

PRESIDENT'S COLUMN

MEDICARE: PART "S"?

Karen DeSalvo, MD, President, SGIM

Maybe the medical system, including Medicare, should not be the primary source of funding for addressing the SDOH. Perhaps we should not use Medicare dollars to pay for bike lanes or develop "Medicare: Part S." Rather, the nation should invest in public health, social care, and other key sectors that impact health more than the healthcare sector.



I was recently searching the SGIM *Forum* site to find one of my President's columns from this year and one that I had penned in 2005 popped up. Rereading them after all this time brought back a swirl of memories. I wrote it in the intense weeks just after Hurricane Katrina made landfall. We were scrambling to rebuild our city and healthcare system after it had been

knocked to its knees.

Early on, I wanted to bring opportunity from tragedy, not rebuild the same system that led to generations of poor health and inequity. Rather, I hoped we would build a person-centered system that could meet the physical, emotional, and social needs that I knew were driving inequities and suffering. Some of the work was grass roots and institutional, including standing up our academic infrastructure and building prototypes of community health sites that could show what addressing whole health in teams would look like.

Our plans were grander than building prototypes. We also were focused on driving systemic policy that would move the frontline care sites from prototypes and projects to sustained, vibrant care options. As we laid out our vision and action plan, we knew that we would need to make a big shift in how money was allocated. Given the heavy reliance on federal funds to support the healthcare infrastructure, HHS was a key actor in long term financing of our new vision. Amongst our many asks, one was support for non-medical social drivers and built environment upgrades to make a more walkable community. They said they "pay for beds, not bike lanes." In essence, they were clear that there wasn't a "Medicare: Part S"—S for social determinants of health (SDOH).

How times have changed! Fifteen years later, HHS is now actively putting forward models in SDOH. Amongst

the many things that have come full circle is that the architect of the CMMI Accountable Health Communities, SGIM member Alex Billioux, is now assistant secretary for health in Louisiana and instrumental in translating that SDOH model to Medicaid policy.¹

Starting with innovation from State Medicaid programs, the nationwide trend is finding ways for Medicare and Medicaid to be flexible enough to support, and sometimes encourage, the healthcare system to identify and address SDOH in the patient population. For the Medicare Advantage programs, this includes allowing supplemental benefits to be used to support social care services. So, our dreams from 2005 are coming to fruition.²

This narrative of increased SDOH activity is playing out across the country. Innovative models of care, education, and health system community partnerships aimed at addressing the social determinants of health are providing valuable insights into what works and what doesn't. The recent National Academy of Medicine Report—"Integrating Social Care in to the Delivery of Medicine"—provides many examples and a framework for action. For members who will be at the May 2020 Annual Meeting in Birmingham, they will have a chance to hear from authors of this report in a special symposium and in the Saturday Plenary.

This work by the healthcare system amounts to finding pathways to leverage the medical systems financial and other resources to assist patients with addressing SDOH. But the reality is that the challenges faced by our patients are bigger than what the health system can do alone. It is even "bigger" than major national health systems, like Kaiser, and health plans, like United. Although they are doing good with downstream actions for individual patients through referrals to a food bank, rideshare support, and air-conditioning units, the

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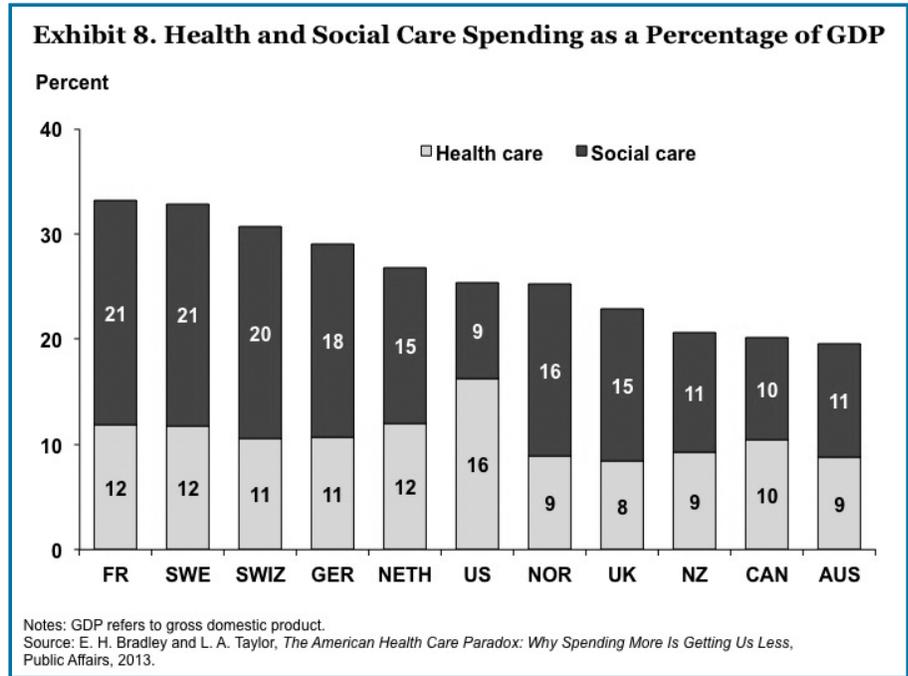
social care, public health, and other systems to which these health care organizations are referring their patients are under-resourced and becoming ever more strained by new referrals and expectations. Further, these new care models aren’t often informed by the decades of deep experience and knowledge that the social care providers could bring to bear.

Funding partnerships and actions between and by the medical and social care systems is increasingly an important topic. Paying for addressing SDOH from healthcare dollars has the downside of missing the opportunity to address social drivers upstream before they impact health. It also runs the risk of medicalizing social needs and linking key things like housing to enrollment in an insurance plan or linkage to a specific healthcare provider.

In the past year, there has been an exciting sea change in the policy environment. Luminary health economists from across the political spectrum are calling for an approach to financing SDOH. Rather than relying upon transfers from the health care payment sources, they are looking to identify alternatives.

The options essentially include: 1) creating a modified version of social impact bonds that allow the private sector to recoup their investments down the road; 2) pooling public dollars from various health and social care programs; and 3) making investments upstream to more appropriately resource the social care system to better balance the funding along the lines of our peer nations (see figure). I am delighted to see that these brilliant minds are beginning to build a roadmap for funding SDOH that doesn’t require us to depend upon the health care system or on the creation of Medicare: Part S.

One approach is described by Len Nichols and Lauren Taylor as a way to create a private sector solu-



tion for a failure of the public sector. They have outlined an innovative model driven by the private sector allowing for even the most pragmatic to see the self-interest in funding social services. This model would involve pooling private sector dollars with long-term sharing of gains from the rewards of better community health and lower social services expenditures.³ Dr. Nichols is working with communities across the country to roll out demonstrations of this approach.

Another great economist who is traditionally considered conservative is Stuart Butler. In January, he published a brief and really interesting paper in *JAMA* that called out the need for public sector funding of services and systems that address SDOH. Butler writes the following:

“But examples from the federal, state, and local levels show what can be done and often is being done to braid or blend financial resources to achieve cross-sector goals. If we make greater use of such tools to make it easier to

combine funds in this manner, we will help to realize the full potential of this broader approach to achieving good health.”⁴

Allowing communities to pool funding from disparate sources helps spread, scale, and sustain successful multi-sectoral approaches to address SDOH at the community level. Unfortunately, the lack of clarity on how communities can pool disparate sources of funds can be a barrier to community-level interventions to address SDOH. Agencies in the federal government should use existing authorities to help communities build and leverage pooled funding approaches and test these approaches.

In truth, that HHS official was perhaps right in what she said to me that day in Baton Rouge after Hurricane Katrina. Maybe the medical system, including Medicare, should not be the primary source of funding for addressing the SDOH. Perhaps we should not use Medicare dollars to pay for bike lanes or develop “Medicare: Part S.” Rather,

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the nation should invest in public health, social care, and other key sectors that impact health more than the healthcare sector. In this way, we are more likely to have a partnership models where the strengths of all the sectors can come together to develop a seamless experience in an appropriately resourced *system* that really is capable of addressing the physical, emotional, and social needs of our patients and communities.

References

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