The Medical Care Advisory Committee for State Medicaid programs: Current status and trends

by Stephen M. Davidson, Terry E. Herold, and Marlene B. Simon

Each State Medicaid program is required by Federal Regulations to have a Medical Care Advisory Committee (MCAC) which includes provider, consumer, and government representatives and which participates in policy development and program administration. Data are presented about the composition of these committees, their structure, the administrative and financial support they receive, and the nature of their activities. It is argued that they can play an important role in policy formulation and implementation, but that they need to be reformed in order to exploit that potential.

Introduction

A Medical Care Advisory Committee (MCAC) ". . . to advise the Medicaid agency about health and medical care services" is required by Federal regulation for each State Medicaid program.[1] The regulations specify the committee's membership, its participation in policy development and program administration, and the support for its operation.

Advisory committees historically have been used principally for two purposes: to present the opinions of relevant interest groups and to provide expertise (McMahon, 1930). Policymakers, in developing legislation and regulations bearing on MCAC's, apparently sought to design an advisory committee that would blend these purposes. The first purpose was expressed by describing an essential function of the MCAC as "providing a two-way channel of communication with the individuals, organizations, and institutions in the community that, with the administering agency, provide and/or pay for medical care and services" (U.S. Department of Health, Education, and Welfare, 1975). Recognizing the technical complexity of a medical assistance program, the designers fashioned an MCAC which could contribute "specialized knowledge and experience . . . to that available within the single State agency administering the program (U.S. Department of Health, Education, and Welfare, 1975).

Since the role of Federal and State Governments in the Medicaid program lies largely in the areas of financing and eligibility determination while medical services are provided by the private health care sector, a high degree of cooperation between the public and private sectors is required to realize the objectives of the program. For example, the Medicaid program was developed to make medical services in the mainstream of American medicine financially accessible to eligible low-income people. The complex problems involved in realizing that aim cannot be solved without the ingenuity and resources of both the public and private sectors. Recognizing the dependency of the Medicaid program on the private health care sector, the MCAC in each State is an organizational device aimed, in part, at maintaining and facilitating that cooperative relationship. One way it performs that function is by providing a forum for the expression of the interests of the private sector in the formulation and review of Medicaid policy.

The need to control escalating Medicaid outlays has led many States to propose a variety of innovations; and with the passage of several recent amendments to Title XIX of the Social Security Act, they have more freedom to do so. However, even some of those proposals with impressive theoretical and empirical support fail to be implemented, in part, because of the opposition of client advocates or provider groups.[2] A thorough airing of the complexities in an MCAC forum in which legitimate concerns are thoughtfully explored and self-serving objections are exposed may increase the acceptance rate for, and implementation of, innovative proposals. The MCAC can provide feedback and review of proposed innovations. It can also ease the acceptance of innovations by the larger communities it represents—both the private health care providers and the public.

Despite all these functions of MCAC's, however, very little is known about them. A Medical Services Administration (MSA) survey reporting on the composition of MCAC's in 1970 is the only published systematic information pertaining to them.[3] The objective of this study is to describe the structural and operational characteristics of existing MCAC's and as-

[1]Code of Federal Regulations, Title 42, Part 431, Subpart A, Section 431.12(a), 1978.

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[2]The recent abandonment of prepaid managed health care initiatives for East Harlem and Boston offer two cases in point.

[3]Two unpublished studies focus on certain aspects of the MCAC. One of these studies, conducted by the State of Michigan MCAC, surveyed all States as to the composition and operation of MCAC's in February 1979. The other study, conducted by the American Academy of Pediatrics through a contact chapter member in each of the 50 States, asked respondents to describe the MCAC and assess its effectiveness.

sess their function in the formulation of Medicaid policy.

Methodology

A mail survey was conducted of 50 State Medicaid programs (including the District of Columbia). The one-page questionnaire (Figure 1) sent to the administrator of the State Medicaid agency was intended to produce information about structural and operational characteristics of MCAC's in 1979. In addition to the information requested in the questionnaire, all available minutes of 1979 meetings were collected. A 92 percent response rate was achieved for the questionnaire.[4] Illinois and Nebraska responded but did not have an active MCAC in 1979. Excluding those States, 44 State responses were obtained. Responses to the questionnaire for each State included in the survey are presented in Tables 1 and 2. An analysis of the minutes of the MCAC meetings yielded additional data on the operation and function of the MCAC's. This study is largely descriptive. The original intent was to conduct a second study, which was never pursued, of several States selected to maximize variation on the characteristics described below. That in-depth study would have been an analytical attempt to explain the variation and to determine the effects of different MCAC policies.

Findings

Composition

As can be seen in Table 1, in 1979 the total members for an MCAC ranged from 6 to 50 with the average size being 20. Although individual MCAC's varied in size between 1970 and 1979, the average size was virtually unchanged, 19 in 1970 (U.S. Department of Health, Education, and Welfare, 1975). The more critical issue is not size, but the composition of the MCAC's, and that did change considerably.

Differing perspectives and specialized knowledge are needed to plan the Medicaid program, to formulate the policies that guide it, to set standards, and to assess and interpret the problems and needs of professional groups. The interdependence is reflected in the Federal guidelines for the composition of the MCAC, which specify three groups of members: providers of health care, consumers, and government representatives.[5] Members of MCAC must include:

- Board-certified physicians and other representatives of the health professions who are familiar with the medical needs of low-income population groups and with the resources available and required for their care;
- Members of consumers' groups, including Medicaid recipients and consumer organizations such as labor unions, cooperatives, consumer-sponsored prepaid group practice plans, and others; and
- The director of the public welfare department or the public health department, whichever does not head the Medicaid agency.

Providers of health care, the first group, accounted for more than 50 percent of the MCAC membership in 44 of the 48 States in the 1970 MSA study; by 1979, on the other hand, providers accounted for more than 50 percent in only 23 of the 44 States in the study. Moreover, in 72 percent of the MCAC's, the proportion of providers decreased from 1970 to 1979. Nonetheless, providers were still the largest group in 31 of the 44 States and, overall, accounted for 59 percent of the membership.

Consumers, the second group, who in 1970 were 30 percent or less of the MCAC's in 45 States, increased their representation so that in 1979 they comprised that small a proportion in only 24 States. The proportion of consumers increased over that period in 77 percent of the MCAC's.

Most of the change in composition was concentrated in those two groups. Government representatives, the third group specified in the regulations, comprised 30 percent or less of each committee in both 1970 and 1979. The percentage of MCAC's with minimal government representation (10 percent or less) did increase during those years from 29 percent of the MCAC's in 1970 to 43 percent in 1979.

The array of provider representatives on MCAC's in 1979 is also shown in Table 1. Not only did the number of providers decrease considerably from 1970 to 1979 but also, within the provider group, physicians were no longer dominant. A broad distribution within the provider groups of various health care providers—hospitals, nursing homes, laboratory representatives, pharmacists and others—is shown in Table 1. In 1970, one-third of the MCAC's reported that physicians accounted for over 50 percent of the provider representation on MCAC's. By 1979, in only 2 percent of the MCAC's did physicians account for over 50 percent of the provider representation.

The Secretary's Task Force on Medicaid and Related Programs, in its 1970 report, advocated that "State agencies should be required by the Federal Government to have majority representation of consumer representatives on State Advisory Committees on Medicaid" (U.S. Department of Health, Education, and Welfare, 1970). Medicaid policy includes Title XIX recipients as consumers who should have representation on MCAC's.[6] As noted earlier, the proportion of consumers on the MCAC's increased considerably from 1970, although consumers were still far from the majority group. Further, in 1970, only one-third of the MCAC's reporting included recipients as consumer representatives, but by 1979 that number had more than doubled. As indicated in Table 1, recipients were the majority of the consumer group in 17 MCAC's (42 percent).

[4]The States of North Carolina, Tennessee, and Wisconsin and the District of Columbia did not respond to the questionnaire.

[5]Code of Federal Regulations, Title 42, Part 431, Subpart A, Section 431.12(d), 1978.

[6]See footnote 5.

Figure 1

Medical Care Advisory Committees (MCAC) Questionnaire

1. How many members are on the Medical Care Advisory Committee to your State Medicaid program? _____

2. How many are:
   physicians? _____
   hospital representatives? _____
   nursing home representatives? _____
   pharmacists? _____
   laboratory representatives? _____
   other providers? _____
   Government representatives? _____
   Medicaid recipients? _____
   Non-recipient public members? _____

3. How many times did the MCAC meet in 1979? _____

4. Were agendas prepared for the meetings? _____
   (If so, we would appreciate receiving copies.)

5. Were minutes kept of the meetings? _____
   (If so, we would appreciate receiving copies.)

6. Have subcommittees or task forces been formed? _____
   If so, please name them:

   _____

   _____

   _____

7. Does the MCAC have staff assigned to it? _____
   If so, how many full-time equivalents? _____
   Please identify the key staff person, if any:

   _____
   (Name and Title)

   _____
   (Address) (City and State) (Zip) (Telephone No.)

8. Is a budget set aside for the functioning of the MCAC? _____
   If so, how much was it for 1979? _____

9. In your estimation, is the Medical Care Advisory Committee a useful concept in the administration of Medicaid? _____. Please explain your answer. (You may use reverse side for responding.)

THANK YOU!

RETURN TO:

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_____
(Name of person completing this questionnaire)

_____
(Title)

_____
(Address)

_____
(City) (State) (Zip)

_____ _____
(Telephone No.) (Date)

Table 1
Composition of Medical Care Advisory Committees (MCAC): 1979

State	All members [1]	Providers							Consumers			Government representatives	
		Total	Physicians	Hosp. reps.	Nursing home reps.	Pharmacists	Lab reps.	Other	Total	Recipients	Non-recipients	Total	Ex-officio
Alabama	20	8	4	1	1	1	—	1	10	—	10	2	—
Alaska	7	4	2	1	—	—	1	—	2	1	1	1	—
Arizona [2]													
Arkansas	16	7	2	1	1	1	—	2	9	2	7	—	—
California	13	4	3	1	—	—	—	—	6	2	4	3	—
Colorado	11	8	2	1	1	1	—	3	3	—	3	[6] 2	2
Connecticut	26	13	2	1	1	—	—	9	4	2	2	9	—
Delaware	30	21	3	1	1	2	—	14	7	6	1	2	—
Washington, D.C. [3]													
Florida	26	9	1	1	1	1	—	5	14	11	3	3	—
Georgia [4]	44	44	5	5	5	5	—	24	—	—	—	—	—
Hawaii	16	8	3	2	1	1	—	1	7	5	2	1	—
Idaho	16	8	1	1	2	1	—	3	1	1	—	7	—
Illinois [5]													
Indiana	25	14	3	1	1	1	—	8	7	—	7	[6] 4 + 1	1
Iowa	22	13	3	2	1	1	—	6	4	1	3	5	—
Kansas	16	13	4	2	—	1	—	6	3	1	2	—	—
Kentucky	15	9	1	1	1	1	—	5	5	1	4	1	—
Louisiana	23	11	5	1	1	1	—	3	10	4	6	2	—
Maine	15	7	2	1	1	—	—	3	8	2	6	—	—
Maryland	30	15	2	2	1	1	—	9	13	10	3	2	—
Massachusetts	34	16	2	1	1	—	—	12	16	12	4	2	—
Michigan	24	9	2	1	1	1	1	3	11	[7] 11	—	4	—
Minnesota	10	3	1	—	1	—	—	1	3	2	1	4	—
Mississippi	20	6	1	1	1	1	—	2	10	[7] 10	—	4	—
Missouri	20	12	4	1	1	1	—	5	2	1	1	6	—
Montana	9	6	1	1	1	1	—	2	1	1	—	2	—
Nebraska [5]													
Nevada [4]	50	43	11	7	11	7	—	7	7	[7] 7	—	—	—
New Hampshire	32	24	3	1	2	1	—	17	4	4	—	4	—
New Jersey	12	6	2	1	1	1	—	1	6	3	3	[6] 3	3
New Mexico	12	2	1	—	—	—	—	1	8	2	6	2	—
New York	20	14	6	5	—	1	1	1	6	1	5	—	—
North Carolina [3]													
North Dakota	13	5	1	[8] 1	1	—	—	2	5	[7] 5	—	3	—
Ohio	21	11	3	2	1	1	—	4	6	1	5	4	—
Oklahoma	23	18	[6] 7 + 3	[6] 3 + 1	[6] 3 + 1	1	—	4	2	—	2	3	5
Oregon	13	8	3	1	1	1	—	2	4	1	3	1	—
Pennsylvania	20	15	4	2	3	1	—	5	3	3	—	2	—
Rhode Island	20	13	6	1	1	1	1	3	2	—	2	5	—

See footnotes at end of table.

Table 1—Continued
Composition of Medical Care Advisory Committees (MCAC): 1979

State	All members [1]	Providers							Consumers			Government representatives	
		Total	Physicians	Hosp. reps.	Nursing home reps.	Pharmacists	Lab reps.	Other	Total	Recipients	Non-recipients	Total	Ex-officio
South Carolina	28	10	3	1	1	1	—	4	7	4	3	11	—
South Dakota	6	4	1	1	—	1	—	1	1	1	—	1	—
Tennessee [3]													
Texas	32	27	8	3	2	1	—	13	4	—	4	1	—
Utah	21	10	1	1	1	1	1	5	10	1	9	1	—
Vermont	9	7	1	1	1	1	—	3	1	—	1	1	—
Virginia	18	10	4	2	1	2	—	1	8	4	4	[6] 3	3
Washington	20	12	3	2	1	1	—	5	8	5	3	—	—
West Virginia	8	6	1	1	1	1	—	2	2	—	2	[6] 1	1
Wisconsin [3]													
Wyoming	16	8	4	1	1	1	—	1	5	1	4	3	—

[1] Does not include ex-officio members.
[2] No program in 1979.
[3] State not reporting in survey.
[4] MCAC is a congregation of discrete subcommittees.
[5] No active MCAC in 1979.
[6] Ex-officio (non-voting) members.
[7] Both Title XIX recipients and general public.
[8] Hospital and nursing home representatives.

Resources

The resources devoted to an MCAC can have a large impact on its effectiveness as an advisory body. Recognizing the importance of resources made available to MCAC's, the regulations state that "the agency must provide the committee with staff assistance from the agency and independent technical assistance as needed to enable it to make effective recommendations." [7] Furthermore, the regulations stipulate that Federal financial participation of 50 percent is available to offset the operating expenses of the MCAC.[8]

In spite of the regulations, however, only limited resources are devoted to the operation of the MCAC's by most State Medicaid agencies as shown in Table 2. Agency staff were assigned to serve 55 percent (24) of the reporting MCAC's, but only 21 percent had the equivalent of at least one full-time employee.

That only one-quarter of the MCAC's had a budget to finance their operation is shown in Table 2. Of those 11 MCAC's with budgets, only 4 had funds independent of other agency budget items from which they could finance studies and obtain other technical assistance at their own discretion.

Inevitably some members of the MCAC are more familiar with the issues than others because of their relationship to the program or the availability to them of outside organizational resources. Providers are more likely than consumers to have relevant information available to them, but even providers are dependent on staff for updates of program changes and for data on utilization and expenditures. Thus, the limited commitment of resources not only constrains the functioning of MCAC's, but also increases the influence of providers relative to consumers.

Subcommittees

Subcommittees can serve two interrelated functions: to provide a structure through which an MCAC member can focus on certain issues and develop an expertise in those areas, and to provide detailed analyses of issues that enable the full MCAC to make informed recommendations.

Slightly over half of the MCAC's reporting (26) had developed a subcommittee structure (Table 2).[9] For those MCAC's, the usual administrative procedure was to refer issues to the relevant subcommittee for study and the formulation of recommendations. The work of the subcommittee was generally conducted in the period between meetings of the full MCAC. The success of the subcommittee in addressing issues was apparently largely determined by the perseverence of its chairperson. This person acted as coordinator for the group in terms of scheduling meetings, facilitating communication with interested external groups, and gaining access to relevant information. The chair worked closely with MCAC and agency staff in securing resources and agency input. The meetings of the subcommittees were commonly working sessions and required prior preparation on the part of members. The subcommittee's product was generally a report, including one or more recommendations, which was presented to the full MCAC for discussion and action.

The subcommittee appears to be a structural component of MCAC's closely related to the vitality of the MCAC as measured by the number of meetings of the full membership. MCAC's with subcommittees met twice as often as those without (an average of six versus three meetings in 1979).

To go beyond the kind of data presented to this point, the minutes of MCAC meetings provided by 32 States were examined in order to learn the attendance, format, and content of meetings as well as to gain some insights into how the MCAC's actually function. (See Table 2 for the States that reported keeping minutes.)

Meetings

Meetings were not only where the business of the MCAC was transacted but also were important occasions in which public and private interests in the Medicaid program came together. The administrator of the State Medicaid program was nearly always in attendance, and the political head of the department in which the program was located often attended as well. Their presence enabled the MCAC to convey concerns directly to the program's policymakers and to direct inquiries and clarifications to the individuals responsible for program policy. While the MCAC staff person can act as the link between the MCAC and the agency, inevitable problems of communication and liaison can be minimized when senior agency staff are in attendance. The materials received from the States reveal a high level of such staff participation in the MCAC meetings.

Public attendance at the meetings varied from State to State and was largely dependent on the encouragement of the MCAC and agency as well as MCAC bylaws.

A chairperson was generally elected by the membership of the MCAC. This person presided over the meeting and, with the MCAC staff, was responsible for formulating an agenda and scheduling the meeting.

The analysis of the minutes showed that, in addition to substantive issues, almost three-fourths of the MCAC's considered organizational issues, as well. The primary types of organizational issues discussed in 1979 are reported in Table 3.

Almost half of the MCAC's (48 percent) dealt with the issue of representation at one or more meetings in 1979. Some were concerned with expanding provider representation; some, with representation of the public, including recipients. The need for increasing public input at meetings was a concern of 30 percent of the MCAC's. The problem of poor membership attendance at MCAC meetings was an issue for 30 percent.

[7]Code of Federal Regulations, Title 42, Part 431, Subpart A, Section 431.12(f), 1978.

[8]Code of Federal Regulations, Title 42, Part 431, Subpart A, Section 431.12(g), 1978.

[9]The description of subcommittee operations which follows is based on the minutes of those MCAC's that reported a subcommittee structure.

Table 2

Selected characteristics of Medical Care Advisory Committees (MCAC): 1979

State	Times met	Kept minutes	Sub-committees	Committee staff	Budget	MCAC useful
Alabama	4	Yes	No	No	NA	Yes
Alaska	2	No	No	No	No	Yes
Arizona [1]						
Arkansas	0	NA	No	No	No	Yes
California	10	Yes	Yes	Yes	Yes	Yes
Colorado	11	No	Yes	Yes	No	Yes
Connecticut	2	No	Yes	Yes	No	No
Delaware	3	Yes	Yes	Yes	No	Yes
Washington, D.C. [2]						
Florida	3	Yes	Yes	Yes	Yes	Yes
Georgia	20	Yes	Yes	No	No	Yes
Hawaii	3	Yes	Yes	No	Yes	Yes
Idaho	3	Yes	Yes	Yes	Yes	No
Illinois [3]						
Indiana	4	Yes	No	Yes	No	Yes
Iowa	5	Yes	No	Yes	No	Yes
Kansas	4	Yes	No	No	No	Yes
Kentucky	4	Yes	Yes	Yes	No	Yes
Louisiana	3	Yes	Yes	Yes	No	Yes
Maine	9	Yes	No	No	No	Yes
Maryland	7	Yes	Yes	Yes	Yes	Yes
Massachusetts	12	No	Yes	Yes	No	Yes
Michigan	6	Yes	Yes	Yes	Yes	Yes
Minnesota	10	Yes	Yes	Yes	No	Yes
Mississippi	4	Yes	No	Yes	No	Yes
Missouri	2	Yes	Yes	No	No	Yes
Montana	1	Yes	No	No	No	No
Nebraska [3]						
Nevada	12	Yes	Yes	Yes	Yes	Yes
New Hampshire	4	Yes	Yes	NA	No	Yes
New Jersey	4	Yes	No	Yes	No	Yes
New Mexico	6	Yes	No	No	No	Yes
New York	3	Yes	Yes	No	No	No
North Carolina [2]						
North Dakota	0	No	No	Yes	No	Yes
Ohio	2	Yes	Yes	Yes	No	Yes
Oklahoma	3	No	Yes	Yes	Yes	Yes
Oregon	7	Yes	No	No	No	Yes
Pennsylvania	3	Yes	Yes	Yes	No	Yes
Rhode Island	0	NA	Yes	No	No	No
South Carolina	4	Yes	Yes	Yes	Yes	Yes
South Dakota	1	No	No	No	No	No
Tennessee [2]						
Texas	5	Yes	Yes	Yes	Yes	Yes
Utah	10	No	Yes	Yes	No	Yes
Vermont	1	No	No	No	No	No
Virginia	3	Yes	Yes	No	No	Yes
Washington	4	Yes	No	No	Yes	Yes
West Virginia	2	Yes	No	No	No	Yes
Wisconsin [2]						
Wyoming	1	No	No	No	No	No

[1] No program in 1979.
[2] State not reporting in survey.
[3] No active MCAC in 1979.

NOTE: NA = No answer.

Table 3

Organizational issues considered by Medical Care Advisory Committees (MCAC)

Type of organizational issue	Percent of MCAC
Meetings: scheduling and content [1]	13
Attendance problems	30
Role and function of MCAC	70
Representation	48
General composition issues [2]	17
Provider representation	9
Public and recipient representation	9
Other	13
Need for public input	30
Need for information from agency	26
Other	39
No organizational issues	28

[1]Minutes of 1979 meetings were provided by 32 States. Issues were derived from analysis of these minutes.
[2]An MCAC may have dealt with more than one issue; for each issue, a committee is counted only once, regardless of the number of times the issue came up at meetings during 1979.

One-quarter of the MCAC's reporting expressed discontent with the amount, nature, and timeliness of the information provided by the agency.

The scheduling and content of MCAC meetings were an issue for 13 percent of the MCAC's, which expressed a desire to schedule meetings more frequently. Displeasure with the content of the meetings generally centered around the perception that the MCAC meetings were solely didactic presentations and not a forum to formulate and review Medicaid policy.

The issue considered by the greatest number of MCAC's (70 percent) was that of its own role and function. This concern reflects the general lack of clear definition and can be discussed more meaningfully after an examination of the way the MCAC's operate.

Operation

The regulations state that the MCAC "must have opportunity for participation in policy development and program administration . . . " [10] The minutes indicated that MCAC's participated to varying degrees in the identification of problems and the formulation of their solutions. In the MCAC's studied, three means of identifying problems could be abstracted.

The most frequent way was through the agency, which identified the problem internally and then presented it to the MCAC for advice. For 56 percent of the MCAC's, problems were predominately identified and referred to the MCAC by the agency. A second means, found in only 16 percent of the MCAC's, was through internal processes of the MCAC. In this case, the problem facing the program was either directly defined and identified by the MCAC or it was defined, identified, and referred to the MCAC by an external agent or organization (a provider, a consumer, or an interested organization). A combination of the above means was observed in the remaining 28 percent of MCAC's.

In general, the problems identified by the agency tended to be internal administrative or operational issues, while the problems identified by the MCAC were more likely to be distributional issues. Examples of agency-identified problems were fiscal difficulties caused by funding cuts and administrative problems growing out of new regulations. MCAC-identified problems generally emanated from outside organizations, the constituencies represented by committee members. Thus, coverage of additional services or procedures (for example, chiropractic, dental, etc.) were raised through provider organizations, and issues such as the maintenance of benefits in the face of funding cuts, came through consumer groups.

Once a problem was identified, the MCAC participated to varying degrees in formulating the solution. In 19 percent of the MCAC's the level of participation in problem solution was low. The agency would formulate a proposal, which was presented to the MCAC members for their information. Typically, some discussion of the problem and solution ensued in the MCAC, but the MCAC's primary effort was to obtain additional information and clarification.

A moderate level of participation in the formulation of the solution of identified problems was observed in approximately one-third of the MCAC's. The MCAC's involvement centered on the solution presented to it by the agency expressly for review; here, too, discussion focussed on gaining clarification about specific points in the agency's proposal. Following the discussion, a motion was made to accept or reject the proposed solution. Very little outside preparation by individuals or subcommittees was evident from the minutes.

In 28 percent of the MCAC's, although the solution to the problem was generated by the State agency, the MCAC review was quite critical and specific and revealed evidence of prior preparation by members. Recommendations were made by the MCAC on methods to improve the solution, and important feedback was offered regarding the ways in which the solution would affect various groups; subcommittees were an important adjunct to the review and comment process. Following the discussion and review, a member would move that the solution be accepted as presented, accepted with MCAC revisions, or rejected.

A very high level of participation in the formulation of problem solutions by the MCAC was evidenced by several MCAC actions: the MCAC formulated its own solution to the problem identified; this solution was developed principally in MCAC subcommittees; and preparation of the solution was the product of in-depth study and consultation with affected outside groups. Evidence of outside preparation on the part of MCAC members, including extensive subcommittee reports, was apparent; and solutions were presented to the agencies in the form of recommendations for action. This pattern was found in 19 percent of the

[10]Code of Federal Regulations, Title 42, Part 431, Subpart A, Section 431.12(e), 1978.

MCAC's. The extent to which MCAC recommendations were actually incorporated into Medicaid policy is not known.

Earlier it was noted that 70 percent of the MCAC's which dealt with internal MCAC organizational issues defined the lack of clarity in the MCAC's role and function as a problem. The MCAC role is largely defined by the State Medicaid agency, which can allot it an active or passive role in the operation of the program. Discord is created when MCAC members are frustrated by the role they are allowed to play by the State agency.

The nonspecific nature of the Federal regulations requiring the establishment of the MCAC has added to the problem. Interpretation of the regulation that the MCAC must have "opportunity for participation in policy development and program administration" [11] is an issue. In several cases where an impasse was reached between the MCAC and the agency regarding the committee's role in policy development, the MCAC resorted to litigation with inconsistent results. In Hawaii, a Federal court ordered that all changes in Medicaid policy and administration be made in accordance with the regulations mandating MCAC involvement (*Ho et al.* v. *Chang et al.*, 1977). In an Ohio case, on the other hand, another Federal court concluded that it was not necessary for State officials to obtain the consent of the MCAC for the reduction of optional benefits (*Benton et al.* v. *Rhodes et al.*, 1978).

MCAC-agency interaction

Examination of MCAC-agency interaction on a specific issue confronting the program provided further insight into MCAC operations. Escalating costs have been a continuing problem and approximately three-quarters of the MCAC's that provided minutes of their meetings dealt with cost-containment measures at some time during 1979 (Table 4).

Program costs were identified as a problem predominately by the agency and the Health Care Financing Administration (HCFA). The problem was presented to the MCAC both with and without cost-containment measures proposed by the agency. Generally, the cost-containment recommendation presented by the agency in 1979 included one or more of the following measures: copayment, prior authorization, utilization control, elimination of optional services, maximum reimbursement for services and limitation of benefits, eligibility control, fraud and abuse control, third-party collections, and freezing provider fees. Basically the agency's proposals can be summarized as attempts to introduce controls on the existing Medicaid program.

In discussions following the presentation of agency cost-containment measures, the MCAC generally opposed those measures that would reduce benefits or restrict services. The MCAC tended to prefer the following: deinstitutionalization, changing the locus of care (for example, from emergency room to physician's office), emphasis on preventive health care, and recipient-provider education on effective utilization.

Other strategies—prospective reimbursement, substitution of generic for brand name prescription drugs, and designation of a drug formulary—were advocated and proposed by both State Medicaid agencies and MCAC's.

Not surprisingly, the evidence shows that the MCAC members advocated the private interests they represented and strongly opposed measures they thought would have had an adverse impact on their constituencies. Yet, paradoxically, while many agency proposals tended to be incremental tinkering, some MCAC positions included changes which, to a substantial degree, would have altered the traditional structures and patterns of health care. This juxtaposition suggests there may be opportunities in the MCAC forum for serious discussion of some of the more fundamental changes that have received increased attention since 1979.

Table 4

Cost-containment measures considered by Medical Care Advisory Committees (MCAC) [1]

Type of cost-containment measures [2]	Percent of MCAC
Copay	39
Prior authorization	4
Utilization control	9
Elimination of optional services	9
Maximum reimbursement; limitation of benefits	13
Eligibility control	9
Fraud and abuse control	17
Third-party collections	9
Freezing provider fees	9
Deinstitutionalization	26
Changing locus of care	22
Preventive health care	9
Recipient-provider education	9
Prospective reimbursement	22
Drug substitution	9
Drug formulary	9
No cost-containment measures	28

[1] Minutes of 1979 meetings were provided by 32 states. Cost-containment measures were derived from analysis of these minutes.
[2] An MCAC may have dealt with more than one measure. For each measure, a committee is counted only once, regardless of the number of times the measure came up at meetings during 1979.

[11] See footnote 10.

Conclusion

Medicaid programs throughout the country are facing large financial problems; and the increased flexibility permitted by Federal law may improve the ability of State agencies to manage, if not solve, them. But a number of States have been thwarted by the opposition of one or more groups from introducing some of the innovations they hope will control runaway expenditures. In that context, the potential value of MCAC's is increased. They can help State policymakers to identify and deal with the problems that inevitably will arise in such a complex program; and when a final proposal emerges, MCAC's can help to promote it among their constituencies. Yet, the data presented here reveal that certain structural characteristics (including few meetings, few subcommittees, small budgets, and limited staffs) militate against an MCAC's having a significant role in the development or successful implementation of State Medicaid policy. If the MCAC's are to realize their potential as sources of workable ideas, as forums to refine and shape the ideas of others, or as support for the program in the halls of State government or within their own constituent groups, then it is clear that reforms are required. While there has been considerable change in committee composition, many MCAC's are still hampered by inadequate resources, the absence of a subcommittee structure, infrequent meetings, and agency leadership that, apparently, has failed to recognize and nurture the MCAC's potential in the policy formulation and implementation processes. Now, more than ever before, the times call for active MCAC's, committed to the integrity of the program and, at the same time, seeking reliable means to contain rising expenditures. If MCAC's are to play a constructive role, however, it is apparent from the descriptive data presented here that they will need to be reformed.

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