Implications of Federalism: Lessons from Medicaid

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First, Medicaid specific

• ACA expansion in half the states (with more to come?). Many folks with new access will be in this population.
• Regardless of expansion, a growing focus (in Medicaid and elsewhere) on more holistic models of care.
  • Behavioral health
  • Care coordination and management
  • Greater recognition of the impact of social determinants.
• Notable efforts to improve data and analytical capacity (e.g., Mapping community needs and tracking health care quality and gaps).
Relevance to this Committee

These shifts are reflective of what this committee is addressing. Young adults don’t fit neatly into defined needs and services.

Bad News:

• At the Federal and state level, health care, mental health, education, work, housing and social supports often misaligned or fragmented.

Good news:

• Medicaid reform is afoot, both in expansion states and non-expansion states. And more and more of these services are under Medicaid.
Federalism lessons from Medicaid

Reforms across a wide-range of services types and programs is difficult, but what can we learn from Medicaid’s experience?

• States are often the best positioned for this kind of alignment of services, funds and policy.

• But much of the $ is Federal so they can and must set the goals and frame, but with flexibility on the “how”.

• Why flexibility—because across and within states there is variability. Problems, resources and approaches will shift, and Federal policies and goals will need to flex.

• The Federal approach includes both very tailored and very large programs, and balancing these can be difficult.
Examples of each concept

- States as integrators: local communities cannot change licensure laws for health care professionals and the Federal government cannot sit down with multiple stakeholder groups.

- Federal dollars in the mix means shared decision making and accountability. Medicaid is essentially 60/40. So states decide, and receive Federal approval for the general approach.

- Variability: No two Medicaid programs look alike, not capriciously but by design. Managed care is one such factor. Court rulings another.

- Tailored vs. large programs. Public health is very disease specific, while Medicaid is a huge and expensive program that must meet the needs of many. Creates turf issues and barriers to coordination. Each envies the others’ qualities.
Resolution of challenges

• Identify specific Federal barriers that prevent good, coordinated care and encourage their change. (e.g., the sharing of behavioral health information)

• Describe potential “best practices” in the application of Federal policy into state policies and programs. But allow for multiplicity of possible approaches.

• Provide ideas on how to balance the big vs. targeted program issues and to address the siloes. Perhaps recommend “wrap-around” concepts. (e.g., braided funding for housing or school-based services).

• Beyond dollars and policy, encourage Federal support for learning and networking, as well as data and analytical tools to help guide practice.

• Most importantly, recognize the limitations of the current structures and keep a real world vision in mind with interim solutions.