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Racial, Ethnic, and Gender Disparities in Health Care in Medicare Advantage

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Office of Minority Health
in collaboration with the RAND Corporation

Contents

Executive Summary

Racial, Ethnic, and Gender Disparities in Health Care in Medicare Advantage

This report describes quality of health care received in 2017 by Medicare beneficiaries enrolled in Medicare Advantage (MA) plans nationwide (30.6 percent of all Medicare beneficiaries). The report highlights racial and ethnic differences in health care experiences and clinical care, compares quality of care for women and men, and looks at racial and ethnic differences in quality of care among women and men separately.

The report is based on an analysis of two sources of information. The first source is the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey, which is conducted annually by the Centers for Medicare & Medicaid Services (CMS) and focuses on experiences with the health and drug plans (e.g., ease of getting needed care, how well providers communicate, and getting needed prescription drugs) of Medicare beneficiaries across the nation. The second source of information is the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS collects information from medical records and administrative data on the technical quality of care that Medicare beneficiaries receive for a variety of medical issues, including diabetes, cardiovascular disease, and chronic lung disease. A comprehensive list of measures included in this report appears on p. viii. Scores on CAHPS measures are case-mix adjusted, as described in the appendix. HEDIS measures are not case-mix adjusted.

Distribution of Race, Ethnicity, and Gender Among Medicare Advantage Beneficiaries

In 2017, an estimated 69.5 percent of all MA beneficiaries were White, 13.8 percent were Hispanic, 9.9 percent were Black, 4.3 percent were Asians or Pacific Islanders (API), 2.1 percent were multiracial (not included in this report), and 0.4 percent were American Indians or Alaska Natives (AI/AN), compared with 76.1 percent, 8.5 percent, 8.9 percent, 3.6 percent, 2.3 percent, and 0.6 percent, respectively, in the general Medicare population. An estimated 56.3 percent of all Medicare Advantage beneficiaries were female and 43.7 percent were male, compared with 54.1 percent and 45.9 percent, respectively, in the general Medicare population.

Racial and Ethnic Disparities in Health Care in Medicare Advantage

With just one exception, MA beneficiaries in racial and ethnic minority groups reported experiences with care that were either worse than or similar to the experiences reported by White beneficiaries (see figure on p. ix). Compared with White beneficiaries, AI/AN beneficiaries reported worse[1] experiences on 1 measure and similar experiences on the other 6 measures. API beneficiaries reported worse experiences than Whites on 6 measures and better experiences on 1 measure. Black beneficiaries reported worse experiences than Whites on 2 measures and similar experiences on the other 5 measures. Likewise, Hispanic beneficiaries reported worse experiences than Whites on 2 measures and similar experiences on the other 5 measures.

Racial and ethnic disparities were more variable for the clinical care measures than for the patient experience measures (see figure on p. x). API beneficiaries received worse clinical care than Whites for 3 measures but received care of similar quality for 16 measures and better quality for 14 measures. Black beneficiaries received worse clinical care than Whites for 14 measures but received care of similar quality for 16 measures and better quality for 3 measures. Hispanic beneficiaries received worse clinical

[1] Here, “worse” and “better” are used to characterize differences that are statistically significant and exceed a magnitude threshold, as described in the appendix. “Similar” is used to characterize differences that are not statistically significant, fall below a magnitude threshold, or both.

care than White beneficiaries for 13 of 33 measures but received care of similar quality for 14 measures and better quality for 6 measures.[2]

Gender Disparities in Health Care in Medicare Advantage

In general, the quality of care received by women and men was similar. Women and men reported similar experiences with care for all measures of patient experience (see figure on p. xi). Clinical care received by women and men was of similar quality for 23 of 29 measures.[3] For the 6 remaining measures, women received worse care than men for 4 measures and better care for 2 measures.

Racial and Ethnic Disparities by Gender in Health Care in Medicare Advantage

Patterns of racial and ethnic differences in patient experience among women and among men parallel the differences that were observed among both groups combined (see figure on p. xii). Among both women and men, API beneficiaries reported worse experiences than White beneficiaries with getting needed care, getting appointments and care quickly, customer service, doctor communication, care coordination, and getting needed patient drugs and had higher rates of vaccination for the flu. Among both women and men, Black beneficiaries and Hispanic beneficiaries reported worse experiences than White beneficiaries with getting appointments and care quickly and had lower rates of vaccination for the flu. Otherwise, the experiences of Black beneficiaries and Hispanic beneficiaries were similar to those of Whites, regardless of gender.

Patterns of racial and ethnic differences in clinical care among women and men also parallel the differences observed among both groups combined (see figure on p. xiii). Among both women and men, API beneficiaries received worse clinical care than White beneficiaries for 4 of 31 measures; 3 of those 4 measures were the same for women and men. API women received better care than White women for 9 measures, whereas API men received better care than White men for 10 measures; of those 9 or 10 measures, 8 were the same for women and men. Black women received worse clinical care than White women for 14 measures. Black men received worse clinical care than White men for those same 14 measures plus an additional 3 measures. Among both men and women, Black beneficiaries received better clinical care than White beneficiaries for 3 measures; 2 of those 3 measures were the same for women and men. Among both women and men, Hispanic beneficiaries received worse clinical care than White beneficiaries for 11 measures; 9 of those 11 measures were the same for women and men. Hispanic men received better clinical care than White men for 4 measures. Hispanic women received better clinical care than White women on those same 4 measures plus an additional 2 measures.

Conclusion

The focus of this report is on racial, ethnic, and gender differences in quality of care that exist at the national level. Although this analysis revealed few gender differences in care, it did reveal patterns in which (1) Black and Hispanic beneficiaries received worse clinical care than White beneficiaries on a

[2] For reporting HEDIS data stratified by race and ethnicity, racial and ethnic group membership is estimated using a methodology that combines information from CMS administrative data, surname, and residential location. Estimates of membership in the AI/AN group are less accurate than for other racial and ethnic groups; thus, this report does not show scores for AI/AN beneficiaries on the clinical care measures.

[3] Two clinical care measures, Breast Cancer Screening and Osteoporosis Management in Women Who Had a Fracture, pertained to women only and so were not eligible for stratified reporting by gender. Two other measures, Statin Use for Cardiovascular Disease and Medication Adherence for Cardiovascular Disease—Statins, were defined differently for men and women and so were also not eligible for stratified reporting by gender.

large portion of the clinical care measures examined and (2) API beneficiaries reported worse patient experiences than White beneficiaries on almost all measures of patient experience. The results presented in this report lead to a conclusion that quality improvement efforts should focus on enhancing clinical care for Black and Hispanic beneficiaries and investigating differences between API and White beneficiaries' patient experience. This information may be of interest to MA organizations and Medicare Part D sponsors as they consider strategies to improve the quality of care received by racial and ethnic minorities and reduce disparities.

Patient Experience and Clinical Care Measures Included in This Report

Patient Experience Measures

Getting Needed Care
Getting Appointments and Care Quickly
Customer Service
Doctors Who Communicate Well
Care Coordination
Getting Needed Prescription Drugs
Annual Flu Vaccine

Clinical Care Measures

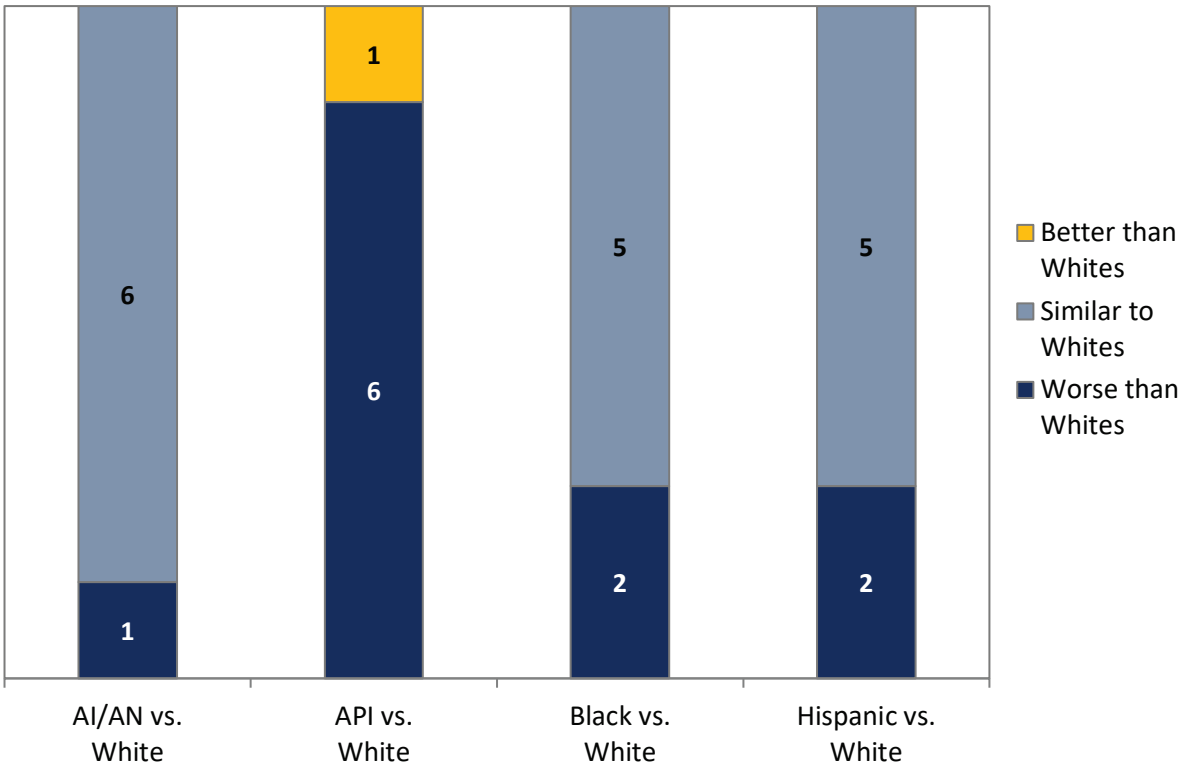
Colorectal Cancer Screening
Breast Cancer Screening*
Diabetes Care—Blood Sugar Testing
Diabetes Care—Eye Exam
Diabetes Care—Kidney Disease Monitoring
Diabetes Care—Blood Pressure Controlled
Diabetes Care—Blood Sugar Controlled
Statin Use in Patients with Diabetes
Medication Adherence for Diabetes—Statins
Adult Body Mass Index (BMI) Assessment
Controlling High Blood Pressure
Statin Use in Patients with Cardiovascular Disease†
Medication Adherence for Cardiovascular Disease—Statins†
Persistence of Beta-Blocker Treatment
Asthma Medication Ratio in Older Adults
Testing to Confirm Chronic Obstructive Pulmonary Disease (COPD)
Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid
Pharmacotherapy Management of COPD Exacerbation—Bronchodilator
Rheumatoid Arthritis Management
Osteoporosis Management in Women who Had a Fracture*
Appropriate Monitoring of Patients Taking Long-Term Medications
Avoiding Use of High-Risk Medications in the Elderly
Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with Chronic Renal Failure
Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with Dementia
Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with a History of Falls
Older Adults' Access to Preventive/ Ambulatory Services
Medication Reconciliation After Hospital Discharge
Antidepressant Medication Management—Acute Phase Treatment
Antidepressant Medication Management—Continuation Phase Treatment
Follow-Up Visit After Hospital Stay for Mental Illness (within 7 days of discharge)
Follow-Up Visit After Hospital Stay for Mental Illness (within 30 days of discharge)
Initiation of Alcohol or Other Drug Treatment
Engagement of Alcohol or Other Drug Treatment

* These measures are specific to women and are thus not included in the set of comparisons by gender.

† These measures are defined differently for men and women and thus are not included in the set of comparisons by gender. They are, however, included in the set of comparisons by race and ethnicity within gender.

Racial and Ethnic Disparities in Care: All Patient Experience Measures

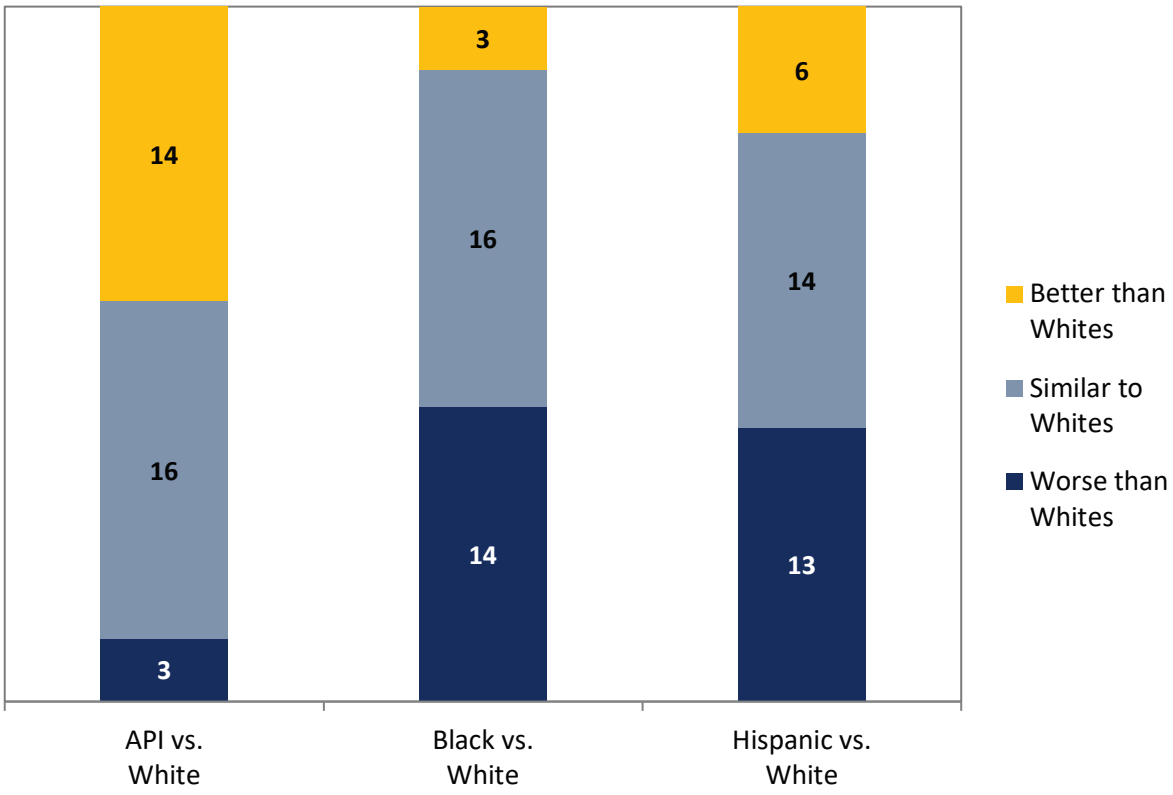
Number of patient experience measures (out of 7) for which members of selected groups reported experiences that were worse than, similar to, or better than the experiences reported by Whites in 2017



SOURCE: This chart summarizes data from all Medicare Advantage beneficiaries nationwide who participated in the 2017 Medicare CAHPS survey.
NOTES: AI/AN = American Indian or Alaska Native. API = Asian or Pacific Islander. Racial groups such as Blacks and Whites are non-Hispanic. Hispanic ethnicity includes all races.

Racial and Ethnic Disparities in Care: All Clinical Care Measures

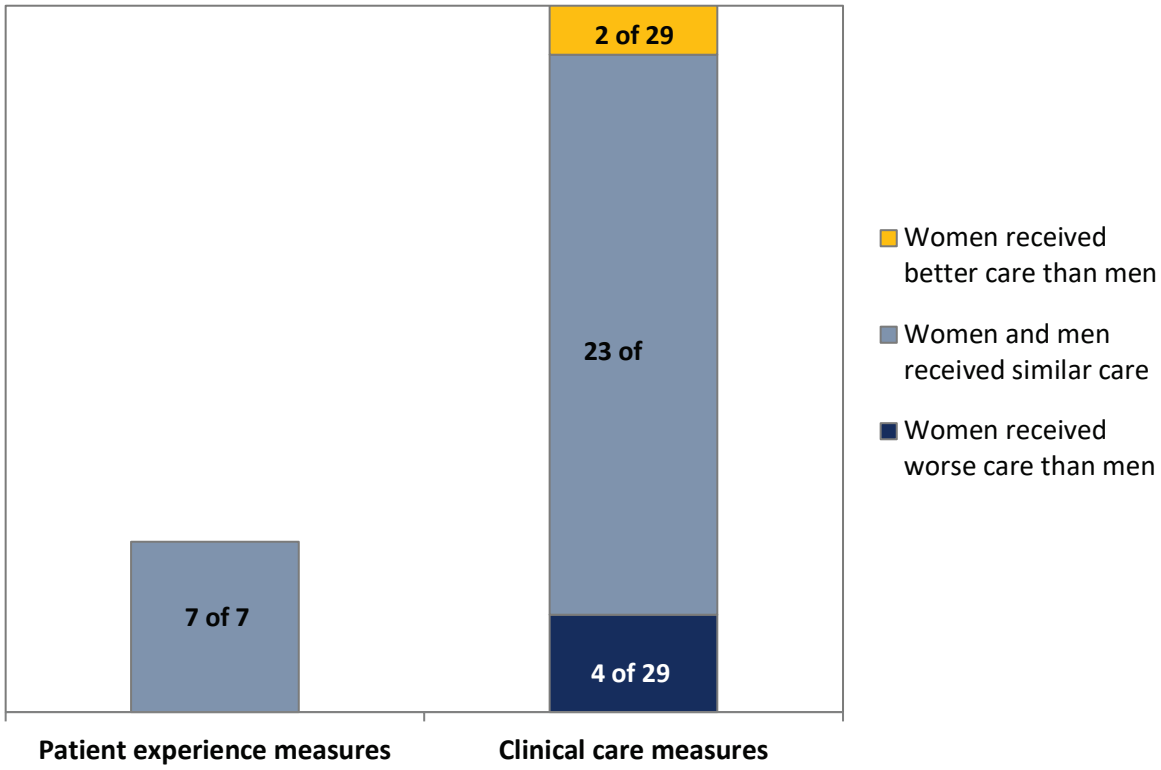
Number of clinical care measures (out of 33) for which members of selected groups experienced care that was worse than, similar to, or better than the care experienced by Whites in 2017



SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2017 from Medicare health plans nationwide.
NOTES: API = Asian or Pacific Islander. Racial groups such as Blacks and Whites are non-Hispanic. Hispanic ethnicity includes all races.

Gender Disparities in Care:
All Patient Experience and Clinical Care Measures

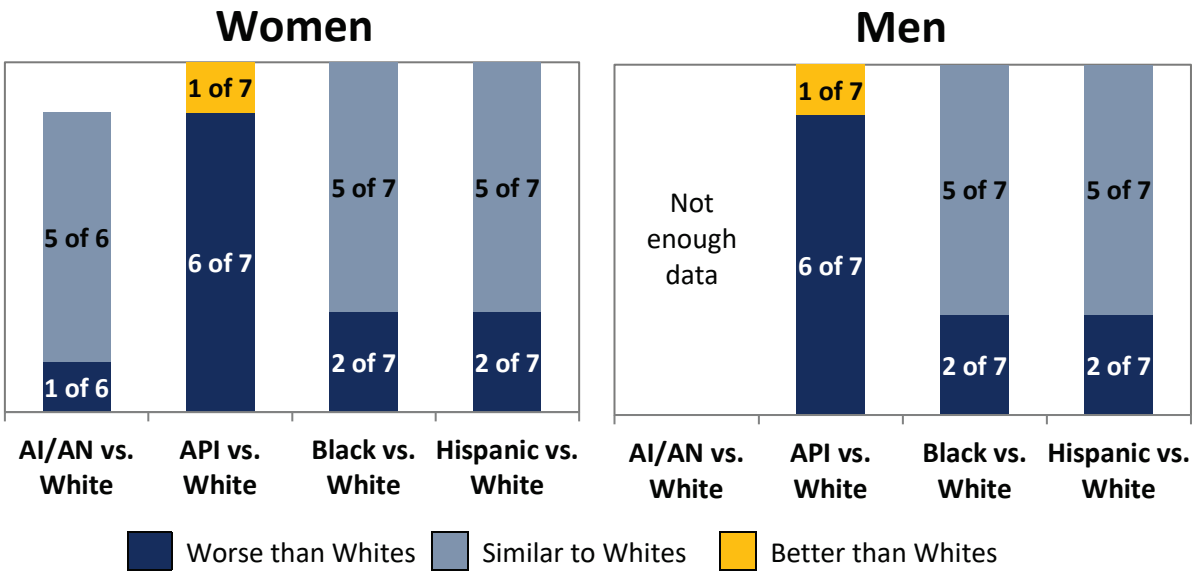
Number of patient experience measures (out of 7) and clinical care measures (out of 29) for which women received care that was worse than, similar to, or better than the care received by men in 2017



SOURCES: The bar on the left (patient experience measures) summarizes data from all Medicare Advantage beneficiaries nationwide who participated in the 2017 Medicare CAHPS survey. The bar on the right (clinical care measures) summarizes clinical quality (HEDIS) data collected in 2017 from Medicare health plans nationwide.

Racial and Ethnic Disparities in Care by Gender: All Patient Experience Measures

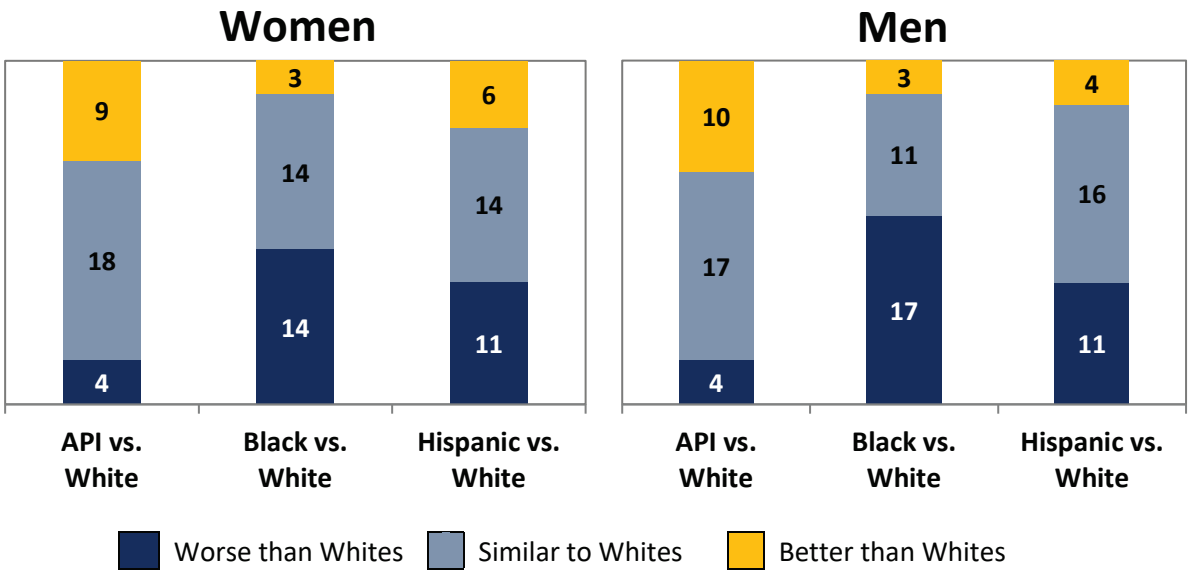
Number of patient experience measures (out of 7) for which women/men of selected racial and ethnic minority groups reported experiences that were worse than, similar to, or better than the experiences reported by White women/men in 2017



SOURCE: This chart summarizes data from all Medicare Advantage beneficiaries nationwide who participated in the 2017 Medicare CAHPS survey.
NOTES: AI/AN = American Indian or Alaska Native. API = Asian or Pacific Islander. Racial groups such as Blacks and Whites are non-Hispanic. Hispanic ethnicity includes all races. There were not enough data from AI/AN men to compare their patient experiences to those of White men. For one patient experience measure, there were not enough data from AI/AN women to permit a comparison to White women.

Racial and Ethnic Disparities in Care by Gender: All Clinical Care Measures

Number of clinical care measures (out of 31) for which women/men of selected racial and ethnic minority groups experienced care that was worse than, similar to, or better than the care experienced by White women/men in 2017



SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2017 from Medicare health plans nationwide.

NOTES: Racial groups such as Blacks and Whites are non-Hispanic. Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Background

Racial, Ethnic, and Gender Disparities in Health Care in Medicare Advantage

Overview

This report presents summary information on the quality of health care received in 2017 by Medicare beneficiaries enrolled in Medicare Advantage (MA) plans nationwide. In 2017, 30.6 percent of Medicare beneficiaries were enrolled in MA. Two types of quality of care data are presented in this report: measures of patient experience, which describe how well the care patients receive meets their needs for such things as timely appointments, respectful care, clear communication, and access to information; and measures of clinical care, which describe the extent to which patients receive appropriate screening and treatment for specific health conditions. The Institute of Medicine has identified the equitable delivery of care as a hallmark of quality.[4] Assessing equitability in the delivery of care requires making comparisons of quality by personal characteristics of patients, such as gender, race, and ethnicity. Three sets of such comparisons are presented in this report. In the first set, quality of care for racial and ethnic minority groups is compared with quality of care for Whites. In the second, quality of care for women is compared with quality of care for men. In the third, quality of care for racial and ethnic minority groups is compared with quality of care for Whites of the same gender. As in the 2018 report, this information—which may be of interest to Medicare beneficiaries, MA organizations, and Part D sponsors—is being presented in a single report to provide a more comprehensive understanding of the ways in which care differs by race and ethnicity, gender, and the intersection of these two characteristics. The focus of this report is on differences that exist at the national level. Interested readers can find information about health care quality for specific Medicare plans at https://www.medicare.gov/find-a-plan/questions/home.aspx and information about racial and ethnic differences in health care quality within Medicare plans at https://www.cms.gov/About-CMS/Agency-Information/OMH/research-and-data/statistics-and-data/stratified-reporting.html.

Data Sources

In all, this report provides data regarding 7 patient experience measures and 33 clinical care measures. The patient experience data were collected from a national survey of Medicare beneficiaries, known as the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. This survey is administered each year; the data in this report are from the 2017 Medicare CAHPS survey (detailed information about this survey can be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/mcahps.html). Examples of patient experience measures include how easy it is to get needed care, how well doctors communicate with beneficiaries, and how easy it is for beneficiaries to get the prescription drugs they need.

The clinical care data were gathered through medical records and insurance claims for hospitalizations, medical office visits, and procedures. These data, which are collected each year from MA plans nationwide, are part of the Healthcare Effectiveness Data and Information Set (HEDIS; detailed information about these data can be found at https://www.ncqa.org/hedis/measures/). Examples of clinical care measures include whether beneficiaries received appropriate screening for colon cancer, whether beneficiaries with diabetes received a test that determines whether their blood sugar is under control, and whether appropriate treatment was provided to beneficiaries with chronic obstructive pulmonary disease (COPD). Two of the clinical care measures presented in this report, one pertaining to breast cancer screening and the other to management of osteoporosis, are specific to women. Thus, the set of comparisons by gender and the set of comparisons by race and ethnicity within gender exclude these two measures. Two other clinical care measures, both dealing with statin therapy for patients with

[4] Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century,* Washington, D.C.: National Academy Press, 2001.

cardiovascular disease, are defined differently for men and women and thus are excluded from the set of comparisons by gender. The HEDIS data reported here were collected in 2017. Whereas all patient experience measures are applicable to beneficiaries aged 18 years and older, certain HEDIS measures apply to beneficiaries in a more limited age range, as noted throughout the report.

In 2017, an estimated 69.5 percent of all Medicare Advantage beneficiaries were White, 13.8 percent were Hispanic, 9.9 percent were Black, 4.3 percent were Asians or Pacific Islanders, 2.1 percent were multiracial, and 0.4 percent were American Indians or Alaska Natives, compared with 76.1 percent, 8.5 percent, 8.9 percent, 3.6 percent, 2.3 percent, and 0.6 percent, respectively, in the general Medicare population. An estimated 56.3 percent of all Medicare Advantage beneficiaries were female and 43.7 percent were male, compared with 54.1 percent and 45.9 percent, respectively, in the general Medicare population. For the racial and ethnic group comparisons that combine data from women and men, scores on patient experience measures are provided for all racial and ethnic groups except multiracial. These racial and ethnic groups were chosen because enough information was available to describe the experiences of beneficiaries in these groups. Scores on clinical care measures are provided for the same groups except for American Indians or Alaska Natives because the clinical care data lack information that allows us to reliably determine whether a beneficiary is in this group. In previous versions of this report, patient experience scores for American Indians or Alaska Natives were excluded from the racial and ethnic group comparisons within gender because sample sizes were insufficient for reliable reporting. For this version of the report, there were enough data to report patient experience scores for American Indian or Alaska Native women but not enough to report patient experience scores for American Indian or Alaska Native men.

Racial and Ethnic Disparities in Health Care in Medicare Advantage

Section I of the report begins with a stacked bar chart showing the number of patient experience measures (out of 7) for which members of each racial and ethnic minority group reported experiences of care that were worse than, similar to, or better than the experiences reported by Whites.[5] Following this stacked bar chart are separate, unstacked bar charts for each patient experience measure. These charts show the average score for each racial and ethnic group on a 0–100 scale. The average score represents the percentage of the best possible score for a given demographic group for that measure. For example, consider a measure for which the best possible score is 4 and the worst possible score is 1. If a given group's score on that measure is 3.5, then that group's score on a 0–100 scale is ([3.5−1]/[4−1])*100 = 83.3. After the patient experience measures, Section I presents a stacked bar chart showing the number of clinical care measures (out of 33) for which members of each racial and ethnic minority group experienced care that was worse than, similar to, or better than the care experienced by Whites. Following this stacked bar chart are separate, unstacked bar charts for each clinical care measure that show the percentage of beneficiaries in each racial and ethnic group whose care met the standard called for by the specific measure (e.g., a test or treatment).

Gender Disparities in Health Care in Medicare Advantage

Section II of the report begins with a pair of stacked bar charts that show the number of patient experience measures (out of 7) and the number of clinical care measures (out of 29) for which women received care that was worse than, similar to, or better than the care received by men. Gender data for

[5] Here, "similar" is used to characterize differences that are not statistically significant, fall below a magnitude threshold, or both, as described in the appendix. "Worse" and "better" are used to characterize differences that are statistically significant and exceed a magnitude threshold.

each of the patient experience and clinical care measures are then presented in the form of unstacked bar charts.

Racial and Ethnic Disparities by Gender in Health Care in Medicare Advantage

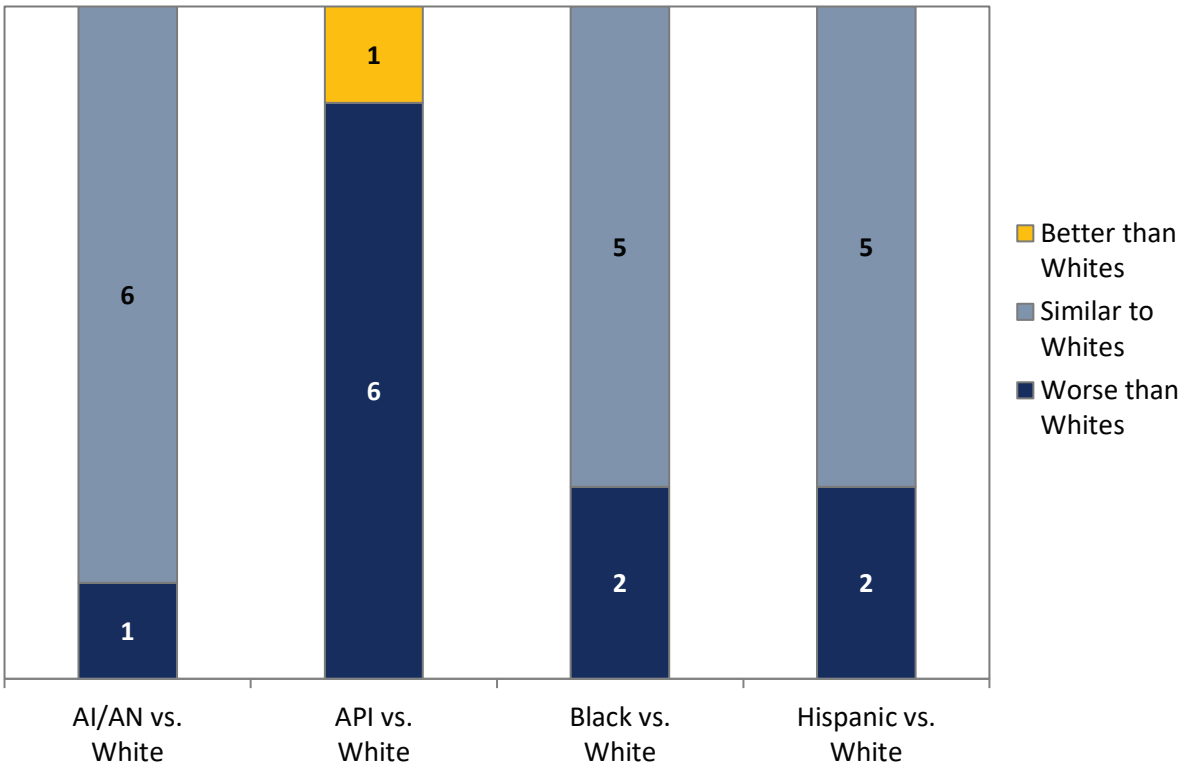
Section III of the report begins with a pair of stacked bar charts that show, separately for women and men, the number of patient experience measures (out of 7) for which members of each racial and ethnic minority group reported experiences of care that were worse than, similar to, or better than the experiences reported by Whites. Following these stacked bar charts are separate, unstacked bar charts for each patient experience measure. These charts show, separately for men and women, the average score for each racial and ethnic group on a 0–100 scale. After the patient experience measures, Section III presents a pair of stacked bar charts that show, separately for men and women, the number of clinical care measures (out of 31) for which members of each racial and ethnic minority group experienced care that was worse than, similar to, or better than the care experienced by Whites. Following these stacked bar charts are separate, unstacked bar charts for each clinical care measure that show, separately for men and women, the percentage of beneficiaries in each racial and ethnic group whose care met the standard called for by the specific measure.

For detailed information on data sources and analytic methods, see the appendix.

Section I: Racial and Ethnic Disparities in Health Care in Medicare Advantage

Disparities in Care: All Patient Experience Measures

Number of patient experience measures (out of 7) for which members of selected groups reported experiences that were worse than, similar to, or better than the experiences reported by Whites in 2017



SOURCE: This chart summarizes data from all MA beneficiaries nationwide who participated in the 2017 Medicare CAHPS survey.
NOTES: AI/AN = American Indian or Alaska Native. API = Asian or Pacific Islander. Racial groups such as Blacks and Whites are non-Hispanic. Hispanic ethnicity includes all races.

The relative difference between a selected group and Whites is used to assess disparities.

- **Better** = Population received better care than Whites. Differences are statistically significant ($p < 0.05$), are equal to or larger than 3 points† on a 0–100 scale, and favor the racial or ethnic minority group.
- **Similar** = Population and Whites received care of similar quality. Differences are less than 3 points on a 0–100 scale (differences greater than 3 points were always statistically significant). Differences may be statistically significant.
- **Worse** = Population received worse care than Whites. Differences are statistically significant, are equal to or larger than 3 points on a 0–100 scale, and favor Whites.

† A difference that is considered to be of moderate magnitude (C. A. Paddison, M. N. Elliott, A. M. Haviland, D. O. Farley, G. Lyratzopoulos, K. Hambarsoomian, J. W. Dembosky, and M. O. Roland, "Experiences of Care Among Medicare Beneficiaries with ESRD: Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Results," *American Journal of Kidney Diseases*, Vol. 61, 2013, pp. 440–449).

AI/AN beneficiaries received worse care than White beneficiaries

- Getting appointments and care quickly

API beneficiaries received worse care than White beneficiaries

- Getting needed care
- Getting appointments and care quickly
- Customer service
- Doctors who communicate well
- Care coordination
- Getting needed prescription drugs

API beneficiaries received better care than White beneficiaries

- Annual flu vaccine

Black beneficiaries received worse care than White beneficiaries

- Getting appointments and care quickly
- Annual flu vaccine

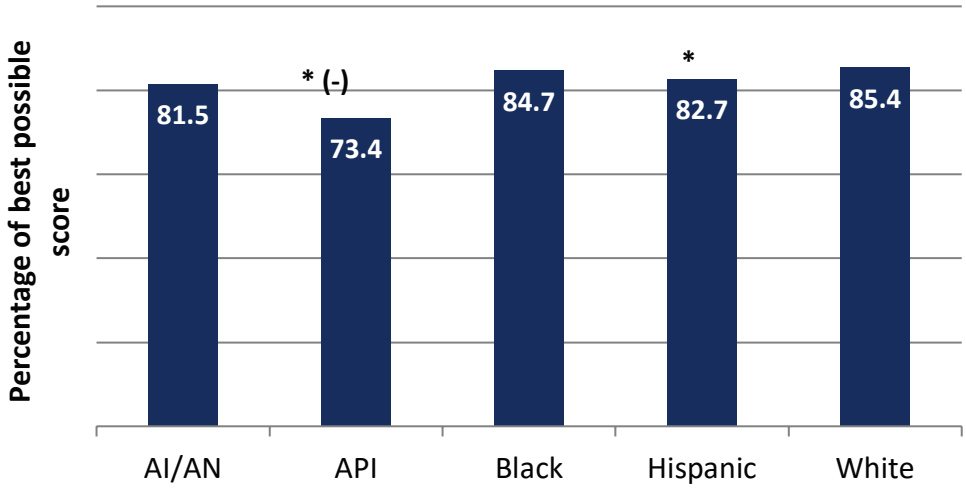
Hispanic beneficiaries received worse care than White beneficiaries

- Getting appointments and care quickly
- Annual flu vaccine

Patient Experience

Patient Experience: Getting Needed Care

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for patients to get needed care,† by race and ethnicity, 2017



SOURCE: Data from the Medicare CAHPS survey, 2017.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. AI/AN = American Indian or Alaska Native. API = Asian or Pacific Islander.

Disparities

- Asians or Pacific Islanders reported worse†† experiences getting needed care than Whites reported. The difference between these groups was greater than 3 points on a 0–100 scale.
- Hispanics also reported worse experiences getting needed care than Whites reported, but the difference between these groups was less than 3 points on a 0–100 scale.
- American Indians or Alaska Natives and Blacks reported experiences getting needed care that were similar to the experiences Whites reported.

***** Significantly different from the score for Whites ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

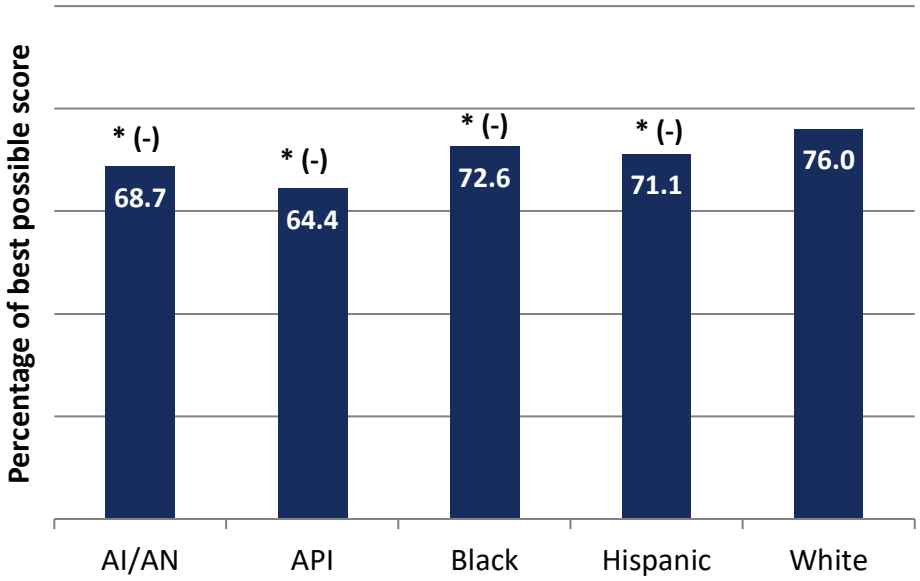
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

† This includes how often in the last 6 months patients got appointments with specialists as soon as they needed them and how easy it was to get needed care, tests, or treatment.

†† Unlike on the previous two pages, we use the terms "better" or "worse" to describe all statistically significant differences on individual patient experience measures. We note in the "Disparities" section for each of these measures where differences are greater or less than 3 points.

Patient Experience: Getting Appointments and Care Quickly

Percentage of the best possible score (on a 0–100 scale) earned on how quickly patients get appointments and care,† by race and ethnicity, 2017



SOURCE: Data from the Medicare CAHPS survey, 2017.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. AI/AN = American Indian or Alaska Native. API = Asian or Pacific Islander.

Disparities

- American Indians or Alaska Natives, Asians or Pacific Islanders, Blacks, and Hispanics reported worse experiences getting appointments and care quickly than Whites reported. The difference between each of these groups and Whites was greater than 3 points on a 0–100 scale.

***** Significantly different from the score for Whites ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:

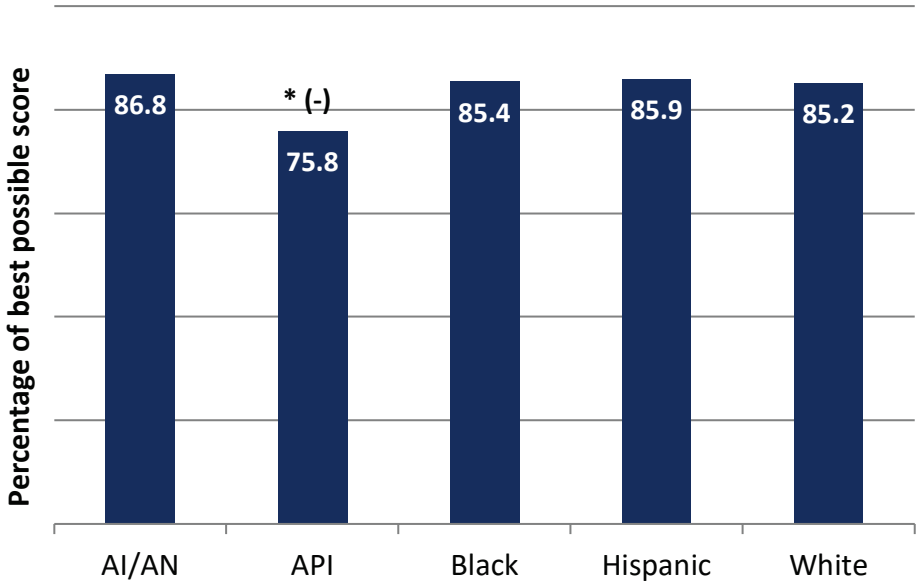
(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

† This includes how often in the last 6 months patients got care that was needed right away, as well as how easy it was to get appointments for checkups and routine care.

Patient Experience: Customer Service

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is to get information and help from one's plan when needed,† by race and ethnicity, 2017



SOURCE: Data from the Medicare CAHPS survey, 2017.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. AI/AN = American Indian or Alaska Native. API = Asian or Pacific Islander.

Disparities

- Asians or Pacific Islanders reported worse experiences with customer service than Whites reported. The difference between Asians or Pacific Islanders and Whites was greater than 3 points on a 0–100 scale.
- American Indians or Alaska Natives, Blacks, and Hispanics reported experiences with customer service that were similar to the experiences that Whites reported.

***** Significantly different from the score for Whites ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:

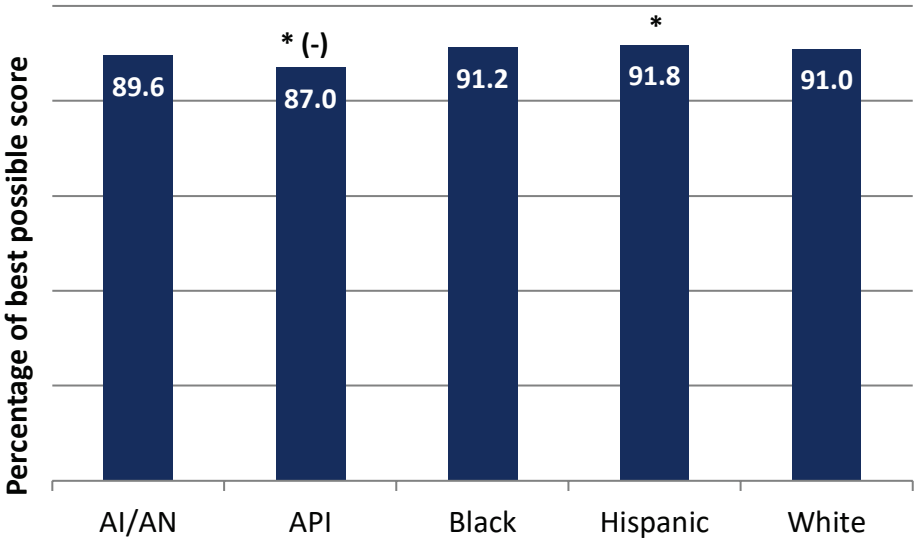
(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

† This includes how often in the last 6 months health plan customer service staff provided the information or the help that beneficiaries needed, how often beneficiaries were treated with courtesy and respect, and how often forms from the health plan were easy to fill out.

Patient Experience: Doctors Who Communicate Well

Percentage of the best possible score (on a 0–100 scale) earned on how well doctors communicate with patients,† by race and ethnicity, 2017



SOURCE: Data from the Medicare CAHPS survey, 2017.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. AI/AN = American Indian or Alaska Native. API = Asian or Pacific Islander.

Disparities

- Asians or Pacific Islanders reported worse experiences with doctor communication than Whites reported. The difference between these groups was greater than 3 points on a 0–100 scale.
- Hispanics reported experiences with doctor communication that were better than the experiences that Whites reported. The difference between these groups was less than 3 points on a 0–100 scale.
- American Indians or Alaska Natives and Blacks reported experiences with doctor communication that were similar to the experiences reported by Whites.

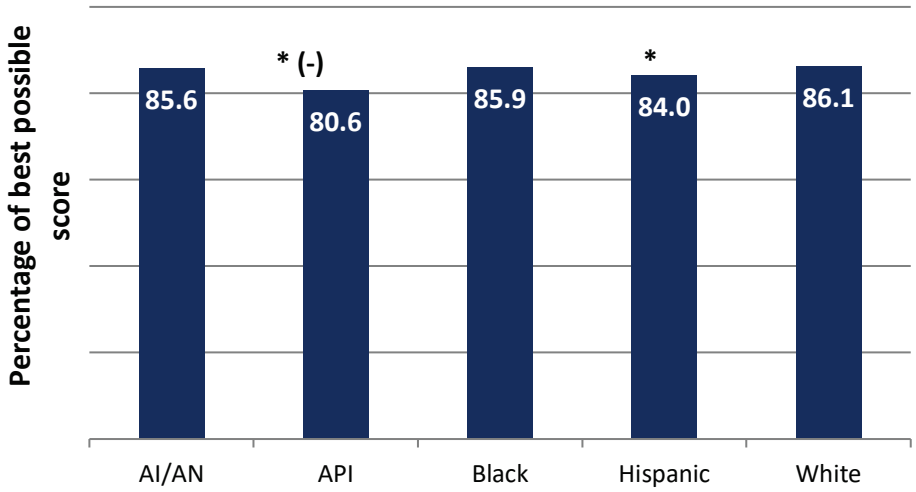
***** Significantly different from the score for Whites ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

† This includes how often in the last 6 months doctors explained things in a way that was easy to understand, listened carefully, showed respect for what patients had to say, and spent time with patients.

Patient Experience: Care Coordination

Percentage of the best possible score (on a 0–100 scale) earned on how well patients' care was coordinated,† by race and ethnicity, 2017



SOURCE: Data from the Medicare CAHPS survey, 2017.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. AI/AN = American Indian or Alaska Native. API = Asian or Pacific Islander.

Disparities

- Asians or Pacific Islanders reported worse experiences with care coordination than Whites reported. The difference between these groups was greater than 3 points on a 0–100 scale.
- Hispanics reported worse experiences with care coordination than Whites reported. The difference between Hispanics and Whites was less than 3 points on a 0–100 scale.
- American Indians or Alaska Natives and Blacks reported experiences with care coordination that were similar to the experiences reported by Whites.

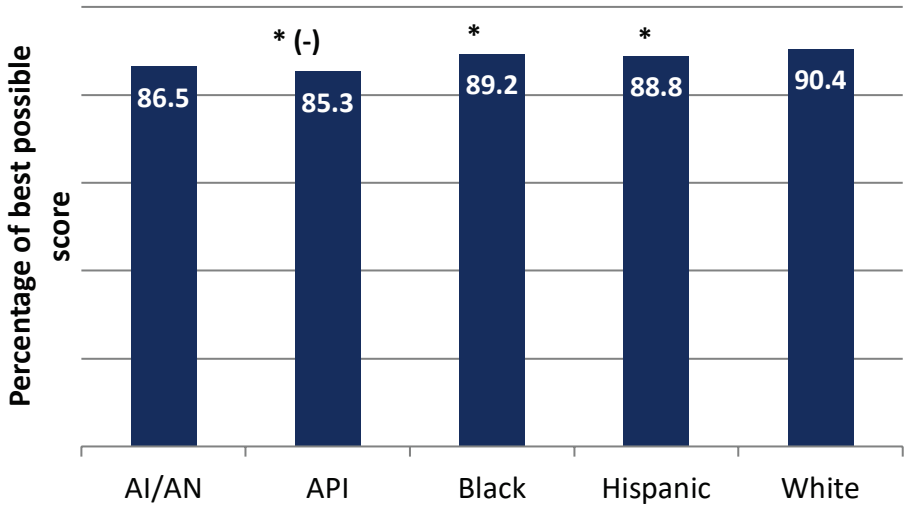
***** Significantly different from the score for Whites ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

† This includes how often in the last 6 months doctors had medical records and other information about patients' care at patients' scheduled appointments and how quickly patients received their test results.

Patient Experience: Getting Needed Prescription Drugs

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for beneficiaries to get the prescription drugs they need using their plan,† by race and ethnicity, 2017



SOURCE: Data from the Medicare CAHPS survey, 2017.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. AI/AN = American Indian or Alaska Native. API = Asian or Pacific Islander.

Disparities

- Asians or Pacific Islanders reported worse experiences getting needed prescription drugs than Whites reported. The difference between these groups was greater than 3 points on a 0–100 scale.
- Blacks and Hispanics reported worse experiences getting needed prescription drugs than Whites reported. The difference between each of these groups and Whites was less than 3 points on a 0–100 scale.
- American Indians or Alaska Natives reported experiences getting needed prescription drugs that were similar to experiences reported by Whites.

***** Significantly different from the score for Whites ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:

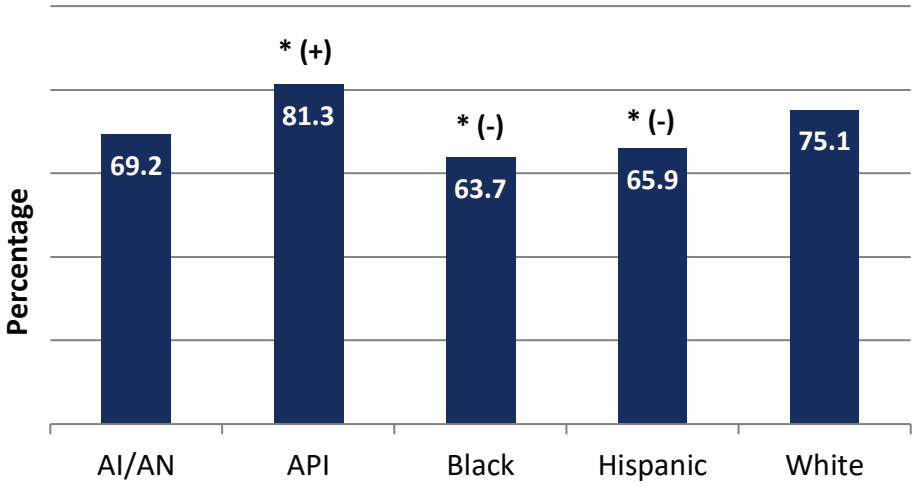
(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

† This includes how often in the last 6 months it was easy to use the plan to get prescribed medications and how easy it was to fill prescriptions at a pharmacy or by mail.

Patient Experience: Annual Flu Vaccine

Percentage of Medicare enrollees who got a vaccine (flu shot), by race and ethnicity, 2017



SOURCE: Data from the Medicare CAHPS survey, 2017.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. AI/AN = American Indian or Alaska Native. API = Asian or Pacific Islander.

Disparities

- Asians or Pacific Islanders were more likely than Whites to have received the flu vaccine. The difference between Asians or Pacific Islanders and Whites was greater than 3 percentage points.
- Blacks and Hispanics were less likely than Whites to have received the flu vaccine. The difference between each of these groups and Whites was greater than 3 percentage points.
- American Indians or Alaska Natives were about as likely as Whites to have received the flu vaccine.

***** Significantly different from the score for Whites ($p < 0.05$).

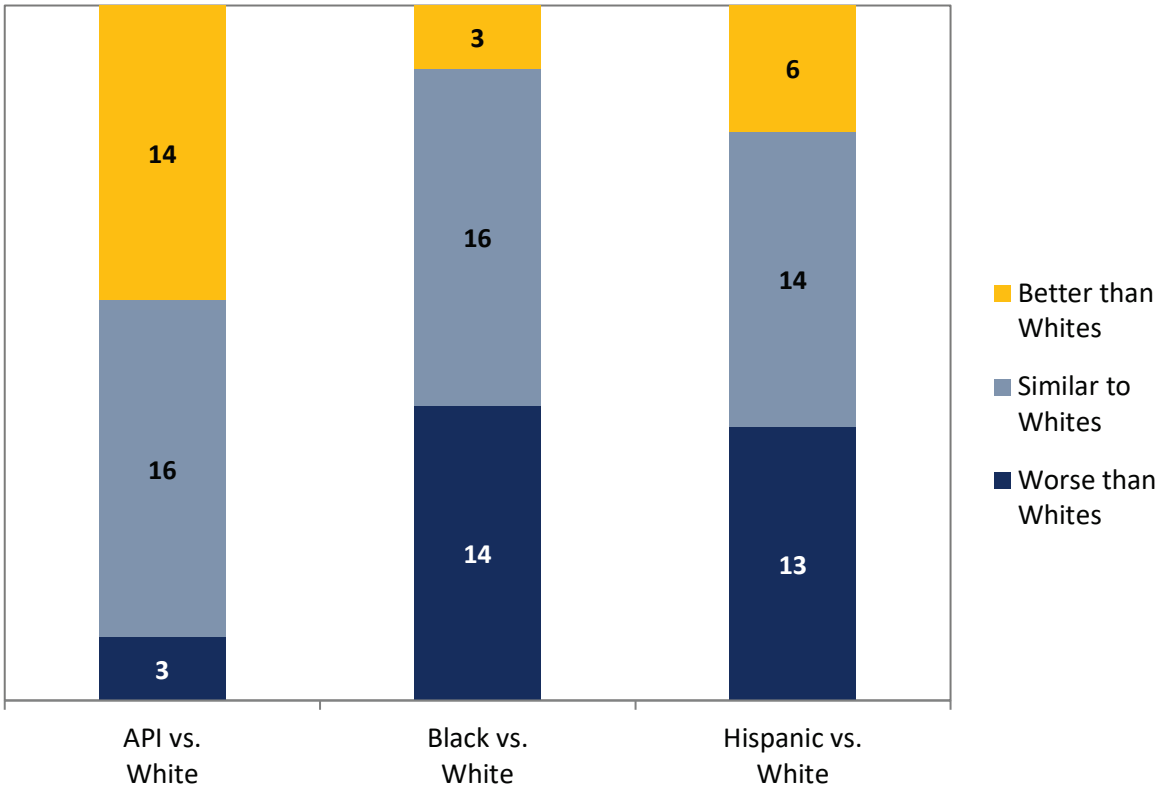
For differences that are statistically significant, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Disparities in Care: All Clinical Care Measures

Number of clinical care measures (out of 33) for which members of selected groups experienced care that was worse than, similar to, or better than the care experienced by Whites in 2017



SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2017 from Medicare health plans nationwide.
NOTES: API = Asian or Pacific Islander. Racial groups such as Blacks and Whites are non-Hispanic. Hispanic ethnicity includes all races.

The relative difference between a selected group and Whites is used to assess disparities.

- **Better** = Population received better care than Whites. Differences are statistically significant ($p < 0.05$), are equal to or larger than 3 points† on a 0–100 scale, and favor the racial or ethnic minority group.
- **Similar** = Population and Whites received care of similar quality. Differences are less than 3 points on a 0–100 scale (differences greater than 3 points were always statistically significant). Differences may be statistically significant.
- **Worse** = Population received worse care than Whites. Differences are statistically significant, are equal to or larger than 3 points on a 0–100 scale, and favor Whites.

† A difference that is considered to be of moderate magnitude (Paddison et al., 2013).

API beneficiaries received worse care than White beneficiaries

- Antidepressant medication management—acute phase treatment
- Antidepressant medication management—continuation phase treatment
- Initiation of alcohol or other drug treatments

API beneficiaries received better care than White beneficiaries

- Colorectal cancer screening
- Breast cancer screening
- Diabetes care—eye exam
- Diabetes care—blood pressure controlled
- Diabetes care—blood sugar controlled
- Statin use in patients with diabetes
- Pharmacotherapy management of COPD exacerbation—use of systemic corticosteroids
- Pharmacotherapy management of COPD exacerbation—use of bronchodilators
- Osteoporosis management in women who had a fracture
- Avoiding use of high-risk medications in the elderly
- Avoiding potentially harmful drug-disease interactions in elderly patients with dementia
- Avoiding potentially harmful drug-disease interactions in elderly patients with a history of falls
- Medication reconciliation after hospital discharge
- Follow-up after hospital stay for mental illness (within 7 days of discharge)

Black beneficiaries received worse care than White beneficiaries

- Colorectal cancer screening
- Diabetes care—blood pressure controlled
- Diabetes care—blood sugar controlled
- Medication adherence for diabetes—statins
- Controlling blood pressure
- Medication adherence for cardiovascular disease—statins
- Continuous beta-blocker treatment after a heart attack
- Asthma medication ratio in older adults
- Avoiding potentially harmful drug-disease interactions in elderly patients with chronic renal failure
- Medication reconciliation after hospital discharge
- Antidepressant medication management—acute phase treatment
- Antidepressant medication management—continuation phase treatment
- Follow-up after hospital stay for mental illness (within 7 days of discharge)
- Follow-up after hospital stay for mental illness (within 30 days of discharge)

Black beneficiaries received better care than White beneficiaries

- Breast cancer screening
- Avoiding potentially harmful drug-disease interactions in elderly patients with dementia
- Avoiding potentially harmful drug-disease interactions in elderly patients with a history of falls

Hispanic beneficiaries received worse care than White beneficiaries

- Colorectal cancer screening
- Diabetes care—blood sugar controlled
- Medication adherence for diabetes—statins
- Medication adherence for cardiovascular disease—statins
- Continuous beta-blocker treatment after a heart attack
- Asthma medication ratio in older adults
- Pharmacotherapy management of COPD exacerbation—use of systemic corticosteroids
- Pharmacotherapy management of COPD exacerbation—use of bronchodilators
- Avoiding potentially harmful drug-disease interactions in elderly patients with chronic renal failure
- Avoiding potentially harmful drug-disease interactions in elderly patients with dementia
- Antidepressant medication management—acute phase treatment
- Antidepressant medication management—continuation phase treatment
- Initiation of alcohol or other drug treatments

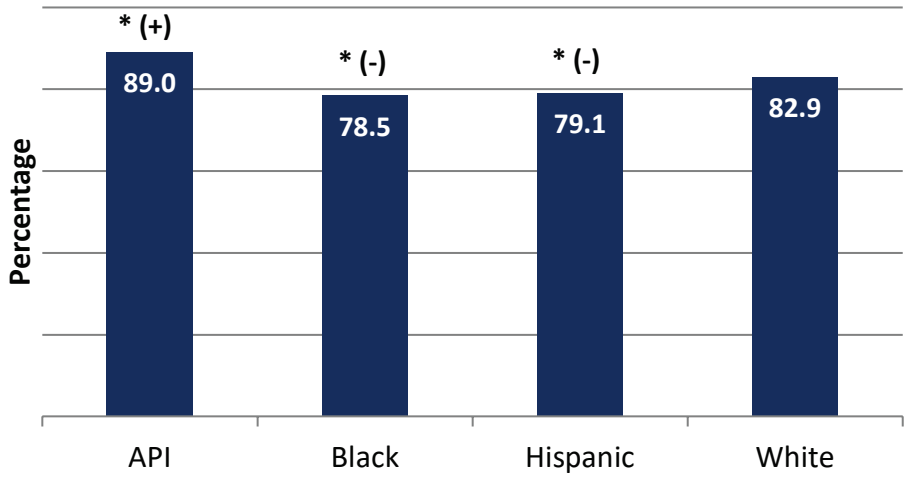
Hispanic beneficiaries received better care than White beneficiaries

- Breast cancer screening
- Diabetes care—eye exam
- Diabetes care—blood pressure controlled
- Osteoporosis management in women who had a fracture
- Follow-up after hospital stay for mental illness (within 7 days of discharge)
- Follow-up after hospital stay for mental illness (within 30 days of discharge)

Clinical Care

Clinical Care: Colorectal Cancer Screening

Percentage of Medicare enrollees aged 50–75 years who had appropriate screening for colorectal cancer, by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Asians or Pacific Islanders were more likely than Whites to have been appropriately screened for colorectal cancer. The difference between these groups was greater than 3 percentage points.
- Blacks and Hispanics were less likely than Whites to have been appropriately screened for colorectal cancer. The difference between each of these groups and Whites was greater than 3 percentage points.

***** Significantly different from the score for Whites ($p < 0.05$).

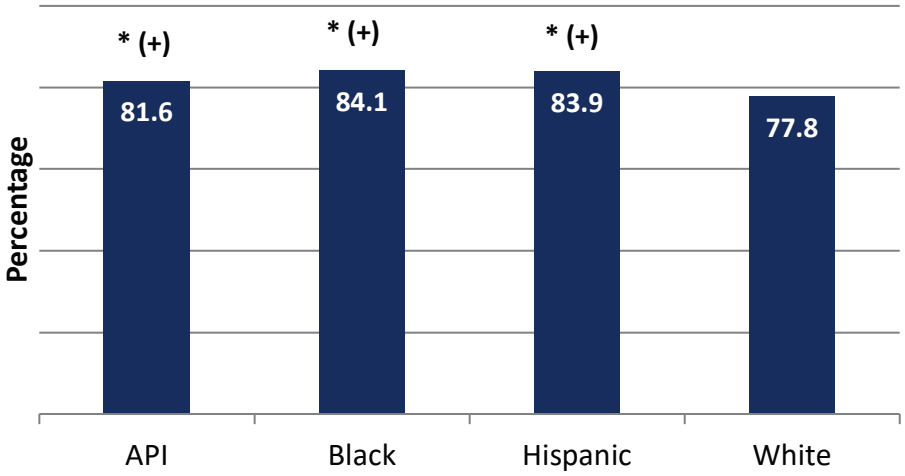
For differences that are statistically significant, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Breast Cancer Screening

Percentage of Medicare enrollees (women) aged 50–74 years who had appropriate screening for breast cancer, by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Asian or Pacific Islander, Black, and Hispanic women were more likely than White women to have been appropriately screened for breast cancer. The difference between each of these groups of women and White women was greater than 3 percentage points.

***** Significantly different from the score for Whites ($p < 0.05$).

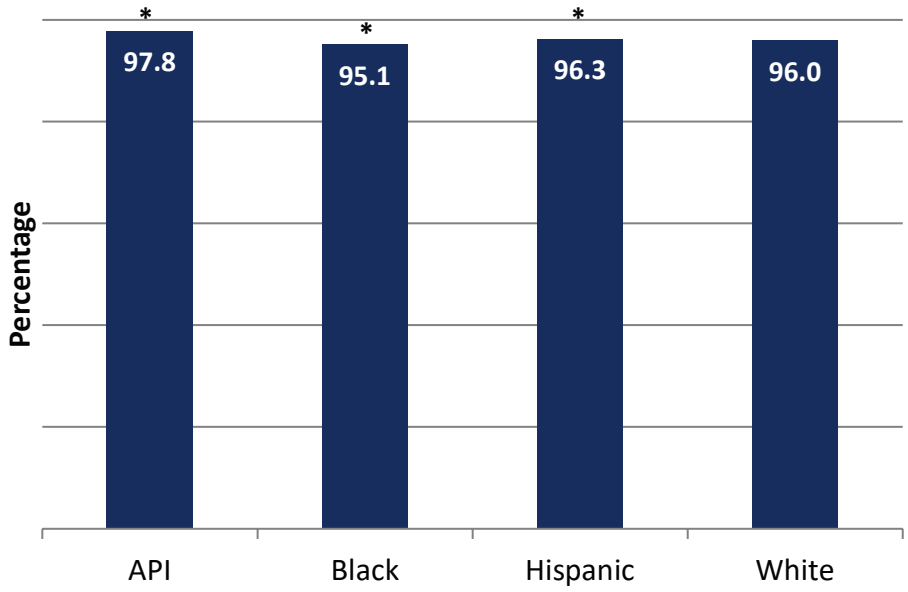
For differences that are statistically significant, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Diabetes Care—Blood Sugar Testing

Percentage of Medicare enrollees aged 18–75 years with diabetes (type 1 and type 2) who had one or more HbA1c tests in the past year, by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Asians or Pacific Islanders and Hispanics with diabetes were more likely than Whites with diabetes to have had their blood sugar tested at least once in the past year. The difference between each of these groups and Whites was less than 3 percentage points.
- Blacks with diabetes were less likely than Whites with diabetes to have had their blood sugar tested at least once in the past year. The difference between Blacks and Whites was less than 3 percentage points.

***** Significantly different from the score for Whites ($p < 0.05$).

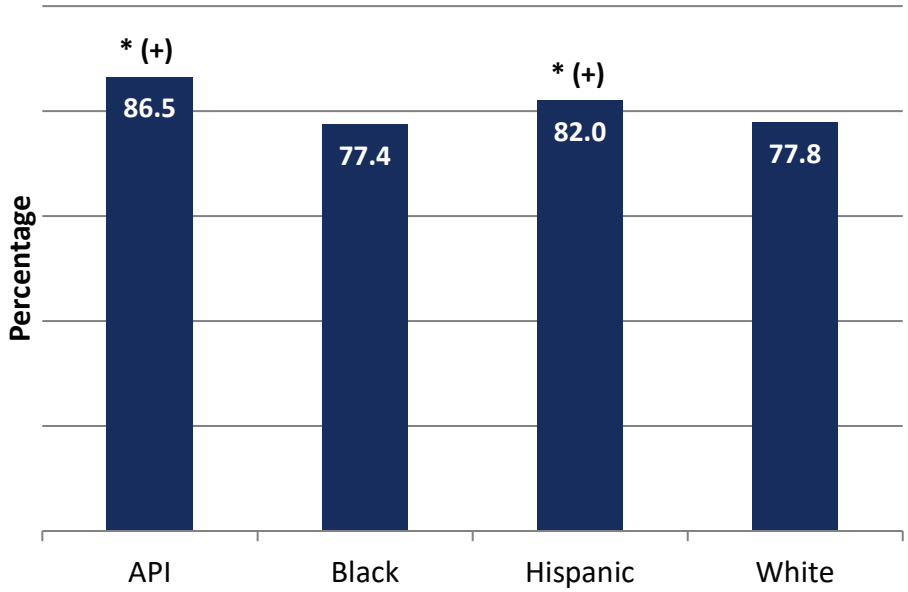
For differences that are statistically significant, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Diabetes Care—Eye Exam

Percentage of Medicare enrollees aged 18–75 years with diabetes (type 1 and type 2) who had an eye exam (retinal) in the past year, by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Asians or Pacific Islanders and Hispanics with diabetes were more likely than Whites with diabetes to have had an eye exam in the past year. The difference between each of these groups and Whites was greater than 3 percentage points.
- Blacks with diabetes were about as likely as Whites with diabetes to have had an eye exam in the past year.

***** Significantly different from the score for Whites ($p < 0.05$).

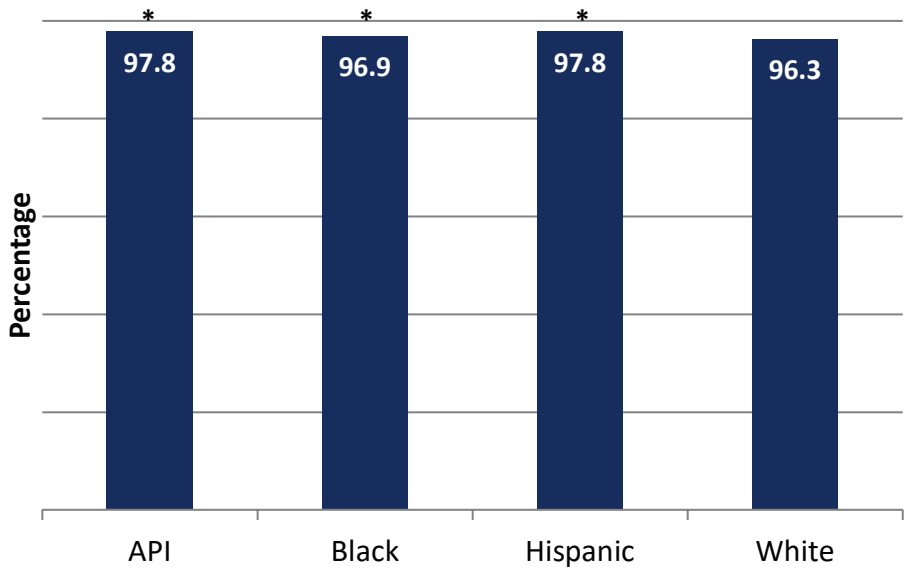
For differences that are statistically significant, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Diabetes Care—Kidney Disease Monitoring

Percentage of Medicare enrollees aged 18–75 years with diabetes (type 1 and type 2) who had medical attention for nephropathy in the past year, by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Asians or Pacific Islanders, Blacks, and Hispanics with diabetes were more likely than Whites with diabetes to have had medical attention for nephropathy in the past year. The difference between each of these groups and Whites was less than 3 percentage points.

***** Significantly different from the score for Whites ($p < 0.05$).

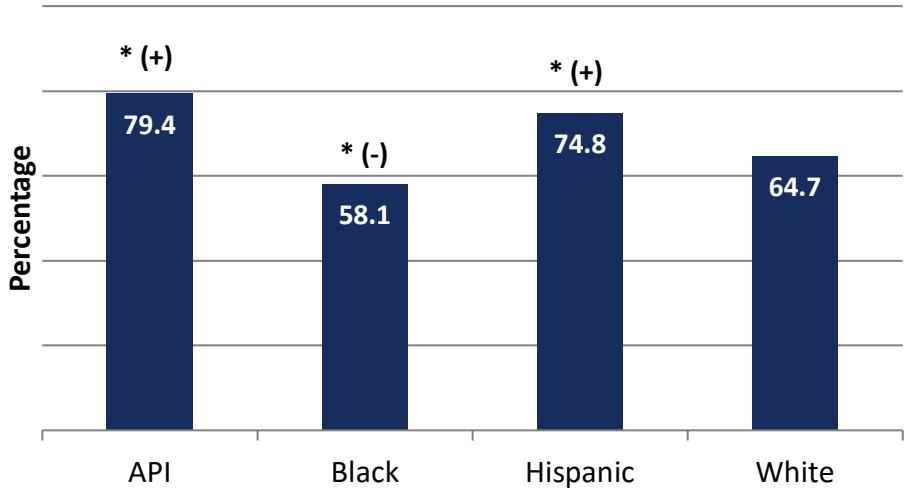
For differences that are statistically significant, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Diabetes Care—Blood Pressure Controlled

Percentage of Medicare enrollees aged 18–75 years with diabetes (type 1 and type 2) whose most recent blood pressure was less than 140/90, by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Asians or Pacific Islanders and Hispanics with diabetes were more likely than Whites with diabetes to have their blood pressure under control. The difference between each of these groups and Whites was greater than 3 percentage points.
- Blacks with diabetes were less likely than Whites with diabetes to have their blood pressure under control. The difference between these groups was greater than 3 percentage points.

***** Significantly different from the score for Whites ($p < 0.05$).

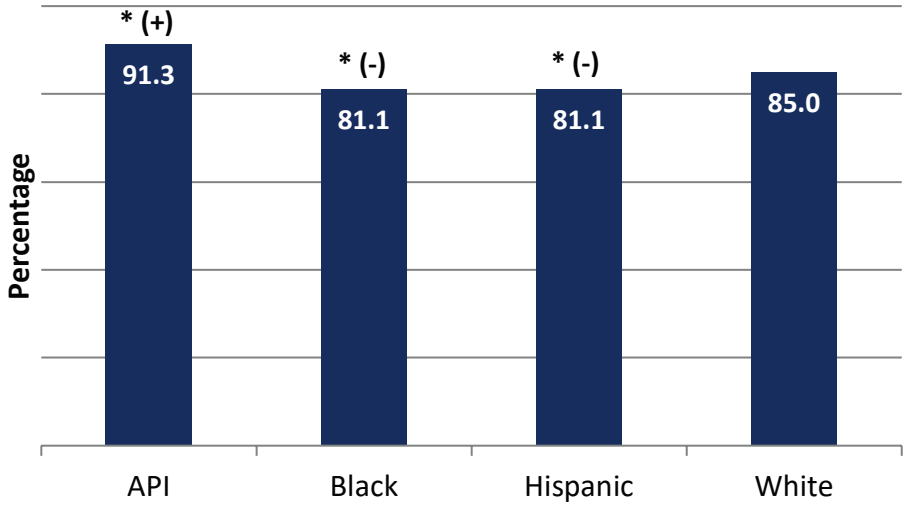
For differences that are statistically significant, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Diabetes Care—Blood Sugar Controlled

Percentage of Medicare enrollees aged 18–75 years with diabetes (type 1 and type 2) whose most recent HbA1c level was 9 percent or less, by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Asians or Pacific Islanders with diabetes were more likely than Whites with diabetes to have their blood sugar level under control. The difference between Asians or Pacific Islanders and Whites was greater than 3 percentage points.
- Blacks and Hispanics with diabetes were less likely than Whites with diabetes to have their blood sugar level under control. The difference between each of these groups and Whites was greater than 3 percentage points.

***** Significantly different from the score for Whites ($p < 0.05$).

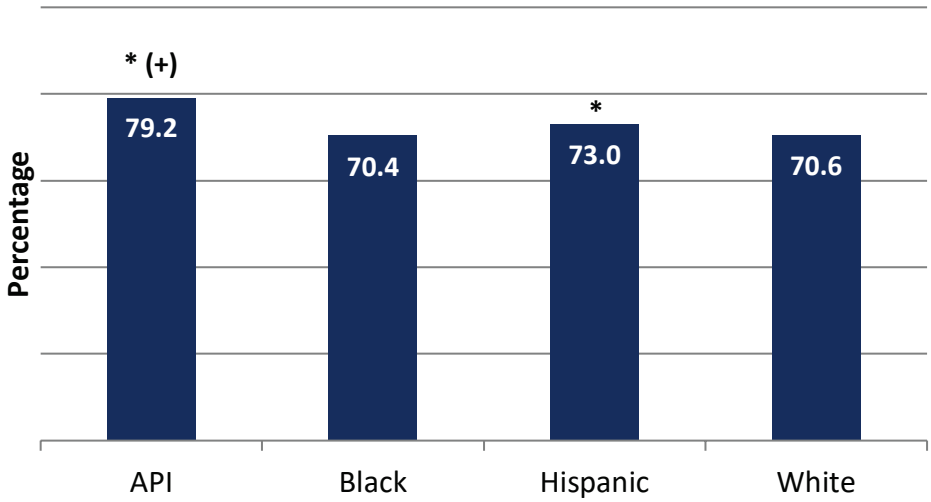
For differences that are statistically significant, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Statin Use in Patients with Diabetes

Percentage of Medicare enrollees aged 40 to 75 years with diabetes (type 1 and type 2)† who received statin therapy, by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Asians or Pacific Islanders with diabetes were more likely than Whites with diabetes to have received statin therapy. The difference between Asians or Pacific Islanders and Whites was greater than 3 percentage points.
- Hispanics with diabetes were more likely than Whites with diabetes to have received statin therapy. The difference between Hispanics and Whites was less than 3 percentage points.

Blacks with diabetes were about as likely as Whites with diabetes to have received statin therapy.

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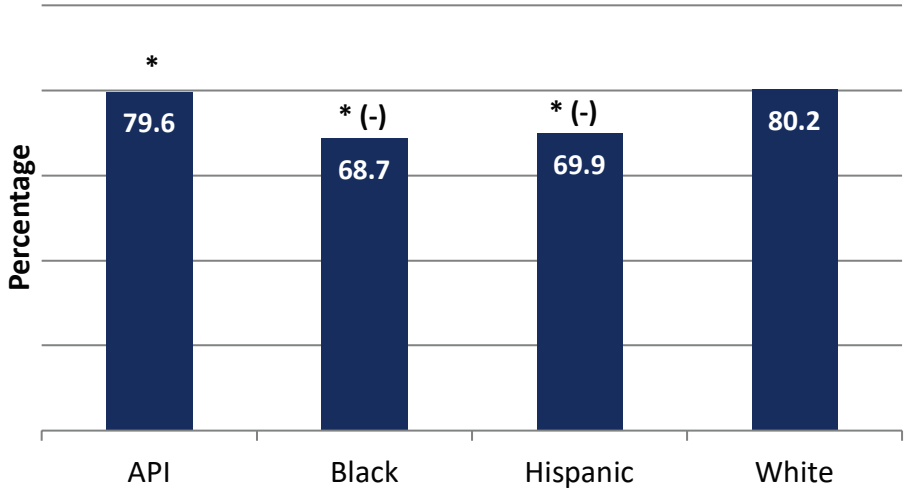
† Excludes those who also have clinical atherosclerotic cardiovascular disease.

***** Significantly different from the score for Whites ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Medication Adherence for Diabetes—Statins

Percentage of Medicare enrollees aged 40 to 75 years with diabetes (type 1 and type 2)† who were dispensed a statin medication during the measurement year who remained on the medication for at least 80 percent of the treatment period, by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Blacks and Hispanics with diabetes were less likely than Whites with diabetes to have had proper statin medication adherence. The difference between each of these groups and Whites was greater than 3 percentage points.

Asians or Pacific Islanders with diabetes were less likely than Whites with diabetes to have had proper statin medication adherence. The difference between Asians or Pacific Islanders and Whites was less than 3 percentage points.

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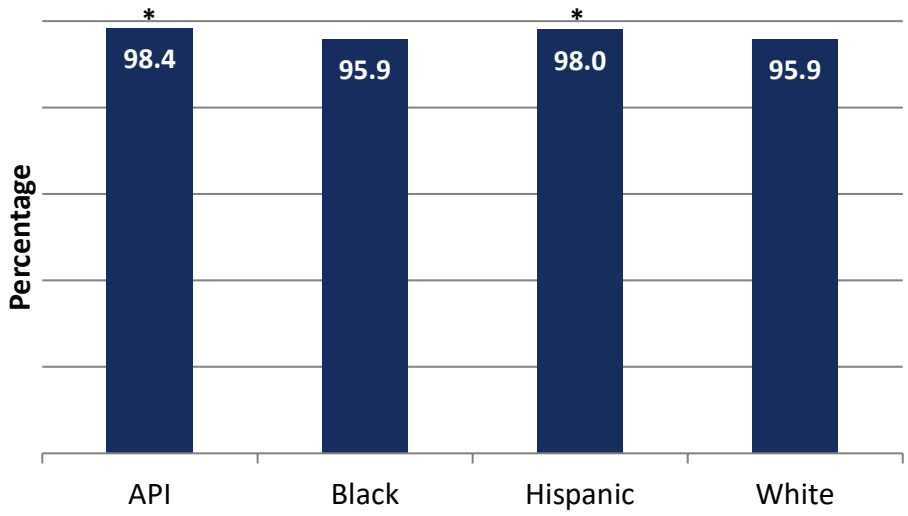
† Excludes those who also have clinical atherosclerotic cardiovascular disease.

***** Significantly different from the score for Whites ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Adult Body Mass Index Assessment

Percentage of Medicare enrollees aged 18–74 years who had an outpatient visit whose body mass index (BMI) was documented in the past two years, by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Asians or Pacific Islanders and Hispanics were more likely than Whites to have had their BMI documented. The difference between each of these groups and Whites was less than 3 percentage points.

Blacks were about as likely as Whites to have had their BMI documented.

***** Significantly different from the score for Whites ($p < 0.05$).

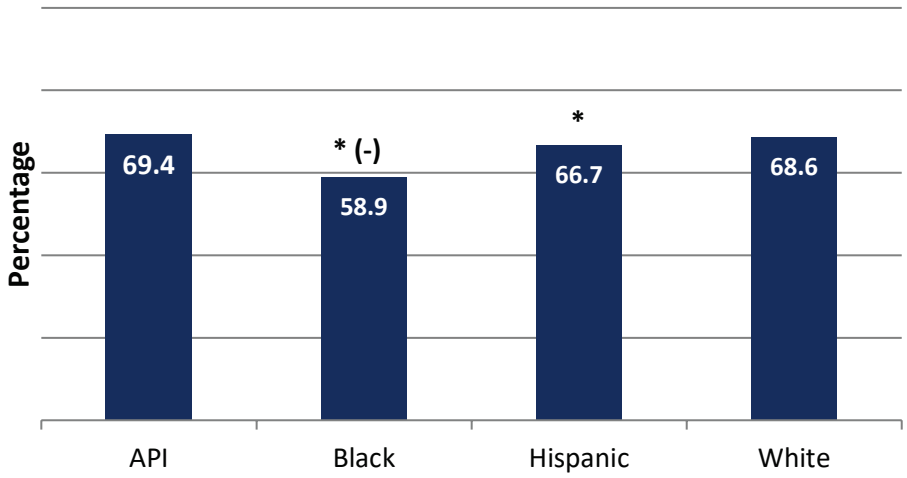
For differences that are statistically significant, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Controlling Blood Pressure

Percentage of Medicare enrollees aged 18–85 years with a diagnosis of hypertension whose blood pressure was adequately controlled† during the past year, by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Blacks who had a diagnosis of hypertension were less likely than Whites who had a diagnosis of hypertension to have had their blood pressure adequately controlled. The difference between Blacks and Whites was greater than 3 percentage points.
- Hispanics who had a diagnosis of hypertension were less likely than Whites who had a diagnosis of hypertension to have had their blood pressure adequately controlled. The difference between Hispanics and Whites was less than 3 percentage points.
- Asians or Pacific Islanders who had a diagnosis of hypertension were about as likely as Whites who had a diagnosis of hypertension to have had their blood pressure adequately controlled.

***** Significantly different from the score for Whites ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:

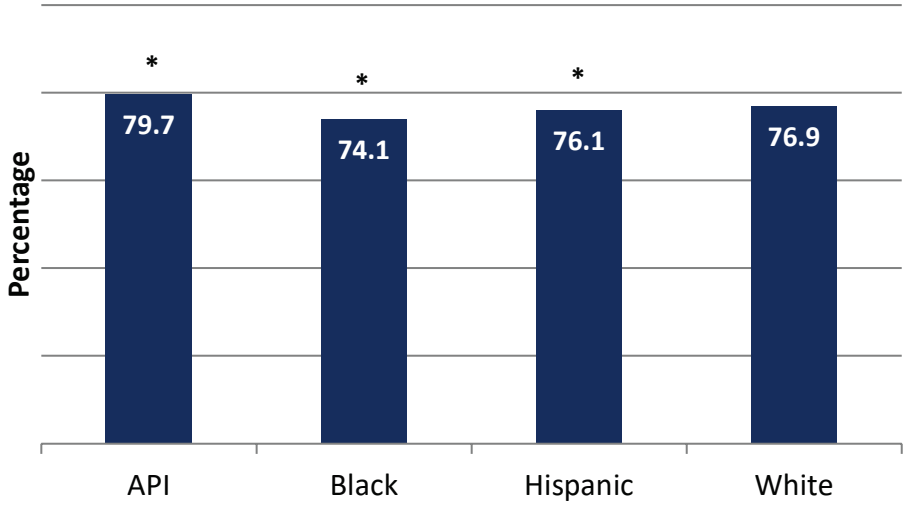
(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

† Less than 140/90 for enrollees 18–59 years of age and for enrollees 60–85 years of age with a diagnosis of diabetes, or less than 150/90 for members 60–85 years of age without a diagnosis of diabetes.

Clinical Care: Statin Use in Patients with Cardiovascular Disease

Percentage of male Medicare enrollees aged 21 to 75 years and female Medicare enrollees aged 40 to 75 years who have clinical atherosclerotic cardiovascular disease (ASCVD) who received statin therapy, by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

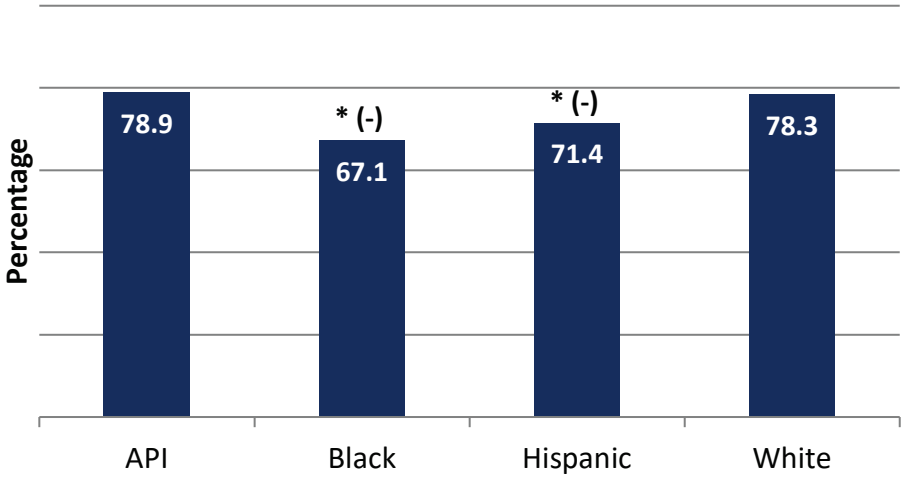
- Asians or Pacific Islanders with ASCVD were more likely than Whites with ASCVD to have received statin therapy. The difference between Asians or Pacific Islanders and Whites was less than 3 percentage points.
- Blacks and Hispanics with ASCVD were less likely than Whites with ASCVD to have received statin therapy. The difference between each of these groups and Whites was less than 3 percentage points.

***** Significantly different from the score for Whites ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Medication Adherence for Cardiovascular Disease—Statins

Percentage of male Medicare enrollees aged 21 to 75 years and female Medicare enrollees aged 40 to 75 years who had clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed a statin medication during the measurement year who remained on the medication for at least 80 percent of the treatment period, by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

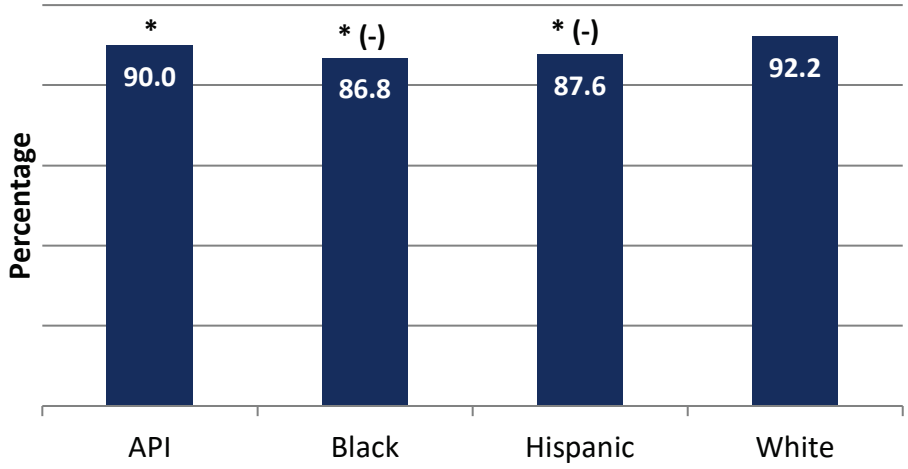
- Blacks and Hispanics with ASCVD were less likely than Whites with ASCVD to have had proper statin medication adherence. The difference between each of these groups and Whites was greater than 3 percentage points.
- Asians or Pacific Islanders with ASCVD were about as likely as Whites with ASCVD to have had proper statin medication adherence.

***** Significantly different from the score for Whites ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Continuous Beta-Blocker Treatment

Percentage of Medicare enrollees aged 18 years and older who were hospitalized and discharged alive with a diagnosis of acute myocardial infarction (heart attack) who received persistent beta-blocker treatment for 6 months after discharge, by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Blacks and Hispanics who were hospitalized for a heart attack were less likely than Whites who were hospitalized for a heart attack to have received persistent beta-blocker treatment. The difference between each of these groups and Whites was greater than 3 percentage points.
- Asians or Pacific Islanders who were hospitalized for a heart attack were less likely than Whites who were hospitalized for a heart attack to have received persistent beta-blocker treatment. The difference between Asians or Pacific Islanders and Whites was less than 3 percentage points.

***** Significantly different from the score for Whites ($p < 0.05$).

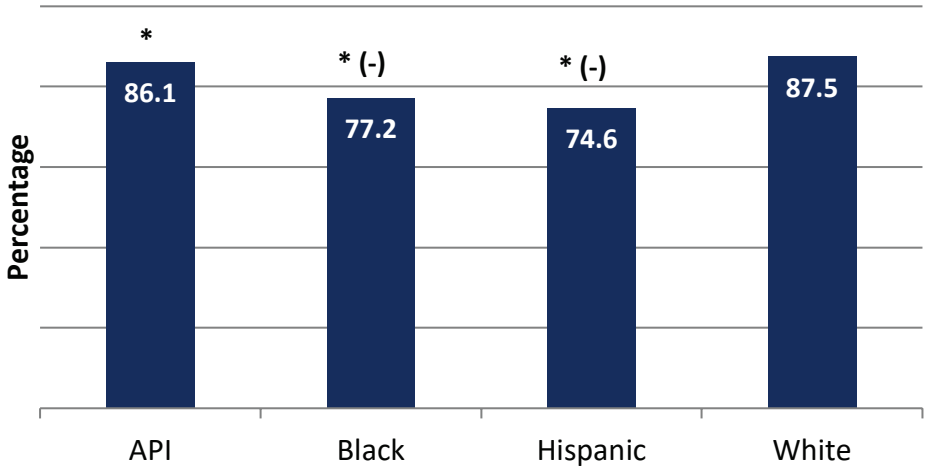
For differences that are statistically significant, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Asthma Medication Ratio in Older Adults

Percentage of Medicare enrollees aged 65 to 85 years who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the past year, by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

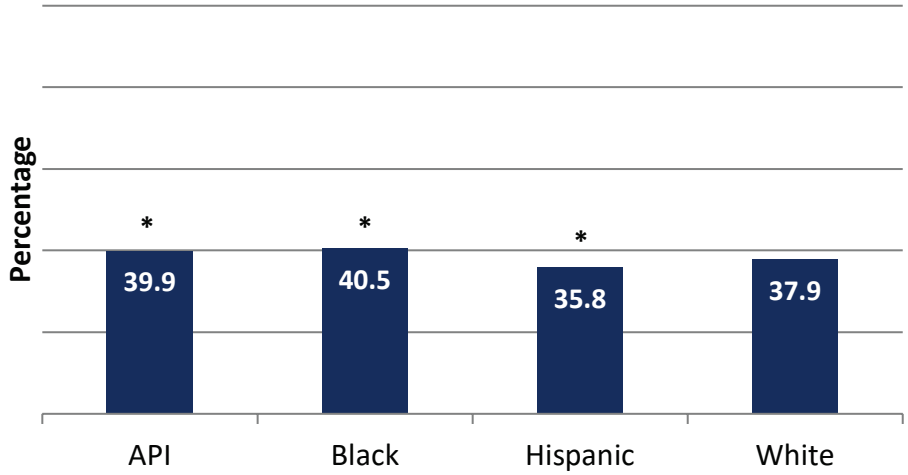
- Black and Hispanic older adults with persistent asthma were less likely than White older adults with persistent asthma to have had appropriate asthma medication management during the past year. The difference between Black and White older adults was greater than 3 percentage points; the difference between Hispanic and White older adults was also greater than 3 percentage points.
- Asian or Pacific Islander older adults with persistent asthma were less likely than White older adults with persistent asthma to have had appropriate asthma medication management during the past year. The difference between Asian or Pacific Islander and White older adults was less than 3 percentage points.

***** Significantly different from the score for Whites ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Testing to Confirm COPD

Percentage of Medicare enrollees aged 40 years and older with a new diagnosis of chronic obstructive pulmonary disease (COPD) or newly active COPD who received appropriate spirometry testing to confirm the diagnosis, by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

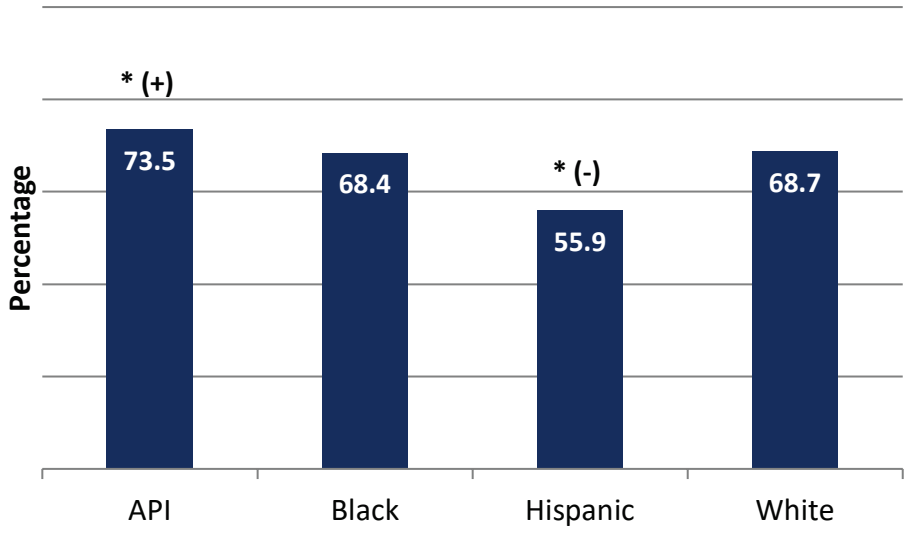
- Asians or Pacific Islanders and Blacks with a new diagnosis of COPD or newly active COPD were more likely than Whites with a new diagnosis of COPD or newly active COPD to have received a spirometry test to confirm the diagnosis. The difference between each of these groups and Whites was less than 3 percentage points.
- Hispanics with a new diagnosis of COPD or newly active COPD were less likely than Whites with a new diagnosis of COPD or newly active COPD to have received a spirometry test to confirm the diagnosis. The difference between Hispanics and Whites was less than 3 percentage points.

***** Significantly different from the score for Whites ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid

Percentage of COPD exacerbations for MA enrollees aged 40 years and older who had an acute inpatient discharge or emergency department encounter in the past year in which a systemic corticosteroid was dispensed within 14 days of the event, by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Asians or Pacific Islanders who experienced a COPD exacerbation were more likely than Whites who experienced a COPD exacerbation to have been dispensed a systemic corticosteroid within 14 days of the event. The difference between these groups was greater than 3 percentage points.
- Hispanics who experienced a COPD exacerbation were less likely than Whites who experienced a COPD exacerbation to have been dispensed a systemic corticosteroid within 14 days of the event. The difference between these groups was greater than 3 percentage points.
- Blacks who experienced a COPD exacerbation were about as likely as Whites who experienced a COPD exacerbation to have been dispensed a systemic corticosteroid within 14 days of the event.

***** Significantly different from the score for Whites ($p < 0.05$).

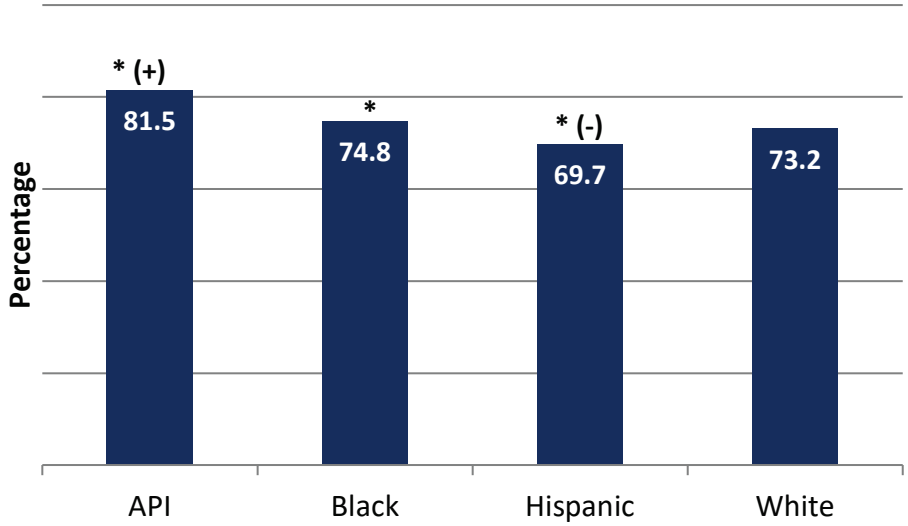
For differences that are statistically significant, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Pharmacotherapy Management of COPD Exacerbation—Bronchodilator

Percentage of MA enrollees aged 40 years and older who had an acute inpatient discharge or emergency department encounter for COPD exacerbation in the past year who were dispensed a bronchodilator within 30 days of experiencing the event, by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

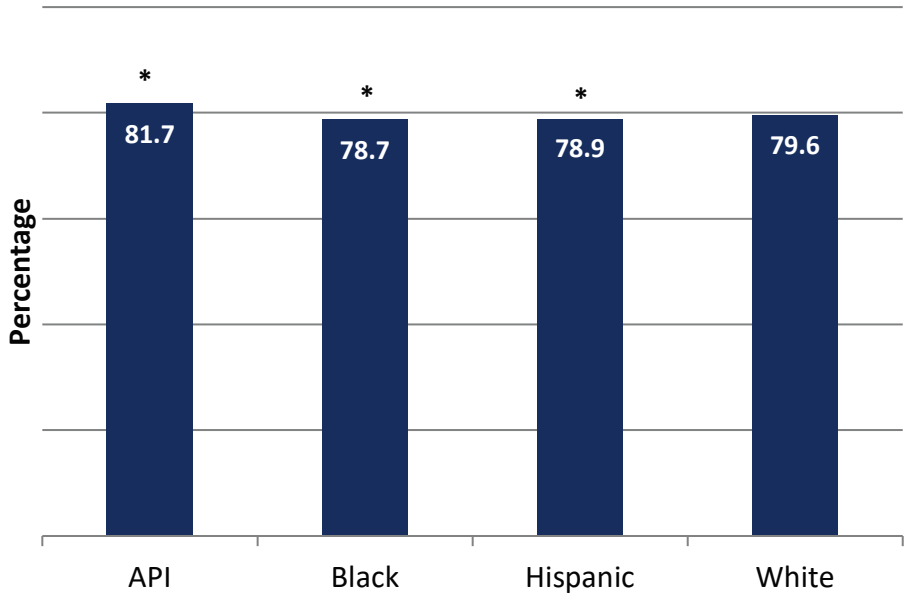
Disparities

- Asians or Pacific Islanders who experienced a COPD exacerbation were more likely than Whites who experienced a COPD exacerbation to have been dispensed a bronchodilator within 30 days of the event. The difference between Asians or Pacific Islanders and Whites was greater than 3 percentage points.
- Blacks who experienced a COPD exacerbation were more likely than Whites who experienced a COPD exacerbation to have been dispensed a bronchodilator within 30 days of the event. The difference between Blacks and Whites was less than 3 percentage points.
- Hispanics who experienced a COPD exacerbation were less likely than Whites who experienced a COPD exacerbation to have been dispensed a bronchodilator within 30 days of the event. The difference between Hispanics and Whites was greater than 3 percentage points.

***** Significantly different from the score for Whites ($p < 0.05$).
For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Rheumatoid Arthritis Management

Percentage of Medicare enrollees aged 18 years and older who were diagnosed with rheumatoid arthritis during the past year who were dispensed at least one ambulatory prescription for a disease-modifying antirheumatic drug (DMARD), by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Asians or Pacific Islanders who were diagnosed with rheumatoid arthritis were more likely than Whites who were diagnosed with rheumatoid arthritis to have been dispensed at least one DMARD. The difference between these groups was less than 3 percentage points.
- Blacks and Hispanics who were diagnosed with rheumatoid arthritis were less likely than Whites who were diagnosed with rheumatoid arthritis to have been dispensed at least one DMARD. The difference between each of these groups and Whites was less than 3 percentage points.

***** Significantly different from the score for Whites ($p < 0.05$).

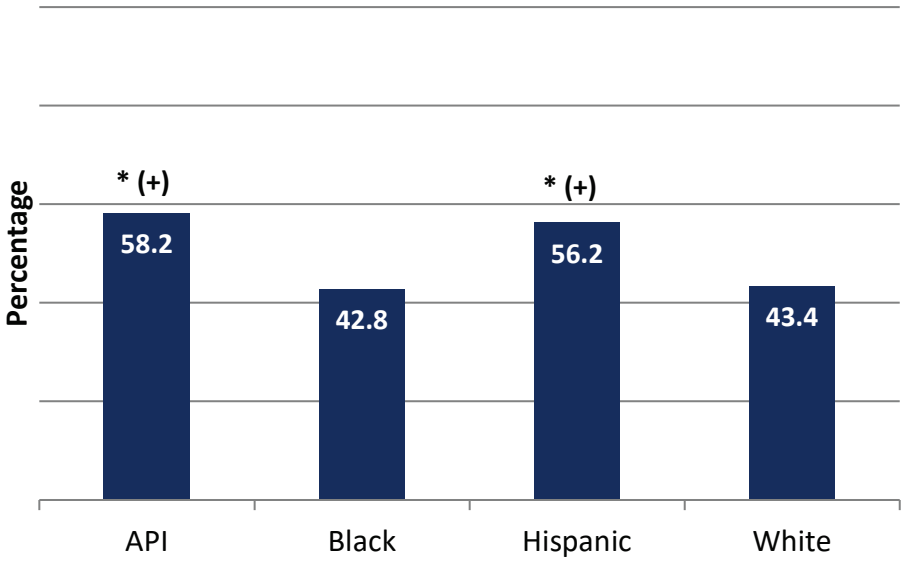
For differences that are statistically significant, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Osteoporosis Management in Women Who Had a Fracture

Percentage of Medicare enrollees (women) aged 67–85 years who suffered a fracture who had either a bone mineral density test or a prescription for a drug to treat osteoporosis in the 6 months after the fracture, by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Asian or Pacific Islander and Hispanic women who suffered a fracture were more likely than White women who suffered a fracture to have had either a bone mineral density test or a prescription for a drug to treat osteoporosis. The difference between each of these groups and Whites was greater than 3 percentage points.
- Black women who suffered a fracture were about as likely as White women who suffered a fracture to have had either a bone mineral density test or a prescription for a drug to treat osteoporosis.

***** Significantly different from the score for Whites ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
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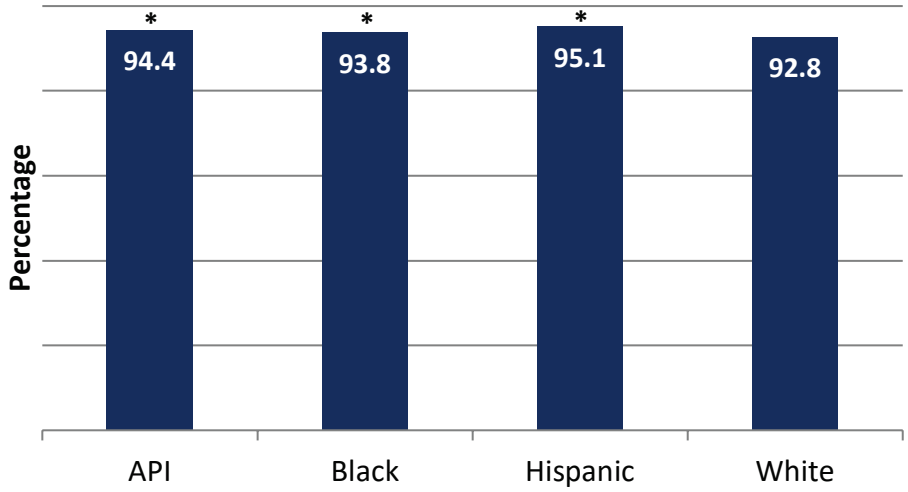
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Appropriate Monitoring of Patients Taking Long-Term Medications

Percentage of Medicare enrollees aged 18 years and older who received at least 180 treatment days of ambulatory medication therapy for a selected therapeutic agent† during the past year who also had at least one therapeutic monitoring event for the therapeutic agent, by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Asians or Pacific Islanders, Blacks, and Hispanics were more likely than Whites to have had at least one appropriate follow-up visit during the year to monitor their use of a higher-risk medication. The difference between each of these groups and Whites was less than 3 percentage points.

***** Significantly different from the score for Whites ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:

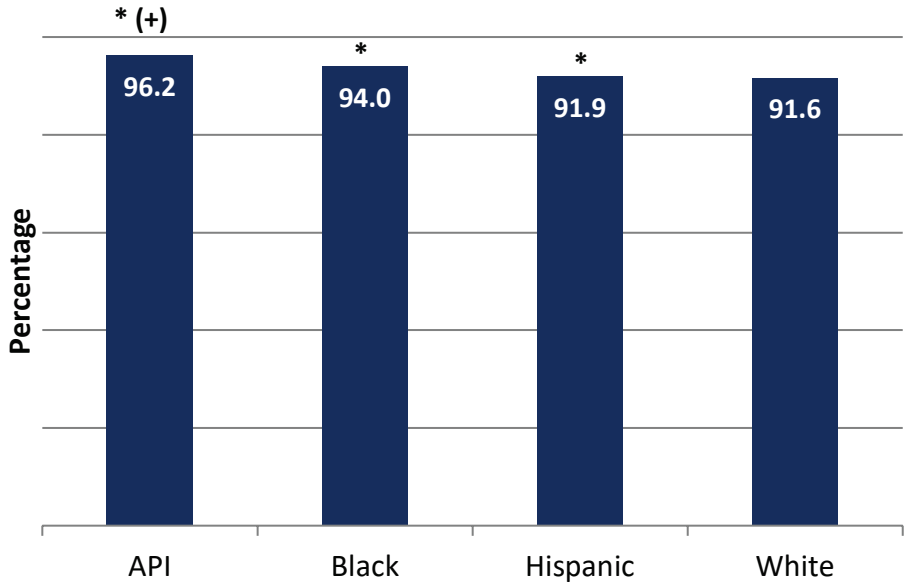
(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

† This measure is limited to those who had a prescription for one or more of the following drugs for 6 months or longer: angiotensin converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARBs), digoxin, diuretics, anticonvulsants, and statins. These drugs are known to have possibly harmful side effects if used long term.

Clinical Care: Avoiding Use of High-Risk Medications in the Elderly

Percentage of Medicare enrollees aged 65 years and older who were not prescribed a high-risk medication, by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Long-term use of high-risk medication should be avoided in the elderly. In the 2017 data, it was observed that this standard of care was met more often for Asians or Pacific Islanders than for Whites. The difference between Asians or Pacific Islanders and Whites was greater than 3 percentage points.
- In the 2017 data, it was observed that this standard of care was met more often for Blacks and Hispanics than for Whites. The difference between each of these groups and Whites was less than 3 percentage points.

***** Significantly different from the score for Whites ($p < 0.05$).

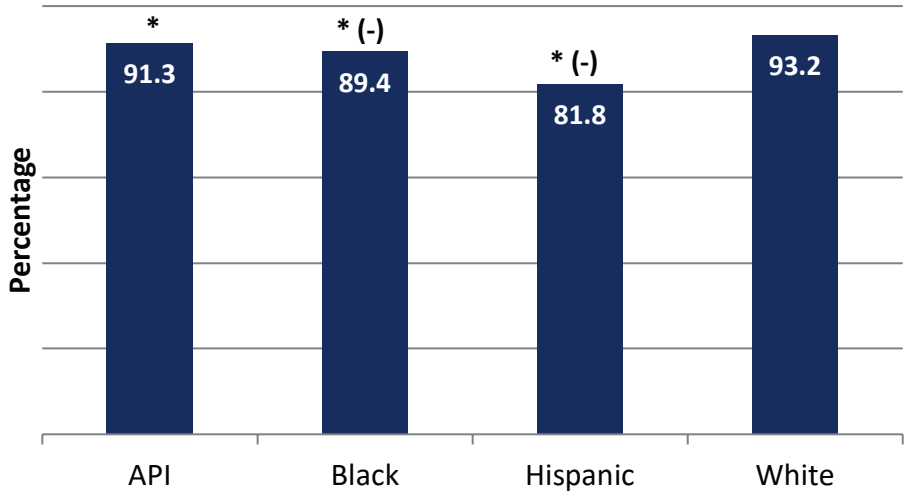
For differences that are statistically significant, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with Chronic Renal Failure

Percentage of Medicare enrollees aged 65 years and older with chronic renal failure who were not dispensed a prescription for a potentially harmful medication,† by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Elderly Blacks and Hispanics with chronic renal failure were less likely than elderly Whites with chronic renal failure to not have been dispensed a potentially harmful medication. The difference between each of these groups and Whites was greater than 3 percentage points.
- Elderly Asians or Pacific Islanders with chronic renal failure were less likely than elderly Whites with chronic renal failure to not have been dispensed a potentially harmful medication. The difference between Asians or Pacific Islanders and Whites was less than 3 percentage points.

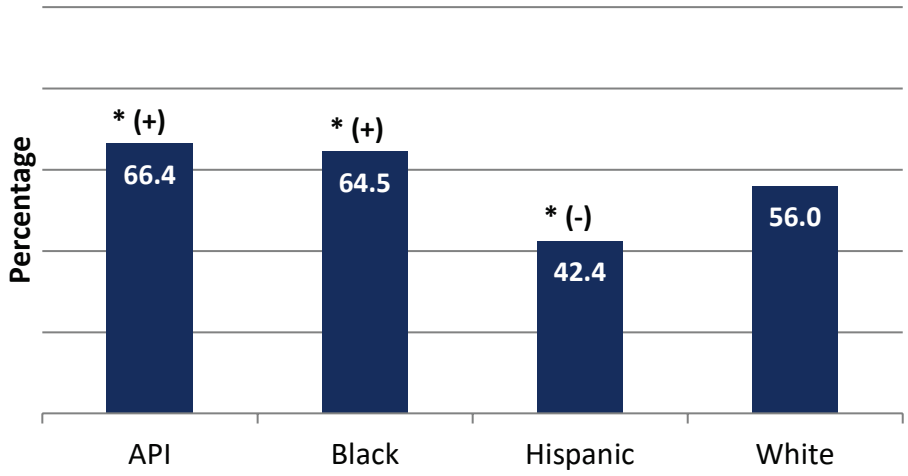
***** Significantly different from the score for Whites ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

† This includes cyclooxygenase-2 (COX-2) selective nonsteroidal anti-inflammatory drugs (NSAIDs) or nonaspirin NSAIDs.

Clinical Care: Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with Dementia

Percentage of Medicare enrollees aged 65 years and older with dementia who were not dispensed a prescription for a potentially harmful medication,† by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Elderly Asians or Pacific Islanders and Blacks with dementia were more likely than elderly Whites with dementia to not have been dispensed a potentially harmful medication. The difference between each of these groups and Whites was greater than 3 percentage points.
- Elderly Hispanics with dementia were less likely than elderly Whites with dementia to not have been dispensed a potentially harmful medication. The difference between Hispanics and Whites was greater than 3 percentage points.

***** Significantly different from the score for Whites ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:

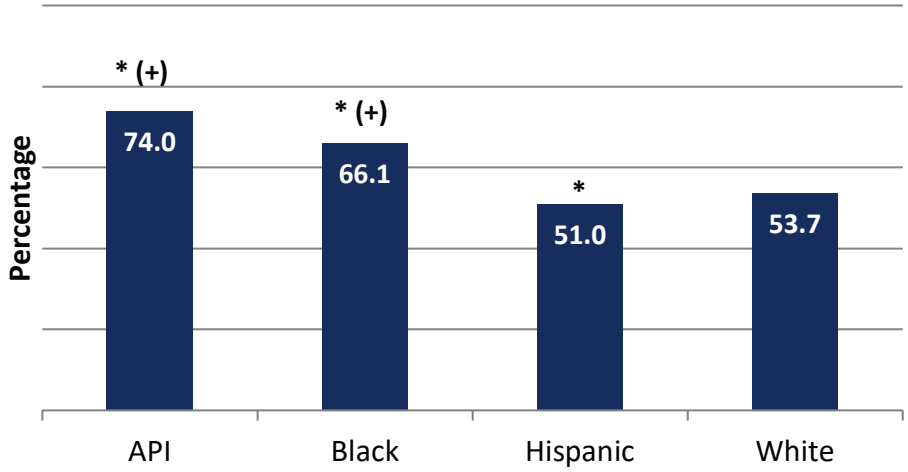
(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

† This includes antiemetics, antipsychotics, benzodiazepines, tricyclic antidepressants, H2 receptor antagonists, nonbenzodiazepine hypnotics, and anticholinergic agents.

Clinical Care: Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with a History of Falls

Percentage of Medicare enrollees aged 65 years and older with a history of falls who were not dispensed a prescription for a potentially harmful medication,† by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Elderly Asians or Pacific Islanders and Blacks with a history of falls were more likely than elderly Whites with a history of falls to not have been dispensed a potentially harmful medication. The difference between each of these groups and Whites was greater than 3 percentage points.
- Elderly Hispanics with a history of falls were less likely than elderly Whites with a history of falls to not have been dispensed a potentially harmful medication. The difference between these groups was less than 3 percentage points.

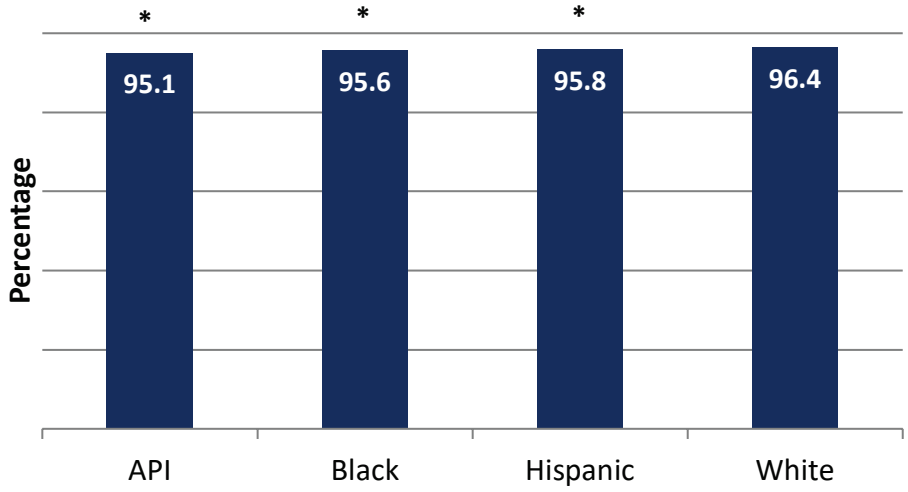
***** Significantly different from the score for Whites ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

† This includes anticonvulsants, nonbenzodiazepine hypnotics, selective serotonin re-uptake inhibitors (SSRIs), antiemetics, antipsychotics, benzodiazepines, and tricyclic antidepressants.

Clinical Care: Older Adults' Access to Preventive/Ambulatory Services

Percentage of Medicare enrollees aged 65 years and older who had an ambulatory or preventive care visit, by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Asians or Pacific Islanders, Blacks, and Hispanics were less likely than Whites to have had an ambulatory or preventive care visit. The difference between each of these groups and Whites was less than 3 percentage points.

***** Significantly different from the score for Whites ($p < 0.05$).

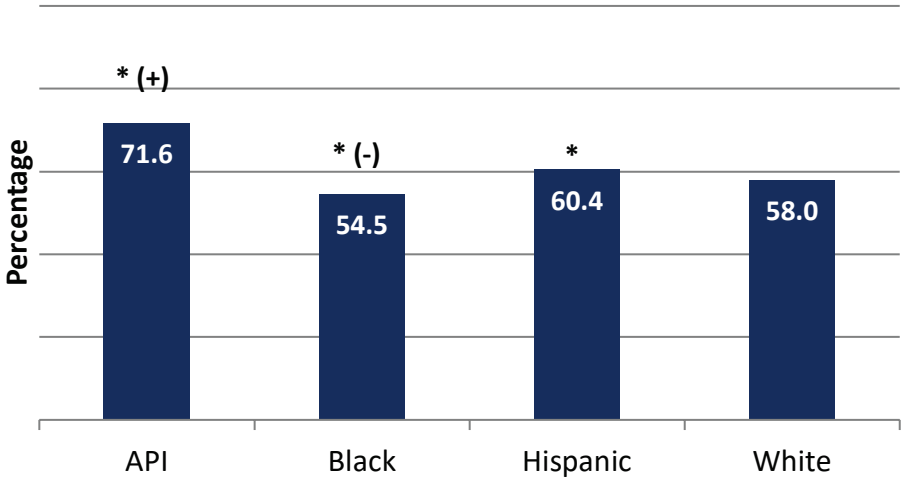
For differences that are statistically significant, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Medication Reconciliation After Hospital Discharge

Percentage of Medicare enrollees aged 18 years and older who were discharged from an inpatient facility and had their medications reconciled within 30 days, by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

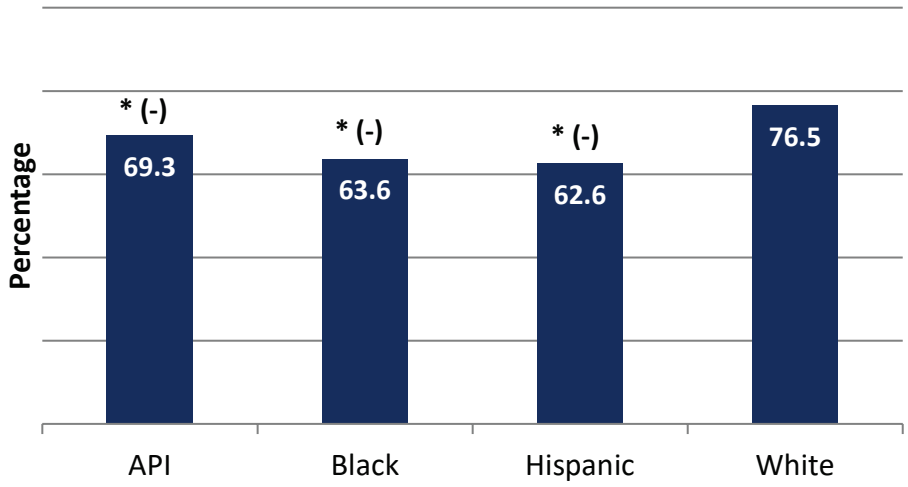
- Asians or Pacific Islanders who were discharged from an inpatient facility were more likely than Whites who were discharged from an inpatient facility to have had their medications reconciled within 30 days. The difference between Asians or Pacific Islanders and Whites was greater than 3 percentage points.
- Hispanics who were discharged from an inpatient facility were more likely than Whites who were discharged from an inpatient facility to have had their medications reconciled within 30 days. The difference between Hispanics and Whites was less than 3 percentage points.
- Blacks who were discharged from an inpatient facility were less likely than Whites who were discharged from an inpatient facility to have had their medications reconciled within 30 days. The difference between these groups was greater than 3 percentage points.

***** Significantly different from the score for Whites ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Antidepressant Medication Management—Acute Phase Treatment

Percentage of Medicare enrollees aged 18 years and older who were diagnosed with a new episode of major depression who remained on antidepressant medication for at least 84 days, by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Asians or Pacific Islanders, Blacks, and Hispanics who were diagnosed with a new episode of major depression were less likely than Whites who were diagnosed with a new episode of major depression to have remained on antidepressant medication for at least 84 days. The difference between each of these groups and Whites was greater than 3 percentage points.

***** Significantly different from the score for Whites ($p < 0.05$).

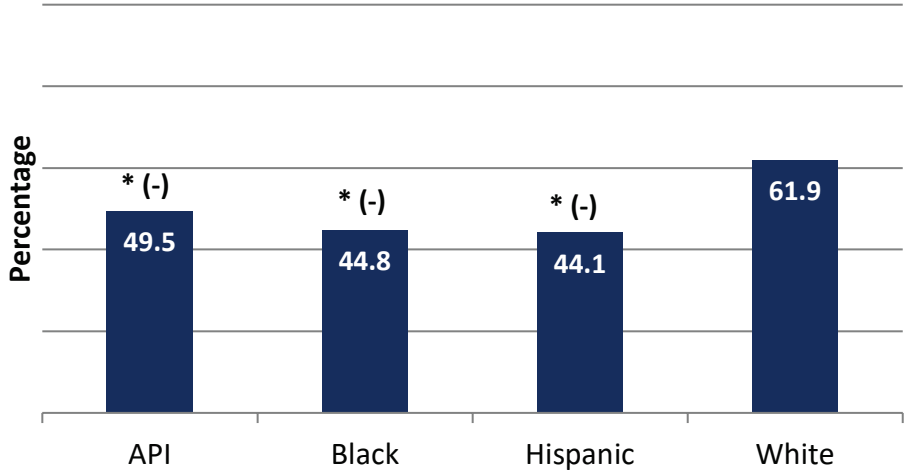
For differences that are statistically significant, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Antidepressant Medication Management—Continuation Phase Treatment

Percentage of Medicare enrollees aged 18 years and older with a new diagnosis of major depression who were newly treated with antidepressant medication who remained on an antidepressant medication treatment for at least 180 days, by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Asians or Pacific Islanders, Blacks, and Hispanics who were diagnosed with a new episode of major depression were less likely than Whites who were diagnosed with a new episode of major depression to have remained on antidepressant medication for at least 180 days. The difference between each of these groups and Whites was greater than 3 percentage points.

***** Significantly different from the score for Whites ($p < 0.05$).

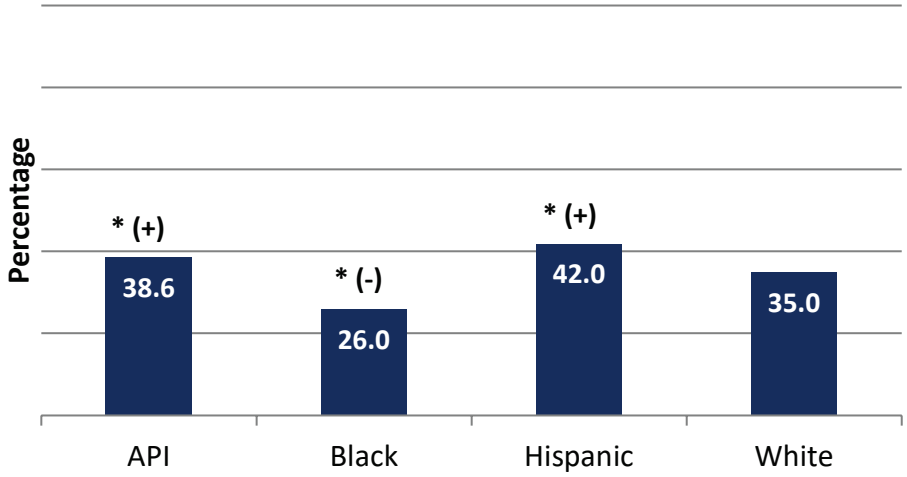
For differences that are statistically significant, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Follow-Up Visit After Hospital Stay for Mental Illness (within 7 days of discharge)

Percentage of Medicare enrollees aged 18 years and older† who were hospitalized for treatment of selected mental health disorders who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge, by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Asians or Pacific Islanders and Hispanics who were hospitalized for a mental health disorder were more likely than Whites who were hospitalized for a mental health disorder to have had appropriate follow-up care within 7 days of being discharged. The difference between each of these groups and Whites was greater than 3 percentage points.
- Blacks who were hospitalized for a mental health disorder were less likely than Whites who were hospitalized for a mental health disorder to have had appropriate follow-up care within 7 days of being discharged. The difference between Blacks and Whites was greater than 3 percentage points.

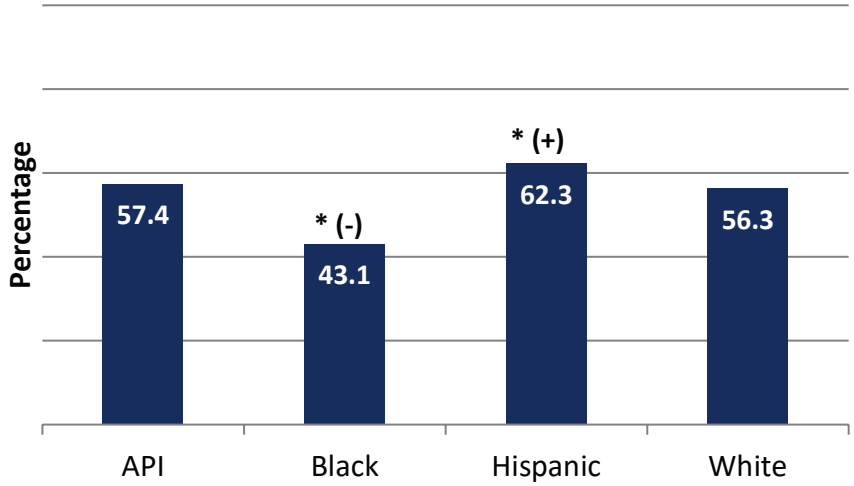
***** Significantly different from the score for Whites ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

† Although the lower-bound age cutoff for this HEDIS measure is 6 years old, the data used in this report are limited to adults.

Clinical Care: Follow-Up Visit After Hospital Stay for Mental Illness (within 30 days of discharge)

Percentage of Medicare enrollees aged 18 years and older† who were hospitalized for treatment of selected mental health disorders who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge, by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

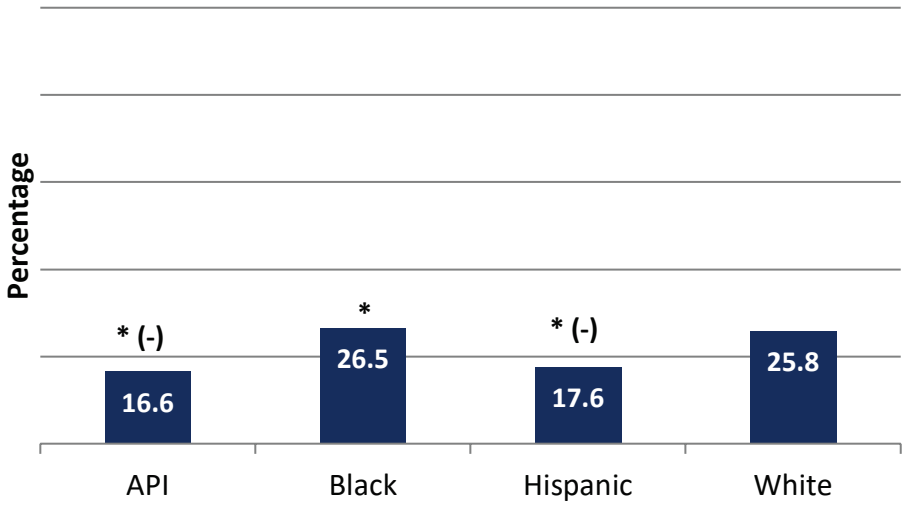
- Hispanics who were hospitalized for a mental health disorder were more likely than Whites who were hospitalized for a mental health disorder to have had appropriate follow-up care within 30 days of discharge. The difference between these groups was greater than 3 percentage points.
- Blacks who were hospitalized for a mental health disorder were less likely than Whites who were hospitalized for a mental health disorder to have had appropriate follow-up care within 30 days of discharge. The difference between these groups was greater than 3 percentage points.
- Asians or Pacific Islanders who were hospitalized for a mental health disorder were about as likely as Whites who were hospitalized for a mental health disorder to have had appropriate follow-up care within 30 days of discharge.

***** Significantly different from the score for Whites ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.
† Although the lower-bound age cutoff for this HEDIS measure is 6 years old, the data used in this report are limited to adults.

Clinical Care: Initiation of Alcohol or Other Drug Treatment

Percentage of Medicare enrollees aged 18 years and older† with a new episode of alcohol or drug (AOD) dependence who initiated‡ treatment within 14 days of the diagnosis, by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Asians or Pacific Islanders and Hispanics with a new episode of AOD dependence were less likely than Whites with a new episode of AOD dependence to have initiated treatment within 14 days of the diagnosis. The difference between each of these groups and Whites was greater than 3 percentage points.
- Blacks with a new episode of AOD dependence were more likely than Whites with a new episode of AOD dependence to have initiated treatment within 14 days of the diagnosis. The difference between Blacks and Whites was less than 3 percentage points.

***** Significantly different from the score for Whites ($p < 0.05$).

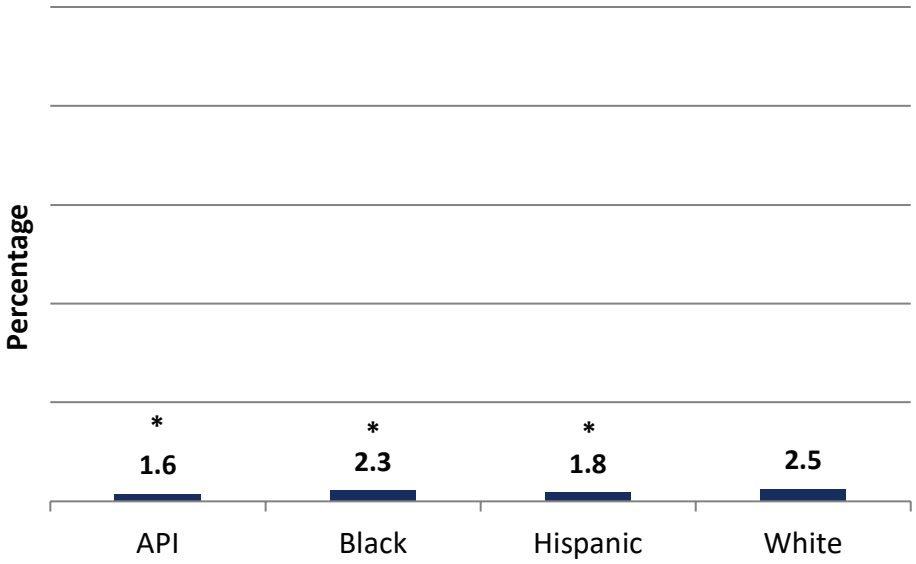
For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

† Although the lower-bound age cutoff for this HEDIS measure is 13 years old, the data used in this report are limited to adults.

‡ Initiation may occur through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization.

Clinical Care: Engagement of Alcohol or Other Drug Treatment

Percentage of Medicare enrollees aged 18 years and older† with a new episode of AOD dependence who initiated treatment who had two or more additional services within 30 days of the initiation visit, by race and ethnicity, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Asians or Pacific Islanders, Blacks, and Hispanics with a new episode of AOD dependence who initiated treatment were less likely than Whites with a new episode of AOD dependence who initiated treatment to have had two or more additional services within 30 days of the initiation visit. The difference between each of these groups and Whites was less than 3 percentage points.

***** Significantly different from the score for Whites ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

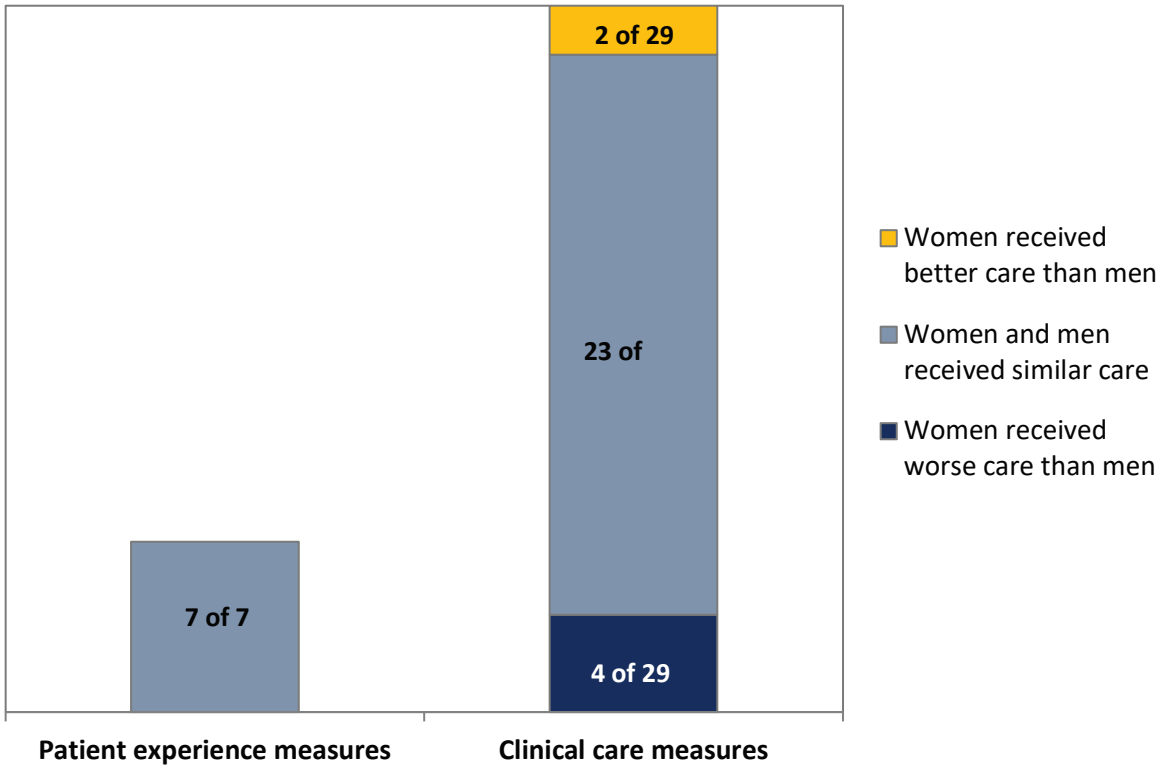
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

† Although the lower-bound age cutoff for this HEDIS measure is 13 years old, the data used in this report are limited to adults.

Section II: Gender Disparities in Health Care in Medicare Advantage

Disparities in Care: All Patient Experience and Clinical Care Measures

Number of patient experience measures (out of 7) and clinical care measures (out of 29) for which women received care that was worse than, similar to, or better than the care received by men in 2017



SOURCES: The bar on the left (patient experience measures) summarizes data from all Medicare Advantage beneficiaries nationwide who participated in the 2017 Medicare CAHPS survey. The bar on the right (clinical care measures) summarizes clinical quality (HEDIS) data collected in 2017 from Medicare health plans nationwide.

The relative difference between men and women is used to assess disparities.

- **Better** = Women received better care than men. Differences are statistically significant ($p < 0.05$), are equal to or larger than 3 points† on a 0–100 scale, and favor women.
- **Similar** = Women and men received care of similar quality. Differences are less than 3 points on a 0–100 scale (differences greater than 3 points were always statistically significant). Differences may be statistically significant.
- **Worse** = Women received worse care than men. Differences are statistically significant, are equal to or larger than 3 points on a 0–100 scale, and favor men.

† A difference that is considered to be of moderate magnitude (Paddison et al., 2013).

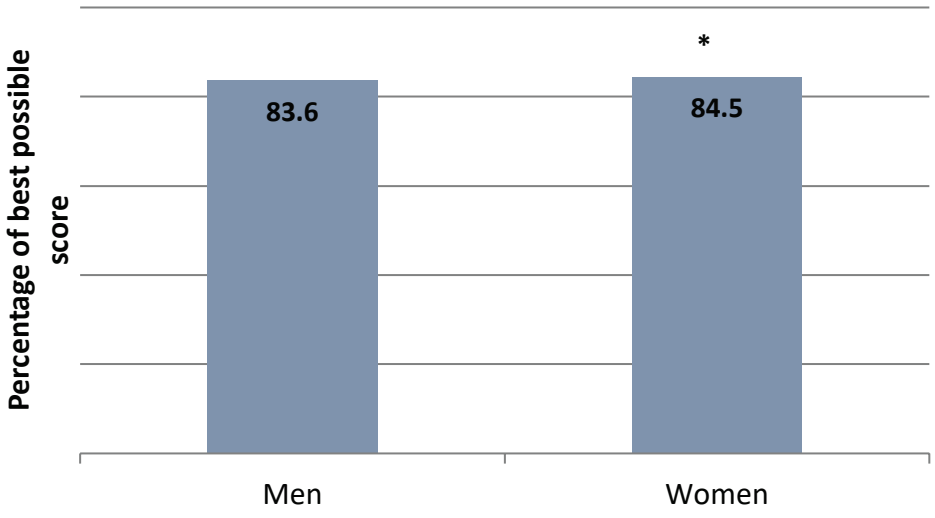
Women receive worse clinical care than men
• Avoiding use of high-risk medications in the elderly • Avoiding potentially harmful drug-disease interactions in patients with dementia • Avoiding potentially harmful drug-disease interactions in patients with a history of falls • Initiation of alcohol or other drug treatment

Women receive better clinical care than men
• Follow-up visit after hospital stay for mental illness (within 7 days of discharge) • Follow-up visit after hospital stay for mental illness (within 30 days of discharge)

Patient Experience

Patient Experience: Getting Needed Care

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for patients to get needed care,† by gender, 2017



SOURCE: Data from the Medicare CAHPS survey, 2017.

Disparities

- Women reported better‡ experiences getting needed care than men did, but the difference between women and men was less than 3 points on a 0–100 scale.

***** Significantly different from the score for men ($p < 0.05$).

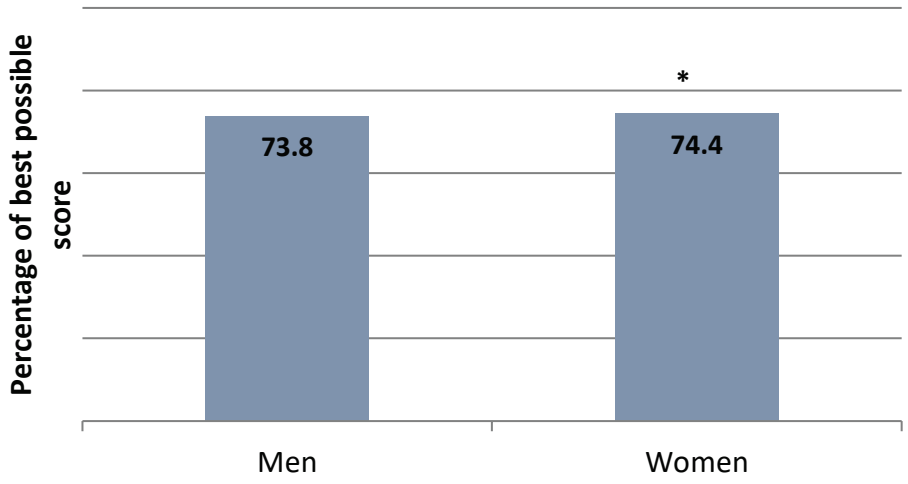
For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors women.
(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

† This includes how often in the last 6 months patients got appointments with specialists as soon as they needed them and how easy it was to get needed care, tests, or treatment.

‡ Unlike on the previous two pages, we use the terms "better" or "worse" to describe all statistically significant differences on individual patient experience measures. We note in the "Disparities" section for each of these measures where differences are greater or less than 3 points.

Patient Experience: Getting Appointments and Care Quickly

Percentage of the best possible score (on a 0–100 scale) earned on how quickly patients get appointments and care,† by gender, 2017



SOURCE: Data from the Medicare CAHPS survey, 2017.

Disparities

- Women reported better experiences with getting appointments and care quickly than men did, but the difference between women and men was less than 3 points on a 0–100 scale.

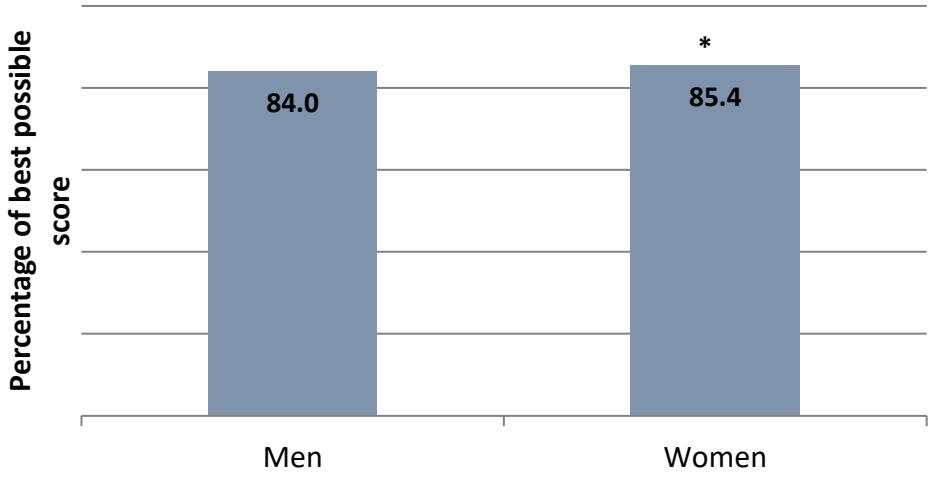
***** Significantly different from the score for men ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors women.
(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

† This includes how often in the last 6 months patients got care that was needed right away, as well as how easy it was to get appointments for checkups and routine care.

Patient Experience: Customer Service

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is to get information and help from one's plan when needed,† by gender, 2017



SOURCE: Data from the Medicare CAHPS survey, 2017.

Disparities

- Women reported better experiences with customer service than men did, but the difference between women and men was less than 3 points on a 0–100 scale.

***** Significantly different from the score for men ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:

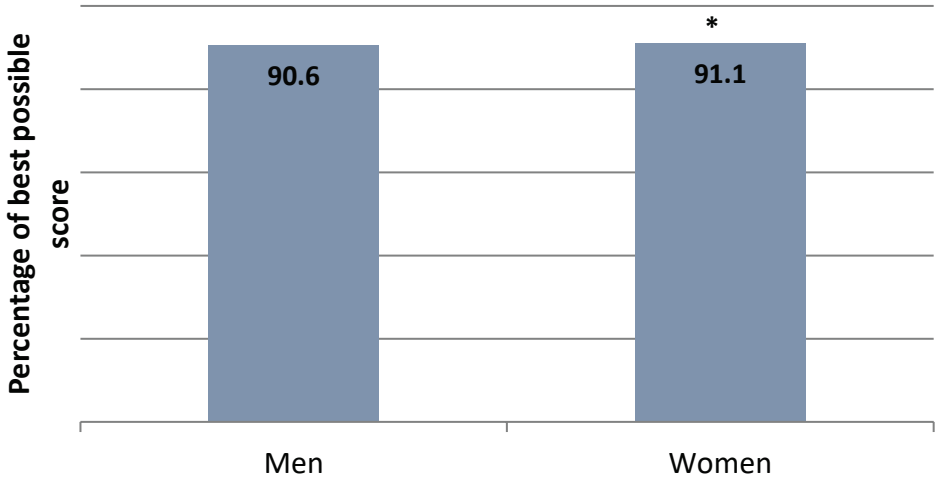
(+) Difference is equal to or larger than 3 points (before rounding) and favors women.

(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

† This includes how often in the last 6 months health plan customer service staff provided the information or help that beneficiaries needed, how often beneficiaries were treated with courtesy and respect, and how often forms from the health plan were easy to fill out.

Patient Experience: Doctors Who Communicate Well

Percentage of the best possible score (on a 0–100 scale) earned on how well doctors communicate with patients,† by gender, 2017



SOURCE: Data from the Medicare CAHPS survey, 2017.

Disparities

- Women reported better experiences with doctor communication than men reported, but the difference between women and men was less than 3 points on a 0–100 scale.

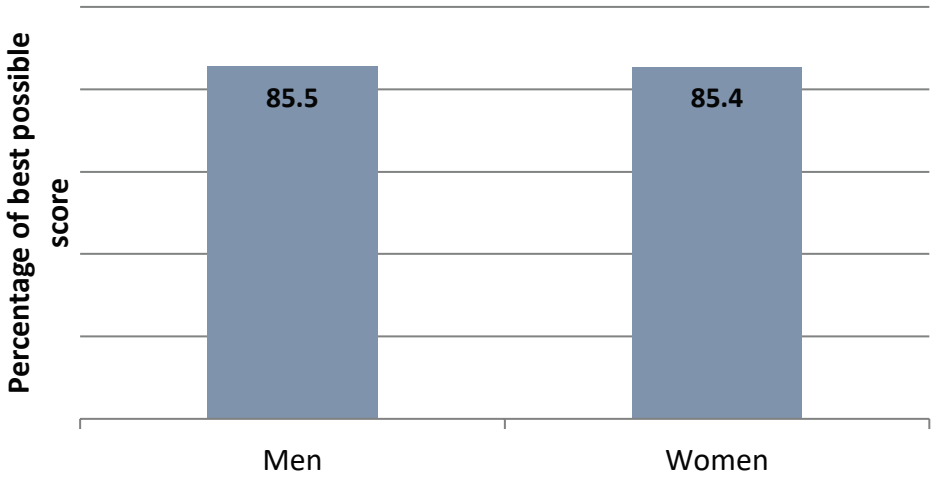
***** Significantly different from the score for men ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors women.
(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

† This includes how often in the last 6 months doctors explained things in a way that was easy to understand, listened carefully, showed respect for what patients had to say, and spent time with patients.

Patient Experience: Care Coordination

Percentage of the best possible score (on a 0–100 scale) earned on how well patient care is coordinated,† by gender, 2017



SOURCE: Data from the Medicare CAHPS survey, 2017.

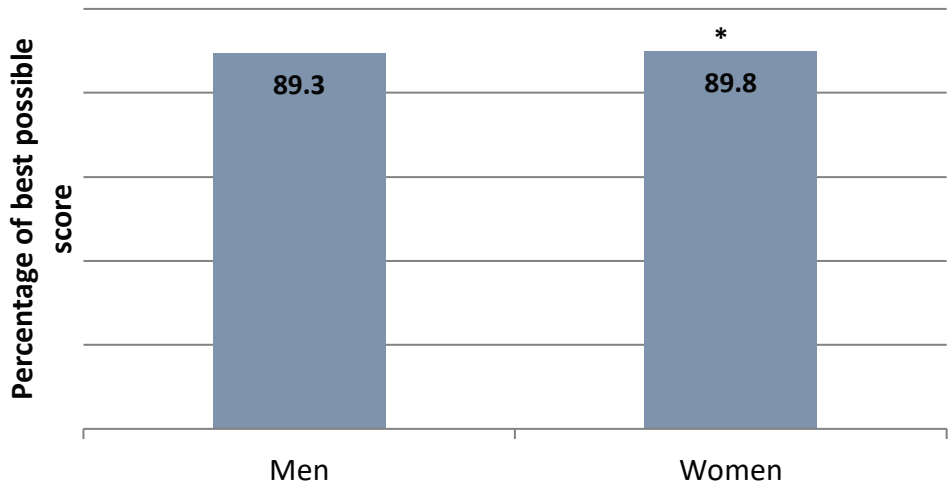
Disparities

- Care coordination experiences reported by women were similar to care coordination experiences reported by men.

† This includes how often in the last 6 months doctors had medical records and other information about patients' care at patients' scheduled appointments and how quickly patients received their test results.

Patient Experience: Getting Needed Prescription Drugs

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for beneficiaries to get the prescription drugs they need using their plans,† by gender, 2017



SOURCE: Data from the Medicare CAHPS survey, 2017.

Disparities

- Women reported better experiences getting needed prescription drugs than men reported, but the difference between women and men was less than 3 points on a 0–100 scale.

***** Significantly different from the score for men ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:

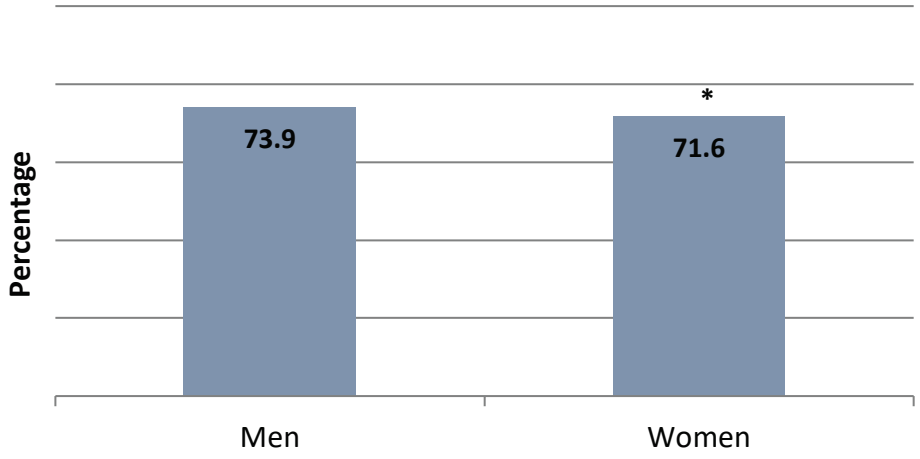
(+) Difference is equal to or larger than 3 points (before rounding) and favors women.

(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

† This includes how often in the last 6 months it was easy to use the plan to get prescribed medications and how easy it was to fill prescriptions at a pharmacy or by mail.

Patient Experience: Annual Flu Vaccine

Percentage of Medicare enrollees who got a vaccine (flu shot), by gender, 2017



SOURCE: Data from the Medicare CAHPS survey, 2017.

Disparities

- Women were less likely than men to have received the flu vaccine, but the difference between women and men was less than 3 points on a 0–100 scale.

***** Significantly different from the score for men ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:

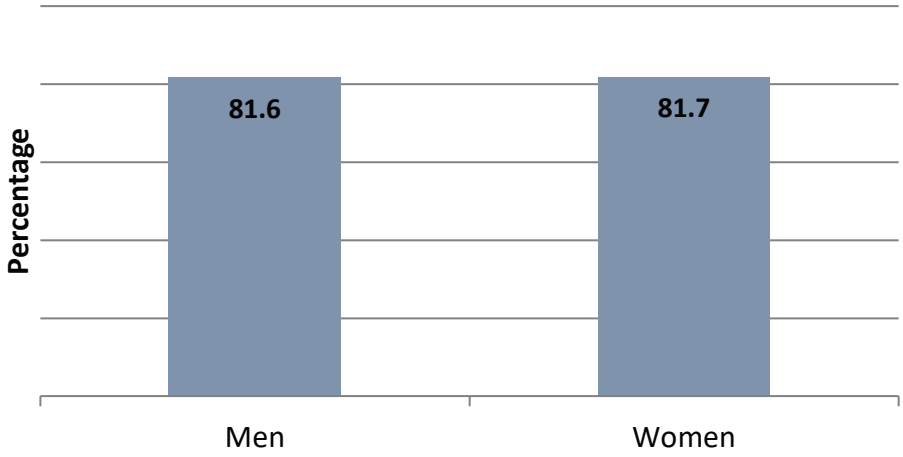
(+) Difference is equal to or larger than 3 points (before rounding) and favors women.

(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

Clinical Care

Clinical Care: Colorectal Cancer Screening

Percentage of Medicare enrollees aged 50–75 years who had appropriate screening for colorectal cancer, by gender, 2017



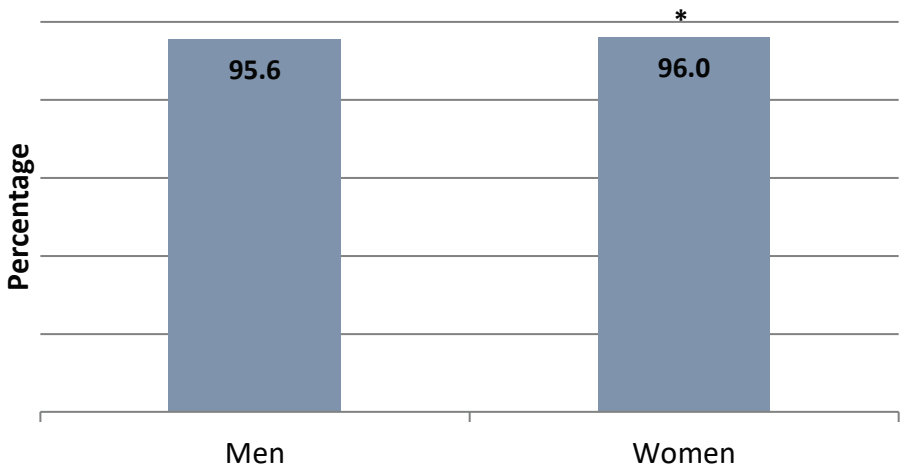
SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.

Disparities

- Women were about as likely as men to have been appropriately screened for colorectal cancer.

Clinical Care: Diabetes Care—Blood Sugar Testing

Percentage of Medicare enrollees aged 18–75 years with diabetes (type 1 and type 2) who had one or more HbA1c tests in the past year, by gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.

Disparities

- Women with diabetes were more likely than men with diabetes to have had their blood sugar tested at least once in the past year. The difference between women and men was less than 3 percentage points.

***** Significantly different from the score for men ($p < 0.05$).

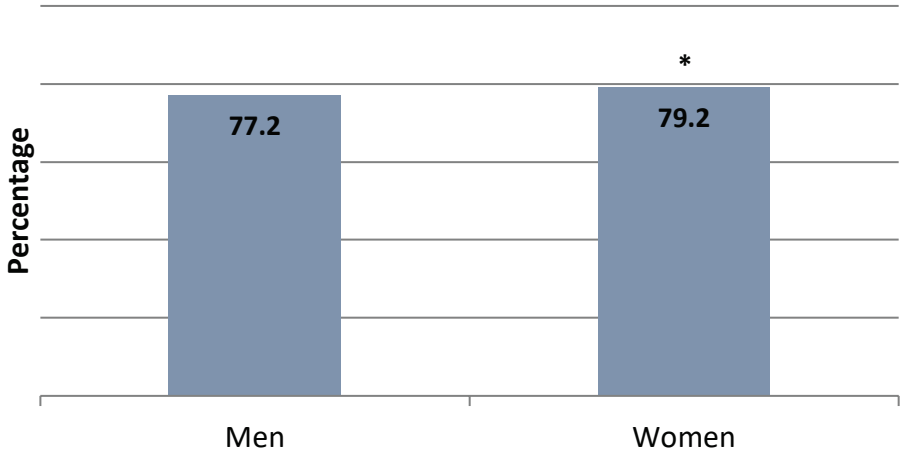
For differences that are statistically significant, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors women.

(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

Clinical Care: Diabetes Care—Eye Exam

Percentage of Medicare enrollees aged 18–75 years with diabetes (type 1 and type 2) who had an eye exam (retinal) in the past year, by gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.

Disparities

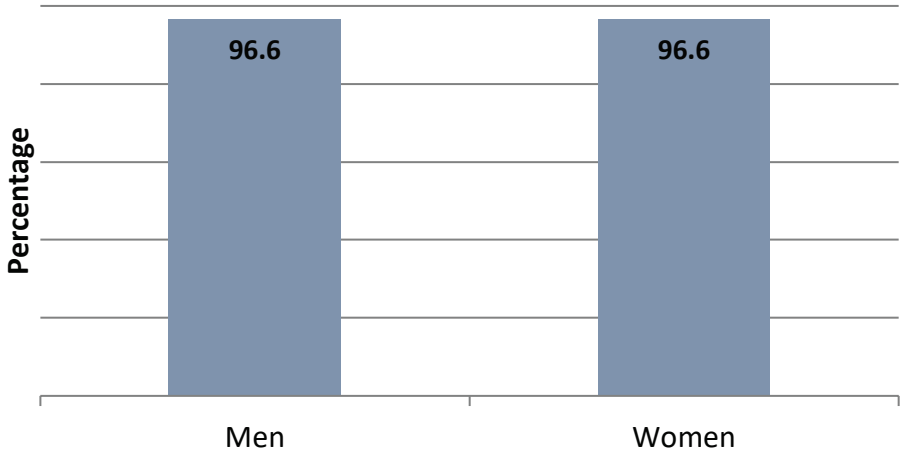
- Women with diabetes were more likely than men with diabetes to have had an eye exam in the past year. The difference between women and men was less than 3 percentage points.

***** Significantly different from the score for men ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors women.
(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

Clinical Care: Diabetes Care—Kidney Disease Monitoring

Percentage of Medicare enrollees aged 18–75 years with diabetes (type 1 and type 2) who had medical attention for nephropathy in the past year, by gender, 2017



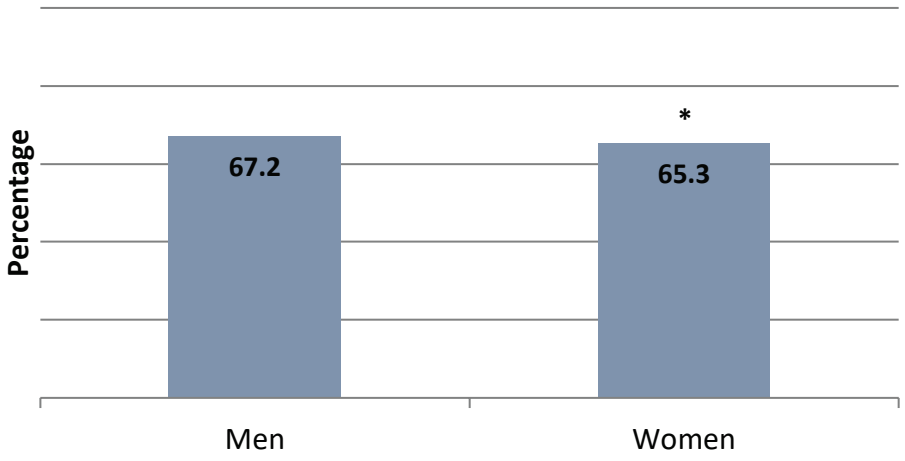
SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.

Disparities

- Women with diabetes were about as likely as men with diabetes to have had medical attention for nephropathy in the past year.

Clinical Care: Diabetes Care—Blood Pressure Controlled

Percentage of Medicare enrollees aged 18–75 years with diabetes (type 1 and type 2) whose most recent blood pressure was less than 140/90, by gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.

Disparities

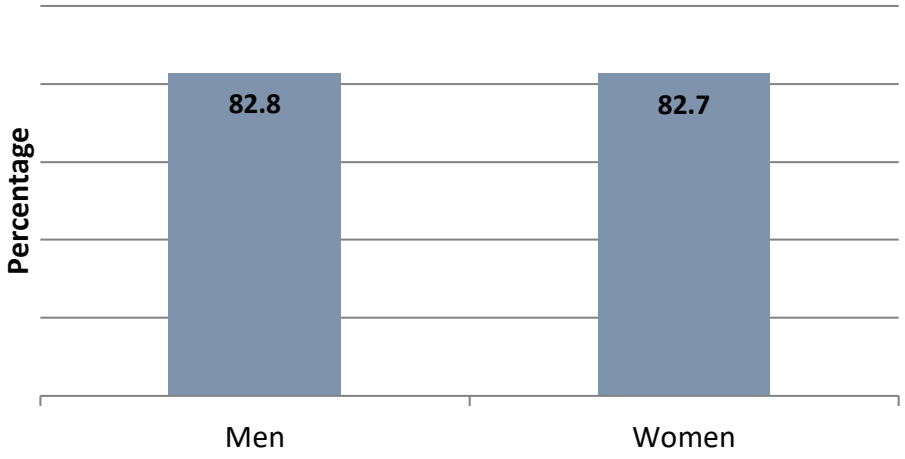
- Women with diabetes were less likely than men with diabetes to have their blood pressure under control. The difference between women and men was less than 3 percentage points.

***** Significantly different from the score for men ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors women.
(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

Clinical Care: Diabetes Care—Blood Sugar Controlled

Percentage of Medicare enrollees aged 18–75 years with diabetes (type 1 and type 2) whose most recent HbA1c level was 9 percent or less, by gender, 2017



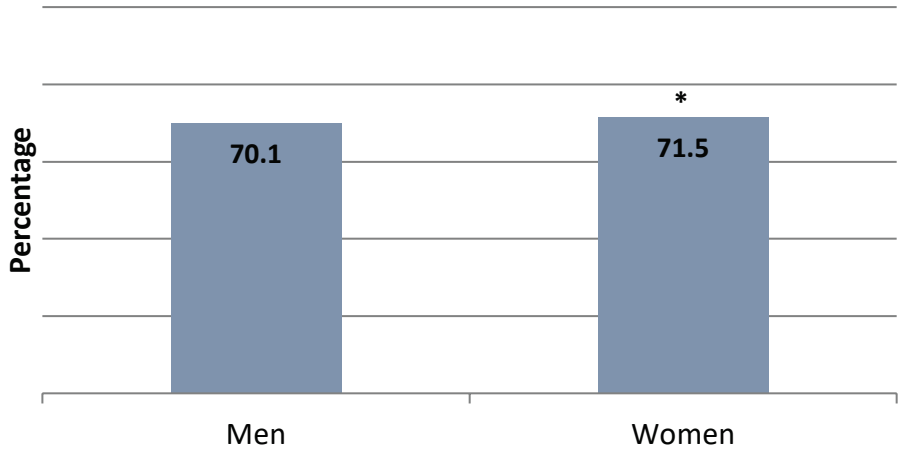
SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.

Disparities

- Women with diabetes were about as likely as men with diabetes to have their blood sugar levels under control.

Clinical Care: Statin Use in Patients with Diabetes

Percentage of Medicare enrollees aged 40 to 75 years with diabetes (type 1 and type 2)† who received statin therapy, by gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.

Disparities

- Women with diabetes were more likely than men with diabetes to have received statin therapy. The difference between women and men was less than 3 percentage points.

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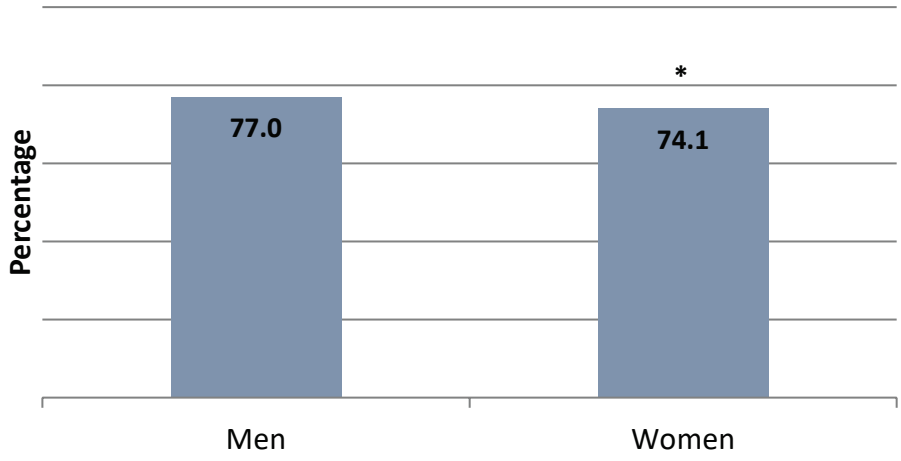
† Excludes those who also have clinical atherosclerotic cardiovascular disease.

***** Significantly different from the score for men ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors women.
(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

Clinical Care: Medication Adherence for Diabetes—Statins

Percentage of Medicare enrollees aged 40 to 75 years with diabetes (type 1 and type 2)† who were dispensed a statin medication during the measurement year who remained on the medication for at least 80 percent of the treatment period, by gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare Advantage plans nationwide.

Disparities

- Women with diabetes were less likely than men with diabetes to have had proper statin medication adherence. The difference between men and women was less than 3 percentage points.

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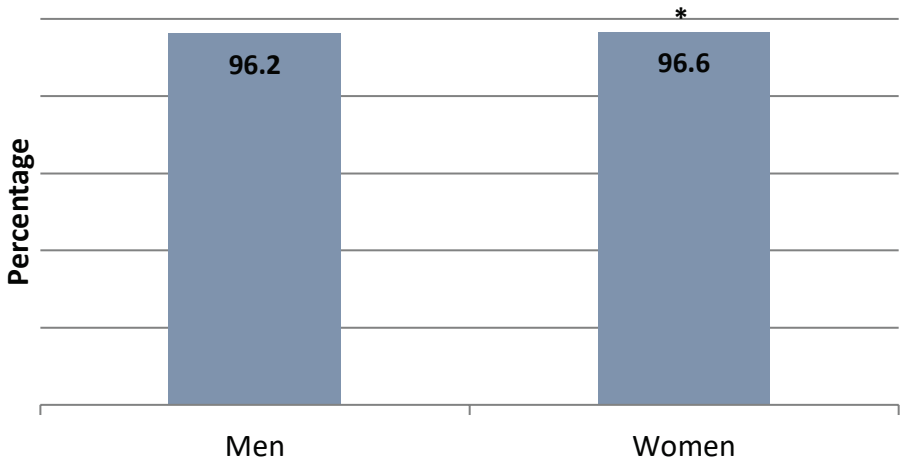
† Excludes those who also have clinical atherosclerotic cardiovascular disease.

***** Significantly different from the score for men ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors women.
(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

Clinical Care: Adult BMI Assessment

Percentage of Medicare enrollees aged 18–74 years who had an outpatient visit whose BMI was documented in the past two years, by gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.

Disparities

- Women were more likely than men to have had their BMIs documented. The difference between women and men was less than 3 percentage points.

***** Significantly different from the score for men ($p < 0.05$).

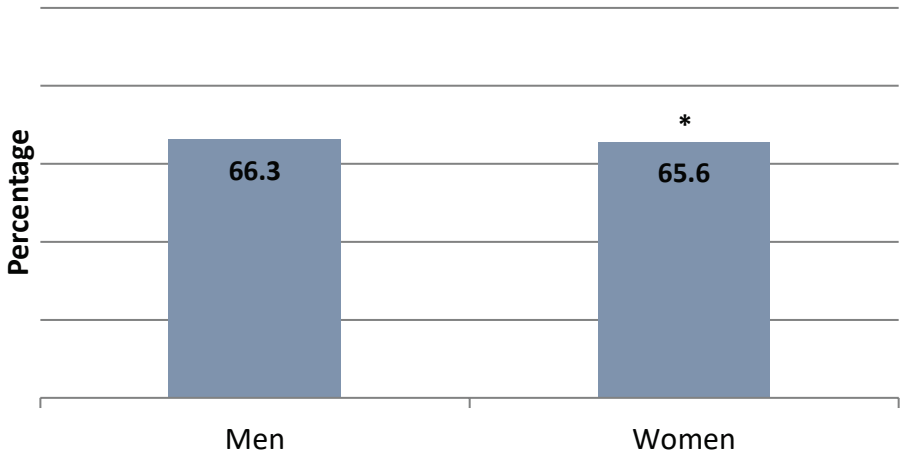
For differences that are statistically significant, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors women.

(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

Clinical Care: Controlling Blood Pressure

Percentage of Medicare enrollees aged 18–85 years who had a diagnosis of hypertension whose blood pressure was adequately controlled† during the past year, by gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.

Disparities

- Women who had a diagnosis of hypertension were less likely than men who had a diagnosis of hypertension to have had their blood pressure adequately controlled. The difference between women and men was less than 3 percentage points.

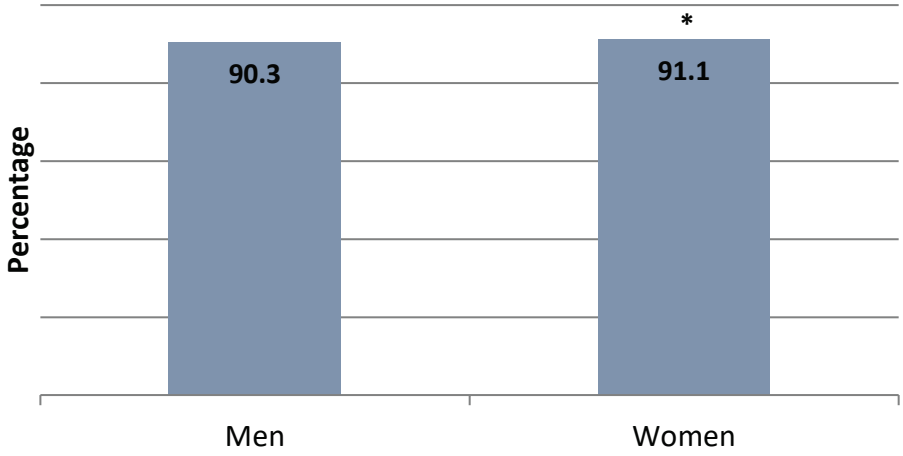
***** Significantly different from the score for men ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors women.
(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

† Less than 140/90 for enrollees 18–59 years of age and for enrollees 60–85 years of age with a diagnosis of diabetes, or less than 150/90 for members 60–85 years of age without a diagnosis of diabetes.

Clinical Care: Continuous Beta-Blocker Treatment

Percentage of Medicare enrollees aged 18 years and older who were hospitalized and discharged alive with a diagnosis of acute myocardial infarction (heart attack) who received persistent beta-blocker treatment for 6 months after discharge, by gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.

Disparities

- Women who were hospitalized for a heart attack were more likely than men who were hospitalized for a heart attack to have received persistent beta-blocker treatment. The difference between women and men was less than 3 percentage points.

***** Significantly different from the score for men ($p < 0.05$).

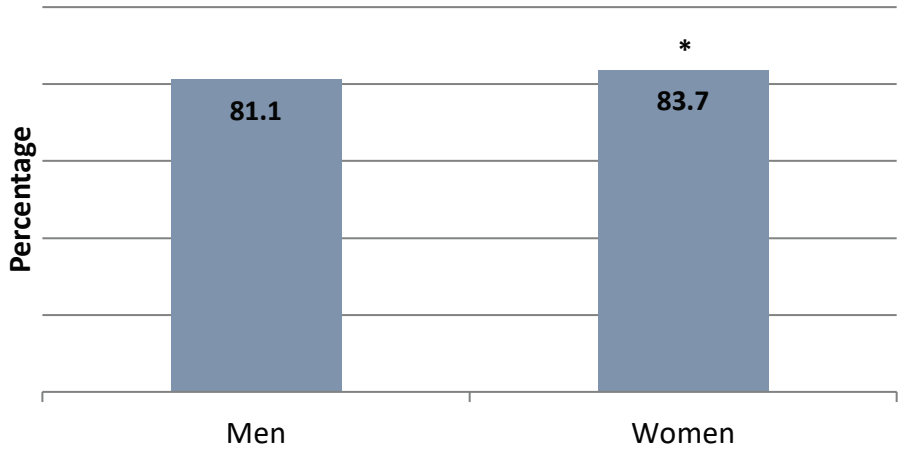
For differences that are statistically significant, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors women.

(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

Clinical Care: Asthma Medication Ratio in Older Adults

Percentage of Medicare enrollees aged 65 to 85 years who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the past year, by gender, 2017



SOURCE: Clinical quality data collected in 2017 from MA plans nationwide.

Disparities

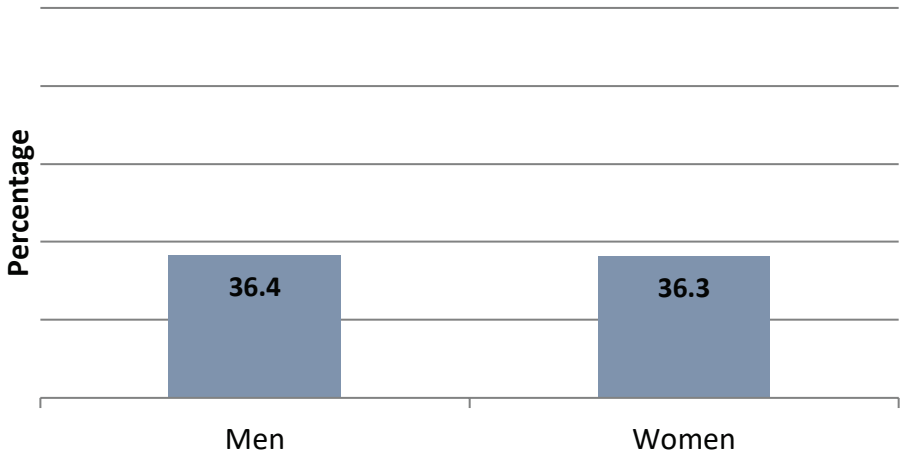
- Older women with persistent asthma were more likely than older men with persistent asthma to have had appropriate asthma medication management during the past year. The difference between women and men was less than 3 percentage points.

***** Significantly different from the score for men ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors women.
(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

Clinical Care: Testing to Confirm COPD

Percentage of Medicare enrollees aged 40 years and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis, by gender, 2017



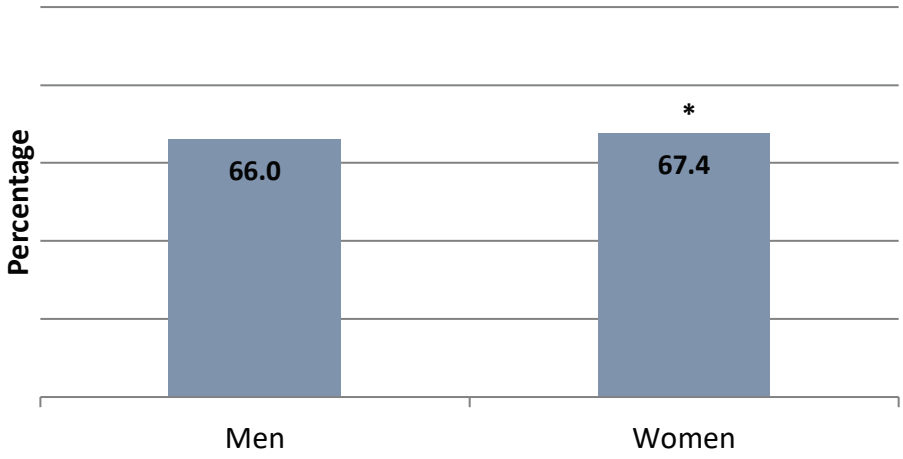
SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.

Disparities

- Women with a new diagnosis of COPD or newly active COPD were about as likely as men with a new diagnosis of COPD or newly active COPD to have received a spirometry test to confirm the diagnosis.

Clinical Care: Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid

Percentage of COPD exacerbations for MA enrollees aged 40 years and older who had an acute inpatient discharge or emergency department encounter in the past year in which a systemic corticosteroid was dispensed within 14 days of the event, by gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.

Disparities

- Women who experienced a COPD exacerbation were more likely than men who experienced a COPD exacerbation to have been dispensed a systemic corticosteroid within 14 days of the event. The difference between women and men was less than 3 percentage points.

***** Significantly different from the score for men ($p < 0.05$).

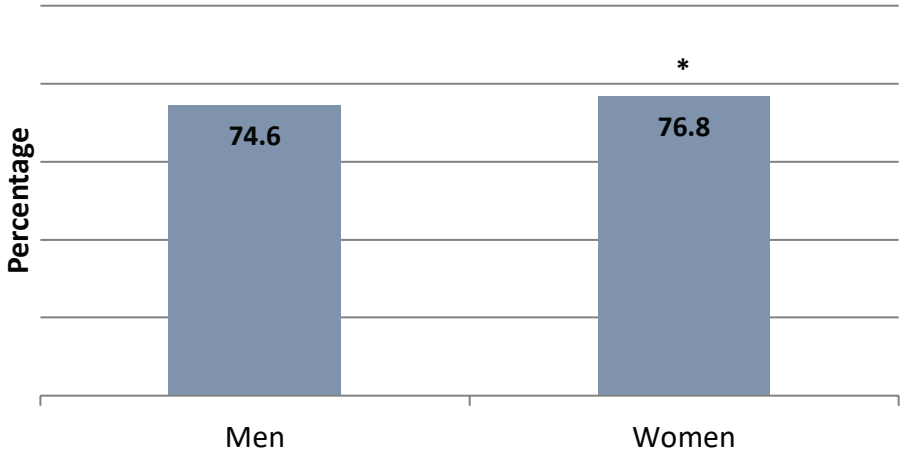
For differences that are statistically significant, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors women.

(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

Clinical Care: Pharmacotherapy Management of COPD Exacerbation—Bronchodilator

Percentage of COPD exacerbations for Medicare enrollees aged 40 years and older who had an acute inpatient discharge or emergency department encounter in the past year who were dispensed a bronchodilator within 30 days of experiencing the event, by gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.

Disparities

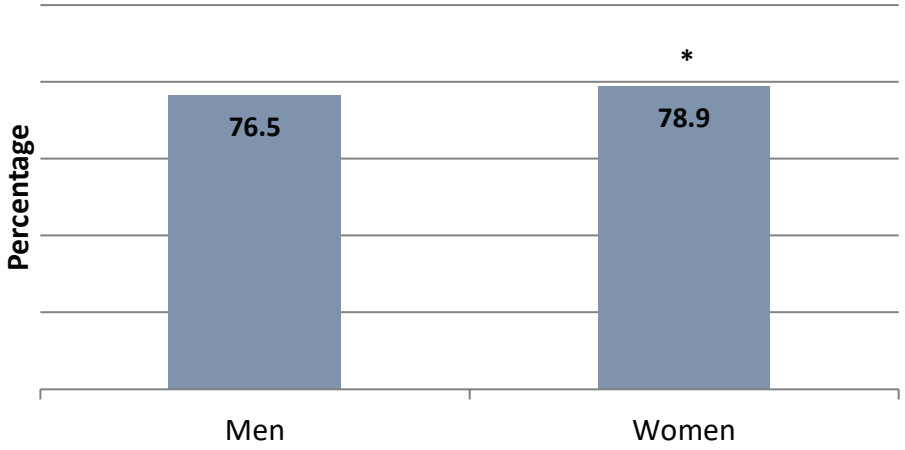
- Women who experienced a COPD exacerbation were more likely than men who experienced a COPD exacerbation to have been dispensed a bronchodilator within 30 days of the event. The difference between women and men was less than 3 percentage points.

***** Significantly different from the score for men ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors women.
(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

Clinical Care: Rheumatoid Arthritis Management

Percentage of Medicare enrollees aged 18 years and older who were diagnosed with rheumatoid arthritis during the past year who were dispensed at least one ambulatory prescription for a disease-modifying antirheumatic drug (DMARD), by gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.

Disparities

- Women who were diagnosed with rheumatoid arthritis were more likely than men who were diagnosed with rheumatoid arthritis to have been dispensed at least one DMARD. The difference between women and men was less than 3 percentage points.

***** Significantly different from the score for men ($p < 0.05$).

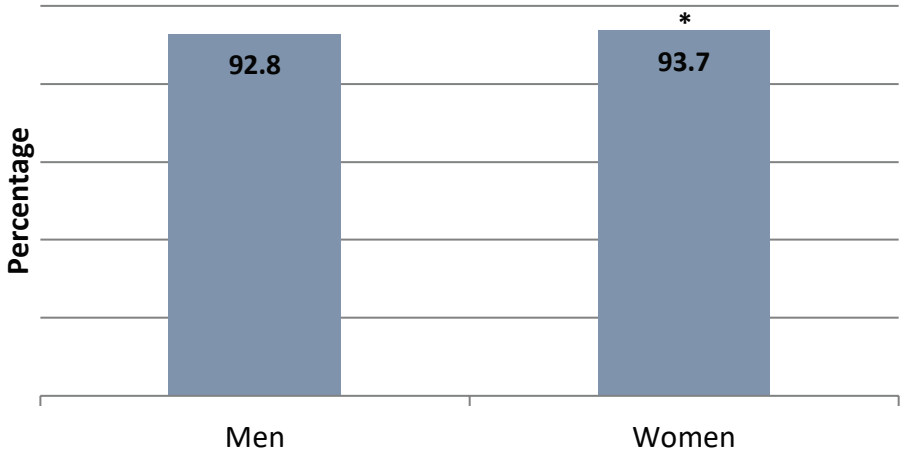
For differences that are statistically significant, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors women.

(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

Clinical Care: Appropriate Monitoring of Patients Taking Long-Term Medications

Percentage of Medicare enrollees aged 18 years and older who received at least 180 treatment days of ambulatory medication therapy for a selected therapeutic agent† during the past year who also had at least one therapeutic monitoring event for the therapeutic agent, by gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.

Disparities

- Women were more likely than men to have had at least one appropriate follow-up visit during the year to monitor their use of a higher-risk medication. The difference between women and men was less than 3 percentage points.

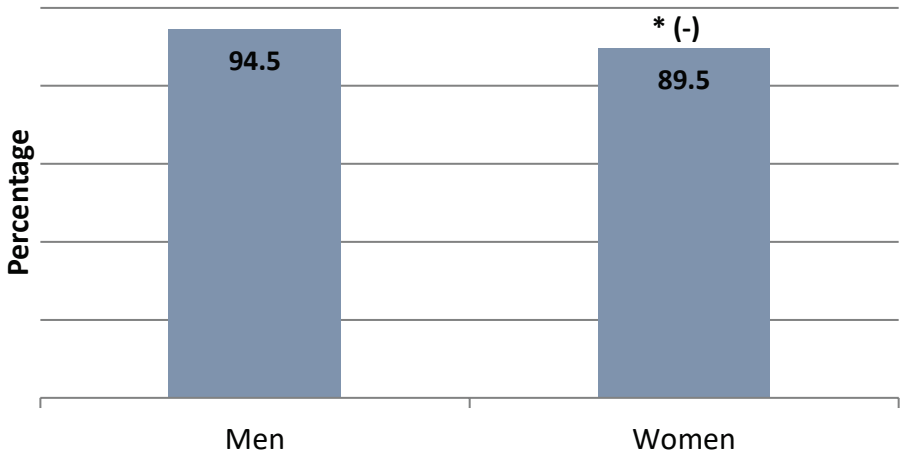
***** Significantly different from the score for men ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors women.
(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

† This measure is limited to those who had a prescription for one or more of the following drugs for 6 months or longer: ACE inhibitors, ARBs, digoxin, diuretics, anticonvulsants, and statins. These drugs are known to have possibly harmful side effects if used long term.

Clinical Care: Avoiding Use of High-Risk Medications in the Elderly

Percentage of Medicare enrollees aged 65 years and older who were not prescribed a high-risk medication, by gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.

Disparities

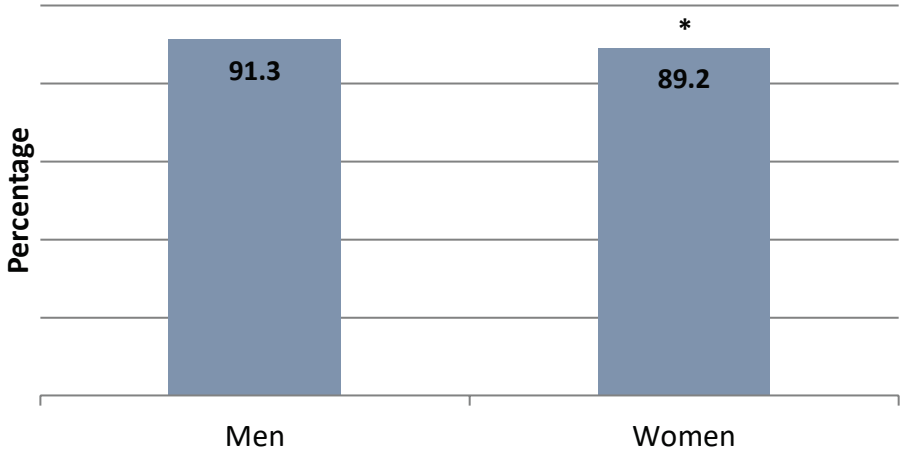
- Long-term use of high-risk medication should be avoided in the elderly. In the 2017 data, it was observed that this standard of care was met less often for women than for men. The difference between women and men was greater than 3 percentage points.

***** Significantly different from the score for men ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors women.
(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

Clinical Care: Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with Chronic Renal Failure

Percentage of Medicare enrollees aged 65 years and older with chronic renal failure who were not dispensed a prescription for a potentially harmful medication,† by gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.

Disparities

- Potentially harmful medication† should be avoided among elderly adults with chronic renal failure. In the 2017 data, it was observed that this standard of care was met less often for elderly women with chronic renal failure than for elderly men with chronic renal failure. The difference between women and men was less than 3 percentage points.

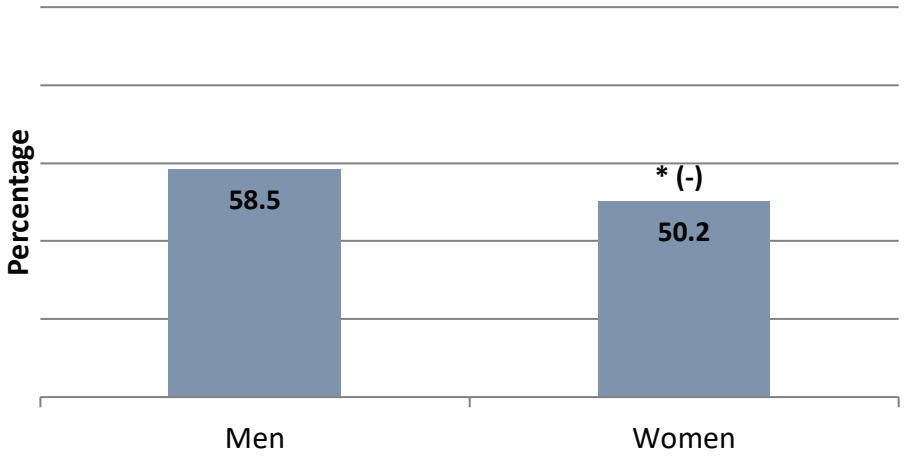
***** Significantly different from the score for men ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors women.
(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

† This includes COX-2 selective NSAIDs or nonaspirin NSAIDs.

Clinical Care: Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with Dementia

Percentage of Medicare enrollees aged 65 years and older with dementia who were not dispensed a prescription for a potentially harmful medication,† by gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.

Disparities

- Potentially harmful medication† should be avoided among elderly adults with dementia. In the 2017 data, it was observed that this standard of care was met less often for elderly women with dementia than for elderly men with dementia. The difference between women and men was greater than 3 percentage points.

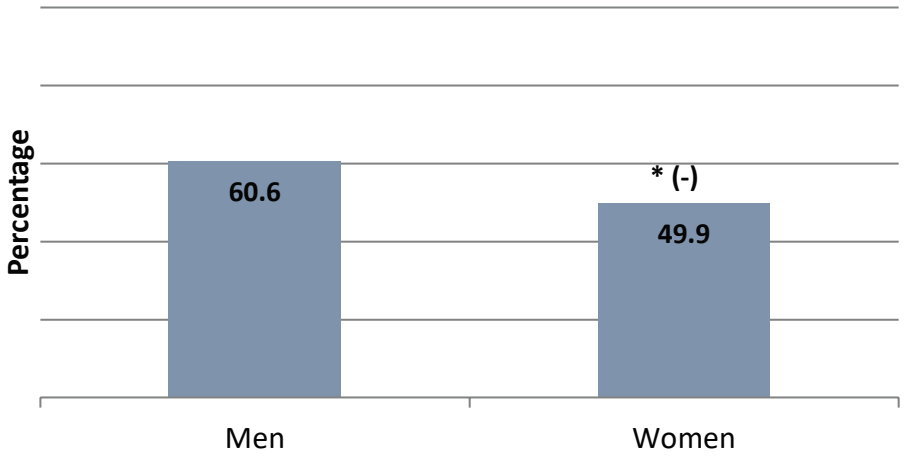
***** Significantly different from the score for men ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors women.
(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

† This includes antiemetics, antipsychotics, benzodiazepines, tricyclic antidepressants, H2 receptor antagonists, nonbenzodiazepine hypnotics, and anticholinergic agents.

Clinical Care: Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with a History of Falls

Percentage of Medicare enrollees aged 65 years and older with a history of falls who were not dispensed a prescription for a potentially harmful medication,† by gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.

Disparities

- Potentially harmful medication† should be avoided among elderly adults with a history of falls. In the 2017 data, it was observed that this standard of care was met less often for elderly women with a history of falls than for elderly men with a history of falls. The difference between women and men was greater than 3 percentage points.

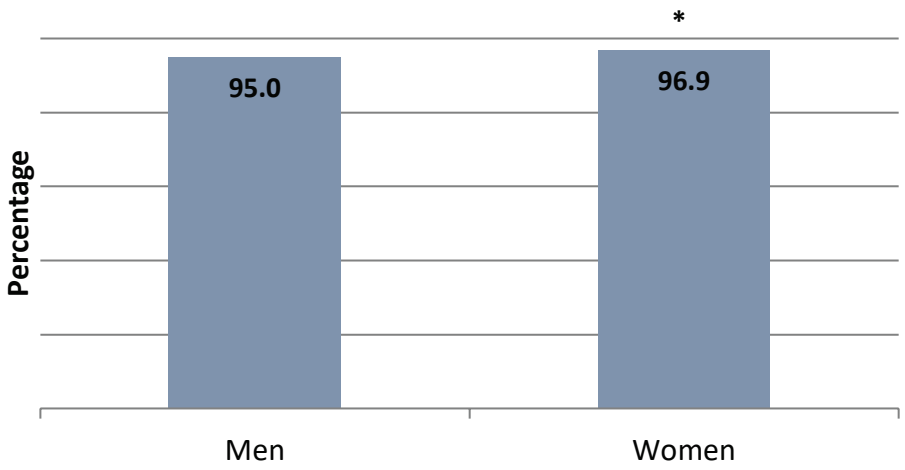
***** Significantly different from the score for men ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors women.
(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

† This includes anticonvulsants, nonbenzodiazepine hypnotics, SSRIs, antiemetics, antipsychotics, benzodiazepines, and tricyclic antidepressants.

Clinical Care: Older Adults' Access to Preventive/Ambulatory Services

Percentage of Medicare enrollees aged 65 years and older who had an ambulatory or preventive care visit, by gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.

Disparities

- Women were more likely than men to have had an ambulatory or preventive care visit. The difference between women and men was less than 3 percentage points.

***** Significantly different from the score for men ($p < 0.05$).

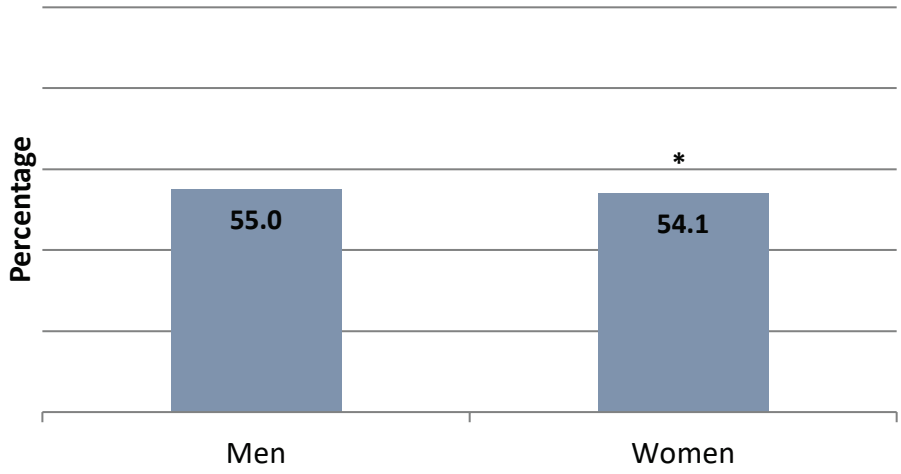
For differences that are statistically significant, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors women.

(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

Clinical Care: Medication Reconciliation After Hospital Discharge

Percentage of Medicare enrollees aged 18 years and older who were discharged from an inpatient facility and had their medications reconciled within 30 days, by gender, 2017



SOURCE: Clinical quality data collected in 2017 from MA plans nationwide.

Disparities

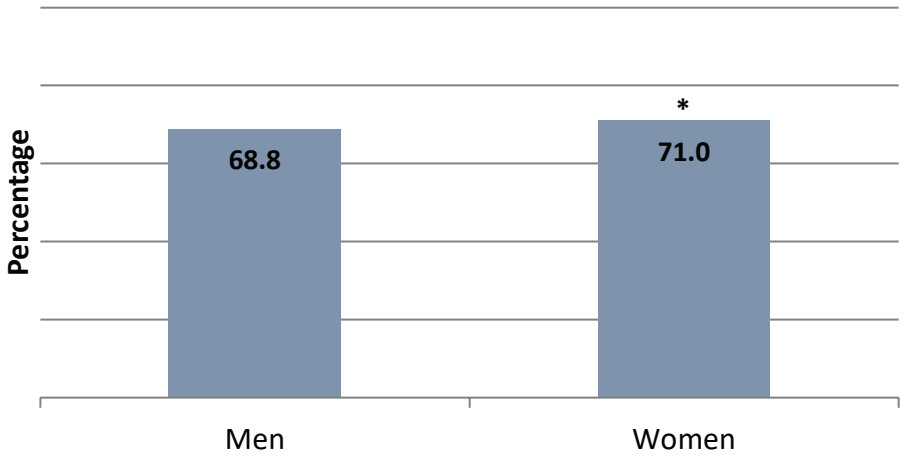
- Women who were discharged from an inpatient facility were less likely than men who were discharged from an inpatient facility to have had their medications reconciled within 30 days. The difference between women and men was less than 3 percentage points.

***** Significantly different from the score for men ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors women.
(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

Clinical Care: Antidepressant Medication Management—Acute Phase Treatment

Percentage of Medicare enrollees aged 18 years and older who were diagnosed with a new episode of major depression who remained on antidepressant medication for at least 84 days, by gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.

Disparities

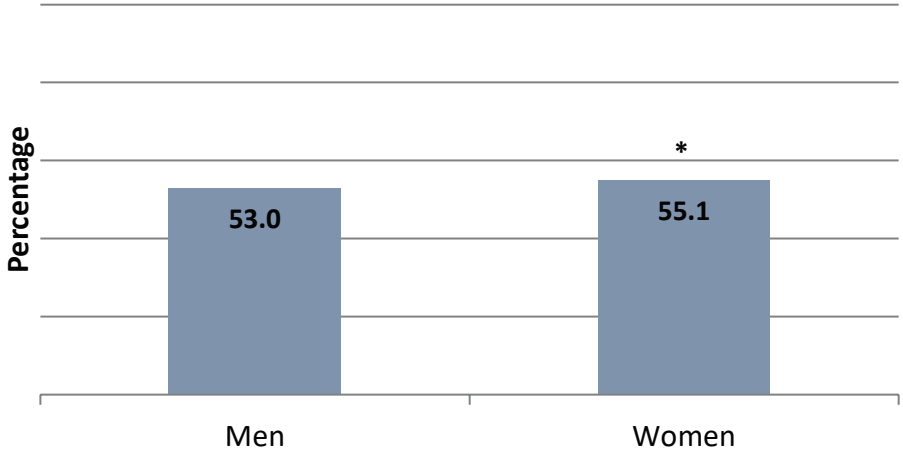
- Women who were diagnosed with a new episode of major depression were more likely than men who were diagnosed with a new episode of major depression to have remained on antidepressant medication for at least 84 days. The difference between women and men was less than 3 percentage points.

***** Significantly different from the score for men ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors women.
(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

Clinical Care: Antidepressant Medication Management—Continuation Phase Treatment

Percentage of Medicare enrollees aged 18 years and older with a new diagnosis of major depression who were newly treated with antidepressant medication who remained on an antidepressant medication treatment for at least 180 days, by gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.

Disparities

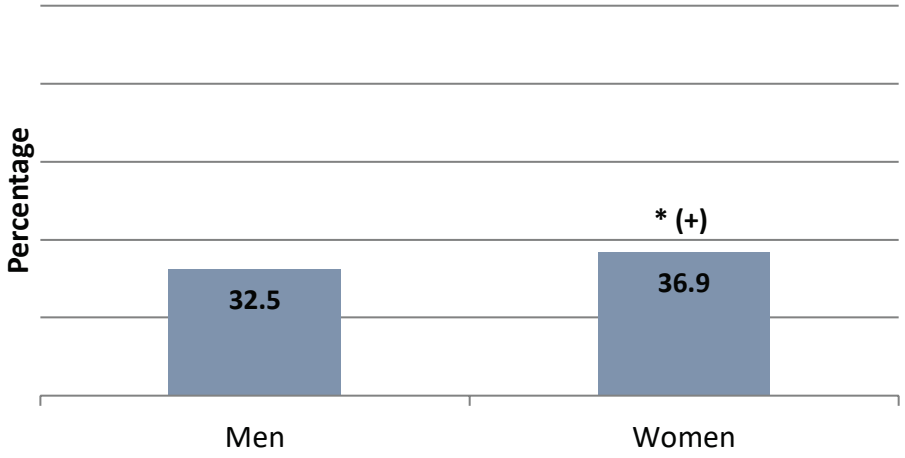
- Women who were diagnosed with a new episode of major depression were more likely than men who were diagnosed with a new episode of major depression to have been treated with and to have remained on antidepressant medication for at least 180 days. The difference between women and men was less than 3 percentage points.

***** Significantly different from the score for men ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors women.
(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

Clinical Care: Follow-Up Visit After Hospital Stay for Mental Illness (within 7 days of discharge)

Percentage of Medicare enrollees aged 18 years and older† who were hospitalized for treatment of selected mental health disorders who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge, by gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.

Disparities

- Women who were hospitalized for a mental health disorder were more likely than men who were hospitalized for a mental health disorder to have had appropriate follow-up care within 7 days of being discharged. The difference between women and men was greater than 3 percentage points.

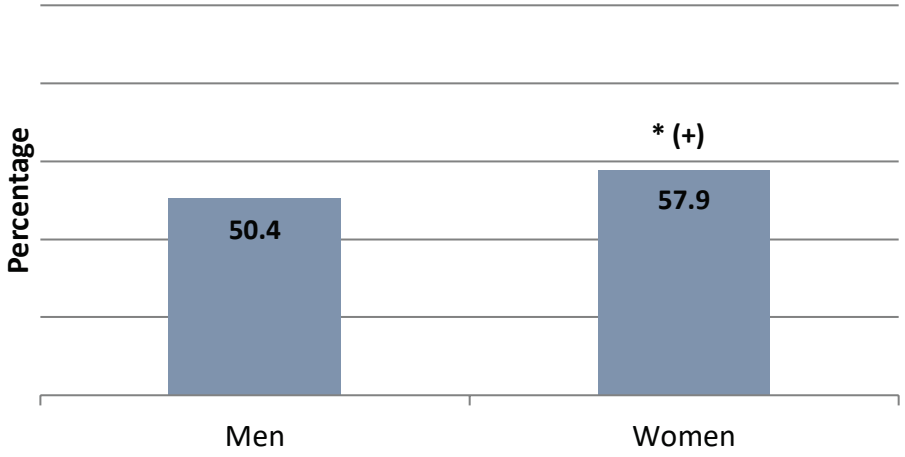
***** Significantly different from the score for men ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors women.
(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

† Although the lower-bound age cutoff for this HEDIS measure is 6 years old, the data used in this report are limited to adults.

Clinical Care: Follow-Up Visit After Hospital Stay for Mental Illness (within 30 days of discharge)

Percentage of Medicare enrollees aged 18 years and older† who were hospitalized for treatment of selected mental health disorders who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge, by gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.

Disparities

- Women who were hospitalized for a mental health disorder were more likely than men who were hospitalized for a mental health disorder to have had appropriate follow-up care within 30 days of discharge. The difference between women and men was greater than 3 percentage points.

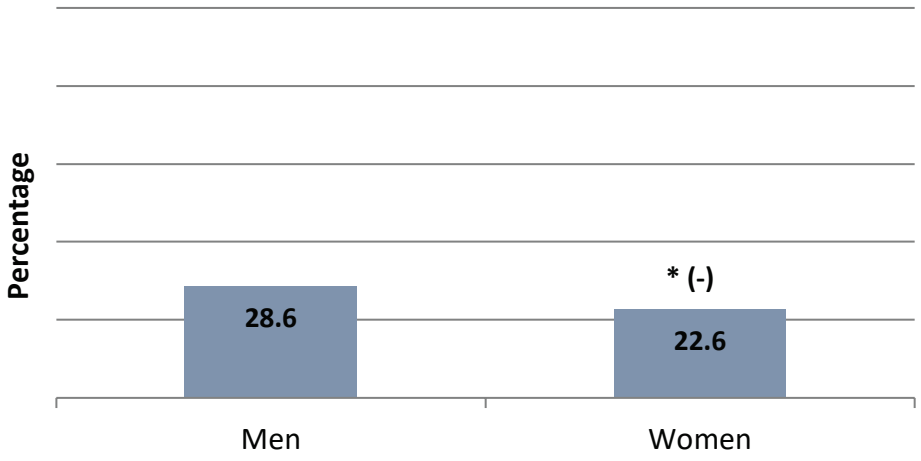
***** Significantly different from the score for men ($p < 0.05$).

For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors women.
(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

† Although the lower-bound age cutoff for this HEDIS measure is 6 years old, the data used in this report are limited to adults.

Clinical Care: Initiation of Alcohol or Other Drug Treatment

Percentage of Medicare enrollees aged 18 years and older† with a new episode of AOD dependence who initiated‡ treatment within 14 days of the diagnosis, by gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.

Disparities

- Women with a new episode of AOD dependence were less likely than men with a new episode of AOD dependence to have initiated treatment within 14 days of the diagnosis. The difference between women and men was greater than 3 percentage points.

***** Significantly different from the score for men ($p < 0.05$).

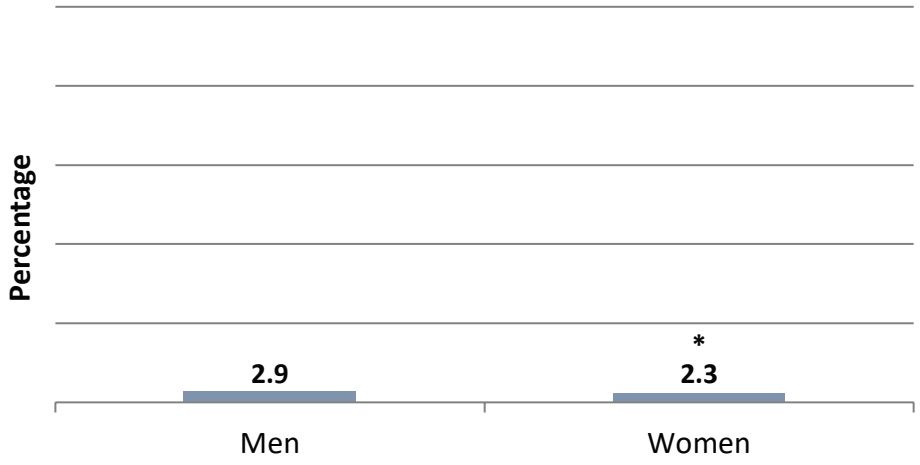
For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors women.
(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

† Although the lower-bound age cutoff for this HEDIS measure is 13 years old, the data used in this report are limited to adults.

‡ Initiation may occur through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization.

Clinical Care: Engagement of Alcohol or Other Drug Treatment

Percentage of Medicare enrollees aged 18 years and older† with a new episode of AOD dependence who initiated treatment who had two or more additional services within 30 days of the initiation visit, by gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.

Disparities

- Women with a new episode of AOD dependence who initiated treatment were less likely than men with a new episode of AOD dependence who initiated treatment to have had two or more additional services within 30 days of the initiation visit. The difference between women and men was less than 3 percentage points.

***** Significantly different from the score for men ($p < 0.05$).

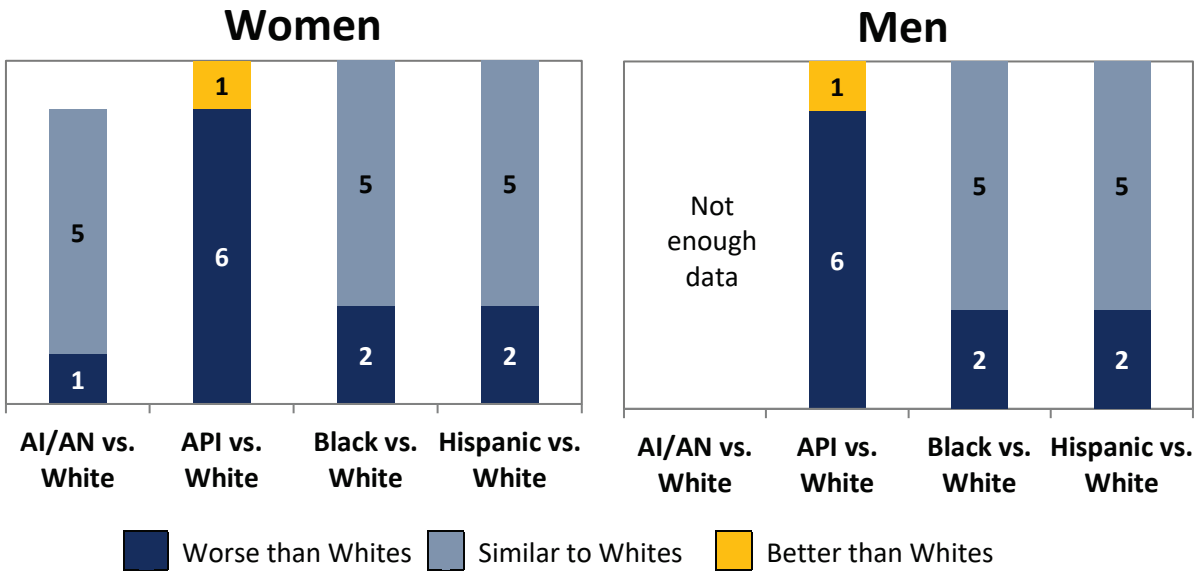
For differences that are statistically significant, the following symbols are also used when applicable:
(+) Difference is equal to or larger than 3 points (before rounding) and favors women.
(-) Difference is equal to or larger than 3 points (before rounding) and favors men.

† Although the lower-bound age cutoff for this HEDIS measure is 13 years old, the data used in this report are limited to adults.

Section III: Racial and Ethnic Disparities by Gender in Health Care in Medicare Advantage

Disparities in Care: All Patient Experience Measures

Number of patient experience measures (out of 7) for which women/men of selected racial and ethnic minority groups reported experiences that were worse than, similar to, or better than the experiences reported by White women/men in 2017



SOURCE: This chart summarizes data from all Medicare Advantage beneficiaries nationwide who participated in the 2017 Medicare CAHPS survey.
NOTES: AI/AN = American Indian or Alaska Native. API = Asian or Pacific Islander. Racial groups such as Blacks and Whites are non-Hispanic. Hispanic ethnicity includes all races. There were not enough data from AI/AN men to compare their patient experiences to those of White men. For one patient experience measure, there were not enough data from AI/AN women to permit a comparison to White women.

Within each gender, the relative difference between a selected group and Whites is used to assess disparities.

- **Better** = Population received better care than Whites. Differences are statistically significant ($p < 0.05$), are equal to or larger than 3 points† on a 0–100 scale, and favor the racial or ethnic minority group.
- **Similar** = Population and Whites received care of similar quality. Differences are less than 3 points on a 0–100 scale and/or not statistically significant.
- **Worse** = Population received worse care than Whites. Differences are statistically significant, equal to or larger than 3 points on a 0–100 scale, and favor Whites.

† A difference that is considered to be of moderate magnitude (Paddison et al., 2013).

AI/AN women received worse care than White women
• Getting appointments and care quickly

API women received worse care than White women
• Getting needed care • Getting appointments and care quickly • Customer service • Doctors who communicate well • Care coordination • Getting needed prescription drugs

API women received better care than White women

- Annual flu vaccine

Black women received worse care than White women

- Getting appointments and care quickly
- Annual flu vaccine

Hispanic women received worse care than White women

- Getting appointments and care quickly
- Annual flu vaccine

API men received worse care than White men

- Getting needed care
- Getting appointments and care quickly
- Customer service
- Doctors who communicate well
- Care coordination
- Getting needed prescription drugs

API men received better care than White men

- Annual flu vaccine

Black men received worse care than White men

- Getting appointments and care quickly
- Annual flu vaccine

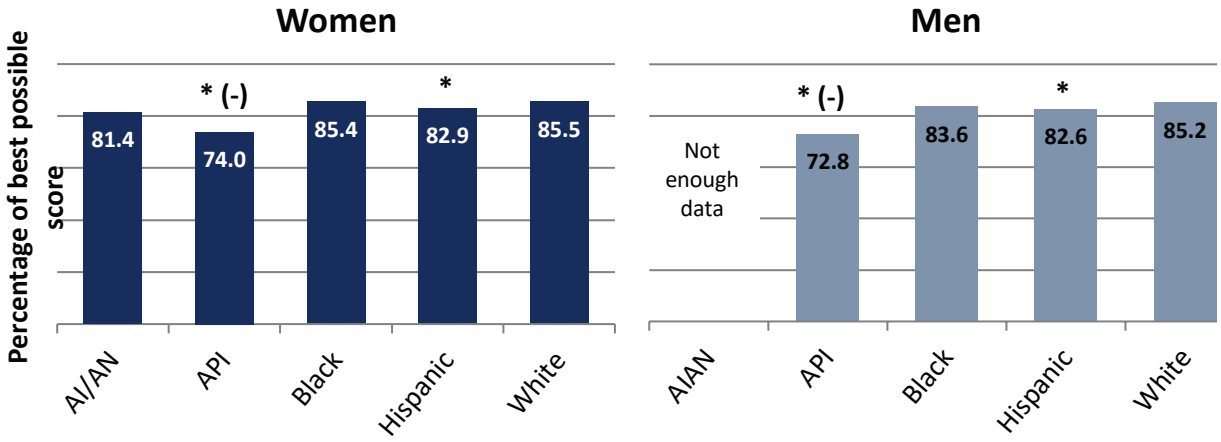
Hispanic men received worse care than White men

- Getting appointments and care quickly
- Annual flu vaccine

Patient Experience

Patient Experience: Getting Needed Care

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for patients to get needed care,† by race and ethnicity within gender, 2017



SOURCE: Data from the Medicare CAHPS survey, 2017.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. AI/AN = American Indian or Alaska Native. API = Asian or Pacific Islander. There were not enough data to report a score on this measure for AI/AN men.

Disparities

- API and Hispanic women reported worse†† experiences getting needed care than White women reported. The difference between API and White women was greater than 3 points on a 0–100 scale. The difference between Hispanic and White women was less than 3 points on a 0–100 scale. AI/AN and Black women reported experiences with getting needed care that were similar to the experiences reported by White women.
- API and Hispanic men reported worse experiences getting needed care than White men reported. The difference between API and White men was greater than 3 points on a 0–100 scale. The difference between Hispanic and White men was less than 3 points on a 0–100 scale. Black men reported experiences with getting needed care that were similar to the experiences reported by White men.

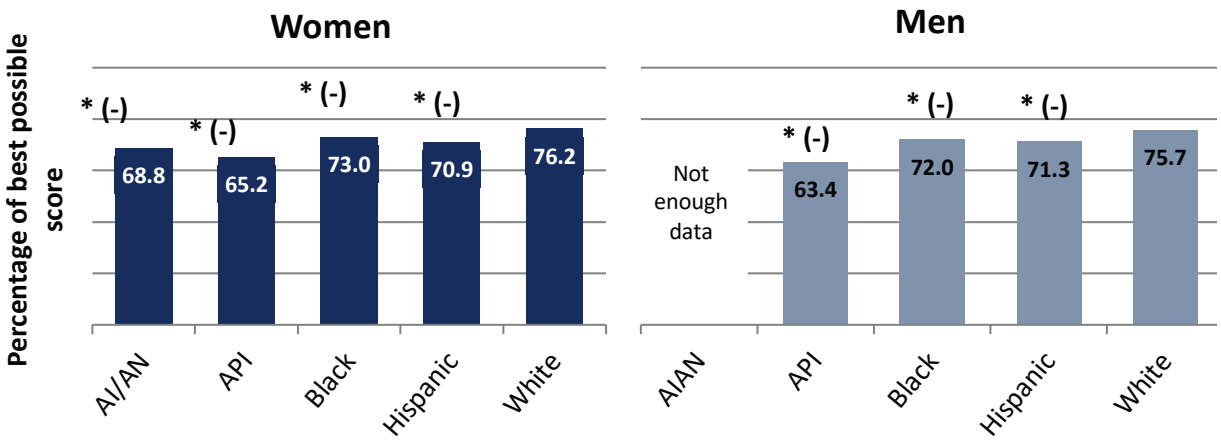
***** Significantly different from the score for Whites ($p < 0.05$).
For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

† This includes how often in the last 6 months patients got appointments with specialists as soon as they needed them and how easy it was to get needed care, tests, or treatment.
†† Unlike on the previous two pages, we use the terms "better" or "worse" to describe all statistically significant differences on individual patient experience measures. We note in the "Disparities" section for each of these measures where differences are greater or less than 3 points.

Patient Experience: Getting Appointments and Care Quickly

Percentage of the best possible score (on a 0–100 scale) earned on how quickly patients get appointments and care,† by race and ethnicity within gender, 2017



SOURCE: Data from the Medicare CAHPS survey, 2017.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. AI/AN = American Indian or Alaska Native. API = Asian or Pacific Islander. There were not enough data to report a score on this measure for AI/AN men.

Disparities

- AI/AN, API, Black, and Hispanic women reported worse experiences getting appointments and care quickly than White women reported. In each case, the difference was greater than 3 points on a 0–100 scale.
- API, Black, and Hispanic men reported worse experiences getting appointments and care quickly than White men reported. In each case, the difference was greater than 3 points on a 0–100 scale.

***** Significantly different from the score for Whites ($p < 0.05$).

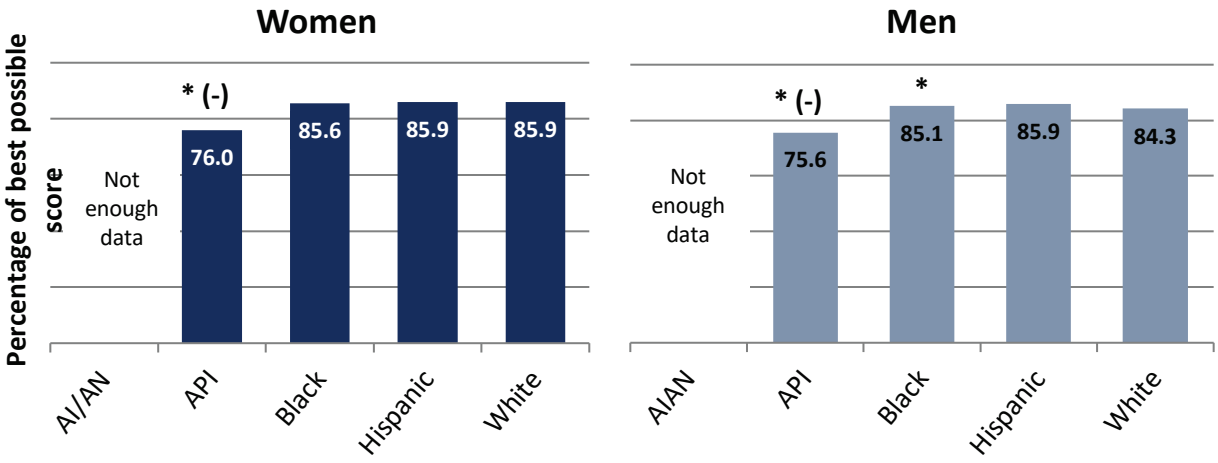
For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

† This includes how often in the last 6 months patients got care that was needed right away, as well as how easy it was to get appointments for checkups and routine care.

Patient Experience: Customer Service

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is to get information and help from one's plan when needed,† by race and ethnicity within gender, 2017



SOURCE: Data from the Medicare CAHPS survey, 2017.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. AI/AN = American Indian or Alaska Native. API = Asian or Pacific Islander. There were not enough data to report a score on this measure for AI/AN men or for AI/AN women.

Disparities

- API women reported worse experiences with customer service than White women reported. The difference between API and White women was greater than 3 points on a 0–100 scale. Black and Hispanic women reported experiences with customer service that were similar to the experiences reported by White women.
- API men reported worse experiences with customer service than White men reported. The difference between API and White men was greater than 3 points on a 0–100 scale. Black men reported better experiences with customer service than White men. The difference between Black and White men was less than 3 points on a 0–100 scale. Hispanic men reported experiences with customer service that were similar to the experiences reported by White men.

***** Significantly different from the score for Whites ($p < 0.05$).

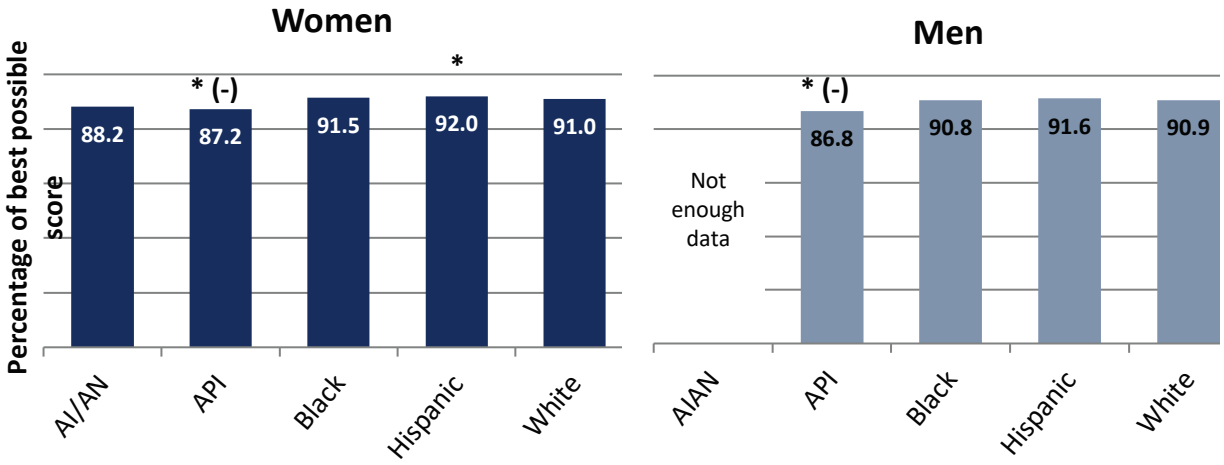
For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

† This includes how often in the last 6 months health plan customer service staff provided the information or help that beneficiaries needed, how often beneficiaries were treated with courtesy and respect, and how often forms from the health plan were easy to fill out.

Patient Experience: Doctors Who Communicate Well

Percentage of the best possible score (on a 0–100 scale) earned on how well doctors communicate with patients,† by race and ethnicity within gender, 2017



SOURCE: Data from the Medicare CAHPS survey, 2017.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. AI/AN = American Indian or Alaska Native. API = Asian or Pacific Islander. There were not enough data to report a score on this measure for AI/AN men.

Disparities

- API women reported worse doctor communication than White women reported. The difference between API and White women was greater than 3 points on a 0–100 scale. Hispanic women reported better doctor communication than White women reported. The difference between Hispanic and White women was less than 3 points on a 0–100 scale. AI/AN and Black women reported experiences with doctor communication that were similar to the experiences reported by White women.
- API men reported worse doctor communication than White men reported. The difference between API and White men was greater than 3 points on a 0–100 scale. Black and Hispanic men reported experiences with doctor communication that were similar to the experiences reported by White men.

***** Significantly different from the score for Whites ($p < 0.05$).

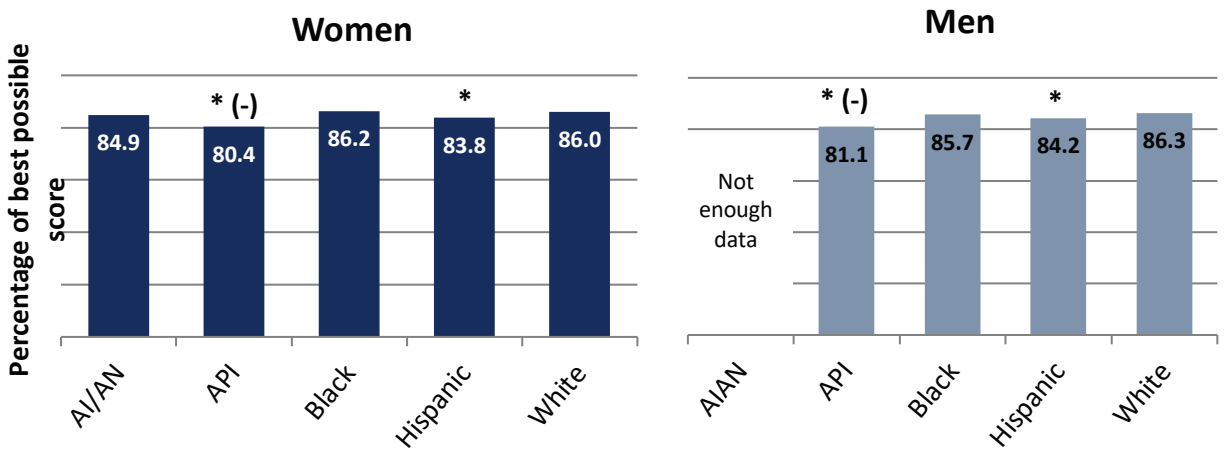
For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

† This includes how often in the last 6 months doctors explained things in a way that was easy to understand, listened carefully, showed respect for what patients had to say, and spent time with patients.

Patient Experience: Care Coordination

Percentage of the best possible score (on a 0–100 scale) earned on how well patient care was coordinated,† by race and ethnicity within gender, 2017



SOURCE: Data from the Medicare CAHPS survey, 2017.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. AI/AN = American Indian or Alaska Native. API = Asian or Pacific Islander. There were not enough data to report a score on this measure for AI/AN men.

Disparities

- API and Hispanic women reported worse experiences with care coordination than White women reported. The difference between API and White women was greater than 3 points on a 0–100 scale; the difference between Hispanic and White women was less than 3 points on a 0–100 scale. AI/AN and Black women reported experiences with care coordination that were similar to the experiences reported by White women.
- API and Hispanic men reported worse care coordination than White men reported. The difference between API and White men was greater than 3 points on a 0–100 scale; the difference between Hispanic and White men was less than 3 points on a 0–100 scale. Black men reported experiences with care coordination that were similar to the experiences reported by White men.

***** Significantly different from the score for Whites ($p < 0.05$).

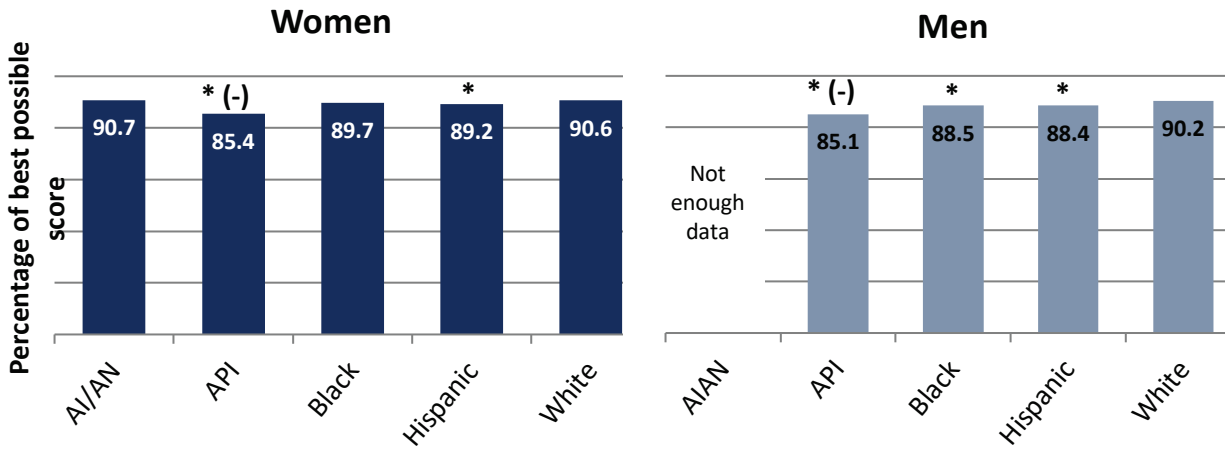
For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

† This includes how often in the last 6 months doctors had medical records and other information about patients' care at patients' scheduled appointments and how quickly patients received their test results.

Patient Experience: Getting Needed Prescription Drugs

Percentage of the best possible score (on a 0–100 scale) earned on how easy it is for beneficiaries to get the prescription drugs they need using their plans,† by race and ethnicity within gender, 2017



SOURCE: Data from the Medicare CAHPS survey, 2017.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. AI/AN = American Indian or Alaska Native. API = Asian or Pacific Islander. There were not enough data to report a score on this measure for AI/AN men.

Disparities

- API and Hispanic women reported worse experiences getting needed prescription drugs than White women reported. The difference between API and White women was greater than 3 points on a 0–100 scale; the difference between Hispanic and White women was less than 3 points on a 0–100 scale. AI/AN and Black women reported experiences getting needed prescription drugs that were similar to the experiences reported by White women.
- API, Black, and Hispanic men reported worse experiences getting needed prescription drugs than White men reported. The difference between API and White men was greater than 3 points on a 0–100 scale. The difference between Black and White men was less than 3 points on a 0–100 scale, as was the difference between Hispanic and White men.

***** Significantly different from the score for Whites ($p < 0.05$).

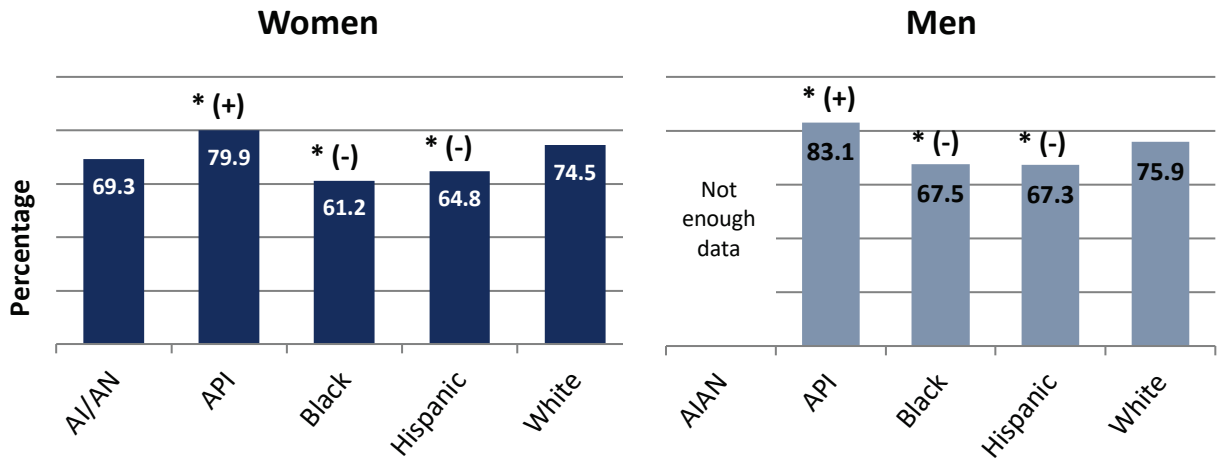
For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

† This includes how often in the last 6 months it was easy to use the plan to get prescribed medications and how easy it was to fill prescriptions at a pharmacy or by mail.

Patient Experience: Annual Flu Vaccine

Percentage of Medicare enrollees who got a vaccine (flu shot), by race and ethnicity within gender, 2017



SOURCE: Data from the Medicare CAHPS survey, 2017.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. AI/AN = American Indian or Alaska Native. API = Asian or Pacific Islander. There were not enough data to report a score on this measure for AI/AN men.

Disparities

- API women were more likely than White women to have received the flu vaccine. The difference between API women and White women was greater than 3 percentage points. Black and Hispanic women were less likely than White women to have received the flu vaccine. In each case, the difference was greater than 3 percentage points. AI/AN women were about as likely as White women to have received the flu vaccine.
- API men were more likely than White men to have received the flu vaccine. The difference between API men and White men was greater than 3 percentage points. Black and Hispanic men were less likely than White men to have received the flu vaccine. In each case, the difference was greater than 3 percentage points.

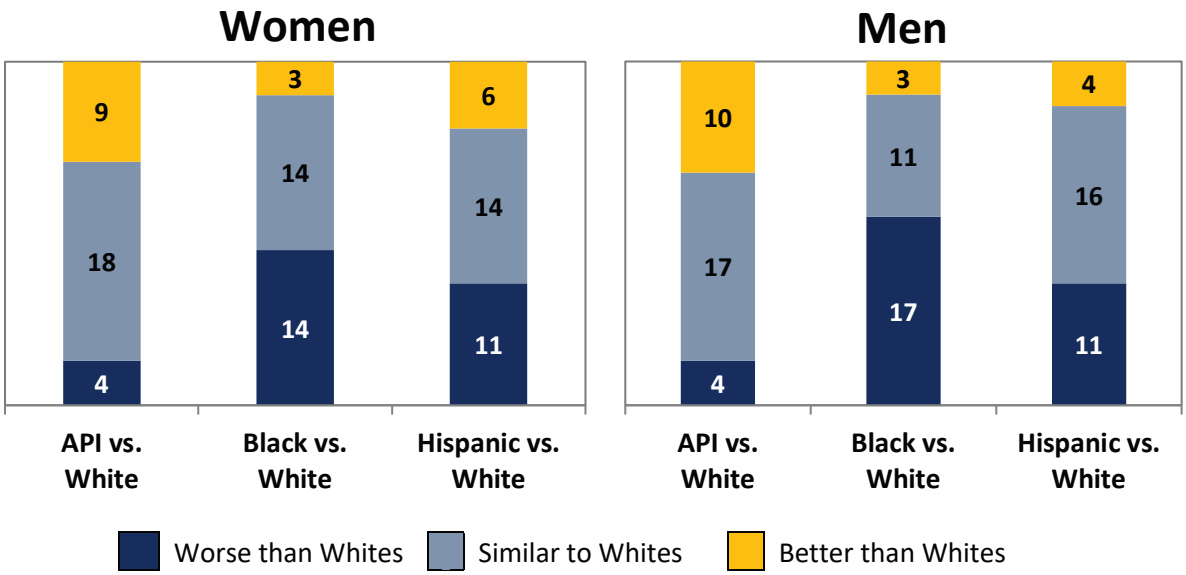
***** Significantly different from the score for Whites ($p < 0.05$).

For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Disparities in Care: All Clinical Care Measures

Number of clinical care measures (out of 31) for which women/men of selected racial and ethnic minority groups experienced care that was worse than, similar to, or better than the care experienced by White women/men in 2017



SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic. Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Within each gender, the relative difference between a selected group and Whites is used to assess disparities.

- **Better** = Population received better care than Whites. Differences are statistically significant ($p < 0.05$), are equal to or larger than 3 points† on a 0–100 scale, and favor the racial or ethnic minority group.
- **Similar** = Population and Whites received care of similar quality. Differences are less than 3 points on a 0–100 scale and/or not statistically significant.
- **Worse** = Population received worse care than Whites. Differences are statistically significant, are equal to or larger than 3 points on a 0–100 scale, and favor Whites.

† A difference that is considered to be of moderate magnitude (Paddison et al., 2013).

API women received worse care than White women
• Continuous beta-blocker treatment after a heart attack
• Antidepressant medication management—acute phase treatment
• Antidepressant medication management—continuation phase treatment
• Initiation of alcohol or other drug treatments

API women received better care than White women

- Colorectal cancer screening
- Diabetes care—eye exam
- Diabetes care—blood pressure controlled
- Diabetes care—blood sugar controlled
- Statin use in patients with diabetes
- Avoiding use of high-risk medications in the elderly
- Avoiding potentially harmful drug-disease interactions in elderly patients with dementia
- Avoiding potentially harmful drug-disease interactions in elderly patients with a history of falls
- Medication reconciliation after hospital discharge

Black women received worse care than White women

- Colorectal cancer screening
- Diabetes care—blood sugar controlled
- Diabetes care—blood pressure controlled
- Medication adherence for diabetes—statins
- Controlling blood pressure
- Medication adherence for cardiovascular disease—statins
- Continuous beta-blocker treatment after a heart attack
- Asthma medication ratio in older adults
- Avoiding potentially harmful drug-disease interactions in elderly patients with chronic renal failure
- Medication reconciliation after hospital discharge
- Antidepressant medication management—acute phase treatment
- Antidepressant medication management—continuation phase treatment
- Follow-up after hospital stay for mental illness (within 7 days of discharge)
- Follow-up after hospital stay for mental illness (within 30 days of discharge)

Black women received better care than White women

- Avoiding use of high-risk medications in the elderly
- Avoiding potentially harmful drug-disease interactions in elderly patients with dementia
- Avoiding potentially harmful drug-disease interactions in elderly patients with a history of falls

Hispanic women received worse care than White women

- Medication adherence for diabetes—statins
- Medication adherence for cardiovascular disease—statins
- Continuous beta-blocker treatment after a heart attack
- Asthma medication ratio in older adults
- Pharmacotherapy management of COPD exacerbation—use of systemic corticosteroids
- Pharmacotherapy management of COPD exacerbation—use of bronchodilators
- Avoiding potentially harmful drug-disease interactions in elderly patients with chronic renal failure
- Avoiding potentially harmful drug-disease interactions in elderly patients with dementia
- Antidepressant medication management—acute phase treatment
- Antidepressant medication management—continuation phase treatment
- Initiation of alcohol or other drug treatments

Hispanic women received better care than White women

- Diabetes care—eye exam
- Diabetes care—blood pressure controlled
- Statin use in patients with diabetes
- Medication reconciliation after hospital discharge
- Follow-up after hospital stay for mental illness (within 7 days of discharge)
- Follow-up after hospital stay for mental illness (within 30 days of discharge)

API men received worse care than White men

- Avoiding potentially harmful drug-disease interactions in elderly patients with chronic renal failure
- Antidepressant medication management—acute phase treatment
- Antidepressant medication management—continuation phase treatment
- Initiation of alcohol or other drug treatments

API men received better care than White men

- Colorectal cancer screening
- Diabetes care—eye exam
- Diabetes care—blood pressure controlled
- Diabetes care—blood sugar controlled
- Statin use in patients with diabetes
- Pharmacotherapy management of COPD exacerbation—use of systemic corticosteroids
- Pharmacotherapy management of COPD exacerbation—use of bronchodilators
- Avoiding potentially harmful drug-disease interactions in elderly patients with dementia
- Avoiding potentially harmful drug-disease interactions in elderly patients with a history of falls
- Medication reconciliation after hospital discharge

Black men received worse care than White men

- Colorectal cancer screening
- Diabetes care—eye exam
- Diabetes care—blood sugar controlled
- Diabetes care—blood pressure controlled
- Medication adherence for diabetes—statins
- Controlling blood pressure
- Statin use in patients with cardiovascular disease
- Medication adherence for cardiovascular disease—statins
- Continuous beta-blocker treatment after a heart attack
- Asthma medication ratio in older adults
- Rheumatoid arthritis management
- Avoiding potentially harmful drug-disease interactions in elderly patients with chronic renal failure
- Medication reconciliation after hospital discharge
- Antidepressant medication management—acute phase treatment
- Antidepressant medication management—continuation phase treatment
- Follow-up after hospital stay for mental illness (within 7 days of discharge)
- Follow-up after hospital stay for mental illness (within 30 days of discharge)

Black men received better care than White men

- Avoiding potentially harmful drug-disease interactions in elderly patients with dementia
- Avoiding potentially harmful drug-disease interactions in elderly patients with a history of falls
- Initiation of alcohol or other drug treatments

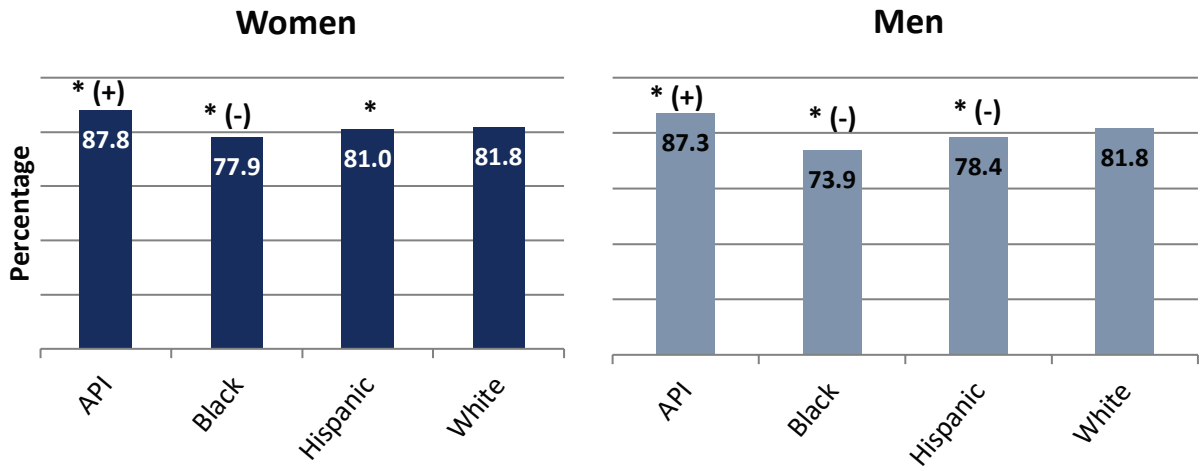
Hispanic men received worse care than White men
• Colorectal cancer screening • Medication adherence for diabetes—statins • Medication adherence for cardiovascular disease—statins • Continuous beta-blocker treatment after a heart attack • Asthma medication ratio in older adults • Pharmacotherapy management of COPD exacerbation—use of systemic corticosteroids • Avoiding potentially harmful drug-disease interactions in elderly patients with chronic renal failure • Avoiding potentially harmful drug-disease interactions in elderly patients with dementia • Antidepressant medication management—acute phase treatment • Antidepressant medication management—continuation phase treatment • Initiation of alcohol or other drug treatments

Hispanic men received better care than White men
• Diabetes care—eye exam • Diabetes care—blood pressure controlled • Follow-up after hospital stay for mental illness (within 7 days of discharge) • Follow-up after hospital stay for mental illness (within 30 days of discharge)

Clinical Care

Clinical Care: Colorectal Cancer Screening

Percentage of Medicare enrollees aged 50–75 years who had appropriate screening for colorectal cancer, by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- API women were more likely than White women to have been appropriately screened for colorectal cancer. The difference between API and White women was greater than 3 percentage points. Black and Hispanic women were less likely than White women to have been appropriately screened for colorectal cancer. The difference between Black women and White women was greater than 3 percentage points; the difference between Hispanic and White women was less than 3 percentage points.
- API men were more likely than White men to have been appropriately screened for colorectal cancer. The difference between API and White men was greater than 3 percentage points. Black and Hispanic men were less likely than White men to have been appropriately screened for colorectal cancer. The difference between Black and White men was greater than 3 percentage points, as was the difference between Hispanic and White men.

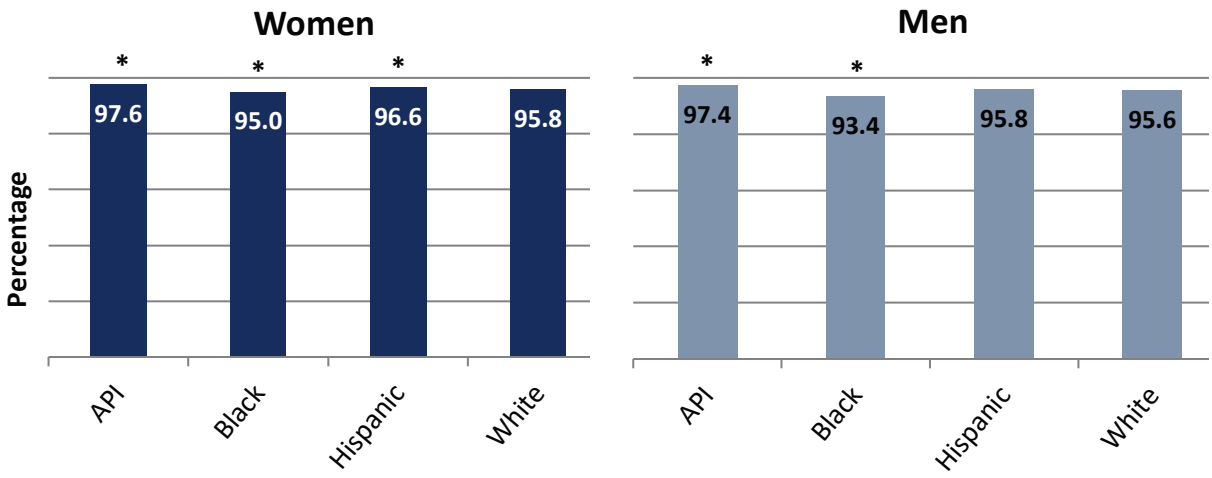
***** Significantly different from the score for Whites ($p < 0.05$).

For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Diabetes Care—Blood Sugar Testing

Percentage of Medicare enrollees aged 18–75 years with diabetes (type 1 and type 2) who had one or more HbA1c tests in the past year, by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- API and Hispanic women with diabetes were more likely than White women with diabetes to have had their blood sugar tested at least once in the past year. In each case, the difference was less than 3 percentage points. Black women with diabetes were less likely than White women with diabetes to have had their blood sugar tested at least once in the past year. The difference between Black women and White women was less than 3 percentage points.
- API men with diabetes were more likely than White men with diabetes to have had their blood sugar tested at least once in the past year. The difference between API and White men was less than 3 percentage points. Black men with diabetes were less likely than White men with diabetes to have had their blood sugar tested at least once in the past year. The difference between Black and White men was less than 3 percentage points. Hispanic men with diabetes were about as likely as White men with diabetes to have had their blood sugar tested at least once in the past year.

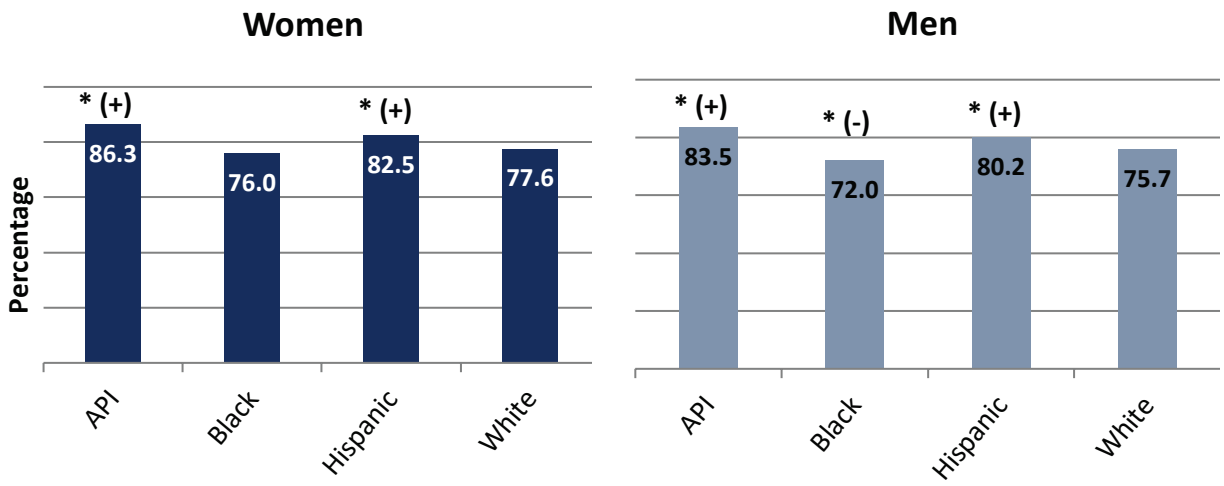
***** Significantly different from the score for Whites ($p < 0.05$).

For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Diabetes Care—Eye Exam

Percentage of Medicare enrollees aged 18–75 years with diabetes (type 1 and type 2) who had an eye exam (retinal) in the past year, by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- API and Hispanic women with diabetes were more likely than White women with diabetes to have had an eye exam in the past year. In each case, the difference was greater than 3 percentage points. Black women with diabetes were about as likely as White women with diabetes to have had an eye exam in the past year.
- API and Hispanic men with diabetes were more likely than White men with diabetes to have had an eye exam in the past year. In each case, the difference was greater than 3 percentage points. Black men with diabetes were less likely than White men with diabetes to have had an eye exam in the past year. The difference between Black men and White men was greater than 3 percentage points.

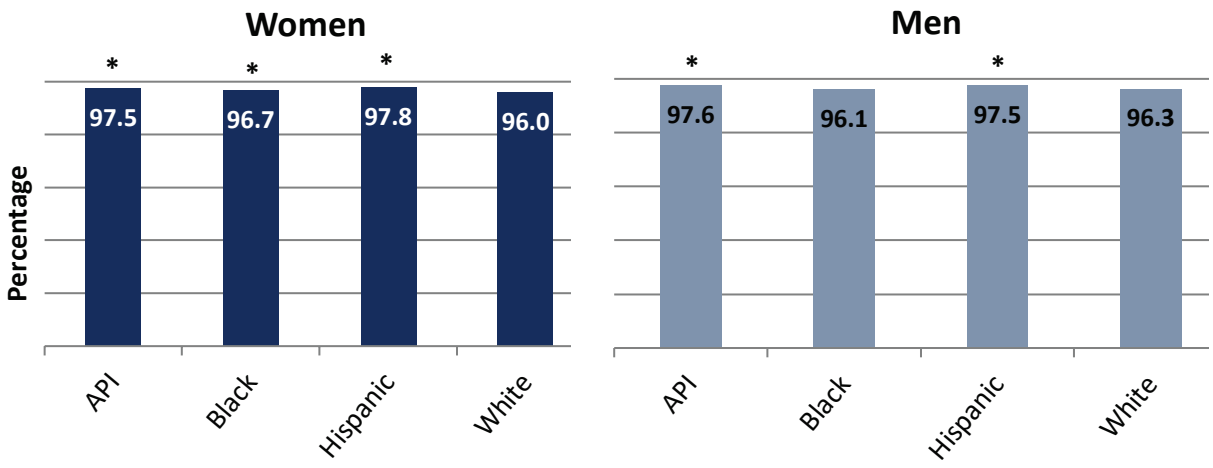
***** Significantly different from the score for Whites ($p < 0.05$).

For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Diabetes Care—Kidney Disease Monitoring

Percentage of Medicare enrollees aged 18–75 years with diabetes (type 1 and type 2) who had medical attention for nephropathy in the past year, by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- API, Black, and Hispanic women with diabetes were more likely than White women with diabetes to have had medical attention for nephropathy in the past year. In each case, the difference was less than 3 percentage points.
- API and Hispanic men with diabetes were more likely than White men with diabetes to have had medical attention for nephropathy in the past year. In each case, the difference was less than 3 percentage points. Black men with diabetes were about as likely as White men with diabetes to have had medical attention for nephropathy in the past year.

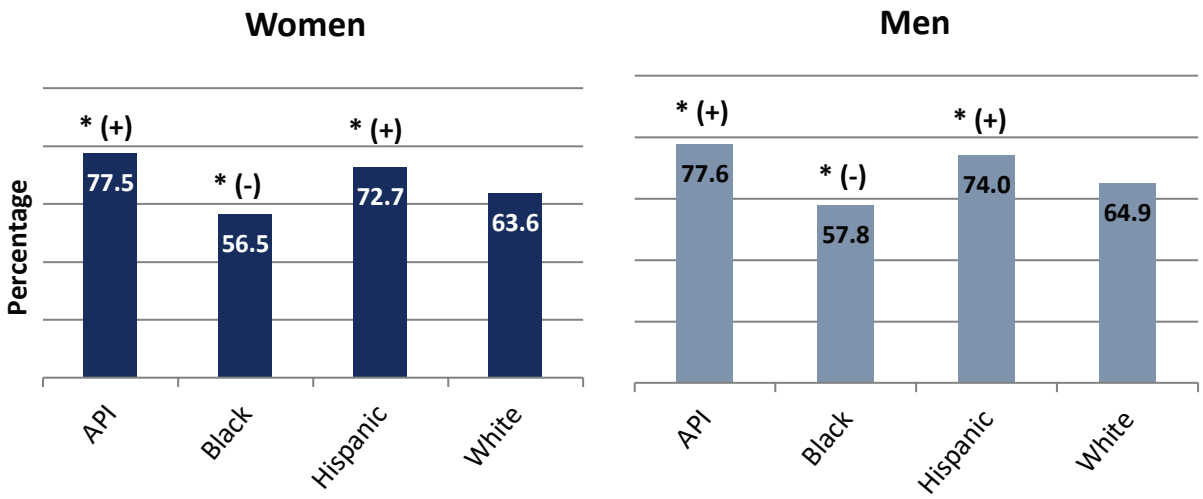
***** Significantly different from the score for Whites ($p < 0.05$).

For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Diabetes Care—Blood Pressure Controlled

Percentage of Medicare enrollees aged 18–75 years with diabetes (type 1 and type 2) whose most recent blood pressure was less than 140/90, by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- API and Hispanic women with diabetes were more likely than White women with diabetes to have their blood pressure under control. In each case, the difference was greater than 3 percentage points. Black women with diabetes were less likely than White women with diabetes to have their blood pressure under control. The difference between Black and White women was greater than 3 percentage points.
- API and Hispanic men with diabetes were more likely than White men with diabetes to have their blood pressure under control. In each case the difference was greater than 3 percentage points. Black men with diabetes were less likely than White men with diabetes to have their blood pressure under control. The difference between Black and White men was greater than 3 percentage points.

***** Significantly different from the score for Whites ($p < 0.05$).

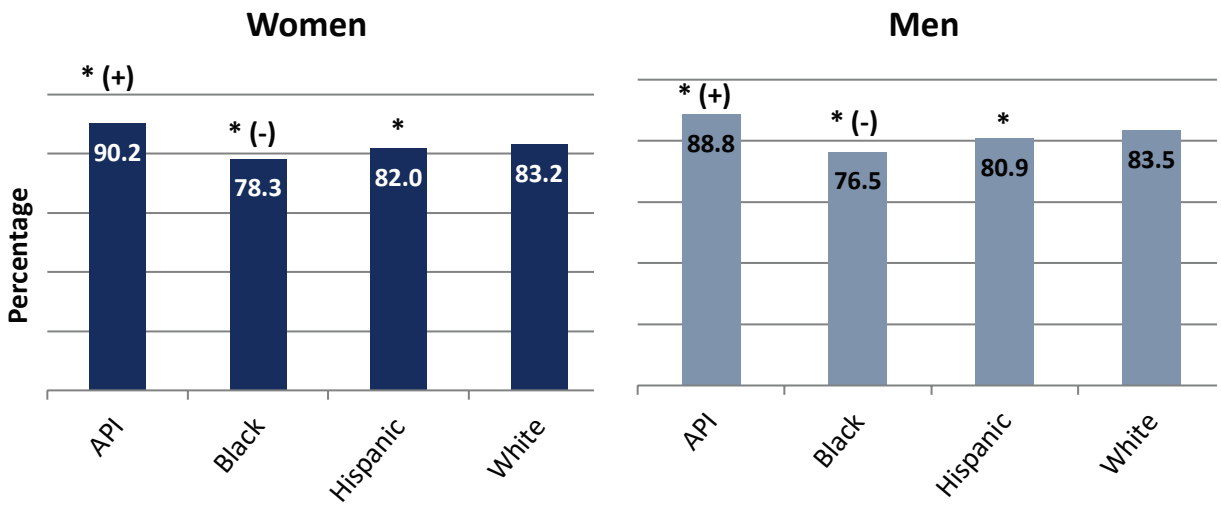
For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Diabetes Care—Blood Sugar Controlled

Percentage of Medicare enrollees aged 18–75 years with diabetes (type 1 and type 2) whose most recent HbA1c level was 9 percent or less, by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- API women with diabetes were more likely than White women with diabetes to have their blood sugar levels under control. The difference between API and White women was greater than 3 percentage points. Black and Hispanic women with diabetes were less likely than White women with diabetes to have their blood sugar levels under control. The difference between Black and White women was greater than 3 percentage points. The difference between Hispanic and White women was less than 3 percentage points.
- API men with diabetes were more likely than White men with diabetes to have their blood sugar levels under control. The difference between API and White men was greater than 3 percentage points. Black and Hispanic men with diabetes were less likely than White men with diabetes to have their blood sugar levels under control. The difference between Black and White men was greater than 3 percentage points. The difference between Hispanic and White men was less than 3 percentage points.

***** Significantly different from the score for Whites ($p < 0.05$).

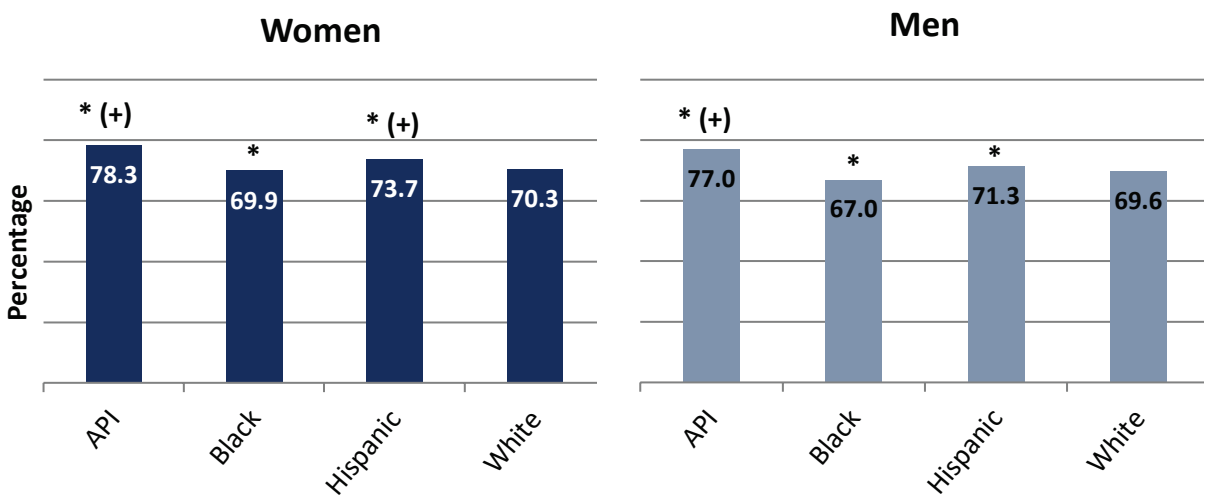
For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Statin Use in Patients with Diabetes

Percentage of MA enrollees aged 40 to 75 years with diabetes (type 1 and type 2)† who received statin therapy, by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- API and Hispanic women with diabetes were more likely than White women with diabetes to have received statin therapy. The difference between API and White women was greater than 3 percentage points; the difference between Hispanic and White women was also greater than 3 percentage points. Black women with diabetes were less likely than White women with diabetes to have received statin therapy. The difference between Black and White women was less than 3 percentage points.
- API and Hispanic men with diabetes were more likely than White men with diabetes to have received statin therapy. The difference between API and White men was greater than 3 percentage points. The difference between Hispanic and White men was less than 3 percentage points. Black men with diabetes were less likely than White men with diabetes to have received statin therapy. The difference between Black and White men was less than 3 percentage points.

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† Excludes those who also have clinical atherosclerotic cardiovascular disease.

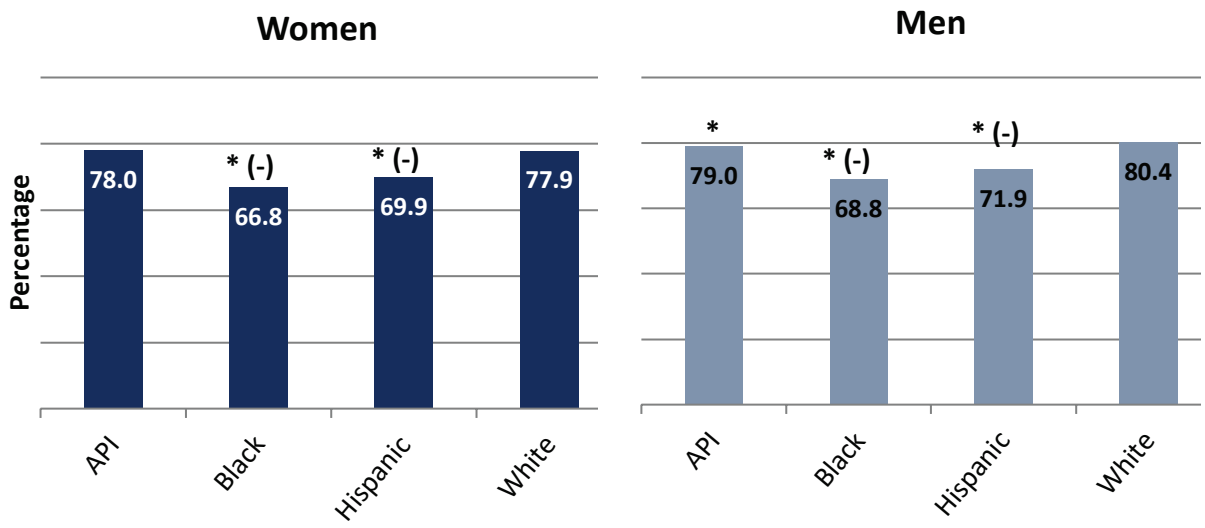
***** Significantly different from the score for Whites ($p < 0.05$).

For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Medication Adherence for Diabetes—Statins

Percentage of MA enrollees aged 40 to 75 years with diabetes (type 1 and type 2)† who were dispensed a statin medication during the measurement year who remained on the medication for at least 80 percent of the treatment period, by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Black and Hispanic women with diabetes were less likely than White women with diabetes to have had proper statin medication adherence. The difference between Black and White women was greater than 3 percentage points, as was the difference between Hispanic and White women. API women with diabetes were about as likely as White women with diabetes to had proper statin medication adherence.
- API, Black, and Hispanic men with diabetes were less likely than White men with diabetes to have had proper statin medication adherence. The difference between API and White men was less than 3 percentage points. The difference between Black and White men was greater than 3 percentage points; the difference between Hispanic and White men was also greater than 3 percentage points.

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† Excludes those who also have clinical atherosclerotic cardiovascular disease.

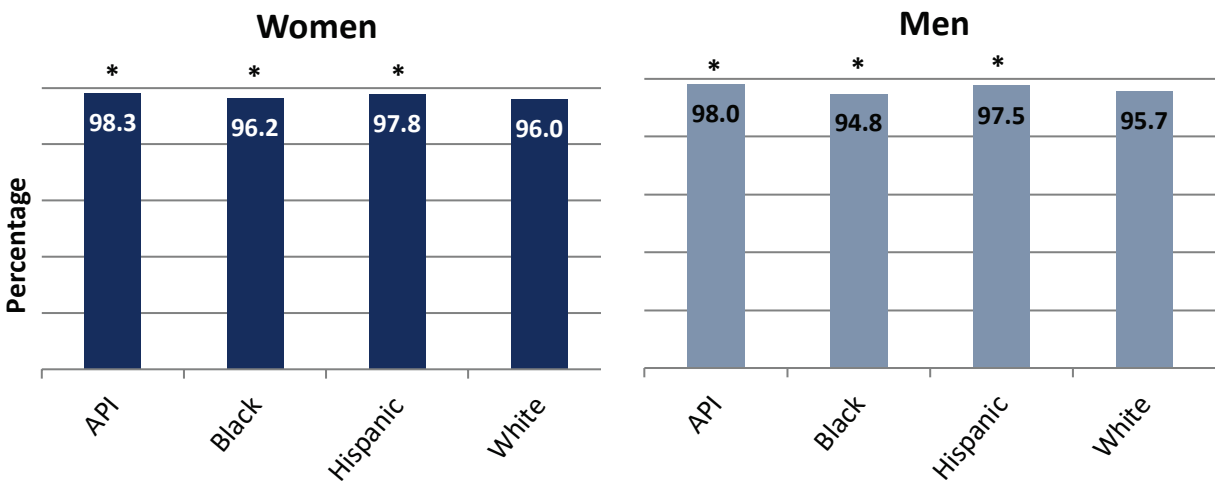
***** Significantly different from the score for Whites ($p < 0.05$).

For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Adult BMI Assessment

Percentage of Medicare enrollees aged 18–74 years who had an outpatient visit whose BMI was documented in the past two years, by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- API, Black, and Hispanic women were more likely than White women to have had their BMIs documented. In each case, the difference was less than 3 percentage points.
- Whereas API and Hispanic men were more likely than White men to have had their BMIs documented, Black men were less likely than White men to have had their BMIs documented. In each case, the difference was less than 3 percentage points.

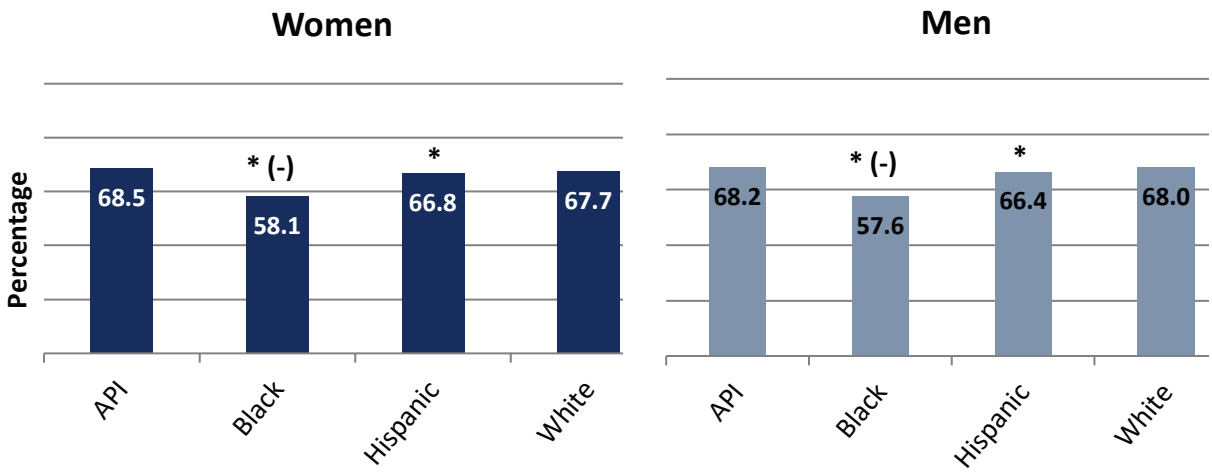
***** Significantly different from the score for Whites ($p < 0.05$).

For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Controlling Blood Pressure

Percentage of Medicare enrollees aged 18–85 years who had a diagnosis of hypertension whose blood pressure was adequately controlled† during the past year, by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Black and Hispanic women with a diagnosis of hypertension were less likely than White women with a diagnosis of hypertension to have had their blood pressure adequately controlled. The difference between Black and White women was greater than 3 percentage points; the difference between Hispanic and White women was less than 3 percentage points. API women with a diagnosis of hypertension were about as likely as White women with a diagnosis of hypertension to have had their blood pressure adequately controlled.
- Black and Hispanic men with a diagnosis of hypertension were less likely than White men with a diagnosis of hypertension to have had their blood pressure adequately controlled. The difference between Black and White men was greater than 3 percentage points; the difference between Hispanic and White men was less than 3 percentage points. API men with a diagnosis of hypertension were about as likely as White men with a diagnosis of hypertension to have had their blood pressure adequately controlled.

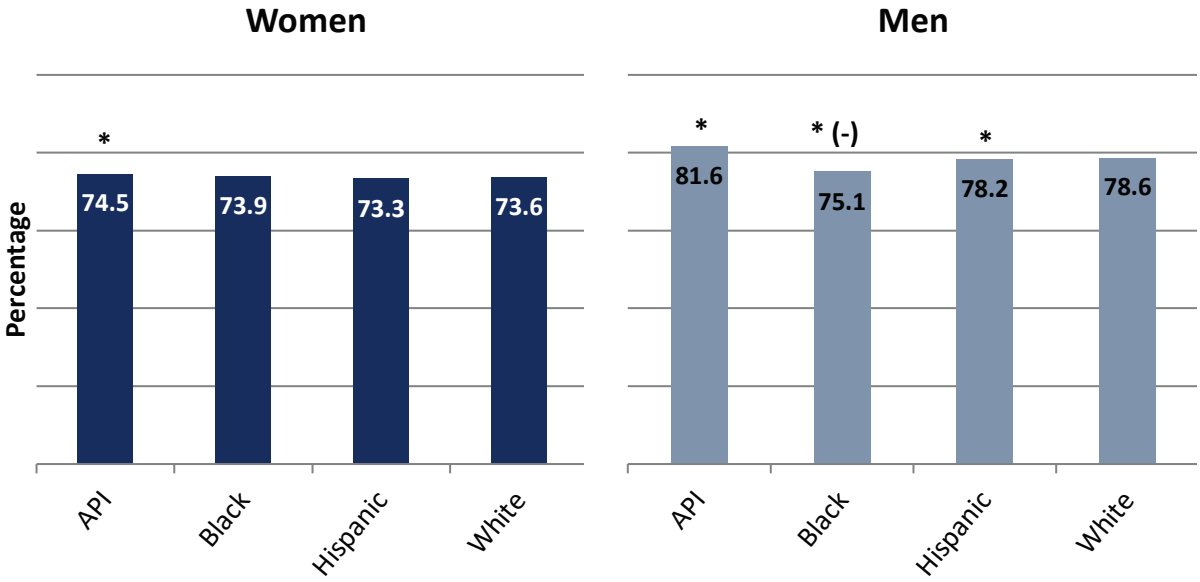
***** Significantly different from the score for Whites ($p < 0.05$).
For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

† Less than 140/90 for enrollees 18–59 years of age and for enrollees 60–85 years of age with a diagnosis of diabetes, or less than 150/90 for members 60–85 years of age without a diagnosis of diabetes.

Clinical Care: Statin Use in Patients with Cardiovascular Disease

Percentage of male MA enrollees aged 21 to 75 years and female MA enrollees aged 40 to 75 years who have clinical atherosclerotic cardiovascular disease (ASCVD) who received statin therapy, by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- API women with ASCVD were more likely than White women with ASCVD to have received statin therapy. The difference between API and White women was less than 3 percentage points. Black and Hispanic women with ASCVD were about as likely as White women with ASCVD to have received statin therapy.
- API men with ASCVD were more likely than White men with ASCVD to have received statin therapy. The difference between API and White men was less than 3 percentage points. Black and Hispanic men with ASCVD were less likely than White men with ASCVD to have received statin therapy. The difference between Black and White men was greater than 3 percentage points. The difference between Hispanic and White men was less than 3 percentage points.

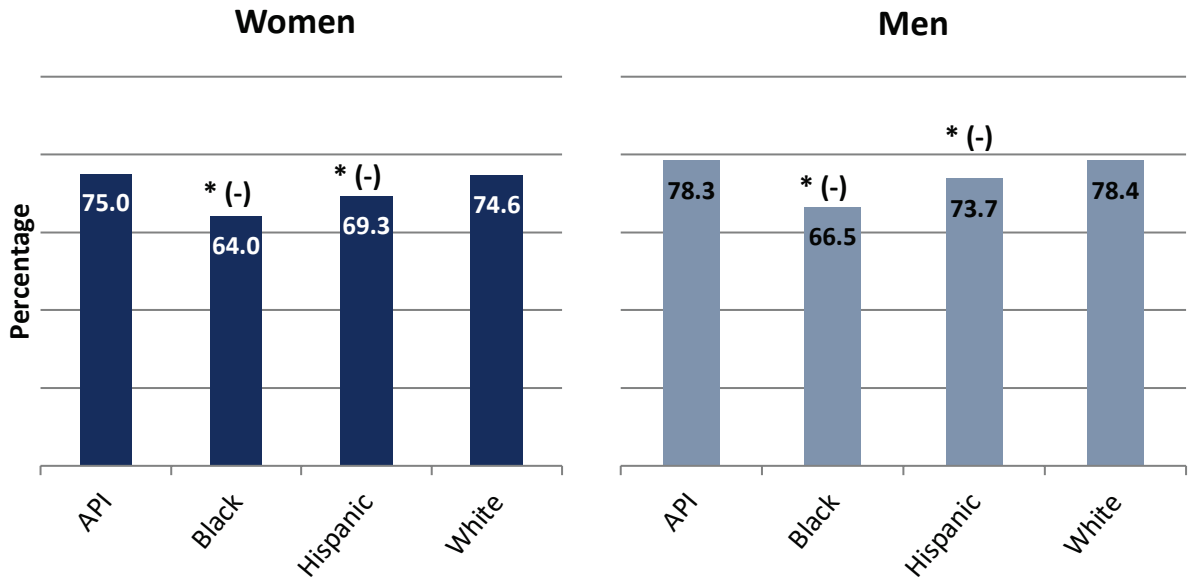
***** Significantly different from the score for Whites ($p < 0.05$).

For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Medication Adherence for Cardiovascular Disease—Statins

Percentage of male MA enrollees aged 21 to 75 years and female MA enrollees aged 40 to 75 years who had clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed a statin medication during the measurement year who remained on the medication for at least 80 percent of the treatment period, by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Black and Hispanic women with ASCVD were less likely than White women with ASCVD to have had proper statin medication adherence. The difference between Black and White women was greater than 3 percentage points; the difference between Hispanic and White women was also greater than 3 percentage points. API women with ASCVD were about as likely as White women with ASCVD to have had proper statin medication adherence.

- Black and Hispanic men with ASCVD were less likely than White men with ASCVD to have had proper statin medication adherence. The difference between Black and White men was greater than 3 percentage points; the difference between Hispanic and White men was also greater than 3 percentage points. API men with ASCVD were about as likely as White men with ASCVD to have had proper statin medication adherence.

***** Significantly different from the score for Whites ($p < 0.05$).

For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

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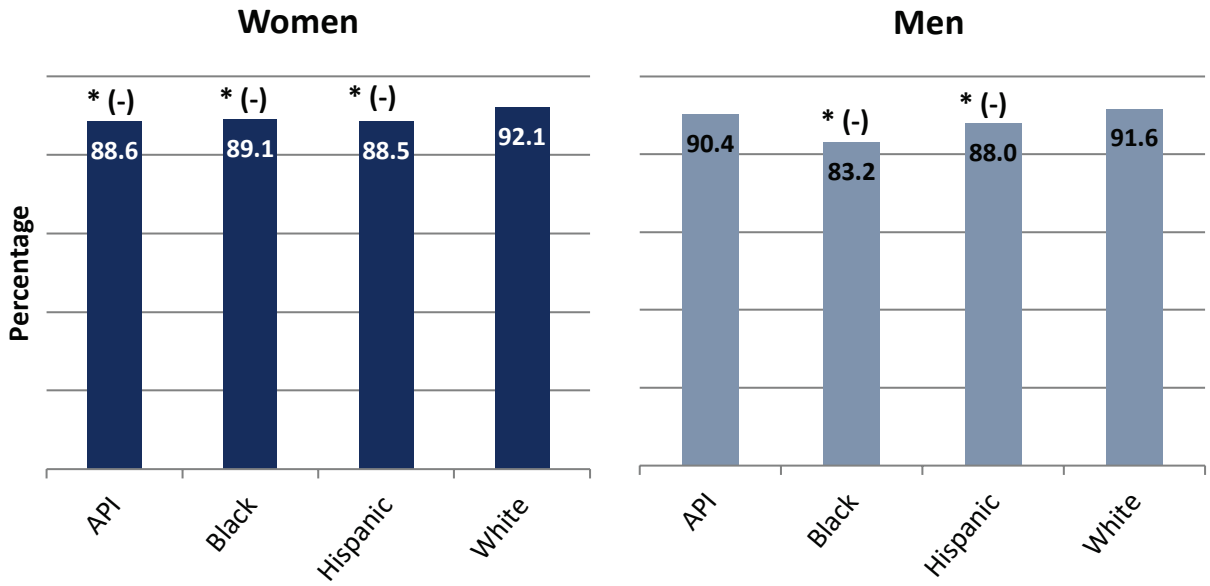
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Continuous Beta-Blocker Treatment

Percentage of Medicare enrollees aged 18 years and older who were hospitalized and discharged alive with a diagnosis of acute myocardial infarction (heart attack) who received persistent beta-blocker treatment for 6 months after discharge, by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- API, Black, and Hispanic women who were hospitalized for a heart attack were less likely than White women who were hospitalized for a heart attack to have received persistent beta-blocker treatment. In each case, the difference was greater than 3 percentage points.
- Black and Hispanic men who were hospitalized for a heart attack were less likely than White men who were hospitalized for a heart attack to have received persistent beta-blocker treatment. In each case, the difference was greater than 3 percentage points. API men who were hospitalized for a heart attack were about as likely as White men who were hospitalized for a heart attack to have received persistent beta-blocker treatment.

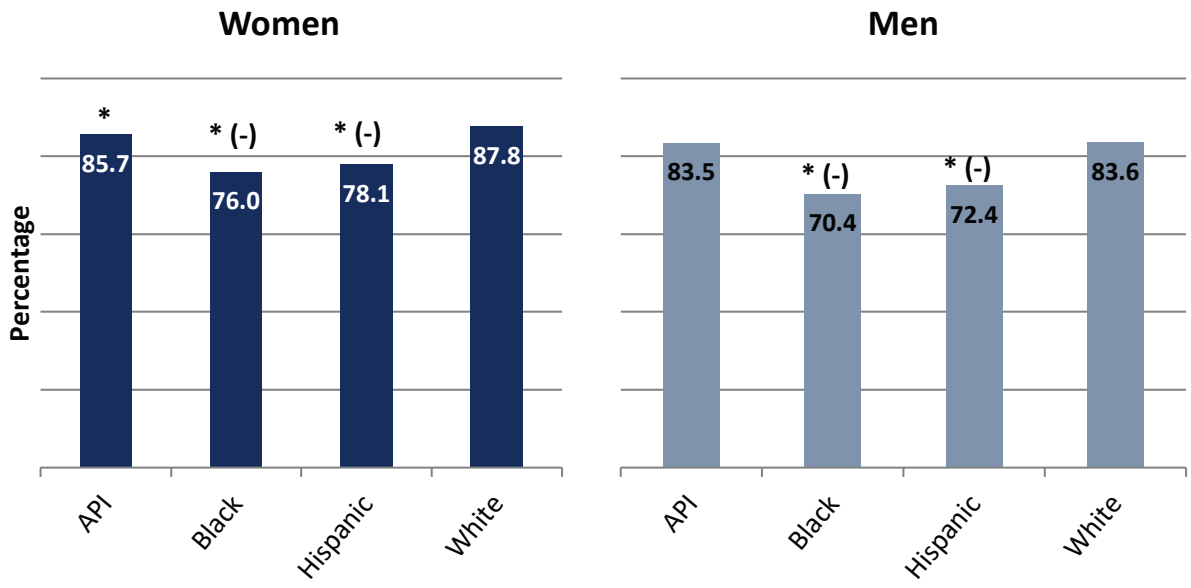
***** Significantly different from the score for Whites ($p < 0.05$).

For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Asthma Medication Ratio in Older Adults

Percentage of MA enrollees aged 65 to 85 years who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the past year, by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

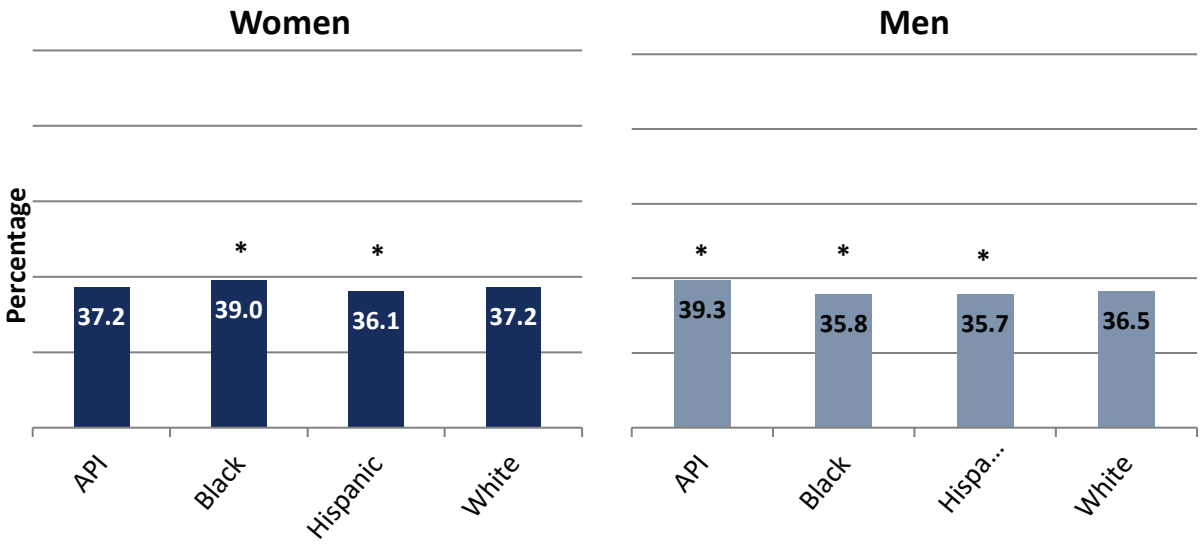
- API, Black, and Hispanic older women with persistent asthma were less likely than White older women with persistent asthma to have had appropriate asthma medication management during the past year. The difference between API and White women was less than 3 percentage points. The difference between Black and White women was greater than 3 percentage points; the difference between Hispanic and White women was also greater than 3 percentage points.
- Black and Hispanic older men with persistent asthma were less likely than White older men with persistent asthma to have had appropriate asthma medication management during the past year. In each case, the difference was greater than 3 percentage points. API older men with persistent asthma were about as likely as White men with persistent asthma to have had appropriate asthma medication management during the past year.

***** Significantly different from the score for Whites ($p < 0.05$).
For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Testing to Confirm COPD

Percentage of Medicare enrollees aged 40 years and older with a new diagnosis of COPD or newly active COPD who received a spirometry test to confirm the diagnosis, by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Black women with a new diagnosis of COPD or newly active COPD were more likely than White women with a new diagnosis of COPD or newly active COPD to have received a spirometry test to confirm the diagnosis. This difference was less than 3 percentage points. Hispanic women with a new diagnosis of COPD or newly active COPD were less likely than White women with a new diagnosis of COPD or newly active COPD to have received a spirometry test to confirm the diagnosis. This difference was also less than 3 percentage points. API women with a new diagnosis of COPD or newly active COPD were about as likely as White women with a new diagnosis of COPD or newly active COPD to have received a spirometry test to confirm the diagnosis.
- API men with a new diagnosis of COPD or newly active COPD were more likely than White men with a new diagnosis of COPD or newly active COPD to have received a spirometry test to confirm the diagnosis, whereas Black and Hispanic men with a new diagnosis of COPD or newly active COPD were less likely than White men with a new diagnosis of COPD or newly active COPD to have received a spirometry test to confirm the diagnosis. In each case, the difference was less than 3 percentage points.

***** Significantly different from the score for Whites ($p < 0.05$).

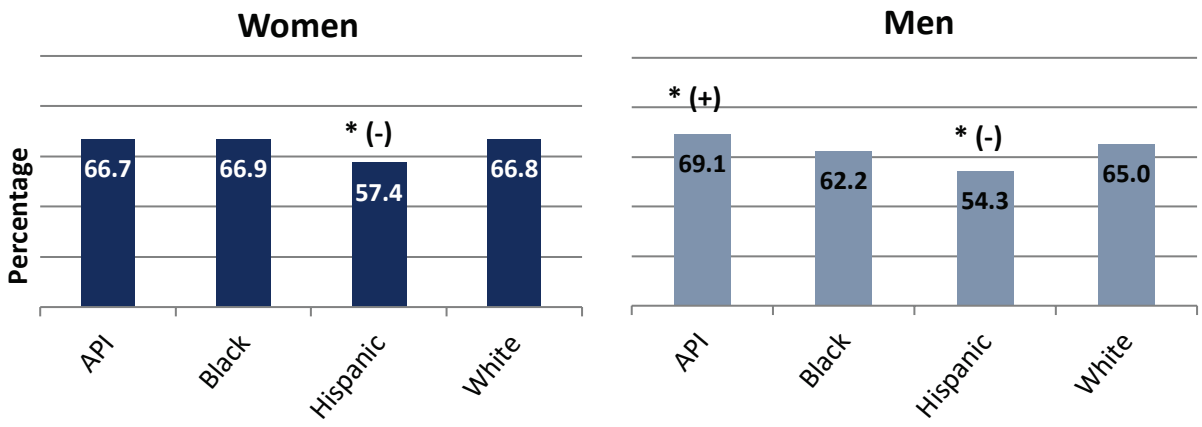
For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Pharmacotherapy Management of COPD Exacerbation Systemic Corticosteroid

Percentage of COPD exacerbations for MA enrollees aged 40 years and older who had an acute inpatient discharge or emergency department encounter in the past year in which a systemic corticosteroid was dispensed within 14 days of the event, by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Hispanic women who experienced a COPD exacerbation were less likely than White women who experienced a COPD exacerbation to have been dispensed a systemic corticosteroid within 14 days of the event. The difference between Hispanic and White women was greater than 3 percentage points. API and Black women who experienced a COPD exacerbation were about as likely as White women who experienced a COPD exacerbation to have been dispensed a systemic corticosteroid within 14 days of the event.
- API men who experienced a COPD exacerbation were more likely than White men who experienced a COPD exacerbation to have been dispensed a systemic corticosteroid within 14 days of the event. The difference between API and White men was greater than 3 percentage points. Hispanic men who experienced a COPD exacerbation were less likely than White men who experienced a COPD exacerbation to have been dispensed a systemic corticosteroid within 14 days of the event. The difference between Hispanic and White men was greater than 3 percentage points. Black men who experienced a COPD exacerbation were about as likely as White men who experienced a COPD exacerbation to have been dispensed a systemic corticosteroid within 14 days of the event.

***** Significantly different from the score for Whites ($p < 0.05$).

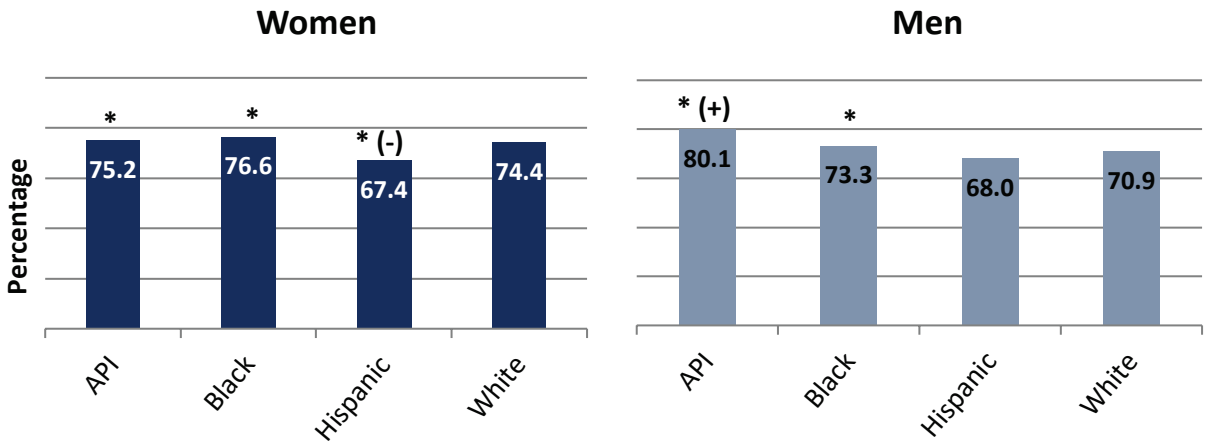
For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Pharmacotherapy Management of COPD Exacerbation Bronchodilator

Percentage of COPD exacerbations for Medicare enrollees aged 40 years and older who had an acute inpatient discharge or emergency department encounter in the past year who were dispensed a bronchodilator within 30 days of experiencing the event, by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- API and Black women who experienced a COPD exacerbation were more likely than White women who experienced a COPD exacerbation to have been dispensed a bronchodilator within 30 days of the event. In each case, the difference was less than 3 percentage points. Hispanic women who experienced a COPD exacerbation were less likely than White women who experienced a COPD exacerbation to have been dispensed a bronchodilator within 30 days of the event. The difference between Hispanic and White women was greater than 3 percentage points.
- API and Black men who experienced a COPD exacerbation were more likely than White men who experienced a COPD exacerbation to have been dispensed a bronchodilator within 30 days of the event. The difference between API and White men was greater than 3 percentage points; the difference between Black and White men was less than 3 percentage points. Hispanic men who experienced a COPD exacerbation were about as likely as White men who experienced a COPD exacerbation to have been dispensed a bronchodilator within 30 days of the event.

***** Significantly different from the score for Whites ($p < 0.05$).

For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

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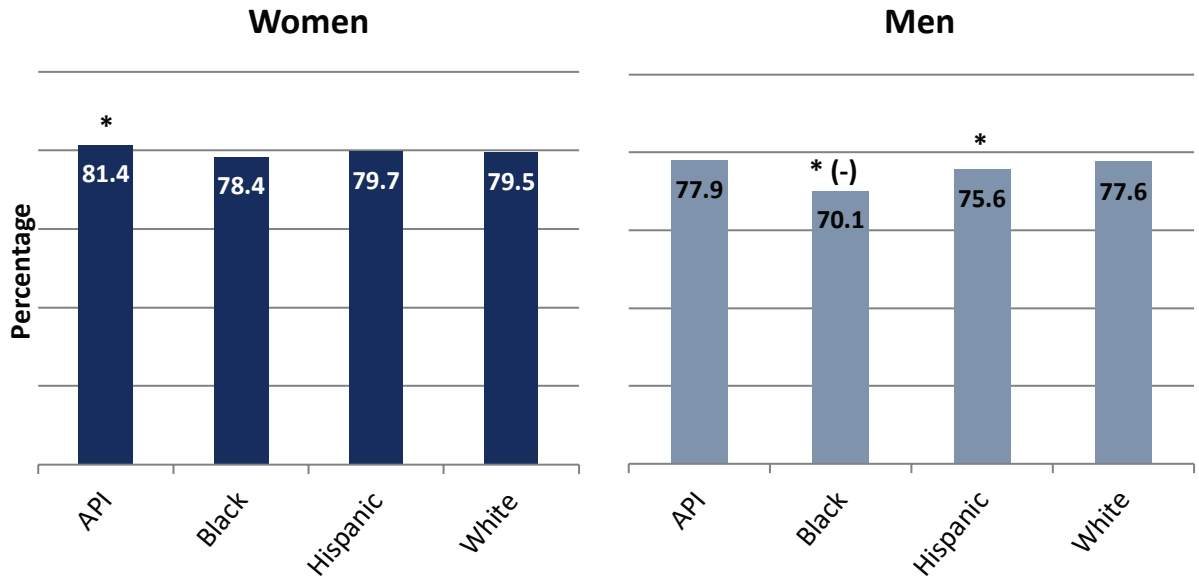
Clinical Care: Rheumatoid Arthritis Management

Percentage of Medicare enrollees aged 18 years and older who were diagnosed with rheumatoid arthritis during the past year who were dispensed at least one ambulatory prescription for a DMARD, by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- API women diagnosed with rheumatoid arthritis were more likely than White women diagnosed with rheumatoid arthritis to have been dispensed at least one DMARD. The difference between API and White women was less than 3 percentage points. Black and Hispanic women diagnosed with rheumatoid arthritis were about as likely as White women diagnosed with rheumatoid arthritis to have been dispensed at least one DMARD.
- Black and Hispanic men diagnosed with rheumatoid arthritis were less likely than White men diagnosed with rheumatoid arthritis to have been dispensed at least one DMARD. The difference between Black and White men was greater than 3 percentage points. The difference between Hispanic and White men was less than 3 percentage points. API men diagnosed with rheumatoid arthritis were about as likely as White men diagnosed with rheumatoid arthritis to have been dispensed at least one DMARD.

***** Significantly different from the score for Whites ($p < 0.05$).
For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
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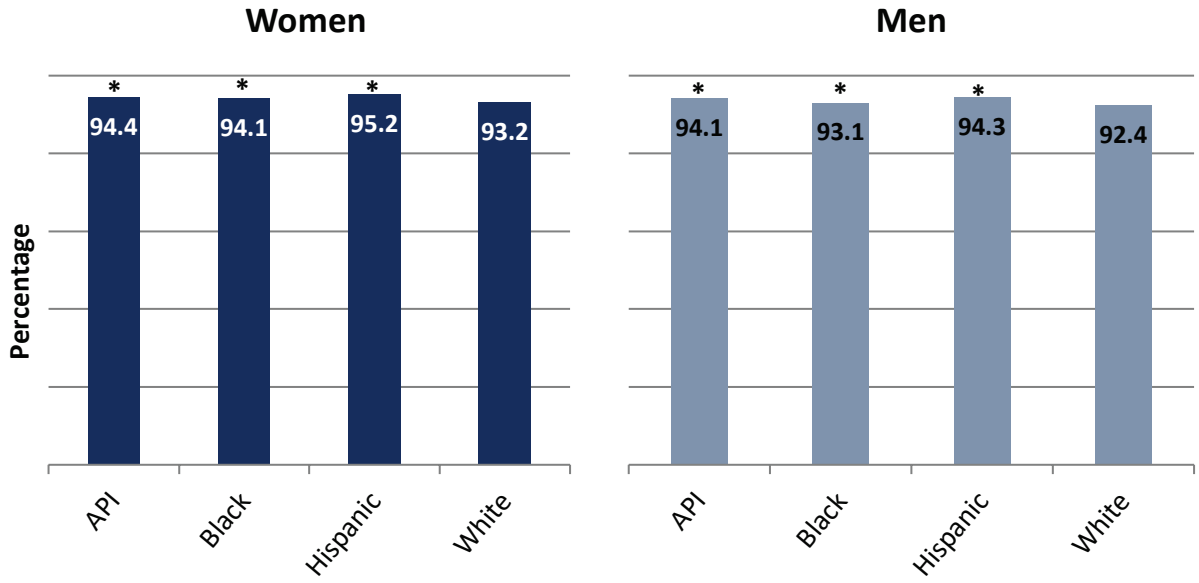
Clinical Care: Appropriate Monitoring of Patients Taking Long-Term Medications

Percentage of Medicare enrollees aged 18 years and older who received at least 180 treatment days of ambulatory medication therapy for a selected therapeutic agent† during the past year who had at least one therapeutic monitoring event for the agent during the year, by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- API, Black, and Hispanic women were more likely than White women to have had at least one appropriate follow-up visit during the year to monitor their use of a higher-risk medication. In each case, the difference was less than 3 percentage points.
- API, Black, and Hispanic men were more likely than White men to have had at least one appropriate follow-up visit during the year to monitor their use of a higher-risk medication. In each case, the difference was less than 3 percentage points.

***** Significantly different from the score for Whites ($p < 0.05$).

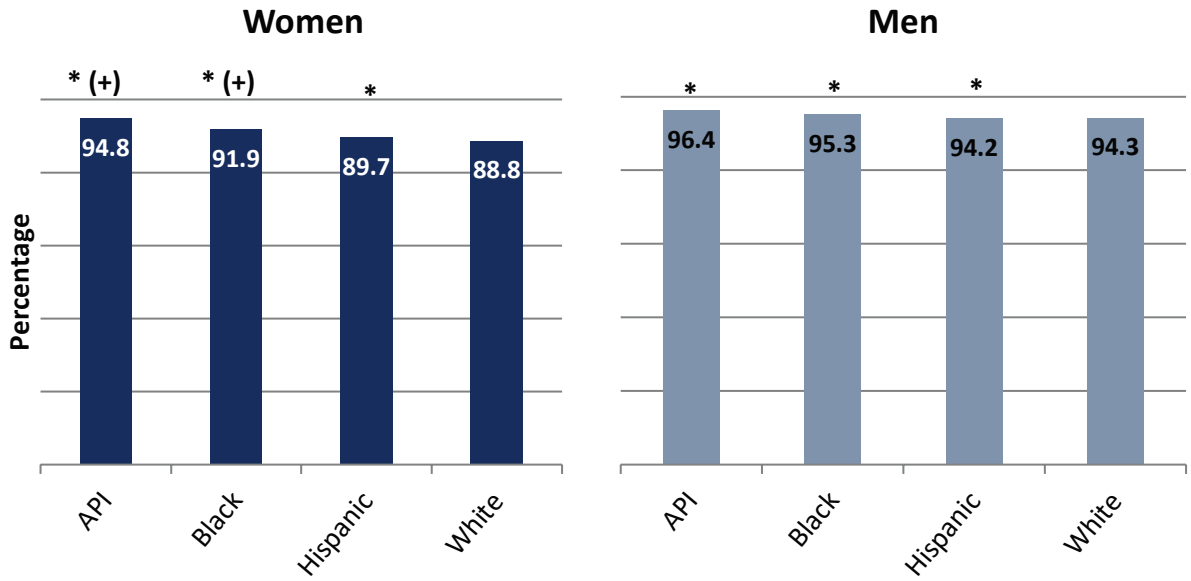
For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

† This measure is limited to those who had a prescription for one or more of the following drugs for 6 months or longer: ACE inhibitors, ARBs, digoxin, diuretics, anticonvulsants, and statins. These drugs are known to have possibly harmful side effects if used long term.

Clinical Care: Avoiding Use of High-Risk Medications in the Elderly

Percentage of Medicare enrollees aged 65 years and older who were not prescribed a high-risk medication, by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Long-term use of high-risk medication should be avoided in the elderly. In the 2017 data, it was observed that this standard of care was met more often for elderly API, Black, and Hispanic women than for elderly White women. The difference between elderly API women and elderly White women was greater than 3 percentage points, as was the difference between elderly Black women and elderly White women. The difference between elderly Hispanic women and elderly White women was less than 3 percentage points.

- In the 2017 data, it was observed that this standard of care was met more often for elderly API and Black men than for elderly White men. The difference between API and White men and between Black and White men was less than 3 percentage points. This standard of care was met less often for elderly Hispanic men than for elderly White men. This difference was also less than 3 percentage points.

***** Significantly different from the score for Whites ($p < 0.05$).

For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

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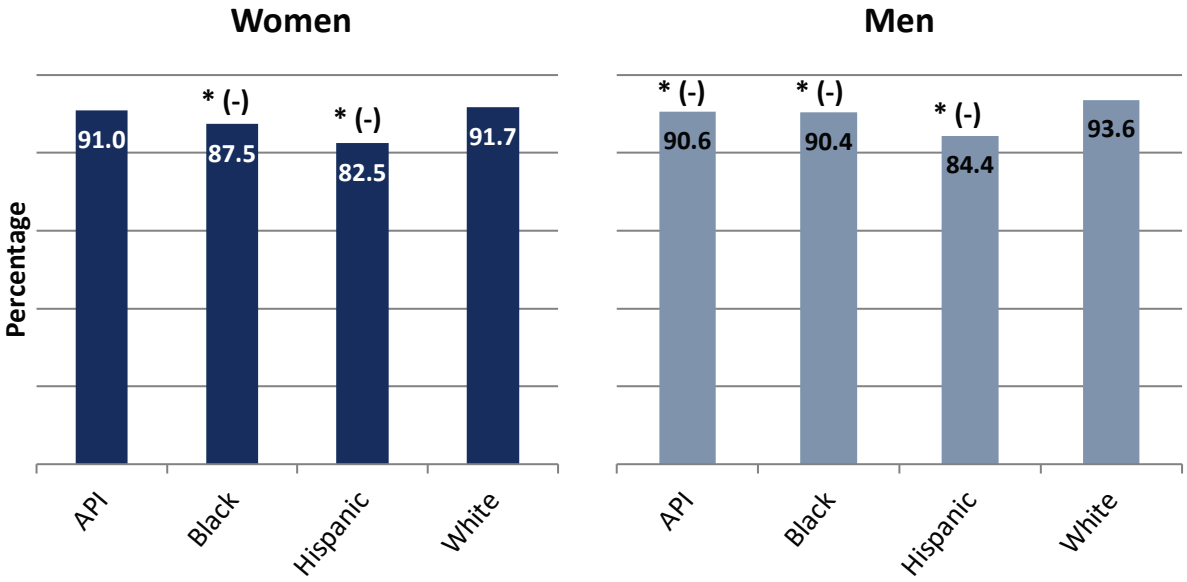
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with Chronic Renal Failure

Percentage of Medicare enrollees aged 65 years and older with chronic renal failure who were not dispensed a prescription for a potentially harmful medication,† by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Potentially harmful medication† should be avoided among elderly adults with chronic renal failure. In the 2017 data, it was observed that this standard of care was met less often for elderly Black and Hispanic women than for elderly White women. In each case, the difference was greater than 3 percentage points. This standard of care was met about as often for elderly API women as it was for White women.
- In the 2017 data, it was observed that the standard of care was met less often for elderly API, Black, and Hispanic men than for elderly White men. In each case, the difference was greater than 3 percentage points.

***** Significantly different from the score for Whites ($p < 0.05$).

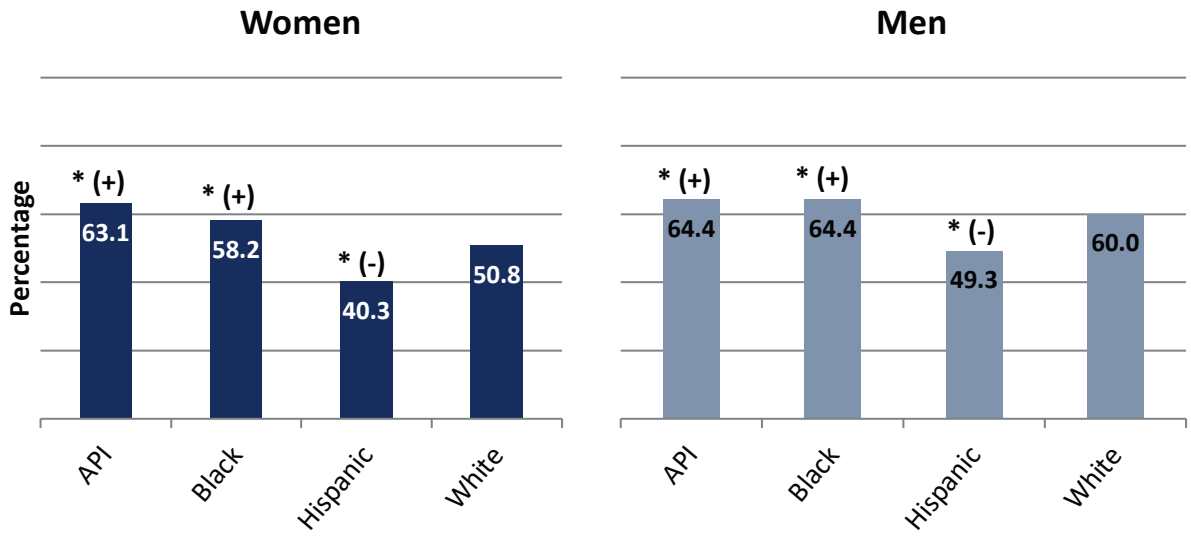
For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

† This includes COX-2 selective NSAIDs and nonaspirin NSAIDs.

Clinical Care: Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with Dementia

Percentage of Medicare enrollees aged 65 years and older with dementia who were not dispensed a prescription for a potentially harmful medication,† by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Potentially harmful medication† should be avoided among elderly adults with dementia. In the 2017 data, it was observed that this standard of care was met more often for elderly API and Black women with dementia than for elderly White women with dementia. In each case, the difference was greater than 3 percentage points. The standard of care was met less often for elderly Hispanic women with dementia than for elderly White women with dementia. This difference was also greater than 3 percentage points.

- In the 2017 data, it was observed that the standard of care was met more often for elderly API and Black men with dementia than for elderly White men with dementia. In each case, the difference was greater than 3 percentage points. The standard of care was met less often for elderly Hispanic men with dementia than for elderly White men with dementia. This difference was also greater than 3 percentage points.

***** Significantly different from the score for Whites ($p < 0.05$).
For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

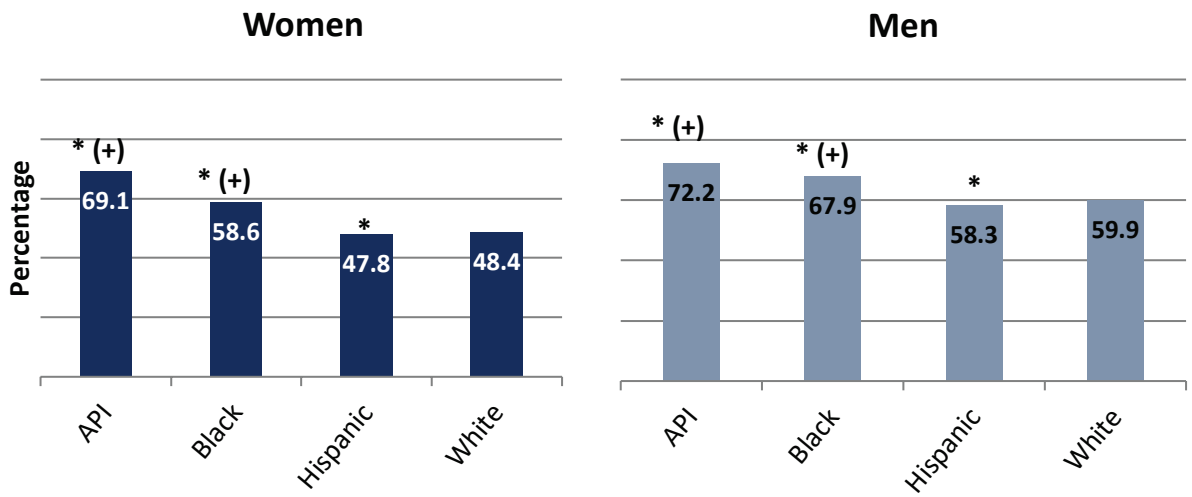
(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

† This includes antiemetics, antipsychotics, benzodiazepines, tricyclic antidepressants, H2 receptor antagonists, nonbenzodiazepine hypnotics, and anticholinergic agents.

Clinical Care: Avoiding Potentially Harmful Drug-Disease Interactions in Elderly Patients with a History of Falls

Percentage of Medicare enrollees aged 65 years and older with a history of falls who were not dispensed a prescription for a potentially harmful medication,† by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Potentially harmful medication† should be avoided among elderly adults with a history of falls. In the 2017 data, it was observed that this standard of care was met more often for elderly API and Black women with a history of falls than for elderly White women with a history of falls. In each case, the difference was greater than 3 percentage points. This standard of care was met less often for elderly Hispanic women with a history of falls than for elderly White women with a history of falls. In this case, the difference was less than 3 percentage points.

- In the 2017 data, it was observed that the standard of care was met more often for elderly API and Black men with a history of falls than for elderly White men with a history of falls. In each case, the difference was greater than 3 percentage points. This standard of care was met less often for elderly Hispanic men with a history of falls than for elderly White men with a history of falls. In this case, the difference was less than 3 percentage points.

***** Significantly different from the score for Whites ($p < 0.05$).

For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

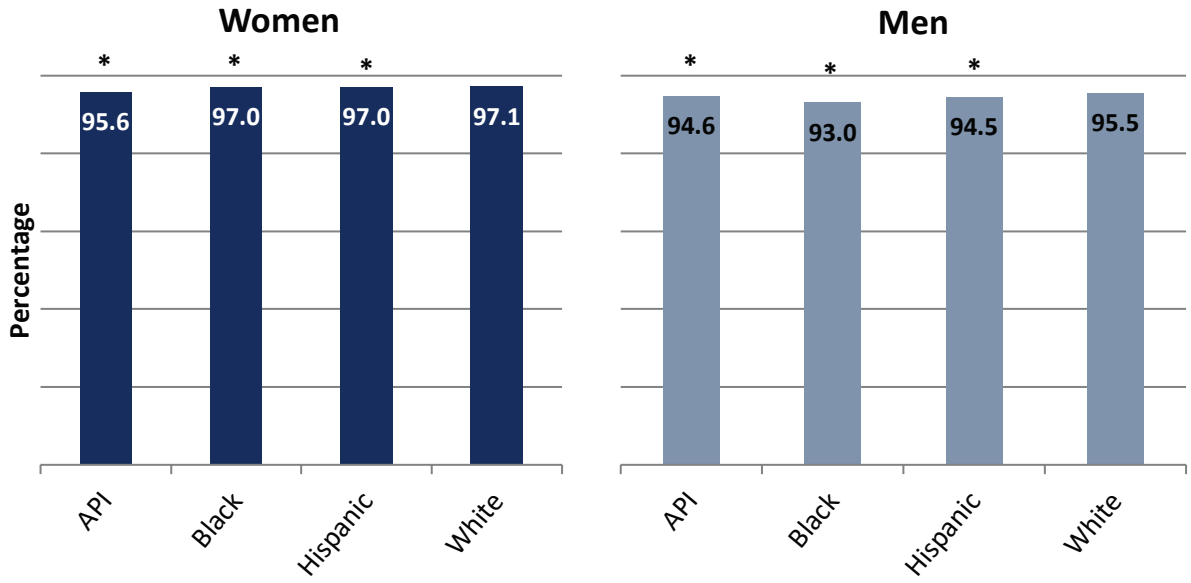
(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

† This includes anticonvulsants, nonbenzodiazepine hypnotics, SSRIs, antiemetics, antipsychotics, benzodiazepines, and tricyclic antidepressants.

Clinical Care: Older Adults' Access to Preventive/Ambulatory Services

Percentage of Medicare enrollees aged 65 years and older who had an ambulatory or preventive care visit, by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- API, Black, and Hispanic women were less likely than White women to have had an ambulatory or preventive care visit. In each case, the difference was less than 3 percentage points.
- API, Black, and Hispanic men were less likely than White men to have had an ambulatory or preventive care visit. In each case, the difference was less than 3 percentage points.

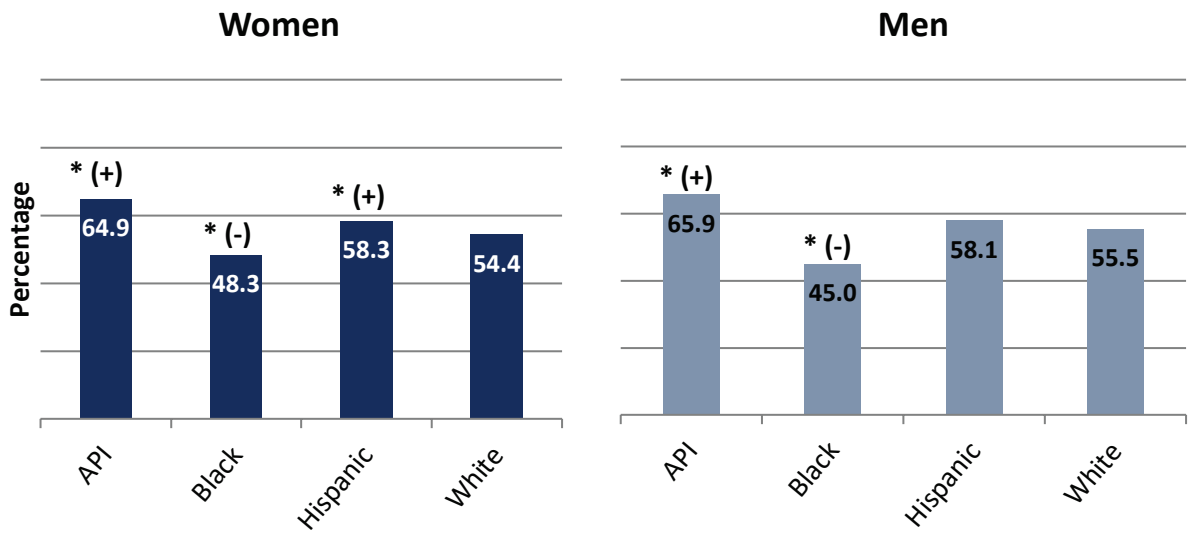
***** Significantly different from the score for Whites ($p < 0.05$).

For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Medication Reconciliation After Hospital Discharge

Percentage of MA enrollees aged 18 years and older who were discharged from an inpatient facility and had their medications reconciled within 30 days, by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

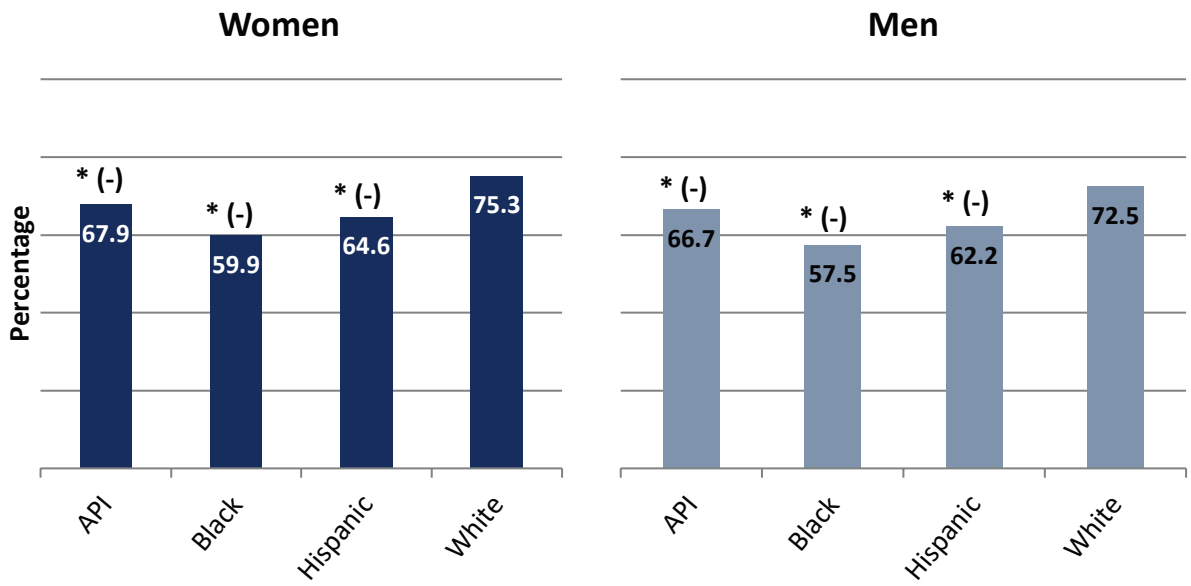
- API and Hispanic women who were discharged from an inpatient facility were more likely than White women who were discharged from an inpatient facility to have had their medications reconciled within 30 days. In each case, the difference was greater than 3 percentage points. Black women who were discharged from an inpatient facility were less likely than White women who were discharged from an inpatient facility to have had their medications reconciled within 30 days. This difference was also greater than 3 percentage points.
- API men who were discharged from an inpatient facility were more likely than White men who were discharged from an inpatient facility to have had their medications reconciled within 30 days. The difference between API and White men was greater than 3 percentage points. Black men who were discharged from an inpatient facility were less likely than White men who were discharged from an inpatient facility to have had their medications reconciled within 30 days. The difference between Black and White men was greater than 3 percentage points. Hispanic men who were discharged from an inpatient facility were about as likely as White men who were discharged from an inpatient facility to have had their medications reconciled within 30 days.

***** Significantly different from the score for Whites ($p < 0.05$).
For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Antidepressant Medication Management—Acute Phase Treatment

Percentage of Medicare enrollees aged 18 years and older who were diagnosed with a new episode of major depression who remained on antidepressant medication for at least 84 days, by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- API, Black, and Hispanic women who were diagnosed with a new episode of major depression were less likely than White women who were diagnosed with a new episode of major depression to have remained on antidepressant medication for at least 84 days. In each case, the difference was greater than 3 percentage points.
- API, Black, and Hispanic men who were diagnosed with a new episode of major depression were less likely than White men who were diagnosed with a new episode of major depression to have remained on antidepressant medication for at least 84 days. In each case, the difference was greater than 3 percentage points.

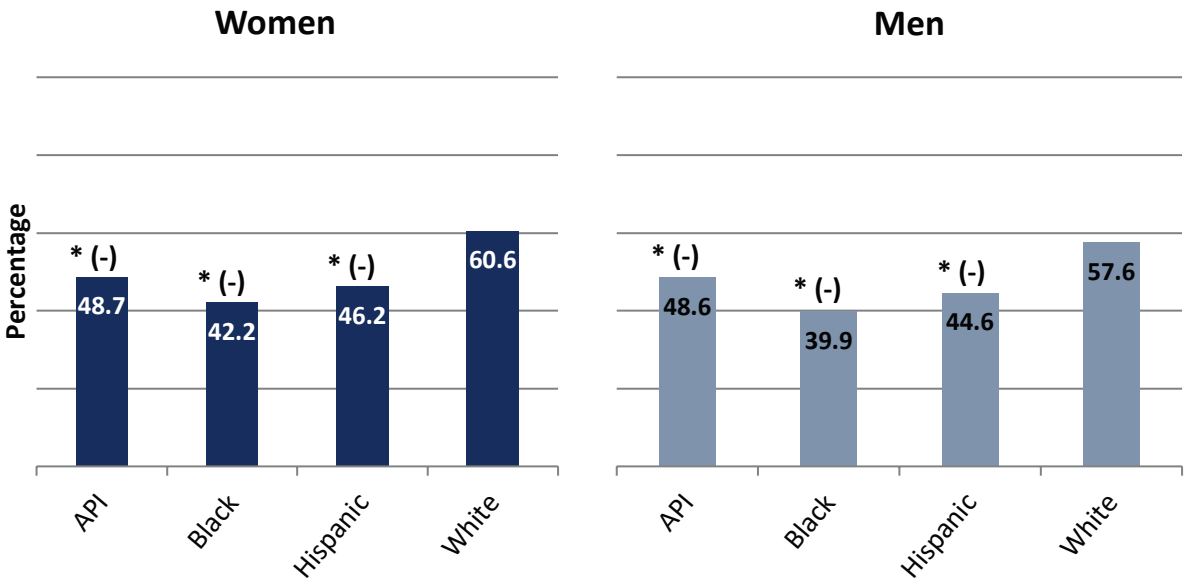
***** Significantly different from the score for Whites ($p < 0.05$).

For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Antidepressant Medication Management—Continuation Phase Treatment

Percentage of Medicare enrollees aged 18 years and older with a new diagnosis of major depression who were newly treated with antidepressant medication who remained on an antidepressant medication treatment for at least 180 days, by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- API, Black, and Hispanic women who were diagnosed with a new episode of major depression were less likely than White women who were diagnosed with a new episode of major depression to have remained on antidepressant medication for at least 180 days. In each case, the difference was greater than 3 percentage points.
- API, Black, and Hispanic men who were diagnosed with a new episode of major depression were less likely than White men who were diagnosed with a new episode of major depression to have remained on antidepressant medication for at least 180 days. In each case, the difference was greater than 3 percentage points.

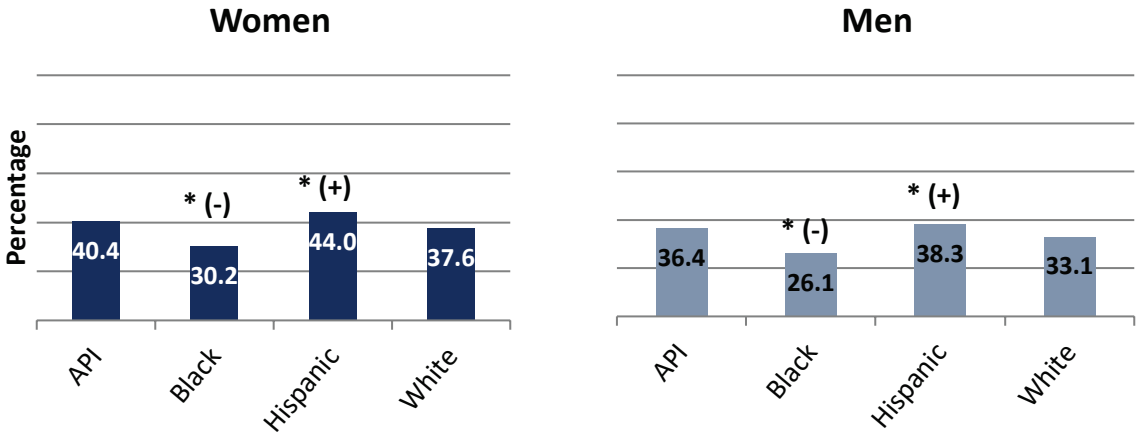
***** Significantly different from the score for Whites ($p < 0.05$).

For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

Clinical Care: Follow-Up Visit After Hospital Stay for Mental Illness (within 7 days of discharge)

Percentage of Medicare enrollees aged 18 years and older† who were hospitalized for treatment of selected mental health disorders who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge, by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Hispanic women hospitalized for a mental health disorder were more likely than White women hospitalized for a mental health disorder to have had appropriate follow-up care within 7 days of discharge. In contrast, Black women hospitalized for a mental health disorder were less likely than White women hospitalized for a mental health disorder to have had appropriate follow-up care within 7 days of discharge. In each case, the difference was greater than 3 percentage points. API women hospitalized for a mental health disorder were about as likely as White women hospitalized for a mental health disorder to have had appropriate follow-up care within 7 days of discharge.
- Hispanic men hospitalized for a mental health disorder were more likely than White men hospitalized for a mental health disorder to have had appropriate follow-up care within 7 days of discharge. In contrast, Black men hospitalized for a mental health disorder were less likely than White men hospitalized for a mental health disorder to have had appropriate follow-up care within 7 days of discharge. In each case, the difference was greater than 3 percentage points. API men hospitalized for a mental health disorder were about as likely as White men hospitalized for a mental health disorder to have had appropriate follow-up care within 7 days of discharge.

***** Significantly different from the score for Whites ($p < 0.05$).
For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

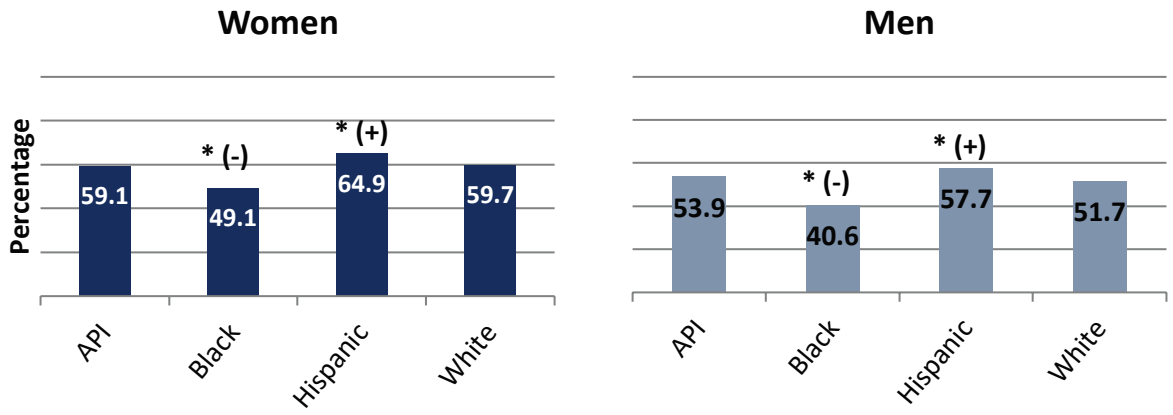
(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

† Although the lower-bound age cutoff for this HEDIS measure is 6 years old, the data used in this report are limited to adults.

Clinical Care: Follow-Up Visit After Hospital Stay for Mental Illness (within 30 days of discharge)

Percentage of Medicare enrollees aged 18 years and older† who were hospitalized for treatment of selected mental health disorders who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge, by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Black women hospitalized for a mental health disorder were less likely than White women hospitalized for a mental health disorder to have had a follow-up visit with a mental health practitioner within 30 days of discharge. In contrast, Hispanic women hospitalized for a mental health disorder were more likely than White women hospitalized for a mental health disorder to have had such a follow-up visit. Each difference was greater than 3 percentage points. API women hospitalized for a mental health disorder were about as likely as White women hospitalized for a mental health disorder to have had a follow-up visit with a mental health practitioner within 30 days of discharge.
- Black men hospitalized for a mental health disorder were less likely than White men hospitalized for a mental health disorder to have had a follow-up visit with a mental health practitioner within 30 days of discharge. In contrast, Hispanic men hospitalized for a mental health disorder were more likely than White men hospitalized for a mental health disorder to have had such a follow-up visit. Each difference was greater than 3 percentage points. API men hospitalized for a mental health disorder were about as likely as White men hospitalized for a mental health disorder to have had a follow-up visit with a mental health practitioner within 30 days of discharge.

***** Significantly different from the score for Whites ($p < 0.05$).

For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

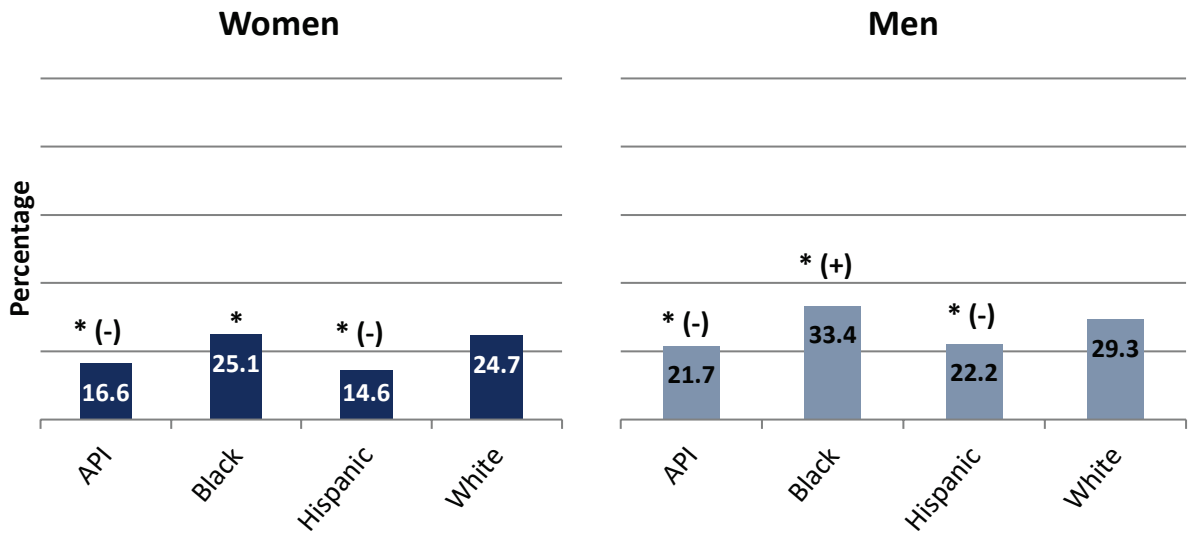
(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

† Although the lower-bound age cutoff for this HEDIS measure is 6 years old, the data used in this report are limited to adults.

Clinical Care: Initiation of Alcohol or Other Drug Treatment

Percentage of Medicare enrollees aged 18 years and older† with a new episode of AOD dependence who initiated‡ treatment within 14 days of the diagnosis, by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- API and Hispanic women with a new episode of AOD dependence were less likely than White women with a new episode of AOD dependence to have initiated treatment within 14 days of diagnosis. In each case, the difference was greater than 3 percentage points. Black women with a new episode of AOD dependence were more likely than White women with a new episode of AOD dependence to have initiated treatment within 14 days of diagnosis. This difference was less than 3 percentage points.
- API and Hispanic men with a new episode of AOD dependence were less likely than White men with a new episode of AOD dependence to have initiated treatment within 14 days of diagnosis. In each case, the difference was greater than 3 percentage points. Black men with a new episode of AOD dependence were more likely than White men with a new episode of AOD dependence to have initiated treatment within 14 days of diagnosis. This difference was also greater than 3 percentage points.

***** Significantly different from the score for Whites ($p < 0.05$).

For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

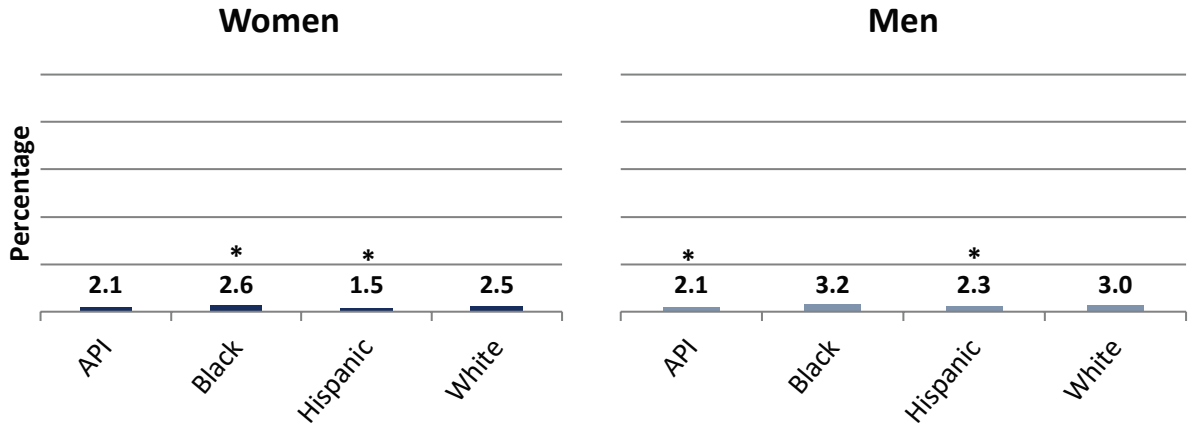
(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

† Although the lower-bound age cutoff for this HEDIS measure is 13 years old, the data used in this report are limited to adults.

‡ Initiation may occur through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization.

Clinical Care: Engagement of Alcohol or Other Drug Treatment

Percentage of Medicare enrollees aged 18 years and older† with a new episode of AOD dependence who initiated treatment who had two or more additional services within 30 days of the initiation visit, by race and ethnicity within gender, 2017



SOURCE: Clinical quality data collected in 2017 from Medicare health plans nationwide.
NOTES: Racial groups such as Blacks and Whites are non-Hispanic; Hispanic ethnicity includes all races. API = Asian or Pacific Islander.

Disparities

- Black women with a new episode of AOD dependence who initiated treatment were more likely than White women with a new episode of AOD dependence who initiated treatment to have had two or more additional services within 30 days of the initiation visit. In contrast, Hispanic women with a new episode of AOD dependence who initiated treatment were less likely than White women with a new episode of AOD dependence who initiated treatment to have had two or more additional services within 30 days of the initiation visit. In each case, the difference was less than 3 percentage points. API women with a new episode of AOD dependence who initiated treatment were about as likely as White women with a new episode of AOD dependence who initiated treatment to have had two or more additional services within 30 days of the initiation visit.
- API and Hispanic men with a new episode of AOD dependence who initiated treatment were less likely than White men with a new episode of AOD dependence who initiated treatment to have had two or more additional services within 30 days of the initiation visit. In each case, the difference was less than 3 percentage points. Black men with a new episode of AOD dependence who initiated treatment were about as likely as White men with a new episode of AOD dependence who initiated treatment to have had two or more additional services within 30 days of the initiation visit.

***** Significantly different from the score for Whites ($p < 0.05$).
For statistically significant differences between Whites and racial or ethnic minorities of the same gender, the following symbols are also used when applicable:

(+) Difference is equal to or larger than 3 points (before rounding) and favors the racial or ethnic minority group.

(-) Difference is equal to or larger than 3 points (before rounding) and favors Whites.

† Although the lower-bound age cutoff for this HEDIS measure is 13 years old, the data used in this report are limited to adults.

Appendix: Data Sources and Methods

The Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys

Medicare CAHPS surveys are mail surveys with telephone follow-ups based on a stratified random sample of Medicare beneficiaries, with contracts serving as strata for Medicare Advantage (MA) beneficiaries and for fee-for-service (FFS) beneficiaries enrolled in prescription drug plans (PDPs) and states serving as strata for FFS beneficiaries not enrolled in a PDP. The 2017 survey attempted to contact 844,320 Medicare beneficiaries and received responses from 340,645, a 40 percent response rate. The 2017 surveys represent all FFS beneficiaries, MA beneficiaries from 447 MA contracts that either were required to report (minimum of 600 eligible enrollees) or reported voluntarily (450–599 enrollees), and PDP beneficiaries from 55 PDP contracts with at least 1,500 eligible enrollees. The data presented in this report pertain only to MA beneficiaries.

The Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS consists of more than 90 measures across 6 domains of care (National Committee for Quality Assurance [NCQA], 2018). These domains include effectiveness of care, access/availability of care, experience of care, utilization and risk adjusted utilization, relative resource use, and health plan descriptive information. HEDIS measures are developed, tested, and validated under the direction of NCQA. Although CAHPS data are collected only via surveys, HEDIS data are gathered both via surveys and via medical charts and insurance claims for hospitalizations, medical office visits, and procedures. In selecting HEDIS measures to include in this report, we excluded measures that underwent a recent change in specification, were similar to reported measures preferred by the Centers for Medicare & Medicaid Services (CMS), or were deemed unsuitable for this application by CMS experts.

Information on Race/Ethnicity

The 2017 CAHPS survey asked beneficiaries, “Are you of Hispanic or Latino origin or descent?” The response options were: “Yes, Hispanic or Latino” and “No, not Hispanic or Latino.” The survey then asked, “What is your race? Please mark one or more,” with response options of “White,” “Black or African American,” “Asian,” “Native Hawaiian or other Pacific Islander,” and “American Indian or Alaska Native.” Following a U.S. Census approach, answers to these two questions were used to classify respondents into 1 of 7 mutually exclusive categories: Hispanic, multiracial, American Indian/Alaska Native (AI/AN), Asian/Pacific Islander (API), Black, White, or unknown.

- Respondents who endorsed Hispanic ethnicity were classified as Hispanic regardless of races endorsed.
- Non-Hispanic respondents who endorsed two or more races were classified as multiracial, with a single exception: Those who selected both “Asian” and “Native Hawaiian or other Pacific Islander” but no other race were classified as API.
- Non-Hispanic respondents who selected exactly one race were classified as AI/AN, API, Black, or White, according to their responses.
- Respondents without data regarding race/ethnicity were classified as unknown.
- Unknown cases were dropped from the analysis. The multiracial group was included in the analysis, but estimates for this group are not presented in this report.
- In prior versions of this report, we did not include estimates for AI/AN beneficiaries because there were too few AI/AN respondents to make accurate comparisons between this group and

Whites when looking at women and men separately. For this year's report, there were sufficient data to report scores on some patient experience measures for AI/AN women only.

HEDIS data, unlike CAHPS data, do not contain the patient's self-reported race/ethnicity. Therefore, we imputed race/ethnicity for the HEDIS data using a methodology that combines information from administrative data, surname, and residential location (Martino et al., 2013). This methodology is recommended for estimating racial/ethnic disparities for Black, Hispanic, API, and White beneficiaries, but not for AI/AN or multiracial beneficiaries. In 2017, there were 537 MA contracts that supplied the 20,596,107 HEDIS measure records used.

Information on Gender

Information on the gender of MA beneficiaries is gathered from administrative records.

Analytic Approach

The CAHPS measures presented in this report are composite measures that summarize, through averaging, the answers to two or more related CAHPS survey questions, or items. The annual flu vaccine measure is included in the CAHPS survey and is thus grouped with other CAHPS measures in this report. It is, however, considered to be a HEDIS measure. This is a single-item measure rather than a composite.

CAHPS estimates for different racial/ethnic groups are from case-mix-adjusted linear regression models that contained health contract intercepts, racial/ethnic indicators, and the following case-mix adjustors: age, education, self-rated health and mental health, dual eligibility/low-income subsidy, and proxy status. No adjustment was made for survey language. Race/ethnicity was coded as Hispanic, Black, API, AI/AN, multiracial, and unknown, with White as the (omitted) reference group. CAHPS estimates for men and women are from case-mix-adjusted linear regression models that contained health contract intercepts, an indicator for female gender (with male as the reference group), and the same set of case-mix adjustors used in the racial/ethnic group models. CAHPS estimates for men and women of different racial/ethnic backgrounds are from case-mix-adjusted linear regression models, stratified by gender, that contained health contract intercepts, racial/ethnic indicators, and the case-mix adjustors.

Predicted probabilities of race/ethnicity were used as weights to develop HEDIS measure estimates for each racial/ethnic group (Elliott et al., 2009). None of the HEDIS measures reported (including the annual flu vaccine measure) is case-mix adjusted.

Statistical significance tests were used to compare the model-estimated scores for each racial/ethnic minority group with the score for Whites and to compare the model-estimated scores for women and men. A difference in scores is denoted as statistically significant if there is less than a 5 percent chance that the difference could have resulted due to sampling error alone. Differences that are statistically significant and larger than 3 points on a 0–100 scale (CAHPS) or 3 percentage points (HEDIS) are further denoted as practically significant. That is, in the charts that present national data on racial/ethnic and gender differences in patient experience (CAHPS) and clinical care (HEDIS), differences that are not statistically significant or are statistically significant but less than 3 points in magnitude are distinguished (through the use of symbols and labeling) from differences that are both statistically significant and 3 points in magnitude or larger. The 3-point criterion was selected because a difference of this size is considered to be of moderate magnitude (Paddison et al., 2013).

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