Fact Sheet

Medicaid Medical Care Advisory Committees

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Federal law requires states to have a Medical Care Advisory Committee (MCAC) to advise the Medicaid agency about health and medical care services, help develop Medicaid policies, and give ideas about how the program should be run. Although MCACs have been federally required for over twenty-five years, surveys by the National Health Law Program have found that MCACs are seriously underutilized and do not function at all in some states.[1] Given the serious threats to Medicaid services and eligibility at the state level and to judicial enforcement in federal and state courts, advocates should work to reinvigorate their state's MCAC so that it becomes a vital, functioning two-way channel of communication between Medicaid policy makers and the individuals and providers who participate in the Medicaid program.

This Fact Sheet sets forth the legal requirements for MCACs, reviews the relevant case law, offers examples of state laws and activities, and lists essential ingredients for making the MCAC an important component in Medicaid policy development and consumer involvement.

Legal requirements

Federal regulations set forth the requirements for the MCAC. *See* 42 C.F.R. § 431.12 (2004). These regulations implement a Medicaid Act provision which requires the state to "provide . . . for the training and effective use . . . of non-paid or partially paid volunteers … in assisting any advisory committees established by the State agency." 42 U.S.C. § 1396a(a)(4) (2004).[2] Medicaid managed care marketing provisions also require consultation with the MCAC. *See* 42 U.S.C. § 1396u-2(d)(2)(A)(ii).

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[1] *See* National Health Law Program, *Making the Consumers' Voice Heard in Medicaid Managed Care–A Guide to Effective Consumer Involvement* (Apr. 1999) (available from National Health Law Program, Los Angeles, CA); National Health Law Program and Cecil G. Sheps Center for Health Services Research, *Making the Consumers' Voice Heard in Medicaid Managed Care: Increasing Participation, Protection and Satisfaction–Report on Required and Voluntary Mechanisms* (Dec. 1996) (available from National Health Law Program, Los Angeles, CA).

[2] Other Medicaid provisions are sometimes cited. *See* MaineCare Benefits Manual, Ch. 1, § 1, 1.23-1 (citing 42 U.S.C. § 1396a(a)(22) (requiring state to describe the standards and methods it will use "to assure that medical or remedial care and services provided to

Purpose of the MCAC. According to the federal regulation, the purpose of the MCAC is to advise the Medicaid agency about health and medical care services. Specifically, the MCAC must have "opportunity for participation in policy development and program administration. . . ." 42 C.F.R. § 431.12(e). The MCAC is also intended to support the role of recipients in the Medicaid program. *Id.*[3]

Composition of the MCAC. The rules also address composition of the MCAC. The MCAC is to be selected on a "continuous and rotating" basis by the director of the Medicaid agency or a higher state official. 42 C.F.R. § 431.12(c). Membership must include members of consumers' groups, Medicaid recipients, and consumer-oriented organizations such as labor unions, cooperatives, and consumer-sponsored prepaid group practice plans. Board-certified physicians and providers who are familiar with the medical needs of Medicaid populations and understand the resources needed to meet those needs must also be included. The director of the welfare department or the public health department—whichever one does not run the Medicaid agency—must also sit on the MCAC. *Id.* at § 431.12(d).[4]

The Centers for Medicare & Medicaid Services (CMS), which administers Medicaid federally, has recently verified that the regulatory listing of required membership is not exhaustive.

> The State may always add to the current MCAC composition requirements to include representatives of any affected groups or entities. . . . We encourage States to have an [sic] MCAC membership that is diverse and represents groups served by the State's program, for example, minorities and individuals with special needs. . . . . We would encourage States to ensure that the public is clearly and completely informed about eh role and membership of the MCAC or any similar committee.

66 Fed. Reg. 6228, 6280 (Jan. 19, 2001) (final rule with comment period).

Agency support for the MCAC. The Medicaid agency is required to support the MCAC. The agency must provide staff assistance to assist the MCAC with its meetings

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recipients of medical assistance are of high quality")); *see also, e.g., Morabito v. Blum*, 528 F. Supp. 252, 264 (S.D.N.Y. 1981) (citing § 1396a(a)(22)(D) and § 1396a(a)(19) (requiring program administration in best interest of recipients)).

[3] Not all states refer to their committee as the MCAC. For example, in Oklahoma, the MCAC is called the "Advisory Committee on Medical Care for Public Assistance Recipients," *see* Okla. Stat. tit. 63, § 5009.2 (2004); in Kentucky, the "Advisory Council for Medical Assistance," *see* Ky. Rev. Stat. § 205.540 (2004); in West Virginia, the "Medical Services Fund Advisory Council," *see* W.V. Code § 9-4-3 (2004).

[4] When neither the public health nor the welfare director is the head of the Medicaid agency, the Centers for Medicare & Medicaid Services will allow the state to decide if only one of the departments is represented on the MCAC or if both are included. *See* 66 Fed. Reg. 6228, 6280 (Jan. 19, 2001).

and activities. 42 C.F.R. § 431.12(f). The agency should offer financial help to MCAC members to make it possible for them to participate in the MCAC.[5] *Id.* In addition, the agency is to provide for independent technical help, as needed, to the MCAC "to enable it to make effective recommendations." *Id.* at § 431.12(f).[6]

Federal funding will cover half of the cost of the MCAC's work. *Id.* at § 431.12(g). When particular expertise is needed to assist the MCAC, the activities may qualify for higher matching rates. *See* 42 C.F.R. § 432.50.

MCAC Review of marketing materials. Congress recently specified a particular role for the MCAC in Medicaid managed care: As states review and approve marketing materials from managed care entities, they must consult with the MCAC. *See* 42 U.S.C. § 1396u-2(d)(2)(A)(ii); 42 C.F.R. § 438.104(c).

This Congressional designation of responsibility to the MCAC generated a surprising number of comments to CMS as it implemented the statute. Some of those commenting labeled the requirement "impractical, burdensome, unrealistic, and an example of micro-management," and others objected to allowing consumers to review marketing materials at all. *See* 67 Fed. Reg. 40989, 41028 (June 14, 2002) (final rule); 66 Fed. Reg. at 6280. In response, CMS noted that states have flexibility in their implementation of the statute. For example, the state could require the MCAC to review actual marketing materials concurrently with the state's review, or it could consult with the MCAC in the development of standardized protocols to be used as the state reviews materials. *Id.* CMS also allows the state to designate a separate committee to perform this function so long as it also complies with the existing MCAC requirements in the federal regulation, 42 C.F.R. § 431.12. *See* 66 Fed. Reg. at 6280. CMS has cautioned, however, that the statutory language precludes consulting with the committee retroactively. *Id.* (quoting § 1396u-2(d)(2)(A)(ii), which specifies consultation "in the process of reviewing and approving"). Moreover, in responding to the comments, CMS reiterated the importance of the MCAC:

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[5] For example, Vermont requires at least one-third of the members of the MCAC to be recipients of Medicaid or SCHIP. Such members receive a per diem compensation and reimbursement of expenses, including costs of travel, child care, personal assistance services, and any other service necessary for participation on the committee approved by the commissioners. *See* Vt. Stat. Ann. tit. 33, § 1901c(f) (2004).

[6] For example, Idaho provides a manager to provide support to the members and officers of the MCAC and work with the vice chair to provide orientation to new members; a secretary responsible for minutes, packets, mailings, secretarial support for the MCAC, and distribution of material including agendas, and upon approval of the Medicaid director, other staff to provide technical assistance to the MCAC. Idaho Medical Care Advisory Committee Bylaws, *at* http://www.healthandwelfare.idaho.gov/_Rainbow/Documents%5Cmedical/MCAC%20Bylaws.pdf.

> We realize that public and physician consultation are important factors in the development of Medicaid managed care initiatives and encourage stakeholder input at all stages of managed care development. . . . Each State is required to have a Medical Care Advisory Committee (MCAC) established for the purpose of advising the Medicaid agency about health and medical services. This committee, by regulatory definition, is required to include physicians and beneficiaries. We encourage States to continue to use the MCAC as a mechanism for obtaining input on managed care issues.

66 Fed. Reg. at 6337; *see also* 67 Fed. Reg. at 41076 ("Each State is required to have a Medical Care Advisory Committee (MCAC) established for the purpose of advising the Medicaid agency about health and medical services.").

The relevant case law

The MCAC regulation is discussed in judicial opinions. A number of courts have required the state to consult its MCAC before implementing policy and programmatic changes. States' efforts to restrict the subject matter of MCAC review have typically failed. The holding of *Morabito v. Blum*, 528 F. Supp. 252 (S.D. N.Y. 1981) illustrates:

> In sum, on the basis of the language of the regulation, the guidelines issued thereunder, and the statutory provisions that medical care advisory committees exist to serve, the Court concludes that the 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.

Id. at 264.

The timing of the consultation with the MCAC is significant. For example, the most recent opinion discussing the role of the MCAC, *Rosen v. Tennessee Com'r of Finance and Administration*, 280 F. Supp. 2d 743 (M.D. Tenn. 2002), *opinion set aside on other grounds*, 2003 WL 22383610 (M.D.Tenn. Oct 14, 2003), provides an example. In this case, Medicaid recipients charged that a MCAC did not review significant changes to eligibility policies and procedures prior to their submission to CMS. State agency personnel had met with advocacy groups to share information, and a state legislative committee had previewed and approved the changes prior to their submission to CMS. In addition, an advisory committee that did not include a Medicaid recipient had been constituted after the fact and had reviewed various policy suggestions. The Court found these actions to be no substitute for consultation with a duly constituted MCAC, because "[t]he requirement of consultation with persons knowledgeable about the needs of the beneficiary population is not a meaningless formality." 280 F. Supp. 2d at 823. *Rosen* held that the MCAC's input had to be sought and received before the date of the action in question, not after the fact, and that the failure to properly consult the MCAC invalidated any attempt by the agency to effect the policy change. *Id.* at 825.

Courts in addition to *Rosen* have also found that, where consultation with the MCAC is required, the committee's input must be sought and received before the state action in question, not after the fact. As stated in *Morabito*:

> The requirement of prior consultation is rooted in the fact that medical care advisory committees are purely advisory in nature, having no power either to ratify or to veto any action that the state Medicaid agency proposes to take. . . . Thus, the only way that medical care advisory committees can be given the "meaningful participation" that is required by 42 C.F.R. § 431.12(e) is to consult them prior to the action in question.

528 F. Supp. at 264-65. *See also, e.g., Benton v. Rhodes*, 586 F.2d 1, 3 (6th Cir. 1978); *Jennings v. Alexander,* Medicare & Medicaid Guide (CCH), ¶ 30,735 (M.D.Tenn. Sept. 3, 1980); *Becker v. Toia,* 439 F. Supp. 324, 332-33 (S.D.N.Y. 1977); *Ho v. Chang*, Medicare & Medicaid Guide (CCH), ¶ 28,433 (D.Haw. Apr. 27, 1977); *Robinson v. Maher,* Medicare & Medicaid Guide (CCH), ¶ 27,707 (D.Conn. Jan. 19, 1976). *See also Visiting Nurse Ass'n of North Shore, Inc. v. Bullen,* 93 F.3d 997, 1010 n.14 (1st Cir. 1996) (noting that case law under § 431.12 "suggests that States should undertake their [MCAC] consultations as early in the Plan amendment process as practicable, preferably before any final decision on proposed changes to their reimbursement methodologies," and that it is reasonable to think that "[MCAC] consultation is sufficient as along [sic] as it occurs before final HCFA approval of the Plan amendment"). *Compare Mississippi Hosp. Ass'n v. Heckler*, 701 F2d. 511, 523 (5th Cir. 1983). ("Conceivably the complete absence of an MCAC or one that is improperly constituted or exists in name only, or in the failure to consult the committee on a fundamental policy change in a reimbursement plan, might contravene the vague requirement in 42 C.F.R. § 431.12(e) that "[t]he committee must have the opportunity for participation in policy development and program administration, including furthering the participation of recipient members in the agency program.").

Like *Rosen,* courts have also found the state's prior consultation of a properly constituted MCAC to be mandatory on matters involving policy development and program administration. *See Rosen*, 280 F. Supp. 2d at 825. *See also, e.g., Burgess v. Affleck,* 683 F.2d 596, 599 (1st Cir. 1982) (stating that "[u]nder the regulation, the MCAC should have the opportunity to consider and discuss the available alternative policies, not merely the chance to make minor suggestions concerning a single policy already adopted by the state"); *see also Morgan v. Cohen,* 665 F. Supp. 1164, 1179 (E.D. Pa. 1987); *Turner v Heckler*, 573 F. Supp. 867, 872 (N.D. Ohio 1983), *rev'd on other grounds*, 783 F.2d 657 (6th Cir. 1986); *Morabito*, 528 F. Supp. at 264; *Stevens v. Childers*, 1994 WL 76166 (E.D. Ky. 1994). *Compare Himes v. Shalala*, 999 F.2d 684, 691 (2d Cir. 1993) (finding MCAC regulation is inapplicable to changes made by the state legislature); *Methodist Hospitals, Inc. v. Indiana Family and Soc. Serv. Admin*, 860 F. Supp. 1309, 1327-29 (N.D. Ind. 1994) (finding no violation of the regulation where record showed repeated consultations with the MCAC prior to final program change).

Some states consult with subcommittees of the MCAC or committees that are not MCACs. The extent to which a Medicaid agency may rely on other advisory bodies to meet its federal MCAC requirements is not clear. In *Georgia Hosp. Ass'n v. Dept. of Medical Assistance*, 528 F. Supp. 1348 (N.D. Ga. 1982), the Medicaid agency consulted a hospital subcommittee of the MCAC regarding hospital reimbursement rates, but failed to consult the entire committee. The court held that the law "neither requires the Committee's review of every project undertaken by the Department nor compels the participation of the entire committee in the review of each project submitted to the committee." *Id.* at 1354. Notably, this case did not address the question whether the full MCAC must be consulted on policies involving the more dramatic system re-design being considered in many states today. And as noted above, CMS has recently allowed use of committees in the Medicaid managed care marketing review context but specified that these committees would need to meet the existing MCAC requirements in the federal regulation, 42 C.F.R. § 431.12.

In contrast to *Rosen* and other case, some courts have held that a MCAC violation does not warrant injunctive relief. *Compare, e.g., Becker v. Toia*, 439 F. Supp. 324, 336 (S.D.N.Y. 1977) (awarding injunction), *with Rite Aid of Pennsylvania, Inc. v. Houstoun*, 171 F.3d 842 (3d Cir. 1999) (refusing injunction where violation was not "egregious") and *Burgess v. Affleck*, 683 F.2d 596, 599-600 (1st Cir. 1982) (finding in a case of "borderline" compliance with the MCAC regulation that, as the MCAC's involvement was advisory, an injunction was not an appropriate remedy and that relief at best would involve requiring consultation with the MCAC before implementation of revisions).

Moreover, courts are split on the question of whether the MCAC requirement can be privately enforced pursuant to 42 U.S.C. § 1983. The weight of the authority favors private enforcement. However, the decisions must be viewed guardedly because they pre-date the Supreme Court's decision in *Gonzaga University v. Doe*, 536 U.S. 273 (2002), which tightened the test for private enforcement. *Compare Rite Aid of Pennsylvania, Inc.*, 171 F.3d at 842, 856 n.14 (3d Cir. 1999) (allowing enforcement); *Rosen*, 280 F. Supp. 2d at 279-80 (same); *Methodist Hospitals, Inc. v. Indiana Family and Social Services***,** 860 F. Supp. 1309, 1324 (N.D. Ind. 1994) (same); *Oklahoma Nursing Home Ass'n v. Demps*, 792 F. Supp. 721, 725-26 (W.D. Okla. 1992) (same); *Morabito*, 528 F. Supp. at 266 (same) *with Florida Pharmacy Ass'n v. Cook*, 17 F. Supp. 2d 1293, 1302 (N.D.Fla. 1998) (refusing to allow private enforcement) and *Kansas Hosp. Ass'n v. Whiteman,* 835 F. Supp. 1556 (D. Kan. 1993) (same). Although refusing to allow private enforcement, the *Florida Pharmacy Ass'n* Court stated that the regulation is not a "dead letter." Rather, "State legislators and executive branch officials, no less than federal judges, have a solemn duty to comply with federal law" and "take an oath to support and defend the Constitution of the United States; one of the Constitution's provisions is the Supremacy Clause, under which federal law is fully binding on the states and state officials." *Id.* at 1303.[7]

[7] For more information about private enforcement of Medicaid Act provisions, *see* Jane Perkins and Sarah Somers, National Health Law Program, *NAPAS Q&A on Gonzaga University v. Doe* (July 5, 2002) (on file with NAPAS, Washington, DC).

There are other avenues for enforcement, however, For example, as discussed below, many states have enacted statutes that require a functioning MCAC. And, a State Medicaid Plan pre-print requires each state to verify that it has a MCAC. *See* Revision HCFA-AT-80-38 (BPP) (May 22, 1980). Medicaid beneficiaries and providers may be able to enforce this provision through a third party beneficiary contract action. *See* Jane Perkins and Steve Hitov, National Health Law Program, *Enforcing the Bargain: An Overview of Third Party Beneficiary Claims in Medicaid Cases* (Sept. 2003), available at: http://www.healthlaw.org/pubs/200310.issuebrief.html.

Exemplary state laws and activities

States' statutes, regulations, and bylaws provide detail regarding the operation of the MCAC at the state level. Advocates should become familiar with these state-specific requirements because they offer additional, independent legal support for states' need to reinvigorate their MCAC as a source of consumer involvement in the Medicaid program. As discussed below, a number of states have enacted provisions that should assist advocates' efforts in the state and that advocates elsewhere can seek to replicate.

Purpose of the MCAC. A number of state statutes set forth specific responsibilities for the MCAC, beyond those listed in the federal regulations. For example, Vermont law provides that the MCAC

> shall have the opportunity to review and comment upon agency policy initiatives pertaining to health care benefits and beneficiary eligibility. It also shall have the opportunity to comment on proposed rules prior to commencement of the rulemaking process and on waiver or waiver amendment applications prior to submission to the Centers for Medicare and Medicaid Services. Prior to the annual budget development process, the department shall engage the [MCAC] in priority setting, including consideration of scope of benefits, beneficiary eligibility, funding outlook, financing options, and possible budget recommendations. . . . During the legislative session, the commissioner shall provide the committee at regularly scheduled meetings updates on the status of policy and budget proposals.

Vt. Stat. Ann. tit. 33, § 1901c (2004). Maryland's MCAC is commissioned to advise the Medicaid director on the implementation, operation and evaluation of managed care programs, review standards used in managed care contracts, review data collected regarding managed care, and assist the department in evaluating managed care enrollment. The MCAC is to publish and submit an annual report to the Governor. *See* Md. Code Ann., Health-General § 15-103(a)(27) (2003). Nevada says a function of its MCAC is to "participate, and increase the participation of welfare recipients, in the development of policy and the administration of programs by the division." Nev. Rev. Stat. § 422.151 (2004). The Mississippi MCAC is asked to gather information on the reasons why providers do not participate in Medicaid and to offer changes that could be made to encourage participation. Miss. Code Ann. § 43-13-107 (2004). A California statute provides:

> The director, with the advice of the Medicaid Advisory Committee required by federal law or regulation, shall determine which of the health care and related remedial or preventive services are elective. The director and the committee shall consult with representatives of providers of such services before making a determination.

Cal. Wel. & Inst. Code § 14103.4 (2004). Maine requires the committee which makes decisions regarding Medicaid drug formularies to include at least two nonvoting members to be appointed by the MCAC. Me. Rev. Stat. tit. 22, § 3174-M (2003).

Composition of the MCAC. Some states have broadened the composition of the MCAC beyond the membership required by the federal regulation. For example, a Maryland statute requires the MCAC to include three members of the Maryland House of Delegates. *See* Md. Code Ann., Health-General § 15-103(a)(27) (2003). Mississippi's MCAC must include the respective chairpersons of the House and Senate Public Health and Welfare and Appropriations Committees, or their designees. *See* Miss. Code Ann. § 43-13-107 (2004). Bylaws establishing the Louisiana MCAC require the committee to include four state legislators (two senators and two representatives). *See* Louisiana State Department of Health and Hospitals, Office of the Secretary, *Medical Care Advisory Committee Bylaws* (2001), at www.dhh.state.la.us/offices/publications/pubs-133/BYLAWS112901-mcac.pdf. The participation of state legislators in the MCAC is important because it gives Medicaid beneficiaries and providers a way to communicate their ideas and on-the-ground information directly to those individuals who are making appropriations and policy decisions for the state.

Oklahoma has enacted legislation that is explicit regarding participation of consumer organizations on the MCAC. The law requires representatives from each of the following consumer organizations, which represent the interests of: (1) people who are economically disadvantaged, (2) children, (3) the elderly, (4) people with mental illness, (5) people who are developmentally disabled, and (6) people with alcohol or substance abuse problems. *See* Okla. Stat. tit. 63, § 5009.2 (2004). Some states require "citizens" to be on the MCAC. *See* Ind. Code Ann. § 12-15-33-3 (2004) (requiring three members who represent Indiana citizens); Alaska Division of Health Care Services, *Alaska State Medical Care Advisory Committee Bylaws* (Nov. 21, 2003) (requiring participation of a "private non-recipient citizen").

An Idaho statute requires the MCAC to include an oversight subcommittee consisting of providers of personal assistance services and participants of such services and advocacy organizations representing such participants for purposes of planning, monitoring and recommending changes to the Medicaid waiver and personal assistance programs. Idaho Code § 39-5609 (2004).

For current membership of your state's MCAC, contact your state Medicaid agency. The state may post MCAC membership on its website, as have:
Alaska: http://health.hss.state.ak.us/dhcs/mcac.htm;
Arizona: www.achcccs.state.az.us/Community/smac.asp;

South Carolina: www.dhhs.state.sc.us/InsideDHHS/Committees/MedicalCareAdvisory Committee/Default.htm?wbc_purpose=Basic; and
Oklahoma: www.ohca.state.ok.us/General/Boards/MAC/mac_board members.htm.

Highlighted states—Pennsylvania and Ohio. The MCACs in Pennsylvania and Ohio are particularly noteworthy. The discussion below provides detail regarding the development and use of the MCACs in these states.

In **Pennsylvania,** a relatively informal group, with a primarily provider-driven agenda, has evolved into an influential and business-like entity that primarily focuses on issues important to Medicaid consumers. The committee, known in Pennsylvania as the Medical Assistance Advisory Committee (MAAC), has 15 to 25 members who are appointed by the Secretary of the Department of Public Welfare (DPW). The operating guidelines for the MAAC are published on the DPW website at http://www.dpw.state.pa.us/omap/geninf/maac/omapmaacopguide.asp.

The MAAC is divided into four subcommittees focusing on four issues: (1) Consumer; (2) Fee-for-service; (3) Managed Care; and (4) Long Term Care. The purpose of Consumer Subcommittee is "to review and advise the MAAC on policy development and program administration of publicly funded medical assistance programs." DPW, *Operating Guidelines of the MAAC and Subcommittees*, Article IX, Sec. 2. Members of the Consumer Subcommittee must either be a consumer (i.e. receiving Medicaid), the parent of a consumer or a consumer advocate.

The Consumer Subcommittee membership represents the various interests of Medicaid beneficiaries. Currently, about one third of the members are African-American; the rest, white. About half live in urban or suburban settings while the other half are rural residents. Individuals representing the interests of low-income beneficiaries serve along with those representing people with disabilities. Though the members' various interests may present the potential for conflicting goals, committee members have historically taken unified positions and have not allowed themselves to be pitted against each other.

The full MAAC meets ten times per year in the state capitol. The current MAAC chair has a strong commitment to ensuring that face-to-face meetings take place, rather than using telephone conferencing. To this end, travel reimbursement is provided by the state Medicaid agency. Typically, the Consumer Subcommittee will meet prior to the meeting of the full MAAC. During this meeting, the Subcommittee review the agenda, obtains legal advice, discusses the positions it will take on proposed policies, and formulates issues for investigation.

The Pennsylvania Health Law Project (PHLP), a private, non-profit law firm, serves as legal counsel to the Consumer Subcommittee. PHLP attorneys provide advice and support to the Subcommittee during its pre-meeting and are available to advise the Chair of the Subcommittee during the meeting of the full MAAC. For more information

about the activities of the Pennsylvania Health Law Program, please contact Mike Campbell, PHLP, www.phlp.org.

The MAAC's meeting agenda is set by DPW and the MAAC Chair, with input from subcommittee members. A typical agenda includes a presentation by DPW on new initiatives and review of draft regulations, bulletins and notices. The subcommittees make reports and recommendations. There is time allowed for committee feedback. The meetings are open to the public, and time is allowed for public comment.

In recent years, the Consumer Subcommittee has been involved in a wide variety of issues including: (1) appeals and due process procedures; (2) managed care quality; (3) consumer outreach; (4) provider reimbursement; (5) access to services; (6) personnel decisions; and (7) budget priorities. According to consumer advocates, the MAAC has achieved positive results in a number of these areas. Cuts to Medicaid eligibility and services have been averted. Coverage has been enhanced for workers with disabilities. As a result of advocacy efforts by the MAAC, the state has a broad and progressive definition of medical necessity. Information about managed care entities has been made simpler and more accessible.

DPW's website contains information about the MAAC, including meeting schedules, member contact information and operating guidelines. The minutes are also published on the website: www.dpw.state.pa.us/omap/geninf/maac/omapmaacmin.asp.

In **Ohio**, the MCAC went through a metamorphosis similar to the MAAC in Pennsylvania. Increased formality in structure and process was seen as beneficial. Moreover, many in the advocate community believed that the group had become too exclusionary. It was difficult for outsiders to learn when the MCAC met, much less to influence which issues received attention. Accordingly, about seven years ago, the MCAC was reorganized, motivated by pressures from all sides, including physicians, hospitals, consumer advocates and unions.

According to the website for the Medicaid agency, the Ohio Department of Jobs and Financial Support (ODJFS), the purpose of the MCAC is "to assist ODJFS in the development and refining of the Medicaid program by providing a sounding board and, as an advisory group, gives ODJFS feedback on current and evolving issues in Medicaid. Advocates, service providers, and public agencies strive to work together and share their experience and knowledge to maximize the care available to low-income Ohioans." Ohio MCAC Overview, http://jfs.ohio.gov/ohp/bcps/OhMedAdvComm/index.stm.

ODJFS has created operating guidelines governing the MCAC. According to the guidelines, MCAC membership should be at least 15 and no more than 30 persons. Members must be selected on the basis of "individual knowledge and interest" in health and medical service programs, "rather than serving as a representative of a specific group or organization." ODJFS, *Medical Care Advisory Committee Operating Guidelines*, § 3 (July 2002) (on file with authors). Health care professionals and consumers must be

included, and a member must disclose financial interests in service programs or policies. Members serve for a three year period, but can be removed by majority vote after two absences without prior notice. *Id.* Unlike Pennsylvania, committees are not required, but the MCAC Chair is authorized to appoint up to three committees and chairs, upon approval of the MCAC. Ad hoc committees and chairs may also be appointed "from time to time." *Id.* at § 4.

The MCAC must meet at least four times per year and meetings are to be conducted pursuant to Robert's Rules of Order. Actions must be recorded in minutes of meetings. The committee is authorized to:

- Review and make recommendations on Medicaid, SCHIP and other publicly-funded health care programs;
- Identify unmet health and service needs;
- Assist with program planning and evaluations regarding service problems, policy issues and concerns of providers and consumers involved in Medicaid, the State Children's Health Insurance Program and "other publicly funded health care programs;"
- Assist with the Medicaid agency's efforts to improve communications and education programs regarding program goals and objectives; and
- Provide a written annual report, along with periodic reports, resolutions, findings and recommendations to the Medicaid director.

Id. at § 2.

A webpage contains schedules of future and past meetings, archives of past resolutions, a listing of members and links to handouts and presentations from previous years. *See* http://jfs.ohio.gov/ohp/bcps/OhMedAdvComm/index.stm. Presentations from 2004 addressed a variety of issues, including a pharmacy and dental services update (March 17, 2004); alternatives for reforming Ohio's prescription drug program (Nov. 17, 2004); a detailed budget update (Jan. 21, 2004); a presentation on ending chronic homelessness (Sept. 15, 2004); and a medical director's presentation (Sept. 15, 2004). The medical director's presentation focused on enhanced care management, a new managed care program underway in Ohio. The link on the webpage leads to a 76-page report discussing the program in depth–outlining reasons for its creation, trends in Medicaid spending (including detailed statistics on costs), and means of assuring quality and access. *See* http://jfs.ohio.gov/ohp/bcps/OhMedAdvComm/documents/MCAC091504_MedicalDir.pdf.

Consumer advocates who sit on the MCAC find that it is most useful as a source of information. Advocates and consumers (as well as other constituencies) are able to gain access to in-house information as well as access to individuals within the Medicaid

agency. ODJFS officials, on the other hand, have the opportunity to float ideas and get a sense of how various constituencies might react before they decide whether to vet the proposal widely. Also, if the MCAC has input into controversial ideas, ODJFS will be able to tell other consumers and advocates that the ideas where reviewed by a consumer-oriented MCAC. For more information about the functioning of the Ohio MCAC, please contact the MCAC Vice-Chair, Gene King, Ohio Legal Services Association, www.oslsa.org.

Essential components of a functioning MCAC

- As required under federal law, the MCAC must include a range of consumers, consumer-oriented groups, and Medicaid-participating providers.

- Procedures and requirements should be in writing (e.g. bylaws, manuals) and readily accessible to the public. Requirements should also be embodied in state statutes and regulations.

- Membership should reflect the cultural, linguistic and racial composition of the Medicaid population and should be chosen on the basis of recommendations of consumer and community-based organizations.

- Initial and ongoing training and orientation should address the Medicaid program and meeting protocols.

- The MCAC should be used as a forum for information sharing and policy advice. Members should identify concerns and informational needs, and the Medicaid agency should provide needed information and education promptly.

- The Medicaid agency should obtain advice from the MCAC prior to commencement of the rulemaking or state plan amendment process and on waiver applications or amendments prior to their submission to the federal government.

- Projects undertaken by the MCAC should be well-defined, meaningful projects that reinforce its purpose.

- A consumer subcommittee should address relevant issues involving covered populations, including children with special needs, persons needing mental health or substance abuse services, individuals with developmental disabilities, and individuals with limited English proficiency. The Consumer Subcommittee should have legal support.

- The MCAC should work with partners to create clear channels of communication to and from members, community stakeholders, state representatives and Medicaid-participating providers and health plans.

- Meetings should be held at accessible sites, such as community centers and public housing sites, and at convenient times. Consumers should be asked to make suggestions for how meetings should be run. Accommodations (access for individuals using wheelchairs, sign language interpreters) should be ensured, if needed.

- Meetings should be conducted in a way that encourages participation of all members. More experienced members should partner with and mentor new members.

- The Medicaid agency should cover transportation, child care, lodging, and personal assistance services expenses, if necessary to assure participation of the committee member. The agency should provide dedicated staff to assist the MCAC with preparation and conduct of meetings and maintenance of an up-to-date website of MCAC membership, agendas, minutes, and activities. When needed by the MCAC, the state agency should provide technical support and, if appropriate, seek enhanced federal payments for these personnel.

Conclusion

The National Health Law Program is interested in working with you to improve your MCAC. Please contact us.