

## Key Findings from the Medicaid MCO Learning Hub Discussion Group Series and Roundtable – Focus on Member Engagement and the Consumer Voice

**The NORC Medicaid Managed Care Organization (MCO) Learning Hub shares timely and relevant resources to support Medicaid MCOs and other stakeholders in improving the health of their members and increasing advancements in health equity and health care transformation. We encourage you to share your experiences and feedback on future Medicaid MCO Learning Hub work so we can better serve your needs. To start the conversation or join our distribution list, please email us at [MCOLearningHub@norc.org](mailto:MCOLearningHub@norc.org).**

In November 2020, the NORC team convened four discussion groups, one with each of its Medicaid MCO Learning Hub partners—Community Catalyst, the Association for Community Affiliated Plans (ACAP), America’s Health Insurance Plans (AHIP), and Families USA—and their affiliated Medicaid MCOs and advocacy experts. We discussed challenges with member and family engagement, strategies for better engagement, and how COVID-19 affected engagement efforts. After assessing key themes, the team convened a roundtable with representatives from our four partners to discuss main findings and identify insights and opportunities to address those findings.

This brief, the third in a series of discussion groups and Roundtable discussions detailing findings and opportunities around key issues, will provide the Robert Wood Johnson Foundation (RWJF), its grantees, MCOs, and community-based organizations, among other stakeholders, with information on key member engagement challenges before and during COVID-19, and local, state, and federal-level opportunities for addressing those challenges.

Medicaid member and family engagement strategies are multifaceted vital components of Medicaid managed care organization (MCO) programs. MCOs engage with members from enrollment and at other touch points using outreach and other communication strategies. The insights derived from member engagement can shape strategy, service design, delivery, and program structure at the plan and state level. Member engagement can drive effective use of benefits and address member health care needs.

This brief presents key findings from a series of discussion groups organized with our Medicaid MCO Learning Hub partners—Community Catalyst, the Association for Community Affiliated Plans (ACAP), America’s Health Insurance Plans (AHIP), and Families USA—and a

subsequent Roundtable where MCOs and consumer advocacy representatives:

- Described the various touch points at which MCOs engage members and their families
- Discussed challenges with and strategies for more effectively engaging Medicaid members
- Assessed how MCOs can elevate the consumer voice, including strategies for and challenges with this process

# Key Findings from the Discussion Groups

This brief focuses on two key areas:

- **Member and family engagement broadly**, which occurs on a [continuum](#),<sup>1</sup> from outreach (primarily providing the community with information) to shared leadership (a strong bidirectional relationship and partnership structure where final decision-making occurs at the community level).
- **Elevating the consumer voice**, which ensures that the experiences of members and their families inform Medicaid MCO program design and policy decisions. Elevating the consumer voices often focuses on the collaboration and shared leadership end of the member engagement continuum. In this brief, we primarily focus on consumer advisory councils.

## MEMBER AND FAMILY ENGAGEMENT

This section presents findings on the ways MCOs engage their individual Medicaid members and their families and facilitators and barriers to engagement.

### I. MCO ENGAGEMENT OF MEDICAID MEMBERS AND THEIR FAMILIES

#### MCOs engage with Medicaid members and their families at various touch points

MCOs reach out to members to provide them with multiple types of important information via mailings, phone calls, face-to-face interactions, text messages, interactive voice response (IVR), and social media. At an individual level, MCOs first engage with members during a welcome call after a member has chosen an MCO through an enrollment broker. They then communicate at various other touch points throughout the member's enrollment. MCOs also collaborate with community-based organizations (CBOs) to participate in or host events (e.g., health fairs) as an additional way to communicate important information to members. In addition, MCOs conduct member surveys and leverage community advisory councils (discussed in more detail in the next section) to solicit member input.

#### Ideas about what constitutes meaningful member engagement differs between the MCO and advocacy representatives lens

MCO representatives noted that meaningful engagement consists of bi-directional exchange with Medicaid members and their families. Meaningful engagement goes beyond simple outreach and sending information to Medicaid

members. It involves having intentional communication between a care coordinator/care manager and a member to establish a care plan or positively affect the effectiveness of a member's behavior. For example, a member may take some positive action to get or improve the care they need or receive (e.g., health needs assessment, health care visit), and/or contact the MCO or its care coordinator/care manager.

An MCO representative described meaningful engagement as MCOs engaging members at multiple touch points in their health care journey, with the overall goal of improving the health of that member. Another described meaningful engagement as beyond a "check-the-box" exercise, noting MCOs should understand members' needs, how care delivery strategies do or do not work for a member, and how engagement influences and changes a member's health care behavior.

**"To [understand meaningful engagement], we need substantial evidence of what a member came on board with, what the interventions were, what worked, and what didn't; we're a long way from that. It's what you do and how you show that you influence behaviors as opposed to a 'check the box' exercise of having sent a letter." – MCO Representative**

From the advocacy representative perspective, meaningful engagement builds the individual and collective power of members to inform program policies and design to ultimately improve the delivery of and access to health care services and health outcomes.

**"From the community advocacy perspective, meaningful engagement is about building the power of individuals into a collective whole that helps improve care." – Advocacy Representative**

#### Level of member engagement varies by population, with complex and high-needs populations being more highly engaged

MCO representatives described level of member engagement as varying by population and initiatives. MCO representatives estimated that the share of Medicaid members with whom they engage (e.g., initial welcome call once a member is enrolled and additional outreach to remind members about needed preventive care visits or to address care gaps members may have) is around 30 to 60 percent.

<sup>1</sup> See Principles of Community Engagement: [https://www.atsdr.cdc.gov/communityengagement/pce\\_what.html](https://www.atsdr.cdc.gov/communityengagement/pce_what.html)

MCO representatives noted that Medicaid members with more complex needs are significantly more engaged, given they are assigned to care managers and/or care coordinators to address their various needs. These include adults who are older; individuals who are dually eligible; individuals with disabilities; individuals with serious mental illness (SMI); people with special needs; and members otherwise receiving long-term services and supports (LTSS). States most often have care management requirements for MCOs, which can vary depending on the specific population (e.g., development of care plans, in-person visits, and other similar requirements). MCO representatives estimated that level of engagement of these populations with their care manager/coordinators ranges from 50 to 90+ percent.

Participants stated that members receiving Temporary Assistance for Needy Families (TANF) assistance, who are part of the Children's Health Insurance Program (CHIP) or part of the Medicaid expansion population, tend to have lower engagement levels and are the hardest to reach due to challenges described further in the facilitators and barriers section below. They also noted that the level and types of engagement may vary for different initiatives (e.g., a dental or maternal and child health campaign).

## II. MEMBER ENGAGEMENT AND COVID-19<sup>2</sup>

**MCO and advocacy representatives noted that COVID-19-related outreach has led to increased engagement with their members**

Participants noted that because of the COVID-19 pandemic, MCOs increased outreach to their members, especially individuals older than 55 years and populations receiving LTSS, primarily by increasing the number of phone calls to those members. These efforts have allowed MCOs to reach members who they previously considered unreachable.

**“With COVID-19 outreach, we have been able to reach about 96 percent of our members for telephonic and virtual interactions. Some of our members that had been in the ‘unreachable’ category now, due to COVID-19, we were able to begin some engagement with them and are now working on continuing to develop those relationships.” — MCO Representative**

Participants noted that their member services call centers experienced a higher volume of calls from members during COVID-19. They reported the content of the calls shifted during the pandemic, with many members asking about social determinants of health (SDOH)-related needs like food delivery, access to transportation, and home delivery of medications. A few participants noted that calls to their customer service departments dropped rather than increased during the pandemic.

In addition, participants noted that COVID-19 highlighted the myriad ways in which they can conduct outreach to their members outside of “snail mail.” For example, policy changes to increase access to telehealth provided a new avenue for plan care coordinators to communicate with members. Others noted that care managers are increasingly using text messaging with members. Some participants also noted increases in the use of member portals to support engagement and access to information. One participant described an increase in their member outreach using targeted campaigns during COVID-19. The participant noted that people might be more accessible because they are stuck at home due to the pandemic and therefore potentially easier to reach.

**However, some participants described challenges in reaching out to their members during the pandemic**

Despite reports of increased outreach during the pandemic, some participants noted challenges. For example, COVID-19 caused MCOs to halt in-person outreach for populations with high needs who were receiving home visits or members who are hard to reach. Some plans eventually resumed face-to-face outreach, though they ensure both their staff and members have sufficient availability of personal protective equipment.

For populations with limited or no access to smartphones, Wi-Fi, data, and/or technology, shifts from in-person to phone or virtual engagement was ineffective. However, some plans are working with their providers to [bridge the digital divide](#), for example, by expanding access to Wi-Fi and data plans and helping supply members with phones or other devices that they can use to access virtual care. Participants also reported MCO delays in sending COVID-19 communications to members, given that states may require all communications to go through state clearance and approval processes.

<sup>2</sup> Most comments related to this section in group discussions came from MCO representatives.

**“In states with more robust programs relative to funding more data and technology, we’ve had a higher penetration of reaching people through text, tele-visits, etc., regardless of the population, including people with high instances of behavioral health issues who right now are heavily impacted by face-to-face limitations. Behavioral health is probably one of the biggest challenges right now. Some want to engage and are reaching out and or taking our calls, but others are falling into a deep hole and getting them to engage is challenging.” – MCO Representative**

### III. MEMBER ENGAGEMENT FACILITATORS

**Initial enrollment/welcome calls are an important outreach touch point to Medicaid members and their families at the outset of enrollment**

Discussion group participants noted that initial outreach and welcome calls when a member first enrolls in a plan help build trust, help members receive answers to questions, and are valuable for the participant. During these calls, MCOs advise members about the need to complete health needs assessments and gather preferences for communications (e.g., opting into receiving messages via text or email). Some plans have dedicated onboarding specialists who become a member’s main contact as they navigate the health plan. An MCO representative noted success in using this “single contact” model to develop relationships with members from the beginning versus having multiple people calling members for different purposes, and that this has improved engagement with hard-to-reach members by connecting with them early in their enrollment with the MCO.

**In-person and face-to-face engagements are effective mechanisms for outreach**

In-person outreach, including home visits, helps MCOs assess members’ environments and their risks, goals, and preferences. Pre-COVID-19, some plans had dedicated care coordinators conducting home visits. One MCO representative noted their plan launched two community-based centers staffed by people from the community where members can engage with the MCO, get help with work training and job referrals, receive education on maternal health issues, and access workspaces, among other services.<sup>3</sup> By embedding themselves in the community, plans can meet members “where they are.” One MCO representative noted that having network providers and peer support workers with lived experience is the “secret sauce” for outreach and engagement.

Other plans embed MCO staff in long-term care facilities, federally qualified health centers (FQHCs), and other settings to engage members where they receive care. MCOs may collaborate with FQHCs, clinics, and other community providers to conduct enrollment assistance, fund staff to serve as care managers to focus on Medicaid high-need populations for care coordination and disease management, and/or sit in providers’ lobbies to answer members’ questions and provide information. An advocacy representative noted that one Medicaid plan has an agreement with an FQHC association to fund several FQHC employees, housed in the Medicaid plan, to serve as care managers for Medicaid members, who are particularly high utilizers.

**MCOs partner with CBOs to engage with members**

MCOs work with CBOs in multiple ways to facilitate member engagement. For example, MCOs participate in or cohost community-based health fairs, baby showers, 5K races, flu shot events, food assistance events, and other community events. In some cases, MCO staff partner with CBOs to assist members with their SDOH needs, including the following:

- **Food insecurity:** Second Harvest Heartland, a nonprofit based in Minnesota, partners with Medicaid MCOs and Minnesota’s Integrated Health Partnerships (IHPs), and established a [FOODRx](#) program that provides food resources and nutrition solutions to plan members or attributed populations. The nonprofit is seen as a trusted partner in the community for engaging Medicaid members, and their data warehouse allows for bidirectional information sharing of a member’s health and food needs with health care organizations.
- **Housing and homelessness:** [Circle the City](#), a community health organization and FQHC based in Maricopa County, Arizona, partners with MCOs to provide respite care and wraparound services to individuals experiencing homelessness. MCO financial support of Circle the City’s services and staff who engage individuals experiencing homelessness helps these individuals—around 85 percent of whom are Medicaid members—receive housing and SDOH-related supports and prevents unnecessary hospital and emergency department utilization.

<sup>3</sup> For more information, please visit: <https://www.bcbsil.com/bdnc>.

**“Where we have seen good success is with partnerships with existing, trusted individual leaders or community entities—whether that’s the FQHC, food bank, or church—that people already trust and feel comfortable with. For some of the populations we’re talking about where we’re seeing disparate health impacts, Medicaid and the state may not be well-trusted if they did not fulfill what they said they would do. Having trusted folks to shepherd in that contact is helpful.” — Advocacy Representative**

Advocacy representatives noted that consumer and community advocacy organizations have frequent contact with members. As such, they are in an ideal position to identify issues faced by members and to work with MCOs and policymakers to address them. They also play an important role in supporting members in participating in advisory bodies and other structures for consumer engagement (see section on elevating the consumer voice).

**Technology can be an effective strategy for member and family engagement, but federal and state Medicaid policies limit their use**

Various MCO and advocacy representatives noted that they are using or looking forward to using texting as a promising mechanism to engage members in their state; an advocate also noted that a health plan uses Facebook and social media as tools to engage with members. However, discussion group participants noted that federal and state policies, as states set their own health plan communication requirements, have been slow to allow new outreach modalities such as text messaging and social media, which limits MCOs to phone calls and mailings in some states. They also noted that while texting has potential, it is important to ensure that members do not feel overwhelmed by the number of messages they receive and to adhere to restrictions laid out by regulations issued by the Federal Communications Commission (FCC) under the Telephone Consumer Protection Act (TCPA). An advocacy representative stated, *“A lot of us say [that texting] is the way of the future, but in terms of how it’s being consumed, it’s not necessarily a silver bullet approach.”* In addition, a few advocacy representatives noted some concerns about the privacy and security of texting.

Some MCO representatives described using customer relationship management (CRM) software to understand member preferences for receiving correspondence. Online provider directories have also offered members an easier way to search for providers, including the ability to filter by location or specialty.

#### **IV. BARRIERS TO EFFECTIVE MEMBER ENGAGEMENT**

**Incorrect or outdated contact information in state enrollment data makes it difficult for MCOs to conduct effective outreach to Medicaid members**

MCO and advocacy representatives noted two interrelated barriers to outreach—having incorrect contact information from the state and/or outdated information for transient and hard-to-reach populations. Resoundingly, participants noted that contact information from states is of poor quality, which makes it difficult to make initial contact with new members. Relatedly, populations that are transient, individuals experiencing homelessness, and families with high cellphone turnover or limited access to cellphone plans may have outdated contact information. Participants noted that this is particularly relevant to populations receiving TANF assistance or CHIP coverage.

An MCO representative described an effective mechanism for overcoming challenges with incorrect or outdated contact information. In a state with a robust health information exchange system, MCOs can log into the exchange to see updated contact information that members are giving their providers when they go to a doctor’s visit. They also receive real-time notifications of individuals checking into emergency rooms and the updated contact information the individual provides to the emergency room. Another MCO representative noted that their state has been enhancing their capabilities to collect more accurate enrollment data, find Medicaid members, and share updated contact information back and forth between the state and the MCO. Some MCOs also reach out to pharmacies and provider offices, who often have more updated members’ contact information.

**Medicaid members are often confused about the role of state Medicaid agencies versus MCOs, making it difficult for them to know who they can reach out to with concerns**

Participants resoundingly noted that many Medicaid members do not understand the role of the state Medicaid agency versus the MCO. Some members may know they have Medicaid coverage but not know that they are enrolled in a managed care plan. For others, branded Medicaid programs (e.g., Wisconsin’s Badger Care) may lead to Medicaid members’ confusion about which entity is the Medicaid agency and which is the health plan.

**“People may know their individual health plan, but MCO branding hasn’t really permeated into the community... there is not a strong feeling about managed care companies outside of their connection to the state.” — Advocacy Representative**

This confusion can leave Medicaid members unsure about whom to reach out to with questions or problems. When members have an issue (e.g., a claim denial or change in service), they do not know which entity is making the decision and who is accountable: the state Medicaid agency, the MCO, the enrollment broker, or the waiver services.

### Grievances and appeals processes are often cumbersome and long

Participants reported that members experience challenges understanding and accessing the grievance and appeals process within a health plan. Medicaid members can find working through the insurance quasi-appeals process and multiple levels of review cumbersome and confusing. They may also give up on the appeals process if they believe that the determination outcome will ultimately not change.

A few participants noted that it can be difficult to access information about the grievance and appeals process online. In addition, MCOs may use difficult-to-understand language to describe the grievance and appeals process. Furthermore, they noted that availability of phone and face-to-face support is often available only during business hours when individuals may be working. Participants noted that members might instead rely on their care managers/care coordinators as a point of contact for concerns.

### Written communications are often too long to be effectively consumed and understood by members

Participants noted that the welcome packages and other written communications MCOs mail to members are too long and complex to be helpful for members. Instead, participants noted there are opportunities for written communications to be more visually oriented and accessible, and written as simply as possible. For example, they noted postcards and customized flyers with member-specific information (e.g., a member's primary care provider, date of next visit) might be more effective strategies for written outreach. An MCO representative said that coordinating with communication consultants has improved their written communications. In addition, getting input directly from members, for example, through consumer advisory councils, can help improve communication and accessibility of written documents.

## V. MEMBER ENGAGEMENT AND HEALTH EQUITY

### Language barriers continue to limit engagement of immigrant and non-English speaking populations

Participants noted insufficient information and support by MCOs in the languages of immigrant and non-English speaking populations. Even if an interpreter is available, it may take time to connect an interpreter with a member. An advocacy representative noted a need for MCOs to look at processes that can more quickly connect members to

someone fluent in their preferred language. Participants also noted a general lack of accessibility for languages other than English or Spanish.

For paper-based communications, translated documents are often included within larger packets, requiring members to dig through pages to find the information they are seeking. Participants urged that communication should consist of more than translations of existing English materials—it should present messaging that is culturally sensitive and appropriate.

**“We should be bending over backwards to meet communities where they are and in their preferred language. Instead of being reactive, be proactive in creating content and messages. Not just translating documents from one language to another, but understanding that different communities need to hear different messages.” – Advocacy Representative**

### Medicaid members often face additional SDOH challenges, which limits their engagement with the health plan

MCO and advocacy representatives described that Medicaid members experiencing other challenges related to SDOH may have more difficulty engaging with their MCO. As such, MCO representatives reported helping to connect them with programs related to food, housing, job supports, etc. Participants noted that some MCO contracts include provisions to address SDOH and incentives to improve health outcomes.

Some plans have care coordinators/care managers use digital health tools (e.g., NowPow, Unite Us, Healthify, Aunt Bertha) to connect members with resources to address their SDOH needs. Some MCOs noted that they plan to use opportunities like enrollment/welcome calls to leverage these digital health tools and inform members of SDOH programs.

### There is a need for better data, including race and ethnicity data, to inform engagement efforts

MCO and advocacy representatives noted a need for better data on members' race and ethnicity. Participants noted that while MCOs generally want to address disparities, they need more information to tailor programs effectively. Participants also noted that members' preferred language is not always accurate in the state enrollment data. For example, a child may speak English and therefore the preferred language is listed as English in state enrollment data; however, the parent may communicate in another language. Others noted preferred language may be missing from the data entirely. This makes it difficult to conduct outreach in the preferred

language of the household, especially in automated modalities.

In trying to reach specific populations, MCOs must understand barriers in the community, address the barriers, and evaluate their efforts to ensure a particular initiative is effective, all of which takes time. However, even with access to data, it is also important to ensure MCOs have the capacity to use the data effectively. For example, an advocacy representative described an MCO that had data on health disparities but lacked the capacity and staff expertise to analyze and use the data effectively to engage their members differently. Advocacy representatives noted they would like to see more data transparency overall, and for the state to collect more meaningful data, including on which issues people are facing based on grievances and appeals data, missed appointments, reasons for delays in data sharing, etc.

**“The question of race and ethnicity is important. We have thought about disparity and equity through the lens of complex care, members with social, economic, behavioral, or clinical challenges, and based on disability, but we haven’t been focusing on race and ethnicity. We need to shine a lens on race/ethnicity but data from the state are pretty bad and our data are not much better. There is a huge push to improve data to understand disparities through a race/ethnicity lens.” – MCO Representative**

**MCOs should improve efforts to address cultural competency and hire more diverse staff**

Participants noted the importance of having bilingual MCO staff to engage with non-English speaking members. In addition, participants noted a need to be intentional in hiring so that the racial and ethnic makeup of boards, staff, and providers mirrors that of their membership.

**“We have to be intentional about hiring our employees to represent the racial/ethnic makeup of our membership, from the boardroom down, so that the right people are a part of program design and program decisions. That intentionality is missing... A lot of companies and CEOs have come out with messages on diversity and integration efforts happening at the corporate level. But it’s not about just tweeting a message to be inclusive; how are we actually moving the needle inside the company and translating that to employee behavior?” – MCO Representative**

An MCO representative mentioned that as call centers have moved to a remote staffing model due to COVID-19, the MCO has been able to hire people from the communities they serve, increasing the diversity of their staff. In addition, participants noted they need to continue to better match their members with providers who look like them based on racial/ethnic background, gender, etc., and MCOs need to have a more diverse and representative provider network. However, they noted that increasing diversity of providers requires expanding the pipeline of students to medical school and other related fields, given current shortcomings in the diversity of available providers.

## ELEVATING THE CONSUMER VOICE

This section presents findings across discussion groups about the ways in which MCOs can elevate the consumer voice through consumer advisory councils, and facilitators and barriers to this approach.

### VI. FACILITATORS AND CHALLENGES TO ELEVATING THE CONSUMER VOICE THROUGH ADVISORY COUNCILS

**Advisory councils can help MCOs better understand member needs and perspectives**

Based on the engagement continuum in the Principles of Community Engagement, effective advisory councils can promote shared leadership and decision-making where MCOs can seek meaningful input from members to drive program design and policymaking. Effective advisory councils incorporate bidirectional communication and feedback loops that flow between executive leadership and members.

For example, a participant described how a consumer-led advisory body in their state was able to drive change. The advisory council worked with executive staff at the MCO to document the impact of a benefit design on members and bring the documented concerns back to the plan. As a result, the plan made changes to address the concern, and staff provided that information back to the council.

**“We have a model on the long-term care side. The board has pretty broad representation... A case manager brought up a problem that had gone unaddressed for years. We immediately took that on. We conducted a survey and found many people who experienced this. We were able to develop a best practices framework. The board was able to turn our proposal into Medicaid policy.” – Advocacy Representative**

### Various barriers can render advisory councils less effective in elevating the consumer voice

Both MCOs and advocacy representatives resoundingly noted that while there is genuine intent to engage the consumer voice, there are many challenges to recruiting members into and maintaining member engagement in advisory councils.

**“It is challenging to make member advisory councils work. It is important to include the member voice in policymaking and advocacy, but it is so hard. For the most part, few plans and states have found the right way to do it so that voices and really useful insights are consistently and meaningfully included in policy process.” — MCO Representative**

Participants noted that oftentimes advisory council meetings are largely attended by plan and other stakeholder staff versus Medicaid members and their families due to the challenges members and families face carving out time for the meetings or for other reasons. The few member voices that are on the councils either really love or really hate the plans, providing important but perhaps somewhat biased perspectives.

Advocacy representatives noted that, despite good intentions, advisory councils often serve to provide members and their families with information instead of offering members opportunities for meaningful input. Furthermore, members and their families may feel intimidated at advisory council meetings and therefore may not feel comfortable talking about their or others' experiences. Some individuals may not feel comfortable bringing individualized questions to a group setting and sharing personal stories.

### Incentives, flexibility, and formalized board seats are ways of demonstrating to consumers that their time and voices are valued

Participants noted various strategies that can help make advisory councils more effective in elevating the consumer voice. For example:

- Providing members with incentives can demonstrate to consumer advisory council members that their time and input are valued. Incentives can include stipends, lunch, transportation, gift cards, childcare, etc. Incorporating celebrations like annual dinners and awards ceremonies also encourages participation and demonstrates to members and their families that their input is valued.

- Having flexibility, including shorter meeting sessions, night or weekend hours, and multiple ways of accessing meetings (e.g., via phone, video conference, etc.) may help consumers with competing priorities to participate. In addition, eliminating any extra paperwork or burden for participation can make it easier for interested members to feel they can participate while navigating competing interests.

**“[Members] have to find out about these boards, then contact someone from the board, then fill out paperwork, and then they can participate. There's so much opportunity there, but it's not quite there.” — Advocacy Representative**

- Having advisory councils or participants be part of official governance structures within the plan and explaining how feedback from the councils are relayed to leadership can provide gravitas to the role and assure members that they can have true input into MCOs' decision-making process. However, this often requires member training on governance structures and effective participation, as well as delineating clear responsibilities and having clear council charters and expectations.
- Establishing clear feedback loops between the members and the plan on how the plan received and implemented input demonstrates value to advisory board members. In addition, it is important to have MCO staff who are dedicated to supporting advisory councils and are responsive to consumer input and questions.
- Working with CBOs and community leaders can help MCOs recruit members. In addition, creating community-based coalitions with groups of CBOs to convene work on certain issues or councils across plans can help with recruiting potential members.
- Working with CBOs can serve as a bridge to member perspectives. Community health workers (CHWs) and enrollment brokers and assisters often have an “ear to the ground” for Medicaid members' concerns and can provide an added consumer perspective.
- Ensuring that advisory councils that include a mix of stakeholders are not predominantly MCO staff but instead have significant consumer representation can help alleviate MCO concerns about biased perspectives. Having more consumers on the board contributes more diverse viewpoints and can help members feel more comfortable sharing their experiences.

- Offering trainings, including on finance, policy, operations, Robert's Rules of Order, etc., can ensure that members can equitably participate in conversations and provide informed decisions. In addition, offering mentorship opportunities for those participating on a council can provide members with additional support.

For example, an MCO representative described having a robust committee and advisory council structure that has broad representation, bidirectional feedback loops, multiple touchpoints, is member-driven, and elevates a diverse consumer voice. The MCO implements stigma reduction- and trauma-informed approaches and has regular committee leadership training for consumer members. In addition, some states include language in their contract that requires plans to integrate advisory into their quality assurance programs.

## Insights and Opportunities for Improving Medicaid Member Engagement — Highlights from a Roundtable Discussion

After discussion groups with Medicaid MCO and advocacy representatives, the MCO Learning Hub convened a Roundtable with representatives from the four partner organizations: Community Catalyst, the Association for Community Affiliated Plans, America's Health Insurance Plans, and Families USA. The Roundtable focused on key takeaways from the discussion groups and potential opportunities for addressing the challenges described during these meetings. Here, we describe insights and opportunities proposed by Roundtable participants on ways in which MCOs can strengthen member engagement and elevate consumer voices.

### I. IMPROVE DATA COLLECTION, DATA QUALITY, AND DATA SHARING

Discussion group and roundtable participants resoundingly asserted that limitations in the quality of state enrollment data make it difficult to conduct outreach to Medicaid members, in particular due to having no or inaccurate phone numbers and other contact information.

**“Medicaid members are hard to find. They change addresses and phone numbers all the time. Even with social media and texting efforts that have improved communication over time, Medicaid members are still a difficult population to engage. It requires a lot more intentionality on the health plan part and still it's mostly information being thrown at them rather than meaningful engagement. We're moving in the right direction, but it's sort of like moving a rock up a hill.” — Roundtable Participant**

A major challenge is that states deem their enrollment data to be the “source of truth” and, as such, state data are often difficult to change or update, even if the MCO is able to gather more accurate data. In some cases, states prohibit plans from collecting updated information from participants at time of enrollment, requiring additional contact attempts to the participant after enrollment to get this information. Participants noted a need to improve both the quality of state enrollment data and communication channels between MCOs and the state, so that MCOs can update incorrect or outdated data.

### Insights and Opportunities

- Focus on ways to improve the quality of state enrollment data, including contact information, and collect more meaningful data, including what issues people are facing based on grievances and appeals data, missed appointments, reasons for delays in data sharing, etc.
- Reconsider state regulations that limit the ability of MCOs to gather or update data, or that rely on state enrollment data as the “source of truth”
- Promote better data and information sharing between the state, MCOs, state health information exchange systems, providers, and other relevant stakeholders

### II. SIMPLIFY PROCESSES FOR MEMBER COMMUNICATION WITH THE MCO

Discussion group and roundtable participants described member confusion and difficulty understanding who to reach out to for questions and not fully being able to distinguish between the roles of the Medicaid MCO versus the state entity.

**“[Members] just don’t understand the managed care structure and interaction between managed care and the state. They don’t care about authority. They care about who can solve their problem. They don’t want to call a number to be told to call another number... If you want to make things streamlined and integrated, having a process that solves people’s more pressing issues goes a really long way.” — Roundtable Participant**

### Insights and Opportunities

- Promote better coordination across entities (e.g., MCOs, states) for improving communication and education to members.
- Streamline the process through which members contact plans and states, similar to the Affordable Care Act’s “no wrong door” policy. Members can rely on one phone number or point of contact rather than requiring the member to identify which entity and number to call depending on their concern.
- Ensure there is a clear process through which issues and concerns are elevated within the organization and up to the state level.

### III. ELIMINATE DISPARITIES IN MEMBER ENGAGEMENT

Participants noted the need for more diverse MCO staff, including improving language access for non-English speaking members. They also described lack of quality data that MCOs can use to stratify by race and ethnicity, primary language, disability status, etc., so that they can identify, measure, and address health disparities and inequities.

### Insights and Opportunities

- Promote better collection and standardization of demographic and other race and ethnicity data

**“You can talk about trying to inform members about their processes and how Medicaid works and managed care, but that doesn’t matter... if you don’t know anything about their race/ ethnicity, you won’t know in which language to appropriately engage with them. Having data is foundational to member engagement.” — Roundtable Participant**

- Be more intentional in and promote hiring of employees that reflect the diversity of health plan membership.

- Collaborate with CBOs to conduct outreach during the enrollment process, including helping members address their SDOH needs. This may include supporting existing community resources, building community capacity, and working with trusted entities in the community.
- Provide cultural competency training for providers and MCO staff.
- Encourage MCOs to embed principles and goals of health equity into their missions.
- Advocate for and support increased diversity in the pipeline of students to medical school and other medical fields.

### IV. ENCOURAGE MEMBER ENGAGEMENT IN ADVISORY COUNCILS

Participants described the importance of meaningful engagement with members to ensure their input can inform program design and service delivery. However, they acknowledge that effective advisory councils remain a challenge that few plans have accomplished. Participants described the need for MCOs to employ various strategies to better engage with their members and promote higher levels of engagement beyond outreach or dissemination of information.

**“I’ve worked with some plans where they want to elevate members of their advisory council to their governance board. It’s a lot of responsibility. You should first identify a good group of participants on the advisory structures and conduct skill building training and support so they’re prepared and can serve as a full board member and not a token community member slot, to serve effectively. I think that sends a signal to all members of the advisory body that it’s a useful structure.” — Roundtable Participant**

### Insights and Opportunities

- Demonstrate to members that their input is valued through the use of incentives, including advisory councils within official governance structures, trainings, and clear and bidirectional feedback loops between members and executive staff
- Ensure that states are providing sufficient structure and resources to MCOs for better member engagement, including state requirements for participation, giving advisory council structures official mandates, etc.

- Dedicate sufficient resources to support development and maintenance of advisory councils, including formalizing advisory council structures, engaging with executive leadership, and delineating clear responsibilities and charters
- Work with CBOs and other trusted entities to recruit advisory council participants and to sit on advisory councils to advocate on behalf of their members
- Create opportunities for plans to focus on strengthening the role and responsibilities of advisory councils
- Identify and specify best practices among MCOs nationally in member engagement at the MCO level
- Develop opportunities for plans to learn from each other and from culturally competent experts on engaging and lifting member voices in decision-making processes

#### ABOUT NORC MEDICAID MCO LEARNING HUB

The key goal of the NORC Medicaid MCO Learning Hub is to serve as a source of information, expertise, and best practices to support managed care organizations in moving forward with system reform. NORC and its partner organizations identify, develop, and disseminate promising approaches and emerging opportunities for MCOs to improve the physical health, behavioral health, and social needs of their members.

Your ideas and opinions are important to us. We welcome your feedback on future Medicaid MCO Learning Hub work or programs you are working on to better serve your needs.

We want to hear from you. Please contact us at [MCOLearningHub@norc.org](mailto:MCOLearningHub@norc.org) to start the conversation or join our distribution list.

[www.norc.org/Research/Projects/Pages/medicaid-managed-care-organization-learning-hub.aspx](http://www.norc.org/Research/Projects/Pages/medicaid-managed-care-organization-learning-hub.aspx)

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