September 21, 2021

The Honorable Cheri Bustos
The Honorable Tom Cole
The Honorable GK Butterfield
The Honorable Markwayne Mullin

**Re: Congressional Social Determinants of Health Caucus — Request for Information**

Dear Ms. Bustos, Mr. Cole, Mr. Butterfield, Mr. Mullin, and other members of the Social Determinants of Health Caucus:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to the request for information (RFI) regarding challenges and opportunities in addressing social determinants of health (SDOH). Accountable care organizations (ACOs) are groups of doctors, hospitals, and/or other health care providers that work together to improve the quality of patient care while lowering costs. NAACOS is the largest association of ACOs and Direct Contracting Entities (DCEs) representing more than 12 million beneficiary lives through hundreds of Medicare Shared Savings Program (MSSP), Next Generation ACO Model, Global and Professional Direct Contracting Model (GPDC), and commercial ACOs. NAACOS is a member-led and member-owned nonprofit that works on behalf of ACOs and DCEs across the nation to improve the quality of Medicare delivery, population health, patient outcomes, and healthcare cost efficiency. NAACOS is committed to advancing the value-based care movement, and our members, more than many other health care organizations, want to see an effective, coordinated, patient-centric healthcare system that focuses on keeping all individuals healthy. Strengthening the ACO model and other total cost of care models provides an important opportunity to reduce health inequities and transition our health system to a culture of value.

Improving health equity is critical to delivering high quality care in a cost-effective manner and focusing on the broader concept of an individual's overall health, as SDOH contribute significantly to health outcomes. These social factors cannot be addressed if they are not adequately identified, measured, tracked, and reported. Many ACOs have been doing important work to address social needs and inequities among their patient populations. Strengthening ACO and other total cost of care models provides an important opportunity to reduce health inequities often caused by negative SDOH and transition our health system to a culture of value.

ACOs face specific challenges in treating patients with negative SDOH, but they also have a unique opportunity to help these patients. ACOs are held accountable for the total cost and quality of care of their assigned patient populations, and as such, they are incentivized to address social factors affecting the health outcomes of their patients in order to improve quality scores and control costs. Additionally, the upfront investments that ACOs make in health information technology (HIT) and infrastructure to provide coordinated care make them uniquely poised to screen for and address SDOH. However, our

current healthcare system is not set up to support this type of work and many hurdles inhibit ACOs from effectively addressing SDOH.

**NAACOS responses to RFI questions on challenges and opportunities with addressing SDOH:**

I. Experience with SDOH Challenges
   a. What specific SDOH challenges have you seen to have the most impact on health? What areas have changed most during the COVID-19 pandemic?

Studies have shown that ACOs are increasingly working to address patients' nonmedical needs to improve their health, such as partnering with other organizations in the community to meet housing and transportation needs and addressing food insecurity.[1] These are the most common nonmedical needs addressed by ACOs. Housing instability is a difficult challenge because it has no standard definition, and it can include overcrowding, periods of homelessness, moving frequently, or spending the bulk of income on housing costs.[2] One study has found that housing instability is associated with not having a usual source of health care, postponing needed health care, and postponing needed medications, as well as increased number of emergency department (ED) visits and hospitalizations.[3] Food insecurity is commonly defined as the disruption of food intake or eating patterns because of a lack of money and resources.[4] Food insecurity is even more common than housing instability and has been found to be associated with postponing needed health care and medications and increased hospitalizations.[3] Additionally, when individuals lack access to adequate and reliable transportation, they may delay care, miss necessary health care appointments, and delay filling prescriptions.[5] The COVID-19 pandemic has not only highlighted but also exacerbated many of these issues, limiting access to care and increasing economic instability for many.

Another example is medication affordability, which is part of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) questions for quality. The CAHPS for ACOs survey was developed to collect information about patient experience of care received from ACOs. The survey questions are designed to measure access to and use of specialist care, experience with care coordination, patient involvement in decision-making, experiences with a health care team, health promotion and patient education, patient functional status, and general health. The CAHPS for ACOs Summary Survey Measures (SSMs) comprise 25 percent of an ACO's quality score. One ACO reported that many of their providers were scoring poorly on the question "Has someone on your care team asked you about the affordability of your medications?" In order to address this, the ACO worked to develop a workflow within their electronic health record (EHR) to prompt providers to ask this question and connect with an automatic referral to their pharmacy reimbursement team, who could connect the patient with appropriate programs. In the pilot phase of this program, they found that about 10 percent of their patients needed assistance with medication affordability. With the significant changes in employment that occurred during the pandemic, this number is likely much higher now.

b. Are there other federal policies that present challenges to addressing SDOH?

*The "Rural Glitch"*

The current methodology used by Medicare for setting MSSP benchmarks places rural ACOs and ACOs that hold a large market share at a disadvantage. This is because CMS includes an ACO's own beneficiaries in the regional benchmark adjustment, which is meant to aid ACOs that have lowered spending compared to other providers in their region. When ACOs that cover a large portion of their region's fee-for-service (FFS) beneficiaries lower spending, that regional adjustment is nullified, and ACOs are placed at a disadvantage. This problem is often referred to as the "rural glitch" because it disproportionately affects rural ACOs, but the issue actually harms all ACOs that have lower Medicare FFS spending compared to their region. If these ACOs were put on a level playing field with others, they would be more likely to earn shared savings, which could be used to fund additional SDOH initiatives or important care coordination programs.

*Medicare Payment Rules*

In order for ACOs to be able to test innovative approaches to improving health equity and addressing SDOH, additional flexibility with Medicare rules for providers to deliver supplemental benefits to patients is necessary. For example, this memo[6] shares information on flexibility for providing transportation to patients. NAACOS was very pleased to see this guidance from the Department of Health and Human Services (HHS) Office of Inspector General, providing flexibility from the federal healthcare program anti-kickback statute. We recommend HHS and CMS be directed to provide additional flexibilities to allow ACOs to deliver other benefits such as those related to housing or food insecurity.

There is precedent in Medicare for allowing such flexibilities, recently illustrated by new policies in Medicare Advantage (MA) that allow premium dollars to go towards addressing social needs. The Bipartisan Budget Act of 2018 expanded the types of benefits that may be offered by MA plans for chronically ill patients.[7] These supplemental benefits may include things like meals, food and produce, transportation for non-medical needs, pest control, indoor air quality equipment, social needs, complementary therapies, structural home modifications, services supporting self-direction, and/or general supports for living. Because ACOs are accountable for the total health outcomes of the populations they serve and total cost of care, they should be allowed similar flexibilities in how they allocate resources to meet the needs of a certain population. Congress could enact similar legislation that allows such expanded benefits to be offered by MSSP ACOs.

*Stark Law and Anti-Kickback Statute*

Stark Law and Anti-Kickback Statute (AKS), as they are currently written, create challenges for ACOs to be able to effectively address SDOH and coordinate care. NAACOS appreciates the work that was done in 2019 to expand Stark Law and AKS exceptions and safe harbors for providers engaged in value-based arrangements. NAACOS has sent comments to federal agencies in both 2018[8] and 2019[9] detailing how strict application of the Stark Law and AKS is a barrier to value-based models. NAACOS has urged for the expansion of waivers for non-risk bearing ACOs and for the clarification on the reach of these waivers.[10] Under existing waivers, there is significant uncertainty concerning whether, as well as the extent to which, an incentive program offered to a physician with respect to assigned MSSP patients may, without

creating potential Stark Law issues, also be offered to the same physician for non-MSSP patients. This makes it difficult for ACOs to establish SDOH initiatives, as there are concerns about which patients qualify for these programs, and it limits the potential for these programs to have a meaningful impact on SDOH, as enrollment and benefits change regularly. This also creates confusion for providers, limiting uptake.

*42 CFR Part 2*

NAACOS continues to call for the alignment of 42 CFR Part 2 (Part 2), which governs patient substance abuse treatment records, with the Health Insurance Portability and Accountability Act (HIPAA). This alignment will improve care coordination and quality improvement and allow ACOs and other providers to deliver the kind of patient-centered, well-coordinated care necessary to improve health outcomes and reduce inequities. While substance use disorder (SUD) affects all racial and ethnic groups, Black and Latinx Americans are less likely to complete treatment for SUD.[11] By equipping providers with the necessary information for coordinated, whole-person care, these disparities can begin to be addressed. Currently, ACOs lack access to the full suite of necessary information to allow them to achieve the goals of well-coordinated patient care, improved quality, and preventive care required to limit opioid overdose deaths and other adverse events associated with SUD. While ACOs are provided claims data through Claim and Claim Line Feed (CCLF) files, these data lack SUD-related information, thus limiting ACOs' ability to treat the whole person and potentially harming patient care and outcomes. We thank Congress for the work done through the Coronavirus Aid, Relief, and Economic Security (CARES) Act to allow the sharing of this important SUD data after initial patient consent. However, while Section 3221 of the CARES Act helped to align Part 2 with HIPAA, implementation has been challenging. For example, Section 3221 did not provide specifics on what is required to obtain the initial patient consent. Additionally, because care coordination is not considered by CMS to fall under treatment, payment, and health care operations, ACOs still lack access to vital SUD-related data on their patients. We ask Congress to work with HHS and CMS to revise regulations and implement changes such that SUD patients being treated by providers in an ACO are not adversely affected. As mentioned previously, many ACOs are implementing new initiatives to address health inequities and SDOH, but these programs cannot effectively reach the right patients if ACOs do not have the appropriate data to target outreach to vulnerable populations. NAACOS urges Congress to ensure that implementation lives up to the intent of the legislation, potentially by sending a letter from Congress to CMS with guidance on how to successfully implement the changes in the law.

c. Is there a unique role technology can play to alleviate specific challenges (e.g., referrals to community resources, telehealth consultations with community resource partners, etc.)? What are the barriers to using technology in this way?

Technology has an important role to play in screening for, tracking, and addressing SDOH. Data-driven approaches that use EHR data allow ACOs and other health care providers to implement targeted outreach that prioritizes the most at-risk patients.[12] Some specific ways ACOs are using data to address SDOH include mapping to identify communities with poor internet access to address the digital divide and developing tools to identify and reach out to high-risk patients with trained staff to check for food insecurity and verify that patients have access to needed medications. One of the largest ways technologies can help to address SDOH is by improving communication and referrals between health

care organizations and community-based organizations (CBOs).[13] Many providers screen for SDOH, but without the tools and resources to meet social needs, providers may be hesitant to screen for these needs. When communication channels are in place for health care providers to make referrals for social services, screenings can be effective tools.

Some barriers to using these technologies involve ineffective closed-loop referral systems. Some ACOs have noted that the community partners involved are often not trained on how to "close the loop" and send information back to providers for tracking and follow up. As a result, these ACOs are not seeing the outcomes they would expect from integrating these referral programs. Many of these community organizations are small and often under-funded, and therefore lack the time and resources to effectively and consistently send this needed feedback to health care organizations. One option to close the loop internally would be via follow up questions for patients to confirm whether they received services or were otherwise able to connect with community partners. Another challenge lies within the variety among tools available for electronic referrals to community resources. When a number of ACOs are trying to employ numerous different tools to already over-burdened community organizations, burnout may result. A consistent database with a feedback loop that is interoperable with multiple referral programs would help to facilitate this data exchange without adding burdens onto community partners. Overall, there is a need for more interoperable electronic tools to be developed. One option for encouraging this development would be through legislative grants that support this work.

II. Improving Alignment

a. Where do you see opportunities for better coordination and alignment between community organizations, public health entities, and health organizations? What role can Congress play in facilitating such coordination so that effective social determinant interventions can be developed?

While ACOs have historically fostered coordination and partnership with local health care providers and payers to improve health outcomes, many ACOs have begun partnering with other organizations such as public health agencies and CBOs in order to achieve their population health goals. There are several policy options to support and enhance these partnerships. One option is to provide funding to support coordination with public health agencies and community organizations that provide social services as well as to enhance ACOs' internal capacity to target underserved populations and meet social needs. Another possibility involves the establishment of a Center for Medicare & Medicaid Innovation (CMMI) model within MSSP in which ACOs could apply for upfront funding to develop SDOH interventions. These funds could later be recouped through shared savings, and if they do not generate savings, the funds could be forgiven so long as the ACO remains in the program. This would be akin to the ACO Investment Model (AIM), which has been one of the Innovation Center's most successful models to date, being one of only six CMMI models to show significant savings.[14]

Supplemental benefits are another way to support ACOs in addressing SDOH. While Medicare allows for billing of Chronic Care Management (CCM) services, these do not include services that target the underlying social needs and SDOH that can contribute to chronic illness. This could be accomplished through new chronic social determinants management services, modeled after CCM to allow ACOs to bill Medicare for services that address social determinants, improve health equity, and meet social

needs. NAACOS also urges Congress to support and pass the Seniors' Chronic Care Management Improvement Act of 2021 (H.R. 4755), which would waive cost-sharing requirements for CCM services.[15] Cost-sharing obligations related to CCM services have led to low utilization. Eliminating the 20 percent coinsurance requirement to receive CCM services would expand access to CCM to low-income beneficiaries who could otherwise not afford to receive CCM services. This is especially important since we know that patients with negative SDOH are more likely to be affected by chronic conditions, regardless of biological factors.[16]

One immediate opportunity for congressional action is to support the Value in Health Care Act (H.R. 4587), which includes provisions to accelerate Medicare's move to value-based payment and incentivize participation in ACOs and other Advanced Alternative Payment Models (APMs). Research has shown that ACOs are more likely than non-ACO health systems to invest in and address SDOH among the patient populations they serve.[17] The Value Act strengthens the MSSP by updating the program to recognize and reward ACOs for the work they are doing to improve quality while reducing costs. Additionally, the Value Act has been estimated to be a cost saver for the Medicare program, saving $280 million over ten years if enacted.[18] We urge Congress to support and pass this legislation to aid ACOs in their ongoing work to address SDOH.

b. What opportunities exist to better collect, understand, leverage, and report SDOH data to link individuals to services to address their health and social needs and to empower communities to improve outcomes?

While many ACOs utilize SDOH screening tools to identify social needs for the patients they serve, there is no one standardized screening tool, and many clinicians are hesitant to screen for social needs if they have no way to connect the patient with services to fill those needs. One way to improve this would be to provide incentives for ACOs to use a SDOH screening tool of their choosing. This would incentivize ACOs to use the screening tool that is most appropriate for their organization and to conduct the screening in the manner that is most appropriate and feasible for the ACO and its existing provider workflows. As ACOs continue to use these tools, best practices can be identified, and these efforts can be expanded to further encourage use of SDOH screening tools with the eventual goal of identifying standardized screening and reporting practices.

Another key challenge is that providers lack the time to review SDOH data and address unmet needs with their patients. A 2018 survey by the American Academy of Family Physicians (AAFP) found that 80 percent of providers did not have the time to discuss SDOH with patients.[19] Adequate reimbursement for the time it takes to collect and assess SDOH data and to discuss individual needs with patients would allow providers the time and resources to effectively address SDOH.

Additionally, there are financial barriers and resource constraints that inhibit this work. ACOs should be funded and incentivized to develop and expand connections with CBOs and to enhance ACOs' internal capacity to target underserved populations and meet social needs. A study examining health systems that were investing in social determinants found that only 9.1 percent of health systems invest in social determinant and/or community health programs, and of those investing health systems, 86 percent participate in an ACO, compared to only 52 percent of non-investing health systems.[17] This shows that

ACOs are more likely than non-ACOs to invest in social determinants work and this work should be supported and expanded by providing additional compensation for this work to be done.

c. What are the key challenges related to the exchange of SDOH data between health care and public health organizations and social service organizations? How do these challenges vary across social needs (i.e., housing, food, etc.)? What tools, resources, or policies might assist in addressing such challenges?

It has been reported that many ACOs lack data on both their patients' social needs and the capabilities of their potential community partners.[20] There is an overwhelming lack of standardization in data collection and sharing, which has significantly affected organizations' abilities to address SDOH. A 2019 HHS report provides key recommendations for improving the exchange of SDOH data, including defining and standardizing SDOH data, creating a sustainable infrastructure for SDOH data by improving financial alignment, strengthening the capacity of community organizations, and supporting local and state-based decision-makers.[21]

The structure of HIPAA laws also creates challenges for collecting, tracking, and reporting SDOH data. For example, health information exchange (HIE) data requirements create data-sharing barriers for ACOs because they are not considered Medicare suppliers or providers. Even when a patient has given consent for data sharing, ACOs may not be able to share data shared across the ACO and its care plan partners, leading to impediments in communication within ACOs and with CBOs. CMS does not consider care coordination and accountability to fall under payment, treatment, and operations, and therefore ACOs are limited in sharing data for these purposes. However, care coordination is necessary for addressing SDOH and providing integrated, whole-person care. Accordingly, HIPAA requirements should be adapted to facilitate data sharing across an ACO and with CBOs for the purposes of care coordination and community referrals.

Payment systems add onto these barriers, as traditional FFS payment models do not allow maximum flexibility for providers to tailor care to the needs of an individual patient, making coordinated, whole-person care challenging to deliver. NAACOS advocates that MSSP ACOs be provided with more payment flexibility, such as through optional capitated payment through MSSP to emphasize value instead of volume. Shifting away from FFS payment and towards a hybrid payment model can provide financial flexibility and accountability, which would allow ACOs to more easily address SDOH at the population level. Examples of this at work can be found in Medicaid ACOs, which can be formed through state plan amendments, 1115 waivers, or Medicaid Managed Care Organizations (MCOs). In Massachusetts, Medicaid ACOs receive capitated monthly payments to support social needs screening and behavioral health, and these ACOs are required to partner with CBOs to provide supports and community referrals.[22] Given the size and success of MSSP, there is great potential to address SDOH for the 10.6 million beneficiaries the program serves. We support Congress' work to statutorily allow partial capitation options for ACOs under Section 10307 of the Patient Protection and Affordable Care Act (ACA) and encourage Congress to work with CMS to implement this option into practice.[23]

III. Best practices and opportunities

a. What are some programs/emergency flexibilities your organization leveraged to better address SDOH during the pandemic (i.e., emergency funding, emergency waivers, etc.)? Of the changes made, which would you like to see continued post-COVID?

In the wake of the COVID-19 pandemic, ACOs were able to quickly pivot to telehealth and remote patient monitoring to meet the needs of their patients in a safe and accessible manner. Virtual care has provided unprecedented access for patients, but it has become clear that uncertainty as to the future of telehealth under Medicare will halt or reverse further adoption and utilization—to the detriment of both patients and providers. While the digital divide remains an issue for patients without access to reliable broadband services, telehealth has greatly expanded access to primary and specialty care for patients in rural areas with limited access to services.

NAACOS supports broader telehealth coverage and wants to see many of the flexibilities granted during the COVID-19 pandemic be made permanent; however, there are concerns about potential adverse effects on spending and ACO attribution. To ensure that telehealth is expanded in a cost-effective manner that ensures the continued delivery of high-quality care and does not disrupt ongoing patient-provider relationships, we recommend ACOs and other total cost of care models be used to test broader reforms. To prevent a disruption in care continuity, incentives should be provided to have care delivered in virtually integrated practices as part of an ongoing comprehensive care strategy. Deference should be given to Medicare providers who are accountable for patients' spending, quality, and health outcomes, such as ACOs.

Another flexibility ACOs have leveraged is the waiving of the requirement for a three-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay. NAACOS has advocated for the expansion of SNF waivers for ACOs in all MSSP tracks, as eliminating this requirement will allow ACOs to provide the right care for their patients in the most appropriate location. This also eliminates the costs associated with an emergency department visit and/or hospital stay. Since ACOs are held accountable for total cost of care, they would not be incentivized to over-use SNF waivers for their patients. Allowing all MSSP ACOs the opportunity to utilize the SNF waiver post-pandemic will help to improve care for patients and cut down on costly hospital stays, allowing more funds for SDOH initiatives.

IV. Transformative actions

a. Alternative payment models help to measure health care based on its outcomes, rather than its services. What opportunities exist to expand SDOH interventions in outcome-based alternative payment models and bundled payment models?

Negative SDOH can increase the level and cost of care required to achieve equal health outcomes. Since ACOs are held accountable for the total cost and quality of care for their assigned patient populations, they are already incentivized to address SDOH in order to reduce costs and improve quality. As such, the ACO model should be utilized to test and expand SDOH interventions. For example, new chronic social determinants management services could be modeled after existing CCM to allow ACOs to bill Medicare for services that address social determinants, improve health equity, and meet social needs. ACOs should also be provided with additional flexibilities to allow ACOs to deliver benefits related to transportation, housing, food insecurity, as well as supports for other social needs. Caring for patients

with greater social risk requires more time and resources, and providers will not be able to meet the needs of these patients without appropriate flexibilities and funding.

As mentioned in a previous section, support for the Value Act offers an immediate and meaningful opportunity for Congress to support ACOs through a variety of positive policy changes, which if enacted would keep ACOs on the path to value and improve their ability to screen for, track, target, and address SDOH among their assigned patient populations. In addition, the bill includes a requirement for the Government Accountability Office (GAO) to prepare a report on the impact of value-based care programs on certain conditions in which racial health disparities are common. This information will be critical in understanding how value-based care programs such as ACOs are most effective in addressing SDOH and affecting health equity. It will also provide insights for ACOs looking to integrate health equity and SDOH interventions into their programs.

b. What are the main barriers to programs addressing SDOH and promoting in the communities you serve? What should Congress consider when developing legislative solutions to address these challenges?

Capacity and workforce training issues are an impediment to addressing SDOH. Addressing SDOH requires significant change management and workforce development for which most organizations do not have the funding or bandwidth. Congress should work to ensure that medical education includes training on addressing social determinants, and it should support programs that offer training and technical assistance to practices looking to address the negative SDOH of their patients.

Another major barrier to addressing SDOH is access to meaningful, standardized data. Currently, there is no standardized way to make referrals to CBOs, and the CBO referral platforms that do exist often have limited or no interoperability with EHRs. ACOs need actionable data in order to develop and target effective SDOH interventions to the populations that need them most. Congress should work with ACOs and EHR vendors in order to develop standards to collect data consistently across the industry, support the creation of standardized referral platforms, and ensure these standards meet privacy guidelines.

The main barrier for these programs is financial. Most community-based programs are funded through philanthropy, and if the money dries up, so does the program. There is a need for funding to develop and sustainably implement SDOH interventions and referral programs. Even for ACOs, it is challenging to provide these needed resources because there is no reimbursement for them. While many ACOs are using shared savings to fund this, they do not get reimbursement for doing this work. Additionally, earning shared savings remains challenging and varies year-to-year, meaning ACOs don't have a reliable funding stream. To address these challenges, Medicare and other payers could be required to reimburse for addressing social needs, for example through grants and/or other means such as a new chronic social determinant management program. Additionally, CBOs should receive dedicated funding to build infrastructure such as data collection systems and HIPAA protocols. The commitment and innovation from ACOs to address SDOH is laudable, but both ACOs and their community partners need appropriate funding to make SDOH interventions work and to ensure this important work continues.

**Conclusion:**

Thank you for the opportunity to provide comments on the Congressional Social Determinants of Health Caucus Request for Information. Should you have any questions about our comments, please contact Allison Brennan, SVP, Government Affairs at abrennan@naacos.com.

Sincerely,

Clif Gaus
President & CEO
NAACOS

---

[1] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0727
[2] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/housing-instability#1
[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1484604/
[4] https://www.ers.usda.gov/webdocs/publications/45655/29206_err29_002.pdf?v=41334
[5] https://www.aha.org/system/files/hpoe/Reports-HPOE/2017/sdoh-transportation-role-of-hospitals.pdf
[6] https://www.naacos.com/summary-of-anti-kickback-statute-safe-harbor-for-transportation?servId=7312
[7] https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf
[8] https://www.naacos.com/naacos-response-to-start-rfi-august-24-2018
[9] https://www.naacos.com/index.php?option=com_content&view=article&id=846:patients-over-paperwork-rfi&catid=20:site-content
[10] https://www.naacos.com/naacos-stark-aks-comments
[11] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3570982/
[12] https://journal.ahima.org/addressing-social-determinants-of-health-with-technology-during-public-health-emergencies/
[13] https://www.managedhealthcareexecutive.com/view/how-technology-addressing-sdoh
[14] https://www.healthaffairs.org/do/10.1377/hblog20210812.211558/full/
[15] https://www.amga.org/about-amga/amga-newsroom/press-releases/072921/
[16] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5328595/
[17] https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01246
[18] https://www.naacos.com/assets/docs/pdf/2021/ValueActScore082021.pdf
[19] https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/sdoh-survey-results.pdf
[20] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.01266
[21] http://reports.opendataenterprise.org/Leveraging-Data-on-SDOH-Summary-Report-FINAL.pdf
[22] https://www.milbank.org/wp-content/uploads/2021/02/Duke-SDOH-and-VBP-Issue-Brief_v3-1.pdf
[23] https://chqpr.org/downloads/PartialCapitationPaymentforACO.pdf