

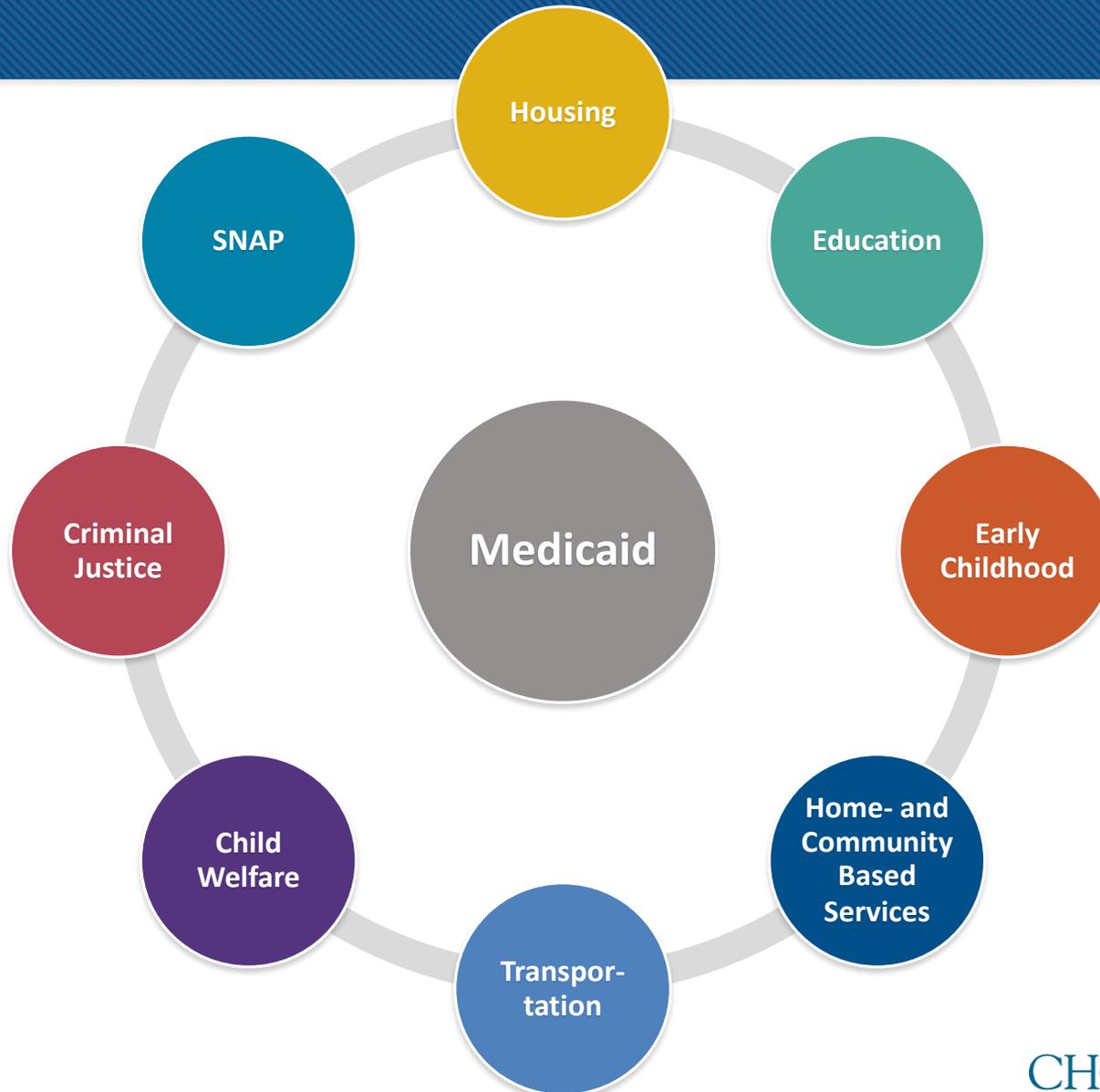
# Medicaid and the Culture of Health: Addressing Social Determinants of Health

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# Medicaid/Social Services Linkages



# Fast *Backward* to October 2016

- Wide recognition among Medicaid stakeholders that social determinants of health (SDOH) matter
  - » Fueled significantly by Medicaid expansion population and its more predominant social needs (e.g., supportive housing, criminal justice transitions, etc.)
  - » Also driven by broader Delivery System/Payment Reforms for expansion group and broader Medicaid populations (e.g., Medicaid ACOs, health homes, DSRIP, etc.)
  - » Led to concerted and innovative state Medicaid efforts to integrate health and social services: community-based prevention; supportive housing; criminal justice; etc.

# Fast *Forward* to January 2017

- Wobbly status of coverage for expansion population
- Wide recognition among Medicaid stakeholders that SDOH still matter – *it's in the water*
- More circumspect/circumscribed Medicaid interest in social services
- But no abandonment of commitment to integrate health and social services especially for high-need, high-cost populations

# Addressing SDOH: Examples

- **6|18** – Evidence-based prevention (e.g., asthma and housing/ environmental triggers)
- **Early Childhood Innovations** – (e.g., trauma informed care, home visiting)
- **Physical Health/Behavioral Health Integration** – (e.g., Health Homes in 20 states)
- **Criminal Justice** – (e.g., discharge planning, supportive housing)
- **Dual Eligibles** – (e.g., transportation, nutrition)

# Circumspection: Broad population health vs. targeting to high-need, high-cost populations

- Likely to be heightened imperative for targeting in search of early and sure ROI
- This could drive interest in better:
  - » SDOH screening tools & data mining/predictive modeling capacity
  - » SDOH measures of effectiveness (both health and social)
  - » Models for *blending* health and social services programs *and \$\$*
  - » Rapid cycle demonstration/evaluation

# Possible good news: Greater state flexibility

- To experiment further
- Waive current Federal regulatory constraints

# Possible bad news: Greater state flexibility without stable/sufficient resources to design or pay for Culture of Health innovations

- Most likely to survive reduced federal \$ and reduced state bandwidth are:
  - » Evidence-based delivery system and payment reforms that improve outcomes and increase efficiency (add value)
  - » Incremental innovation targeted to high-need, high-cost populations with the greatest potential ROI (outcomes & \$)