Medicaid Advisory Committee (MAC) and Beneficiary Advisory Council (BAC) Annual Report

July 8, 2026

MONTANA DPHHS

DEPARTMENT OF
PUBLIC HEALTH &
HUMAN SERVICES

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EXECUTIVE SUMMARY

The Montana Department of Public Health and Human Services (DPHHS) submits this report on the activities and accomplishments of its two primary Medicaid advisory bodies: the Medicaid Advisory Committee (MAC), known as the Montana Health Coalition, and the Beneficiary Advisory Council (BAC).

During the reporting period, both bodies were active and engaged. The MAC held three meetings during the last year: June 2025, August 2025, and May 2026, with discussions centered on federal legislative developments, Home and Community-Based Services (HCBS) waiver programs, behavioral health services, and Montana's planned Section 1115 HELP (Health and Economic Livelihood Partnership) Demonstration Waiver.

The newly established BAC held three meetings during the last year: a webinar in December 2025, an individual orientation in March 2026, and a large group session in April 2026. The BAC received over 50 applications for its initial 15-member council, reflecting strong community interest.

Key themes across both bodies included access to care in rural and frontier communities, behavioral health service gaps, workforce shortages, and the need for clearer beneficiary communication.

Looking ahead, DPHHS will prioritize integrating BAC and MAC recommendations into initiatives, advancing transparency aligned with federal Medicaid Access Rule requirements, and expanding engagement strategies to reach underserved populations. Both advisory bodies are viewed as essential partners in building a Medicaid program that is equitable, accessible, and reflective of the Montanans it serves.

MEMBERSHIP AND REPRESENTATION

DPHHS utilizes two primary advisory bodies to support Medicaid and ensure meaningful stakeholder engagement: the MAC, referred to in Montana as the Montana Health Coalition, and the BAC. Together, these groups provide complementary perspectives, combining system-level expertise with lived experience, to inform Medicaid policy, program design, and service delivery.

MAC – MONTANA HEALTH COALITION

The Montana Health Coalition serves as the state's MAC. It is a federally required advisory body that guides the DPHHS Director, State Medicaid Director, and DPHHS leadership on health and medical care services. The MAC is composed of appointed members representing both providers and consumers, ensuring balanced input across the health care system. Members typically serve two-year terms and can renew their term if desired. Key functions include advising on policy and program changes, reviewing state and federal initiatives, identifying service gaps, monitoring service adequacy, and supporting cross-system problem-solving.

The MAC was meeting annually but has increased meetings to quarterly and serves as a formal mechanism for stakeholder input into Medicaid programs. The MAC offers flexible participation options, including in-person, virtual, and phone-based engagement. Recruitment efforts for the MAC included referrals from fellow professionals, emails to the interested parties' group, and drawing from the BAC pool of applicants who were professionals and did not meet the guidelines of the BAC.

BAC

The BAC is a federally required advisory group composed of Medicaid beneficiaries, family members, and caregivers. Its primary purpose is to provide a dedicated forum for individuals with lived experience to share feedback on Medicaid access, services, and overall program experience. The BAC meets quarterly and offers flexible participation options, including in-person, virtual, and phone-based engagement to ensure accessibility for members across Montana. Members are appointed by DPHHS through an application process and typically serve three–to four-year terms. The initial BAC council members are serving staggered terms of 1-4 years to ensure there is not a total turnover of members due to term limits.

The BAC received over 50 applications for the initial appointment. The application process is on a rolling basis and is continuously open. If individuals apply, their applications will remain open and active for 12 months after submission to ensure a robust applicant pool. BAC members whose terms have expired must wait 12 months before reapplying for an appointment. Recruitment efforts include posting the

application to the BAC webpage, sending out mass email notifications, and communicating with service provider staff.

The selection of members was based on a wide range of criteria (Beneficiary Advisory Council). All applicants were screened by a selection panel, and then a list of recommended individuals was presented to the Medicaid Director. These individuals were screened by the Medicaid Director, and a final recommendation list was provided to the Director of DPHHS for appointment. Letters of appointment were sent to those who were selected. Other applicants were informed that they had not been selected but may be considered for future positions as spots open.

RELATIONSHIP BETWEEN MAC AND BAC

The MAC and BAC are designed to work in alignment to ensure comprehensive stakeholder input. While the MAC provides broad system-level and policy guidance, the BAC centers on beneficiary voice and lived experience. This structure ensures that Montana Medicaid decision-making is informed by both technical expertise and real-world experiences of individuals and communities it serves. Montana DPHHS ensures that both the MAC and BAC reflect diverse perspectives across the Medicaid program, including providers, beneficiaries, advocates, and other stakeholders.

MEMBERSHIP COMPOSITION

- MAC – Montana Health Coalition
  - Total members: 6
  - Representation includes:
    - Health care providers (e.g., physicians, behavioral health, long-term services and support)
    - Medicaid beneficiaries and family representatives
    - Advocacy organizations
    - Tribal and rural health representation
    - Other system stakeholders
  - 19 individuals as part of the interested parties list
    - Advocates
    - Stakeholders
    - State Legislators

- BAC
  - Total members: 15
  - Representation includes:
    - Medicaid beneficiaries across eligibility groups
    - Family members and caregivers
    - Individuals representing diverse geographic regions, including rural and frontier communities

ACTIVITIES AND TOPICS OF DISCUSSION

MAC

The MAC met in June 2025, August 2025, and May 2026. Agendas and supplemental materials can be found on the Health Coalition webpage: Health Coalition. All three meetings covered how Montana's Medicaid programs must respond to evolving federal rules and legislation, especially H.R. 1. In addition, HCBS waivers for vulnerable populations (people with disabilities, mental illness, and the elderly) are standing agenda items. The HEART was discussed in each meeting as well, underscoring the sustained focus on the substance use services.

Of note, the August 2025 meeting was a dedicated forum focused entirely on Montana's intent to apply for a new Section 1115 Health and Economic Livelihood Partnership (HELP) Demonstration Waiver. DPHHS presented information about the planned application, explaining that the waiver is being pursued to comply with Montana state law MCA (Montana Code Annotated) 53-6-1307, -1308, and -1309 and to align with new federal requirements under H.R. 1 related to community engagement and cost-sharing for Medicaid expansion enrollees. A draft of the waiver application was made available at help.mt.gov. Most of the meeting was structured to allow public comment on the proposal.

BAC

The BAC is a newly formed organization and held three meetings during the reporting period. A webinar was conducted in December 2025, orientation sessions were conducted in March 2026, and a large group meeting was held in April 2026. There was ongoing communication with members between sessions. The webinar was available online, and a recording is on the BAC website. Orientation sessions occurred virtually through Teams or Zoom (depending on beneficiary preference) or over the phone. The large group meeting was hybrid, with in-person and virtual participation. All members of the council provided introductions and identified what they hoped this group would accomplish. The BAC liaison facilitated all three meeting types during the reporting period. There were one-on-one discussions during orientation sessions and after the large-group meeting. After the large-group meeting, a questionnaire was sent out to members to gather feedback on scheduling, leadership positions, participation in the MAC, and general preferences and accessibility needs.

Moving forward, BAC members will set their own agenda, facilitate meetings (with assistance from state staff), and plan group goals. The BAC will also be editing and voting on the drafted bylaws. BAC members will work with DPHHS staff to provide recommendations and feedback on a variety of topics.

RECOMMENDATIONS

During the reporting period, the MAC and BAC discussions centered on core Medicaid program and policy areas, alongside aligned recommendations to improve services, access, and beneficiary experience. Key topics included:

- Access to care, particularly provider availability in rural and frontier areas, appointment wait times, network adequacy, and transportation barriers
- Quality of services, including the use of data and performance metrics, and opportunities to strengthen care coordination
- HCBS, with emphasis on access, workforce shortages, provider capacity, and person-centered service delivery
- Beneficiary experience and person-centered care, including the need for clearer communication, improved system navigation, and ensuring dignity and autonomy in care
- Behavioral health services were a major focus, including access to mental health and substance use disorder services, integration with physical health, and crisis care continuity
- Across all areas, workforce and provider capacity challenges were identified as critical factors affecting service availability and quality.

Recommendations consistently emphasized improving access and reducing barriers to care, strengthening clear and accessible communication for beneficiaries, addressing workforce challenges, and advancing person-centered, equitable care across the Medicaid system.

Topic Area	Recommendation	State Action
Access to Care	Provider availability in rural and frontier areas Appointment wait times and scheduling barriers Network adequacy and provider participation	1. Primary Care Montana (PCMT) is Montana Medicaid's redesigned primary care case management program. PCMT is a value-based Primary Care Case Management (PCCM) designed to strengthen care coordination and reduce participation barriers. Through a tiered structure, PCMT offers enhanced payments for capabilities many practices already have, making value-based care more achievable without requiring large new investments. PCMT providers must demonstrate after-hours access and offer urgent or acute appointments consistent with nationally recognized standards, helping ensure members receive timely care. While members may continue to see any Medicaid-enrolled primary care provider, PCMT incentivizes practices that expand access and

	Transportation barriers limiting access	improve coordination, promoting availability and continuity of care across the state. 2. Montana Medicaid has contracted with a Non-Emergency Medical Transportation (NEMT) broker, Modivcare, to implement new modernized service model of NEMT. As work moves forward, the program will be updated with new technology and less barriers to transportation, including updated scheduling and reimbursement. With the new broker, reimbursement will be expedited and Montana DPHHS will focus on recruitment of providers throughout Montana to address access issues in rural areas. The new program is expected to begin Fall 2026. 3. The implementation of the Certified Community-Based Behavioral Health Center (CCBHC) is expected to expand provider capacity, increase service availability in rural and frontier communities, reduce wait times statewide, and enhance network adequacy through mandated care coordination. Enhanced funding will also support clinics in addressing transportation and geographic barriers that limit access to care. 4. Pediatric Complex Care Assistance Service was authorized to increase access to care for Montana's medically complex children, as it allows parents and other family members to become paid caregivers for specific, skilled tasks that were previously available only under Private Duty Nursing (PDN). 5. The HB (House Bill) 419 Cost Reporting Study was implemented in October 2025 for Behavioral Health and Developmental Disabilities, Senior and Long-Term Care, and Human Resources Division (BHDD/SLTC/HRD) providers, focusing on services not included in the Resource-Based Relative Value Scale (RBRVS) reimbursement methodology. Training on the cost reports was completed in February 2026. Cost report submissions are completed and are going through information verification process. This information will be used to assess Medicaid rate adequacy, which in turn, supports network adequacy.
Quality of Services	Use of data and performance metrics to assess service quality	1. Community First Choice (CFCS) and Personal Care Services (PCS) conducts annual provider prepared standards reports to assess service quality. In addition, CFCS/PCS conducts Quality Assurance Reviews on a regular basis (1-, 2-, or 3-year cycle depending upon previous compliance rating). Providers are required to submit SMART (Specific, Measurable, Achievable,

	Opportunities to strengthen care coordination across providers	Relevant, Time-Bound) goals for areas of noncompliance. CFCS/PCS provides ongoing provider training as well as new provider training which addresses data and performance metrics as well as the need to coordinate care with partner programs such as Developmental Disabilities Program (DDP), Severe Disabling Mental Illness (SDMI), and Big Sky Waiver (BSW). 2. BSW implemented MedCompass, DPHHS's care management system. This supports coordination of services across Medicaid programs by providing a centralized platform for care planning, documentation, and case management activities. Integration between MedCompass and CHIMES (Combined Healthcare Information and Montana Eligibility System) promotes information sharing, reduces duplication of effort, and supports a more coordinated experience for members receiving services. 3. The Targeted Case Management for High-Risk Pregnant Women (HRPW) program was updated effective January 1, 2026. The update expands coverage to include home visiting providers and adds additional Healing and Ending Addiction through Recovery and Treatment (HEART) populations. Newly covered individuals include parents and caregivers with a child aged 0–5 in the household who have a substance use disorder or Severe Disabling Mental Illness (SUD/SDMI) diagnosis. In addition to adding the additional covered populations, the provider requirements have been updated to match other Targeted Case Management programs to provide consistency throughout Montana Medicaid. 4. Primary Care Montana (PCMT) is Montana Medicaid's redesigned primary care case management program. PCMT uses data and performance metrics to tie payment to measurable quality outcomes. PCMT strengthens care coordination by requiring practices to systematically manage labs, imaging, and referrals, provide timely access (including same-day and after-hours care), and support team-based care processes. 5. BHDD CMHB assesses the impact of school-based behavioral health services for children with serious emotional disturbance (SED) on a quarterly basis, analyzing program metrics including cost of care, behavioral assessment scores, child mental health service placement (i.e., in-home, residential treatment), school attendance, and youth court involvement, as well as the provision of additional services including preventive care and Targeted Case

		Management (TCM). CMHB assesses the quality of Targeted Case Management (TCM) services for children with SED on a biannual basis, collecting data on service provision (e.g., substance use screening, suicide prevention), behavioral assessment scores, child mental health service placement (i.e., in-home, residential treatment), school attendance, and youth court involvement.
Home & Community-Based Services (HCBS)	Access to HCBS and service availability gaps Workforce shortages and provider capacity limitations Person-centered service delivery practices	1. The Targeted Case Management for High-Risk Pregnant Women (HRPW) program was updated effective January 1, 2026. The update expands coverage to include home visiting providers and adds additional Healing and Ending Addiction through Recovery and Treatment (HEART) populations. Newly covered individuals include parents and caregivers with a child ages 0–5 in the household who have a substance use disorder or Severe Disabling Mental Illness (SUD/SDMI) diagnosis. In addition to adding the additional covered populations, the provider requirements have been updated to match other Targeted Case Management programs to provide consistency throughout Montana Medicaid. 2. Pediatric Complex Care Assistance Service were implemented to help address PDN service availability gaps in Montana. 3. CFCS/PCS providers submit annual reports with person centered planning practices compliance. CFCS/PCS completed regular Quality Assurance Reviews on a 1-, 2-, or 3-year cycle (depending upon previous compliance rating) part of which includes a review of Person-Centered Plan (PCP). 4. Health Care for Health Care Workers Initiative has been refined, resulting in a user-friendly interface. The intention for this refinement was to simplify provider reporting and encourage participation. It has been determined that provider agencies with participating direct care workers experience a 50% increase in employee retention. 5. Developmental Disabilities Direct Service Provider Training and Credentialing: Administered by DDP with the National Alliance for Direct Support Professionals (NADSP), this initiative enables Direct Support Professional(s) (DSPs) to earn professional credentials through targeted training and badge acquisition. DDP has also partnered with IntellectAbility to provide Person-Centered Thinking training to state staff, provider personnel, and Targeted Case Managers (TCMs). This professional development is supported by quarterly virtual training sessions and the addition of

		the "Fatal Five Plus" course to the Learning Management System platform for DSPs and TCMs. 6. Children's Mental Health Bureau Targeted Case Management Training: In response to stakeholder-identified training gaps, the Children's Mental Health Bureau (CMHB) partnered with the University of Montana Center for Children, Families, and Workforce Development (Center) to create a TCM eLearning program. Designed for the workforce serving youth with serious emotional disturbance (SED), the first cohort completed the program in April 2026 and will continue to be offered twice a year. Designed as a hybrid learning experience, the eLearning program combines online modules, live discussions, and a workbook with written activities.
Beneficiary Experience & Person-centered Care	Need for clearer communication and plain-language materials Improved navigation of the Medicaid system Ensuring dignity and autonomy in care delivery	1. CFCS/PCS providers are required to complete annual member surveys. 2. The Senior and Long-Term Care Division has enhanced member access to information by redesigning and expanding program information on the DPHHS website. SLTC has also developed brochures, fact sheets, and other plain-language educational materials to help members, families, providers, and stakeholders better understand available programs, services, eligibility requirements, and resources. 3. Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys for Montana Medicaid provides a comprehensive tool for assessing members' experiences with their health plan and health care services (including Medicaid, Children's Health Insurance Program aka CHIP, CFCS/PCS, BSW, SDMI). Centers for Medicare & Medicaid Services (CMS) calculates state-level performance results for both the Child and Adult Core Measure reporting on behalf of states using data submitted to the Agency for Healthcare Research and Quality (AHRQ) CAHPS Health Plan Survey Database. This will help these programs to better understand whether care is truly person-centered. By using CAHPS results, programs can identify opportunities to improve member experience and deliver more person focused care. 4. CFCS/PCS surveyed OPA workers to assess knowledge of programs and provided education and brochures to increase the

		knowledge of front-line workers as to available programs and participation guidelines. 5. All Medicaid Members were sent information about CFCS/PCS programs. 6. CFCS/PCS brochures have been developed and distributed to pharmacies, medical offices, etc. across the State. 7. CMHB has partnered with the Center to create a Family Ambassador Board (FAB). To improve services and policies, FAB provides the state with crucial, firsthand insights. The board serves as an advisory body, ensuring that state-level system improvements are guided by family voices. FAB consists of nine paid members who bring essential lived experience in navigating the children's mental health system, allowing the state to learn directly from families. Based on recent feedback from FAB, the Department plans to develop clear, family-friendly communication materials for families entering various programs. This initiative will make it easier for families to navigate their care options and clearly see how each service can help them. 8. Primary Care Montana (PCMT) is Montana Medicaid's redesigned primary care case management program. PCMT supports improved navigation of the Medicaid system by designating a primary care practice as the member's central "home" for preventive, chronic, and post-hospital care needs. PCMT practices use team-based care, outreach, and care coordination requirements (including lab/test follow-up, referral management, and transition-of-care support) to help members understand where to go, how to access services, and what steps to take after visits or hospitalizations. PCMT's tiered structure also encourages practices to proactively identify care gaps and contact members, making it easier for them to stay current on screenings, WellCare visits, and follow-up care. PCMT is built around patient-centered primary care, emphasizing dignity, respect, and member choice in how and where care is delivered. Members retain the autonomy to receive services from any Medicaid-enrolled primary care provider who will see them, while PCMT incentives focus on providers that expand access, coordinate care, and support member preferences in scheduling and communication. Through comprehensive assessments,

		person-centered care planning, and support for culturally and linguistically appropriate services, PCMT encourages practices to involve members and families in decisions and to align care with each members goals and circumstances.
Behavioral Health Services	Access to mental health and substance use disorder (SUD) services Integration of behavioral health with physical health care Crisis care continuity and responsiveness	1. Montana continues to expand the Meadowlark Initiative. Meadowlark integrates behavioral health screening and services into prenatal and postpartum care for pregnant women and families. It delivers team-based, culturally responsive care that is aimed at improving outcomes and keeping families intact. Participating practices provide: • Universal screening for anxiety, depression, substance use, and social determinants of health during prenatal/postpartum visits. • Behavioral health professionals are available onsite during visits. • Care coordination connects patients to resources like housing, food, transportation, and behavioral health support. • In addition, the Meadowlark sites and all providers serving the perinatal population and children up to age 21 can call the Montana Psychiatric Access Line (MTPAL) free of charge to consult with a psychiatrist for issues relating to mental health and substance use disorders. 2. The implementation of tenancy support services and contingency management through the HEART Waiver. Tenancy support services can help individuals acquire and maintain safe, reliable housing. This includes housing application fees and assistance with security deposits. Contingency management is the most effective evidence-based treatment for individuals with a stimulant use disorder. This is a 12-week program that reinforces positive behavior change by rewarding individuals who remain stimulant-free with motivational incentives. 3. The implementation of CCBHC's support improvements across the behavioral health System. CCBHC standards and funding are designed to expand access to mental health and SUD services, strengthen integration of behavioral and physical health care through required care coordination, and enhance crisis care by expanding crisis response services statewide. 4. Primary Care Montana (PCMT) is Montana Medicaid's redesigned primary care case management program.

		• Tier 1, PCMT includes "Screening for Depression and Follow-Up Plan" for adolescents and adults in its quality measure menu, requiring practices to routinely screen for behavioral health needs and close follow-up gaps, similar to integrated care models that use universal behavioral health screening in primary care. • Tier 2 builds on this by requiring comprehensive social, behavioral, and physical health assessments; implementation of evidence-based decision support for mental health and substance use conditions; systematic medication reconciliation; and active management of hospital and Emergency Department (ED) transitions. • Tier 3 design will look at imbedding Integrated Behavioral Health (IBH) into high-risk member case management and will be phased in at a future date. 5. Behavioral Health Services for Future Generations (BHSFG) Recommendation #8: Implement a Care Transitions Program. This will implement Critical Time Intervention (an evidence-based practice) to help individuals with severe mental illness released from institutional settings. The initial target population will be individuals with multiple admissions to the Montana State Hospital. The program will provide support as they transition to the community. Implementation is underway with services expected to begin in summer 2026.
Workforce & Provider Capacity	Workforce shortages identified as a critical factor across all topic areas Provider recruitment, retention, and capacity gaps in Medicaid programs Impact on service availability, quality, and timely access	1. BHSFG Recommendation #19: Incentivize Providers to Join the Behavioral Health (BH) and Developmental Disabilities (DD) Workforce will address BH and DD workforce shortages by establishing a tuition reimbursement program for case managers and direct care workers. It will also create dual enrollment programs for people to earn tuition-free college credits in these fields. 2. BHSFG Recommendation #6: Targeted Case Management (Access Grants) aims to expand the workforce of TCMs by assisting providers with recruitment, hiring, onboarding and training costs associated with hiring new TCMs. 3. BHSFG Near Term Initiative (NTI) #3 supports Mobile Crisis Response and Crisis Receiving and Stabilization Services. Through this initiative, one-time grants were provided to existing mobile crisis response providers to help stabilize and sustain their programs, specifically by covering operational costs not

		reimbursable through Medicaid. Additionally, one-time grants were awarded to counties to expand crisis receiving and stabilization service capacity, including funding for facility purchases. 4. BHSFG NTI #4 focused on the Development and Deployment of a Comprehensive Crisis Worker Curriculum and Certification Course. Through this initiative, the Department contracted with the University of Montana to develop a training course for crisis service providers. The curriculum covers key areas including suicidology, intervention strategies, and community resources. 5. BHSFG NTI #5: Healthcare and I/DD Workforce Training and Certification created a pilot credentialing structure for DSPs through NADSP, allowing for career advancement opportunities. Additionally, IntellectAbility developed training for healthcare professionals on how to support individuals with IDD. 6. An evaluation of the Health Care for Health Care Workers Initiative was completed in early 2026. This study validates that affordable health insurance is a useful recruitment tool, many workers would leave without it, and that it has resulted in a significantly lower turnover rate (22% versus industry standard turnover rate of 75%). It has been determined that this initiative serves best as a retention tool. Workers surveyed also reported that increased pay, professionalism, and additional benefits such as paid sick time, vacation time, mileage. 7. Montana's Rural Health Transformation Program (RHTP) plan directly addresses provider workforce challenges through Initiative 1 which is focused on recruitment, training, and retention of health care workers in rural and frontier communities. In collaboration with the Montana Department of Labor and Industry, the Department plans to attract, train, and retain health care professionals in rural areas by: • Expanding apprenticeships, credentials, and micro-pathways, and early exposure programs; offsetting training costs with time-limited education awards and tuition assistance • Increasing clinical training capacity in rural communities by growing residency programs, offering preceptor incentives, and expanding rural training tracks

		• Enhancing supportive services and professional development to better connect and sustain health workers in rural communities.

ENGAGEMENT SUCCESS

PARTICIPATION AND ENGAGEMENT

DPHHS supports active participation through multiple engagement methods to ensure accessibility and inclusivity. Meaningful advisory engagement requires more than simply holding meetings; it demands that every member has a genuine opportunity to contribute. DPHHS designs its engagement practices with this principle in mind, continuously refining its approach based on member feedback and emerging best practices.

MEETING FORMATS - DPHHS offers flexible meeting formats to reduce barriers to participation and accommodate the diverse circumstances of advisory members across Montana:

- Virtual (video and phone)
- In-person (as applicable)
- Hybrid options

ENGAGEMENT STRATEGIES - DPHHS employs a layered set of engagement strategies designed to build member confidence, sustain active participation, and translate advisory input into actionable program improvements:

- Questionnaires and follow-up reminders sent after meetings
- Individual orientation sessions with new members
- Public comment opportunities at each meeting
- Pre-meeting materials sent early to support informed participation
- Use of plain language and accessibility supports (e.g., interpretation, accommodations)

HOW INDIVIDUALS WERE INVOLVED

During the reporting period, BAC and MAC members were active contributors to the work of improving Montana's Medicaid program. Participation took many forms:

- Members shared personal experiences with navigating the Medicaid system, including barriers encountered when accessing services, challenges with provider availability, and experiences with enrollment and renewal processes. These firsthand accounts brought depth and urgency to discussions that data alone cannot provide.

- Members reviewed and responded to program data, including access and utilization reports, quality metrics, and information on proposed policy or regulatory changes. Both advisory bodies engaged in facilitated discussion around what the data showed, what it might be missing, and what it meant for the people DPHHS serves.

- Members identified emerging priorities that warranted attention, including workforce shortages in specific service areas, gaps in behavioral health access, and challenges facing tribal communities and individuals transitioning from institutional to community-based care.

- Members contributed to public-facing processes by participating in comment periods, supporting outreach within their own networks, and, in some cases, engaging with DPHHS staff outside of formal meetings to provide follow-up input on specific topics.

BUILDING TRUST

DPHHS recognizes that trust is not assumed; it is built over time through consistent, respectful, and transparent engagement. Several practices during this reporting period were specifically aimed at strengthening trust between the Department and advisory members:

- Closing the loop on recommendations. DPHHS provided updates on the status of prior recommendations, communicating what actions had been taken, what was still under consideration, and where constraints existed. This follow-through signals to members that their input has real consequences and is not simply received and filed away.
- Welcoming critical feedback. DPHHS staff actively encouraged members to raise concerns, disagreements, and critiques. This creates a culture where honest feedback is valued over comfortable consensus. Facilitators were trained to hold space for dissenting perspectives and ensure that all viewpoints were documented.
- Meetings were held with adequate advance notice. Consistent staffing and facilitation helped members build working relationships with DPHHS contacts.
- Honoring diverse forms of expertise. DPHHS staff approached BAC members as experts in their own experiences and MAC members as experts in their professional domains. Advisory discussions were structured to elevate perspectives.

WHAT SUPPORT LOOKS LIKE

DPHHS provides ongoing support to advisory members to ensure that participation is sustainable and meaningful:

- Dedicated DPHHS staff serve as points of contact for member questions, logistical needs, and follow-up between meetings.
- Accessibility accommodations are arranged proactively and without burden on the members requesting them.
- New and returning members alike have access to reference materials, program overviews, and DPHHS staff expertise to help contextualize meeting content.

- Informal check-ins and relationship-building opportunities are built into the meetings to ensure members feel connected to the work beyond the formal meeting structure.

MEETING ACTIVITIES AND OUTCOMES

During the reporting period, both advisory bodies held regular meetings focused on program updates, stakeholder engagement, and structured feedback collection. Core activities included:

- Presentations from DPHHS divisions on program performance, policy changes, federal requirements, and emerging issues. This gave members relevant information to base their input on.
- Facilitated group discussions designed to surface diverse perspectives and move beyond surface-level agreement toward substantive dialogue about program strengths and gaps.
- Review of data and proposed changes, with opportunities for members to ask questions, request clarification, and offer recommendations before decisions are finalized.
- Public comment periods at every open meeting, ensuring that the broader community beyond formal membership has an ongoing voice in program direction.
- Identification of emerging priorities, with member-generated topics documented and incorporated into future meeting agendas and DPHHS workplans.

Together, these activities ensure that Medicaid policies and operations are informed by both rigorous, data-driven analysis and the lived experiences of those directly impacted. The combined contributions of MAC and BAC reflect a shared commitment to a Medicaid program that is not designed for Montana beneficiaries, but with them.

LOOKING AHEAD

DPHHS will continue to build on MAC and BAC engagement to strengthen Medicaid program performance and compliance with federal access and transparency requirements. The Department recognizes that meaningful advisory engagement is foundational to a high-performing Medicaid program, one that is responsive to the people it serves, accountable to federal partners, and aligned with Montana's unique healthcare landscape. In the coming year, DPHHS will deepen its investment in both the MAC and the BAC as complementary mechanisms for continuous program improvement.

KEY PRIORITIES

- Strengthening integration of BAC and MAC recommendations with state decision-making
- Enhance transparency and reporting aligned with federal Medicaid Access Rule requirements
- Improve access to care, with a focus on rural and underserved populations
- Advance person-centered planning and beneficiary experience initiatives
- Address workforce capacity challenges across service areas

PLANNED ACTIONS

- Expand engagement strategies to increase participation and representation
- Improve data collection and reporting to support informed decision-making
- Implement communication improvements for beneficiaries and stakeholders
- Continue cross-divisional collaboration to address system-wide issues

DPHHS remains committed to ensuring that both stakeholder expertise and beneficiary experience inform Medicaid policies and programs. The Department views MAC and BAC groups not simply as compliance mechanisms, but as essential partners in building a Medicaid program that is equitable, accessible, and person-centered. Through continued investment in meaningful engagement, transparent reporting, and responsive action, the MAC and BAC groups will continue to play a critical role in shaping a more accessible, equitable, and responsive Medicaid program in Montana, one that reflects the voices, needs, and priorities of the communities it serves.

ACKNOWLEDGMENTS

The Montana Department of Public Health and Human Services (DPHHS) extends its sincere appreciation to the members of the Medicaid Advisory Committee (MAC) and the Beneficiary Advisory Council (BAC) for their continued commitment to strengthening Montana's Medicaid program. Their time, expertise, and lived experience are essential in ensuring that Medicaid policies and services reflect the needs, priorities, and voices of the people they serve.

DPHHS also recognizes the dedication of staff across divisions who support the planning, facilitation, and follow-through of MAC and BAC activities. Their efforts to coordinate meetings, share information, analyze feedback, and implement improvements are critical to advancing a responsive and effective Medicaid program.

In addition, we thank community partners, providers, advocates, and stakeholders who contribute to these efforts through participation, public comment, and ongoing collaboration. Together, these contributions support a more transparent, equitable, and person-centered Medicaid system for Montanans.

APPENDIX

Links for additional information regarding the information presented in this report

- Beneficiary Advisory Council: Beneficiary Advisory Council
- Medicaid Advisory Committee / Montana Health Coalition: Health Coalition
- Behavioral Health System for Future Generations (BHSFG): Future Generations
- Healing and Ending Addiction Through Recovery and Treatment (HEART): HEART Waiver Services
- Rural Health Transformation Program: Rural Health Transformation Program
- Behavioral Health and Developmental Disabilities: Behavioral Health and Developmental Disabilities
- Senior and Long-Term Care: Senior and Long-Term Care
- Health Resources Division: Health Resources Division
- The Meadowlark Initiative: The Meadowlark Initiative® - Montana Healthcare Foundation
- Targeted Case Management Services: Targeted Case Management (TCM) Services
- Targeted Case Management Services for High Risk Pregnant Women: Targeted Case Management Services for High Risk Pregnant Women | Montana SOS
- DDP Training: Training
- Health Care for Health Care Workers: hchcw
- Community First Choice Services and Personal Care Services: CFCS-PCS
- Pediatric Complex Care Assistant Services: Pediatric Complex Care Assistant Services
- Children's Mental Health Bureau: Children's Mental Health
- Big Sky Waiver: Big Sky Waiver Program
- Report on Certified Community Behavioral Health Clinics: Certified Community Behavioral Health Clinics Report — SFY 2026 Quarter 2 Report
- Presentation on NEMT: Non-Emergency Medical Transportation Presentation
- Primary Care Montana: Primary Care Montana
- HB 419: CH0654.pdf