GoHealth™

Uncovering Medicare Needs Through Member Care Assessments

The role of Member Care Assessments in developing personalized member journeys and identifying gaps and inequalities in healthcare

TABLE OF CONTENTS

60-SECOND SUMMARY

- Member Care Assessments (MCAs) are health-related surveys administered to a member of a health plan.
- At an individual level, MCA data can be used to create personalized care journeys by identifying and connecting members to benefits that best address their needs. This high degree of personalized membership engagement helps drive Star Ratings for health insurance plans.
- At a population level, MCA data can identify inequality in the health system and gaps in plan benefits. Discovering health inequalities and gaps in offerings are useful for showing plans and provider groups member needs at an aggregate level.
- To achieve this level of insight from MCAs, they are designed with member and strategic priorities in mind, partnerships are established to effectively leverage MCA data, and cost, timeliness, and completion rates are weighed when selecting administration method. MCAs are regularly conducted to ensure up-to-date awareness of member needs, and develop robust data governance tools.

INTRODUCTION TO MCAs

What They Are

Over the past decade, healthcare organizations have been challenged by the lack of a cost-effective and timely means of identifying clinical and social needs early in their members' health journeys. MCAs were born to identify these unmet needs. MCAs are surveys typically administered by health plans or insurance brokers to learn about members' health needs and personalize engagement. This survey is often administered to Medicare and Medicaid enrollees. Used to trigger member engagement, MCAs often produce the following types of data:

- Physical Health-Related Conditions (emergency room admissions, chronic conditions, alcohol consumption)
- SDOH (food insecurity, transportation needs, health literacy)
- Prescription and Pharmacy Access (pickup preferences, affordability, vaccinations)
- Extra Benefit Needs & Mental Health (dental, fitness, loneliness, anxiety)

What They Aren't

For the purposes of this whitepaper, the term MCAs describes the questionnaires used to screen members for a variety of social determinants of health (SDOH) and health preferences, which are used to activate member engagement. That said, the industry is still aligning on verbiage in this space. Specifically, the terms MCAs, value-based enrollments (VBEs), and health risk assessments (HRAs) are sometimes used interchangeably. The term VBE is essentially another term for MCAs. GoHealth views HRAs as encounter-focused appointments, executed by a provider, which are often completed well after point of enrollment. However, not all members are heavily targeted for HRAs. MCAs, along with carrier HRA specifications, may be used to drive segmentation for conducting HRAs. One of the benefits or pairing HRAs with an AWVs is that they can be used to help inform risk adjustment. AWVs refer to the annual provider visit that all members are encouraged to attend. Completing AWVs is key in member satisfaction in their plan and in preventative care.

When comparing MCAs with HRAs, their different purposes become clear, including targeted member segment, data types, collection method, and timeline.

	Member Care Assessments (MCAs)	**Health Risk Assessments (HRAs)**
Used For	Segmentation for personalized engagement	Segmentation and risk adjustment
Completed For	All members	Goal to reach all members, but only those who are high-risk or do not currently leverage regular care routines (regular primary care physician or PCP appointments) are heavily targeted
Types of Data Collected	✓ Self-reported data on chronic conditions ✓ Member preferences ✓ SDOH needs	✓ Diagnostic ✓ Physical Health ✓ Mental Health ✓ Historic Health Records ✓ Family Health History ✓ Demographic Data
Completed By	Licensed or non-licensed professionals (brokers, carriers), or the member	Licensed medical professionals (providers), or self-reported if the member has diagnostic devices in-home
Place in Member Journey	Very early in member experience (e.g., at point-of- sale, pre-effectuation) 	Later in member experience (e.g., post-effectuation) 

MCAs help segment high acuity members for targeted engagement to address specific care needs. Unlike MCAs, HRAs are designed to collect information for clinical coding to generate risk scores, which predict an individual's healthcare costs. The risk scores for enrollees in a plan impact the plan's overall risk adjustment, which is critical to ensure adequate compensation for health plans to fund care for their members. MCAs can be completed by licensed or non-licensed professionals (e.g., brokerage agents), whereas HRAs are administered by certified health professionals. Both can be self-reported by the member when the right equipment is available (e.g., HRAs require basic medical tools to collect vitals and assess physical health). HRAs are typically more costly than MCAs, and they occur later in the member journey.

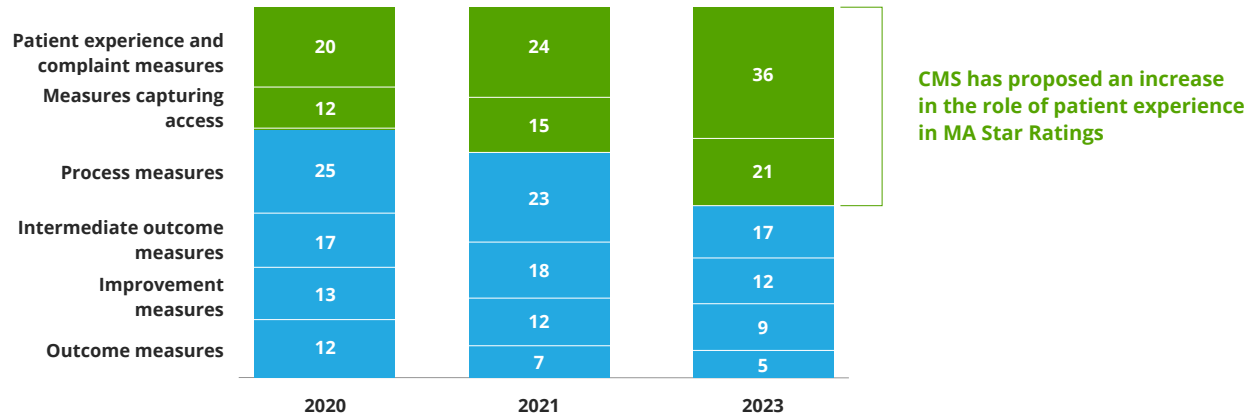
USE CASES OF MCA'S

Primary – Inform Member Engagement

MCAs are a door to enabling personalized and coordinated comprehensive care services for members once they are enrolled in a Medicare Advantage plan. The industry has acknowledged that needs among Medicare Advantage members vary greatly. A 65-year-old new to Medicare member with a pre-existing chronic condition, an 80-year-old dual eligible Medicare and Medicaid member, and a 90-year-old member with dementia living alone, have vastly different needs and expectations. Data captured from MCAs provides net new insight into a member's health and well-being, which is used to segment membership and drive meaningful, tailored engagement journeys that address the identified needs.

Creating a personalized member journey and outreach plan is essential, as member experience heavily impacts Star Ratings. Star Rating performance data comes from surveys, administrative data, claims data, and clinical data. The chart below shows which specific measures impact Star Ratings. As shown, over the next two years, CMS plans to shift the weighting of different measures that contribute most heavily to Star Ratings. The measures related to member engagement and experience are expected to rise in proportion.

Relative Weight of Quality Measure Types in MA-PD Star Ratings, %[1]

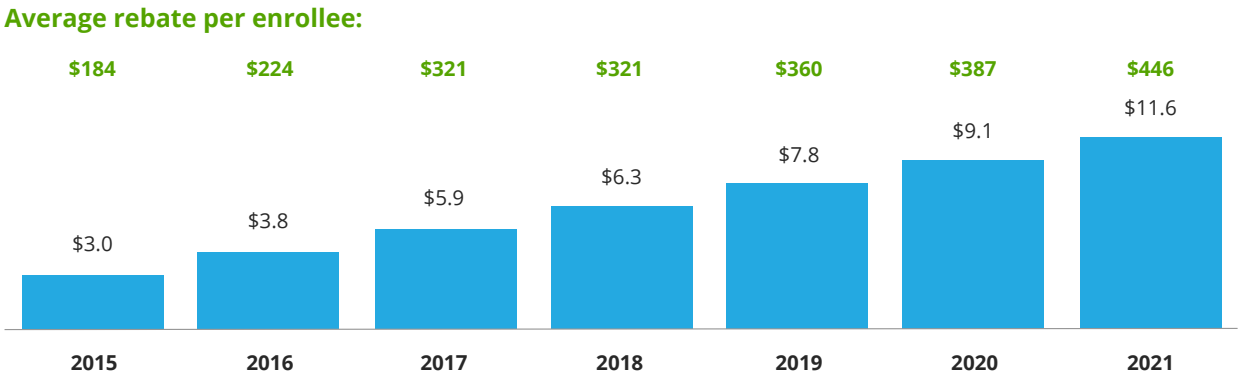


Source: CMS analysis of Medicare 2020 Part C & D Star Ratings Technical Notes, 2019

Star Ratings are important because they impact both quality bonus payouts (QBPs) and rebate percentages insurers receive from CMS. QBPs were mandated as part of the Affordable Care Act (ACA) to be paid out for all contracts that earn a certain number of Stars in Medicare's Star Rating program. These bonuses have quadrupled in the past six years, as the number of plans receiving bonuses and the number of enrollees in these plans have both increased.[2]

$11.6B in Stars-based bonuses were paid to MA Plans in 2021

Total Medicare Advantage Plan Bonuses, 2015-2021 *(in billions)*



Source: KFF analysis of CMS Enrollment and Plan Quality and Performance Ratings Files, 2015-2021

The ACA also tied rebates to Star Ratings, which determine the percentage of CMS savings (the difference between MA plans' bids and benchmarks) returned to plans as rebates. Higher Star Ratings increase the size of the rebate. **MCAs are the first step in heightening personalization of the member experience, which is required to drive improved Star Ratings performance and receive larger quality bonus payouts and rebate percentages.**

Ways to leverage MCAs to inform how to interact with members:

1. Scheduling provider visits

Understanding which members don't have a regular doctor and haven't visited the doctor in the past year can help inform the likelihood of canceling their plan and therefore drive outreach to engage members to ensure they are prepared to successfully utilize their benefits and receive required care. This scenario could look like triggering a personalized care pathway to help schedule an appointment with a PCP to address immediate needs and perform preventative care.

Members' feelings toward their PCP experience drive retention. Members who keep their existing PCP, versus those who select a new PCP at the point-of-sale, have different PCP support needs. While the member who sticks with their existing PCP is likely comfortable

with the existing scheduling process, members who switch into a new PCP often benefit from additional assistance. Switching PCPs can be a confusing and frustrating process. When looking at cancellation numbers, GoHealth found PCP-related frustrations are among the top reasons members cancel their plan. Setting up initial PCP appointments helps decrease cancellation rates.

2. Insights and education for chronic disease management

Learning a member's existing chronic conditions can help predict health outcomes, and therefore drive outreach. Almost 70% of adults over the age of 65 have two or more chronic conditions[3]. MCAs help carriers understand members' chronic conditions earlier than claims data, which is important in proactively reaching out to manage care and reduce costs (and create a greater margin on the member). Even though member self-reported medical information can be inaccurate, the data can still be utilized by incorporating a measurement error that, together with the member's responses, can inform the creation of a customized member engagement journey. Many members with chronic conditions benefit from streamlined care with a PCP guiding specialist referrals. Payers and brokers can trigger follow-up calls to inquire how satisfied the member is with their care team and help make additional referrals as deemed necessary.

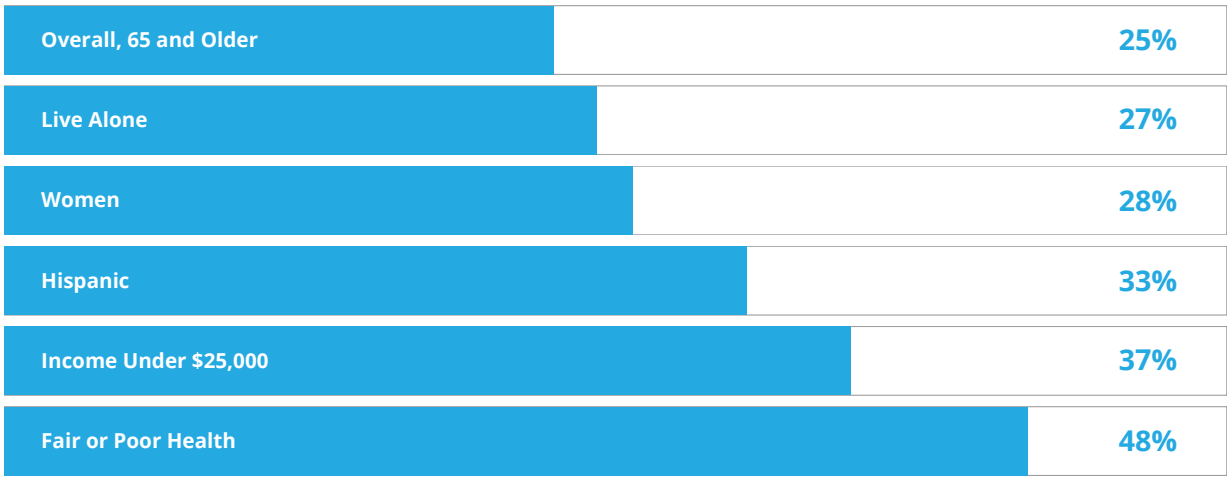
Understanding a member's conditions and prescriptions can improve member health and plan Star Ratings. For example, MCAs can be used to help segment members with diabetes, hypertension, and/or high cholesterol. Targeting these members for enrollment in 90-day prescription delivery is important because the three conditions are triple weighted for medication adherence Star Ratings, and they impact several Part D and Part C measures. This segmentation can then help trigger follow-up calls to learn how they are currently managing their condition, assure 90-day deliveries are set up for the prescriptions to enhance adherence, and offer additional solutions that address their condition needs.

Understanding the member's home environment and risks can lead to successful interventions. For example, knowing the number of times a member has fallen recently can help predict the likelihood of hospitalization, and therefore drive outreach to the member to decrease fall risk and identify what facilities are best in case a fall occurs.

3. Identification for behavioral health

Determining which members are part of the 24-48% of members who have felt lonely, depressed, or anxious in the last month can trigger outreach. The behavioral and mental health industry is flooded with digital solutions, online programs, and in-person support groups. Payers and brokers work with these health organizations to determine the right program based on member needs and preferences.

A Quarter of Older Adults Reported Anxiety or Depression Amid the Coronavirus Pandemic, While Some Groups Reported Higher Rates



NOTE: Analysis is among adults age 65 and older. Self-reported health status. Adults of Hispanic origin may be of any race, but are categorized as Hispanic for analysis. All other groups are non-Hispanic.

Source: KFF analysis of U.S. Census Bureau's Household Pulse Survey, August 19-31, 2020

As shown in the graphic by KFF, mental health is worse for members who have poor health, are low income, are from diverse backgrounds, are women, and who live alone.[4] MCAs help identify if a member falls into one of these categories to help inform how much to focus on behavioral health solutions.

4. Referrals for SDOH

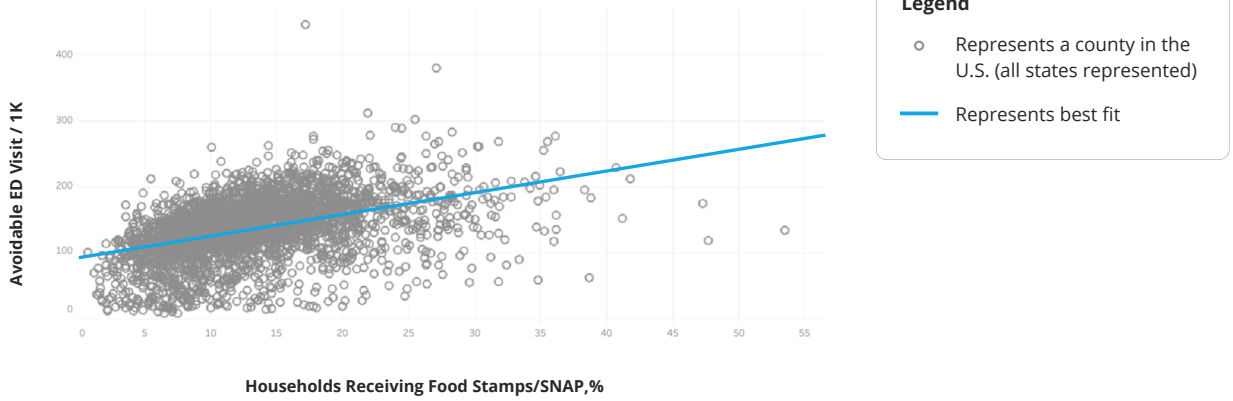
Understanding a member's SDOH needs can help inform anticipated health outcomes and drive outreach to refer members into local community-based organizations to receive support. SDOH are the conditions in which people are born, work, and age. Developing approaches to reduce health disparities caused by social determinants is another way MCAs help achieve health equity[5]

At GoHealth, while only ~28% of members are on Medicaid, over 63% of members have used food assistance programs in the past year. Meal needs span from lacking access to healthy food to lacking the financial ability to pay for food. Medicare Advantage plans may provide more comprehensive SDOH coverage for members than traditional Medicare. According to KFF, 39% of Medicare Advantage plans include a meal benefit.[6] There are many SDOH gaps that are yet to be successfully closed and should be explored in the coming year.

Higher Food Insecurity Correlates to an Increase in Avoidable ED Visits

X Axis: **Households Receiving Food Stamps/SNAP,%**

Y-Axis: **Avoidable ED Visit/1K; State: All**



This graph developed in 2019 by Care Journey[7] shows that as the percentage of households who rely on food stamps increases, the likelihood of avoidable emergency department (ED) visits also increases. This is a great example of how unmet SDOH needs drive up the cost of healthcare for carriers. According to value-based care provider, Chen Med, SDOH "represent an enormous economic burden, an estimated $93 billion in excess medical costs and $42 billion in lost productivity every year[8]."

UnitedHealthcare's Chief Consumer Officer, Rebecca Madsen comments on the importance of SDOH

"Today and historically, we know that Social Determinants are a substantial part of overall health. In our mission to help members lead healthier lives, we want to make sure that we are not only looking at the clinical aspect but also the entire individual." [9]

5. Supporting pharmacy needs

Learning about a member's pharmacy preferences can help inform which pharmacy solution is best suited for each person. Pharmacy offerings are expansive and getting the pharmacy selection right is important to driving retention on a Medicare or Medicaid plan. Several of the many choices that the member faces include:

- How to get the prescription – in the mail, delivered by courier, in-person pickup
- Where to get the prescription – from pharmacy at local drug store, from carrier preferred pharmacy (e.g., Humana Pharmacy Home Delivery), from big tech (e.g., Amazon PillPack)
- How often to pick up prescriptions – once monthly for routine, sporadically throughout the month as refills become available

MCAs enable stakeholders to identify those with SDOH needs, which can trigger immediate referrals into a local community-based organization that has the resources to help.

Secondary – Identify Health Inequalities

MCAs play a major role in supporting health equity attainment, which is achieved when every person has the opportunity to reach their full health potential and no one is disadvantaged from the ability to reach this potential due to social position or other socially determined circumstances.[10] The CMS Equity Plan for improving quality in Medicare was developed to provide an action-oriented, results-driven approach for advancing health equity by improving the quality of care provided to minority and other underserved Medicare beneficiaries.

The foundational framework of the CMS Equity Plan consists of three interconnected domains:[11]	**GoHealth supports the CMS Equity Plan for Medicare by:**
Increasing understanding and awareness of disparities	Increasing awareness of inequalities based on MCAs and equipping community-based organizations with needs-based segmentation to inform outreach
Creating and sharing solutions	Hiring agents who speak in languages most common to the area they are serving, offering MCAs in different languages; developing eminence in the SDOH space to increase understanding of gaps and proposed solutions
Accelerating implementation of effective actions	Leveraging MCA data and an understanding of effective programs and organizations, such as many VBC players, to help members in need find programs that cater to their accessibility, preferred provider demographic, and affordability

Dr. Lisa Cooper's published "Why Are Health Disparities Everyone's Problem?" in Summer 2021

"Health is determined by far more than a person's choices and behaviors. Social and political conditions, economic forces, physical environments, institutional policies, health care system features, social relationships, risk behaviors … many of these factors are derived from a lingering history of unequal opportunities and unjust treatment for people of color and other vulnerable communities. But they aren't the only ones who suffer because of these disparities—everyone is impacted by the factors that degrade health for the least advantaged among us."

Dr. Cooper's writings remind the country that health equality will benefit all, not only those on the fringes. Dr. Cooper is an internal medicine physician and health services researcher who was among the first to document how doctor-patient relationships can help overcome racial and ethnic disparities in healthcare. In September 2021, President Biden appointed her to be on his Council of Advisors on Science and Technology.

MCAs are one of the many tools that can effectively help uncover, address, and circumvent health inequality.

Tertiary – Inform Plan Design

A tertiary use of MCA data is to inform future plan design by analyzing population level MCA data and anecdotal feedback from agents. **Understanding high-level results of MCAs shed light on how carriers could evolve their plans in the future to ensure they remain competitive.** MCAs indicate demand for benefits and help identify the extra benefits that members would use most often.

1. When agents are administering MCAs, they dive a level deeper into member needs. For example, transportation is a common "extra benefit," however, GoHealth has found that most transportation benefits do not comprehensively meet member needs. They often only offer transportation to and from a specified number of doctors' appointments, when members need help getting to the grocery store, pharmacy, and around town.

2. 55% of GoHealth members need major dental procedures in the next 6-12 months, while only 33% of members have seen their dentist in the past 12 months, proving a clear need for more preventative care. According to KFF, "Almost half of all Medicare beneficiaries did not have a dental visit within the past year (47%), with higher rates among those who are Black (68%) or Hispanic (61%), have low income (73%), or who are in fair or poor health (63%)."[12] Very high out-of-pocket costs keep many members from receiving the major dental procedures they require. Carriers should keep in mind and account for this variation in dental visits based on race / ethnicity. Compared to all Medicare products available, Medicare Advantage members already receive some of the best support for major dental procedures, despite the annual dollar cap that most plans impose and limitations on procedures covered by the plan.[13]

This analysis on transportation and dental data from MCAs is an example of how carriers can leverage knowledge yielded through MCA data to inform plan design in the future. MCA data can help carriers inform where to focus their member engagement efforts and their future plan design. Based on MCA data, organizations can determine which referral is right for each member. It is important to have an intentional MCA strategy in place.

Anthem acknowledges the need for flexible plan design

Anthem allows Medicare Advantage members to choose one or two "Essential or Everyday Extras" to tailor their plan to best suit their needs. Their wide variety of options allow members to select the benefits that best fit their needs.

Essential or Everyday Extras at Anthem includes:

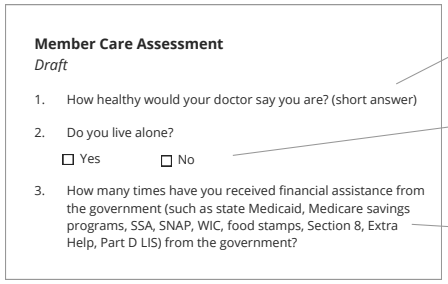
- ✓ **Healthy Meals**
- ✓ **Assistive Devices**
- ✓ **Fitness Trackers**
- ✓ **Home Helper**
- ✓ **Transportation**
- ✓ **In-Home Support**
- ✓ **Grocery Card and more**

BEST PRACTICES OF MCAs

Design of MCAs

When looking at the design of MCAs, including a small number of simple questions that are highly predictive in nature is an industry best practice. By first defining the purpose of the question, and then designing the question set, organizations can limit the number of questions while simultaneously increasing the value of the data. The visual to the right shows questions to ask when deciding which questions to include in an MCA.

Illustrative MCA Edits



Ask simple questions.
- ✓ In general, how would you rate your health? (same multiple choice answers: Excellent, very good, good, fair, poor)

Ask questions where self-reporting has a high probability of accuracy.
- ✓ How often do you feel alone? (multiple choice: Never, rarely, sometimes, often, always)

Ask questions that allow you to understand the bigger-picture and aren't too specific.
- ✓ Have you used food assistance programs in the last year? (Y/N)

Some carrier MCA question sets may be upwards of 70 questions in length, requiring over 60 minutes to complete. Other carrier MCAs only have 3 questions and are completed online by the member in seconds. Typically, narrowing down the number of questions asked, while asking impactful questions is a best practice. Tailoring MCAs to member needs and to drive insight into what matters most for your organization should drive the design of MCAs.

Enabling Partnerships

Having referral pathways in place to leverage MCA data effectively and address the needs identified often requires strategic partnerships. Sharing MCA data with those best positioned to act downstream is important. An alternative to sharing data is setting up quality referrals downstream, which is a critical part to the success and effectiveness of using MCA data. However, organizations face difficulty in successfully following back up with the member to ensure fulfillment of the appropriate care and services. This creates a challenge in knowing which referrals are most effective and lack of clarity on where to send members next.

GoHealth has established a strategic partnership with FindHelp, which equips GoHealth TeleCare agents with connections to community-based organizations in all 50 states. This partnership equips GoHealth with the resources to respond to the MCA. FindHelp is an online platform, with 1,300+ resources in each county and over 300,000 free or reduced cost programs nationwide. Each of these 300,000+ programs belong to a Community Based Organization (CBO) with different offerings available, different eligibility requirements, and different referral preferences. All of these options are confusing for members to navigate. GoHealth leverages the FindHelp platform and the TeleCare enablement platform to help match members to the local program that best suits their SDOH needs. GoHealth agents are trained to have SDOH conversations with members, which is essential to effectively making SDOH referrals.

Administration of MCAs

There are several ways in which MCAs can be completed. When assessing the options, there are three key considerations:

- **Cost:** Completing MCAs for all members regardless of segmentation or condition is recommended. However, due to the sheer volume of members, managing cost per MCA is key.
- **Timeliness:** Collecting MCAs quickly upon becoming a member (near the point-of-sale) is important because needs identified are often emergent.
- **Completion Rate:** MCA data is a crucial driver in the member journey, completing MCAs for as many members as possible helps carriers and brokers have a comprehensive understanding of their member base.

		Cost	Timeliness	Completion Rate
Administered by a Human	Telephonic	High Cost	Quick	High Completion
	In-person at affiliate events and care settings	High Cost	Slow	Average Completion
Self-Service	Telephonic powered by IVR	Mid Cost	Quick	Average Completion
	Online survey administered through text or email	Low Cost	Quick	Low Completion
	Mail-in form	Low Cost	Slow	Average Completion

As shown above, MCA administration and collection is complex. Leveraging a multichannel strategy can help increase response rate while managing costs. When considering agent workforce, industry dynamics make insurance brokers uniquely well-positioned to administer MCAs and own more of the process, which has historically been the responsibility of carriers. Brokers have ramped up agent capacity for the Annual Enrollment Period (AEP) and the technological infrastructure in place to administer MCAs.

Regardless of owner and method of administration, organizations should keep in mind that MCAs ask members about sensitive and personal topics. As a result, building a level of trust with the member is important. Therefore, effectively communicating the purpose of the survey, possibly diving into a bit of the details around how the data will help streamline care management and navigation, is key in helping the member feel comfortable completing the MCA.

Frequency of MCAs

Today, MCAs are completed soon after a member enrolls in a new Medicare and/or Medicaid plan. As discussed, this informs how the carrier and broker should engage with the members to ensure they are satisfied with their plan. In the future, most carriers will transition to completing MCAs on a more regular basis (e.g., annually). This is necessary to track the evolutions in members' health, socioeconomic status, and satisfaction with plans. Members' needs and preferences will evolve over time. In addition, it is important to maintain touchpoints with the members over time. A higher frequency of MCAs being administered will also drive carriers to explore different ways to get MCAs into the hands of members and leveraging digital solutions will be essential.

Data Governance and Integrity

Creating a robust data management and analytic strategy helps get the most out of an MCA. Establishing the right processes in place to effectively capture, accurately interpret, and efficiently respond to the data is another challenging but critical part to the success of MCAs.

Developing data governance and data quality programs for MCA data also comes with its similarly unique challenges. Some organizations have teams entirely focused on MCA data to ensure it is collected, stored, and leveraged effectively while maintaining compliance. Comprehensive data governance is required to enable the personalized member engagement journey.

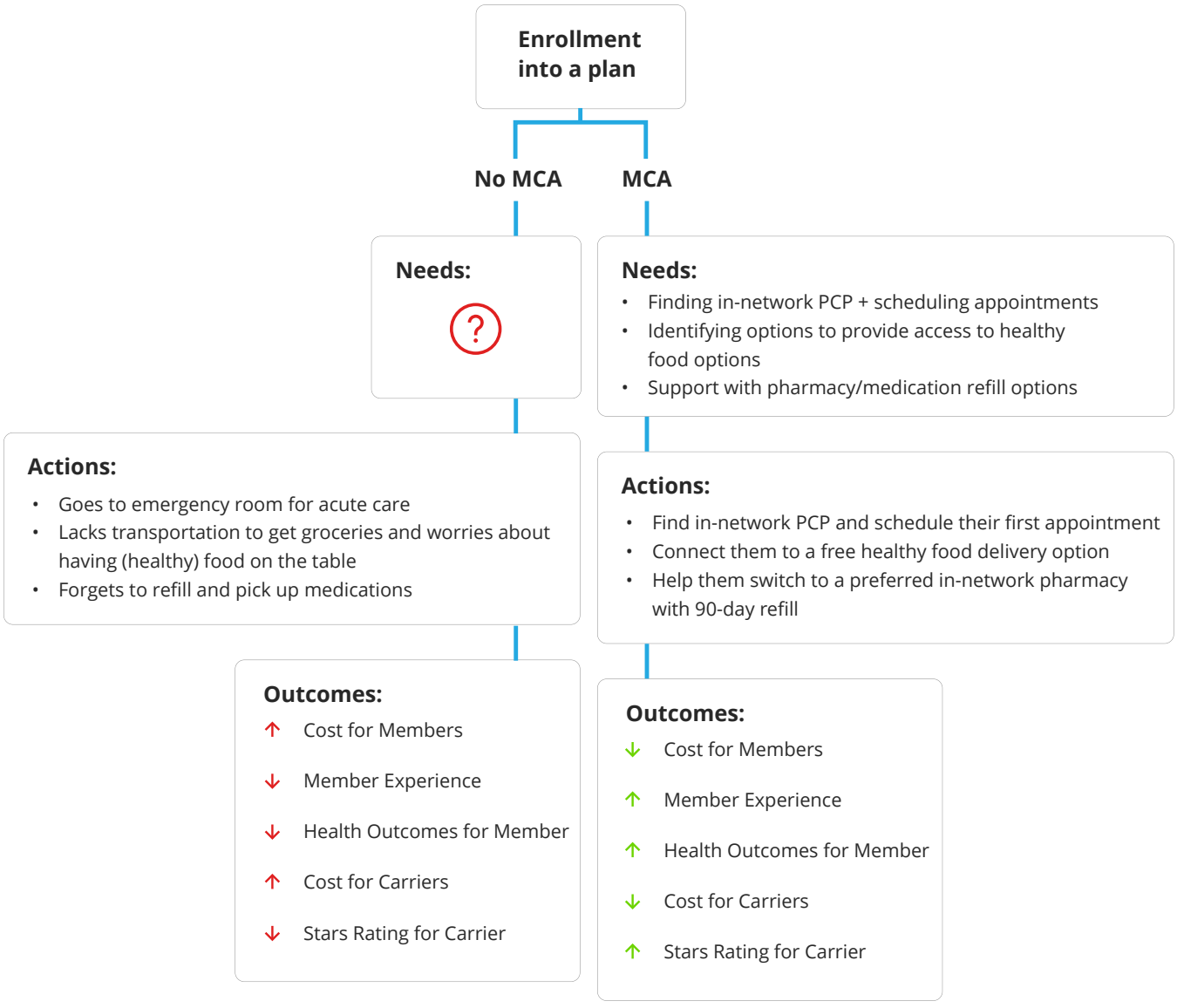
Designing an MCA with intentional guardrails in place to increase the integrity and trustworthiness of the data coming in is essential. For a variety of reasons, such as mistrust, poor health literacy, and fear, members incorrectly self-report MCA answers. Establishing a relationship with the member, tweaking verbiage to be in a language that the member understands, and explaining how the data in the MCA will be used are several ways to combat inaccurate self-reporting. As discussed previously, designing the MCA to include questions that members feel comfortable answering is also key.

Overall, developing a best-in-class MCA strategy takes years of iteration and dozens of minds working together. Following the best practices above can help organizations looking to roll out their own MCA and other risk assessments.

EXAMPLE SCENARIO

Without MCAs, carriers and digital health companies providing care struggle to know what to engage members on because their needs are not fully identified. There are an innumerable number of ways to support members. Without MCAs, some member's needs and conditions slip through the cracks, leading to a poor and costly experience for members and carriers.

With MCAs, organizations are better able to target their outreach based on the members' identified needs. With MCAs, members' most pressing needs can quickly be addressed in a cost-effective manner before symptoms worsen. This leads to members who are satisfied with their plan and fully leveraging their benefits, while not driving up costs for carriers.



CONCLUSION

The healthcare industry increasingly relies on data to inform segmentation, drive meaningful engagement, and address member care needs. MCAs raise awareness of conditions, identify gaps in care, and trigger personalized care journeys. While a tool to source the data proves to be promising, how to design and leverage results from MCAs to best address member needs remains a challenge. Over time, MCA questions and use cases will evolve to meet the ever-changing member demands and to better fit into the holistic member care experience. As MCA data reveals insight into member needs, health inequities and plan gaps will be revealed, leaving a new gap for the industry to close. As healthcare starts to see more alignment of incentives across stakeholders, the industry is learning to better address holistic health and improve senior healthcare.

GoHealth remains committed to serving as a trusted advisor to seniors, helping them navigate the healthcare ecosystem and addressing their individual needs. GoHealth's Encompass Platform, fueled by MCA data, provides carriers and members with robust member engagement solutions that fill unmet needs across the industry. GoHealth is proud to play a role in improving the health of seniors in America.

ABOUT GOHEALTH

GoHealth is a leading health insurance marketplace and Medicare-focused digital health company. We unravel the confusing details of health insurance and Medicare to make every piece easier for you. GoHealth's goal is to help you reach optimal health and financial wellness, starting with enrolling you in a plan that best meets your needs at the right cost.

And we don't stop there. After enrollment, we help people utilize their plan and support them along their healthcare journey from checking benefits, explaining claims, finding doctors/ specialists, and even setting up appointments.

We're here to help. Please visit our website to learn more about GoHealth's industry-leading Encompass platform.

partnerships@GoHealth.com

THANK YOU

GoHealth's mission is to improve access to healthcare in America. Enrolling in a health insurance plan can be confusing for customers, and the seemingly small differences between plans can lead to significant out-of-pocket costs or lack of access to critical medicines and even providers. GoHealth combines cutting-edge technology, data science and deep industry expertise to match customers with the healthcare policy, carrier, and benefits that are right for them. Since its inception, GoHealth has enrolled millions of people in Medicare plans and individual and family plans.

For more information, visit www.gohealth.com.

Contacts
Investor Relations, IR@gohealth.com
Media Relations, pressinquiries@gohealth.com

APPENDIX

1. https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/Star-Ratings-Technical-Notes-Oct-10-2019.pdf
2. https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-star-ratings-and-bonuses/
3. https://www.ncoa.org/article/the-top-10-most-common-chronic-conditions-in-older-adults
4. https://www.kff.org/medicare/issue-brief/one-in-four-older-adults-report-anxiety-or-depression-amid-the-covid-19-pandemic/
5. https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH_Dwnld-CMS_Equity-PlanforMedicare_090615.pdf
6. https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2020/
7. https://go.carejourney.com/jumpstart-sdoh-acs?submissionGuid=ee-1b616a-f86c-498f-9398-a587dc4775ae
8. https://www.chenmed.com/blog/addressing-health-disparities-good-policy-and-good-medicine
9. https://www.healthleadersmedia.com/clinical-care/unitedhealthcare-boosts-efforts-address-social-determinants-health
10. https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/overview/healthequity.htm
11. https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH_Dwnld-CMS_Equity-PlanforMedicare_090615.pdf
12. https://www.kff.org/medicare/issue-brief/medicare-and-dental-coverage-a-closer-look/
13. https://www.kff.org/medicare/issue-brief/medicare-and-dental-coverage-a-closer-look/


GoHealth