REPORT 10 OF THE COUNCIL ON MEDICAL SERVICE (A-19)
Alternative Payment Models and Vulnerable Populations
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2018 Annual Meeting, the House of Delegates referred Resolution 712, which was introduced by the New England Delegation and assigned to the Council on Medical Service for study. Resolution 712-A-18 asked: That our American Medical Association (AMA): (1) study the impact of current advanced Alternative Payment Models (APMs) and risk adjustment on providers caring for vulnerable populations; and (2) advocate legislatively that advanced APMs examine the evaluation of quality performance (for bonus or incentive payment) of providers caring for vulnerable populations in reference to peer group (similarities in SES status, disability, percentage of dual eligible population).

Heath care disparities often occur in the context of wider inequality. It has been shown that if patients' basic needs are not met, they are not likely to stay healthy regardless of the quality of health care received. And because APMs are typically designed to be flexible to compensate for care that is not traditionally reimbursed, they present an opportunity to better care for and serve vulnerable populations. However, as Resolution 712 points out, value-based payment programs can disproportionately penalize physicians serving the poorest and most vulnerable populations. Therefore, the Council offers a set of recommendations that it hopes mitigates these negative outcomes, penalties, and events. In doing so, the Council recommends ways in which the health care system can do more to address non-medical factors that often go undetected and untreated among vulnerable populations within the context of a changing payment and delivery system.

The Council's recommendations build upon the AMA's current policy on value-based payment programs and social determinants of health. The Council recommends reaffirming existing AMA policies to highlight the need for health equity across populations and the corresponding need for APMs and risk adjustment methodologies to protect against financially penalizing the physicians who care for and serve populations who are overwhelmingly sicker and poorer. The Council is sensitive to concerns that APMs may have the impact of not only financially penalizing physicians caring for at-risk populations, but also causing adverse selection in patient treatment. The Council believes that it is critical that social determinants of health be meaningfully incorporated into APM quality measures to encourage and support physicians to care for these patients, and the Council recommends that APMs be designed with the flexibility needed to address the unique challenges of vulnerable populations.

The Council understands and agrees with the sponsor's concern that APMs may have adverse effects on vulnerable populations because current risk adjustment methodologies are not accurate enough to distinguish between suboptimal care and high-quality care provided to high-risk individuals. Accordingly, the Council believes that it is critical that the AMA continue to advocate for appropriate risk adjustment of performance results based on clinical and social determinants of health.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 10-A-19

Subject: Alternative Payment Models and Vulnerable Populations (Resolution 712-A-18)

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee G (Rodney Trytko, MD, Chair)

At the 2018 Annual Meeting, the House of Delegates referred Resolution 712, which was introduced by the New England Delegation and assigned to the Council on Medical Service for study. Resolution 712-A-18 asked:

> That our American Medical Association (AMA): (1) study the impact of current advanced Alternative Payment Models (APMs) and risk adjustment on providers caring for vulnerable populations; and (2) advocate legislatively that advanced APMs examine the evaluation of quality performance (for bonus or incentive payment) of providers caring for vulnerable populations in reference to peer group (similarities in SES status, disability, percentage of dual eligible population).

This report provides an overview of vulnerable populations and the emergence of APMs, highlights numerous APMs and value-based care initiatives incorporating social determinants of health into their models, summarizes relevant AMA policy, provides a summary of AMA advocacy activities, and recommends policy to encourage the development of APMs that serve vulnerable populations while protecting physicians from being financially penalized.

BACKGROUND

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula and created new ways for the Medicare program to pay physicians for the care they provide to Medicare beneficiaries. Specifically, MACRA's physician payment program is the Quality Payment Program (QPP). The QPP has two tracks of participation: APMs and the Merit-based Incentive Payment System (MIPS). As part of the QPP's drive to value-based care, it creates incentives for physicians to participate in APMs, which aim to provide greater flexibility to manage the health of patient populations by aligning provider incentives with cost and quality goals. MACRA specifically encourages the development of Physician-Focused Payment Models (PFPMs), which are APMs wherein Medicare is the payer, physician group practices or individual physicians are APM participants, and the focus is on the quality and cost of physician services. MACRA established the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to review and assess PFPM proposals submitted by stakeholders to the committee based on certain criteria defined in regulations. The PTAC is an 11-member independent federal advisory committee. Since its inception, the PTAC has received 31 proposals for consideration, a few of which have not been reviewed yet by PTAC. Of those proposals, PTAC has recommended 15 proposals to the Secretary of Health and Human Services (HHS) to test in various ways.

As the national push toward value-based payment and care delivery continues, many studies have demonstrated substantial evidence linking social circumstances to health and health outcomes.[1] It is now understood that non-medical factors, such as social determinants of health (SDH), account for about 60 percent of a person's health outcomes.[2] Together, the drive toward value and recognition of SDH impacts on health are fueling interest in the ways in which addressing SDH may be incorporated into new payment and delivery models like APMs. Within an APM, physicians often are financially rewarded for keeping patients healthy and out of the hospital and emergency departments. To achieve this goal, APMs often have the flexibility to support services that can significantly improve health outcomes. Therefore, physicians can respond to APM incentives by improving care coordination and integration, which may be particularly beneficial for vulnerable populations.

However, APMs may inadvertently create incentives for physicians to avoid caring for vulnerable patients who are at increased risk for high costs and poor outcomes that are beyond the physician's control.[3] In order to increase health equity and to fully realize the benefits of APMs, APMs must contemplate and account for vulnerable populations.

Impact of Vulnerable Population Status on Patient Outcomes

Vulnerable populations in health care include the economically disadvantaged, racial and ethnic minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ) groups; uninsured individuals; rural individuals who may have trouble accessing care; and those with stigmatized chronic conditions such as severe mental illness or human immunodeficiency virus (HIV).[4] These populations may be more likely to suffer from hunger and access to healthy food options, lack social and economic support, have lower education levels, live in unsafe neighborhoods devoid of parks and playgrounds, and often are subjected to discrimination.[5]

Vulnerable populations are less likely to have health coverage, struggle with health care access, and often have little interaction or trust in the health care system. They are less likely to receive preventive services and are more likely to go to the emergency department or hospital for a condition that might have been treated in a lower cost facility.[6] As a result, their medical interventions generally come much later and at significantly higher cost than for other populations. Moreover, lower income populations are twice as likely as those with higher incomes to have behavioral health problems, three times as likely to be socially isolated, and 10 times more likely to experience food insecurity.[7] Additionally, there is considerable overlap in vulnerable populations. For example, Black and Hispanic American minorities are significantly more likely than Whites to be uninsured, live below the poverty line, and have higher rates of HIV or AIDS diagnosis and death rates.[8]

Though access to health care is essential for well-being, it is not the greatest health determinant.[9] Zip Code™ now is understood to be a stronger predictor of quality of health than even genetic code. Research suggests that health-related behaviors such as smoking, diet, and exercise, are more important determinants of early death than health care itself. Furthermore, there is a growing consensus that non-medical factors shape an individual's ability to engage in health behaviors. For example, children born to parents who have not completed high school are more likely to live in an environment that poses barriers to health such as lack of safety, exposed garbage, and substandard housing.[10] Such environmental factors may have multi-generational impacts.

Generally, the current health care system is not built around the poorest and most vulnerable. Exacerbating the ability to effectively care for these populations is the fact that many physicians are not able to identify high-risk patients. Some of the current risk algorithms used by payers were

originally developed without access to electronic medical record (EMR) data, so many current predictive risk tools have limited utility. The link between non-medical factors and poor health outcomes is well-documented, but few traditional payment and delivery models are equipped to address these non-medical factors that drive high health care costs and poor outcomes.

Addressing the Unique Needs of Vulnerable Populations in Payment and Delivery

There are a growing number of initiatives to address SDHs and challenges unique to vulnerable populations within and outside of the health care system. These include multi-payer federal and state initiatives, Medicaid initiatives led by states or health plans, and physician-level activities focused on identifying and addressing the social needs of their patients. APMs can provide opportunities to cover services that can help provide care and support that vulnerable or high-risk populations need but that are generally not available under traditional payment models. Examples of such initiatives are highlighted below and include: Accountable Health Communities, the Chinese Community Accountable Care Organization (ACO), the Acute Unscheduled Care Model, and the Patient-Centered Opioid Addiction Treatment (P-COAT) APM.

Accountable Health Communities

In 2016, the Center for Medicare and Medicaid Innovation (CMMI), which was established by the Affordable Care Act, announced the Accountable Health Communities model, which is focused on connecting Medicare and Medicaid beneficiaries with community services to address health-related social needs.[11] The model provides funding to examine whether systematically identifying and addressing social needs of beneficiaries through screening, referral, and community navigation services affects health costs and reduces health care utilization. In 2017, CMMI awarded grants to organizations to participate in the model over a five-year period.[12]

Twenty awardees will encourage partner alignment to ensure that community services are available and open to the needs of beneficiaries. To implement the alignment approach, bridge organizations will serve as "hubs" in their communities that will identify and partner with clinical delivery sites to conduct systematic screenings of beneficiary health-related social needs and make referrals to community services that may be able to address the recognized social needs; coordinate and connect beneficiaries to community service providers through community service navigation; and align model partners to optimize community capacity to address these social needs.

The Chinese Community ACO

The Chinese Community ACO (CCACO) is a community-based physician-owned ACO that serves about 12,000 Medicare fee-for-service (FFS) beneficiaries in the Chinese communities in New York City.[13] The aim of the model is to reduce overall health care costs and disparities by identifying high-risk individuals and undertaking proactive disease management. The CCACO establishes a network of organizations by partnering with hospitals, nursing homes, home health agencies, senior centers, and others to facilitate coordinated care. The model anticipates that, due to care coordination efforts, it will prevent emergency room visits and hospital readmissions in this population.

Acute Unscheduled Care Model (AUCM) Enhancing Appropriate Admissions from the American College of Emergency Physicians (ACEP)

The AUCM was developed by the ACEP. The particular payment model was submitted to the PTAC, and the PTAC subsequently recommended to the Secretary of HHS that the model be implemented. It centers on incentivizing improved quality and decreased costs associated with the discharge decisions made by emergency department (ED) physicians.[14] The model proposes that it may reduce Medicare spending and improve quality care by reducing avoidable hospital inpatient admissions and observation days by giving ED physicians the ability to coordinate and manage post-discharge home services. The model is a bundled payment, and the episode of care begins with a qualifying ED visit and ends after 30 days or with the patient's death.[15] All of the Medicare services received within that 30-day window are included in the bundle. To assist in care transformation efforts, the model also uses several waivers in order to allow ED physicians to offer telehealth services, bill for transitional management codes, and permit clinical staff to offer home visits.

Patient-Centered Opioid Addiction Treatment (P-COAT) APM

The P-COAT model is a payment model created jointly by the American Society of Addiction Medicine (ASAM) and the AMA. The model proposes to manage opioid use disorder, a highly stigmatized condition, by increasing utilization of and access to medications for the treatment of opioid use disorder by providing the appropriate financial support to successfully treat patients and broaden the coordinated delivery of medical, psychological, and social supports.[16] The current payment system offers little support for the coordination of behavioral and social supports that patients being treated for opioid use disorder need. Therefore, under P-COAT, treatment teams are eligible to receive two new types of payments that would be expected to provide the necessary financial support to enable providers to deliver the appropriate opioid addiction treatment.[17]

AMA POLICY

The AMA has a wealth of policy on both APMs and SDH. Regarding APMs, Policy H-385.913 promulgates goals for physician-focused APMs, develops guidelines for medical societies and physicians to begin identifying and developing APMs, encourages the Centers for Medicare & Medicaid Services (CMS) and private payers to support assistance to physician practices working to implement APMs, and states that APMs should account for the patient populations, including non-clinical factors. Policy H-385.908 states that the AMA will continue to urge CMS to limit financial risk requirements to costs that physicians participating in an APM have the ability to control or influence, will work with stakeholders to design risk adjustment systems that identify new data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a patient's health and success of treatment, such as disease stage, access to health care services, and socio-demographic factors.

Moreover, AMA policy is committed to promoting physician-led payment reform programs that serve as models for others working to improve patient care and lower costs. Policy D-390.953 directs the AMA to advocate with CMS and Congress for alternative payment models developed in concert with specialty and state medical organizations. Policy H-390.844 emphasizes the importance of physician leadership and accountability to deliver high quality and value to patients and directs the AMA to advocate for providing opportunities for physicians to determine payment models that work best for their patients, their practices, and their regions. Policy H-450.961 states that incentives should be intended to promote health care quality and patient safety and not primarily be intended to contain costs, provide program flexibility that allows physicians to

accommodate the varying needs of individual patients, adjust performance measures by risk and case-mix to avoid discouraging the treatment of high-risk individuals and populations, and support access to care for all people and avoid selectively treating healthier patients. Additionally, Policy D-35.935 supports physician-led, team-based care delivery recognizing that the interdisciplinary care team is well equipped to provide a whole-person health care experience.

The AMA has myriad policies on health disparities, health inequities, and diversity, and the AMA continues to exercise leadership aimed at addressing disparities (Policies H-350.974, D-350.991, D-350.995, D-420.993, H-65.973, H-60.917, H-440.869, D-65.995, H-150.944, H-185.943, H-450.924, H-350.953, H-350.957, D-350.996, H-350.959). Policy H-350.974 affirms that the AMA maintains a zero-tolerance policy toward racially or culturally based disparities in care and states that the elimination of racial and ethnic disparities in health care are an issue of highest priority for the organization. The policy encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, Policy H-350.974 supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons. Moreover, the policy actively supports the development and implementation of training regarding implicit bias and cultural competency. Policy H-280.945 calls for better integration of health care and social services and supports while Policy H-160.896 calls to expand payment reform proposals that incentivize screening for social determinants of health and referral to community support systems. Additionally, Policy D-350.995 promotes diversity within the health care workforce, which can help expand access to care for vulnerable and underserved populations.

Recognizing that current risk adjustment and performance measure systems may disincentivize caring for the most vulnerable, Policy H-450.924 supports that hospital program assessments should account for social risk factors so that they do not have the unintended effect of financially penalizing hospitals, including safety net hospitals, and physicians that may exacerbate health care disparities.

AMA ACTIVITY

The AMA continues to work to aid physicians in the implementation of MACRA and by encouraging and enabling physician participation in APMs. The AMA has been active in educational activities including webinars and regional conferences for physicians and staff and will be continuing these activities. Recent AMA advocacy activity has called for improvements in the methodologies behind APMs. Such areas for improvement in methodology include performance targets, risk adjustment, and attribution. The AMA recognizes that proper methodologies enable more physicians to participate in APMs and promotes design of APMs in such a way that prioritizes the patient's need.

The AMA continues to strive to ensure that all communities of Americans receive equal access to quality health care. The AMA is committed to working toward the goal of all Americans having access to affordable and meaningful health care. It is addressing this issue systemically by striving for health equity by mitigating disparity factors. For example, the AMA has developed numerous resources including a Health Disparities Toolkit that helps connect physicians and care teams to chronic disease prevention programs in the community. The AMA STEPSForward™ module entitled Addressing Social Determinants of Health describes how a practice can select and define a plan to address SDH issues. Additionally, steps toward health equality are being taken in the AMA's effort toward creating the medical school of the future. Within the AMA's Accelerating Change in Medical Education (ACE) initiative, some medical schools are incorporating education on disparities within their curricula while others are addressing diversity in the health care

workforce by changing admissions and pipeline programs to ensure that our nation has the diverse workforce that it needs.

Additionally, the AMA is integrating SDH into its Integrated Health Model Initiative (IHMI), a collaborative effort that supports a continuous learning environment to enable interoperative technology solutions and care models that evolve with real world use and feedback. IHMI's collaborative platform is discussing SDH with the goal of identifying those factors that should be incorporated into the IHMI data model. Moreover, the IHMI team has delivered a module that incorporates two of the widely accepted SDH: the nine-digit Zip Code™ where one lives and those who are dually-eligible for Medicaid and Medicare.

Importantly, the AMA recognizes that health quality can only happen in concert with efforts to improve physician satisfaction and wellbeing. Therefore, the AMA is helping create an engaged workforce and mitigating burnout. To that end, the AMA has developed STEPSForward™ resources and Burnout Assessment Tools to allow physicians to assess their practices and find ways to leverage their entire care team to improve physician and patient experience and care. The AMA knows that advocating for physicians and patients is critical to achieve health equity. Patients and the public are partners in the quest for equitable access to quality health and health care.

Moreover, the AMA is establishing a new Health Equity Center with the goal of enabling optimal health for all with an eye on social justice. The Center will serve as a demonstration of the AMA's long-term and enduring commitment to health equity.

DISCUSSION

Heath care disparities often occur in the context of wider inequality. It has been shown that if patients' basic needs are not met, they are not likely to stay healthy regardless of the quality of health care received. Because APMs are typically designed to be flexible to compensate for care that is not traditionally reimbursed, they present an opportunity to better care for and serve vulnerable populations. However, several studies have demonstrated that value-based payment programs disproportionately penalize physicians serving the poorest and most vulnerable populations, possibly disincentivizing physicians from caring for them. Therefore, the Council offers a set of recommendations that it hopes mitigates these negative outcomes, penalties, and events. In doing so, the Council recommends ways in which the health care system can do more to address non-medical factors that often go undetected and untreated among vulnerable populations within the context of a changing payment and delivery system.

The Council's recommendations build upon the AMA's current policy on value-based payment programs and social determinants of health. The Council notes that reaffirming existing AMA policies helps to highlight the need for health equity across populations and the corresponding need for APMs and risk adjustment methodologies to protect against financially penalizing the physicians who care for and serve populations who are overwhelmingly sicker and poorer. The Council is sensitive to concerns that APMs may have the impact of not only financially penalizing physicians caring for at-risk populations, but also causing adverse selection in patient treatment. The Council believes that it is critical that social determinants of health be meaningfully incorporated into APM quality measures to encourage and support physicians to care for these patients. The current health care system was not built for vulnerable populations, and they remain woefully underserved. Therefore, the Council recommends that APMs be designed with the flexibility needed to address the unique challenges of vulnerable populations and believes that PFPMs provide an excellent opportunity to transform care delivery to better meet the needs of underserved populations.

The Council understands and agrees with the sponsor's concern that APMs may have adverse effects on vulnerable populations because current risk adjustment methodologies are not accurate enough to distinguish between suboptimal care and high-quality care provided to high-risk individuals. Accordingly, the Council believes that it is critical that the AMA continue to advocate for appropriate risk adjustment of performance results based on clinical and social determinants of health. The Council is steadfast in its belief that the structure and quality reporting of APMs must protect against penalizing physicians whose performance and aggregated data are impacted by factors outside of the physician's control. Furthermore, because of the Council's commitment to this principle, the Council believes that the topic of risk adjustment warrants revisiting and notes that at the 2019 Interim Meeting, it will present a report specifically addressing ways in which risk adjustment methodology and implementation can be improved.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 712-A-18 and the remainder of the report be filed:

1. That our American Medical Association (AMA) support alternative payment models (APMs) that link quality measures and payments to outcomes specific to vulnerable and high-risk populations and reductions in health care disparities. (New HOD Policy)

2. That our AMA continue to encourage the development and implementation of physician-focused APMs that provide services to improve the health of vulnerable and high-risk populations. (New HOD Policy)

3. That our AMA continue to advocate for appropriate risk adjustment of performance results based on clinical and social determinants of health to avoid penalizing physicians whose performance and aggregated data are impacted by factors outside of the physician's control. (New HOD Policy)

4. That our AMA reaffirm Policy H-385.913 stating that APMs should limit physician accountability to aspects of spending and quality that they can reasonably influence; APMs should understand their patient populations, including non-clinical factors; and support new data sources that enable adequate analyses of clinical and non-clinical factors that contribute to a patient's health and success of treatment. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-385.908 stating that the AMA should continue advocating for APMs limiting the financial risk requirements to costs that physicians participating in an APM have the ability to control or influence and work with stakeholders to design risk adjustment systems that identify new data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a patient's health and success of treatment, such as severity of illness, access to health care services, and socio-demographic factors. Moreover, Policy H-385.908 recognizes that technology should enable the care team and states that the AMA should work with stakeholders to develop information technology (IT) systems that support and streamline clinical participation and enable IT systems to support bi-directional data exchange. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-350.974 recognizing that racial and ethnic health disparities is a major public health problem, stating that the elimination of racial and ethnic disparities in health care is an issue of highest priority for the AMA, and supporting education and training on implicit bias, diversity, and inclusion. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy D-35.985 supporting physician-led, team-based care recognizing that interdisciplinary physician-led care teams are well equipped to provide a whole-person health care experience. (Reaffirm HOD Policy)

8. That our AMA reaffirm Policy D-350.995 promoting diversity within the workforce as one means to reduce disparities in health care. (Reaffirm HOD Policy)

9. That our AMA reaffirm Policy H-440.828 on community health workers (CHWs) recognizing that they play a critical role as bridgebuilders between underserved communities and the health care system and calling for sustainable funding mechanisms to financial CHW services. (Reaffirm HOD Policy)

10. That our AMA reaffirm Policy H-450.924 supporting that hospital program assessments should account for social risk factors so that they do not have the unintended effect of financially penalizing safety net hospitals and physicians that exacerbate health care disparities. (Reaffirm HOD Policy)

11. That our AMA reaffirm Policy H-280.945 supporting better integration of health care and social services and supports. (Reaffirm HOD Policy)

12. That our AMA reaffirm Policy H-160.896 calling to expand payment reform proposals that incentivize screening for social determinants of health and referral to community support systems. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1] Gottlieb, L., Colvin, J.D., Fleegler, E. et al. J GEN INTERN MED (2017) 32: 345. Available at: https://doi.org/10.1007/s11606-016-3920-y
[2] Cityblock: Better Care for Healthier Neighborhoods. Available at: https://www.cityblock.com/mission
[3] Joynt Maddox, K. N Engl J Med 2018; 378:977-979. Alternative Payment Models Help or Hurt? Available at: https://www.nejm.org/doi/full/10.1056/NEJMp1715455
[4] The American Journal of Managed Care. Vulnerable Populations: Who Are They? Available at: https://www.ajmc.com/journals/supplement/2006/2006-11-vol12-n13suppl/nov06-2390ps348-s352
[5] Artiga, S., Hinton, E. Kaiser Family Foundation. Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. Available at: https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/
[6] Riley, P. The Commonwealth Fund. Making Health Care Work Better for Vulerable Patients. Available at: https://www.commonwealthfund.org/blog/2018/making-health-care-work-better-vulnerable-patients
[7] Riley, P. The Commonwealth Fund. Making Health Care Work Better for Vulerable Patients. Available at: https://www.commonwealthfund.org/blog/2018/making-health-care-work-better-vulnerable-patients
[8] Orgena, K., Artiga, S. Kaiser Family Foundation. Disparities in Health and Health Care: Five Key Questions and Answers. Available at: https://www.kff.org/disparities-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/
[9] Artiga, S., Hinton, E. Kaiser Family Foundation. Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. Available at: https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/
[10] Artiga, S., Hinton, E. Kaiser Family Foundation. Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. Available at: https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

[11] Artiga, S., Hinton, E. Kaiser Family Foundation. Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. Available at: https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

[12]Centers for Medicare and Medicaid Services. Accountable Health Communities Model. Available at: https://innovation.cms.gov/initiatives/ahcm/

[13] Chinese Community Accountable Care Organization. Available at: http://www.ccaco.org/about/mission/

[14] The Physician-Focused Payment Model Technical Advisory Committee. Report to the Secretary of Health and Human Services Comments and Recommendation on the Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admissions American College of Emergency Physicians. Available at: https://aspe.hhs.gov/system/files/pdf/255726/ReportToTheSecretary_ACEP_10.20.18.pdf

[15] Firth, S. Medpage Today. PTAC Backs New Payment Models for Emergency, Primary Care. Available at: https://www.medpagetoday.com/publichealthpolicy/medicare/75025

[16] American Medical Association. ASAM, AMA Announce Model to Improve Treatment of Opioid Use Disorder. Available at: https://www.ama-assn.org/press-center/press-releases/asam-ama-announce-model-improve-treatment-opioid-use-disorder

[17] American Society of Addiction Medicine. Patient-Centered Opioid Treatment Alternative Payment Model. Available at: https://www.asam.org/advocacy/advocacy-principles/cover-it/p-coat-apm