate time and resources to implement a multipronged, culturally appropriate approach needed to recruit diverse and representative MMAC membership. ➤ Develop and partner with community-based organizations to identify and recruit members.
Compensation	➤ Provide a stipend to caregivers and family members who support members' ability to attend and contribute to MMAC meetings.
Meeting logistics	➤ Consider one to two in-person meetings to increase relationship building and collaboration — these could be held regionally rather than statewide to increase accessibility. ➤ Provide interpretation and translation in additional languages as needed to include Medi-Cal members.
Meeting facilitation	➤ Limit MMAC meetings to one to two new topics and reduce the amount of information presented to give more space for collaborative discussion among DHCS and members. Spend multiple sessions on one topic. ➤ Manage the discussion time to ensure that every MMAC member has ample time to share their thoughts.
Building trust	➤ Consistently close the feedback loop by reporting status updates, action steps, and timing for incorporating items for which members provided input or concerns that they raised.
Supporting and preparing Medi-Cal members	➤ Ensure that all members can access and utilize the "in-between sessions." ➤ Offer optional trainings or information on Medi-Cal to ensure that all MMAC members have the same baseline understanding of the Medi-Cal system. This can be especially useful for non-English-speaking members who need information about Medi-Cal provided in plain language. ➤ Consider developing a peer mentor system for MMAC members by pairing seasoned members with new ones, especially during the initial onboarding stage. Peer mentors should be compensated at a higher rate for their peer support. ➤ Create additional venues for members to share their feedback and challenges as well as collaborate before and after meetings. Examples that members offered were surveys, a Slack channel, and optional virtual sessions.

Source: Bright Research Group analysis of MMAC post-meeting surveys from May 2023 to May 2024.

Note: *MMAC* is Medi-Cal Member Advisory Group.

The Planning Team and DHCS staff informants underscored the importance of DHCS identifying and prioritizing policies and practices that match MMAC members' concerns and can be changed by their input. Some informants reflected that at times DHCS invited MMAC member feedback on programs and policies that are out of the scope of DHCS to influence. MMAC members also indicated that the MMAC could be more effective in influencing the policies and practices of DHCS if they better understood the internal processes, timing, and decision making of DHCS. In discussions and post-meeting surveys, some members expressed a desire to better understand specific Medi-Cal programs and policies. MMAC member informants agreed that DHCS should close the feedback loop by providing regular status updates or reports on the actions that result from MMAC member input. Consistently closing the feedback loop and explaining decision making processes and constraints would build trust between DHCS and MMAC members and help members understand what decisions they can influence.

"One thing I like about the [fellow members'] suggestion [of] a report at [the] end: It can show what the MMAC has done, how DHCS listened to us, and [how] they implement changes we [suggested]. That could be a [form of] gratitude and a way to recognize that our voices do matter."

—MMAC member

"DHCS asked for our input in the enrollment infographic — they wanted to remove the live phone line to register and/or ask for assistance and office hours and make it digital. The majority of the members felt strongly that they needed to keep the help line for folks that have digital divide/technology challenges as well as for folks with disabilities. Our recommendation was to leave both options. I would like for DHCS to loop back to let us know what the final decision was."

—MMAC member

"I agree it is a lot of information, especially since we meet once a quarter. It would be helpful to cover the topics longer. For example, mental health — we just covered [it] in one session, and we asked for another session. Maybe not asking the committee what topics they would like to cover, but maybe a Rolodex of suggested topic[s]. . . . And the committee can vote on which meeting can address which topic."

—MMAC member

Table 3 captures suggestions surfaced through the evaluation. It is important to note that throughout the implementation of the MMAC, the Planning Team has made real-time adjustments; informants may not be aware that some of their suggestions are changes the Planning Team is already operationalizing to strengthen the MMAC.

What are considerations for the next phase of the MMAC as it adheres to the guidelines of CMS?

Overall, most MMAC members expressed enthusiasm for and hope about the next phase of the MMAC under the CMS Access Rule guidelines, encouraging DHCS to maintain and strengthen the existing design of the MMAC.

The majority of MMAC members expressed strong interest in continuing as committee members when the MMAC transitions to the BAC under the CMS guidelines. They hoped that the BAC has diverse representation among the committee members that reflects the Medi-Cal population. The MMAC member informants also encouraged the leaders of DHCS to continue to attend all the committee meetings. They emphasized that MAC meetings with providers and other stakeholders should be member centered — that their voices are at the forefront and still being heard. Some MMAC members raised concerns about the impact of the new federal administration on Medicaid and its effect on access and use of services, as well as the role of the MMAC.

Members voiced the following feedback on the transition to the BAC during small-group sessions and during the MMAC meeting presentation on the CMS guidelines:

- **Member terms.** Members want clarity about their status and role as the inaugural cohort of the MMAC and whether they would be "grandfathered in" when the MMAC adopts and follows the CMS guidelines as a BAC. They also suggested a two-to-three-year term for BAC members.
- **Member privacy.** For the new MAC meetings that include providers and other stakeholders, members stressed the importance of protecting the identity of members, especially those from vulnerable populations (e.g., transgender, undocumented, neurodivergent), and creating a safe, inclusive space. This is important for the two meetings open to the public.
- **Meeting facilitation.** Members recommended keeping BAC meetings to two to three hours with a break during evening hours after 5:00 PM and strengthening the accountability of and transparency between DHCS and members.

"I would like all the members I started with to be a part of the next phase. We are just getting started and have built trust as a team."

—MMAC member

"I hope there is a diversity of individuals that speak many different languages and represent different Medi-Cal patients. Also, geographic [diversity], gender identity, ability diversity, and all the ways to be inclusive of many different individuals, and that there is a good balance between members and stakeholders. Stakeholders tend to dominate voices sometimes, [so we] want to make sure community is still at the forefront."

—MMAC member

Recommendations

As the MMAC transitions to the BAC, the evaluation findings suggest the following recommendations to strengthen the value and influence of the committee of Medi-Cal members.

Deepening the Influence of the MMAC on DHCS

1. **Continue to apply the MMAC design recommendations from the research stage and uphold the three effective elements that emerged from the evaluation.** The effective elements included:
    - DHCS leadership's participation at all MMAC meetings
    - A diverse MMAC member body that reflects the Medi-Cal member population
    - Human-centered design and facilitation of meetings

2. **Continue to have a learning mindset in the implementation of the MMAC.** DHCS listening and applying MMAC member feedback about their experience on the advisory council supports MMAC members' abilities to influence the policies, practices, and programs of DHCS.

3. **Sustain trust and partnership with members by sharing DHCS decision-making processes, what members can influence within the agency, and a plan for closing the feedback loop.** DHCS should share the internal timeline, decision-making process, constraints, and scope of influence of the MMAC members. Members appreciate knowing where their perspectives and ideas can result in changes within the agency and when to expect changes at a state or regional level. For example, DHCS could:
    - Share ongoing updates on how DHCS is responding to members' concerns and whether they are looking into issues with a systemic or regional lens during individual meetings with members
    - Explain to members what issues and points of feedback DHCS cannot take action on and why
    - Provide status updates on timelines, decisions, and actions on the collaborative projects of the MMAC (e.g., input on community-facing materials or a Q&A on enrollment processes) during MMAC sessions
    - In alignment with CMS guidelines, create an annual report that highlights the process and success of how the MMAC members have influenced DHCS policies, programs, and practices

4. **Proactively identify specific decisions and projects that can benefit from MMAC input and that DHCS can act on.** These topics should align with the CMS guidelines on topic areas for BAC input. Based on the progress of the MMAC thus far, communications to enrollees and providers is an area where MMAC members can provide valuable and actionable insight. Communication to enrollees/members is not specific to a type of program or service. MMAC members can also provide insight on how to make information easy to understand, culturally competent, at the right health literacy level, and easy to act on.

    By reducing the scope of the input of the MMAC, DHCS could more easily:
    - Identify specific training topics for MMAC members
    - Close the feedback loop on processes and decisions, which builds trust

- Demonstrate the concrete successes of MMAC members' influence on DHCS policies and practices
- Create subcommittees with specific topics/projects based on the interest and expertise of members

Supporting and Preparing Members

5. **Continue to assess the composition of the MMAC to ensure the committee represents the diverse Medi-Cal population.** Ensure the MMAC reflects the diversity of Medi-Cal members regarding gender, race/ethnicity, language, geographic representation, age, ability, and service utilization.

6. **Continue to respond to and address members' concerns about Medi-Cal policies, practices, and programs raised during meetings.** To focus the MMAC meeting time on the key topics or projects at hand, consider maintaining multiple, separate forums for members to share and resolve additional Medi-Cal concerns. For example, maintain time at the front of the agenda or create subgroups of DHCS staff and members to work on member-identified challenges and concerns.

7. **Build MMAC members' knowledge and understanding of the Medi-Cal system.** Providing additional training on Medi-Cal can enable MMAC members to leverage both lived and learned expertise when providing input to DHCS. They want to understand how the system works so that they can provide applicable and valuable consultation. Opportunities to build their capacity include:
   - A peer mentor role in which seasoned or termed-out MMAC members can orient, coach, and support new MMAC members
   - Individualized technical assistance and support for members for onboarding/orientation and throughout their term
   - Substantive training on the specific Medi-Cal policies and programs that MMAC members will be providing input on
   - Orientation on how state-level Medi-Cal policy affects regional implementation
   - Translated training materials that are written in plain language and at the appropriate health literacy level

Implementation and Sustainability

8. **Institutionalize the MMAC within DHCS.** DHCS should continue to dedicate budget, staff, and resources to sustain the MMAC. By documenting the MMAC design and lessons learned in implementation, DHCS can ensure the effectiveness of MMAC in the next phase.

9. **Champion authentic member engagement across the Medi-Cal system and share the effective elements of the MMAC.** DHCS should share the best practices and lessons learned from the design and implementation of the MMAC. They can also model authentic member engagement internally at DHCS and externally to MCPs and decision makers.

Conclusion

Prior to the CMS-issued "Ensuring Access to Medicaid Services" rule to maintain a BAC, the California DHCS launched its inaugural member-only Medi-Cal advisory group, the MMAC, with a commitment to authentic engagement and improving Medi-Cal policies and programs through member input. DHCS designed and implemented the MMAC by applying recommendations from the planning phase and real-time learning and iteration based on member feedback and expertise in community engagement from an external consultant. The evaluation found that MMAC members were highly satisfied and valued their experience with the MMAC. MMAC members were proud of the ways they influenced DHCS, citing concrete examples of how they changed the member-facing communications of DHCS so that all Medi-Cal members can understand and use them. There is also evidence that DHCS is shifting its organizational culture and practices to be more member centered through direct engagement with Medi-Cal members and collaborative implementation of the MMAC with external partners. For a successful transition of the MMAC, DHCS should maintain the integrity of the MMAC design and the three components that enabled MMAC members to influence the policies and practices of DHCS: (1) DHCS leaders' participation at all MMAC meetings, (2) the diversity of MMAC members, and (3) the human-centered design and facilitation of meetings.

Appendix A. MMAC Member Demographics as of December 2024

Table A1. Demographics of MMAC Members

DEMOGRAPHICS	PERCENTAGE OF COMMITTEE MEMBERS (N = 16)	PERCENTAGE OF MEDI-CAL CERTIFIED ELIGIBLE POPULATION OCTOBER 2024
Gender Identity		
Female	63%	53%
Male	31%	47%
Nonbinary	6%	NA
Transgender	6%	NA
Age		
0–20	6%	37%
21–64	81%	52%
65+	13%	11%
Race and Ethnicity		
Black	13%	7%
American Indian and Alaskan Native	6%	0%
Asian, Native Hawaiian, and Pacific Islander	24%	9%
Latino/x	31%	52%
White	31%	16%
Other	6%	NA
Not reported		16%

Source: Medi-Cal Monthly Eligible Fast Facts (PDF), California Department of Health Care Services (DHCS), January 2025; and DHCS MMAC member composition, Everyday Impact Consulting, December 2024.

Note: *MMAC* is Medi-Cal Member Advisory Committee.

Appendix A. MMAC Member Demographics as of December 2024 (continued)

List of MMAC Member Eligibility, Service Use, and Other Characteristics

Eligibility

- Medi-Cal
- Dually eligible

Delivery System

- Managed care plan
- Fee-for-service only

Benefits utilized

- Home and community-based services
- Skilled nursing facility services
- Services for those with intellectual or developmental disabilities

Health conditions

- Serious mental illness
- Chronic physical condition
- Substance use disorder
- Physical disability
- Child with special health care needs

Appendix B. Post-MMAC Meetings Member Survey

EIC administered a post-meeting survey to MMAC members after each MMAC session for five consecutive sessions. The survey tool with close-ended and open-ended questions focused on members' experiences, and feedback on the sessions largely remained consistent, with some variation.

The following tables summarize the quantitative survey data and key qualitative themes.

Table B1. Members' Level of Agreement About Whether the Meeting Was Facilitated Well

MMAC MEETING	*N*	STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE
5/1/23	9	0%	0%	0%	22.2%	77.8%
8/1/23	2	0%	0%	0%	50.0%	50.0%
10/1/23	6	0%	0%	0%	33.3%	66.7%
1/1/24	8	0%	0%	12.5%	0%	87.5%
5/1/24	5	0%	0%	0%	40.0%	60.0%
Grand Total	30	0%	0%	3.3%	23.3%	73.3%

Source: Bright Research Group analysis of MMAC post-meeting surveys from May 2023 to May 2024. EIC, January 2025.
Notes: *MMAC* is Medi-Cal Member Advisory Committee. Figures may not sum to 100% due to rounding.

Table B2. Members' Level of Agreement About Whether the Structure and Approach Were Good for the Meeting

MMAC MEETING	*N*	STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE
5/1/23	9	0%	0%	0.00%	33.33%	66.67%
8/1/23	2	0%	0%	50.00%	50.00%	0.00%
Grand Total	11	0%	0%	9.09%	36.36%	54.55%

Source: Bright Research Group analysis of MMAC post-meeting surveys from May 2023 to May 2024. EIC, January 2025.
Note: *MMAC* is Medi-Cal Member Advisory Committee.

Table B3. What Part of the Meeting Was the Most Valuable? (*N* = 31)

TOP THEMES	*N*
Hearing and learning about other members' concerns and experiences	8
Members providing input to and their personal experiences with DHCS on the presented topic	6
Members and DHCS engaging in collaborative dialogue	4
Learning about the programs, services, and initiatives of DHCS	3

Source: Bright Research Group analysis of MMAC post-meeting surveys from May 2023 to May 2024. EIC, January 2025.
Notes: *MMAC* is Medi-Cal Member Advisory Committee. DHCS is California Department of Health Care Services.

Member Quotes: What Part of the Meeting Was the Most Valuable?

"Whenever we are able to communicate to make the program better, hear others' experiences, and work as a team."

"Learning about the projects the government agency is working on was valuable."

"I believe having those from DHCS, who were knowledgeable about the mental health care process . . . [was] most valuable. Listening to their input and them listening to ours helped us understand each other and limitations in terms of resources and what is needed."

Table B4. How Could the Meeting Content, Process, and/or Agenda Improve? (*N* = 27)

TOP THEMES	*N*
Positive feedback on existing meeting agenda and process	12
Facilitation practices to keep members' input and discussion focused on the topic at hand	4
Process for members to get their personal Medi-Cal concerns addressed	3
More solution-oriented dialogue among members	3
Q&A structure	2

Source: Bright Research Group analysis of MMAC post-meeting surveys from May 2023 to May 2024. EIC, January 2025.
Note: *MMAC* is Medi-Cal Member Advisory Committee.

Member Quotes: How Could the Meeting Context, Process, and/or Agenda Improve?

"Honestly, the meetings are really informative. I wouldn't change anything, really."

"Give [the] agenda and handouts two weeks to a month before the meeting. At the beginning of the meeting, let people know the focus of the meeting and remind them that any topics not covered in the agenda can be covered in the one-on-one afterward."

"Loop in some caseworkers/social workers who could follow up with folks who have individual problems."