September 21, 2021

The Honorable Cheri Bustos
Co-Chair, Congressional SDOH Caucus
1233 Longworth House Office Building
Washington, DC 20515

The Honorable Tom Cole
Co-Chair, Congressional SDOH Caucus
2207 Rayburn House Office Building
Washington, DC 20515

The Honorable G.K. Butterfield
Co-Chair, Congressional SDOH Caucus
2080 Rayburn House Office Building
Washington, DC 20515

The Honorable Markwayne Mullin
Co-Chair, Congressional SDOH Caucus
2421 Rayburn House Office Building
Washington, DC 20515

RE: Congressional Social Determinants of Health Caucus – Request for Information

Dear Representatives Bustos, Cole, Butterfield, Mullin, and other members of the Congressional Social Determinants of Health Caucus,

Aligning for Health appreciates the opportunity to submit comments in response to the Congressional Social Determinants of Health Caucus request for information regarding challenges and opportunities in addressing social determinants of health.

Aligning for Health is an advocacy organization that brings together a broad coalition of members focused on improving health and wellbeing through interventions related to better aligning health and social needs. We are supported by an Advisory Board of individuals representing public health, mental health, housing, community development, human services, and many other sectors. As a coalition, we work to develop and promote actionable policies that create opportunities - and remove challenges - for states and local governments, health care organizations, and non-healthcare organizations to work together to develop cross-sector, coordinated solutions to address both health and social needs. As such, we remain committed to addressing social determinants of health and engaging with the Congressional Social Determinants of Health Caucus to advance policies to improve SDOH in Congress.

Below, we provide comments in response to the specific questions posed in the RFI.

Experience with SDOH Challenges

- ***What specific SDOH challenges have you seen to have the most impact on health? What areas have changed most during the COVID-19 pandemic?***

Housing insecurity and instability affects approximately 30 percent of American households each year and is one of the most well-documented social determinants of health, with health systems and policy makers seeking to better understand where to intervene effectively. In 2019, 37.1 million households nationwide were considered "housing cost burdened," a statistic that has likely worsened as a result of the COVID-19 pandemic. Common issues in thinking about housing as a social determinant of health include affordability, stability, safety, quality, discriminatory housing policies and practices, and more. Housing insecurity is a persistent challenge that many Americans face, but the pandemic created new issues of affordability as millions of people were suddenly out of work and housing prices soared. According to the Census Bureau, nearly a quarter of Americans reported housing insecurity as of May 2020.

The available data around housing insecurity and homelessness likely does not portray the full extent of housing challenges faced across the country. For example, Aligning for Health member CareSource previously used data to identify individuals who were shown to be homeless or to infer that they may be homeless. Over the last year and a half, CareSource implemented the PRAPARE social needs screening tool. While homelessness data previously used showed that 2-2.5 percent of members were likely homeless, results from the PRAPARE tool showed that 10-14 percent of members self-attested to homelessness. The questionnaire was administered telephonically, so this percentage likely still underrepresents the number of people who are homeless.

There is significant evidence of the negative impact of homelessness, housing insecurity, substandard housing conditions, and neighborhood quality on physical and mental health outcomes, as well as the mitigating effects of efforts to provide supportive housing and to ensure stable and secure housing.

Increasing evidence suggests that for interventions around housing to be successful, different sectors must come together to strengthen the housing-health partnership in a meaningful way. As such, Congress should engage stakeholders and partner with social services providers, other cross-sector organizations, and other federal agencies like the U.S. Departments of Housing and Urban Development (HUD) and Health and Human Services (HHS) to better address and improve health and housing outcomes.

In addition to housing, Aligning for Health members have identified other social determinants of health that continue to be most prevalent and have significant impact on overall health outcomes:

- **Food insecurity** – Food insecurity has been exacerbated by the pandemic and can have significant impact on one's health outcomes. Individuals who are food insecure are at increased likelihood of being affected by chronic diseases as adults and developmental issues as children. Feeding America projected that 42 million people, including 13 million children, may experience food insecurity in 2021, and that most of those who have been most impacted by the pandemic were food insecure or at risk of food insecurity prior to COVID-19.
- **Transportation** – Access to reliable, safe transportation can impact a person's ability to access health care services. Not having access to transportation can lead to missed appointments or delayed care, increased health expenditures, and worse health outcomes. Health plans and hospitals partnered with ride share companies like Lyft and Uber during the pandemic to ensure patients could access COVID-19 vaccines, testing, or medical appointments, which has been critical for those experiencing transportation barriers. Examples include a partnership between Blue Cross Blue Shield of Massachusetts and Lyft to offer transportation to and from COVID vaccination sites, with a $1 million contribution from the health plan to provide thousands of rides to members.
- **Economic Stability** – The CDC defines economic stability as "the connection between the financial resources people have – income, cost of living, and socioeconomic status – and their health." Areas that can impact one's financial stability include ability to afford basic needs, utilities, and other payments, as well as persisting issues like poverty, employment, and housing stability.
- **Social Isolation** – COVID has placed a spotlight on the significant number of Americans who are lonely or socially isolated from family and friends. Social isolation, particularly for older or home-bound adults, can have a negative impact on both physical and mental health outcomes.
- **Employment Opportunities** – Lack of employment opportunities and job training can perpetuate poverty, which is at the root of many health disparities. Addressing this would require paying attention to additional support systems such as education, job training, transportation, child care, and having employment available that pays a livable wage that allows a parent to support a family.

- **Digital Equity** – The pandemic has revealed inequities in access to technology and broadband internet, which impacted access to services like telehealth. Often referred to as the digital divide, these disparities can work to exacerbate existing barriers to health and well-being, particularly for those living in rural areas or medically underserved communities.
- **Data Interoperability** – Data collection and the ability to use and share data appropriately can be a significant barrier to addressing social needs. There is a need to collect the appropriate level of data to ensure we can close racial care gaps, but the data doesn't mean much if it cannot be shared effectively with other organizations to address the care of the whole person.
- **Care Aversion** – Community-based organizations have consistently talked about issues around care aversion, particularly when there is cultural or historical distrust of the medical community. There needs to be improvements or solutions around capturing this within the data and finding ways to measure and address this issue.
- **Health Literacy** – The ability to obtain, process and understand the information and resources available to make a decision about one's health is a key social determinant of health. Low health literacy can impact a patient's adherence to a treatment regimen, communication with providers, and likelihood of hospitalization rates.
- **Toxic Stress** – Toxic stress, or the chronic stress of living in impoverished and unhealthy conditions, can have a significant impact on health and wellbeing. Experiencing toxic stress as a child can lead to increased risk of developing poor physical, behavioral, socioemotional, and cognitive health outcomes later in life.

More broadly, the need for coordination across sectors has been emphasized by our experience during COVID-19. Both health care and social service organizations have been forced to rapidly adjust to changing demands on their services – often exposing structural weaknesses in care delivery. Bright spots exist however, where better coordination between health and social service sectors led to stronger, more resilient communities where health and social service organizations were able to respond to the challenge of COVID-19 together.

- ***What types of gaps in care, programs, and services serve as a main barrier in addressing SDOH in the communities you serve? What approaches have your organization, community, Tribal organization, or state taken to address such challenges?***

Prominent barriers to addressing SDOH

Aligning for Health is made up of a coalition of members focused on improving health and wellbeing through interventions related to better aligning health and social needs. Our members are leaders in developing innovative cross-sector partnerships and advancing whole health. We are also supported by an Advisory Board of individuals representing public health, mental health, housing, community development, human services, and many other sectors. Our members represent and serve diverse populations, who often face varying challenges when it comes to having their social needs met.

Below, we list examples of barriers identified by Aligning for Health members and others in addressing SDOH within their organizations and the communities they serve:

- Individuals do not always have awareness of the resources available to them and do not always know information about available services or community resources they may be eligible for or have access to. Many also face barriers in applying to and seeking to enroll in multiple programs.

- Location matters. Food delivery sites, employment services, or health care may not be available close enough to where individuals reside. To eliminate this barrier, some organizations are working to take services directly to the individuals that need them. CareSource, for example, set up clinics within housing sites or other places that individuals are accessing, often in partnership with community-based organizations (CBOs) such as food banks. Other organizations have found success with mobile vans or in offering virtual services, which help to eliminate potential transportation challenges and other barriers to access.
- Program administration often exists in siloes – funding, eligibility, outcome measures, reporting, and data systems all tend to be program specific. Therefore, efforts to better coordinate care and services provided across health and human service programs, or to reduce burden on individuals applying for or receiving services, are often difficult to accomplish. Demonstration projects that waive certain requirements, allow for braided or blended funding, or shared incentives and outcome metrics can help to break down some of these barriers.
- Within the Medicaid program, siloed program administration, such as the provision of home- and community-based services (HCBS) and managed health care, often limits coordination and communication, which is vastly more complex to accomplish in partnership with other federal supports or community-based resources. Comprehensive, standardized, and timely data is a key component to successful coordination. But data sharing requires ensuring privacy and security protections are in place and that CBOs and other entities have the technical capability and capacity to seamlessly share data with the health care system or health care organizations.
- Improving screening and collection of information on individuals' social needs would be helpful to organizations working to address SDOH. Capturing and reporting such data through electronic health records and other systems of record will help health care providers to have a better understanding of a patient's whole health and life history, but allows for data exchange with other health and social service providers. Social needs data can potentially be leveraged alongside health care data to risk adjustment payments or quality in order to provide additional resources to providers working to provide care to more vulnerable and higher risk populations.
- Organizations do not always have the ability to see if someone has been referred or successfully connected to social services or government benefit programs, which is a huge disconnect and gap for ensuring individuals have the resources they need.

Real-World Examples of Innovative Programs to Address SDOH

Many organizations, both those within and outside of Aligning for Health's membership, have worked on innovative initiatives to address social determinants of health in the populations they serve.

Aligning for Health member organizations such as the American Hospital Association, Blue Cross Blue Shield Association, HCSC, Signify Health, Vizient, 3M, and others have shared numerous resources describing their or their members' work to address social determinants.

CareSource's Healthy Beginnings at Home is one example of an innovative initiative to address housing as a social determinant of health for pregnant women and infants. The research project tests the impact of providing rental assistance with housing stabilization services to individuals who are pregnant, living in highly unstable housing, and are at greater risk of infant mortality. The project seeks to ensure needed housing during pregnancy in order to improve maternal and infant health outcomes. Initial results from the initiative found that birth outcomes improved for individuals who received housing intervention services.

UPMC Health Plan's Pathways to Work program recruits individuals to work for the health plan that have the skills that can translate to higher-paid work. The program blends and braids public workforce funding from the Workforce Innovation and Opportunity Act (WIOA), the American Rescue Plan Act (ARPA) and discretionary funding from the Department of Commerce with its own funds to support training and hiring of individuals who are unemployed or underemployed. The Freedom House EMT training provides 10-week EMT training for Medicaid and unemployed individuals in Pittsburgh. Pathways to Work and other programs like it can serve as a ladder for upward mobility for low-wage workers, a notion that was backed by research from the Federal Reserve that explored a skills-based approach to occupational mobility.

Signify Health recently partnered with Humana and the Alamo Area Community Network (AACN) to support Medicare Advantage members in San Antonio by connecting individuals in need with health-related social services and community resources. AACN uses Signify Health's technology platform to ensure the entities that are part of AACN can connect individuals to social services and close the loop on referrals between AACN participants, helping to ensure the needs of individuals in the area are being met and better track and understand clinical outcomes over time. The partnership also leverages Social Care Coordinators that help conduct outreach to address unmet needs and improve health and wellbeing.

Through collective impact and support of the County of San Diego, the Live Well San Diego program aligns efforts across sectors – including health care, social services, education, and others – to improve the lives and health of San Diego County residents. Over 500 organizations throughout the region have committed to partnering to improve health and wellbeing. Organizational leaders and community members gather regionally to identify priority needs, plan community improvements, and conduct activities to improve the health and wellbeing of their communities. Since its inception in 2010, these efforts have resulted in a 12 percent reduction in the percentage of deaths associated with preventable health threats, a 10 percent reduction in the number of homeless individuals in the area, and 4,300 fewer students experiencing obesity, among other results. San Diego 2-1-1 is a highly regarded resource and information hub that connects people with community, health and disaster services and which works in collaboration with Live Well San Diego. San Diego 2-1-1 also established a Community Information Exchange (CIE) Network that provides an integrated technology platform to coordinate care and share information.

- ***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?***

Today, there are many efforts underway to connect health care organizations and community based organizations (CBOs) for purposes of electronic referrals, outcomes tracking, electronic resource directories, and care coordination that can help to promote coordinated care across regions.

In several states, Medicaid Managed Care Organizations (MCOs) are screening for unmet health-related social service resource needs and are providing members with referrals to social services as part of their care management strategies. For example, a 2020 Survey Report commissioned by the Texas Association of Health Plans of social determinants of health strategies employed during the COVID-19 pandemic found that 85 percent of Texas' MCOs, or 11 out of 13 respondents, currently use or are planning to engage a social service referral platform, with almost all using Aunt Bertha or a combination of Aunt Bertha and 2-1-1 systems.

States have also started to require their Medicaid Managed Care organizations to close the loop on referrals made to health care and social service support networks and have required collaboration with

community based organizations and the 2-1-1 systems. As an example, New Hampshire currently requires reporting on closed loop referrals or the overall effectiveness of social determinant care coordination services as part of its MCO contracts.

Additionally, several statewide or regional efforts to connect health care organizations and CBOs for purposes of electronic referrals, outcomes tracking, electronic resource directories, and care coordination have started to emerge, as part of an effort to better coordinate care across regions. In our response, we previously highlighted San Diego 2-1-1, but other examples leverage components of 2-1-1 systems, community directories, and technology platforms, including in Arizona, Oregon, Ohio and Michigan. North Carolina's statewide coordinated care network, NCCARE360, brings together a resource directory and call center powered by North Carolina 2-1-1, a community repository of resources, and a shared technology platform by Unite Us that enables cross-sector referrals and communication.

Coordinated networks like these provide users with greater insight on resource availability and allocation across health and social services providers, while providing a "no wrong door" approach that closes the loop on social services referrals made.

However, the siloed way in which health care, public health, and social services are paid for and administered often limits such cross-sector coordination and data sharing across health and social service organizations. Breaking down these siloes and incentivizing connectivity and coordination between programs and systems will help to ensure that they are most effective in improving health and wellbeing.

Over the past few years, CMS and HHS have made strong investments and taken significant steps to promote and require interoperability and exchange of health data. However, social services organizations and CBOs have not benefitted from the same level of infrastructure and systems funding, and often experience difficulty in connecting with and sharing information with health care organizations. Many CBOs do not have the capacity to invest in the tools and functionality required to connect with individual providers or other entities that would allow for seamless closed loop referrals and data exchange.

Technological infrastructure is needed to connect these sectors together and ensure that funding can flow where the referrals are going. These investments to connect health care and social services organizations can help to reimburse CBOs, track capacity, and understand the true cost of and where such organizations are successful in addressing basic needs.

We recommend that Congress work with CMS and HHS to promote and catalyze additional efforts to develop statewide or regional, integrated networks that have the infrastructure necessary to exchange data.

Aligning for Health supports the *LINC to Address Social Needs Act (S. 509)*, which was introduced in the Senate earlier this year, as an example of a bill that can address this issue. The bill will assist states in building statewide or regional collaborations to better coordinate health care and social services by leveraging local expertise and technology to help connect people to social services and supports.

The *LINC to Address Social Needs Act* will provide one-time seed funding for states to facilitate cross-sector communication, service coordination and consumer assistance, referral and capacity management, and outcome tracking between social service providers and health care organizations. States, through public private partnerships, may establish or expand existing secure, connected technology networks and provide technical assistance and support to entities in connecting to the network. States will have flexibility to design networks that are responsive to the unique cultures and needs of their state.

This bill will create a new and unprecedented ability to share data and measure the impact of social interventions on health, health care spending, and community wellbeing. It will also allow health and social services organizations to better coordinate care and ensure maximum impact for available resources.

Improving Alignment

- ***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?***

Today's health and social services systems and services are largely siloed, despite clear evidence that social needs can have an impact on overall health and wellbeing. Investments to better align and coordinate between health care and social services providers will yield better, more holistic health outcomes, reduce preventable health costs, and keep the most vulnerable populations from falling through the cracks.

States, local governments, health care providers, payers, social services providers, community-based organizations (CBOs), and others are increasingly seeking to partner to better coordinate care and services. Meanwhile, many states are more deeply integrating social determinants of health strategies within their Medicaid programs, with help from CMS.

However, one of the greatest challenges to high-impact interventions is the difficulty in navigating and coordinating fragmented and complex programs aimed at addressing health care needs, food insecurity, housing instability, workforce supports, and transportation reliability, among others. In particular, the siloed funding, data systems, and administration of many of these programs at the state and local, and nongovernmental, levels create barriers to effective coordination and partnership.

There are several opportunities Congress can turn to when thinking about better coordination and alignment between health and social services organizations.

Bolstering CBO capacity is critical, including by providing CBOs with support and assistance in navigating health care partnerships, and in addressing data sharing exchange and privacy concerns. Partnerships between CBOs and trusted community partners such as community health workers or other health care supports close gaps in care and focus on more upstream challenges – improving outcomes.

An example is a "street team" community outreach initiative launched by the Alliance for Better Health during COVID-19 to share information on vaccine safety and increase vaccination appointments in New York's Capital Region. Trusted community messengers trained by the Alliance for Better Health distributed this information and engaged the community in a community-specific, culturally relevant way. This initiative was funded by the Collaborative Approach to Public Goods Investment (CAPGI) model, where a trusted partner like the Alliance convenes stakeholders to invest in a community-wide benefits initiative. Congress can take a more active role in providing supports to these types of collaborations.

Community information exchange (CIEs) or health information exchanges (HIEs) can be leveraged to connect different types of organizations for data sharing purposes. Congress should consider how to best leverage or develop connective infrastructure in states to capture different data sources across federal and other disparate programs. Additionally, data sets do not always include all patient information, which

can be a challenge in getting the full picture and knowing which individual is receiving which services. Finding ways for SNAP, WIC, housing-related programs, and other federal programs to become part of the claims data system would be helpful in connecting these dots.

In addition to the above opportunities, Aligning for Health supports several pieces of legislation that seek to improve coordination and provide the tools needed for organizations to effectively address social determinants of health. The bipartisan *Social Determinants Accelerator Act* (H.R. 2503) is an example, which would combine targeted technical assistance with grant funding to empower communities to develop innovative, evidence-based strategies to address social needs. Additionally, the bill would create an inter-agency technical advisory council on social determinants of health tasked with identifying and coordinating cross-agency opportunities to improve the health and wellbeing of low-income and at-risk populations and to address SDOH.

Other examples of current legislative approaches that seek to improve coordination, capacity, and evaluation of SDOH initiatives include:

- The **Improving Social Determinants of Health Act of 2021 (H.R. 379),** which would establish a social determinants of health program at the Centers for Disease Control and Prevention and would provide grants to public health agencies and CBOs to address social determinants of health.
- The **Social Determinants for Moms Act (H.R. 943)**, which would develop a strategy and coordinate federal efforts to understand and address social determinants of maternal health with respect to pregnant and postpartum individuals.
- The **Collecting and Analyzing Resources Integral and Necessary for Guidance (CARING) for Social Determinants of Health Act (H.R. 3894)**, which would require the Secretary of HHS to provide guidance and technical assistance to states on how to address social determinants of health through Medicaid and CHIP.
- The **Care That's Fair Act (H.R. 4554),** which would empower states to utilize medical claims, clinical, and social data to address racial disparities, SDOH, and maternal health.
- The **LINC to Address Social Needs Act (S. 509),** which would establish statewide or regional partnerships to better coordinate health care and social services.

- ***How could federal programs such as Medicaid, CHIP, SNAP, WIC, etc. better align to effectively address SDOH in a holistic way? Are there particular programmatic changes you recommend?***

Improving coordination of federal programs and services is critical to removing certain barriers faced by individuals in accessing needed benefits and services. We encourage Congress to consider advancing policies and strategies that would help to coordinate eligibility and enrollment processes for cross-sector programs. Examples could include:

- Provide flexibility and/or additional funding to states to cross-train and leverage community health workers, eligibility support workers, Navigators, social workers and others to assist with eligibility and enrollment processes, referrals, and other supports and services. Doing so will help individuals to be able to support applicants in understanding, applying for, and enrolling in multiple benefit programs, or to help provide referrals to other non-governmental support.
- Encourage states to integrate and align eligibility and enrollment processes for benefit programs. This could include use of an integrated application and eligibility system, or expansion of express lane eligibility initiatives to include additional populations, and allowing individuals to jointly apply

for and enroll in programs such as Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and Medicaid, among others.
- Streamline applications for federal programs and enable data sharing across programs that serve the same populations.

Additionally, it is important to ensure that government programs can also help to support the so-called ALICE population, or those that are Asset Limited, Income Constrained, and Employed, who may not qualify for government assistance programs but are still considered "working poor." Individuals in this population are working, but the high cost of transportation, child care, cost of living, employer-sponsored insurance, and other aspects often means such individuals live paycheck to paycheck. Congress could consider approaches to mitigate the "cliff effect" for those reaching ineligibility for programs like SNAP and WIC and to ensure resilience within this population.

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

Comprehensively screening for both health and social needs will allow providers and other clinicians to gain a better understanding of individuals' full story and the barriers that may impact their health and wellbeing. However, social needs screening and referrals have not traditionally been a part of health screenings and such data is often not collected in a standardized way, making it difficult to integrate into health records, to share across coordinated entities, or to use for purposes of risk adjustment. We recommend that Congress take steps to ensure that individuals are comprehensively screened for both their health and social needs, that the data can be seamlessly collected and exchanged across programs, and to provide training, education, and resources for providers and others to make social needs referrals.

Transformative Actions

- ***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?***

Aligning for Health's members have established innovative public and private sector partnerships and instituted groundbreaking strategies to improve overall health outcomes by better addressing social needs and social determinants.

For example, UPMC's Cultivating Health for Success program is a Pay for Success program that works with community service partners through the Pennsylvania Department of Housing and Urban Development to provide stable housing and care management to members experiencing homelessness. The program blends US Department of Housing and Urban Development (HUD) Continuum of Care (CoC) program and voucher dollars with UPMC funding to support these members in need, through providing an opportunity to have regular visits with a primary care doctor for preventive care and resources to help find stable, permanent housing or other supports. The program has resulted in 85 percent of enrolled members finding stable housing and a 42 percent decrease in unplanned medical care.

Many of these models rely on value-based arrangements, which provide needed flexibility to support care that is patient-centered, and which align incentives among participants. We believe that breaking down the siloes and incentivizing coordination between programs and systems will help to ensure that they are

most effective in improving health and wellbeing. We have encouraged CMS to continue to leverage the Center for Medicare and Medicaid Innovation to pilot models that address social needs, and encourage states' efforts to develop value-based arrangements and demonstrations through their Medicaid programs.

For example, Pennsylvania has created Regional Accountable Health Councils (RAHCs), intended to serve as forums for strategic health planning to coordinate activities that promote equity, address regional SDOH needs, and improve value. The long-term goal is to use RAHCs to help align value-based payment arrangements across payors. The state has also added new provisions to MCO contracts requiring plans to incorporate CBOs into moderate and high-risk value-based arrangements in an effort to address SDOH. Additionally, the North Carolina Department of Health and Human Services launched the Healthy Opportunities Pilots, through its Medicaid section 1115 demonstration waiver. The pilots will test and evaluate the impact of providing select evidence-based, non-medical interventions related to housing stability, food insecurity, transportation access, and interpersonal safety to high-need Medicaid enrollees.

Additionally, there are a number of state Medicaid programs that have begun to focus on outcomes and compare how providers are doing against a norm to ensure similar types of patients are receiving similar types of care. States like New York, Maryland, Florida, and Texas have adopted outcomes-based measures to compare expected to actual rates of potentially avoidable hospital admissions, readmissions, and ER visits. These outcome measures, which typically encompass data elements that are already part of claims data, can be risk adjusted to better identify and highlight inequities in outcomes based on race, gender, ethnicity, and other demographic factors.

Other states are using the application and procurement process to ensure Medicaid MCO partners and contractors incorporate a focus on social determinants. In the certification application for Rhode Island's Accountable Entities, for example, applicants are required to demonstrate the capacity to address social determinants by describing how they identify social needs and track and follow-up on social determinant-related referrals.

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Thank you again for the opportunity to provide comments on this important issue. Please do not hesitate to let us know if you have any questions. Please contact Chris Adamec at cadamec@aligningforhealth.org if Aligning for Health can be a resource to the Congressional Social Determinants of Health Caucus.