July 15, 2016

VIA Electronic Submission

Ms. Trina Dutta
Special Projects Officer, DC Department of Health Care Finance
441 Fourth Street NW, 922a,
Washington, DC 20001

RE: Proposed Medical Care Advisory Committee By-Laws

Dear Ms. Dutta:

The National Health Law Program (NHeLP) protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates, and litigates at the federal and state level. NHeLP has conducted periodic surveys of state Medical Care Advisory Committees (MCACs) and the important role they serve in advising agencies on Medicaid policy and operations.[1] Although MCACs have been federally required for over 30 years, NHeLP has found that MCACs are seriously underutilized or may not function at all in some states. Our most recent survey of more than two dozen states has identified best practices to increase the effectiveness of MCACs and maximize stakeholder participation.

The Centers for Medicare & Medicaid Services (CMS) recognizes the importance of stakeholder consultation and engagement in the recently updated Medicaid managed care regulations.[2] Under new requirements, MCACs will play an increasingly important role in policy development and program oversight. For example, states must consult with MCACs when developing and updating state quality strategies. 42 C.F.R. § 438.340(c)(1).

The District of Columbia Medical Care Advisory Committee (DC MCAC) by-laws currently in effect have not been updated since 1995. We appreciate the opportunity to comment on the proposed revisions to the by-laws published on the Department of Health Care Finance website on June 22, 2016. We support many of the proposed revisions, and also identify areas where the by-laws can be

[1] *See* Jane Perkins, *Medical Care Advisory Committees (MCACs): Examples from Ohio & Pennsylvania*, NAT'L HEALTH L. PROGRAM (Mar. 01, 2005)(on file with the National Health Law Program).
[2] *See* Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27655 (May 6, 2016) (to be codified at 42 C.F.R Parts 431, 433, 438, et al).

improved to help facilitate stakeholder engagement and increase transparency, including:

- Clarify DC MCAC functions consistent with federal law and amend the by-laws to adopt best practices from other state MCACs;
- Ensure meaningful stakeholder engagement by increasing the committee membership and requiring broad stakeholder representation, including Medicaid beneficiaries, caregivers, consumer advocates, legal services providers, providers, and other relevant government agencies such as the DC Department of Human Services, the Department of Disability Services, DC HealthLink, and others;
- Increase transparency and provide opportunities for public participation including posting membership, meeting notices, minutes, agenda, reports, and other information on the agency website;
- Provide support to increase participation by Medicaid beneficiaries, including transportation assistance, stipends, as well as technical assistance and training;
- Clarify the process for nominating and appointing new members, and provide a process to remove members with cause; and
- Follow the process for amendments to the by-laws.

ARTICLE IV — MCAC Functions

Under the federal regulation, the purpose of an MCAC is to advise the Medicaid agency about health and medical care services. Specifically, an MCAC must have "opportunity for participation in policy development and program administration. . ." 42 C.F.R. § 431.12(e). Federal courts have weighed in on the scope of MCAC responsibilities:

> "[T]he scope of such committees' advisory authority is intended to cover *the entire field of state decision-making with respect to the Medicaid program,* and is not limited to discrete areas of concern such as the quality of medical assistance rendered under the program." *Morabito v. Blum*, 528 F. Supp. 252, 263-67 (S.D. N.Y. 1981)(emphasis added).

The proposed by-laws amendments which enumerate DC MCAC functions appear to limit the scope and breadth of the DC MCAC. Moreover, the by-laws omit essential MCAC functions prescribed by federal law, including providing a public comment opportunity for proposed Section 1115 demonstration projects and reviewing Medicaid managed care marketing materials. 42 C.F.R. § 431.408, 42 C.F.R. § 438.104(c). Moreover, the newly revised federal regulations governing Medicaid managed care establish new responsibilities for MCACs, including developing a star quality ratings system and state quality strategy.[3] Accordingly, we recommend revising the Functions section to reflect the broad scope of MCAC responsibilities consistent with federal law, as well as opportunities to facilitate stakeholder input.

[3] Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27655 (May 6, 2016) (to be codified at 42 C.F.R Parts 431, 433, 438, et al).

ARTICLE V AND VI — Committee Size and Composition

The proposed by-laws establish a 15 member DC MCAC, down from the current by-laws which require 26 members.[4] According to our survey, MCACs range from as high as 56 to as low as 9 members.[5] Larger MCAC groups tend to have more vacancies while smaller MCAC groups provide for limited participation from a narrow range of stakeholders. However, states with a medium range of membership, from 19 to 26 members, ensure diversity of viewpoints and broad-based participation from both consumer and provider groups. We urge the MCAC By-Laws Workgroup to establish an MCAC that ranges between 19 and 26 members for more effective subcommittees and input from essential stakeholders.

Successful MCACs have representation from a wide range of stakeholders, including provider and beneficiary groups. For example, MCACs in Iowa and Pennsylvania represent the interests of pharmacists, community mental health centers, hospitals, specialized medical providers and professional associations, and nursing and long-term care providers.[6] With 19 and 25 members, respectively, Missouri and Maryland's MCAC size allows for representation from more consumer and provider groups, and representatives from social services, mental health, and senior services departments.[7]

NHeLP strongly supports the proposed by-laws revision that a majority of DC MCAC members should be beneficiaries and beneficiary advocates. Legal services providers, patient advocates, consumer organizations are additional groups that possess unique knowledge about the Medicaid federal and state requirements. These groups work directly with Medicaid enrollees and have on-the-ground expertise that would serve as a great asset to the DC MCAC.

Although DHCF is the single state agency, several DC government agencies are involved in ensuring effective implementation of Medicaid, including eligibility determinations by the Department of Human Services (DHS) and agencies that contract for or deliver services. 42 C.F.R. § 431.12(b)(3) states committee membership must include "the director of the public welfare department or the public health department, whichever does not head the Medicaid agency." We urge revised by-laws to require, rather than suggest, all of the sister agencies listed in the proposed by-laws be invited to serve as ex-officio members. In addition, we recommend adding the Department of Youth Rehabilitation Services to the list of ex-officio members.

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[4] By-Laws and Procedures of the State (D.C.) Medical Care Advisory Committee (MCAC) (Nov. 29, 1995) (originally adopted July 25, 1973).

[5] IND. FAMILY & SOCIAL SERVS. ADMIN., OFFICE OF MEDICAID POLICY & PLANNING, MEDICAID ADVISORY COMMITTEE: MEMBER HANDBOOK (2015), http://www.in.gov/fssa/files/MAC_Member_Handbook_2015(Updated).pdf.

[6] IOWA DEP'T OF HUMAN SERVS., MEDICAL ASSISTANCE ADVISORY COUNCIL, MAAC EXECUTIVE COMMITTEE MEMBERS (2016), https://dhs.iowa.gov/sites/default/files/SFY16_MAAC_Executive_Committee_Members_0.pdf, PA DEP'T OF HUMAN SERVS., MEDICAL ASSISTANCE ADVISORY COMMITTEE (MAAC), http://www.dhs.pa.gov/communitypartners/informationforadvocatesandstakeholders/medicalassistanceadvisorycommitteemaac (last visited July 12, 2016).

[7] MO. DEP'T OF SOCIAL SERVICES, MO HEALTHNET OVERSIGHT COMM. MEMBERS (Nov. 19, 2014) http://dss.mo.gov/mhd/oversight/members.htm; MD. DEP'T OF HEALTH AND MENTAL HYGEINE, MARYLAND MEDICAID ADVISORY COMMITTEE BY-LAWS (Jan. 09, 2012), https://mmcp.dhmh.maryland.gov/docs/MMAC_BYLAWS_070109.pdf.

ARTICLE VI — Membership and Appointment

The MCAC is intended to serve as an independent advisory body to state Medicaid agencies in order to facilitate open discussion and provide honest recommendations on the development and implementation of the Medicaid program. As an advisory group, MCACs are not divisions of the agency, nor are its members employees, working under the agency's direction. Protecting the MCAC's role as an independent advisor to the agency fosters communication about ways improvements may be achieved. NHeLP urges the MCAC By-Laws Workgroup to maintain this level of autonomy and independence between the Department and DC MCAC by:

1. Clarifying that MCAC members serve the duration of their appointed terms and cannot be removed without good cause;
2. Allowing DC MCAC members to participate in the nominations process of new DC MCAC appointees;
3. Providing clarification on the term limit provisions;
4. Clarifying that DC MCAC should reflect a diverse range of experience and expertise; and
5. Facilitating attendance and improving meetings.

1. Set terms and a process for removal

We strongly oppose the proposed change to the by-laws stating that DC MCAC members "serve at the pleasure of the Director." The broad language in § 6.1 grants the Director the power to exclude or terminate DC MCAC members, including Medicaid beneficiaries. The proposed by-laws also require that DC MCAC members refer all media inquiries to the Director. In recognition of DC MCAC's role as an independent advisory body, we strongly recommend that members be appointed to set terms and that members be allowed to serve for the duration of their appointments. The DC MCAC serves to advise the Department, and does not serve under the direction of the Department. The by-laws should also establish procedures for "good cause" removal of members, and these processes should not operate based on the sole discretion of the Department.

2. Nominations process

Federal law authorizes the agency director or higher state authority to appoint MCAC members on a continuous and rotating basis. 42 C.F.R. § 431.12(c). However, participation from DC MCAC members in the nominations process would ensure that members are engaged and solicit diverse viewpoints. Alaska's MCAC, for example, allows for provider and consumer input for recommendations and nominations.[8] The nomination process eases the burden on the Department director to find new DC MCAC members and enables DC MCAC members to pass on institutional knowledge on functions, responsibilities, and expectations of the DC MCAC to incoming DC MCAC members.

[8] ALASKA DEP'T OF HEALTH CARE SERVICES, ALASKA STATE MEDICAL CARE ADVISORY COMMITTEE BYLAWS (amended Oct. 29, 2005). http://dhss.alaska.gov/dhcs/Documents/MCAC/news_rec_bylaws_mcac/bylawsrev_102905_mcac.pdf

3. Term limits

NHeLP urges further clarification on DC MCAC member term limits. As written, it is unclear whether § 6.7 of the proposed by-laws would allow members initially appointed to one year terms, two-years terms, or serving a remainder of a term left open by a vacancy, to serve two additional three-year terms. Furthermore, the proposed by-laws do not address whether the current DC MCAC members will be reinstated or discharged once the proposed by-laws are finalized.

4. "Qualifications"

NHeLP supports the MCAC By-Laws Workgroup's commitment to creating a committee consisting of members with a diverse range of experiences and perspectives. We recommend that the qualifications not be limited to individuals with specialized knowledge and should recognize that beneficiaries and beneficiary advocates have unique perspectives on the Medicaid program that are instrumental to the decision-making process. The qualifications sections should provide a broad overview of the types of members the DC MCAC *hopes* to attract, rather than specifications on a narrow view of what "knowledge" members *must* possess. (Or, the specifications should be listed as considerations but not requirements). We also recommend that DHCF and DC MCAC establish an orientation and training program so that new members, Medicaid enrollees, and other stakeholders can better understand Medicaid requirements and agency operations.

ARTICLE VII — Meetings

NHeLP supports the MCAC By-Laws Workgroup's stated goal of "facilitating transparency, creating public understanding, and ensuring that DC services meet the needs of the people served at a reasonable cost to the taxpayer." We welcome the clarification the Open Meetings Act applies to the DC MCAC. The DC MCAC should help meet this goal by providing adequate public notice of all meetings. Pursuant to the Open Meetings Act, the DC MCAC should establish an annual schedule of its meetings - updated throughout the year - and provide notice on the DC MCAC website and in the District of Columbia Register.[9] NHeLP recommends amending the first sentence of § 7.5 to conclude with "… no less than 48 hours or 2 business days, whichever is greater, before a meeting."

In-person attendance to meetings may be preferred, but we oppose making this a requirement. Most states allow members and the public to teleconference into all MCAC meetings. This alternative form of participation acknowledges the importance of MCAC member attendance, distinguishes between members who are absent due to lack of interest and a genuine inability to physically attend the meetings, and provides flexibility for individuals, especially MCAC members who are Medicaid enrollees, with families or are unable to attend in person due to transportation or accessibility issues. Moreover, easy accessibility of meetings and information promotes community trust and leadership

[9] Open Meetings Act, D.C. Code § 2-576(1), § 2-576(2)(B), § 2-575(6) (2016).

building, thus DC MCAC should strive to hold meetings in public locations such as the town hall or public libraries.

When feasible, NHeLP recommends that regular and specials meetings be held in different locations within the District, particularly wards with high Medicaid enrollment rates, and at different times of day to reach all parts of the District and to allow working families to participate in DC MCAC meetings. Accordingly, the DC MCAC should ensure that meeting places are wheelchair accessible and easily accessible by public transportation.

We appreciate opportunities for non-members to participate in DC MCAC discussions when recognized. Accordingly, § 9.2 of the by-laws should clarify which subcommittees or issues are appropriate for public participation or remove "if and when deemed, appropriate." In addition, NHeLP urges the DC MCAC to provide an opportunity for public comments within the by-laws section on the order of business to allow non-members to raise issues that may not have been included on the agenda or to voice concerns about the Medicaid program.

ARTICLE XI — Conflict of Interest

NHeLP supports the MCAC By-Laws Workgroup's efforts to identify conflicts of interest among DC MCAC members and agrees in the full disclosure of all conflicts of interest before and during appointment. NHeLP also recognizes that DC MCAC members with conflicts of interest may still have a vested interest in the issue at hand and contribute to the diversity of viewpoints that DC MCAC strives to achieve. The proposed by-laws should reflect this distinction and allow DC MCAC committee members to recuse themselves from voting on a matter in which he or she has a verified conflict. However, we oppose the proposal to prevent DC MCAC members from speaking on an issue where they may have a conflict, if that conflict has been publicly acknowledged by the speaker.

ARTICLE XII — Reimbursement of Expenses

NHeLP recognizes the challenges in obtaining participation of Medicaid enrollees who experience challenges due to their socioeconomic and/or health status. The MCAC By-Laws Workgroup should make provide clear guidance on how it will ensure beneficiary participation within the Committee. Stipends are one way to encourage their continued participation. For example, North Carolina's MCAC provides some members with $15 worth of compensation and travel reimbursements.[10] Members and beneficiaries should be able to request stipends and other forms of assistance when travel assignments create a financial hardship. We believe the Department should also consider other ideas to support consumer participation, such as child care assistance.

[10] *Medical Care Advisory Committee (MCAC)*, N.C. DIV. OF MEDICAL ASSISTANCE, http://dma.ncdhhs.gov/get-involved/committees-work-groups#Medical_Care_Advisory_Committee (last visited on July 12, 2016) ("Non-state employee members receive a $15 compensation for each day of service, round-trip mileage reimbursement of 25 cents per mile, and applicable subsistence according to state guidelines." "Necessary forms will be provided at each meeting to claim reimbursement.").

NHeLP recommends a neutral third party to determine the rates of reimbursement in accordance to D.C. Official Code § 1-611.08, which states "the Executive Office of the Mayor is authorized to establish by rule and regulation the rates of compensation or reimbursement of expenses for members of any board or commission." The Mayor is required "to conduct a comprehensive study of the compensation and stipend loves of the District's boards and commission" to identify "the best practices in the compensation and stipend policies." D.C. Official Code § 1-611.08(e).

ARTICLE XIV — Records and Minutes

We agree with the by-laws amendment clarifying that the DC Open Meetings Act and all of its requirements should apply to DC MCAC. To ensure transparency and public accountability, NHeLP recommends that the MCAC By-Laws Workgroup clarify in the final by-laws all information that should be publicly available. [11] Public participation in DC MCAC regular and special meetings is one way to ensure that the needs of the community are being met by DC MCAC and DHCF. Adequate public notice of all regular and special meetings, and posting of all DC MCAC meeting recordings and documents, including minority reports, will further advance the goals of a responsive committee and agency.[12] Minutes, including draft minutes, should be as detailed as possible and made available to the public as soon as practicable, but no later than 3 business days after the DC MCAC meeting to approve them.[13] Compliance with the Open Meetings Act will provide interested individuals the opportunity to remain updated on the DC MCAC discussions.

ARTICLE XVI — Amendments

§ 8.1 of the current By-Laws and Procedures states:

> "These By-Laws and Procedures may be altered, amended, or repealed, in whole or in part, by the affirmative vote of two-thirds (2/3) of the membership of the Committee at a regular or special session..."[14]

The proposed by-laws should retain the procedures outlined in the current by-laws for amending. NHeLP requests clarification on how the proposed by-laws will be modified in relation to the procedures outlined in the current DC MCAC by-laws, including whether the current committee members remain and how this will affect term limits.

[11] Record of meetings, Open Meetings Act, D.C. Code § 2-578 (2016).
[12] *Id.* at § 2-578(a).
[13] *Id.* at § 2-578(b)(1).
[14] By-Laws and Procedures of the State (D.C.) Medical Care Advisory Committee (MCAC) (Nov. 29, 1995) (originally adopted July 25, 1973).

Conclusion

If you have any questions or need any further information, please contact Wayne Turner, Staff Attorney (turner@healthlaw.org; (202) 289-7661 ext. 307), at the National Health Law Program.

Sincerely,

Wayne Turner